

'Offenders, Deviants or Patients' - Comments on Part Two of the White Paper*

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Introduction

The Government White Paper Reforming the Mental Health Act² follows closely on the heels of the Green Paper - Reform of the Mental Health Act, 1983 which derives from (but also departs from in many respects) the Report of the Expert Committee chaired by Professor Geneva Richardson.³ One could say, with some justification, that mental health professionals have been 'deluged' with paper in this area in the past year or two, so that trying to discern trends has become very difficult. In particular, the material in the White Paper is somewhat closely written and needs to be read with a good deal of care (or, so it seemed to me). To complicate matters further, offender-patients are also discussed in Part I of the White Paper (The Legal Framework) whereas it would have been more logical to have dealt with the proposed provisions for them in Part II. For clarity, I propose to deal with all these matters under one heading.

* *I have used the title of my book, Prins, H. (1995) Offenders, Deviants or Patients? Routledge, to reflect the ambiguity and uncertainty which surrounds 'High Risk' patients and offender-patients as evidenced in the White Paper.*

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2 *Reforming the Mental Health Act. Parts I and II. Cm 5016-I and II. Department of Health and Home Office. 2000.*

3 *Reform of the Mental Health Act, 1983 - Proposals For Consultation, Department of Health, 1999, and Expert Committee Report Review of the Mental Health Act, 1983. (Richardson Committee). Just how far the Green Paper departs from the Richardson Committee may be discerned in Peay's article in this Journal, Peay, J. (2000) Reform of the Mental Health Act, 1983 - Squandering An Opportunity. Journal of Mental Health Law. 3, 5-15. For the Human Rights implications of the Green Paper proposals see Bowen, P. (2000) Reform of the Mental Health Act, 1983: Convention Implications of the Green Paper. Journal of Mental Health Law, 4, 99-120.*

High Risk Patients

Some general matters are addressed in Part I - as follows -

(i) Simplified procedures are proposed for both assessment and treatment; and, unlike the current arrangements, will apply to both lower and higher courts. Powers are proposed for hospital or community based treatment.

(ii) Sentencing powers after assessment

(a) Courts may, as now, make a criminal justice disposal, such as a life sentence in murder cases, an automatic life sentence in cases falling within the scope of Section 2 of the Crime (Sentences) Act, 1997, a determinate sentence or any other disposal.

The power to make a Hospital and Limitation Direction (the so-called 'Hybrid Order') is retained, but will now be available for *all forms* of mental disorder and not, as now, only for psychopathic disorder. The Home Secretary's powers to transfer individuals to hospital from prison will be retained.

(b) Courts will be able to make a Care and Treatment Order and, in appropriate cases, add a restriction order as at present. In the latter case, the newly created Tribunal's powers will be similar to those of existing Mental Health Review Tribunals.⁴ Arrangements for discharge will be similar to the current system, but an important safeguard is proposed, namely that 'no conditional discharge will be deferred indefinitely without review'. (p.42). The role of the Parole Board in relation to mentally disordered prisoners who have been given a life sentence will remain much the same as at present.

Specific Matters (Part II)

It comes as no surprise that the focus in Part II is very much concerned with public protection. 'Public protection is one of the Government's highest priorities. Public protection and the modernisation of mental health powers and services are complementary aims.' (p.1). The paper goes on to suggest that the 'vast majority of people treated under mental health legislation are treated in their own best interest ... (and largely) to protect them from self harm'. (p.1) 'By contrast there are a smaller number of people ... who are characterised by the risk they present to others. This group includes a very small number of people detained under civil powers and others who are remanded or convicted offenders ... within this wider group are a number of individuals whose risk is a result of a severe personality disorder.' (p.5). The White Paper goes on to recognise that 'At present neither mental health nor criminal justice legislation deals adequately with the risks this group pose to the public.' (p.9). One might question whether it is the *legislation* that is at fault or rather the sad gaps in our knowledge and skills. Such statements illustrate the futility of passing enactments for purely political reasons and out of 'moral panic'.⁵ They go on, 'Until now, a lack of strategic direction has meant little progress in developing a robust long-term solution to this problem.' (p.9). In recognition of this, the Government propose that 'a small number of

4 The role of the new Tribunal is mentioned in both parts of the White Paper. Of note, is the deletion of the word Review from the title; this arises no doubt because the new body will have both admitting and discharging powers. A major departure, and of some concern in

respect of civil liberties.

5 Maybe our political masters and mistresses would do well to read or re-read Cohen's masterly work *Folk Devils and Moral Panics*, McGibbon and Key, 1972.

individuals' will be made subject to detention in a mental health facility even though they may have committed no current offence, but are, in the view of mental health professions, too dangerous to be at large. Many will view this proposal with considerable disquiet in terms of an individual's civil liberties. In addition, how easy will it be to find professionals prepared to undertake such 'crystal ball' forecasting? One is left wondering if the Government has been very realistic about the scope of effective interventions with this extremely difficult group of people.⁶ To be fair, there is an acknowledgement of the massive funding required for both new estate and services. The main thrust of the White Paper is, as already indicated, concerned with that comparatively small group of individuals adjudged to be dangerous as a result of their severe personality disorder (DSPD). For this purpose, the sum of £126 million will be allocated over the next three years to the provision of new specialist services. Such services will be the subject of pilot studies and 'rigorously and independently evaluated as part of a comprehensive research agenda'. (p.3). 320 additional specialist places across the Prison Service and the NHS will be provided as will 75 special hostel places. The Government is sensibly circumspect at this stage in not deciding which of the two treatment options it proposed as possibilities in the 1999 consultation document.⁷ They are also circumspect in their use of the term 'dangerous people with severe personality disorder' (DSPD), regarding it as a 'working definition'. In their words, 'it is designed to cover individuals who:

- show significant disorder of personality;
- present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover, e.g. homicide, rape, arson; and in whom,
- the risk presented appears to be functionally linked to the personality disorder.' (p.13).

It is encouraging to note this indication of caution, since a number of observers (including the present author) have been critical of the original consultation document in that it did not seem to show sufficient awareness of the hazards involved in defining and delineating exactly what constitutes a dangerous severe personality disorder.⁸ The second element in their statement, namely 'serious physical or psychological harm' is very reminiscent of the Butler Committee's well-known attempt to define dangerousness as long ago as 1975. We might ask ourselves whether we are any further on some twenty-five years later? The White Paper indicates that there will be an attempt to 'refine this definition ... as we develop a clearer picture of the nature and characteristics of this group'. (p.13). We can only live in hope. Concerning the number of DSPD individuals involved, the White Paper estimates that there is a total of between 2,100 and 2,400 men who fall

6 For some discussion of this aspect see Prins, H. (1999) *Will They Do It Again? Risk Assessment and Management in Criminal Justice and Psychiatry*. Routledge.

7 Department of Health and Home Office (1999) *Managing People With Severe Personality Disorder - Proposals for Policy Development. The two options were Option A, amended criminal justice legislation to allow for greater use of discretionary life sentences, an amendment to the 1983 Mental Health Act, to remove the 'treatability' criterion for civil detainees. Services would continue to be provided in both prison and NHS*

facilities. Option B proposed new powers in civil and criminal proceedings for indeterminate detention of DSPD individuals (including powers for supervision and recall following detention). Individuals would be held in a new service separately managed from mainstream prison and health services - a 'third service'.

8 See for example, Prins, H. (2000) *Dangerous Severe Personality Disorder - An Independent View. (Based on an address given at the launch of the Home Office and Department of Health Consultative Document)*. *Prison Service Journal*, 126, 8-10.

into this category. No precise figures are available for women, but the problems they present are recognised and attempts are being made to ascertain how many women might be so designated. The need for public protection from DSPD individuals has to be placed within the wider context of the need for more general 'protective' measures. For example, the registration of sex offenders, the powers to make sex offender orders under the Crime and Disorder Act, 1998 and the power to impose an automatic life sentence for a serious violent or sex offence - Crime (Sentences) Act, 1997. The decision as to which of the two options will be implemented (see footnote 7 *supra*) will wait upon the evaluation of the provisions currently being piloted (for example those in Rampton Hospital and HMP Whitemoor).

Summary of Arrangements for Assessment and Treatment

(a) Civil Proceedings

Those individuals thought to be demonstrating DSPD may be referred for initial specialist assessment in an NHS secure facility. If further, more comprehensive assessment is required, it will be provided in a specialist DSPD assessment centre. Long-term detention will require the authorisation of the new Mental Health Tribunal.

(b) Criminal Proceedings

Following an initial screening assessment, a defendant may be transferred to a specialist DSPD/NHS assessment centre. Following this assessment period, the sentencer will be provided with a detailed report and will make whatever disposal seems appropriate in the circumstances. The newly constituted Mental Health Tribunal will have an important role to play in cases where a health care disposal (such as a Care and Treatment Order) is being made. Para 3.16 gives some indication of the composition of the new Tribunal.

'The Tribunal will have a legally qualified chair and two members with experience of mental health services. One of the members will be a person with a clinical background and the other will usually have a background of community or voluntary sector service provision.' (p.17).

It would appear that the composition of the proposed new Tribunal will have a somewhat broader base than the existing Review Tribunal with its legal, medical and 'lay' membership. This is in line with recent views concerning the need to extend the Tribunal's membership to include, for example, such professionals as clinical psychologists.⁹ The medical input will in future be provided by the 'independent medical expert' who will be appointed to see the patient, replacing the 'medical member' under the present system. Such experts 'will have expertise in the particular type of disorder from which [the patient] is suffering' (p.18). One may ask whether such expertise will *always* be available. In cases involving DSPD 'the medical expert will generally have a background in forensic psychiatry or psychology' (p.18). This proposal seems to stem from concerns expressed about the absence of forensic-psychiatric tribunal membership in restricted cases. The president in such cases will be required to be qualified as a sentencer in much the same way as at present:

9 See for example. Blom-Cooper, L.Q.C., Grounds, A., Guinan, P., Parker, A. and Taylor, M. (1996) The Case of Jason Mitchell: Report of the Independent Panel of Inquiry. Duckworth. For comment on the proposal to

remove the medical member from the Tribunal see Rooth, G. (2001) The Future (or not) of the Medical Member: An Aspect of the 1983 Mental Health Act Review. *Psychiatric Bulletin*, 25, 8-9.

'A lawyer with experience of sentencing in the higher courts will chair a Mental Health Tribunal dealing with a restricted patient' (p.27) ... 'it is essential ... to preserve the confidence of the sentencing court in the efficacy of powers for compulsory care and treatment as an alternative to a prison sentence'. (p.27). The White Paper sets great store by the development of new enhanced techniques of assessment. New assessment techniques will make use of the latest actuarial devices such as the Hare Psychopathy check-lists. It would appear that previous assessments made in suspected DSPD cases will not be thought sufficient, and prisoners or offender-patients will be subjected to a system of rigorous re-appraisal. Laudable though this intention may be, one must speculate on the degree to which improved assessment outcome will be likely over and above the numerous previous attempts that will have been made. Time will tell, but one cannot be particularly optimistic. It is almost as though there is an expectation that some 'magic' will be forthcoming. As the late doctor Peter Scott wisely commented some twenty-five years ago, there is no 'magic' in the assessment of dangerousness, merely patience and thoroughness and a capacity to take a rounded, longitudinal view.¹⁰ Professionals should be wary of being seduced into the trap of a public expectation, that they will get it right every time. Human error will always operate, and occasional mistakes will occur however excellent the assessment skills. To give the impression that we are infallible will mean that we will 'fall from grace' even more heavily than we do, on occasion, at present. The White Paper makes one further and, no doubt for some, somewhat controversial proposal. This is to the effect that 'appropriate' information will be provided for victims of mentally disordered offenders who have committed serious violent or sexual offences. This will be concerned with the offender's detention and discharge, and will permit victims to make representations to Tribunals about 'discharge conditions that relate to contact with them and their family'. (p.27). Such release of information and the opportunity to make representations will require very careful handling, and there are likely to be issues of patient confidentiality to surmount. The White Paper is, for the most part silent on the detailed arrangements for such disclosure and representation.

Concluding Comment

There is little doubt that the 1983 Act was in need of re-examination. The locations for psychiatric interventions have changed in recent years and, on occasion, the Act has proved difficult to interpret - as is evidenced by the number of cases taken to judicial review, particularly in restricted cases. Serious under-resourcing has hampered adequate care and control of offender-patients. Whether the ministerially and heavily prescribed 'root and branch' review of the legislation was entirely necessary is a matter for debate. Much store is set in Part II of the White Paper on the capacity of professionals to assess and manage risk - notably in DSPD cases. Governments would do well to recognise human fallibility in this area and not create unrealistic and potentially damaging expectations based on political expedience. However, the Government appears to have *some* awareness of this, despite its persistent preoccupation with the 'moral panic' of the need for public protection. Para 2.15 states as follows:

'Our proposals in this White Paper, and the sequencing of their introduction provide a practical way of making progress on these issues of concern whilst also addressing the fundamental

¹⁰ Scott, P.D. (1977) Assessing Dangerousness in Criminals. *British Journal of Psychiatry*, 131, 127-42.

challenge of public protection. This is not a problem that can be solved in its entirety at a stroke. It will require years of research, service development, specialist staff training work to determine the best possible environmental setting and most effective treatments before we can be sure that we have the most effective services for this group. Indeed we can always improve services and knowledge. But this cannot be a reason to fail now to embark on the process or to take powers which are needed to protect the public.' (p.12).

A Bill is promised when 'Parliamentary time allows'. We shall have to wait and see.