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# *This strange republic of the good*

## Community treatment orders and their conditions

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### Introduction

The Community Treatment Order (CTO) was introduced by the *Mental Health Act 2007*, and from the start, it was controversial. There is evidence that even the principle of community compulsion was opposed by a majority of psychiatrists,<sup>2</sup> and it was said that many would resign rather than implement CTOs. Happily, that prediction has not been realised. In fact, it seems that many psychiatrists, and more than one Approved Mental Health Professional (AMHP), have seized upon CTOs with something approaching alacrity.

In the seventeen months after 3 November 2008, when the changes came into effect, 6,237 CTOs were made; and as at 31 March 2010, there were 4,272 of them still in place.<sup>3</sup> In fact, recent estimates published by the Mental Health Alliance suggest that by the end of July 2010, over 7,000 CTOs had been made and the numbers were still rising.<sup>4</sup> If we consider another set of figures, however, it seems something else is going on.

According to the Mental Health Minimum Dataset, between 1 April 2008 and 31 March 2009, there were about 32,600 detentions under the *Mental Health Act*.<sup>5</sup> That 'headline' figure is virtually the same as in the previous year, but it hides significantly different ethnic trends: while the proportion of detained patients in the 'White' census category fell, by 1.6 per cent, that of 'Black/Black British' patients rose, by 9.7 per cent. Patients in the 'Black/Black British' category accounted for 12.3 per cent of those detained

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  2. Vanessa Pinfold and Jonathan Bindman, 'Is compulsory community treatment ever justified?' *The Psychiatrist* (2001) 25: 268.
  3. The Health and Social Care Information Centre ['HSCIC'], October 2010, 'In-patients formally detained

in hospitals under the *Mental Health Act 1983* and patients subject to supervised community treatment', *Annual Figures, England 2009/10*, pages 4 & 13.

4. Mental Health Alliance, August 2010, Briefing Paper 2 – 'Supervised Community Treatment', pages 2, 5 & 6.
5. HSCIC, November 2009, *Mental Health Bulletin: Third report from Mental Health Minimum Dataset annual returns, 2004-2009*.

in hospital under the *Mental Health Act*. While that might be worrying in itself, it is made more so by the fact that patients in this category represented fully 18 per cent of those on CTOs.<sup>6</sup>

We know that black patients form a greater proportion of the detained than of the general population of the United Kingdom: if they form a still greater proportion of community patients, that is surely an even greater cause for concern. They might, of course, be finding it easier than white patients to gain at least some form of discharge; but equally, they might be finding it harder *absolutely* to gain their discharge.

## Before the CTO

It is clear that community compulsion existed long before the CTO. The Parliamentary committee that scrutinised the Draft Mental Health Bill of 2004 said:

*“In reality, both the 1959 and the 1983 Acts [...] contained ‘back-door’ methods which allowed scope for treating people under compulsory powers in the community.”*<sup>7</sup>

Those ‘back-door’ methods were threefold: guardianship, extended leave and supervised discharge.

Supervised discharge had a relatively brief life. Introduced in 1996,<sup>8</sup> it was abolished by the *Mental Health Act 2007* and disappeared entirely nearly two years ago.<sup>9</sup> A patient on supervised discharge might have been made subject to conditions concerning residence, attendance and access.<sup>10</sup> These were the only conditions that could be applied, and yet a study published in 1998 found that in a third of cases in which supervised discharge was used, the patient was subject to a requirement that he accept medication.<sup>11</sup>

As much as a decade before the CTO, therefore, it seems some clinicians were finding imaginative, if unlawful, ways of bolstering their control of patients in the community. The same might be said of leave, but only to a degree.

In section 17, the *Mental Health Act 1983* says a detained patient may be given leave of absence.<sup>12</sup> Such leave may be granted only by the patient’s Responsible Clinician (RC), and it may be made subject to conditions. The RC enjoys wide discretion in that regard. The *Mental Health Act Code of Practice* says only that the conditions should be “*necessary in the interests of the patient or for the protection of other people*”.<sup>13</sup>

As the Code acknowledges, leave may be granted for lengthy, even indefinite periods of time.<sup>14</sup> In 2005, the *Mental Health Act Commission* said:

*“There is an unknown but probably relatively significant proportion of the approximately 13,500 patients detained under the 1983 Act at any one time whose care and treatment involves significant periods of leave from hospital.”*<sup>15</sup>

6. This would appear to be supported by statistics cited in *Mental Health Act Commission, 2009, Coercion and consent: Thirteenth Biennial Report, 2007-2009*, paragraph 1.36 et seq.

7. *Joint Committee on the Draft Mental Health Bill* [‘Joint Committee’], Session 2004-05, *Draft Mental Health Bill*, HL Paper 79-1, HC 95-1, paragraph 184.

8. *Mental Health (Patients in the Community) Act 1995*.

9. *Mental Health Act 2007* [‘MHA 2007’], section 55 & Schedule 11, Part 5.

10. *Mental Health Act 1983* [‘MHA 1983’], section 25D(3).

11. A Knight, D Mumford and B Nichol, *Supervised discharge orders: the first years in the South and West Region*, *Psychiatric Bulletin* (1998) 22: 418.

12. *MHA 1983*, section 17(1).

13. *Department of Health, 2008, Code of Practice: Mental Health Act 1983* [‘MHA 1983 Code’], paragraph 21.7.

14. *Ibid.*

15. *Joint Committee, op cit*, Ev 13, paragraph 2.36.

Now, of course, if a RC is to give a patient leave for more than seven consecutive days, he or she must first consider using a CTO.<sup>16</sup> That is because of changes made by the *Mental Health Act 2007*, and those changes were themselves prompted by a line of cases on leave of absence. In 1986, the High Court said a patient's detention could not be renewed while he was on leave, and that he could not be recalled to hospital simply to enable renewal to take place.<sup>17</sup> Since then, however, things have gone the other way. In 1999, the Court of Appeal said detention *could* be renewed during leave, provided the treatment contained some elements of in-patient care.<sup>18</sup> And in 2002: the High Court said it was sufficient that a patient was attending the hospital two-days-a-week, for occupational therapy and the ward round;<sup>19</sup> and it upheld the refusal to discharge a patient who was only attending hospital every four weeks, for a ward round and injections.<sup>20</sup>

Reflecting upon this state-of-affairs, Brenda Hale, has asked whether CTOs were in fact necessary:

*"Once the courts had increased the flexibility of long term leave of absence, where was the need to introduce another power to achieve something not quite as effective?"*

She concludes: *"The situation needs to be watched"*.<sup>21</sup>

## Making conditions

Conditions are, of course, a significant element of a community treatment order. Every CTO will have at least two of them: a patient must make himself available for examination, both when the prospect of renewal presents itself and when a SOAD certificate is required.<sup>22</sup>

If a CTO were confined to those mandatory conditions, all would be fine; it is the possibility of *discretionary* conditions that is most troubling. There are civil liberty concerns, of course, but they are apt to be over-stated. If one wanted to make a civil liberties case *for* the CTO, for example, one might seek to draw attention to the bigger picture. Consider, for example, John Stuart Mill, that 'Saint of Rationalism' (as Gladstone called him), who perhaps did most to elucidate the liberal ideal. Mill argued that some of the poor should be prevented by law from having children.<sup>23</sup>

It should not surprise us, therefore, that some have tried to see the good in the CTO. The British Psychological Society, for example, said community compulsion might *"offer a better 'least restrictive alternative' than the [un-amended] Act, which permits only admission"*.<sup>24</sup> Even the Richardson Committee was in favour.<sup>25</sup> The longer-term treatment order the Committee proposed would, of course, have been made by a mental health tribunal. But crucially, it would have been available on an in-patient or a community basis.

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16. MHA 1983, section 17(2A).

17. *R v Hallstrom, ex parte W* [1986] QB 1090.

18. *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* [1999] 1 FLR 106.

19. *R (DR) v Mersey Care NHS Trust* [2002] MHLR 386.

20. *R (CS) v Mental Health Review Tribunal* [2002] MHLR 355.

21. Brenda Hale, 'Mental Health Law', Sweet & Maxwell, 2010, 5th edition, page 252.

22. MHA 1983, section 17B(3).

23. John Stuart Mill, 'On Liberty', 1859, chapter V.

24. British Psychological Society (Ev 594, question 2), quoted in Joint Committee, *op cit*, paragraph 188. Less surprisingly, perhaps, this was also the line of argument adopted by the government (see: Letter dated 17 January 2007, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health, quoted in Joint Committee on Human Rights ['JCHR'], Fourth Report of Session 2006-07, Legislative Scrutiny: Mental Health Bill, HL Paper 40, HC 288, paragraph 55 and Appendix 3).

25. Department of Health, 1999, Review of the Mental Health Act 1983: Report of the Expert Committee, paragraphs 5.105-5.113.

- a) Any conditions would be set out in the order itself, and they would be based on the committee's key principle of reciprocity: the compulsory order would identify "the services which the health or social services NHS Trust or other service provider is required to provide".<sup>26</sup>
- b) The patient would have to reside in a particular place and make himself available for visits by care workers.<sup>27</sup>
- c) The conditions would cut both ways: the Richardson Committee envisaged a "parallel obligation" on the care team to keep appointments.<sup>28</sup>

In fact, the amended Act is a good deal less prescriptive about the conditions of a CTO. We are told that they may only be ones that the RC thinks "necessary or appropriate" for certain purposes. That is a disjunctive test, but it does not posit two equal alternatives: 'appropriate' will always suffice; and whereas something can be 'appropriate' even if it isn't 'necessary', anything 'necessary' is surely also 'appropriate'. So 'necessary' is never actually necessary.

The *Mental Health Bill 2006* was quite specific as to the types of condition that could be added to a CTO:<sup>30</sup>

- a) That the patient reside at a particular place.
- b) That he make himself available at particular times and places for the purposes of medical treatment.
- c) That he receive medical treatment in accordance with the RC's directions.
- d) That he make himself available for examination.
- e) That he abstain from particular conduct.

The Joint Committee on Human Rights was, however, concerned that the parameters were vague; so vague that they might permit conditions that breached a patient's privacy rights.<sup>31</sup> The government's response was to be even less specific.

Now, the permitted purposes are:

- a) Ensuring that the patient receives medical treatment.
- b) Preventing the risk of harm to the patient's health or safety.
- c) Protecting others.<sup>32</sup>

These are pretty broad, and the job of setting limits is left to the Code of Practice. It says, first of all, that the broad statutory purposes are the only ones for which a CTO may be made,<sup>33</sup> and secondly, that they should:

- a) Be kept to the minimum necessary.
- b) Restrict the patient's liberty as little as possible.
- c) Have a clear rationale, linked to one or more of the three permitted purposes.

26. *Ibid*, paragraph 5.106(i).

27. *Ibid*, paragraph 5.106(ii) & (iv).

28. *Ibid*, paragraph 5.106(iv).

29. MHA 1983, section 17B(2).

30. *Mental Health Bill 2006*, clause 25.

31. JCHR, *op cit*, paragraphs 38-58.

32. MHA 1983, section 17B(2).

33. MHA 1983 Code, paragraph 25.31.

d) Be clearly and precisely expressed, so that the patient can readily understand what is expected.<sup>34</sup>

But this fairly loose combination of Act and Code is as prescriptive as the law gets, and it probably would not satisfy the Human Rights Committee. The Committee recommended that any limits on CTO conditions be placed in primary legislation; and that those limits ensure that “provisions for non-residential orders [are] simple and used to specify only: requirements or limitations on a person’s place of residence; and medical treatment”.<sup>35</sup>

The breadth of its possible conditions has, of course, led to the community treatment order being described as a ‘mental health ASBO’.<sup>36</sup>

A question often arises as to whether any discretionary conditions must be agreed by the patient to whom a CTO will apply: It seems they must. There is nothing in the Act to say that, of course, but the Minister did tell Parliament:

“[...] if an individual did not accept the conditions of the CTO, it would not work so there would be no point giving it in the first place. This is not about saying, ‘This is what you are going to do’, with the person sitting there saying, ‘I don’t accept any of that’, because a CTO will not be given if the individual does not accept the conditions.”<sup>37</sup>

That message is reinforced in subsequent guidance (although the Code of Practice speaks not of the patient ‘accepting’ the conditions, but of his “agreeing to keep” them).<sup>38</sup> But what of someone who is in no position properly to register an objection? May an incapable patient ever be put on a CTO? Neither the Act nor the guidance tells us, but the logic of the position – a community patient must both understand and accept what is expected of him – suggests that he may not.

## Challenging conditions

There is no direct way of challenging the conditions of a CTO; not in the legislation, at least. An amendment providing a right of appeal was defeated in Parliament. The government said it was not necessary, because no condition could be made that the patient had not agreed. Concern persists, however, despite the government’s attempts at reassurance.<sup>39</sup>

The Human Rights Committee, for example, has noted that under the 2004 Draft Bill, the CTO, its conditions and, indeed, the treatment plan would have had to be approved by the tribunal. The Committee said the need to obtain AMHP approval would not be a significant safeguard, as the AMHP might not be truly independent of the RC and the clinical team. It recommended that the requirement for any conditions to be proportionate should be enshrined in statute, and that every community patient should have right to have his conditions reviewed by the mental health tribunal.<sup>40</sup>

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34. *Ibid*, paragraph 25.33.

35. JCHR, *op cit*.

36. In fact, this term was used not about conditions, but about the effect of a CTO generally (see: Joint Committee, *op cit*, paragraph 194). It appears first to have been the suggestion of the Wales Branch of Depression Alliance (see: *ibid*, HL Paper 79-III, HC 95-III, Ev 895).

37. Rosie Winterton MP, 10 May 2007, *Hansard*, Public Bill Committee, Session 2006-07, Cols 305-358 at col 334.

38. See, for example: NIMHE, 2008, *Supervised Community Treatment: A Guide for Practitioners*, section B; MHA 1983 Code, paragraph 25.35.

39. See, for example: Letter dated 17 January 2007, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health, quoted in JCHR, *op cit*, paragraph 55 and Appendix 3.

40. JCHR, *op cit*, paragraphs 56-58.

## Deprivation of liberty

It is in the nature of CTO conditions that they dictate the terms upon which a community patient may engage with the world. At the most benevolent level, he will have to visit hospital every so often, and perhaps stay away from the Red Lion on a Saturday night.

Despite the government's best intentions,<sup>41</sup> it is at least possible that community patients will have their liberty restricted, to the extent that we shall have to ask whether, in truth, they are deprived of liberty. The Joint Committee on Human Rights is but one of the organisations that have expressed concern about this.<sup>42</sup> But it is not just in respect of the CTO that such concern now arises.<sup>43</sup> First, there is the ASBO.

There must be a real possibility that a community patient will feel as though he is the subject of an Anti-Social Behaviour Order (ASBO). But the ASBO is apparently, and perhaps thankfully,<sup>44</sup> a thing of the past.<sup>45</sup> Next, however, there is conditional discharge.

The Mental Health Act contains special provisions for people who suffer from mental disorder and are convicted of a criminal offence. If necessary, they can be placed under restrictions in hospital and conditions can be attached to their eventual discharge.<sup>46</sup> The High Court has held that to impose a condition requiring a patient to remain at the hospital from which he has ostensibly been discharged will amount to an unlawful deprivation of liberty,<sup>47</sup> and also, that if they are very strict, even community arrangements might have that result.<sup>48</sup> And then there are 'control orders'.

The Government has long been frustrated by those whom it suspects, but cannot prove, to have been involved in terrorism. The 'control order' is the latest of several attempted solutions and it allows someone to be placed under often stringent conditions. By definition, those conditions cannot engage Article 5 of the Human European Convention on Human Rights, so they must not amount to deprivation of liberty.<sup>49</sup>

The most significant decision was made by the House of Lords. It concerned six men, whose control orders confined them to their one-bedroom flats for all but six hours-a-day; allowed those premises to be searched by the police; restricted the areas the men could visit when out-of-doors and required them to wear electronic tags; limited their use of communications equipment; and prohibited them from meeting anyone not authorised by the Home Office. Their Lordships said those orders breached Article 5 and were therefore unlawful.<sup>50</sup> And finally, there are the DoLS.

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41. See: fn 37.

42. JCHR, *op cit*, paragraphs 56-58. See also, for example: Justice, *Mental Health Bill Briefing for House of Lords Second Reading, November 2006*, paragraph 46, quoted in JCHR, *op cit*, paragraph 53.

43. See: David Hewitt, *New perspectives on the Mental Health Act*, *Solicitors Journal*, volume 152 number 44, 18 November 2008, pages 13 & 14.

44. See: David Hewitt, *Bovered? A legal perspective on the ASBO*, *Journal of Forensic and Legal Medicine* 14 (2007) 355-363.

45. The Right Honourable Theresa May MP, *Moving beyond the ASBO*, speech at the Coin Street Community Centre, London on 28 July 2010.

46. MHA 1983, section 41(1).

47. *R (G) v Mental Health Review Tribunal and the Home Secretary* [2004] EWHC (Admin) 2193.

48. *R (Home Secretary) v Mental Health Review Tribunal* [2004] EWHC 2194 (Admin). In an earlier case, however, similar facts led the court to the opposite conclusion (see: *R (Home Secretary and PH) v Mental Health Review Tribunal* [2002] EWCA Civ 1868). The very recent Upper Tribunal decision of *Secretary of State for Justice v RB* [2010] UKUT 454 (AAC) requires us to take a fresh look at this issue.

49. Prevention of Terrorism Act 2005.

50. *Home Secretary v JJ and others* [2007] UKHL 45. They reached the opposite conclusion where the conditions imposed on a suspect were less robust (see: *Home Secretary v E and S* [2007] UKHL 47; *Mahmoud Abu Rideh v Home Secretary* [2007] EWHC (Admin) 2237).

The Deprivation of Liberty Safeguards (DoLS) are now part of the *Mental Capacity Act 2005*.<sup>51</sup> That Act provides a framework within which all kinds of care and treatment may be provided to people who lack the capacity to consent to it. If such is in his best interests, an incapable person may be admitted to a hospital or care home without recourse to the *Mental Health Act*. The novelty of the DoLS lies in the fact that they might allow the person to be deprived of liberty in that place, but only if official permission is obtained first.

Crucially, conditions can be imposed when such permission is given. There is a discrete code of practice on the DoLS, and it says any conditions might concern “*contact issues*”, “*issues relevant to the person’s culture*” and

*“other major issues related to the deprivation of liberty, which – if not dealt with – would mean that the deprivation of liberty would cease to be in the person’s best interests.”*

There is no equivalent in the DoLS of the bit of the *Mental Health Act* that sets out the permitted purposes of CTO conditions. The DoLS Code does, however, suggest that conditions should not be set “*that do not directly relate to the issue of deprivation of liberty*”. And in an echo of what the *Mental Health Act Code* says about CTOs, the Code also says that any deprivation of liberty conditions “*should aim to impose the minimum necessary constraints*”.<sup>53</sup> Although the DoLS Code also warns that conditions should not be a substitute for a properly constructed care plan, the Department of Health says they are in fact being used in that way.<sup>54</sup>

Of course, DoLS conditions differ from CTO conditions: they are directed at the detainor, not the detained; and, as that language – ‘detainor’ and ‘detained’ – makes plain, they only come into effect where someone is already deprived of liberty; they are not what might deprive him of liberty in the first place. In one way, however, those involved in a DoLS admission are in the same position as those involved in conditional discharge or a control order: they need to know what it means to be deprived of liberty. That is no small thing.

Regrettably, the Deprivation of Liberty Safeguards have no clear idea of that which their name connotes: the legislation is silent on the point and the Code of Practice is only slightly more forthcoming. It says we have to look to the cases.<sup>55</sup> Clearly, that is not just mental capacity cases, but across the board; from conditional discharge to control orders. Yet once we do that, the picture becomes less, not more, clear. The cases say, for example, that although the control order suspects confined to their homes for hours on end *were* deprived of liberty, two females who are locked in their bedrooms over night are not.<sup>56</sup>

For different reasons, then, those who make or are subject to Community Treatment Orders find common cause with people involved in conditional discharge, control orders and the DoLS: they are all doomed to frustration when they try to find out what it means to be deprived of liberty.

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51. MHA 2007, section 50 and Schedule 7; *Mental Capacity Act 2005, Schedule A1*.

52. Ministry of Justice, 2008, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice*, paragraphs 4.74 & 4.75.

53. *Ibid*.

54. Department of Health, April 2010, *The Mental Capacity*

*Act 2005 Deprivation of Liberty Safeguards – the early picture*, paragraphs 17 & 18.

55. For example: *Nielsen v Denmark* (1988) 11 EHRR 175; *HM v Switzerland* (2002) 38 EHRR 314; *Storck v Germany* (2005) 43 EHRR 96; *JE v Surrey County Council* [2006] EWHC (Fam) 3459.

56. *A Local Authority v A, B, C, D & E and the Equality and Human Rights Commission* [2010] EWHC 978 (Fam).

## The Great Confinement

The late, great French theorist Michel Foucault spoke about the ‘great confinement’ of the insane, which swept across Europe in the years of the Enlightenment.<sup>57</sup> It began, Foucault says, in 1656, with the founding, from numerous disparate elements, of the *Hôpital Général* in Paris. It is clear that the reach of that institution exceeded its own perimeter. Responsibility was entrusted to directors, who,

*“exercised their powers not only in the buildings of the Hôpital, but throughout the city of Paris, over all those who came under their jurisdiction.”*

This was, in short, a confinement without, as much as within, these walls, and its subjects were the poor of all kinds:

*“of both sexes, of all ages and from all localities, of whatever breeding and birth, in whatever state they may be, able-bodied or invalid, sick or convalescent, curable or incurable.”*

Thirty-two such schemes had developed in France by the time of the Revolution, and they spread to England, with its workhouses and bridewells, and also to Germany, Italy and Spain.

Foucault tells us that the same walls, walls that surrounded the community, and not just the hospital,

*“could contain those condemned by common law, young men who disturbed their families’ peace or who squandered their goods, people without profession, and the insane.”*

This compulsion, we might conclude, is nearly as comprehensive as the one that gives common cause to those with mental disorder or mental incapacity, restricted patients on conditional discharge and terrorism suspects under control orders; to say nothing of people with ASBOs. Foucault, naturally, has a term for this; he calls it *“the abusive amalgam of heterogenous elements”*.

This great confinement produced something new. For the first time, Foucault says,

*“men were confined in cities of pure morality, where the law that should reign in all hearts was to be applied without compromise, without concession, in the rigorous forms of physical constraint. Morality permitted itself to be administered like trade or economy.”*

This was a manifestation of

*“the great bourgeois, and soon republican, idea that virtue, too, is an affair of state, that decrees can be published to make it flourish, that an authority can be established to make sure it is respected.”*

## Discussion

The Community Treatment Order, then, has proved troublingly popular and maybe, in the manner of both its construction and its use, just plain troubling. Its effect is not, however, entirely novel: leave, and even supervised discharge, have long been used – distorted, maybe – to similar effect.

It will be uncomfortable for those involved with CTOs, and more so for those involved with people who suffer from dementia or a learning disability, to have to calibrate their care according to the restrictions placed on terror-suspects. But that seems to be the way of the world.

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57. Michel Foucault, *The History of Madness*, 2006, Routledge, chapter 2 (full English translation of work originally published in 1961 as *Folie et déraison: Histoire de la folie à l'âge classique*).



Care, in these febrile times, is caught up with custody and, inevitably, security, and we are seeing emerge whole new communities of the confined. Michel Foucault seems to have anticipated this. At the height of the *Nouvelle Vague*, employing the present tense but looking only backwards, he said:

*“In the shadows of the bourgeois city is born this strange republic of the good, which is imposed by force on all those suspected of belonging to evil.”*