

Against Our Will

**Our experience of
compulsory psychiatric treatment in the community
as torture and inhuman treatment
(UK)**

**Speak Out Against Psychiatry
2013**

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Universal Declaration of Mental Rights and Freedoms

That all human beings are created different.

That every human being has the right to be
mentally free and independent.

That every human being has the right to
... feel, see, hear, sense, imagine, believe or
experience anything at all, in any way, at any
time.

That every human being has the right to
behave in any way that does not harm
others or break fair and just laws.

That no human being shall be subjected
without consent to incarceration, restraint,
punishment, or psychological or medical
intervention in an attempt to control,
repress or alter the individual's thoughts,
feelings or experiences.

Adbusters

The Icarus Project

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Abbreviations

CAT: (United Nations) Convention against Torture

CQC: Care Quality Commission

CRPD: (United Nations) Convention on the Rights of Persons with Disabilities

CTO: Community Treatment Order

ECHR: European Convention of Human Rights

MHA: Mental Health Act

SCT: Supervised Community Treatment

Introduction

Speak Out Against Psychiatry

Speak Out Against Psychiatry (SOAP) is a small grassroots group established in 2011. It gathers people in the UK who have used or are still using psychiatric services, as well as our friends, family and allies. Our stated aim is to raise awareness of the abuses inherent in forced psychiatry and to seek protection of our rights and freedoms. We do not pretend any expertise in the law, but we all have an interest in human rights and how these rights apply to us. We are all experts by experience in psychiatry and mental health services, by virtue of being "on the receiving end".

While coercive mental health legislations are on the increase in many countries, the fact remains that, in contrast, society does not and probably would not tolerate compulsion or coercion for its general health users (O'Hagan, 2012). The difference in how users of mental health and intellectual disabilities services are treated is reflective of the mood among many legislators and politicians alike for greater control of populations and a will to force societal conformity. The current savage cuts on welfare benefits in the UK are highly illustrative of this mood. Indeed, the UK Government has repeatedly clearly indicated its will to change the way people conduct their lives, in particular those living on benefits, including the sick and the disabled, with the use of demonising descriptors ("scroungers", "feckless", "lazy" etc.), also repeatedly used in the official rhetoric and echoed in the conservative and populist press, playing on people's fears and frustrations in a dramatic financial climate. The situation is further compounded by a mental health workforce that is increasingly under stress due to cut backs, lack of training, and pervasive conservative perspectives on some wards or services and in the community about psycho-social distress which are not self-reflexive. In fact they themselves often have little insight about the quality (or lack of) of their practice.

Human rights in the UK: The legal context

The UN Convention against Torture (CAT) was ratified by the UK in 1988. Article 2 of the convention prohibits torture and requires states parties to take effective measures to prevent it in any territory under their jurisdiction. States parties must put a stop to all acts which constitute cruel, inhuman or degrading treatment under Article 16 of CAT.

These duties on the UK government are absolute and non-derogable; no exceptional circumstances may be invoked to justify torture or inhuman and degrading treatment. The CAT definition of torture includes "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes ... for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" (Article 1).

The UN Special Rapporteur for Torture Juan Mendez has recently commented explicitly on the occurrence of torture and inhuman and degrading treatment in the context of healthcare. His findings confirm that the United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the authoritative framework in the area of torture and ill treatment with regard to persons with disabilities. Applying the standards of the CRPD, as articulated by the CRPD Committee, he repeats that “medical treatments of an intrusive and irreversible nature intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned”. On this basis, he calls for:

an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short- term application. (Méndez, 2013).

He also demands that states parties repeal any legal provisions that allow confinement or compulsory treatment in mental health settings, insisting that they must:

Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity ... Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided. (Méndez, 2013, para 85(e))

The UN Convention on the Rights of Persons with Disabilities (CRPD) was ratified by the UK in 2008. Despite this groundbreaking advancement in their human rights, persons diagnosed with mental illness or simply in contact with mental health services have continued to be treated under the Mental Health Act 1983 (amended in 2007) which neither conforms nor respects the CRPD. This abuse has been widespread and commonplace.

In this report, we highlight a particular aspect of the incompatibility of this legislation with the binding obligations on the UK under the CRPD, that of forced treatment in the community. All the testimonies in this report come from group members who came forward to contribute to this report. It was not difficult to collect them; almost everyone who has experienced the full force of treatments without free and informed consent has profound misgivings about it. All of us who have used psychiatric services understand that our rights are profoundly and routinely violated by legislation that flouts human rights.

Limitations of this report: this document deals only with England and Wales.

PART ONE: The context

1. The UN Convention on the Rights of Persons with Disabilities (and its Optional Protocol): Current situation in the UK

1.1 Attempts by the UK government to exclude persons diagnosed mentally ill from human rights protections under the UN CRPD

There has been controversy in the UK around whether persons diagnosed with mental illnesses or using mental health services should be defined as disabled and be included as persons with disabilities under the UNCRPD. This is in complete contradiction with the 2010 Equality Act¹ which defines disability thus:

“A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P’s ability to carry out normal day-to-day activities”

The UK Government’s position ignores and contradicts the drafting and negotiation history of the CRPD in which user/survivor organisations were prominent and the views of the CRPD Committee and the Special Rapporteur for Torture who hold that the CRPD is the binding human rights standard in the context of mental health.

The UK Government’s position also contradicts the welfare legislation which has so far recognised mental illness as a condition that can give rise to disability payments. The changes to the benefits system however, coming into force in April 2013, sees the disappearance of “disability benefits” to be replaced by a Personal Independence Payment (PIP) and a Universal Credit system. As the words “disabled”, “disability” are removed from the rhetoric and discourse on disability, therefore on acceptance of diversity in society, the new rhetoric encourages a change in people’s attitudes that embraces a different societal model based on productivity. This move is purely ideological, wishing to stress that people can function irrespective of their disability (i.e. as productive individuals who pay taxes and are not reliant on society; employment being the prime objective).

This will have drastic consequences for anyone with a disability, and possibly greater for persons with psycho-social disabilities who have already started to lose their benefits under the recent changes to the way they are assessed. In this particular respect, the way the UK Government is proceeding is completely counter to its obligations towards users/survivors under the CRPD. In line with the social model of disability promoted by the CRPD, the Government should ensure that users and survivors have the support they need to live independently and be fully included in the community (art 19) and have housing security and an adequate standard of living (art 28).

¹ http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

1.2 Knowledge and application of the Convention:

Although the UN Convention on the Rights of Persons with Disabilities (CRPD) (and its Optional Protocol) was ratified by the UK in 2008, it remains largely unknown among the service user and survivor community or their carers (formal and informal). The CRPD also remains largely unknown to mental health professionals, including those presiding in mental health tribunals (legal administrative authorities) who are trained to perform their duties within the strict remit of the Mental Health Act, to think that the Act is the only legal reference and that, because it is said to conform to UK Human Rights legislation, is sufficient to safeguard the rights of users and survivors. Thus the CRPD is at the very least ignored, if not dismissed by professionals.

The UK government is obliged to raise awareness about rights and dignity under the CRPD according to its Article 8. It has therefore failed to observe this obligation as well as those under Article 10 of the CAT,

1- Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

2- Each State Party shall include this prohibition in the rules or instructions issued in regard to the duties and functions of any such persons.(UN, 1984)

There is no evidence that anything has so far been organised to educate these different groups about the CRPD and its implications for human rights and the Mental Health Act. Informing and educating users about the CRPD thus largely still resides with a handful of user activists who have little means of reaching out to a wide scale of fellow users and survivors, or to professionals.

2. The domestic legal framework

2.1 The Mental Health Act 1983

The Mental Health Act 1983 (substantially amended in 2007) (DH, 1983, DH, 2007) is the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital under different sections of the Act, and detained and treated without their consent – either for their own health and safety, or for the protection of other people (Scotland and Northern Ireland have their own laws about compulsory treatment for mental ill health.). The term 'sectioned' is used to describe a compulsory admission to hospital. People who are compulsorily admitted to hospital are called 'formal' or 'involuntary' patients. SOAP observes that both the Torture Rapporteur and

the CRPD Committee have called for the repeal of mental health laws of this kind², i.e. laws that allow for compulsory admission and treatment on the basis that they violate the CRPD.

The Human Rights Act 1998 incorporates most of the European Convention on Human Rights (ECHR) into UK law. The Act applies to all courts and tribunals, including mental health tribunals, and all UK legislation is expected to be compatible with the Act. This has been made evident with the advent of the Mental Capacity Act 2005 and the Mental Health Act 1983 (2007), as the respective Codes of Practice describe human rights aspects in the implementation of both Acts.

However, there is no mention of the UN CRPD in the Codes of Practice. Some Government ministers were rebuked for calling the CRPD “soft law” by the Government’s own Human Rights Committee who stressed that the CRPD is “hard law” (legally binding) and in no way “soft law” (guidance). Dr Hywel Francis MP, Chair of the Committee, said,

We are concerned to learn that the right of disabled people to independent living may be at risk through the cumulative impact of current reforms. Even though the UK ratified the UNCRPD in 2009 with cross-party support, the Government is unable to demonstrate that sufficient regard has been paid to the Convention in the development of policy with direct relevance to the lives of disabled people. The right to independent living in UK law may need to be strengthened further, and we call on the Government and other interested organisations to consider the need for a freestanding right to independent living in UK law.

<http://www.enil.eu/news/enil-newsletter-on-the-joint-committee-on-human-rights-report-on-independent-living-and-uncrdp/>

Such misrepresentation of the legal status of the CRPD has the potential to exclude people with psycho-social disabilities from the highest standard of human rights protection for persons with disabilities. This is ignorant and highly pernicious.

In particular, Article 1 of the CRPD states that the purpose of the Convention is to protect and promote all human rights and fundamental freedoms of all persons with disabilities. The Preamble of the treaty also makes clear that disability is an “evolving concept” and that the experience of disability is the result of attitudinal and environmental barriers (i.e. discrimination) that hinder certain people from participating in society on an equal basis with others. This formulation clearly includes users and survivors of psychiatry, who were active in the drafting and negotiation of this human rights treaty.

² CRPD Committee Concluding Observations on Tunisia (CRPD/C/TUN/CO/1, 13 May 2011, para 25), Spain (CRPD/C/ESP/CO/1, 19 October 2011, para 36), Peru (CRPD/C/PER/CO/1, 9 May 2012, para 29).

PART TWO: An example of human right violations in the community under the mental health act

3. Supervised Community Treatments

3.1 Community Treatment Orders

In October 2008 amendments to the Mental Health Act 1983 (DH, 1983) came into effect via the Supervised Community Treatment (SCT) provisions of the Mental Health Act 2007 (DH, 2007). SCT enabled clinicians in England and Wales to make a community treatment order (CTO) under which they could require certain patients to accept treatment in the community following discharge from compulsory detention in hospital. The new sections thus introduce the definition 'community patient' to refer to a person who is subject to a CTO. SCT is discussed in chapter 28 of the Draft revised Mental Health Act 1983 Code of Practice for England ("the draft Code for England") and chapter 26 of the draft Code for Wales.

The latest data for 2011/12 (for England) suggest that the number of people subject to detention under the Mental Health Act continues to rise. There is increasing use of Community Treatment Orders (CTOs) with nearly half ending with the reinstatement of the underlying detention Section. (HSCIC, 2012). Figures for England for 2011/2012 (latest) show that:

- On the 31st March (2012), 22,267 people were subject to detention or CTO restrictions under The Act in NHS and independent sector hospitals. This represents a 6 per cent increase since the previous year and includes 17,503 people were detained in hospital and 4,764 people subject to a CTO.
- There were a total of 48,631 detentions in NHS and independent hospitals during 2011/12. This number was 5 per cent (2,283) greater than during the 2010/11 reporting period. Total detentions in independent sector hospitals increased by 21 per cent; a large proportion of this increase was attributable to a 45 per cent increase in uses of Section 2.
- There were 4,220 CTOs made during 2011/12, an increase of 386 (10 per cent) since 2010/11. The number of CTO recalls increased by 30 per cent and it is estimated that around 70 per cent ended in a revocation (an increase of approximately 10 percentage points since last year). The rise in CTO recalls and revocations may be linked to the 6 per cent reduction (473) in uses of Part II Section 3 of The Act.(HSCIC, 2012)

3.2 Testimonies :

a. Hayward's son was arrested by the police for failing to comply with his CTO.

Basically they took him away in handcuffs, because they suspected he was not taking their drugs...they got him, put him in police van, he waited , handcuffed, for over 2 hrs, maybe three, for a 'hospital bed'. (Anita Hayward, 2012, personal communication)

b. Jean's account of being on a CTO: "A danger and a nuisance"- CTOs in the UK

It began almost as soon as the New Labour government took power in 1997. There were rumours of a new Mental Health Act, to replace the one brought in by Margaret Thatcher's government in 1983. Users and survivors understood it wouldn't be the Mental Health Act we wanted when Frank Dobson, then Minister for Health, famously pronounced that "the mentally ill" were "a danger and a nuisance".

The Zito Trust had been lobbying for a change in the law for some time. This organisation was set up by the widow of Jonathan Zito, a lawyer, who had been randomly stabbed to death by Christopher Clunis, a black man with a diagnosis of schizophrenia. While I have every sympathy with Jayne Zito, I have to say that possibly her organisation did not represent the most balanced view on the subject of compulsion in mental health.

The Government looked to the USA, where some states had already set up Involuntary Outpatient Commitment Programs. It consulted with psychiatrists, who of course told them that the problem was that people weren't taking their medication. If only people would take their medication, they would be safe to live in the community, they wouldn't have to be readmitted, bed occupancy rates would fall, and so on. The Government proposed Community Treatment Orders, also known as Supervised Community Treatment. People would be forced to take medication while they were living in their own homes. "Non-compliance is not an option." thundered another minister.

Users and survivors and our allies mobilized. We demonstrated, we petitioned, we lobbied, we came out to the media, we made music and art and books and films. "Recovery begins with non-compliance" said one placard. We were broadly against coercion and force. We were concerned that the law would be applied widely to thousands of innocent people.

The Government just wouldn't listen to us. I remember going to see my MP, a Labour MP. He wouldn't let me speak, and it was clear to me that he didn't understand the issues at all, he kept talking about "squaring the circle", whatever that means. His mind was entirely focused on dangerousness. What he couldn't recognise was that in front of him was a small middle-aged woman who worked as a library assistant, a mother of a teenage daughter, who'd always voted Labour, had never hurt a soul, and that as someone with a history of psychiatric admissions I was at risk of falling under this legislation.

I sat upstairs in the House of Lords while they debated the issue. By this time the debate had moved on from random stabbings and I had to listen to them talk of those poor

pathetic souls who became revolving door patients with repeated hospital admissions because they didn't understand how important it was to take the medication which was so good for them. This legislation would help them, they agreed, dripping with compassion.

From 2005-2009, I became a revolving door patient. I don't actually know how many hospital admissions I had as it all became a bit of a blur. They would put me in hospital, force me to take the medication, let me out after a few weeks, I would stop taking the medication, they would observe me in the early stages of withdrawal, say I was self-neglecting and put me back in hospital again. It was pretty traumatic. The mental health services refuse to recognise their central role in causing the trauma.

In 2007 the new legislation was passed. They didn't make a new Mental Health Act, they just amended the old one.

In 2009 I was put on a Community Treatment Order. The terms of the order are:

- To reside at my current address*
- To keep appointments with care co-ordinator (usually a nurse or social worker)*
- To keep appointments with psychiatrist*
- To comply with medication*

If I do not keep these conditions I can be recalled to hospital. I can be recalled to hospital even if I do keep all the conditions if there are concerns about my mental health.

I have been recalled once. The doctor sent me a letter instructing me to report to hospital. I ignored it. My social worker got the keys to my flat from my ex-husband, let herself in accompanied by police and I was transported back to hospital in an ambulance. The CTO was revoked and I was held in hospital and treated against my will under the Mental Health Act for three weeks. Then they released me under a CTO again.

After that I was put on depot medication. I have to go to the clinic regularly to be injected in the backside. It is deeply humiliating. I would never agree to this of my own free will.

When I was first on the depot, I just used to lie in bed all day. The medication made me feel totally zonked out and demotivated. I also felt degraded and demoralised because I was on the CTO. When I did get up I just slumped in front of the TV. I stopped reading because I just couldn't take it in. I have always read and I have always been an active and creative person.

I didn't have the energy or the will to argue with the professionals any more. They thought this was an improvement.

More recently my psychiatrist has been persuaded to reduce the dose. I am able to do a bit more and I have more energy, but the principle remains the same. I have no choice about what goes into my own mind and body. This is a human rights issue.

Under a CTO the relationship between doctor and patient becomes that of master and slave.

I do have some rights. I have the right to appeal to a Tribunal once a year. The Tribunal consists of three people who have never met me and my solicitor has about an hour to convince them that my psychiatrist is wrong and I should not be treated this way. Most of this hour is taken up with the psychiatrist's evidence. At the end I get about five minutes to beg for my freedom.

Studies have shown that Black and minority ethnic people are over-represented in the numbers of people subject to mental health legislation. I look around the waiting room at the depot clinic and we are exclusively poor and working class.

According to the Guardian, over 6000 CTO's were issued in the UK up to 2011. This is ten times the original Government estimate.

I put this figure to a senior psychiatrist at the hospital. "That's 6000 people who would otherwise be being treated in hospital," he said, "It's the least restrictive option."

Maybe it's 6000 people who would otherwise be free to make their own treatment decisions, like any other member of society.

(<http://www.guardian.co.uk/society/2011/mar/15/mental-health-patients-forced-detention>)

c. A video by a SOAP member who has experienced CTOs is available here:

<http://speakoutagainstpsychiatry.org/depot-injection-robs-artist-of-her-creativity/>

d. 'My Community Treatment Order was the mental health equivalent of having a tag'

<http://www.independent.co.uk/life-style/health-and-families/health-news/psychiatric-asbos-were-an-error-says-key-advisor-8572138.html>

Paul Chapman had just got married when he was first placed on a Community Treatment Order (CTO) in 2009. He had a history of mental illness and had been admitted to hospital some 25 times since first being diagnosed with bipolar disorder and other forms of psychosis in 1991.

On this occasion, he had been sectioned to a psychiatric ward after he began hearing voices and his psychotic episodes re-ignited. After he absconded from the ward, his wife persuaded the hospital that he would be better cared for at home, so he was discharged on the CTO.

However, Paul, from Brigg in Lincolnshire, says what had first seemed like an attractive option turned into something less positive. The 46-year-old describes how being put on a CTO changed his relationship with his family and carer: rather than being based on empathy, it became a much more legalistic arrangement.

"Instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me," he says.

"I think I had to be seen by my specialist care worker once a fortnight and there was a lockdown on medication – there was no messing with my medication. It was the mental

health equivalent of having a tag. If I became unwell again or stopped taking my medication – like re-offending – I would have gone straight back into hospital."

After a few months, he inquired about being taken off the CTO but was turned down: "I felt stigmatised by it. Because of the nature of my condition, I felt other people might know and think, 'He must be bad, he's on a CTO'."

e. A mother of two daughters with experience of CTOs, says

Well my daughters have both been sectioned. The younger one was drugged as a child. A CTO is all about forced drugging and my elder daughter is on a CTO right now under private sector and is chronic treatment resistant.

Prof X promised a drug free period and she was a voluntary patient to start off with and then ended up on a CTO which is continuing right now. I am in touch with many other mothers who also have sons/daughters on CTOs drugged up to their necks - one mother has her son on 1300 mg of drugs and he can hardly move. By the way the drug being given on this CTO is called Metformine for diabetes 500mg and yet is being given off label for weight loss and on top of this is the Clozapine 300mg. My daughter spoke of staff watching her every move, of staff shouting. She is on a CTO and being forced to take these drugs.

My youngest, a bullying victim was given Risperidal as a child and sectioned. Supervised phone calls/escorted leave as a result of enforced CTO.

f. The moral career of a patient under CTO

An Independent Mental Health Advocate describes what he calls the typical "moral career" of the CTO patient: multiple admissions associated with not taking medication and just not being listened too when they raise concerns about medication and side effects.

Client under CTO: Scenario:

A twenty five year old male who had been detained by police under Section 136 of the MH Act while behaving in a way considered to be "odd" and distressed to police officers. After a 12 hour wait in a police station he was assessed by a duty psychiatrist who thought he was suffering from a "bipolar episode" and needed an acute admission. After a three month admission to a local hospital, during which he raises concerns about side effects, the client agreed to take medication and was discharged home. Three weeks later, having apparently stopped taking, medication he is detained again by police and placed in the secure ward of a local psychiatric hospital. A month later despite his objections to the medication he is discharged from hospital but this time he has to agree to attend a local day hospital for depot injections. Within two weeks he has stopped attending the day hospital and hence accepting the depot injections. Friends say they haven't seen him for a week but that he had complained of medication side effects which they say he had raised with his Community Nurse but which, they say, hadn't resulted in any changes to his medication.

The Mental Health Team decide that they cannot do anything because he isn't subject to the Mental Health Act. Two weeks later the Mental Health Team are called to an incident at his flat and detain him under Section 3 of the Mental Health Act.

During his admission the client expresses constant concerns about medication and will only agree to take it orally. No changes are made to the medication and he is eventually forcefully given a depot injection of medication. Finally 3 months into the admission he agrees to accept depot and appears more engaging and cooperative to the services. However, at the final CPA prior to discharge he is told that they intend to place him on a Community Treatment Order (CTO) and one of the conditions of his discharge will be that he agrees to attend the day hospital. He objects but finally decides that agreeing to this is better than staying in hospital.

A month after being discharged he is told by another ex-patient that he can appeal against the CTO. He contacts his local Independent Mental Health Advocacy Service who help him start an appeals process with regard to the CTO. However, during the process the Mental Health team argue that because of the "nature" of his illness, it is likely that it will return if conditions are not in place to ensure he will continue his depot injections.

(Paul Turner, personal communication, 2013)

g. Statement from another Independent Mental Health Advocate's experience of working with CTO patients

Working as an Independent Mental Health Advocate (IMHA) I meet a lot of clients who are subject to CTOs. What I have seen on several occasions is the professionals tell the patient that they must take the medication because of the CTO, and if they do not they will be taken straight back to hospital. As many patients find hospital to be a distressing environment, this causes them to comply with the treatment out of fear of being taken back in.

I believe this is incorrect practice and not what CTO's were created for.

A CTO is supposed to ensure that a patient can be easily readmitted to hospital in the event they become unwell, and is not designed simply to be a way of coercing them to take medication. Complying with treatment may be one of the conditions of the CTO, but breaking this condition does not mean the patient is automatically taken back to hospital. According to the Mental Health Act Code of practice:

"Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder or withdraws consent to treatment (or begins to object to it). The RC should consider, with the patient (and others where appropriate), the reasons for this and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow SCT to continue safely and which the patient would accept, the RC

should consider such treatment if this can be offered. If so, the treatment plan, and if necessary the conditions of the CTO, should be varied accordingly."

So if a patient is not agreeing with the medication or another condition of the CTO, there should be a discussion with the patient and alternatives should be considered. In reality I have not seen this explained to patients, they are simply told they must comply or they will be taken back to hospital. In reality nobody can be forced to take medication in the community, only under a section in hospital. What I feel is happening with CTOs is professionals are using them to get round this by frightening people into complying with medication.

Many patients I have spoken to have told me that the CTO makes them feel like they cannot be trusted to take care of themselves, and that they will never be free from mental health services.

I have seen many patients apply to the tribunal to try to appeal the CTO, but never successfully. If the patient is doing well, this is often seen as proof the CTO is working so they are kept on it, if they are doing badly and are often being readmitted to hospital then the CTO will be seen as necessary. This creates a catch-22 situation where the patient can be subject to the order for years. I do not think professionals generally appreciate how it feels to be living with the constant threat of being taken back to hospital, and the effect this has on peoples' mental health.

(Jake Sebastian, personal communication, 2013)

h. Mental health patients complain of 'zombification' -Excessive use of forced detention and coerced treatment by the NHS means patients have little control over their treatment- Mark Gould, The Guardian, Tuesday 15 March 2011

"I became 'zombified' for nearly 12 months when I was forced to take mood stabilisers and antipsychotic medication," says Reka Krieg. The 30-year-old has bipolar disorder, so has periods of manic activity and psychotic episodes, which led to her being forcibly detained and treated in hospital in 2009.

Krieg's case exemplifies the crisis in NHS psychiatric care, which is resulting in excessive use of coercive detention and treatment of people with mental illness. Latest statistics released in January show a 17.5% rise in the number of people being "sectioned" – under the Mental Health Act (MHA) – from 32,649 in 2008-09 to 38,369 in 2009-10. This means that nearly 40% of patients in NHS psychiatric units are there under legal duress.

Years of drastic bed cuts mean wards are full of only the most unwell patients – those seen to be a danger to themselves or others. This includes rising numbers coming into hospital via the judicial system. Eight hundred and thirty women detained under the MHA came into hospital via prison or the courts last year, a rise of more than 85%, while the number of men rose by 48%, from 1,982 to 2,935.

The use of community treatment orders (CTOs) has also rocketed. Since they were introduced in 2008, more than 6,200 have been served – 10 times the expected number. Under a CTO, patients are released from detention, but can be forcibly returned to hospital

if they fail to take their medication or other treatment. However, patients complain that once given a CTO, it takes them too long to get it removed, obliging them to stick with medication they believe they no longer need.

CTOs are "a complete waste of money," says Krieg. "I had a history of repeat hospital admission, but I was better when they decided to impose the CTO, which I hated. I felt I had no control over my human rights." She was finally released from the CTO after two appeals with the help of a specialist lawyer.

And it seems that CTOs have not eased the pressure on psychiatric wards. Last November, the Care Quality Commission, which oversees patients detained under the MHA, found that some hospitals were reporting 125% bed occupancy rates, and nearly a third of the 486 locked NHS wards in England and Wales had occupancy rates of 100% or more, meaning they were forced to send patients home early to accommodate new arrivals.

Mental health charities and senior psychiatrists say the situation is appalling, and they are lobbying for changes to the health and social care bill currently going through parliament, to make it harder to impose compulsory treatment.

Tony Zigmond, the Royal College of Psychiatrists' lead on mental health law, says the situation is "a disgrace". He fears some mental health services are becoming so focused on the risk of patients harming themselves or others that they make excessive use of compulsion and coercion. He describes detention under mental health law as "a lobster pot – easy to get into but hard to get out". His college and the Mental Health Alliance, an umbrella group of charities, civil liberties organisations and lawyers, are lobbying MPs to amend the health and social care bill to make it harder to impose CTOs. Otherwise, he fears the use of CTOs could spiral out of control. "The top line is that CTOs have increased the number of detentions," he says. "In effect, they are prisons without walls so the numbers on them could be limitless."

Paul Farmer, chief executive of mental health charity Mind, says he is "extremely worried" about the rise in CTOs, "especially as 30% of them are being imposed on people who have no history of not co-operating with treatment". He adds: "CTOs are a looming threat of readmission hanging over the heads of people who are trying to rebuild their lives and independence."

Lee Milner, 41, has schizoaffective disorder, which results in episodes of elation or depression coupled with hallucinations. A volunteer and campaigner with mental health charity Rethink, Lee has had extensive experience of detention in hospital since 1992 when, following the suicide of his father, he tried to set fire to the family home. He was last sectioned in 2010 and agrees that hospitals are packed with only the most serious cases. "The ward was like being in the dark ages. How the nurses qualified I never know ... When I tried to talk to the consultant about spirituality, he just asked if I wanted more medication."

Zigmond wants a more consensual approach to treatment, and more space set aside in hospitals for patients to use as sanctuaries in times of crisis. "Why not give patients the option of coming off medication and being able to come into hospital if they need to?" he says.

Paul Burstow, care services minister, recognises the need for caution. In opposition, he warned that CTOs were an overly coercive instrument whose remit was too wide. Now Burstow says that officials are keeping a close watch on the rising rates of CTOs. "People who need compulsory treatment ... should be treated fairly, and mental health services are

responsible for making sure that they use the powers in the Mental Health Act appropriately," he says.

The Department of Health says that the MHA contains legal safeguards for people on these treatment orders, including the right to appeal and to have an advocate. But, a spokeswoman says, clinicians are best placed to know if a CTO means patients get appropriate treatment.

Marjorie Wallace, chief executive and founder of mental health charity Sane, says that when she set up the charity 25 years ago, more than 90% of psychiatric inpatients were there voluntarily. She says the NHS needs more beds: "People who are in crisis tell us they have nowhere to go. We are told that it is harder to admit people voluntarily than it once was, and, for those who do find an inpatient bed, our experience is that psychiatric wards offer very little sanctuary, with overworked staff and few therapeutic services."

But Simon Lawton-Smith, head of policy at the Mental Health Foundation, fears NHS psychiatry is "moving in the wrong direction". He wants people to feel able to engage voluntarily with doctors before they become really unwell. "We need the [Mental Health] act when people are a danger to themselves or others, but we want a system where it's used less and less, not more and more."

4. Known issues with CTOs are a distraction from the main point

There are not only many issues with CTOs but also with the academic and professional perspective on the topic, as well as what can be found in the media (e.g. the Guardian article). Indeed, the literature on CTOs mostly focuses on the failings of procedural safeguards and lack of efficacy of CTOs (Burns et al., 2013, Curtice et al., 2011, Patel et al., 2011, Taylor et al., 2013) which are then echoed in the press. The dominant theme can be resumed as: CTOs do not work because they are not implemented properly.

The fact that CTOs have many inherent issues is secondary. Such studies and articles miss the point: the fact that CTOs are first and foremost unlawful in relation to the highest human rights standard for persons with disabilities, the UN CRPD. Ethical concerns about CTOs and the curtailing of human rights usually come low down the list of arguments against CTOs. Again, they are only mentioned as an outcome of inefficient or poorly administered CTOs, not in their own right. Human rights, we argue, should be the primary concern rather trying to find ways of improving CTOs or their implementation, an approach which distracts from the main issue, and neutralises any possibility for alternatives.

The real issues are:

4.1 The detention of persons in the community is unlawful in regard to the UN CRPD:

Effectively until 2008 in the UK users of mental health services were "only" detained forcibly within the walls of psychiatric institutions. Now they can be forcibly "legally" detained in the community as per the terms of an unlawful act, the MHA. It is that detention status that allows forced treatments. Effectively the UK, as state party State Party to the treaty, does not respect its legal obligation to ensure that national laws meet the terms of the CRPD.

However the Code of Practice for the MHA only refers to the UK Human Rights Act 1988 which incorporates most of the and the ECHR (DH, 2008), stressing that much of it is about “proportionality” and balance of decision (Curtice et al., 2011). Proportionality in effect not only clearly supports a risk averse culture but also the curtailing of people’s human rights in the interest of society or of the person’s “best interests”. The issue here is that it should reflect principally the CRPD as the highest human rights standard for persons with disabilities and not the ECHR which echoes much of the outdated and extremely conservative Mental Health Care Principles, in particular insisting on the issue of lack of capacity to justify detention and forced treatment.

It is therefore necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed “best interests”, and where serious violations and discrimination against persons with disabilities may be masked as “good intentions” of health professionals (A/63/175, para. 49). (Méndez, 2013)

CTOs (and all forced treatment and detention) violate article 5 of the CRPD as well (Equality and non-discrimination).

The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any (perceived) disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that “the existence of a disability shall in no case justify a deprivation of liberty”. **(Thematic study of the High Commissioner for Human Rights on implementation on key legal measures for the ratification and implementation of the Convention on the Rights of Persons with Disabilities, A/HRC/10/48, para 48).**

Rapporteur Méndez says,

Important interpretative and guiding principles such as legal capacity, informed consent, and the doctrine of “medical necessity” as well as the concept of stigmatized identities provide useful guidance in understanding the breadth of the problem and the underlying causes that are paramount to most of these abusive practices. (Méndez, 2013)

Under supervised community treatment, patients compulsorily detained in hospital under Section 3 of the MHA (compulsory treatment) may be discharged onto a CTO requiring them to comply with certain conditions, including taking their medication. Effectively the “community” becomes an extension of psychiatric settings by virtue of the constraints which are put on people to respect the legal terms of their detention and forced treatment in said community. As the testimonies show, people felt like prisoners in the community (the GPS bracelet/ “tag” effect), where space for negotiation and refusal of treatment have no place whatsoever. This situation is possibly even worse than for prisoners under licence or probation and the issue of “medical necessity” invoked by CTOs is a (unlawful) red-herring. Unlike existing supervised aftercare powers, CTOs include the

sanction of conveying a noncompliant patient to hospital for compulsory treatment without the necessity of formal readmission.

Under CTOs, individuals not only lose their agency but also the full enjoyment of their human rights on an equal basis with other members of society. In her account in the Guardian, Krieg says she had “no control over her human rights”, she felt “violated”.

Forced psychiatric treatment in the community is a violation of both the spirit and the letter of the CRPD. This practice flouts all principles set out in Article 3 of the CRPD such as respect for inherent dignity, individual autonomy, independence of persons and non-discrimination. It clearly breaches provisions of the treaty, including Articles 12 (Equal recognition before the law), Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) and Article 17 (Protecting the integrity of the person) and Article 25 (Health).

4.2 Forced treatments (psychological and physical constraint) are inhuman and degrading:

Persons under CTOs agree to undertake treatment as per the terms of the MHA. These interventions typically include the taking of mind-altering drugs, such as neuroleptics. In the Patel et al study (2011), virtually all participants on CTOs (99%) were given antipsychotics as the main medication and “Of the total sample 7.2% had antipsychotic (combined) doses exceeding 100% BNF³ limits and 9.7% were prescribed two antipsychotics.

Forced treatment with neuroleptic (anti-psychotic) drugs is contrary to Article 15 of the CRPD and has been recognised as torture by Manfred Nowak, the then UN Special Rapporteur for Torture. In 2008 he wrote:

Inside institutions, as well as in the context of forced outpatient treatment, psychiatric medication, including neuroleptics and other mind-altering drugs, may be administered to persons with mental disabilities without their free and informed consent or against their will, under coercion or as a form of punishment. The administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognised as a form of torture. (Nowak, 2008)

His successor, Rapporteur Juan Méndez also recommended a ban on forced psychiatric drugging and the repeal of laws allowing compulsory mental health treatment (Méndez, 2013).

Psychiatrist Dr Peter Breggin writes of the effect of neuroleptic drugs:

While the neuroleptics are toxic to most brain functions, disrupting nearly all of them, they have an especially well-documented impact on the dopamine neurotransmitter system. As any psychiatric textbook will confirm, dopamine neurotransmitters provide the major nerve pathways from the deeper brain to the frontal lobes and limbic system - the very same

³ British National Formulary, the medication ‘bible’ for all doctors in the UK

areas struck by surgical lobotomy. Most psychosurgery cuts the nerve connections to and from the frontal lobes and limbic system; chemical lobotomy largely interdicts the nerve connections to the same regions. Either way, coming or going, it's a lobotomy effect. Thus the mechanism of action of the neuroleptics is no mystery: clinically the drugs produce a lobotomy and neurologically the drugs produce a lobotomy.(Breggin, 1993)

The use of psychiatric medications, particularly neuroleptics, is also associated with a shortening of the life span. People who use psychiatric medications may experience a number of health problems as adverse effects of these medications, including problems of the neurological, endocrine, metabolic, and cardiovascular systems and cognitive difficulties,

there is a preponderance of evidence showing that standard neuroleptics, over the longterm, increase the likelihood that a person will become chronically ill. This outcome is particularly problematic when one considers that the drugs also cause a wide range of troubling side effects, including neuroleptic malignant syndrome, Parkinsonian symptoms, and tardive dyskinesia. Patients maintained on standard neuroleptics also have to worry about blindness, fatal blood clots, heat stroke, swollen breasts, leaking breasts, impotence, obesity, sexual dysfunction, blood disorders, painful skin rashes, seizures, diabetes, and early death, (Whitaker, 2004).

The long term use of neuroleptics is also proven to cause atrophy of the brain,

In a series of (MRI) studies from 1994 to 1998, investigators reported that the drugs caused basal ganglion structures and the thalamus to swell, and the frontal lobes to shrink, with these changes in volumes "dose related". (Whitaker, 2010)

In animal studies in the last few years, evidence of reduction in brain tissue volume was reported in monkeys given Olanzapine and Haloperidol (commonly-used neuroleptic drugs) over a period of two years, e.g. Dorph et al, (2005).

4.3 A humiliating process:

Long-acting depot forms of neuroleptics are commonly used on people on CTOs. People attend a clinic regularly, usually every two or four weeks, to be given the injection in the buttock. Like cattle waiting to be slaughtered at the abattoir, Jean's video testimony recalls how people were confined to a waiting room to be injected, one by one. It is degrading and intrusive to have a drug administered in this way. No amount of tinkering with the way drugs are administered is going to make it either better or lawful.

Pia Khan, a service user says,

I remember they were forcing me to have medication. I felt violated. I remember being forced into a small room on my own, there was no bed. They pushed me into it. They held

me down and forced medication on me. I am a diminutive 5'1" and they were all bigger than me.

Reka Krieg, a service user says (Guardian),

I became zombified for nearly 12 months when I was forced to take mood stabilizers and anti-psychotic medication

Jean Cozens, former library assistant and mother:

My sister had come to visit. I was angry because she had a two hour journey and had been kept waiting outside the ward because it was not visiting time yet. I complained to the nurses. I didnt swear, I wasnt abusive, I just complained. Next thing I knew, my sister was bundled out the door and told to go home. I was taken to my room, forced to lie face down on the bed, and injected with something that knocked me out for hours. I had bruising to my back.

4.4 Refusing treatment is impossible:

Although in principle, people are allowed, whether they are voluntary or involuntary patients', to refuse treatment, the reality is quite different. It seems that in mental health, poor compliance or refusal of treatment are often considered a symptom of the person's 'illness' or evidence of 'lack of insight'. This allows coercive measures to be used to force hospital admission and treatment on people, as well as to force treatment in the community. Section 23.37 of the MHA Code of Practice, stipulates that:

Although the MHA permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment, wherever practicable. The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent.

In fact, according to Section 23.40 of the Code, compulsory treatment that may otherwise be deemed inhumane can also be justified and not called "inhumane" or "degrading" when it "is convincingly shown to be of therapeutic necessity from the point of view of established principles of medicine".

4.5 Persons under CTOs are vulnerable and open to abuse:

Paul recalls (Independent article) how he had not only lost the full enjoyment of his agency, he was also put in a situation of vulnerability within his own family for whom he had become a soft target.

The most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person. Persons with disabilities often find themselves in such situations, for instance when they are deprived of their liberty in prisons or other places, or when they are under the control of their caregivers or legal guardians. In a given context, the particular disability of

an individual may render him or her more likely to be in a dependant situation and make him or her an easier target of abuse. However, it is often circumstances external to the individual that render them “powerless”, such as when one’s exercise of decision-making and legal capacity is taken away by discriminatory laws or practices and given to others. (Special Rapporteur on Torture, A/63/175, para 50)

Persons under CTOs are also open to psychological abuse by the system itself,

Nobody talked to me as a human being, it's force, force all the way. It's only when you subdue your spirit, and you don't struggle anymore, that they're happy to release you. (Pia Khan, personal testimony, 2012).

5. Who safeguards people’s fundamental rights in the UK on a day to day basis?

5.1 The role of the Care Quality Commission

The Care Quality Commission (CQC) is a governmental agency responsible for protecting the interests of people detained and treated under the Mental Health Act in England, for making sure they are cared for properly, and for ensuring the Mental Health Act is used correctly.

In Wales, the Healthcare Inspectorate Wales's Review Service for Mental Health is responsible for monitoring the Mental Health Act.

(http://www.mentalhealthcare.org.uk/mental_health_act#Compulsory_treatment)

The role and remit of the CQC is set to increase (UK Government, 2012) to explore “how best to align its regulatory and statutory monitoring functions in relation to mental health, including “extending Mental Health Act monitoring to include assessment and admission, supervised community treatment, quality of access to treatment and aftercare”.

However it is clear as far as long as it continues to work only within the terms of the MHA, ignores and does not meet the CRPD standards, the CQC cannot claim that it is “protecting the interests of people detained and treated under the Mental Health Act in England” as it has to which does not conform to the UN CRPD.

This leaves users and survivors are left in a very vulnerable position when the official body that is meant to monitor what is happening within mental health services is not a position to refer to the CRPD in its work.

5.2 The role of mental health advocates

Access to mental health advocacy has become a right for service users detained under the MHA since 2009 as a result of the changes in 2007 to the MHA 1983. The role of the Independent Mental Health Advocate (IMHA) is described in chapter 20 of the MHA Code of Practice and was set up as “an additional safeguard for patients who are subject to the Act”.

IMHAs help people access their rights under the Mental Health Act and understand the powers of the service providers. This includes people subject to Supervised Community Treatment. IMHAs have certain rights and duties including a duty to respond to reasonable requests for advocacy and the power to interview any professionals concerned with the care of the service user, access service users and access medical records.

A mental health advocate says,

People do have rights but don't (can't) enforce them – for example I've only had one person come to me about their CTO in the last 12 months. Other people on the team have seen one or two but the contact with CTO clients is very low. (Paul Turner, personal communication, 2013)

This means that unless service users are aware of their rights and mental health advocacy is properly advertised and supported, they are even less able to enjoy their full human rights when detained.

5.3 The role of the Subcommittee for the Prevention on Torture

As the UK has not only ratified the CRPD but also the OPCAT, this which means that the Subcommittee for the Prevention of Torture (SPT) should do inspections too.

PART THREE:

6. Recommendations

The UK should not be regarded as a model of good practice in terms of human rights since human rights violations committed against persons with disabilities are widespread. This should be borne in mind when considering the UK's influence over what happens elsewhere in the world.

While the UK is able to offer a veneer of respectability and cultural validity through its procedural systems, these do not serve the interest of users and survivors of psychiatry. Indeed, no amount of 'solid' procedure can render forced detention and forced treatments better or lawful in regard to the CRPD in particular, and human rights in general.

To have any meaning in the UK, the CRPD must be fully integrated within domestic laws, and fully implemented, for all of us to feel there is any hope that things can indeed change and that forced psychiatry can come to an end.

There is therefore a need to:

Implement the findings from Rapporteur Mendez' report (Méndez, 2013):

- Immediately repeal all legal provisions allowing for forced psychiatric detention or forced psychiatric treatment, including CTOs as unlawful with regards to the terms of the UN CRPD, in particular articles 14 and 15

- Article 4.1(a) and (b) of the CRPD requires states to take legislative measures to give effect to the rights, and to repeal laws that discriminate against persons with disabilities.
- Free and informed consent should be safeguarded on an equal basis for all individuals without any exception, through the legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be repealed.

Also:

- The CQC should be made to work within the terms of the CRPD, and not only within the remit of the MHA which does not respect the CRPD.
- Ensure that access to mental health advocates is made easy for all service users, in particular those detained under the MHA. This means that advocacy services must be properly advertised on wards, in GP surgeries, in public places (e.g. public libraries) etc.
- The UK Government should provide funding of alternative forms of support that respect the autonomy, will and preferences, dignity and privacy of the person concerned (as required by the CRPD Committee).
- There should be support for independent living in the community, including an adequate standard of living and secure housing (according to arts 19 and 2 of the CRPD).
- Access to reparations/compensation for victims of psychiatric torture and inhuman and degrading treatment (under article 14 of CAT).

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