Chapter 2

Legislation Relevant to the Management of Violence by Persons With Mental Disorders

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Introduction

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

The legislative and ethical framework and guidance regarding children and adolescents is discussed in Chapter 13.

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, to manage the immediate risk of further violence or to 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 and the Mental Capacity Act (Northern Ireland) 2016.

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 United Kingdom 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.

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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 to 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]) [1].

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 maintain public safety [2].

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]) [3].

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 private correspondence (letters, telephone calls, emails, etc.), certain restrictions exist. Relevant exclusions include public safety, prevention of crime, protection of health or morals and the protection of the 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

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legitimate, such as reducing the risk associated with a person's mental disorder and improving their health.

Mental Capacity Act 2005

England and 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]) [3]. 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.

The Mental Capacity Act and an evaluation of 'best interests' are both relevant when considering the legality of administering rapid tranquillisation to a patient who is refusing treatment or lacks capacity to consent to treatment. Subject to the Mental Health Units (Use of Force) Act 2018, sections 5 and 6 of the Mental Capacity Act provide a defence against liability in relation to acts such as restraining mentally incapacitated adults using reasonable force or giving them medication without consent which is necessary in their best interests. Where treatment or restraint is necessary not because it is in the patient's best interests but for the protection of others, defence would come from the common law doctrine of necessity.

The procedure for determining the best interests of a person with impaired capacity is laid down in section 4 of the Mental Capacity Act. This takes into account any valid advanced decisions and statements, the patient's past and present feelings, beliefs and values likely to influence their decision, and any other factors which they would be likely to consider if able to do so. If practicable and appropriate, the views of anyone named by the patient, such as a carer or person interested in their welfare, must also be consulted

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'. 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)' [4].

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. This is currently carried out by

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Deprivation of Liberty Safeguards (DoLS) from the appropriate supervisory body, but this will be replaced by a new scheme, the Liberty Protection Safeguard Scheme (LPS), which was due to come into force in April 2022. On 16 December 2021, the Department of Health and Social Care announced that this implementation date could not be met, given the impact of the pandemic. A new implementation date has not been set. The key changes that will be introduced by the LPS are:

- Three assessments will form the basis of the authorisation of the LPS: mental capacity assessment, medical assessment, necessary and proportionate assessment.
- Greater involvement for families: there will be an explicit duty to consult those caring for the person.
- Best interest assessors (BIA) to be replaced with approved mental capacity professionals (AMCP). This will mean that LPS will become everybody's business and assessments will form part of routine care-planning considerations.
- LPS scheme extending to 16- and 17-year-olds.
- LPS scheme will extend to domestic settings, residential schools, day services and commuting from one place to another without the need for a court order.
- Clinical commissioning groups (CCGs)/integrated care systems (ICS), NHS trusts and local authorities as responsible bodies. The LPS creates a new role for CCGs/ICS and NHS trusts in authorising arrangements.

It should be noted that both DoLS (and the LPS in the future) 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. The interface between the Mental Capacity Act and the Mental Health Act continues to cause confusion, with a lack of 'clarity and consistency' both in practice and in research [5].

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 [6]. 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 maintained for as long as is necessary and should 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

The Mental Capacity Act (Northern Ireland) 2016 was enacted by the Assembly in May 2016. The first Phase of the Act came into operation in two stages: research provisions commenced on 1 October 2019, and provisions in relation to deprivation of liberty, offences, and money and valuables in residential care and nursing homes commenced on 2 December 2019. The Act provides a statutory framework for people who lack capacity to make a decision for themselves and for those who have capacity now but wish to prepare for

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a time in the future when they lack capacity. Restraint and detention amounting to a deprivation of liberty are closely interlinked as they relate to compulsory limitations to a person's liberty. Restraint is not covered by the first phase commencement of the Act. However, restraint that is ongoing, planned or regular will most likely be regarded as deprivation of liberty [7].

Mental Health Act 1983

England and 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 patient [8].

The Act requires appropriate medical treatment to be available to a patient in order to meet the criteria for section 3 detention or a community treatment order (CTO) as defined by Section 145 [1] and Chapter 23 of the Code of Practice. 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 [6].

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 26: 'Safe and therapeutic responses to behavioural disturbance'. Recommendations include suitable assessment for potential risk of violence, identification of warning signs, de-escalation, control and restraint, and seclusion policies [6].

Community treatment orders – CTOs have been in place for some years in the USA, Canada, Australia and New Zealand. They were introduced in Scotland in October 2005, and in England and Wales in November 2008. Under a CTO, 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 CTO, requiring them to comply with certain conditions. Patients have to be considered for a CTO if they are receiving more than seven days of home leave under Section 17, and if a CTO is not implemented then the responsible clinician must document the reason for not doing so. Equally responsible clinicians must not discharge patients onto a CTO prematurely before there is good evidence, including trials of section 17 leave, that demonstrates that the patient is sufficiently stable, and that the use of a CTO is appropriate and workable. A CTO can only be imposed on a patient 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 may eventually have to be compulsorily readmitted to

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hospital. The aim of a CTO is to maintain stability and reduce the risk of relapse through the use of conditions that ensure the patient receives the 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. Recall to an outpatient facility, as well as to a designated hospital, is legally permitted, but other than to consider renewal of a CTO under Section 20 or to allow an assessment by a SOAD, recall to an outpatient facility is usually an impracticable approach as the patient may require inpatient care, and transporting the patient safely from an outpatient to an inpatient facility may prove problematic. The use of a CTO is further described in Chapter 29 of the Code of Practice [6].

Before the advent of the CTO, 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 (although longer term Section 17 leave is still indicated in some cases the majority of Section 17 leave is now mostly short-term leave) and enables patients to receive care in the community where it cannot be provided by the use of compulsory powers. 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, 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.

Are CTOs Effective?

The benefits of CTOs have long been questioned and evidence for their effectiveness is small [9].

Three randomised controlled trials [10–12] have failed to show any benefits of CTOs in reducing the primary outcome measure of readmission to hospital, reduction in clinical symptoms or use of services. CTOs also fail to show improvement in secondary outcome measures such as quality of life, substance abuse, employment and satisfaction with services.

Meta-analyses have failed to support benefits of CTOs in terms of readmission, social functioning or symptomatology [13, 14]. Burns et al.'s follow-up of their OCTET study [15] found no evidence that CTOs improved readmission outcomes or reduced likelihood of disengagement from services in patients with psychosis over 36 months. Readers should note that the OCTET trial has been criticised by some, including David Curtis [16] who robustly states that 'OCTET does not demonstrate a lack of effectiveness for community treatment orders' arguing that 'the patients studied were not those who might have benefited from a CTO and that the psychiatrists involved were unlikely to have used the provisions of a CTO assertively'.

Are CTOs effective in reducing risk of violence to others or of homicide? The answer appears to be 'yes' when compared to no action, but 'probably not' when compared with good community mental health care. The difficulty in predicting a risk incident is acknowledged and there is no reliable way of calculating exactly how many homicides might be prevented by a CTO. It has also been suggested that thousands of people may have to be placed under compulsion in the community to prevent one homicide [17, 18]. 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

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been in contact with the psychiatric service, mandatory since 1994, have commonly cited non-adherence to medication as one factor leading to the incident [19]. In such cases it is possible that, had the individual been under a CTO, they may have adhered to their treatment regime, potentially averting a homicide, but in the absence of other evidence this remains speculative.

Despite a lack of evidence of their effectiveness, CTOs continue to be used. They are perceived as useful in clinical practice and they remain a less restrictive alternative to compulsory admission to hospital. In justifying the use of CTOs, supporters also point towards the limitations of randomised [20, 21] and non-randomised controlled studies [22].in evaluating CTOs and, in particular, the inability of randomised trials to recruit representative patients [23].

Continued 'targeted' use of CTOs is supported by the government's independent review of the Mental Health Act [24], the summary report of which states: 'During the course of the Review we have become convinced that there are some service users for whom, despite our doubts, the CTO does play a constructive role. For these reasons we do not propose their abolition at this stage' (p. 28).

The report acknowledges that CTOs are 'significantly overused' and that the authors would like to see a 'dramatic reduction' in their use, hence a recommendation that the criteria for CTOs should be tightened and that it should be made particularly difficult to extend a CTO beyond two years without a compelling reason.

Whilst the debate continues and CTOs remain available, clinicians must ensure that they are only considered for use with patients for whom they were originally intended – namely, those with severe mental illnesses, an established history of non-adherence with medication and disengagement from services, and for whom the use of a CTO is proportionate to the risks associated with the patient's history and presentation. It is also important to regularly review whether a CTO is indicated, and CTOs should only be continued if use has demonstrated benefit.

Additionally, when considering conditions of a CTO, clinicians must also consider representations from victims who may be involved with or connected to the patient. The responsible clinician must inform the hospital managers if the patient comes within the scope of the Domestic Violence, Crime and Victims Act 2004. Information-sharing with victims is discussed in Chapter 18.

Consent to Treatment and Community Treatment Orders

Consent to treatment regarding CTOs is discussed in Chapter 6.

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 can be indefinite, it may be lifted by the Secretary of State when the order is no longer considered necessary for the protection of others.

Review of the Mental Health Act

In October 2017, the government announced an independent review of the Mental Health Act 1983. The review was tasked with making recommendations for improvements 'in relation to rising detention rates, racial disparities in detention, and concerns that the act is

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out of step with a modern mental health system'. The review team were asked to look at both legislation and practice.

On 1st May 2018, an interim report was published which summarised the work to date and outlined emerging priority areas. The review's final report was published on 6 December 2018 and makes a total of 154 recommendations. The review proposes the following principles:

- Choice and autonomy: Ensuring service users' views and choices are respected
- Least restriction: Ensuring the act's powers are used in the least restrictive way
- Therapeutic benefit: Ensuring patients are supported to get better so they can be discharged from the act
- The person as an individual: Ensuring patients are viewed and treated as rounded individuals

These four principles form the basis for the 154 recommendations set out by the review. The following section summarises those proposed actions.

Of the 154 recommendations, there is frequent reference to the criminal justice system. A large number of recommendations are made by the review relevant to the provision of care of service users in the criminal justice system, and in part relate to the powers of magistrates' courts and tribunals. Further, it is recommended that prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act. In addition, it is recommended that a new statutory, independent role should be created to manage transfers from prisons and immigration removal centres. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days [24].

Scotland

Mental Health [Care and Treatment] (Scotland) Act 2003 – The key differences between this Act and the Mental Health Act have been described elsewhere [25]. 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 – The sentence of Imprisonment for Public Protection (IPP) was created by the Criminal Justice Act 2003 and implemented in April 2005. Similar arrangements were legislated for in Northern Ireland by the Criminal Justice (Northern Ireland) Order 2008. The legislation is not specific to mental health patients, but it may be applied to offenders with a mental health disorder. 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

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must serve before being considered for release. After release they are subject to recall if they breach the terms of their licence.

In England and Wales, IPP sentences were abolished in 2012. Those who remain jailed under them can only be freed by a parole board, and at the time of writing there are still more than 1,700 people in prison today serving an IPP sentence without a release date [26].

In Northern Ireland, public protection sentences, such as an indeterminate or an extended custodial sentence, remain sentencing options for adult offenders [27].

Conclusion

Legislation provides a framework when coercion may be necessary to manage violence or the risk of violence. Health professionals should be familiar with the Human Rights Act 1998, mental health and mental capacity acts, and with legal frameworks pertinent to whichever country in the United Kingdom they are working in.

The Mental Health Act Code of Practice offers guidance on when to use the mental health or mental capacity acts and when to use DoLS. Although no definitive date has been given by the government, DoLS are likely to be replaced by Liberty Protection Safeguards (LPS) either later this year or next year.

CTOs should only be considered for patients for whom they were originally intended, namely those with severe mental illnesses or established history of non-adherence with medication and disengagement from services, and for whom the use of a CTO is proportionate to the risks associated with the patient's history and presentation.

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