

Psychological models of mental disorder, human rights, and
compulsory mental health care in the community

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Abstract

Recent amendments to the 1983 Mental Health Act in the UK (Mental Health Act 2007) include the controversial provision for: “*supervised treatment in the community for suitable patients following an initial period of detention and treatment in hospital*”. This provision is widespread, and more formal, in other English-speaking jurisdictions. Reviews of the international literature, human rights considerations and the perspective of psychological approaches to mental health care suggest that proposed ‘supervised community treatment orders’ are valuable, lawful, and compatible with the European Convention on Human Rights if certain specific conditions are met. Provisions for ‘supervised community treatment orders’ in the UK should be supported, but with the provisos that: the powers of the Mental Health Act are limited as in Scotland, to persons whose “ability to make decisions about the provision of [care] is significantly impaired”, that each order is time-limited and subject to review by a properly constituted Tribunal, and that the use of such orders should represent a benefit to people in terms of more appropriate treatment, or be a least restrictive alternative, or better preserve the person’s private and family life.

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Mental Health Legislation

Compulsory mental health care in the United Kingdom is provided under the auspices of the Mental Health Act 1983 as recently amended by the Mental Health Act 2007. This paper, focussing on psychological models and on care in community settings, will not attempt also to offer a comprehensive review of mental health legislation, which can be found elsewhere (see, for example; Bartlett & Sandlands, 2003; Bindman, Maingay & Szmukler, 2003; Szmukler & Holloway, 2000; Fennell 2007). The Mental Health Act 1983 provided for lawful detention for assessment, or for assessment and treatment, of persons “suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment” and when the “mental disorder is of a nature or degree which makes it appropriate for [the person] to receive medical treatment in hospital”.

In the UK, therefore, compulsory treatment was, until the passage of the Mental Health Act 2007, largely restricted to in-patient hospital settings. In-patients may have been given ‘Section 17’ leave of absence from hospital (i.e. permitted under the auspices of Section 17 of the 1983 Act). People detained under restriction orders for criminal justice purposes could also have been offered conditional discharge (Royal College of Psychiatrists, 2004). Using indefinitely ‘long leave’ to extend community compulsion was, however, deemed unlawful in the United Kingdom (*R v Hallstrom ex parte W*, 1985 QB 109d; Dedman 1990). And, whilst people could not, under mental health legislation, be forced to have medication in the community, there remained the possibility for recall to hospital if they did not comply through a fresh application of the relevant legislation for a new episode of care. Service-users certainly believe they will be returned to hospital if they stop their medication (Mind, 2004).

Several comprehensive reviews of international practice have been conducted: by the Scottish Executive (undated: <http://www.scotland.gov.uk/cru/kd01/purple/review01.htm>), by Rolfe (2001) in Western Australia and by Dawson (2005) in New Zealand. (For the purposes of this paper, provisions will be generally referred to in shorthand as CTOs). New Zealand, most Australian and Canadian States and many States of the USA have forms of community treatment orders (CTOs) (see the Scottish Executive report and Torrey & Kaplan, 1995). Not only does the law differ between these jurisdictions, but varies between States of the USA, and details of implementation of the relevant legislation can vary even between counties within the same State (Gerbasi, Bonnie & Binder, 2000).

Within this admittedly variable picture, it is most common for the criteria for CTOs to be the same as those for compulsory inpatient treatment (although in some states of the USA CTOs

focus on risk of deterioration in the absence of treatment rather than imminent danger to self or others). CTOs generally require compliance, but do not provide for force in the event of non-compliance. CTOs are therefore enforced only by return to hospital. In most jurisdictions, CTOs are time-limited and reviewed regularly by quasi-judicial Tribunals.

Some differences emerge in respect to one criterion: in some jurisdictions, all people meeting the general criteria may be provided with either inpatient or outpatient care; in others, there are additional (or different) criteria for non resident orders. These may involve the nature of the person or their problems, and in the case of Saskatchewan, these identify 'revolving door' patients who have previously beneficially received treatment, but relapsed on cessation of this treatment. Anywhere between 1.7 to 52.8 people per 100,000 of the population can be subject to such legislation internationally (Kings Fund, 2004). Clearly, this is a very wide range. Many commentators would be reassured if the UK position were to resemble the lower end of this range, and concerned if the opposite were true (Mental Health Alliance, 2005).

The reviews of CTOs conducted in New Zealand and Australia conclude that CTOs appear preferable to alternative legal frameworks amongst people who have been subject to them, many of whom later agree they were required (see Rolfe, 2001; Dawson, 2005; Gibbs, Dawson, Ansley & Mullen, 2005). It is unclear whether compulsory treatment orders increase compliance with treatment or alter patterns of health service use (see Rolfe, 2001; Dawson, 2005). It is equally unclear whether CTOs lead to significant improvements or even changes in clinical outcome for clients (Rolfe, 2001; Dawson, 2005), although it must be remembered that there are many legitimate reasons for preferring a structure of mental health legislation with the provision for CTOs other than clinical outcome. At the risk of pre-empting the conclusions of this paper, these could include human rights benefits, benefits for the relatives or carers of people with mental health problems, or improvements in functional outcome in addition to clinical or symptomatic outcome.

Compulsory mental health care occurs in a considerably less clear legislative framework in Britain than in Australia and New Zealand. However, research has indicated that compulsion has helped people maintain contact with health professionals (Atkinson, Garner, Dyer, & Gilmour, 2002; Canvin, Barlett, & Pinfold, 2002). These conclusions may surprise some, especially in the UK, who believe such community treatment provisions to be simply wrong. It may be that people's opinions of CTOs depend on how and what basis such CTOs are administered, and what kinds of care packages are delivered.

Amendments to the UK law

The Mental Health Act 2007 is now law. The changes it introduced are controversial, and include the provision for: "supervised treatment in the community for suitable people following an initial period of detention and treatment in hospital". In these amendments to the Mental Health

Act 1983, the criteria for the application of CTOs are simply those that apply to conventional detention. These criteria, in turn, have been slightly amended to become: “the patient [...] is suffering from mental disorder [with specific caveats in the case of learning disabilities] of a nature or degree which makes it appropriate for [the patient] to receive medical treatment in a hospital; [and] it is necessary for the health or safety of the patient or for the protection of other persons that [the patient] should receive such treatment and it cannot be provided unless [the patient] is detained under this section; [and] appropriate medical treatment is available for [the patient]”. In this context, the 2007 Act makes it clear that “references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case”, that such ‘medical treatment’ includes “psychological intervention”, and that any reference to medical treatment “shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations”.

The mechanism by which CTOs are introduced comes about because, under amendments introduced by the Mental Health Act 2007, Responsible Clinicians (the senior clinicians taking the roles previously described as a ‘responsible medical officer’) may “by order in writing, discharge a detained patient from hospital subject to his being liable to recall”. This means that the clinical care plan, sanctioned by the legislation and subject to the necessary criteria, is still in force, but the person can be discharged from hospital – the compulsion remains, the care plan remains, the authority of the Responsible Clinician remains, and (importantly) the legal criteria are unchanged... but the person is not required physically to remain in hospital accommodation. Tribunals (meeting subsequent to the initial clinical decision to detain a person for treatment or to be discharged from hospital) will review individuals’ cases and decide whether to repeat or alter the assessment or treatment order. Such orders are therefore time-limited. These Tribunals include the provision for legal representation and indeed independent advocacy. The Responsible Clinician will have a duty to review at all stages the appropriateness of resident or non-resident care. It will be possible for CTOs to be rescinded either by the Responsible Clinician or by the Tribunal, and all treatment, whether in-patient or in the community, must be ‘clinically appropriate’ to be lawful (see above).

On the basis of international statistics (taking a mean figure of 21.7 per 100,000 population) it is estimated that some 11,300 people in England and Wales could be subject to a community-based order (Kings Fund, 2004). The Kings Fund estimate that between 200 and 300 mentally disordered offenders might also be placed on supervised community treatment orders from within the criminal justice system. Such persons may be people transferred from prisons following the development of severe mental disorder, people awaiting trial or people found not guilty of crimes by virtue of diminished responsibility. Clearly, these people all pose different

issues, and all raise significantly different issues than do civil patients. Clearly also, any decisions to discharge people in these circumstances from in-patient hospital care to CTOs would be a matter for Courts and judicial authorities in addition to clinical staff.

Concerns over CTOs

CTOs and other forms of mandatory outpatient treatment remain controversial, with wide ranging concerns that they represent fundamental infringements of a person's civil liberties (Burns & Goddard, 1995; McIvor, 1998). Commentators (e.g. Mental Health Alliance, 2005) have suggested that CTOs may increase stigma and that appropriate monitoring and assessment may be very difficult in the community, potentially invalidating their rationale. The debate on the appropriateness of compulsory treatment in the community addresses a volatile mix of clinical, social policy, legal, and philosophical issues. O'Reilly (2004) lists several arguments concerning CTOs.

[TABLE 1 HERE]

Psychological perspective

The 'mediating psychological processes model' of mental disorder (Kinderman, 2005), proposes that biological and environmental factors, together with a person's personal experiences, lead to mental disorder through their conjoint effects on psychological processes. In this approach, disruption or dysfunction in psychological processes is a final common pathway in the development of mental disorder. Kinderman (2005) briefly outlined some of the implications of such a model for health service policy and for research. Kinderman and Tai (2006) extended this discussion to clinical practice.

One implication of such a psychological perspective is that the distinctions between "well", "ill" and "personality disordered" are unsupported. And if, as the mediating psychological processes model suggests, mental disorder is not "illness", there is no expectation that people with mental disorder should be patients in hospital. From a psychological perspective, the proper care for people with mental disorder would be planned around psychological formulations rather than diagnoses (Kinderman, 2006; Kinderman & Tai, 2006). In this context, in-patient medical care assumes a rather different perspective, and it is likely that the most appropriate care plan will occasionally be treatment in the community.

Developments in services and professional practice follow this model. Psychosocial therapies are now recommended for a wide range of problems, including schizophrenia and bipolar disorder. Demands for psychological and psychosocial therapies (Mental Health Foundation, 2000), increased patient choice in wanting greater access to talking therapies (Department of Health, 2006; Sainsbury Centre for Mental Health, 2006), and the socio-economic

arguments concerning improving access to such therapies (Layard, 2006) all mean that this trend is likely to continue.

The central issue is therefore best rendered not as the question “What is medically proper in the case of this illness?” but as “What does the person need; what care best meets their needs?” From a psychological perspective, they may well benefit from something other than in-patient hospital care. Psychological approaches to case formulation attempt to reflect the disruptions or dysfunctions of psychological processes that transpire across diagnoses, but also acknowledge both the multiple causes of such dysfunction and the wide range of possible effective interventions. It follows that these approaches do not reject the role of medication or rule out the use of residential or in-patient care.

Human Rights

Psychologists have argued (Kinderman, 2004) that human rights reflect formalised systems for ensuring that people’s basic needs are satisfied, and are the codifications of how we collectively understand our relationships and obligations to each other (Doise, 2003). The application of human rights considerations to mental health care arises in several areas. The UK Human Rights Act 1998, the European Convention on Human Rights (ECHR) and the very recently-ratified United Nations Convention on the Rights of Persons with Disabilities 2008 are, in part, tools to ensure that services are delivered according to the FRED principles – of fairness, respect, equality and dignity (Kinderman & Butler, 2006).

Article 3 of the ECHR (and therefore of the Human Rights Act 1998) states that “*no one shall be subjected to torture or to inhuman or degrading treatment or punishment*”. Despite the fact that a very great deal of such mental health care is perceived by a very large number of people to be degrading and inhumane (Sainsbury Centre for Mental Health, 2005; Mind, 2004), and the fact that several recent legal cases have invoked Article 3 in this context, this issue does not appear to have impacted greatly on the day-to-day experience of patients. One complicating argument here is that a treatment considered degrading (for example experiencing medication applied through physical force) is lawful if it is necessary. Nevertheless, it seems reasonable to expect a far greater variety of non-degrading treatment options to be available than are in fact observed.

ECHR Article 5 states that “*everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law...*”. Clause (e) addresses “*the lawful detention of ... persons of unsound mind...*” etc. This Article has quite wide applicability and is of key importance in the context of compulsory mental health care. It explicitly allows for exemptions in the case of persons “*of unsound mind*”. This term is not defined in the Human Rights Act, but case law some 24 years old has referred to people with “*real illnesses*” (Winterwerp v. The Netherlands (Article

50) - 6301/73 [1981] ECHR 7 (27 November 1981)). Although, since 1974, the 'Winterwerp' judgement has been reinterpreted, extended, qualified and extensively discussed (see Perlin, Gledhill, Treuthart, Szeli & Kanter, 2006), the basic tenets have remain unchanged – that 'unsound mind' is defined in law and psychiatry as being in some manner equivalent to being diagnosed with a (severe) "real" mental "illness". This conceptualisation, as we shall discuss below, is certainly not universally accepted, and this is a serious problem for all mental health legislation.

Article 8 affirms that "*everyone has the right to respect for his private and family life, his home and his correspondence*" and "*there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*". Article 8 therefore is also of key importance in the context of compulsory mental health care.

Human rights and CTOs from a psychological perspective

Many of the apparent objections to CTOs are in essence objections to compulsion *per se*. Moncreiff and Smyth (1999) and McIvor (1998) suggest that tolerance means recognising that sometimes people will not do what others feel is best for them. In these circumstances, they argue, psychiatrists should respect individuals' decisions and be prepared to help manage the consequences such as providing care during relapses. This argument, although valid, applies to all forms of compulsory mental health treatment. There are more limited questions concerning the relative merits of CTOs over hospital based orders. Care should be taken to separate questions as to the balance between autonomy and care on the one hand (which speaks to compulsion *per se*) and the relative merits of treatment in the least restrictive environment and the avoidance of unnecessary interference with a person's civil liberties (which speaks to the more restricted issue). Opposition to compulsion in the community is not universal. Appelbaum and Thomas (1979) and more recently Schmidt and Geller (1989) emotively termed the preservation of liberty at the expense of the provision of care as 'rotting with your rights on'.

Some service user organisations and voluntary organisations representing service users are opposed to CTOs in principle. They believe that to bring coercion into community mental health care is misplaced (Mental Health Alliance, 2005). However, as outlined above, *de facto* compulsion in the community already occurred in the UK before the passage of the Mental Health Act 2007, albeit poorly regulated by statute (Heginbotham, 2004). It has also been suggested that CTOs will "tend to add further coercion to the existing inpatient coercion" (Hoyer & Fernis, 2001) and 'widen the net' (Bean & Mounser, 1994). Concerns have included (Mental Health Alliance, 2005, Winick & Kress, 2003; O'Reilly, 2004): that coercion is a pernicious and pervasive tendency

in mental health care which could impact most on people from black and minority ethnic backgrounds and that it may be difficult to revoke a CTO, perhaps because of clinical defensiveness, or perhaps to establish adherence to treatment plans. Some service users also fear that CTOs will increase their chances of being compulsorily detained if they disagree with the treatment recommended by their psychiatrist. Finally, it is suggested that the necessary reliance on hospital provision in compulsory care provides an effective limit on the numbers of people subject to coercion whereas CTOs yield no resource limit to the use of that coercion.

As introduced in the UK via the Mental Health Act 2007, however, there is only a single set of criteria for the provision of compulsory care. People not already subject to the powers cannot be at risk of falling under the provisions. In the new UK legislation, CTOs are also time-limited and reviewed by Tribunals and it will be unlawful to continue with a CTO if such a plan of care is considered not to be 'clinically appropriate'. For psychological approaches, moreover, the issue of clinical appropriateness is more valid than a question of illness. Psychological approaches do not tend to base treatment decisions on the basis of illness or indeed on symptomatic presentation, but on the functional consequences of any distress or psychological dysfunction. Although, clearly, any criteria must be robust, unitary, and set at a high threshold, the unitary set of criteria in the Mental Health Act 2007 is psychologically valid.

It has been argued that the introduction of provisions for CTOs in the UK could permit a pernicious general increase in coercion. Many commentators (Mental Health Alliance, 2005; O'Reilly, 2004) point out that such an increase occurred in Australia following the introduction of CTOs. If the proposed changes are introduced, such issues should be tested through monitoring the overall number of uses of the Mental Health Act. If the number of overall uses of the Mental Health Act were to rise, perhaps by simply adding the CTOs to the overall total, there would be real fears of human rights violations. Surely what we would all hope for is a decrease in the number of hospital admissions and reductions in lengths of stay. Still, the relative benefits of appropriate care as opposed to no care at all (Schmidt & Geller, 1989) would need to be considered. Applying a specifically psychological approach to this issue may also have advantages. Coercion is clearly distressing and difficult for all parties. Many psychologists claim, however, that decisions made on the basis of behavioural, functional and psychological criteria, as opposed to putative illnesses and their supposed symptoms, may lead to greater clarity and consensus than other approaches (Kinderman & Tai, 2006). While people may reject medical or psychiatric labels and explanations for their own distress and behaviour, they do seem more ready to admit the reality of those two issues within a psychological framework (Kinderman, Setzu, Lobban & Salmon, 2006).

A similar set of arguments have been advanced in respect to "Article 8" rights; that to extend coercion into a person's home life is an infringement of their privacy. Some service users fear the impact on other family members if those family members have to help enforce undesired

treatment. Many service users also state that they regard their home as a sanctuary; a place where they feel safe and where they would hope that mental health services would not reach (Mental Health Alliance, 2005). A counter-argument is that CTOs may allow a 'least restrictive' alternative increasing choice, the likelihood of a clinically appropriate care plan, individuals' autonomy and help maintain family and personal life. If care is needed under compulsion and the individual was eligible for a non-resident order, then it would be inappropriate to require their detention and severance of their private life (leaving residence and family, for example). It is again consistent with a psychological approach that de-emphasises diagnosis and the presence of symptoms and emphasises functional outcomes and well-being – which naturally would include familial relationships and similar aspects of personal life- that such factors should play proportionately more of a role in influencing decision-making.

Evidence from New Zealand and Australia suggests that service users welcome this protection of their family life offered by CTOs (Rolfe, 2001). Perhaps echoing this, the UK Bar Council has suggested that treatment in the community should at least sometimes be preferred and that it is reasonable for additional criteria for inpatient care to be required: *“There should be an additional threshold criteria to the effect that the patient must be treated / assessed as a non-resident patient unless the examiner or Tribunal are satisfied that treatment can only be given in hospital and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient.”* (Bar Council, 2004).

There are widespread concerns that the application of CTOs may be abused. For example, CTOs might be extended for many years (McIvor, 1998), community detention may be seen as an “easy option” for controlling difficult behaviour or people unwilling to comply with treatment plans and it may be disproportionately used with people from ethnic minorities (McIvor, 1998). CTOs have been described as "community control" (Bean and Mounser, 1994) and fears expressed that mental health staff are becoming "parole agents" (Wexler and Winick, 1998) acquiring a policing role (Prins, 1995) with powers constituting an extension of the police powers of the state. It is also feared that CTOs will be used to enforce medication which people would previously have exercised their right to decline and which may have unpleasant, harmful and in some cases irreversible side effects (Bean & Mounser, 1994; Hoyer & Fernis, 2001). This might lead to increased numbers of people on unnecessary long-term medication (Moncrieff & Smyth, 1999) and a decrease in the use of non-medical forms of treatment such as psychological interventions. Careful monitoring of possible abuse is therefore required (Swartz et al. 1995).

There are concerns that the therapeutic relationship developed between service users and mental health workers could be damaged by compulsory treatment (Burns and Goddard, 1995; McIvor 1998). This relationship is central to the effectiveness of care and the development of successful engagement with services. There are fears that “if compulsory treatment is extended to the community, it may be that even patients who are not in fact subject to compulsion

will feel increased coercion in their relationship with services” (Thornicroft, 2000). This issue has a particular resonance for psychologists whose interventions with service users have traditionally relied heavily on the therapeutic relationship as a medium for change. Until recently, psychologists have not been directly involved in imposing compulsory mental health care. Indeed, Smail has said: “what makes [psychologists] different from other professions in the field is ... [that we] ... can't lock them up; we can't drug them or stun them with electricity; we can't take their children away from them. The only power we have is the power of persuasion and this ... more or less forces us into an attitude of respect towards our clients” (Smail, 1993, pp 12-13). Clearly, this relationship could be threatened by compulsion. But, what makes psychologists (and other profession) different from medical practitioners in particular is not only an absence of power but a markedly different framework of knowledge and skills.

Dawson (2005) and Winick and Kress (2003) emphasise that CTOs depend upon the presence of high quality community services (although Dawson also argues against there being a duty on health providers to deliver services as this would create a perverse disincentive to offering CTOs to individuals). All the arguments in this paper are predicted on the basis that high quality services are indeed available. This means the presence of appropriate facilities, well-trained (and motivated) staff, appropriate policies and service governance etc. However, it should also be remembered that in-patient care frequently falls short of acceptable standards (Sainsbury Centre for Mental Health, 2005; Mind, 2004). From a psychological perspective, service users appear increasingly to demand psychological therapies of a variety of forms (Sainsbury Centre for Mental Health, 2006) – a demand reflected in the media (Pidd, 2006). It may be the case that a focus on these psychosocial approaches could help improve services. Not all people need to be in hospital and a general emphasis on community-based respite facilities designed on non-medical principles may have advantages. These could include not only non-medical treatments, but also formulation of people's problems in psychological terms; stressing recovery and change rather than symptoms and cure.

The Canadian Psychiatric Association (CPA) has reported that it believes that mandatory outpatient treatment has benefits in certain clearly defined situations and supports its use if specific legal rights and safeguards are in place (Canadian Psychiatric Association / O'Reilly, Brooks, Chaimowitz, Neilson, Carr, Zikos, Leichner & Beck, 2003). In the UK, the Royal College of Psychiatrists has stated that CTOs may be beneficial for people who have experienced multiple compulsory admissions but on discharge they relapse severely because they fail to follow care plans (Royal College of Psychiatrists, 1997). The British Psychological Society (2004) has welcomed the concept of mental health care based on a care plan rather than a 'diagnose-admit-treat' model and with an acknowledgement of the concerns noted elsewhere and a call for 'robust controls'. They argue that implementing care plans under compulsion in the community may offer a better 'least restrictive alternative' than the present Act, which permits only admission.

Criteria

Article 5 of the Human Rights Act 1998 explicitly allows for exemptions to the right of liberty (in this case from mental health care to which one has not consented) in the case of persons "of unsound mind", although this term remains undefined in the Human Rights Act. The current legal definition of persons of 'unsound mind' relates only to people with "a real illness" (Winterwerp v The Netherlands, 1981). Clearly, the psychological analysis discussed above rejects the notion of "a real illness" especially if as in the Winterwerp case this is then operationally defined as an illness that is attested to by two medical practitioners. Psychiatric diagnosis can be unreliable, especially in the absence of ideal clinical conditions (Kirk & Kutchins, 1994), as is often the case when compulsion is being considered. Diagnosis is also of doubtful validity and fails adequately to reflect the multi-factorial basis of mental disorder (Bentall, 2003). Up to one person in four has some form of mental health problem (Office of National Statistics, 2001). Even if one were to adopt unquestioningly a medical approach to mental disorder and therefore accept the notion of 'real' illnesses, it is unacceptable to imply that one in four of the population can legitimately have one's rights removed on this basis.

In a psychological approach, people are of 'unsound mind' if they are unable to make valid decisions for themselves. In England and Wales it has been widely suggested (see Kinderman, 2001; Royal College of Psychiatrists, 2004) that neither the 1983 Mental Health Act nor the Mental Health Act 2007 are compatible with the Human Rights Act in this respect. In Scotland however, the Mental Health (Care and Treatment) (Scotland) Act, 2003, makes a provision "*that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired*") and in Canada the relevant criteria include that "*the person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder*". In New Zealand and Australia such a criterion is implicit in the criterion of the New Zealand Health (Compulsory Assessment and Treatment) Act 1992, which defines mental disorder as: "*an abnormal state of mind shown by delusions or disorders of mood, perception*", etc. It is important to recognise that a criterion of 'impaired judgment' is not the same as a 'capacity' test. Clearly many people with a range of mental disorders refuse consent to mental health care. They often do so eloquently and coherently, but nevertheless it is fair to conclude that in many clinical situations their judgement is significantly impaired.

These concepts – operationally defining the criteria on which the impairment of judgement can be assessed, and how conclusions can validly be drawn – have been discussed elsewhere. Appelbaum and Grisso (1995) report on the MacArthur Competence studies, which have identified issues such as; ability to communicate a choice, to understand relevant information, to appreciate the nature of the situation and its likely consequences, and to rationally

manipulate information as significant in determining whether a person (for instance a person with mental disorder) can make appropriate decisions concerning treatment choices. It should be noted, clearly, that these concepts are not symptomatic or diagnostic.

In respect to the more limited issue of non-resident versus resident compulsory treatment orders, the provisions of “liberty and security of person” within Article 5 are relatively neutral. If the same criteria apply to both situations and both incorporate the clause above, Article 5 considerations would be limited to the question of whether “liberty and security of person” were relatively more threatened by non-resident or resident orders. In the context of a psychological perspective on human rights and mental disorder people may well need something other than in-patient hospital care. The law should provide for that possibility.

It follows from an application of the mediating psychological processes model that any impairment in judgement should be a consequence of mental disorder, and should be relevant and specific to the issue of agreement in the care plan. Merely disagreeing with a recommendation, even if such a disagreement were foolish, would not constitute relevant impairment. Thus for example, refusal of medication or hospitalisation would not necessarily mean the person was judged ‘impaired’. Such decisions are complex (Schopp, 2001), but it is more than apparent that current medico-legal decisions are at least equally complex and difficult (Spaulding, Sullivan & Poland, 2003). Such considerations are already present in the Mental Health (Care and Treatment)(Scotland) Act 2003 and the Mental Capacity Act 2005. They are the common subject matter of psychological case formulations (Kinderman & Tai, 2006).

Finally, decisions of sanity versus insanity and soundness of mind are present in criminal cases as well as compulsory mental health care. Concepts of illness and wellness are incompatible with a psychological perspective (Kinderman, 2005). It follows, therefore, that related decisions in criminal cases such as questions as to whether an individual is mentally capable of understanding the case, instructing their advocate and entering a plea should equally be based on an assessment of whether the individual’s judgments and understanding are impaired by disruptions of psychological processes. Once again, this psychological concept emerged from the MacArthur Competence studies, in which specific psychological processes were seen to characterise people able and not able to competently stand trial – echoing the competency markers observed above in respect to decisions regarding treatment (Hoge, Bonnie, Poythress, Monahan, Eisenberg & Feucht-Haviar, 1997).

Conclusions

In a comprehensive review of the Australian provisions for community treatment orders (CTOs) Rolfe (2001) reports that “*there seems a general consensus that for particular patients who require particular mental health services and who live in particular places, the CTO is a*

viable option for maintaining people with a mental illness living in the community". Similar conclusions were arrived at by Dawson (2005).

The provision for CTOs appears a valuable and lawful – that is, compatible with the ECHR – component of mental health law, if the following conditions are met:

- i) Any person subject to CTO provision must otherwise be subject to the provisions of the relevant mental health legislation
- ii) These provisions should limit the powers of this legislation to persons unable to make valid consensual decisions concerning their treatment. An appropriate form of words is used in the Mental Health (Care and Treatment) (Scotland) Act, 2003: *"that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired"*
- iii) Each CTO is time-limited and subject to review by a properly constituted Tribunal (which should incorporate provision for legal counsel for patients).
- iv) The use of non-resident, as opposed to resident, orders should represent the most clinically appropriate care plan, should therefore represent a real therapeutic benefit to the individual in terms of more appropriate treatment, or be a least restrictive alternative, or better preserve the person's private and family life, than the resident alternative. The law should provide for that possibility.

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TABLE 1: Arguments for and against CTOs (adapted from O'Reilly, 2004)**Arguments against CTOs**

1. Involuntary or compulsory mental health care is inherently inappropriate or unlawful.
2. People often refuse medications because of side effects or other bona fide reasons.
3. Coercion drives people away from the mental health system.
4. CTOs extend coercion into the community.
5. It is more difficult to protect patients' rights in the community.
6. If we had sufficient services we would not need CTOs.
7. Coercion will be used as an alternative to providing adequate service.
8. People should not be coerced to accept services when there are others willing to accept, but who cannot access, them.
9. Research on CTOs is inconclusive.
10. CTOs will be used to sweep undesirable individuals off the streets.
11. Hospitals will fill up with nonadherent patients.

Arguments supporting community treatment orders (CTOs)

12. Society has a '*parens patriae*' obligation to care for citizens who cannot care for themselves.
13. Lack of awareness of mental illness is a persistent symptom for many patients.
14. Offering services is often not enough when patients lack insight.
15. It is mistaken to assume that physicians can safely manage patients by committing them just at the point they become dangerous.
16. CTOs are a predictable and acceptable consequence of deinstitutionalisation.
17. CTOs are less restrictive than involuntary hospitalization.
18. Research confirms the effectiveness of CTOs.
19. No evidence indicates negative effects of CTOs.