
When protective powers become threatening

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Indefinite and preventive detention: two archetypal danger-areas for the civil-libertarian mind. Both are permitted by criminal and mental health law, subject to the safeguards provided by common law and the European Convention on Human Rights (ECHR). Watchful eyes need to remain focused on the interpretation of such powers of detention.

That any coercive power that can be abused by authority will be so abused seems a reasonable rule of thumb. Certainly it is the assumption on which responsible legislators ought to work; even if they are willing to trust their own imperturbability in the face of events they have no right to do so, or so to trust their successors. Stop-and-search has been heavily abused,² while the limits on control orders are under judicial scrutiny domestically and at Strasbourg.³

Terrorism trials and those involving notoriously violent criminals catch headlines, especially where mental disorder is involved. My concern here is the looseness of provisions which, operating out of the public eye, can indefinitely detain people on preventive grounds.

Popular fear as basis for detention

In the context of mental health, government has a major anti-stigma campaign in operation. Thus a Department of Health (DoH) perspective:

*'...the killing of strangers by people with mental illness is rare; most stranger homicides are committed by young men without mental illness who are under the influence of alcohol or drugs. The public may fear the mentally ill but they are more at risk from heavy drinkers.'*⁴

Risk-aversion, however, having gained a popular voice which no politician can ignore, has become a political tool which few politicians will eschew. Speaking at the 2010 Conservative Party Conference, Justice Secretary Ken Clarke espoused community sentencing for short-term prisoners while reiterating that the goals of prison were public safety and punishment, 'and also' reduction of reoffending.⁵ His policy shift has not diluted a former Home Secretary's emphasis on risk:

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2. *See for example the comments of Helena Kennedy QC in 'Access to justice after New Labour' (January 2010) Legal Action news 6-9.*

3. *Notably in SoS for the Home Department v AF (No 3); Same v AN; Same v AE [2009] UKHL 28; A and others v United Kingdom [2009] ECHR 3455/05; N v SoS for the Home Department [2010] EWCA Civ 869;*

R (AP) v SoS for the Home Department [2010] UKSC 24.

4. *Department of Health, Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (London: TSO 2001), p152. Government's enthusiasm for wider-reaching anti-discrimination measures will be indicated by the speed of implementation of the Equality Act 2010's public sector equality and socio-economic duties; the latter is disappointingly weak.*

*“I am... proposing to take new powers to enable dangerous and high-risk offenders to be better managed... The plans which we have recently announced to amend mental health legislation will help to ensure that mentally disordered offenders get the treatment they need and that the risk which they pose to the public is minimised...”*⁶

This is an idealised win-win scenario. It suggests that offenders are thus detained for their own sake *and* the protection of others. That is not what the *Mental Health Act* says. Rather, patients can be detained for their own health and safety or for the protection of other people. *The Mental Health Act* – before and after the reform of 2007 – provides for psychiatric detention purely on the grounds of dangerousness.

Both perceptions are true: violence by mentally disordered people represents a minority of crimes but a small number of serious offences remain the high-profile work of seriously disturbed (mainly) men. Policy thus has to tackle stigma and public protection. The question here is whether policy addresses not merely actual but also perceived danger, an inflation resulting in the lawful but unnecessary detention of people whose human rights are inadequately protected by domestic or Convention law.

Though Parliament has not inhibited assaults on civil liberties⁷ and the Courts have shown an uneven resistance,⁸ there are checks on centralised control. Indeed, the Labour administration showed no coherent purpose of increasing such control, in its first term incorporating the ECHR in the *Human Rights Act 1998* and passing the *Freedom of Information Act 2000*.

Nevertheless, thresholds of detention have been falling under criminal and mental health law. That fall relies significantly on public fear. After every public-authority-related tragedy, even while the seeds of future tragedies continue to be sown, the same meaningless mantra is mouthed: ‘it must never happen again’. Where detention is concerned, a sense of entitlement to a uniquely risk-free society combines with denial of the limitations of risk prediction to produce an uncritical appetite for control, or ‘management’.¹⁰ Following rather than engaging with media reactions, politicians help to create a climate within which borderline discharge decisions become ever more difficult.

In relation to criminal law, the Labour government legitimised an expansion of prison populations by arguing that the policy is “protecting the public from thousands of offences a year which might otherwise

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5. <http://www.telegraph.co.uk/news/newsvideo/uk-politics-video/8043713/Ken-Clarke-calls-for-prison-reform.html>
 6. Home Secretary Charles Clarke, *New Public Protection Measures: Home Office press release following the murder of John Monckton in 2005 by a prisoner on licence*, (20 April 2006). <http://press.homeoffice.gov.uk/press-releases/new-protection-measures>. See also the *White Paper on Sentencing, 2002*, quoted in the *Bennett Report, The social costs of dangerousness: prison and the dangerous classes*, Centre for Crime and Justice Studies, (2008) p6.
 7. For example ‘counter-terrorism’ legislation, the growth of administrative penalties and erosion of the jury system. The House of Lords has arguably shown more backbone,

for example in its debates over mental health reform in this century.

8. However, the Appeal Court’s recent ruling in *R (Mohamed) v SoS for Foreign & Commonwealth Affairs* [2010] WL 442342 importantly affirms open justice as one of the central factors to be considered in balancing public interest concerns.
 9. Though some sceptics suggest that these were effectively unavoidable inheritances from the John Smith years.
 10. See H. Southey, ‘A personal overview’, in N. Padfield (ed.), *Who to Release: Parole, fairness and criminal justice*, Willan Publishing, (2007) p239; J. Thompson, ‘The recall and re-release of determinate sentence prisoners’, in the same volume, p157.
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have occurred”.¹¹ Crime is disproportionately presented as violent and sexual, provoking an exaggerated perception of the need for penal and preventive imprisonment.¹²

Inevitably, the stakes are raised by high-profile tragedies. The 2006 Anthony Rice murder¹³ helped to provoke then-Prime Minister Blair into requiring Home Secretary John Reid to question whether judicial interpretation of the HRA was unacceptably overruling government policy.¹⁴ It is a valid question for the executive; but the overall message of government’s response was to use the tragedy as an opportunity of responding to popular fear, rather than of tackling the far-from-zero-sum relationship between individual freedom and public safety.

Scare stories about tragically ill-fated releases of psychiatric patients show a corresponding rationale.¹⁵ A study of ‘Media influences on mental health policy’ following the Clunis and Silcock cases concluded that while press coverage had been partly motivated by a desire to improve psychiatric care, policy responses to public fears had produced increased constraints upon mentally disordered people.¹⁶ Citing a Texan judgment in 2006, Richards LJ commented revealingly on the rights of mentally ill people:

“One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma... It cannot be said, therefore, that it is much better for a mentally ill person to ‘go free’ than for a mentally normal person to be committed.”

‘Furthermore the consequences that may flow from the release of a person suffering from mental disorder include not only a risk to the individual’s own health and safety..., but also a risk of harm to other members of the public.... [A] person whose case is being considered under section 73 was detained in the first place pursuant to a hospital order... following conviction for a criminal offence, often an offence of violence: the appalling facts of N’s [sic] own case are very much in point....’¹⁷

Various points here. Firstly, the belief that neither liberty nor freedom from stigma is possible for a ‘debilitatingly’ mentally ill person, so that incarceration is less bad (damaging? painful? morally suspect?) than for a ‘mentally normal person’. Such demotion of minorities to marginal subhumanity has a malign history. Secondly, note the slippage from the particulars of AN’s ‘appalling’ case to generalisation about people suffering from mental disorder.

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11. Bennett Report (2008) pp14-16, quoting the Home Office, 2006. In particular, he singles out Home Secretary John Reid’s ‘high profile review’ of 2006 which while highlighting concerns about ‘serious, violent and dangerous offenders’, ‘made no attempt at all to define dangerousness, although did specifically mention a range of offences from serious organised crime to domestic violence to the carrying of knives. This again indicates that, for politicians, dangerousness is an imprecise, flexible and broad concept.’ See Home Office (2006), *Rebalancing the Criminal Justice System in Favour of the Law-Abiding Majority: Cutting Crime, Reducing Reoffending and Protecting the Public*, Home Office. See also N. Padfield and S. Maruna, ‘The revolving door at the prison gate: Exploring the dramatic increase in recalls to prison’ (2006) 6 *Criminology & Criminal Justice* 329-352.
12. Bennett Report (2008) p7.
13. ‘a sex attacker who killed a mother-of-one while on licence from a life sentence’: BBC News Channel, 10 May 2006. <http://news.bbc.co.uk/1/hi/uk/4756435.stm>
14. Prime Minister Tony Blair, Letter to Home Secretary John Reid. [Number10.gov.uk](http://number10.gov.uk), 14 May 2006. See also R. Morgan, Review of ‘Who to Release? Parole, Fairness and Criminal Justice’ N. Padfield (Ed.). Willan (2007). (July 2008) 47 *The Howard Journal*, pp332-333.
15. For example in 1992, Jonathan Zito was killed by Christopher Clunis, diagnosed with paranoid schizophrenia, and Ben Silcock, also suffering from schizophrenia, was badly mauled after climbing into a lion’s den at London Zoo. Michael Stone, diagnosed with a personality disorder and drug-induced psychosis, killed Lin and Megan Russell in 1996.
16. A. Hallam, ‘Media influences on mental health policy: long-term effects of the Clunis and Silcock cases’ (2002) 14 *International Review of Psychiatry* 26-33.
17. See R (AN) v Mental Health Review Tribunal (Northern Region) [2006] EWCA Civ 1605 at [74].
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This is not an isolated instance. A few years earlier, quoting a judgment of the European Court of Human Rights (ECtHR), Lord Clyde had referred approvingly to the ECHR's equation of 'persons of unsound mind, alcoholics and drug addicts'.

*"The reason why the Convention allows the latter individuals, all of whom are socially maladjusted, to be deprived of their liberty is not only that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention."*¹⁸

The specific outcome was to legitimise the indefinite detention of 12 men diagnosed with 'psychopathic personality disorders' and assessed as highly dangerous, but not amenable to lawful imprisonment or assessed as treatable; the 'own interests' argument, with no place in mental health law, can be little more than a paternalistic attempt at moral justification.

The problem here is not the (uncontentious) assertion that some mentally disordered people may be 'occasionally dangerous', but the suggested presumption of such a connection. A similar carelessness – or prejudice – marks his judgment a little earlier: "One of the immediate concerns which one has about such persons is that of public safety..."¹⁹ It is a presumption which one-sidedly weights the evidence needed for courts balancing the interests of mentally disordered people and public safety, and which gives authority to popular fears.

The judiciary is not blind to its relationship with popular fear. The Parole Board in 1977 agonised over the extent to which its decisions on notorious prisoners should be influenced by public opinion; its 1986 Report 'felt it necessary to spell out that public perceptions were part of the risk assessment process with the Board taking into account "the degree of abhorrence with which society regards that offence and the likely public reaction to the offender's early release from custody". This can be contrasted with the long-standing principle that public reaction is not relevant to judicial sentencing and release decisions.²⁰ That principle is spelt out by Goff LJ in the Venables and Thompson case: "I wish to draw a distinction... between public concern of a general nature with regard to, for example, the prevalence of certain types of offence, and the need that those who commit such offences should be duly punished; and public clamour that a particular offender whose case is under consideration should be singled out for severe punishment. It is legitimate for a sentencing authority to take the former concern into account, but not the latter".²¹ It is a principle deserving closer consideration in political as well as judicial contexts.²²

Governments shrink from confronting populist fears, being characteristically unwilling to open up discussion of the limits of risk assessment or of the complex relationship between incarceration and risk reduction. The former administration's simultaneous desire to present the DoH anti-stigma campaign made incoherence inevitable. One had to take centre stage; the Ministry of Justice (MoJ) won. The Coalition government has not indicated any shift in this balance.

Levels of detention

What is the evidence to support government's enthusiasm for preventive detention? One needs to look

18. *Anderson v Scottish Ministers* [2003] 2 AC 602 at [63].

19. *Anderson* at [60].

20. S. Creighton, *The Parole Board as a court*, In N. Padfield (ed.), *'Who to Release? Parole, fairness and criminal justice'*, (Willan Publishing 2006) p110.

21. *R (Venables) v SoS for the Home Department*; R

(Thompson) v the same [1998] AC 407 at [491].

22. *For a passionate (and evidenced) indictment of the current administration's record on responding to public opinion rather than evidence see P. Toynbee, Bad politicians are slave to public opinion. Good ones try to change it, The Guardian, (27 November 2009).*

at the kinds of detention involved. Part III of the *Mental Health Act* deals with people who are facing, or have faced, criminal charges, while indeterminate prison sentences – now primarily mandatory and discretionary life sentences and sentences of Imprisonment for Public Protection (IPP) – permit imprisonment beyond the penal minimum term.

Looking therefore at the relevant figures: while overall NHS psychiatric bed numbers are falling,²³ those in NHS medium-secure units have been rising;²⁴ the units for Dangerous & Serious Personality Disordered (DSPD) patients,²⁵ High-Security Hospitals (HSHs) and private facilities²⁶ are additional to that rise. In 2009, the Mental Health Act Commission (MHAC) welcomed a ‘recent upturn’ in the use of s37 hospital orders, ‘on the grounds that every individual case is a diversion from the criminal justice system’; however, ‘in the light of the massive increase in prison population during this period... the overall proportion of diversions may have fallen considerably...’²⁷ Moreover, the upturn is accounted for solely by 37/41 detentions – restricted hospital orders.²⁸ Singh and Moncrieff argue that a rise in ss 2, 3 and 37/41 detentions, combined with steady levels of discharge on appeal, may suggest a lowering of the threshold for detention (restricted and unrestricted) and rise of that for discharge.²⁹ Last year saw a record number of Part III detentions.³⁰

Tracking figures is not straightforward. Though 2009/10 saw a slight reversal in the trend since 2002-03 towards court and prison disposals in private hospitals at the expense of NHS facilities,³¹ the private sector remains significant. ‘Information is not collected by the Department [of Health] on the proportion or cost of personality disorder placements made in the private sector’; furthermore, ‘[i]nformation is not collected centrally on the effectiveness of personality disorder placements commissioned by PCTs [primary care trusts] from the private sector.’³² Given that the Care Quality Commission relies heavily

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23. P. Pillay and J. Moncrieff, ‘The Contribution of psychiatric disorders to occupation of NHS beds: Analysis of Hospital Episode Statistics’, Presented at the Royal College of Psychiatrists Annual Meeting (2009): <http://www.rcpsych.ac.uk/press/pressreleases2009/nhsbedd ays.aspx>. Their research also shows that psychiatric disorders remain among the top ten users of NHS hospital beds in 2007-08. Falling numbers of psychiatric beds and their implications have been under discussion since the 1950s at least: see G. Thomicroft and G. Strathdee, ‘How Many Psychiatric Beds? The Debate Shouldn’t Be Swayed By Moral And Political Considerations’ (1994) 309 *BMJ* 970-971.
 24. An email from Mark Quinlan of the Department of Health Customer Service Centre dated 2 October 2009 evidenced this rise in medium secure units and lack of data on independent sector beds. He adds that ‘the NHS provision represents approximately 60 per cent, the rest being provided by the independent sector providing NHS funded services (at the latest count there were 41 NHS medium secure units and 25 independent medium secure units).’
 25. Introduced by a joint Department of Health/Home Office initiative in 2004 (contemporaneously with the introduction of IPP sentences). See <http://www.dspdprogramme.gov.uk/>
 26. See Hansard: House of Commons Written Answers, (15 June 2009), for secure unit bed numbers; see also Bennett Report (2008) p13 on numbers and role of DSPD units.
 27. Mental Health Act Commission, Thirteenth biennial report: ‘Coercion and consent: monitoring the Mental Health Act 2007-2009’, (2009) para 4.12. On the same caveat, see also K. Edgar and D. Rickford, *Too Little Too Late: an independent review of unmet mental health need in prison*, (2009) p6.
 28. MHAC 2007-09 para 4.13.
 29. See D. Singh and J. Moncrieff, ‘Trends in mental health review tribunal and hospital managers’ hearings in north-east London 1997-2007’ (2009) 33 *Psychiatric Bulletin* p16.
 30. NHS Information Centre (October 2010), table 2.
 31. See NHS Information Centre, *In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/2010* (October 2010), pp 8-9. See also NHS Information Centre, *In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1997-98 to 2007-08*, (2008).
 32. Hansard: House of Commons Written Answers, (15 June 2009): Tom Brake MP.
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on self-assessment by private providers, such lack of information is unsurprising.³³ People confined in a unique 'position of inferiority and powerlessness'³⁴ are being lost to official or public sight.

Meanwhile, seriously worrying numbers of mentally disordered people are in prison³⁵ while prisoner numbers are at a record high and rising, albeit more slowly than in the recent years.³⁶ The rise was linked to the introduction of IPP under the *Criminal Justice Act 2003* (CJA),³⁷ together with an upward trend in recalls, tougher licence conditions, greater surveillance of those on licence and growing risk-aversion by the Board³⁸ and the withdrawal of End of Custody Licence in March 2010. The levelling-off is attributable partly to the *Criminal Justice & Immigration Act 2008* (CJIA),³⁹ including amendments to IPP which reduced the remarkable swathe of offences accounted dangerous.⁴⁰ CJIA also restored judicial discretion in sentencing, abolishing the mandatory assumption that those committing offences potentially attracting IPP were indeed dangerous.⁴¹

Detention for the safety of others

So what are the legal grounds for non-punitive detention on the grounds of dangerousness to others? The quick answer is 'very broad'.

The Parole Board is "the court" responsible under Article 5(4) of the ECHR for deciding the continuing lawfulness of detention of prisoners for whom the original justification under Article 5(1)(a) has ended. Statute and case law have in the last couple of decades produced a complication of sentences, but the Board's remit includes indeterminate prisoners who have served their punitive minimum term. Lawfulness after this is on the grounds solely of public safety. The Board has an apparently-specific criterion for continued imprisonment in the 'life and limb' test for lifers,⁴² recognised as leaving the level

33. All health providers providing publicly funded services are subject to inspection by the Care Quality Commission; however, see www.cqc.org.uk/guidanceforprofessionals/healthcare/guidanceforindependentstaff/ourroleasregulator/risk-basedinspection.cfm for its policy in relation to private providers.

34. *Herczegfalvy v Austria* [1993] 15 E.H.R.R. 437 at [82].

35. See Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, Department of Health, (2009) pp97 et seq.. However, numbers transferred and diverted have fallen proportionate to those imprisoned. See also House of Commons Justice Select Committee: Sentencing (2008) para 201.

36. Prison Reform Trust, Bromley Briefings Prison Fact File, (July 2010); also FactFile (2009). Ministry of Justice, Prison Population Projections 2010-2016, England and Wales: Ministry of Justice Statistics bulletin, (30 September 2010).

37. The range of offences for which the IPP can or must be used contrasts with the outlook of *Stuart Smith LJ* in

1990: 'The imposition of the life sentence itself can only be justified by a very high degree of perceived public danger: there would otherwise be the temptation to impose it altogether too often simply in the interests of long-term public safety.' In *R (Bradley) v Parole Board* [1990] 3 All ER 828 at [146].

38. N. Padfield, 'The Parole Board in Transition' (2006) 3 *Crim.L.R.* 3-23 p8. See also N. Padfield and S. Maruna, 'The revolving door at the prison gate: Exploring the dramatic increase in recalls to prison' (2006) 6 *Criminology & Criminal Justice* 329-352.

39. MoJ statistics bulletin (2009) p16.

40. Under CJA 2003 ss224-36 and Sch 15, subsequently amended by Sch 15A under the CJIA 2008.

41. For some trenchant commentary, see Lord Judge in *R v C; Attorney General's Reference No. 55 of 2008 (C and Others)* [2008] EWCA Crim 2790.

42. See Ministry of Justice, *The Future of the Parole Board: consultation paper 14/09*, (2009) para 29, and Secretary of State's Directions to the Parole Board under Section 32(6) of the Criminal Justice Act (August 2004) para 4.

of acceptable risk 'wholly undefined' because indefinable⁴³ and subject to executive direction.⁴⁴ The concept of burden of proof has been ruled 'inappropriate when one is involved in risk evaluation',⁴⁵ but the prisoner must in practice demonstrate that the risk he poses is not more than minimal.

The element of arbitrariness built into such judgments is illustrated by the comparison of monthly average figures for the numbers detained under IPP pre- and post-2008 and their average pre-tariff sentence-length. Under the original range of offences whose perpetrators were accounted dangerous, 140 IPP prisoners were received per month, serving 38 months. Under the amended terms of reference, 45 IPPs were received, serving 60 months. The sentence now focuses on fewer, more serious offenders. Yet the Parole Board's assessment inevitably has as its starting point the assessment of all these prisoners, pre- and post-2008, as 'dangerous'. The loss of any connection between imprisonment and rehabilitation is an easy casualty, despite the inclusion of rehabilitation in the purposes of imprisonment in the *Criminal Justice Act 2003*.⁴⁶ Nor does this amendment to IPP signal diminished faith in detention; it merely trims a notoriously under-considered piece of legislation.⁴⁷

The Mental Health Tribunal is the Article 5(4) reviewing 'court' for people detained under the MHA and covered by Article 5(1)(e). A criterion for MHA detention is an undefined need for 'the protection of other persons'.⁴⁸ Under that provision, there is a yet more serious loss of connection – that between detention and treatment, even for the symptoms of mental disorder;⁴⁹ to lose that link would be to accept that psychiatry had become an overt means of control.

After 1983, the scope of the original provision of detention solely for the protection of others was gradually extended by the judiciary.⁵⁰ The battle for reform finally producing the MHA 2007 challenged that extension: referring to an earlier Bill but making an argument pertinent to the final Act, the Mental Health Alliance was 'particularly disturbed by the over-emphasis in the Bill on protection of the public from "dangerous" people and the disastrous impact this will have on those people it targets and on the vast majority of mental health patients who pose no danger to anyone.'⁵¹ In the upshot the 2007 Act's inclusion of personality disorders⁵² through abolition of the old 'categories', and its wider definition of

43. In *Bradley at [146]*: 'it seems inevitable that one can say really no more than this: first, that the risk must indeed be "substantial" ..., but this can mean no more than that it is not merely perceptible or minimal. Second, that it must be sufficient to be unacceptable in the subjective judgment of the Parole Board...'

44. See A. Thornton, 'Current practice and future changes: a judicial member's perspective', in N. Padfield (ed.), 'Who to Release? Parole, fairness and criminal justice', Willan Publishing (2007) p130 on the difference between case-law and (then) Home Secretary directions.

45. Keene LJ in *R (Sim) v Parole Board [2004] QB 1288 at [42]*.

46. See *Brown LJ in R (Wells) v Parole Board [2009] UKHL 22 at [48]* for the situation pertaining until July 2008 and the amendments then made.

47. See *Hope LJ in Wells at [3]*; see also *Collins J in R (B) v The Parole Board [2009] EWHC 1638 (Admin) at [23]*.

48. In *Mental Health Act Manual*, 13th ed., Sweet & Maxwell, (2010) para 1-055, Richard Jones remarks

tersely that 'there is no requirement for the two recommending doctors to agree on the nature of the risk which justifies detention under this section'. Neither does the Tribunal have any criteria by which to assess it.

49. See for example *R (A) v Canons Park Mental Health Review Tribunal [1995] QB 60; H [2001]; R (P) v Mental Health Review Tribunal [2002] MHLR 253 CA*.

50. Notably in legitimating hospitalisation for control and supervision: see *Hutchison Reid v United Kingdom [2003] 37 E.H.R.R. 9 and D (1987)*.

51. *Hansard, Joint Committee on the Draft Mental Health Bill Minutes of Evidence: Memorandum from the Mental Health Alliance (DMH 105) (9 March 2005) at para 1.8*. See also *Hansard, Minutes of Evidence taken before Joint Committee on the Draft Mental Health Bill: Uncorrected Transcript of oral evidence to be published as HC 95-xii, (Wednesday 26 January 2005) and Uncorrected transcript of oral evidence to be published as HC95v, (Wednesday 15 December 2004)*.

52. For guidance on treatment of personality disordered patients under the MHA, see *Code of Practice (2008) paras 3.18 and 3.19, and Chapter 35*.

‘treatment’,⁵³ merely confirmed judicial extension of the law.⁵⁴

During the passage of the MHA 2007, the Mental Health Act Commission expressed concern that detention could be legitimised by merely *intended* benefit to the disorder or its symptoms without evidence of *likely* benefit. It cited the draft Code of Practice, case-law and Jones to argue that individual ‘best interests’ should remain a criterion,⁵⁵ but the published Code contained no such reference. Indeed, while under the Code ‘Simply detaining someone – even in a hospital – does not constitute medical treatment’, detaining that person with nursing and ‘specialist day-to-day care’ under clinical supervision and in a ‘safe and secure therapeutic environment with a structured regime’ does.⁵⁶ It is a largely semantic distinction.

The Code follows the case-law.⁵⁷ cited above is Lord Clyde’s assertion of the power under MHA 1983 and the EHRC to detain people for the sake of public protection on the basis of their mental disorder and in the absence of treatment. That judgment followed *Ashingdane*, where only the minority judgment emphasised the difference in purpose between imprisonment and hospital detention, the latter involving the ‘...duty of the executive... to strive after the means most likely to bring a cure...’⁵⁸ The majority followed *Winterwerp* in ruling that the right to appropriate treatment could not be derived from Article 5(1)(e).⁵⁹ For Lady Hale, the indefinite confinement of capable and untreatable non-criminals under MHA could not be a ‘justifiable discrimination’; she deplored Strasbourg’s refusal to define ‘unsound mind’ in Article 5(1)(e) and thus restrict its potential abuse.⁶⁰ Her concern mirrored that of the Mental Health Alliance.⁶¹

This lack of clear definition of ‘mental disorder’ or ‘appropriate treatment’, including the distinction between detention in a therapeutic ‘milieu’ and mere containment, continues to exercise judges. Unfortunately, their rulings remain so hedged about by ‘if’, ‘may’, ‘might’ and other qualifiers that their call to Tribunals to apply the statutory conditions to the specifics of each case produces more appearance than reality of safeguard.⁶² Lack of definition remains a mighty weapon.

53. MHA s145(4).

54. See for example *Auld LJ in R (JB) v Haddock (Responsible Medical Officer)* [2006] on the role of ‘value judgments’ in ‘often difficult and complex questions of diagnosis and prognosis on which there may be some difference of medical opinion.’ See also *Hutchison Reid* [2003].

55. *Mental Health Act Commission, Policy Briefing for Commissioners*, (July 2007) p2. The Briefing also comments wryly on the effectively meaningless circularity of definition of ‘appropriate’. In mental health law, as in penal law in relation to ‘dangerousness’, lack of definition is a useful tool for those wanting to reduce possibilities for appeal against detention. The reference is to *R. Jones*, *Mental Health Act Manual*, 10th ed., Thomson: Sweet & Maxwell, (2006).

56. *Code of Practice* (2008) paras 6.16-6.17.

57. *Phillips LJ* commented obiter on the common law ‘best interest’ requirement for medical treatment, citing the relevance of such ‘wider considerations’ as the possibility of less intrusive treatments to ‘achieve the same result’. Since that ‘same result’ has to include the considerations not only of health but of others’ safety, it is unlikely that ‘best interests’ can go far in limiting the scope of the law. See *R*

(*B*) v (1) *Dr S*; (2) *Dr G*; (3) *SoS for Health* [2006] *EWCA Civ 28* at [62].

58. *Ashingdane v UK* [1985] 7 *EHRR* 528 at [551]. *Ashingdane* also ruled that psychiatric detention must be in an appropriate institution.

59. *Winterwerp v The Netherlands* [1979-80] 2 *E.H.R.R.* 387. See also *Ashingdane* at [44] for a ruling that there must be ‘some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention’.

60. *B. Hale*, ‘Justice and equality in mental health law: The European experience’ (2007) 30 *International Journal of Law and Psychiatry* 18-28 p27. The case is closely similar with the non-definition of ‘appropriate’ treatment and indeed of its ‘availability’; which will also no doubt exercise the judiciary.

61. *Hansard*, Joint Committee on the Draft Mental Health Bill Minutes of Evidence: Memorandum from the Mental Health Alliance (DMH 105) (9 March 2005), in particular Part 4.

62. *DH-L v Devon Partnership NHS Trust* [2010] *UKUT* 102 (AAC) at [33] and [24]; *MD v Nottinghamshire Healthcare NHS Trust* [2010] *UKUT* 59 (AAC) at [48].

Prison or hospital?

If people can be detained purely for the protection of others under criminal and mental health law, what is the distinction between them?

In principle, and probably in practice in terms of the experiential difference between even a HSH and a high-security prison, there is a profound distinction in terms of the institutions' rationale and the motivations and professional ethos of the detaining authorities. Hoggett, now Lady Hale, is a prime proponent of a principled difference between the two regimes. 'The gulf between pure preventive detention and some sort of medical care and treatment may be very narrow, but it is nonetheless deep...; although she also makes it clear that a gulf so narrow is liable to be bridged.⁶³ Dyson LJ subsequently spelled out the 'subtle yet important differences' between Tribunal and Board. Before the Tribunal, '[w]hile risk to the public is a factor it is not determinative in the absence of evidence that the patient meets the criteria for detention in hospital under the Act'. Before the Parole Board, 'primacy of risk' to the public must be respected.⁶⁴

Hallett LJ insists on the principle that 'the Mental Health Act regime under a hospital order focuses on reducing the risk of a recurrence of mental illness as opposed to reducing the risk of re-offending...'⁶⁵ Parallel reasoning holds for restricted patients: the judiciary must resist any temptation to see a transfer direction as a means of prolonging penal detention.⁶⁶ Though restriction-direction patients continue to serve their sentence while detained in hospital, psychiatric detention is not (in principle) punitive. So at least Lady Hale argues, commenting on the tendency of Strasbourg to treat psychiatric hospital and prison together and referencing her own Appeal Court ruling in *Munjaz* on their different purposes.⁶⁷

Sentencing courts must therefore (try to)⁶⁸ distinguish where on the gradient a law-breaker stands: between offences directly attributable to a mental disorder and those where, despite such a disorder, the causal link is 'diminished' or absent.⁶⁹ At the one end lies a hospital order, probably with restriction;⁷⁰ at the other a prison sentence, even if a transfer/restriction direction is subsequently needed;⁷¹ in the middle a hospital/limitation direction.⁷²

63. B. Hoggett, *Mental Health Law*, 3rd ed., London: Sweet & Maxwell, (1990) p289. The reference to 'the gulf' is repeated on page 273 of B. Hale, *Mental Health Law*, 5th ed., London: Sweet & Maxwell (2010).

64. *R v Staines* [2006] EWCA Crim 15 at [22], quoting a 'conspicuously impressive' consultant psychiatrist witness.

65. *R v Rajesh Kumar Dass* [2009] EWCA Crim 1208 at [46].

66. See Stanley Burnton J in *R (D) v SoS for the Home Office, SoS for Wales* [2004] EWHC 2857 (Admin) at [20].

67. B. Hale, 'What can the Human Rights Act do for my mental health?' (May 2005) *J. Mental Health L.*, p10. *R (Munjaz) v Mersey Care NHS Trust and Others* [2003] EWCA Civ 1036 at [55].

68. See J. Shaw et al, 'Rates of mental disorder in people convicted of homicide: National clinical survey' (2006) *188 British Journal of Psychiatry* 143-147, for an analysis of the mental health diagnoses most and least frequently associated with a hospital order, and of the incidence of

those convicted of manslaughter on the grounds of diminished responsibility nevertheless receiving a prison disposal.

69. See Mustill LJ in *R v Birch* [1989] 90 Cr. App. R. 78 at [89]. For a more recent discussion of the 'balancing act' necessary in deciding between hospital and prison disposal, see Hallett LJ in *Dass* at [46] et seq..

70. MHA s37/41. See Birch at [87] for discussion of the difficulty facing the sentencing judge in assessing whether a s41 restriction order is required. The House of Commons Justice Select Committee considered that 'sentencers would benefit from better guidance on their options with regard to persons requiring different levels of mental health support': see its Fifth Report of Session 2007/08: Sentencing, (8 July 2008) para 210.

71. MHA ss47/49.

72. MHA s45A, inserted by the Crime (Sentences) Act 1997, s46. There is no provision for voluntary psychiatric hospitalisation of prisoners; in-patient mental health care must be compulsory, however compliant – or eager for it – prisoners may be.

Such complexities make for effectively arbitrary disposals. The MHA 2007 has removed the separate provisions for mental illness and 'psychopathic disorder'. But legal and clinical understandings of mental disorder continue to differ, driven by different agendas.⁷³ In *Murray*, sentencing guidelines and M'Naghton Rules enforced a penal disposal, though the Appeal Court subsequently moved the claimant to hospital.⁷⁴ However, the rules remain open to the influence of fear: either hospital or prison can be chosen as providing the longest and securest sentence. Thus the MHAC disapprovingly cited the refusal of the sentencing judge to send Nicky Reilly (diagnosed with Asperger's syndrome and learning disability) for assessment in Broadmoor before passing a life sentence.⁷⁵ In *Simpson*, the Appeal Court overturned the original prison disposal primarily on the grounds not of the offender's treatability, but because 'the best chance of minimising the danger lies in a Hospital Order...'. While Toulson LJ spoke of the (dim) hope of rehabilitation through medical treatment, the security implications were decisive.⁷⁶ The situation was even clearer in *IA*, where the sentencing judge handed down a life sentence in the 'hope and expectation' that Mr IA would be detained in hospital; however, 'little or nothing appeared to [be] done to effect the transfer'.⁷⁷

It is partly a question of supply and demand. Given that prison beds are uniquely available on demand whatever the overcrowding, many prisoners assessed as needing hospital are not transferred.⁷⁸ The ruling in *IH* is interesting: continued detention of a patient potentially fit for conditional discharge is not unlawful where the 'nature' criterion is satisfied and where no appropriate community provision is available.⁷⁹ The funding priorities of PCTs and local government thus define the limits of lawful detention.⁸⁰

So while prisons bulge with mentally disordered inmates, beds in secure units and HSHs are occupied by patients 'sectioned' more for security than health reasons. AT indicates the readiness with which Hoggett's 'gulf' can be bridged by the use of hospital as place of indefinite preventive detention.⁸¹ Personality disorder diagnoses in particular are open to control-oriented interpretation: prisoners put forward by the Prison Service for transfer under the MHA can be deemed unsuitable by the Secretary of State [SoS] because of their 'untreatable' personality disorder⁸² yet identically-diagnosed prisoners

73. See G. Richardson and D. Machin, 'Judicial Review and Tribunal Decision Making: A Study of the Mental Health Review Tribunal' (2000) *Public Law* p501 for discussion of the inability of JR processes to define the legal meaning of the criteria under the MHA, definable only on a case-by-case basis.

74. *R v Murray* [2008] EWCA Crim 1792.

75. MHAC 2007-2009 para 4.7.

76. *R v Jonathan Paul Simpson* [2007] EWCA Crim 2666 at [28-30].

77. *R v IA* [2005] WL 1801234 at [2] and [17].

78. See for example Prison Reform Trust, *Too Little Too Late* (2009). In 2007 the Trust had reported continuing high numbers of severely mentally disordered prisoners and persistent serious delays in transfer to hospitals, despite some improvements since 2004: see Prison Reform Trust, *Indefinitely Maybe: how the indeterminate sentence for public protection is unjust and unsustainable*, (2007) pp19 et seq.

79. *R. (IH) v SoS for the Home Department and another* [2003] UKHL 59. See also P. Bartlett and R. Sandland,

Mental Health Law: Policy and practice, 3rd ed., OUP, (2007) p108 for comments on lack of lower-security facilities.

80. See also Creighton 2006, p114 for discussion of *AT v UK* [1995] 20 EHRR CD 59. The possibility of a transfer direction depends upon availability of a hospital bed, and long delays are common.

81. See L. Moncrieff, 'Discharge of Restricted Patients from Special Hospitals in England and Wales', in K. Diesfeld and I. Freckleton (eds.), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment*, Ashgate, (2003) p279 for discussion of the effective bed-blocking in high security hospitals by patients whom the SoS refused to recategorise to lower security levels; and p275 on the way in which indeterminate restricted patients early in their sentences can be confined in high security hospitals on grounds of procedural ineligibility not dangerousness. See also Bartlett and Sandland (2007) p108.

82. Professor Charlie Brooker of Lincoln University, cited in *Prison Reform Trust, 'Too Little Too Late'* (2009) p23.

hitherto deemed 'untreatable' can now be transferred under that same Act, and detained indefinitely.⁸³ In *TF*, the Appeal Court ruled that a transfer direction effected in September 2008, just before MHA 2007 was implemented and on the eve of young TF's release, was under s47(1)(b) unlawful in the absence of adequate medical evidence; the SoS' eleventh-hour attempt to continue detaining that personality-disordered offender had been one degree too clumsy.⁸⁵

The rationale of recalls is similarly blurred. The SoS can recall a conditionally discharged patient though his disorder is not of the statutory 'degree' for initial detention 'because the combination of the patient's mental disorder and his behaviour makes it necessary' for public safety.⁸⁶ The recall decision depends only 'partly' on medical advice, 'comparatively minor irregularities of behaviour or failure to cooperate with supervisors being sufficient'; though behaviour unconnected with the mental disorder does not merit the 'sanction' of recall, 'the decision will always give precedence to public safety considerations' – a powerful catch-all.⁸⁷ The SoS apparently regards recall as a 'sanction' though its role is non-punitive.

But perhaps the most revealing indicator of an effectively arbitrary executive use of detention is the MoJ's range of responses when a conditionally discharged patient is reconvicted and sentenced to prison. '[T]he SoS will often reserve judgement on the patient's status under the *Mental Health Act 1983* until he nears the end of his prison sentence, when he will seek fresh medical evidence....', on the basis of which he may allow conditional discharge to resume, direct immediate recall to hospital or authorise absolute discharge.⁸⁸ The 'need' for hospital is again provoked only by the proximity of release.⁸⁹

Optimists in search of rationales based on criminogenic or therapeutic priorities may despair. The Board's judgments on criminogenic risk can face executive challenge on the grounds that the offender's mental health renders its evidence unsafe, thus challenging the validity of its specialist work.⁹⁰ Meanwhile, the SoS' focus on immediate risk-avoidance must be deeply frustrating for courts aware that for some personalities, continued detention and over-stringent risk management on release increase longer-term risks of reoffending.⁹¹

Again, the Tribunal may review pre-tariff lifer restriction-direction patients whose detention may have no therapeutic or a counter-therapeutic effect, without effective power to discharge them: that lies with the Board. The discharge of post-tariff lifers under restriction directions, assessed by the Tribunal as ready for conditional discharge into the community but not back to prison, may be indefinitely blocked by a

83. As in *Anderson supra* f/n 18.

84. *The arrival of such evidence after the transfer took place did not render the initial action retrospectively lawful.*

85. *R (TF) v SoS for Justice* [2008] EWCA Civ 1457.

86. Ministry of Justice, *Guidance for clinical supervisors*, (18 March 2009) para 63.

87. MoJ *Guidance* (2009) para 62. This guidance closely follows Toulson LJ's ruling in *R (MM) v SoS for the Home Department* [2007] EWCA Civ 687. The judgment emphasises at [48] the potential difficulty of assessing the moment at which recall is justified; the Guidance is simpler in its emphasis on the priority of public safety.

88. MoJ *Guidance* (2009) para 70.

89. *The MoJ Guidance* (2009) must be seen in the light of its

genesis as a response to 'failures in supervision which contributed to homicides being committed by conditionally discharged patients: ' *ibid* para 2.

90. See *Murray v Parole Board* [2003] EWCA Civ 1561 at [13] et seq., quoting *Oldham v UK* (Application no 36273/97, 26 September 2000. Despite strong positive evidence of a prisoner's reduced criminogenic dangerousness, the SoS argued for continued imprisonment on the grounds that 'mental instability posing risks of dangerousness' is innately less amenable to change over time than 'mental disorder in the context of mental illness'.

91. See J. Craissati, 'The paradoxical effects of stringent risk management: community failure and sex offenders', in N. Padfield (ed.), *Who to Release? Parole, fairness and criminal justice*, Willans Publishing, (2007) p227.

Board wary of their lack of criminogenic course-work or testing in open prison.⁹² Tribunal members clinging to belief in the MHA's therapeutic rationale will be troubled by the evidence in *A and Others* of the psychological impact of indefinite detention.⁹³

Anderson presents the incoherences starkly. His disorder having been assessed as untreatable, Mr Anderson could not be held in a prison hospital wing because (unsurprisingly) no treatment was available for him; he could nevertheless be indefinitely detained in hospital. Furthermore, while he required hospitalisation because he was too dangerous to be held in prison, assessment of his dangerousness was deemed to be beyond the Tribunal's sole remit.⁹⁴

Thus while the Board can grant parole to mentally disordered prisoners who have (randomly) avoided restriction directions, the Tribunal cannot free restriction direction patients. The logic is comprehensible given that the criminal sentence has priority as the detaining rationale: Article 5(1)(a) rather than 5(1)(e). But since the Board's task of risk assessment is shared by restricted patient Tribunal panels in addition to their mental health responsibilities, it seems absurd for these Tribunals with their 'exalted membership' not to have the power of release.⁹⁵ The situation is a looking-glass land of situations whose essential likeness is revealed yet divided by law.

Perhaps the least adequately defined of all prisoners and patients are the 'personality disordered',⁹⁶ whose situation encapsulates the potential arbitrariness of the dual system. 'Why does he keep committing crimes? Because he is a psychopath. How do you know he's a psychopath? Because he keeps committing crimes.'⁹⁷ It is the next twist which is deadly: the 'extent to which abnormally aggressive or seriously irresponsible conduct now occurs may throw light on whether there is a psychopathic disorder, but the disorder may still exist, even if there has been no such conduct for several years.'⁹⁸ How do you know he's a psychopath? Because he used to be seriously irresponsible.

The problem has two sub-divisions. One is the legitimacy in principle of indeterminate preventive detention. The other is the lack of any clear division between incontrovertibly dangerous 'psychopaths' and other personality disordered individuals. For Lord Bradley, the government's DSPD programme (for dangerous and severe personality disordered people) was a positive step towards treating the hitherto 'untreatable' PD population.⁹⁹ Others are more suspicious. For them it is a confirmation of all that is prejudiced and stigmatising;¹⁰⁰ an attempt to conceal indefinite detention behind mental health legislation;¹⁰¹ a malign use of hospitalisation for social control.¹⁰² Psychiatrists have denounced the

92. *Current conversations suggest that the current MoJ Consultation (2009) is likely to elicit many calls, from Board members amongst others, for the Board to give itself more flexibility about such requirements.*

93. *See A and others v United Kingdom [2009] ECHR 3455/05 at, for example, [76].*

94. *See Anderson at [63-65], supra fn 18.*

95. *See Hoggett (1990) p291, supra fn 63. With reference to the 'exalted membership', it should be noted that those eligible to preside at restricted patient hearings have been extended beyond Circuit Judges and Recorders who are also Queen's Counsel, to include a number of salaried Tribunal Judges.*

96. *See the anxieties on this subject expressed by the Mental Health Alliance: Memorandum (9 March 2005), para 6.5.*

97. P. Mullen, 'Dangerous and severe personality disorder and in need of treatment' (2007) 190 *British Journal of Psychiatry* s4.

98. *Pill LJ in R (P) v Mental Health Review Tribunal [2002] MHLR 253 CA at [23].*

99. *Bradley Report (2009) p109.*

100. *For a passionate response by a senior psychiatrist, see D. Kingdon, 'DSPD or 'Don't Stigmatise People in Distress'' (2007) 13 *Advances in Psychiatric Treatment* 333-335.*

101. *See Mullen (2007) s3.*

102. *See P. S. Appelbaum, 'Dangerous Severe Personality Disorders: England's Experiment in Using Psychiatry for Public Protection' (2005) 56 *Law & Psychiatry*, pp397-98. Appelbaum quotes the 2000 White Paper which cites public protection as a key priority in mental health legislation.*

categorisation as undefined and clinically unrecognised.¹⁰³ DSPD has been described as a ‘monster’ created by government as a precursor to ‘draconian legislative powers’, which though not themselves materialising had an equivalent in IPP.¹⁰⁴ Moncrieff has a parallel concern, focused on the treatment of patients restricted for a wide variety of reasons ‘as if they were restricted for the same reason – the protection of the public from serious harm.’¹⁰⁵ In a culture in which indefinite detention has become legally normalised, lack of definition permits ‘dangerousness’ to become the scientist’s despair: an unfalsifiable proposition and a statement of prejudice and aversion.¹⁰⁶

Conclusion

Moral cowardice lay at the heart of the previous government’s discussion and formulation of policy on dangerous individuals. The British Association of Social Workers noted the contrast between the extension of compulsory powers to include personality disordered patients under the *Mental Health Bill 2007* with the lack of actual funds for treatment of such disorders, in hospital or the community.¹⁰⁷ It is hard to make sense of government policy save by recognising its desire to be seen as tough on crime and disorder and the individuals which exemplify them, without needing to take on the long-term expenditure needed to address the needs of electorally unrewarding social misfits.

Compulsion, whether in hospital or in the community, is a policy of containment which minimises costs while maximising electoral advantage. Were the motives otherwise, the DoH anti-stigma campaign, supported by coherent policies of health and social care, would be at the forefront of political self-presentation and funds, not the MoJ’s crime and disorder agenda. For the policy rides in the face of evidence that popular fears legitimate unnecessarily harsh legislation and counter-productively cautious decision-making on sentencing and release.¹⁰⁸

Concern about the implications of this legal situation for effectively arbitrary detention need not rest on any political judgment about the intentions of the last or present government. Legal safeguards exist to protect us against potential as well as actual danger; when abuse ceases to be potential, it is probably too late to guard against it. Therein lies the inadequacy of denying the threat to civil liberties posed by recent terrorism legislation on the grounds of government’s benign intentions.

103. A. Buchanan and M. Leese, ‘Detention of people with dangerous severe personality disorders: a systematic review’ (2001) 358 *The Lancet*, p1955. See also Department of Health, *Executive Summary of the Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, (1999)*, its criticisms *inter alia* of the ‘lottery’ by which severely personality disordered people, treatable or not, were consigned to prison or hospital, turning the latter into ‘quasi-prisons’. While Ashworth has undergone significant subsequent reform, the criticism retains a broader currency.

104. P. Tyrer, ‘An agitation of contrary opinions’ (2007) 190 *British Journal of Psychiatry*, s1.

105. Moncrieff (2003) p268. Lady Hale has commented on the tendency of Strasbourg to treat psychiatric hospital and prison together, pointing to the importance of her own ruling in *R (Munjaz) v Mersey Care NHS Trust and Others* [2003] EWCA Civ 1036 at [55] in defining the

difference in their purposes. See Hale (2005) p10, *supra* fn 67.

106. See D. Kingdon, ‘DSPD or ‘Don’t Stigmatise People in Distress’ (2007) 13 *Advances in Psychiatric Treatment* p333.

107. British Association of Social Workers, *Memorandum: evidence to the House of Commons Public Bill Committee on the Mental Health Bill, MH 25, (2007)*, paras 10-14.

108. See for example concerns that the claimant’s previous high-profile escape was colouring the fairness of his consideration for recategorisation in *R (Williams) v SoS for the Home Department* [2002] 1 WLR 2264 at [18]. For a view of how incarceration and frequent recall may feed recidivism, see *Ralph Coleman et al v Arnold Schwarzenegger et al*; *Marciano Plata et al v Arnold Schwarzenegger et al* [2009] NO. CIV S-90-0520 LKK JFM P; NO. C01-1351 TEH at [169-70].

Challenges to populist myths about the equations of mental disorder and crime with dangerousness by one part of government are swamped by executive pronouncements, statute and case-law which validate them. Fantasies about a risk-free society are politically manipulated. Lawful powers exist and are exercised to detain people indefinitely and preventively; such detention can be maximised by the selective use of mental health and criminal law. The ECHR provides protection against abuses, but is generous in its definition of the lawful.

The problem of dangerous anti-social behaviour is real, and the balance to be struck between individual freedom and public safety demands continuing debate. But such conversation must involve more imaginative consideration of how a society can deal with its own 'brokenness', less fear-driven approaches to mental disorder and more historical awareness of the significance of civil liberties.