The Mental Health Bill and the criminal justice system

Tim Spencer-Lane and **Andy Bell** argue that extended provisions for orders for compulsory mental health treatment through the courts would not be in the best interests of human rights or beneficial treatment.

People with mental health problems who come into contact with the criminal justice system are extremely vulnerable. They are often dealt with by organisations (the police, the criminal courts, possibly prison) which do not specialise in mental health. They also account for a significant proportion of those subjected to compulsory treatment under the *Mental Health Act 1983*. The way in which mental health law deals with the criminal justice system has not been subject to detailed scrutiny or public consultation since 1992 (Dept. of Health and Home Office, 1992).

When the Government first decided to review the *Mental Health Act* it set up an expert committee. Its report, in 1999, did not consider criminal justice issues and instead recommended that an independent body should be created to carry out a rigorous and comprehensive review. However, despite the time that has elapsed since, this has not occurred. Instead, the Government has pushed ahead with plans to reform mental health law by introducing a new *Mental Health Bill*.

The major change in the Bill, which we believe to be its fundamental flaw, is the new broad definition of mental disorder coupled with wider and less flexible conditions for compulsory treatment.

Part 3 of the current draft of the *Mental Health Bill* (published last year) deals with patients in criminal proceedings. Anyone who has attempted to read this part of the Bill will know that the provisions are highly complex, difficult to read and at times impenetrable. This view was shared by the Joint Parliamentary Scrutiny Committee which considered the draft Bill. It warned that the consequence of such confusing drafting could be that the final Act would be subject to litigation in which the courts would be asked to rule on the interpretation of the legislation. They recommended that the Government give serious consideration to improving the drafting so that Part 3 can be more easily understood.

Large parts of the *Mental Health Bill* replicate the provisions of the 1983 Act. There are bail and remand provisions which give magistrates and Crown Courts powers to remand to hospital defendants suspected of having a mental disorder. There is also a welcomed new power for the court to remand on bail for a mental health report, which will hopefully remind courts of less restrictive alternatives to remanding to hospital. The Bill also sets out three types of sentencing disposals available to courts. They include a Mental Health Order, which could impose the provision of compulsory treatment in hospital or in the community. The Bill also replicates the Home Secretary's powers in the 1983 Act to direct the transfer of remanded and sentenced prisoners to hospital for treatment.

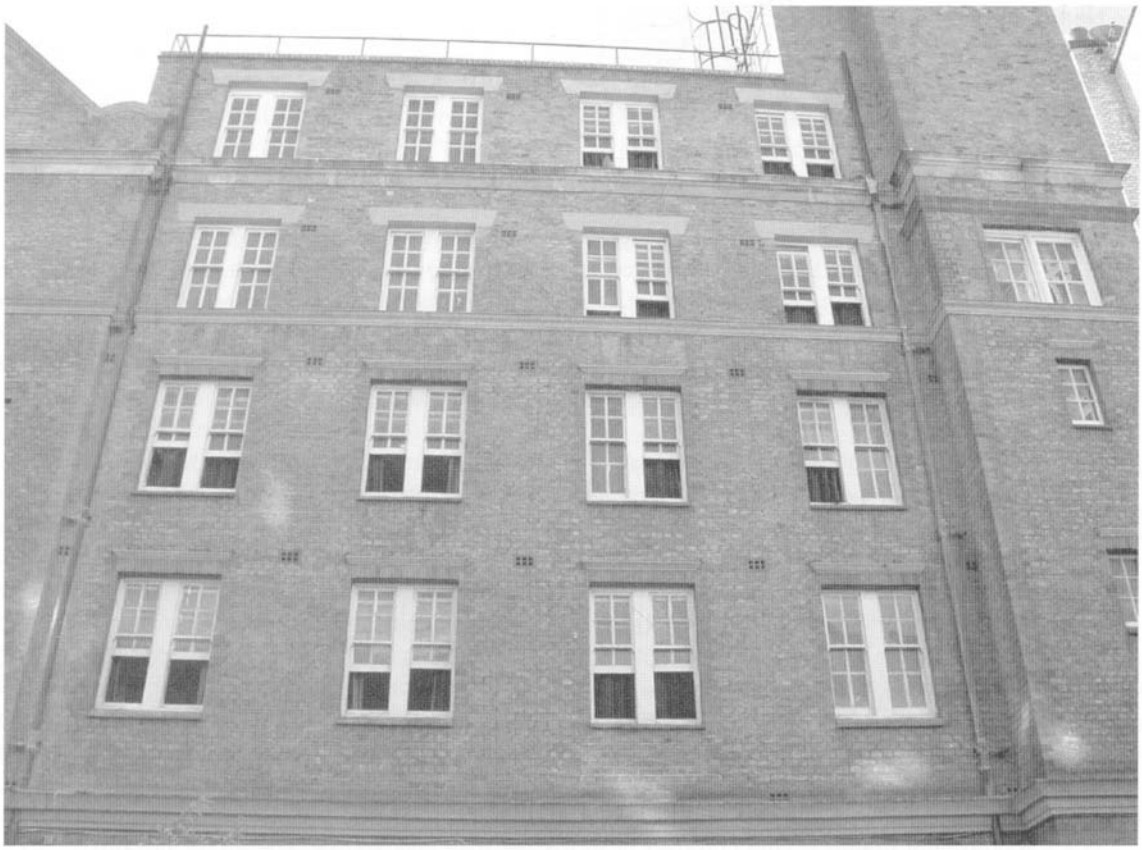
However, the major change in the Bill, which we believe to be its fundamental flaw, is the new broad definition of mental disorder coupled with wider and less flexible conditions for compulsory treatment. We believe that this is likely to lead to a significant increase in the numbers liable to compulsion across the board.

It is under criminal justice, where the conditions for compulsion are even wider than for civil patients, that this increase is likely to be most evident – particularly in under-resourced forensic mental health services. So for instance a person with a mental health problem who appears before the magistrates' courts could be placed on a compulsory order if it appears that it is 'appropriate' for him to have medical treatment, that it is warranted, and that treatment is available. The court would not even have to be satisfied that compulsion was the only way to treat a patient and treatment would not have to be necessary to protect the patient or others from harm.

The Mental Health Alliance is a coalition of some 75 organisations working together to secure a better Mental Health Act. Its members believe that there must be tight and specific conditions for the use of compulsion in the mental health system, whether the patient is involved in criminal proceedings or comes under the civil system. For example we believe that compulsion should not take place where the patient has capacity to make decisions and that any treatment proposed should provide a *therapeutic benefit* to the patient. This would provide the patient with greater safeguards against the unnecessary use of compulsory treatment and would not leave psychiatrists with an invidious role of management when no useful treatment is available: a function better suited to the criminal justice system than to the NHS.

The Alliance is also extremely concerned about the role of criminal courts in approving care and treatment plans. The Bill proposes that when making a Mental Health Order the court will have to approve a care plan for the patient and will have the power to make modifications to that plan. The care plan could authorise compulsory medication in hospital or could set out a regime of care in the community.

We do not believe that judges and criminal advocates have the necessary experience or expertise needed to assess a psychiatric care plan. This would place huge demands on staff time and cause major disruption to court lists. A much better way would be for courts to be given the job of determining whether the legal grounds for detention are satisfied and if so, referring the case to the proposed new Mental Health Tribunal



to decide on the care plan that the mental health team draws up.

The Bill also allows the Crown Court to issue Restriction Orders, which already exist under the 1983 Act, if it believes this is necessary to protect the public from serious harm. One effect is that the patient cannot be transferred or granted leave without the consent of the Home Office. The Alliance would like to see the power to order transfers and leave of absence extended to the Mental Health Tribunal. The problem of restricted patients being detained in inappropriately high conditions of security is well documented. Transfer from high to medium security is an essential precondition of discharge and yet the Tribunal, which has the power to discharge a Restriction Order, would be unable to authorise this precursor to discharge. Giving the Tribunal this power would ensure that the Bill provides an enforceable right to treatment in the least restrictive environment. Although the primary purpose of the Tribunal is to protect the patient, it also has experience and expertise to undertake risk assessments which balance this with the need to protect the public.

In addition to the provisions relating to mentally disordered offenders, the Bill also includes proposals relating to people with mental health problems who come into contact with the police. The Bill includes powers, which already exist under the 1983 Act, for the police to remove to a place of safety a person found in a public place who appears to be suffering from a mental disorder. Too often the place of safety is a police station rather than a hospital. A police cell is not a therapeutic environment for someone experiencing mental health problems and could delay the provision of effective treatment. This is particularly worrying given that research consistently shows that this power is disproportionately used to detain people from Black communities. We believe that the Bill should include a requirement that the place of safety must, wherever possible, be a psychiatric hospital. Where this is not possible there must be clear time limits within which to arrange an assessment and/or transfer of the person to hospital. We would also like to see a 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 Bill also proposes an extension of police powers to allow a constable to enter premises and remove a person who is believed to be suffering from mental disorder, without a warrant. This must be based on the evidence of a single mental health professional and allows detention at a place of safety for up to six hours. We strongly oppose this extension of police powers since 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. We are concerned that this power may be used simply to avoid the trouble of obtaining a warrant. The police already have powers to intervene where a crime has been committed or if there is a risk to 'life and limb' or serious damage to property. We also fear that this power will be disproportionately used against African and Caribbean communities who are already subject to over policing.

The new *Mental Health Bill* is due to be published in this session of Parliament. The Government's response to the scrutiny committee report earlier this year suggests that it is set to reject may of the committee's recommendations and bring forward proposals that closely resemble those in the two drafts. It is essential that criminal justice professionals and agencies play their part in debating and, where necessary, standing up against those aspects of the Bill that affect them. The risk otherwise is that we are left with poor legislation that creates conflict and confusion for many years to come. ■

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Reference

Department of Health & Home Office (1992) *Review of Health and Social Services for Mentally Disordered Offenders: Final Summary Report* (Reed Report) (Cm 2088). London: Stationery Office.