

Journal of Mental Health Law

Articles and Comment

Psychopathic Disorder – Concept or Chimera

Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness

Claiming Damages for Workplace Stress

Mental Disability Law in Central and Eastern Europe: paper, practice, promise
Should We Allow Compulsory Mental Health Treatment in Prisons?

Casenotes

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Nearest Relatives of Gay and Lesbian Patients

Book Review

Neither Mad nor Bad. The Competing Discourses of Psychiatry, Law and Politics

The Draft Mental Health Bill 2002

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Responses

The Law Society

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Liberty

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Robert Brown, Independent trainer of Approved Social Workers and Mental Health Act Commissioner



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Contents	Page
Foreword	243
 Articles and Comment	
Psychopathic Disorder – Concept or Chimera	
<i>Professor Herschel Prins</i>	247
Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness	
<i>Melissa McGrath and Professor Femi Oyebode</i>	262
Claiming Damages for Workplace Stress	
<i>Edward Myers</i>	283
Mental Disability Law in Central and Eastern Europe: paper, practice, promise	
<i>Oliver Lewis</i>	293
Should We Allow Compulsory Mental Health Treatment in Prisons?	
<i>Mat Kinton</i>	304
 Casenotes	
The Home Secretary’s Tribunal Referral Powers following <i>IH</i>	
<i>David Mylan</i>	308
Charging for After-care Services under Section 117 of the Mental Health Act 1983 – The Final Word?	
<i>Nicolette Prialux</i>	313
Nearest Relatives of Gay and Lesbian Patients	
<i>Nicola Cho</i>	323
 Book Review	
Neither Mad nor Bad. The Competing Discourses of Psychiatry, Law and Politics	
<i>James Gray</i>	328
 The Draft Mental Health Bill 2002	
Is Anyone Safe? Civil Compulsion under the Draft Mental Health Bill	
<i>Professor Anselm Eldergill</i>	331
Some Thoughts on the Proposed Mental Health Act	
<i>Professor Michael Gunn and Professor Tony Holland</i>	360
 Responses	
The Law Society	373
The Royal College of Psychiatrists.....	376
Liberty	380
Guy Otten, MHRT Regional Chair for Trent, Yorkshire and Northern Region	386
Robert Brown, Independent trainer of Approved Social Workers and Mental Health Act Commissioner.....	392

Foreword

On 26th June 2002, the Government published its draft Mental Health Bill for England and Wales, which if enacted, would signify the most fundamental reform of mental health laws for nearly half a century.

Since its publication, the mental health field has been very much in a reactive mode, driven by widespread concerns about a number of key proposals contained in the Bill. Described as ‘a serious threat to civil liberties’, ‘unethical and unworkable’, ‘a regressive public order measure masquerading as a therapeutic one’, the subsequent absence of the Bill from the Queen’s Speech in November was perhaps not surprising following its almost universal condemnation. Its omission gave rise to brief speculation that it might be withdrawn in its entirety from the Government’s legislative agenda, although such suspicions were short lived, following the Health Secretary, Alan Milburn’s assurances that the Government would press ahead and introduce a Mental Health Bill into the current parliamentary session. This brief hiatus will undoubtedly be welcomed by those campaigning against the draft Bill and afford Ministers an opportunity to reconsider the Bill’s more controversial proposals.

In the final months leading to the publication of a revised Bill in 2003, this issue of the Journal seeks to highlight the many fundamental concerns about the current draft Bill expressed by sectors working in the mental health field, by bringing together a handful of the estimated 2000 or so responses made during its short consultation period last summer. For ease of reference, the articles and commentaries which focus squarely on the implications of the draft Bill have been placed in a separate section at the end of this Journal (when editing this section, we have assumed that readers have some prior knowledge of the contents of the Bill).

The articles in the main body of the Journal focus on more varied topics in mental health law, although many have direct relevance to the proposed reforms. The complex and often emotive topic of psychopathic disorder is revisited in our first article by Professor Herschel Prins. In his article, which will be of particular interest to those involved in devising the future institutional care for DSPD individuals, the author highlights the enormous psycho-social-legal problems that those labelled as psychopathic cause in their day-to-day management, and recognises the need to adopt a multidisciplinary approach and a better and more effective use of existing services and funding in order to achieve their successful management.

Since 1994, independent inquiries have been mandatory for all homicides committed by persons in contact with mental health services. The recommendations contained in these reports are intended to influence mental health policy and practice, although the extent to which they do is the subject of debate. In their article, Melissa McGrath and Professor Femi Oyeboode present a series of findings following a qualitative review of recommendations from all reports of inquiries after homicide published between 1994 and 2001, and analyse the extent to which such recommendations have directly influenced mental health policy and practice today.

Our third article by Edward Myers looks at the topical issue of stress in the workplace and explores the current legal position of employees considering bringing actions for occupationally related stress against their employers. This article analyses the leading cases in this area of

Walker v Northumberland County Council (1995) and the more recent Court of Appeal decisions of *Hatton v Sutherland and Others* (2002) and discusses the implications of these decisions on the laws surrounding occupational stress.

Oliver Lewis' emotive article "Mental Health Law in Central and Eastern Europe: paper practice promise" focuses on ten countries in central and eastern Europe soon to become members of the European Union and explores the broad socio-legal issues within their mental disability systems. The author highlights the difficulties encountered by these countries in combating human rights violations within mental health services and asks whether the expectation that things will change following membership of the European Union is a realistic one.

Our final article in this section is authored by Mat Kinton and considers whether the powers to provide compulsory treatment under the Mental Health Act 1983 should be extended to prison environments and importantly, whether such an extension of powers should follow the proposals made by the Government in the draft Mental Health Bill.

We include three case reviews in this issue of the Journal. David Mylan reviews the case of *R (on the application of C) v Secretary of State for the Home Department* (2002) which considers the Home Secretary's powers to refer restricted patients who are subject to deferred conditional discharge, to a tribunal. This case follows the ruling in *IH* which was reviewed in the last issue of this Journal. As you will recall, *IH* established a "New Regime" for the ways in which tribunals should approach the conditional discharge of a patient in circumstances where the discharge cannot be immediately implemented, and as a result is deferred. David Mylan concludes that although the ruling in *IH*, to an extent, made the Court of Appeal ruling in *C* a foregone conclusion, it is the first instance decision of the Administrative Court in *C* that is of particular interest, in that it introduced a fetter on the powers of the Secretary of State to refer a restricted patient to a tribunal in certain circumstances.

Nicolette Priaulx reviews the House of Lords' decision in *R v Manchester City Council, ex parte Sennett, R v Redcar and Cleveland Borough Council, ex parte Armstrong, and R v Harrow London Borough Council, ex parte Cobham* (2002) which confirms that services provided under section 117 of the Mental Health Act 1983 are provided as a consequence of a free-standing obligation on the authorities, and are thus free of charge. The author discusses the financial implications of the decision for both social services and the NHS, its significance as a move 'towards protecting one of the cornerstones of community care policy' and asks whether the ruling will be sufficient to ensure a continued protection of the entitlement to free after-care services in light of the Draft Mental Health Bill 2002.

Nicola Cho considers the case of *R (on the application of SSG) v Liverpool City Council (1) Secretary of State for Health (2) and LS (Interested Party)* (2002) in which the Administrative Court approved the naming of gay and lesbian partners of mental health patients as nearest relatives under Section 26 of the Mental Health Act 1983. This decision is not only of significance for patients in same sex relationships, but it also evidences another important step by both the courts and Government towards the full legal recognition of rights of gay and lesbian couples.

The debate surrounding the management of those diagnosed as suffering from severe personality disorder is again highlighted in Deirdre N. Greig's book "Neither Mad nor Bad, the competing discourses of psychiatry, law and politics" which is reviewed by James Gray in this issue of the Journal. This book traces the life of Australian, Garry David and focuses of the responses of

society, parliament, the law and psychiatry to the problems presented by his behaviour and his being diagnosed as suffering from severe personality disorder.

The second section of the Journal considers the implications of the draft Mental Health Bill 2002. Professor Anselm Eldergill's paper "Is Anyone Safe?" analyses the Government's case for reforming mental health laws and analyses the new civil powers of detention and powers of compulsory treatment proposed by the Government in the draft Bill. This essay is based on Professor Eldergill's inaugural professorial lecture, which was delivered at Northumbria University on 13th November, 2002. A digital recording of this lecture can be found at <http://law.unn.ac.uk/mentalhealth/lecture>.

Thoughts on the draft Bill from both a legal and psychiatric perspective are provided by Professor Michael Gunn and Professor Tony Holland, in our second article on the Bill which is followed by a selection of responses to the Bill's consultation period on behalf of the Law Society, the Royal College of Psychiatrists, Liberty, and by MHRT Regional Chair, Guy Otten and by Robert Brown, social worker and approved trainer of ASWs.

As always, our thanks and gratitude to all those who have contributed to this issue of the Journal, and to the editorial board who work very hard to maintain the quality and integrity of the Journal. Unquestionably, the mental health law field continues to be both vital and expansive and we look forward with interest, if not with some trepidation, to the remainder of this parliamentary session.

Charlotte Emmett

Editor

Psychopathic Disorder – Concept or Chimera*

*Professor Herschel Prins***

‘A devil, a born devil, on whose nature Nurture can never stick;
on whom my pains Humanely taken, all, all lost, quite lost.’

The Tempest, IV,i.

‘And thus I clothe my naked villainy ...
And seem a saint when most I play the devil.’

Richard III, I,ii.

This paper, which is divided into five parts, has been prompted by the continuing interest in the complex and emotive topic of psychopathic disorder¹ and the possibility of a government Bill aimed at revising the current mental health legislation being introduced in 2003. The unclear nature of the condition and the controversies surrounding it are well encapsulated in the two quotations that head this paper. One or two other literary allusions will also be called in aid later.

Background

Some twenty-five years ago I made the following observations in a paper that appeared in the *Prison Service Journal*.²

Imagine if you can, a top-level conference has been called to discuss the meaning of that much used and abused word *psychopathy*. You are privileged to be an observer at these discussions at which are present psychiatrists, psychologists, sociologists, lawyers, sentencers, theologians, philosophers, staff of penal establishments and special hospitals and social workers. You have high expectations that some total wisdom will come from this well-informed and experienced group of people and that a definition will emerge that will pass the closest scrutiny of all concerned. After all, *this* is a

* The sub-title is taken from Chapter 5 of the first edition of my book *Offenders, Deviants or Patients? – An Introduction to the Study of Socio-Forensic Problems*, (1980, Tavistock), its purpose being to leave readers to judge the extent to which we have moved in our understanding in something over twenty years.

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1 For purposes of brevity and convenience the term ‘psychopathic disorder’ is used here to encompass severe anti-social personality disorder, dissocial personality disorder and, perhaps more controversially, dangerous severe personality disorder (DSPD).

2 Prins, H. (1977) ‘I think they call them Psychopaths’, *Prison Service Journal*, 28: 8–9.

gathering of experts. Alas, your expectations would have a quality of fantasy about them, for in reality you would find as many definitions as experts present. Let me just present one or two examples of this statement. There would be little agreement amongst psychiatrists; for some continental psychiatrists, the term would be used to cover a very wide range of mental disorders, including those we might describe as neuroses in this country; for some psychiatrists (for example, from the United States) the term might include minor disorders of personality and for others, the term might be synonymous with what we would describe as recidivism. The lawyers in the group would disagree also. Some might well accept the definition in the Mental Health Act, 1959 ... [as it then was] ... which describes psychopathy as a 'persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive behaviour or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment ...' However, they would immediately begin to ask questions about the legal implications of the words 'disability of mind' and 'irresponsible conduct'. At this stage, the philosophers would no doubt chip in and also ask searching questions about the same terms. Later on in the discussion, a theologian might start asking awkward questions about the differences between 'sickness' and 'sin' and 'good' and 'evil'.³ The representative from the field of sociology in the group might usefully remind us that psychopaths lack what they describe as a capacity for role-taking, i.e. seeing yourself in an appropriate role in relation to others in their roles in [their] environment. And so the discussion would go on and on. Don't assume that it has ever been different. For one hundred and fifty years the arguments have raged over definition, classification and management. (pp. 8–9).

Readers of this Journal might well ask 'Have things changed much since you wrote that?' To which I would be forced to answer, 'not that much'. Today, such a group might well be somewhat more representative. We could usefully find space for a geneticist, a developmental paediatrician, representatives from the Home Office and Department of Health, from the voluntary sector (who do so much to cope with these 'hard to like' individuals) and who knows, in this more progressive day and age – a consumer of the service and a victim? A more recent and near parallel to such an hypothetical group can perhaps be seen in the large conference called by the Secretaries of State for Social Services and the Home Department in July 1999, to receive and comment upon their joint proposals for dealing with the management of those persons exhibiting dangerous severe personality disorder (DSPD). As one who was asked to comment upon the proposals at this conference, I was painfully aware of the continuing complexities surrounding the phenomenon we label psychopathic disorder.⁴ It is of particular interest to note that the government (perhaps very wisely) only provided a loose definition of what they understood dangerous severe personality disorder to be and expressed the firm intention to fund major research into the problem – an intention currently being put into practice.⁵ Recent concerns about those individuals posing a

3 For an up-dated discussion of this aspect see Prins, H. (1994) 'Psychiatry and the Concept of Evil: Sick in Heart or Sick in Mind.' *British Journal of Psychiatry*, 165: 297–302.

4 See Home Office and Department of Health (1999) *Managing Dangerous People With Severe Personality Disorder: Proposals For Policy Development*. July 1999. A shortened version of my address may be found in Prins, H. (1999) 'Dangerous Severe Personality Disorder: An Independent View'. *Prison Service Journal*, 126 8–10.

5 Personality disorder is referred to in the document as 'an inclusive term referring to a disorder of the development of personality' ... 'and is not a category of mental illness' (p.5 footnote 1). At page 9, the document states that the phrase 'dangerous severely personality disordered ((DSPD) is used in this paper to describe people who have an identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious anti-social behaviour resulting from their disorder'. These definitions can reasonably be regarded as 'loose'.

serious threat to others and the manner in which successive governments have sought to deal with them have already been addressed by me in this Journal. I shall therefore not repeat them here, but proceed directly to some observations on the development of the concept of psychopathic disorder.⁶

Development of the concept

There are numerous accounts of the development of the concept of psychopathic disorder and, at the risk of being accused of a degree of invidious selection, I shall only refer to one or two specifically. For those wishing to pursue this aspect in more depth the references quoted in footnote⁷ may be of assistance. Although the French psychiatrist Pinel is usually credited with the first description of clinical cases of psychopathic disorder in 1806, there must have been persons exhibiting those characteristics we would regard as psychopathic long before Pinel's time. From an historical perspective one could cite such characters as Gilles de Rais – the sexual sadistic murderer of children, Vlad the Impaler and numerous others. An example from Biblical times is said to be that of Samson, described (no doubt somewhat with tongue in cheek) by Dr. Eric Altschuler of the University of California. According to him, Samson had a number of adult psychopathic characteristics; moreover, as a child Samson showed severe personality disorder, 'setting things on fire, torturing animals and bullying other children'. Doctor Altschuler also cites Samson's mother as a possible pathogenic element in his development. Apparently, in the account in the Book of Judges, 'she is warned not to drink while she is pregnant'. Dr. Altschuler concludes that 'Recklessness and a disregard for others may have run in the family.'⁸ To return to Pinel. It is likely that he included a number of cases in his examples that we should not consider today as falling within current classifications. It was in the 1830's that the English alienist (psychiatrist) and anthropologist Prichard formulated his well known concept of 'moral insanity'. He described it thus:–

a madness, consisting of a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses, without any remarkable disorder or defect of the intellect or knowing or reasoning faculties, and particularly without any insane illusion or hallucination. (Emphases added). (p.135).⁹

In the context of this quotation we should note that 'moral' meant emotional and psychological and was not intended to denote the opposite of 'immoral' as used in modern parlance. This view of 'moral insanity' rested on the then, fairly widely held, controversial belief that there could be a separate moral sense that could, as it were, be diseased. This early notion finds resonance in

6 See Prins, H. (2002) 'Incapacitating the Dangerous in England and Wales – High Expectations – Harsh Reality.' *Journal of Mental Health Law*, (February: 5–20. (Notably at pp 5–8). For useful commentary on current concerns see also Laing (1999), in this Journal, 'An End to the Lottery? – The Fallon Report on Personality Disordered Offenders'. October, 87–104.

7 A summary of some of the earlier writings on the topic may be found in H. Prins (1980) *Offenders, Deviants or Patients?* Chapter 5 at pp 139–141. Some writers are, of course, seminal; for example, H. Cleckley, in his *Mask of Sanity*. (Fifth Ed), (1975, C.V. Mosby Co.). McCord, W. and McCord, J. *Psychopathy and*

Delinquency. (1956, Grune and Stratton). Lewis, A. (1974) 'Psychopathic Personality: A Most Elusive Category.' *Psychological Medicine*, 4: 133–40. In more recent times the work of Professor Robert Hare has had an important influence in the areas of diagnosis. For a summary see for example, Hare, R. *Without Conscience: The Disturbing World of the Psychopaths Amongst Us*. (1993, Pocket Books).

8 As reported in *The Independent* of February 15th, 2002, citing a paper in *The New Scientist*.

9 Prichard, J.C. *Treatise on Insanity*. (1835, Gilbert and Piper).

Cleckley's later postulation that psychopathy was a particular form of 'illness'. Prichard's views need to be seen against the background of the very rudimentary state of psychiatric and psychological knowledge during his lifetime. In the 1880's, Koch formulated the concept of *constitutional psychopathy*, implying that there was a considerable innate predisposition; a line of thinking much in keeping with the then contemporary interest in hereditary factors in the causation of delinquency. It is interesting to note a comparable re-awakening in more recent times in the study of neuro-physio-psychological processes in the causation of persistent deviancy.¹⁰ In 1910, Mercier laid claim to have been the originator of the terms 'moral defective' and 'moral imbecile' – these eventually finding their way into the Mental Deficiency Act of 1913 (and subsequently changed to somewhat less pejorative descriptions in an amending Act of 1927). Certain trends in the 1930's were of importance. Findings from the disciplines of neurology and physiology were being applied to behaviour disorders – prompted no doubt by the sequelae of the widespread epidemics of disorders such as epidemic encephalitis. Freudian perspectives were also being applied increasingly to deviant behaviour in the work of psycho-analytically orientated medical and non-medical professionals such as Melitta Schmideberg, Kate Friedlander, Anna Freud and August Aichorn; they were all interested in the possible childhood roots of serious anti-social behaviour.¹¹ In 1939, Henderson – a distinguished British psychiatrist – published his famous work *Psychopathic States*. He considered that the psychopath's 'failure to adjust to ordinary social life is not a mere wilfulness or badness which can be threatened or thrashed out ... but constitutes a true illness'.¹² Since the nineteen-sixties attention has been focused on the management of adult psychopathically disordered individuals within institutional settings, notably those adopting a therapeutic community or 'social milieu' approach. Figures eminent in this field include psychiatrists such as Jones and Whiteley.¹³

Summarising the foregoing, it is possible to trace three important themes in the development of the concept. The *first*, as Coid¹⁴ has suggested, was the concept of abnormal personality as defined by social maladjustment – developed in France and later in the UK – leading to the current legal definition of psychopathic disorder (of which more later). The *second* was the concept of mental degeneracy, also originating in France. The *third* was the German notion of defining abnormal psychopathic personality types, as illustrated in the work of Kurt Schneider.¹⁵ In addition, the concept has not been without attention from central government over the years. It was considered by the Butler Committee as long ago as the early nineteen-seventies, subsequently in a joint DHSS and Home Office Consultation Document on the topic in 1986, by the Reed Committee in 1994,

10 See, for example, Blair, J., and Frith, U. (2000) 'Neurocognitive Explanations of the Anti-social Personality Disorders.' *Criminal Behaviour and Mental Health*, 10: S66–S81. (Special Supplement).

11 For an interesting compilation of thirties and forties accounts of work in this field see Eisseler, K.R. (ed) *Searchlights on Delinquency: New Psychoanalytic Studies*. (Imago Publishing, 1949). The later work of Lee Robins is also seminal in this area; see, for example, Robins, L.N. *Deviant Children Grown Up. A Sociological and Psychiatric Study of Sociopathic Personality*. (1966, Williams and Wilkins). The work of Bowlby on attachment theory has been of profound importance; see, for example, Bowlby, J. *The Making and Breaking of Affective Bonds*. (1979, Tavistock).

The work of Sir Michael Rutter has also been of great significance; see Rutter M.L. (1999) 'Psychosocial Adversity and Child Psychopathology.' *British Journal of Psychiatry*, 174: 480–493.

12 Henderson, D. *Psychopathic States*. (1939, Norton). p. 13.

13 See, for example, Jones, M. (1963) 'The Treatment of Character Disorders.' *British Journal of Criminology*, 3: 276–282. And, Whiteley, J.S. (1994), 'In Pursuit of the Elusive Category.' *British Journal of Psychiatry Review of Books*, 7: 14–17.

14 Coid, J. 'Current Concepts and Classifications in Psychopathic Disorder.' In P. Tyrer and G. Stein (eds) *Personality Disorder Reviewed*. (Gaskell, 1993).

15 Schneider, K. *Psychopathic Personalities*. (1958 Cassell).

and most recently in the joint Home Office and Department of Health policy development document to which I have already referred.¹⁶ I have provided representation of the stages through which the concept has passed in *Figure I*.

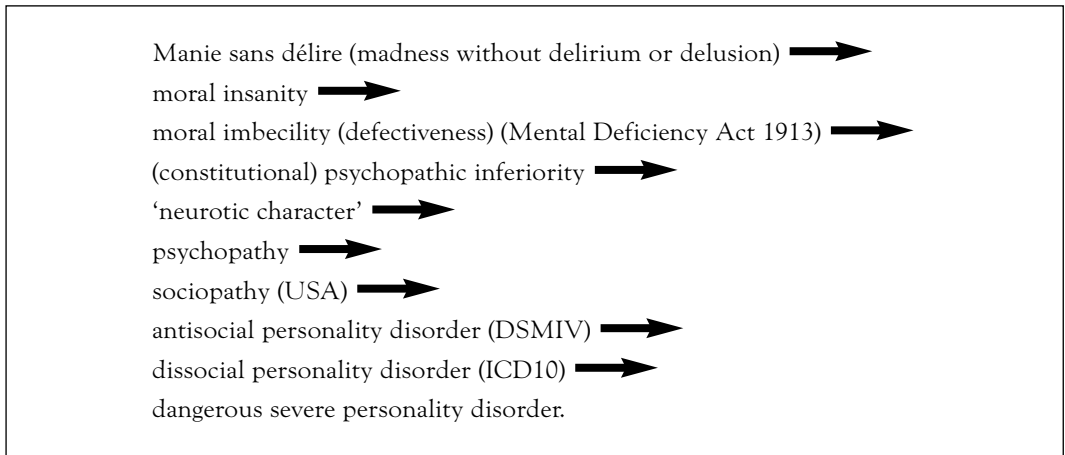


Figure I From Pinel (1806) to Home Office and Department of Health 1999

Causes and characteristics

There is vast literature concerning the postulated origins of psychopathic disorder and an equally vast literature on its characteristic features. No attempt is made here to review this literature at great length, merely to address certain aspects of it as a prelude to some discussion of problems of management.¹⁷ Postulated origins have included genetic and hereditary factors, cortical immaturity showing brain-waves more commonly found in children and close familial and environmental influences. Professor Coid, a respected authority in the field, advocates caution in espousing the notion of psychopathic disorder as a single entity. He suggests that

The sheer complexity and range of psychopathology in psychopathic disorder has previously led to the suggestion that these individuals could be considered to suffer from a series of conditions that would best be subsumed under a broad generic term 'psychopathic disorders' rather than a single entity.¹⁸

16 See Home Office and Department of Health and Social Security, *Report of the Committee on Mentally Abnormal Offenders*. (Chairman, Lord Butler of Saffron Walden). Cmnd. 6244. (HMSO, 1975). Department of Health and Social Security and Home Office, *Consultation Document: Offenders Suffering From Psychopathic Disorder*. (1986, HMSO). Department of Health and Home Office, *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder*. (Chairman, Doctor John Reed, CB. (1994, HMSO). The whole topic was also considered in considerable depth by the Fallon Committee in its inquiry into the Personality Disorder Unit at Ashworth Hospital. See Volume II of the

Report, which contains very extensive expert evidence on the nature of personality disorder. Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital. Chairman His Honour Judge Fallon, Cm 4195. (1999, TSO).

17 A useful review of all these aspects may be found in Livesley, W.J., (ed), *Handbook of Personality Disorders: Theory, Research and Treatment*. (2001, Guilford Press). For a predominantly UK perspective, see Tyrer, P. and Stein, G. (eds), *Personality Disorder Reviewed*. (1993, Gaskell).

18 Coid, J.W. (1989) 'Psychopathic Disorders.' *Current opinion in Psychiatry*, 2: 750–756.

In recent times, interest has been revived concerning possible 'organic' causes, including both major and minor cerebral 'insults' in infancy and in the consequences of obstetric complications. If such developments subsequently prove to have unequivocally firm foundations, one could envisage a situation where issues of responsibility (and notably diminished responsibility) may well have to be addressed. This is an arena already fraught with problems concerning the relationship between medicine (notably neurology and psychiatry) and the law. The environment has also been held to play a powerful part in the aetiology of the disorder. It may well be, that as with similar mental disorders, such as the schizophrenias, it is the interplay of social forces and pressures acting upon an already vulnerable personality (for whatever reason) that may tend to produce the condition. Some of the highly complicated and sophisticated neuro-physio-chemical research undertaken in recent years fosters speculation that *some* of the answers to the problem of aetiology may eventually be found in the area of brain biochemistry. Other possibilities are of equal interest. For example, one cannot ignore the evidence, admittedly laboratory-based, of such factors as low anxiety thresholds, cortical immaturity, frontal lobe damage and, perhaps most relevant of all, the *true* (as distinct from the wrongly labelled) psychopath's need for excitement – the achievement of a 'high'. Such a need is described very graphically in Wambaugh's account of the case of Colin Pitchfork. Pitchfork was convicted of the rape and murder of two teenage girls in Leicestershire during the period 1983–1986. In interviews with the police, it is alleged he stated that he obtained a 'high' when he exposed himself to women (he had previous convictions for indecent exposure prior to his two major offences); he also obtained a 'high' from the knowledge that his victims or likely victims were *virgo intacta*. He is said to have also described an additional aspect of his excitement, namely obtaining sex outside marriage. As with others assessed as psychopathic, he also demonstrated a great degree of charm; for example, he was able to get his wife to forgive him for a number of instances of admitted unfaithfulness. (Pitchfork's case is also of interest in that it involved the earliest attempt to use DNA profiling – a practice that now seems fairly routine).¹⁹

Some Key Characteristics

Some of these have already been alluded to above. Sir Martin Roth, a doyen of British psychiatry, has suggested (in summary form) that the key features are egotism, immaturity in various manifestations, aggressiveness, low frustration tolerance and the inability to learn from experience so that social demands and expectations are never met.²⁰ Roth's brief listing encapsulates many of the more detailed characteristics suggested by Cleckley in the various editions of his seminal work *The Mask of Sanity*.²¹ To these items I would add the following three elements. *First*, the curious *super-ego lacunae*, rather than the *total* lack of conscience suggested by some authorities. *Second*, the greater than usual need for excitement and arousal to which I have already referred. *Third*, a capacity to create chaos among family, friends, and those involved in trying to manage or contain them. I would suggest that this last characteristic is one of the most accurate indicators of the *true*, as distinct from the pejoratively labelled, psychopath and is one often attested to by those who have had extensive clinical experience of dealing with the psychopathic. The lack of true feeling content (empathy) exhibited by the psychopath was stated graphically some forty years ago by

19 Wambaugh, J. *The Bleeding*. (1989, Bantam Books).

20 Roth, Sir Martin, 'Psychopathic (Sociopathic) Personality.' In R. Bluglass and P. Bowden (eds),

Principles and Practice of Forensic Psychiatry. (1990, Churchill Livingstone).

21 See footnote 7 *supra*.

Johns and Quay in their comment that psychopaths ‘know the words but not the music’.²² Rieber and Green add four salient characteristics in support of the foregoing. These are thrill-seeking, pathological glibness, anti-social pursuit of power and absence of guilt. They also give great prominence to the element of thrill-seeking. They describe the psychopath as ‘performing a Mephisto Waltz on the tightrope of danger’.²³ It is as though this phenomenon of ‘thrill-seeking’ is necessary to fill the emotional void so often encountered in the psychopathically disordered. This internal ‘emptiness’ has also been stressed by Whiteley. He quotes a former patient writing to him from prison:

I thought everything I said, did and thought was not real, that I was not real, almost as though I did not exist, so I could never affect anyone because I was not real, no-one could possibly take me seriously because I was not real. (p.16).²⁴

If we see psychopathic disorder as a developmental process then we need not rely exclusively upon clinical depictions. Its nature, early onset and manifestations are depicted clearly in the aged Duchess of York’s reviling of her son Richard III in Act IV Sc. iv of Shakespeare’s play.

... Thou cam’st on earth to make the earth my hell.
A grievous burden was thy birth to me;
Tetchy and wayward was thy infancy;
Thy school-days frightful, desp’rate, wild and furious.
Thy prime of manhood daring, bold and venturous;
Thy age confirm’d, proud, subtle, sly and bloody,
More mild, but yet more harmful kind in hatred.
What comfortable hour can’st thou name
That ever grac’d me with thy company?

Here, we have the aged Duchess describing graphically some of the characteristics we regard as important in terms of both aetiology and presentation. For example, an apparently difficult birth, long-standing anti-sociality (a requirement of the DSM-IV(R), the ICD 10 and current mental health legislation in England and Wales), becoming more marked in adulthood; all this accompanied by a veneer of charm and sophistication which only serves to act as a mask for the underlying themes of chaos and potential for destructiveness.²⁵

Describing and trying to delineate a disorder has the advantage of hopefully setting some boundaries to it and creating typologies that may assist in management, even if the latter is highly

22 Johns, J.H. and Quay, H.C. (1962) ‘The Effects of Social Reward on Verbal Conditioning in Psychopathic and neurotic Military Offenders.’ *Journal of Consulting Psychology*, 26: 217–220.

23 Rieber, R.W. and Green, M.R. (1988), *The Psychopathy of Everyday Life*. Unpublished Manuscript. Quoted in Egger, S.Q., *Serial Murder: An Elusive Phenomenon*. (1990, Praeger). (p.82).

24 Whiteley, J.S. (1994) ‘In Pursuit of the Elusive Category.’ *British Journal of Psychiatry Review of Books*, 7: 14–17.

25 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders. IV(R)*. (1994, Washington DC). World Health Organisation. *The ICD-10 Classification of Mental and Behavioural*

Disorders: Clinical Descriptions and Diagnostic Guidelines. (1992, Geneva). It should be noted that neither the DSM nor the ICD 10 refer to psychopathic disorder; the former refers to anti-social personality disorder and the latter to dissocial personality disorder. Neither descriptions equate exactly with the current legal description – psychopathic disorder – a word that numerous committees have suggested abandoning, preferring personality disorder – which would not be defined further. (See also footnote 17 *supra*). However, we should perhaps be mindful of the reference to ‘naming’ in *Romeo and Juliet*: ‘What’s in a name? That which we call a rose by any other name would smell as sweet.’ (Act II, Sc ii). Changing the name will not necessarily do away with our dislike for such patients/clients/offenders.

problematic (as we shall see shortly). We should also note that a number of authorities feel that the current espousal of the term 'psychopathic' is unhelpful, see for example, Blackburn, Cavadino, Lewis and Appleby.²⁶

Some problems of management

This section of the paper is divided into two parts. *Part One* deals predominantly with legal aspects and *Part Two* with clinical matters. To a great extent the two elements should be seen as a whole, but in an attempt to achieve clarity, I have chosen to split them. Readers should note that this a largely artificial (and somewhat pedantic) distinction.

Part One – Legal Aspects

The nature of psychopathic disorder and the problems it has presented to courts and counsel, are likely to bring to the fore powerful views as to the nature of the attitudes towards the disorder. This state of affairs is exemplified usefully in two brief quotations. Mr. Bumble, the Beadle in *Oliver Twist*, says 'The Law is a ass, a idiot', and the redoubtable jurist Lord Coke stated that 'The Law is the perfection of reason.' In England and Wales, a legal definition of psychopathic disorder was first introduced in the Mental Health Act, 1959. (In Scotland and Northern Ireland the term is not used directly). In the 1959 Act, treatability was linked to the definition of the disorder ... 'and requires, or is susceptible to treatment'. Section 1(4). The definition of the disorder was left substantially unchanged in the 1983 Act, with the important exception of the removal of the sentence relating to treatability; the latter finds expression in Sections 3,37 and 45A of the Act, where it must be demonstrated that ... 'such treatment is likely to alleviate or prevent a deterioration of his condition'. (Emphasis added). Section 45A of the 1983 Act (inserted by Section 46 of the Crime (Sentences) Act, 1997) makes provision for the so-called 'Hybrid Order'. This enables a Crown Court to impose a sentence of imprisonment upon an offender (but only in cases where the sentence is not fixed by law, e.g. in convictions for murder). The patient must be diagnosed as suffering from psychopathic disorder and the court may direct that such an individual shall be admitted to a specified hospital. The provision is known as a 'Hospital and Limitation Direction'. Should the offender/patient no longer need, or be responsive to, treatment before his or her release date, the Responsible Medical Officer may seek the offender/patient's transfer to prison. The 'limitation' element has the effect of a Restriction Order under Section 41 of the 1983 Act. As far as can be ascertained, at the time of writing, it appears that courts have been slow to utilise this new provision. The change occurred due to a growing and understandable reluctance on the part of psychiatrists to manage such people. In the late nineteen-fifties there was a degree of optimism that psychiatry and psychiatrists had the answers not only to treatable *mental illness* (such as the major psychoses, e.g. the schizophrenias and affective psychoses) but that this optimism (which was not wholly justified or eventually sustainable even for the psychoses) could be extended to forms

26 Blackburn, R. (1988) 'On Moral Judgements and Personality Disorders: The Myth of Psychopathic Personality Revisited.' *British Journal of Psychiatry*, 153: 505-512. Cavadino, M. (1998) 'Death to the

Psychopath.' *Journal of Forensic Psychiatry*, 9: 5-8. Lewis, G. and Appleby, L. (1988) 'Personality Disorder: The Patients Psychiatrists Dislike.' *British Journal of Psychiatry*, 153: 44-49.

of mental *disorder* such as psychopathy.²⁷ Professor John Gunn has suggested an additional reason for the change of emphasis regarding treatability. This lies in the parlous state of general psychiatric provision, more particularly in large conurbations such as London.²⁸ The legal connotations of treatment have resulted in a number of court rulings, both in England and Wales and in Scotland. In the case of *R. v. Canons Park Mental Health Review Tribunal (ex parte A. 1995. QB 60)*, the Court of Appeal held that a mere refusal of a patient to participate in group psychotherapy did not, of itself, indicate untreatability. A case in Scotland *Reid v. Secretary of State for Scotland (1999)* re-opened the whole issue.²⁹ In brief, this case concerned an offender-patient detained without limit of time under the provisions of the Scottish Mental Health Act, 1984. In a ruling, the Law Lords held that under Section 145(1) of that Act, medical treatment was to be given a broad meaning and that supervised care which endeavoured to prevent deterioration of the *symptoms*, but not the *disorder itself*, might in a *particular case* justify liability to continued detention. (Emphases added). In hearing this case the Law Lords decided *inter alia* that the Canons Park case had been wrongly decided. Eldergill summarises the degree of latitude which appears to be allowed currently:

It can be seen that the treatability condition is satisfied if medical treatment in its broadest statutory sense – which includes nursing care – is *eventually* likely to bring some symptomatic relief to prevent the patient's mental health from deteriorating. *There are few (if any) conditions which are not treatable in this sense.* (p.225).³⁰

However, the saga does not end with the decision in that case. There have been continuing concerns about possible loopholes in the law that would allow dangerous psychopaths to obtain their freedom. Again, in Scotland, the case of Ruddle³¹ led the Scottish Parliament to pass, as a matter of urgency, the Mental Health (Public Safety and Appeals) (Scotland) Act, 1999, which has added public safety to the grounds for not discharging patients under Scottish mental health legislation. The main effect of this legislation was to change the definition of mental disorder 'to mental illness (including personality disorder) or mental handicap however caused or manifested' and to require continued detention of a restricted patient 'if the patient is suffering from a mental disorder the effect of which is such that it is necessary in order to protect the public from serious harm, that the patient continues to be detained in a hospital whether for medical treatment or not'.³² 'One of the "incidental" effects of this enactment has been to clarify the fact that personality disorder [had] always been included (but by implication only) within the meaning of mental disorder in Scottish mental health legislation.' (op.cit.). Crichton *et al.* suggest that the Act of 1999 merely plugged 'a

27 As to whether personality disorder (psychopathy) is an illness or a disorder see Kendall. Kendall suggests that 'The historical reasons for regarding personality disorders as fundamentally different from mental illnesses are being undermined by both clinical and genetic evidence. Effective treatments for personality disorders would probably have a decisive influence on psychiatrists' attitudes.' Kendall, R.E. (1999) 'the Distinction Between Personality Disorder and Mental Illness.' *British Journal of Psychiatry*, 180: 110–115.

28 Gunn, J. (1999) 'The Ashenputtel Principle.' *Criminal Behaviour and Mental Health*, 9: 205–206.

29 1999 2 WLR 28.

30 Eldergill, A., *Mental Health Review Tribunals: Law and Practice.* (1997, Sweet and Maxwell).

31 *Ruddle v. Secretary of State for Scotland* 1999 GWD 29 1395.

32 Crichton, H.M., Darjee, R., McCall Smith, A. and Chiswick, D. (2001) 'Mental Health (Public Safety and Appeals) (Scotland) Act, 1999: Detention of Untreatable Patients With Psychopathic Disorder.' *The Journal of Forensic Psychiatry*, 12: 647–661.

loophole' and that further developments should wait upon any action that may be taken as a result of the two major reviews of Scottish mental health legislation and practice by the Millan and Maclean Committees.³³

Part Two – Clinical Matters

From all that I have written so far, it should be obvious that those labelled as psychopathic present enormous psycho-socio-legal problems and that their day-to-day management causes the professionals involved both 'headache' and 'heart-ache'. Indeed, the heading of this sub-section of the paper might well have been called 'encounters of an uncomfortable kind'. Some aspects of mental health and criminal justice professionals' engagement in these 'encounters' have already been touched upon and the intention in this section is merely to highlight some of them further. My late friend and colleague – Doctor Peter Scott – addressed some of these issues over twenty-five years ago in a very thought-provoking paper entitled *Has Psychiatry Failed in the Treatment of Offenders?*³⁴ Scott suggested that we most frequently fail those who need us most. These individuals frequently fall into two (perhaps overlapping) categories, the 'dangerous offender' and the 'unrewarding', 'degenerate' and 'not nice' offender. Of the 'embarrassing' patient Scott maintained that he/she is the patient who is 'essentially the one who does not pay for treatment, the coin in which patients pay is '(i) dependence – i.e. being manifestly unable to care for themselves, and thus appealing to the maternal part of our nature; (ii) getting better (responding to our "life-giving" measures); (iii) in either of these processes, showing gratitude, if possible cheerfully'. (p.8) In other words, those patients/clients/offenders that Scott had in mind are just the ones who reject our 'best efforts', are manipulative and delight in giving us a pretext for rejecting them, so that they can continue on their 'unloved' and 'unloving' way. In Scott's terms, 'the "not nice" patients are the ones who habitually *appear* to be well able to look after themselves but don't and, as stated above, reject attempts to help them, break the institutional rules, get drunk, upset other patients, or even quietly go to the devil in their own way quite heedless of nurse and doctor'. Scott went on to suggest other factors which are highly relevant to any consideration of the management of *so-called* psychopaths.³⁵ (Emphasis added). He stated that:

There is a natural philanthropic tendency to extend help to the defenceless – probably an extension of parental caring ... if this fails so that embarrassing people or patients are seen to accumulate, then anxiety is aroused and some form of institution is set up to absorb the problem ... Not all embarrassing patients like being tidied up and these tend to be compulsorily detained ... Within the detaining institution two opposing aims begin to appear – the therapeutic endeavour to cure and liberate on the one hand, and the controlling custodial function on the other. (p.9).

Scott went on to suggest that although these functions should be complementary 'there is a tendency for them to polarise and ultimately, to split, like a dividing cell, into two separate

33 Millan, (Chairman), *Review of the Mental Health (Scotland) Act, 1984: First Consultation*. (1999, S.O.) Maclean, Lord, (Chairman), *Report of the Committee on Serious Violent and Sexual Offenders*. (2000, Scottish Executive). See also, Darjee, R. and Crichton, J.H.M. (2002) 'The Maclean Committee: Scotland's Answer to the "Dangerous People with Severe Personality Disorder" Proposals?' *Psychiatric Bulletin*, 26: 6–8.

34 Scott, P.D., *Has Psychiatry Failed in the Treatment of Offenders?* (1975, Institute For the Study and Treatment of Delinquency (ISTD)).

35 I emphasise the word *so-called* here because Scott did not feel there was much merit in distinguishing psychopaths from hardened chronic (recidivist) criminals – a minority view. See Scott, P.D. (1960) 'The Treatment of Psychopaths.' *British Medical Journal*, 2: 1641–1646.

institutions’. However, he suggests that ‘neither of the two new institutions can quite eliminate the tendency from which it fled, so that the therapeutic institution now begins to miss the custodial function and tries hard to send some of its patients back to custody, and the custodial institution is unable to tolerate being unkind to people all the time and begins to set up a new nucleus of therapy’. (p.10). In time, each institution may divide. It would seem to me that Scott’s perceptive ‘managerial’ observations should be considered carefully by those involved in devising the future institutional care for DSPD individuals envisaged in the policy development paper.³⁶ So, these are the unlikeable clients/patients/offenders. Often the dislike will operate at an unconscious level. Three quotations from the views of psychiatrists are useful in illustrating this problem and their words are applicable to all professionals working in the field of criminal justice and forensic-psychiatry. Maier suggests:

Could it be after all these Freudian years, that psychiatrists have denied the hatred they feel for psychopaths and criminals, and thus have been unable to treat psychopaths adequately because their conceptual basis for treatment has been distorted by unconscious, denied feelings from the start? (p.766).³⁷

A somewhat similar view is proffered by Treves-Brown:

As long as a doctor believes that psychopaths are mostly ‘bad’, his successful treatment rate will be dismal. Since it takes two to form a relationship, an outside observer could be forgiven for suspecting that a doctor who describes a patient as unable to form a relationship, is simply trying to justify his own hostility to this patient. (p.63).³⁸

And the late Doctor Donald Winnicott – doyen of child psychiatry, writing over fifty years ago about the ‘anti-social tendency’, gave further support for such views – as follows:

However much he loves his ... [hard to like] ... patients he cannot help hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does for his patients. (p.71).³⁹

Despite the unattractiveness of such patients and the sometimes unconscious reactions of therapists, a number of forensic-psychiatric and criminal justice professionals have expressed a degree of optimism about treatment. Some years ago Tennent *et al.* sought the opinions of psychiatrists, psychologists and probation officers about treatability. The survey was admittedly small, as was the response rate. However, there was reasonable evidence to suggest that although there were few clear-cut views as to the best treatment modalities, there were clear indications as to those felt to be helpful. For example, there were higher expectations of treatment efficacy with symptoms such as ‘chronically anti-social’, ‘abnormally aggressive’ and ‘lacking control over impulses’ and much lower expectations for symptoms such as ‘inability to experience guilt’, ‘lack of remorse or shame’ and ‘pathological egocentricity’.⁴⁰ Some support for the findings of this modest survey can be found in a more extensive survey by Cope on behalf of the Forensic Section

36 See footnote 5 *supra*.

37 Maier, G.J. (1990) ‘Psychopathic Disorders: Beyond Counter-Transference.’ *Current Opinion in Psychiatry*, 3: 766–769.

38 Treves-Brown, C. (1977) ‘Who is the Psychopath?’ *Medicine, Science and the Law*, 17: 56–63.

39 Winnicott, D.W. (1949) ‘Hate in the Counter-

Transference.’ *International Journal of Psychoanalysis*, 30: 14–17. For a recent very extensive and perceptive study of denial in all its forms, see Cohen, S., *States of Denial: Knowing About Atrocities and Suffering*. (2001, Polity Press).

40 Tennent, G., Tennent, D., Prins, H. and Bedford, A. (1993) ‘Is Psychopathic Disorder a Treatable Condition?’ *Medicine, Science and the Law*, 33: 63–66.

of the Royal College of Psychiatrists. Cope surveyed all forensic psychiatrists working in Secure Hospitals, units and similar settings in England and Wales. The majority of her respondents (response rate 91%) were in favour of offering treatment to severely personality disordered (psychopathic) patients.⁴¹ Some explanation for this optimism derives from another source. In a fairly recent attempt to ascertain the motivations of consultant forensic psychiatrists for working in forensic settings, I discovered that one of the attractions of the work was the challenge presented by psychopaths.⁴² Another fact that emerged from my survey was the need for forensic psychiatrists to work with and encourage their colleagues in general psychiatry to deal with such patients; a point made very cogently recently by Professor John Gunn.⁴³

Some of the statements made by my respondents were very illuminating. One of them enjoyed the challenge presented by the severity and complexity of the cases which produced 'a kind of appalled fascination'. Another attraction was the chance to work with a wide range of agencies and disciplines and to pursue a more eclectic approach to patient care. Stimulation was another important factor (a factor shared with the psychopathic – see earlier discussion). One stated 'I could not envisage twenty years of listening to the neurotic and worried well'; 'after forensic psychiatry, other specialities seemed very tame and had much less variety and challenge'.

Whatever form of professional training is eventually formulated in order to deal more effectively with psychopathically disordered individuals, understanding and management will only be successful through the adoption of a truly multi-disciplinary approach (as suggested in the 'imaginary' seminar quoted at the beginning of this contribution). Such an approach would not only serve to take the broadest possible view of the topic but, at a narrower clinical level, should help to obviate potential missed diagnoses (for example, the importance of organic factors such as brain damage). Severely dangerous and deviant behaviour requires calm and well-informed confrontation. In the words of the late George Lyward – a highly gifted worker with severely personality disordered boys – 'Patience is love that can wait'. Coupled to this is the need to tolerate, without loss of temper, the hate, hostility, manipulation, and 'splitting' shown by such individuals and an ability not to take such personal affronts as attacks. The psychiatrist and psychotherapist Penelope Campling has provided an excellent account of the management of such behaviours.⁴⁴ It is essential for professionals to have more than an intellectual understanding of what the patient has done. Sometimes, this can be 'stomach-turning' and offers many opportunities for denial on the part of the professional. Such understanding requires a degree of what has been described in another context as 'intestinal fortitude'.⁴⁵

It is worth emphasising once again the importance of the phenomenon of denial. It is not the sole prerogative of our clients/patients/offenders. For, as Pericles says in Shakespeare's play of that name, 'Few love to hear the sins they love to act', (Act I, Sc i). The more troublesome and anxiety-

41 Cope, R. (1993) 'A Survey of Forensic Psychiatrists' Views on Psychopathic Disorder.' *Journal of Forensic Psychiatry*, 4: 214–235. For a more recent study, dealing in particular with DSPD, see: Haddock, A., Snowden, P., Dolan, M., Parker, J. and Rees, H. (2001) 'Managing Dangerous People With Severe Personality Disorder: A Survey of Forensic Psychiatrists' Opinions.' *Psychiatric Bulletin*, 25: 293–296.

42 Prins, H. (1998) 'Characteristics of Consultant Forensic Psychiatrists: A Modest Survey.' *Journal of Forensic Psychiatry*, 9: 139–149.

43 Gunn, J. (2000) Editorial: 'A Millennium Monster is Born.' *Criminal Behaviour and Mental Health*, 10: 73–76.

44 See Campling, P. (1996) 'Maintaining the Therapeutic Alliance With Personality Disordered Patients.' *Journal of Forensic Psychiatry*, 7: 535–550.

45 An expression used by Michael Davies, Leader of the BBC Symphony Orchestra, in relation to the playing of certain problematic orchestral works. (BBC2 July 10, 1999).

making the relationship, the more the need *not* to go it alone. This is not an area of work that should be characterised by ‘prima donna’ activities by professionals of either sex. There are dangerous workers as well as dangerous clients/patients/offenders. There are three qualities that are of paramount importance in dealing with the severely personality (psychopathically) disordered individual. These are *consistence* (the capacity to take a firm line in the face of deflecting activities on the part of the client); *persistence* (efforts may need to be expended over very considerable periods of time, maybe years – a view that is supported by the belief in the occurrence of cortical maturation in some cases, aided by therapeutic interventions); *insistence* (the capacity to give clear indications that requirements of supervision are to be met in spite of resistance on the part of the client). Such insistence must take priority of place when expectations of what supervision requires of the client are initially set out in the professional/client relationship.

Conclusion – present and future

We should recognise that in strictly scientific terms we have few hard facts concerning the genesis of severe personality (psychopathic) disorder. What we do know is that those suffering from (or, to be more precise, making others suffer from) it are extremely difficult to work with and manage. ‘The diagnosis of personality disorder is used ... [in the government’s policy documents on DSPD] ... with apparent confidence ... and the government’s recommendations rely heavily on the premise that the term refers to a group of patients who can be clearly defined and gathered together ...’.⁴⁶ As I hope this contribution has shown, this is hardly likely to be the case in the present state of our knowledge.

It is my view that a change in name is of itself unlikely to quell anxieties and a reluctance to work with this group of individuals. Nor is the introduction of new or re-designed specially designated services likely to provide a panacea. Better use of existing and much better funding for such services, shared endeavour (and the encouragement of general psychiatry to become more involved), the encouragement of a greater degree of self-examination on the part of all concerned in the criminal justice and mental health systems may be the most productive ways forward. In June 2002, the Government produced its long-awaited Bill on the reform of mental health legislation. Interestingly, the Bill comes as a draft, and is accompanied by two documents – one containing detailed *Explanatory Notes* on the Bill, and the other is a *Consultation Document*. It would seem that the Government wishes to anticipate likely choruses of criticism and to defuse them as much as possible.⁴⁷ It is of interest to note that this highly complex and complicated proposed piece of legislation runs to some 180 sections and 9 schedules; this compares with 149 sections and 6 schedules in the 1983 Act. Implementation of the new legislation is likely to have enormous financial and human resource implications. *The Consultation Document* refers to matters that are not in the Draft Bill but which will also be brought before Parliament when the Bill is introduced. Notably, these matters concern a specialist division of a new Health Care Inspectorate, which will replace the Mental Health Act Commission; this new body will have wider powers and sharper teeth.

46 See Mann, A. and Moran, P. (2000) ‘Personality Disorder As a Reason For Action.’ *Journal of Forensic Psychiatry*, 11: 11–16. See also Laing, *op. cit.* (notably at pp. 98 *et seq*) – footnote 6 *supra*.

47 *Draft Mental Health Bill. Cm. 5538-II (2002*

Department of Health); Draft Mental Health Bill: Explanatory Notes, CM 5538-II (2002, Department of Health); Mental Health Bill: Consultation Document, CM. 5538-II. (2002, Department of Health). A consultation period has been established which will run for 12 weeks from June, 25th 2002.

There are also proposals for revised legislation in respect of children and for the protection of health care workers and numerous other matters. This is not the place to comment upon the general proposals in the draft legislation, but merely to refer to those proposals for dealing with persons demonstrating severe personality (psychopathic) disorder, and, in particular, DSPD. The Mental Health Bill was conspicuously absent from the Queens Speech to Parliament on November 13th. This had led to some speculation that the reforms were not going to be proceeded with as a result of powerful lobbying against them. However, on November 14th, the Health Secretary, Alan Milburn indicated that the Government would press ahead with a Bill when they had finished considering the 2,000 or so responses they had received. "When we have finished considering these responses we will bring forward a Bill during the course of this session" (The Independent, November 15, p10). It will be interesting to see the extent to which some of the more controversial proposals in the present draft Bill receive some modification when the revised Bill is presented. The Government has accepted the definition of mental disorder suggested in the Richardson Review; it is presented as 'any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning. This new composite definition removes 'psychopathic disorder', and as a result the 'treatability test'. The latter, of course, had the effect of excluding a number of people considered to have a potential for dangerous behaviour towards others. *The Consultation Document* states that 'People with severe responsibility disorders will have access to services in the same way as people with other forms of mental disorder'.(p.1.) In respect of DSPD the document has this to say:

There is no separate legislation for 'DSPD'. The term, which refers to the small group of people with severe personality disorder *who also represent a high degree of risk to the public*, does not appear in the new Bill. (Emphasis added). People with personality disorders will be treated in exactly the same way as patients with other mental disorders and will come under compulsory powers if they meet the same conditions for compulsion. (p.23.)

The Consultative Document goes on to indicate that service developments (for those considered to be dangerous) are not part of legislative proposals but 'are part of the wider agenda to provide better mental health services for everyone.' (p23). However, the document goes on to indicate that services will be provided by specialist units (such as those now being developed at Rampton Hospital and HM Prison Whitemoor). Two further units are planned, one hospital and one prison based.⁴⁸ *The Consultation Document* poses a number of questions to which responses will be welcomed. One significant question in relation to this article is: Will the Legislation allow intermediate detention of dangerous offenders? The answer given is as follows:

The new legislation will allow for the detention of someone with mental disorder for as long as they pose a significant risk of serious harm to others as a result of their mental disorder, thereby meeting the conditions for compulsion. In some cases where the mental disorder, and the behaviours arising from it, are complex and difficult to manage, *and individual may be detained in hospital for a long time*. (Emphasis added). However, to safeguard people from detention where it may not be justified, the new Mental Health Tribunal will regularly review

48 For a very useful and recent account of the regime in the DSPD Unit at HMP Whitemoor see Bennett J (2002) *The Role of Prison Officers in the Dangerous and Severe Personality Disorder Unit at HMP Whitemoor: Prison Service Journal 143 (September)*;9-14. See also

Bowers L (2002) "Working Positively and Productively in a DSPD Unit; *Prison Service Journal 143 (September)* 21-22 and Storey L (2002) 'Staff Development in Personality Disorder Services' *Prison Service Journal 143 (September)*: 23-27.

the patient's compulsory treatment order to consider whether the conditions for compulsion continue to be met. (p.23).

In my mind, a further question arises. What happens if staff in one of the new specialist units consider that such a person is 'untreatable' at any stage? I could not find anything in the documentation that seemed to deal with such an eventuality, but, maybe I missed it.

A fitting conclusion for this contribution can be found in a short statement by Walker and McCabe in their seminal study *Crime and Insanity in England*.

... the history of 'psychopathy' begins with the formation of a concept in the minds of philosophers and mad-doctors. Thereafter, the concept becomes linked with a succession of ill-defined terms of art, until one of these is seized on by legislators and bundled into the statute book. The resulting trouble takes half a century to recognise and remedy, and today it remains uncertain whether the remedy is entirely successful.⁴⁹

Readers are left to decide for themselves whether or not this quotation, written nearly thirty years ago, continues to reflect the position today and is also supportive of the contention in the title of this paper.⁵⁰

Acknowledgements

My sincere thanks to my wife for checking my style and grammar, and to Mrs. Janet Kirkwood for preparing the final typescript with her customary skill.

49 Walker, N. and McCabe, S. *Crime and Insanity in England*, Vol. 2. – *New Solutions and New Problems*. (1973, Edinburgh University Press). Quoted in Crichton et al. *op. cit.*

50 Since this paper was accepted, two highly relevant publications have appeared. Sugarman has discussed the meaning of the term 'unsound mind' within the European Convention context in respect of the Human Rights Act 1998 and the *Journal of Criminal*

Behaviour and Mental Health has produced a useful supplement to its current issue focussing on severe personality disorders. (See Sugerman P.A. (2002) *Persons of Unsound Mind, Dangerousness and the Human Rights Act, 1998*, *Journal of Forensic Psychiatry* 13(3): 569-577 and *Criminal Behaviour and Mental Health – Special Supplement* 12(2) December, 2002 (especially papers by Taylor, P.J., Cordess, C and Hinshelwood, R.D.)

Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness

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and Femi Oyeboode FRCPsych**

'Building a Safer NHS for Patients'¹ proposes significant changes to the reporting of adverse events in Britain's healthcare system including the place of inquiries in the analysis of adverse events. Within mental health services, since 1994 an independent inquiry has been mandatory for all homicides committed by persons in contact with mental health services. The inquiry reviews the care the patient was receiving at the time of the incident, the suitability of that care with regard to the patients history, health and social care needs, and the extent to which the care corresponded with statutory obligations of the health service.² A report is usually published following each inquiry including a set of recommendations based on the findings of the inquiry. The assumption is that these recommendations are intended to influence mental health policy and practice. However, many critics argue that inquiry reports and their recommendations have yet to substantially alter policy and practice.^{3,4}

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1 Department of Health (2001). *Building a Safer NHS for Patients: Implementing Organisation with a*

Memory. London: DOH.

2 Department of Health (1994). *Guidance on the discharge of mentally disordered people and their continuing care in the community*. HSG (94)27. London: NHS Executive.

3 Eastman, N. (1996). *Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries*. *British Medical Journal*, 313, 1069-71.

4 Crichton, J. & Sheppard, D. (1996). *Psychiatric Inquiries: Learning the Lessons*. In Peay, J. (ed.) *Inquiries after Homicide*. Duckworth: London.

In the future, homicides by people in contact with mental health services will be monitored by new NHS-wide arrangements through the newly created National Patient Safety Agency (NPSA). The aim of the new system is to unify the way that adverse events in clinical care are recorded and reported. The NPSA will introduce guidance on procedures for the appropriate use of investigations, and disseminate findings from its analysis as well as other research.⁵ What is implicit to these changes is that prior to the NPSA no systematic collation of adverse events within healthcare institutions existed including the inquiries after homicide. For example, to date, three authors have attempted to collate and review the recommendations from homicide inquiries. Sheppard⁶ compiled the set of recommendations resulting from mental health inquiries since 1969; each recommendation was placed into an appropriate subject heading. Critics have commented that this document is no more than an archive in which recommendations are listed “out of context without any attempt at clarification of the intended messages”.⁷ Furthermore, some of the recommendations are repeated under different headings. In an effort to remedy these problems, Petch and Bradley⁸ analysed 23 homicide inquiry reports in order to extract the meaning from their recommendations. The recommendations were examined for the general message and organised under headings representing various areas of psychiatric services. However, the recommendations were not annotated as to source or actual content. In addition, concrete examples of the recommendations were not given nor was any indication of the relative frequency of the theme of the recommendation given.

In Margaret Reith’s study⁹ the context of the recommendations is provided. She compiled the recommendations from 28 reports along with a short summary of the report from which the recommendation originated. The recommendations appear as found in individual reports and are indexed by subject area to allow the reader to access relevant topics more easily. Implication for policy and clinical practice are also discussed in detail. However, Reith’s study is published in book form which may not be readily accessible to most interested parties, and her analysis only covered 28 reports.

The aim of the present study was to conduct a qualitative review of the recommendations from all reports of inquiries after homicide published between 1994 and 2001. This study investigated in detail all the recommendations including the total number of recommendations, the themes of these recommendations, and the agencies to which the recommendations are addressed. The intention was to include all the reports published and available to the researchers.

Method

The total number of inquiries published between 1994 and 2001 were obtained through a number of sources:

- a) One list of published inquiries was obtained from a website prepared by Dave Sheppard.¹⁰ The website provides details of the title of the inquiry and contact details of the publisher.

5 *Supra*, n. 1

6 Sheppard, D. (1996). *Learning the lessons: mental health inquiry reports published in England and Wales between 1969 and 1996 and their recommendations for improving practice*, 2nd ed. London: Zito Trust.

7 Petch, E. & Bradley, C. (1997). *Learning the lessons from homicide enquiries: adding insult to injury?*

Journal of Forensic Psychology, 8, 161–184.

8 *Ibid.*

9 Reith, M. (1998). *Community Care Tragedies: a practice guide to mental health inquiries*. Birmingham, UK: Venture Press

10 www.davesheppard.co.uk

- b) Another list of published inquiries was prepared by the Secretary of State for Health in response to Parliamentary Question 265 on 4 July 2001. The question called for the list, by name of report and Health Authority, of all independent inquiries into homicide published since February 1994.^{11,12}
- c) The final source included examining all publications on the topic of homicide inquiries and extracting details of inquiries. This source did not recover any additional reports.

The recommendations were analysed by importing the full text of the recommendations from each report into a qualitative software package, Atlas.ti.¹³ Qualitative analysis involved coding the text of each individual recommendation using codes generated by the researchers. A 'grounded theory' approach was used to ascertain codes from the text itself.¹⁴ In general, codes were created to describe which service agency or staff group should carry out the recommendation, what subject area the recommendation referred to, what action was needed, and which client group the recommendation was aimed at helping. The codes were periodically examined for amount of usage and degree of applicability. New codes were created as needed, and redundant or seldom used codes were discarded. Recommendations were then grouped according to their codes, examined for associations with other codes, and representative recommendations were chosen to illustrate each subject area.

The examples chosen for illustration were deemed to be representative if the recommendation embodied the meaning for several text passages in the same topic area. The decision to use this criterion was made in an effort to focus this paper on those recommendations that have the most utility for general application. An attempt has been made to select examples of recommendations from as many different reports as possible to illustrate the different categories. The authors will provide a more detailed report if requested.

Results

Eighty-five independent inquiry reports following homicide committed by a person with a mental illness were known to be published at the end of data collection in July 2001. Seventy-two of these reports were present on both the list prepared by Dave Sheppard and that prepared by the Department of Health of published inquiry reports. Seven additional reports were mentioned on the list prepared by Dave Sheppard, all of which were obtained for analysis. Six additional reports were named on the list prepared by the Department of Health which were not included in the present analysis. One of these reports was obtained after data collection was completed, and the remaining five reports could not be located by the Health Authority named responsible for publication. Therefore, seventy-nine independent inquiry reports were obtained for analysis. The total number of recommendations from these reports is 1959. The mean number of recommendations per report is 24.80 (SD = 18.92).

Two hundred and six codes were created in order to describe the recommendations. This illustrates the diversity of service agencies, staff groups, client groups and areas of service delivery that are

11 Department of Health (2001). *List of Independent inquiries into mental health services published since February 1994*. House of Commons Deposited Papers 01/1105.

12 H.C. Deb. 10 July 2001. Vol. 371, Cc. 17.

13 Muhr, T. (1997). *ATLAS.ti. The Knowledge Workbench. Version 4.1*. Berlin: Scientific Software Development.

14 Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis, 2nd ed.* Thousand Oaks, CA: Sage.

represented by the inquiries and their recommendations. The main service agencies to which the recommendations are addressed are shown in table 1; the staff groups are shown in table 2; and particular aspects of mental illness explicitly targeted in the recommendations are shown in table 3. This analysis has identified a core set of issues, namely, improving routine psychiatric procedures, multidisciplinary working, quality assurance, staff issues, mental health law, and managing specific patient groups. Communication was a concept that ran through each of these issues. In an attempt to reduce as much repetition as possible, communication is mentioned within each of the main issue areas where appropriate. In the following analysis, the codes within each of the main areas are organised from highest to lowest according to the number of recommendations pertaining to the particular area.

Improving Routine Mental Health Care Practices

The bulk of the recommendations suggest improvements to everyday tasks essential to providing a good mental health service. It is here that many of the recommendations for communication and collaboration among mental health service agencies such as NHS Trusts, Health Authorities, and Social Services will be covered. Table 4 lists the categories coded within this area and Box 1 lists example recommendations from each category.

Firstly, the most numerous recommendations pertain to record keeping, which stresses the importance of accurately documenting the patient's travel through the healthcare system. It is emphasised that written care plans and patient records enable the sharing of information among professionals and agencies and that records must be readily available to all clinicians involved in the care of the patient. All mental health service sites (NHS Trusts, hospital, community) and allied services such as social services and probation are encouraged to unify records kept by medical, nursing, and social work staff. Case records should follow the patient during the processes of referral and transferring of cases. Clinical Records should be comprehensive, including information from the patient's previous treatment, previous episodes of violence, convictions, and family and carers' views.

There are recommendations regarding the care programme approach (CPA), assessment, care planning, risk assessment and management, and history taking. These recommendations are unified by the central theme of the quality of formal and structured assessments and the clinical decisions that flow naturally from these. The overall theme of the CPA recommendations is that this approach should be fully implemented in all mental health care agencies for all patients. CPA guidelines should be part of each clinician's training and the adherence to these guidelines should be strictly monitored. On a more practical level, proper application of CPA entails a co-ordinated care plan with multidisciplinary input at regular care planning meetings. All members of the mental health team should attend these meetings, especially the care co-ordinator.

With regard to assessment, it is recommended that assessments should endeavour to identify community care needs of patients, including health, social and housing needs. There are calls for guidance to be issued on assessments and adherence to these to be monitored through audit. Assessments should only be carried out by suitably trained clinicians and families should be included in assessments as informants. The needs of carers should also be assessed.

Risk assessment and management recommendations mostly relate to training in risk assessment. It is recommended that risk assessment should be done consistently, with a standardised tool,

and regularly. Risk assessments should include information from the family, evidence of non-compliance, substance use, and incidents of violence. Joint policies on risk assessments should be devised and implemented among health and social services, criminal justice agencies and housing agencies. Risk assessment should be documented in the patient records and inform the care plan which should be devised to manage assessed risks.

Recommendations regarding discharge planning delineate the arrangements that should take place before a patient is discharged into the community. It is essential that a multidisciplinary meeting take place prior to discharge to discuss the arrangements that have been made. The patient should be assessed before being discharged, and this should include a risk assessment and the patient's history of violence. Discharge summaries should be sent to the general practitioner in a timely manner, preferably within the first two weeks of discharge. The Trust should implement, give training in, and monitor adherence to discharge guidelines.

Planning the care and treatment of patients in mental health services is important because the care plan will designate how the patient is to be managed as an inpatient and in the community. The most numerous recommendation in this section stresses the importance of documenting the care plan in the patient's notes. Just as importantly, regular multiagency care planning meetings should be held to exchange information, voice concerns, and discuss the care plan among all those agencies and individuals involved in the care of the patient. The care plan should be agreed by those providing care and there should be consultation with multidisciplinary team members and carers before any decisions or changes regarding the care plan are made. Care plans must address identified needs and the patient should be involved in this process. It is recommended that the care plan must designate the care co-ordinator who is responsible for making sure care plans are implemented and regularly reviewed.

Providing aftercare that offers continued support, rehabilitation, and treatment in the community for patients with serious mental illness is essential for ensuring patients can lead more normal lives outside of hospital. Aftercare needs should be assessed and arrangements made to meet these needs before the patient is discharged from hospital. A risk assessment should be included and this information should be given to the aftercare team. During aftercare planning, the patient, GP, family and carers should be involved. It is important for the aftercare team to communicate with each other regarding the aftercare arrangements of the patient along with the other agencies involved in aftercare, such as social services, housing, the voluntary sector and the Home Office (for restricted patients). The aftercare programme should be recorded in detail, including but not limited to the name of the care co-ordinator, all care decisions, and appointments made to see the patient.

Taking an accurate history of the patient is important to assessment. Admission, discharge, risk assessment, CPA screening and new or transferred cases should have a complete and accurate documented case history including psychiatric, medical, and social histories. In particular, attention should be paid to known risk factors such as history of violence, previous convictions, history of noncompliance, and history of substance use.

Some recommendations make suggestions for the referral process. There should be ongoing liaison between referring clinician/service and the agency to which a referral has been made, which includes drawing up a plan of communication which designates who is responsible for liaison. Guidance should be established for referral from all sources which can be monitored by the Health Authority to ensure a good quality of service especially for referral agencies outside the NHS.

Forensic Community Psychiatric Nurses and Forensic Psychiatrists make up part of the forensic psychiatric services which according to the set of inquiries, also need improvements. Mostly, the recommendations from this group suggest improving information sharing among forensic mental health staff and other practitioners for patients with a forensic history. Another recurring theme in this group of recommendations is strengthening the management and structure of forensic mental health services. There are recommendations for increases in the number of community forensic services, and the number of forensic staff, including nurses, psychiatrists and social workers and for all staff working within forensic services to have specialist knowledge of forensic issues and supervision.

Incident reporting recommendations focus on the need for Trusts to review policy on handling critical incidents. Critical incident policies should be developed where none are in place. Debriefing or specialist support should be given to staff involved and to the families of the victim and carers following an untoward incident, including homicide. An immediate thorough investigation should be carried out following serious incidents. A policy should govern if the police should be called and who to call in case of a serious incident. Professionals should review police statements regarding incidents.

There are recommendations regarding the transfer of patients. These recommendations are concerned to improve practice when a patient transfers between locations within the Trust, between psychiatric services, or between hospital and prison. Responsibility for the patient should remain with the original team/service until a formal transfer has been completed.

It is also recommended that out of office hours, users, carers and relatives should have access to help and advice 24 hours a day.

These recommended improvements will inevitably require more resources. The majority of recommendations regarding resources tend to refer to training and increasing staffing levels, which are mentioned in subsequent sections. The remaining resource requirements mentioned in the inquiry reports concern reviewing and increasing if necessary funding for specialist services for populations such as persons with substance use problems or learning difficulties. Health Authorities should review spending across mental health services in order to provide an adequate service. Funding should be made available to improve the condition of mental health facilities. The inquiries argue that an increase in the number of general psychiatric beds is needed. There is also a call for an increased number of secure beds, particularly medium secure beds, for mental health services across the country and for patients with personality disorders.

Finally, in light of the many recommendations calling for information sharing, a few recommendations also call for a regard for confidentiality issues. The Department of Health, health care agencies and other agencies in contact with mentally ill persons should design a protocol to address confidentiality when sharing information. The limits of confidentiality should be defined indicating the circumstances under which others should be informed, for example, when a danger to others may be apparent. Access and exchange of information should be allowed without loss of confidentiality. The Department of Health should determine how the confidentiality of patient information can be protected. Patient's consent should be sought for access to records and involvement of family or carers in the diagnosis or treatment of the patient.

Multiagency Working

There are numerous recommendations that are concerned with improvements in communication between different professional groups and between agencies. The essential point is that there should be collaboration and joint working. This section will focus on liaison among those providing community support to traditional mental health services. See Table 5 for the topics covered in this section and Box 2 for examples of recommendations.

The patient's family and carers should be included in discussions concerning the care, treatment, discharge, aftercare, and changes to the care plan for the patient. Specifically, this means inviting families and carers to meetings where the patients care will be discussed and listening to carers and families. In addition, the family and carers can be a valuable information source in assessments. Furthermore, carers and families should be informed about who to contact for help or to discuss concerns. Carers and families should be given patient information on diagnosis, medication, side effects and symptoms to watch for so that the patient's care in the community is enhanced. A separate needs assessment should be carried out on the carer.

Appropriate accommodation is an integral part of the aftercare plan. Above all, communication and information sharing between those involved in planning and delivering care (health and social services) and housing services should be in place to ensure that the housing needs of service users are identified and met. A partnership between health, housing, and social services should be encouraged in order to assess and meet the housing needs of the mentally ill in the community, including developing supported housing initiatives for this population. Two-way communication between mental health services and housing services which enables housing services to seek advice from health and social services, and health and social services to involve housing in the care planning process. There should be a range of suitable accommodation to meet the needs of people with mental illness. This is integral to enabling patients to reside in the community.

It is recommended that General Practitioners should have more involvement in and make a contribution to the planning and reviews of care and medication. GPs should receive up-to-date documentation on patients care, especially discharge summaries, but also assessments on referral, aftercare plans, and when the patient exhibits self-harm or noncompliance.

There are recommendations about improvements to police procedures and liaison between health care agencies and the police. A number of recommendations are aimed at improving communication and collaboration between mental health services and the police for detainees in police stations, and patients in the community. For instance, it is recommended that mental health services should be informed if a patient is causing concern to the police. Police stations should have a protocol for initiating a mental health assessment when there is a suspicion of mental illness in a detainee. Police surgeons and officers should be given training in mental illness.

Other recommendations are directed at the judiciary, particularly calling for increased communication between health services and judiciary services when dealing with clients who are facing court proceedings. Magistrates, CPS advocates and solicitors should be trained in mental health issues, and that training should be given to clinicians in court proceedings and preparation of court reports. Furthermore, it is recommended that court reports should contain information from prison services and mental health services about the mental state of the prisoner and that this must be verified beyond verbal statements given by the patient. It is recommended that the CPS should be in receipt of medical records and previous convictions of mentally disordered offenders

in question. Information on court diversion schemes should be circulated to solicitors and clinicians working with mentally disordered offenders.

Several recommendations endorse reviewing and improving liaison between prison medical staff and mental health services regarding prisoners with mental health problems. Improvements within prisons are called for in areas such as record keeping, health care assessments, and training in mental health issues.

Finally, there are recommendations for improvements to probation services. The most common suggestion for probation services involves improving communication and multiagency working arrangements. There is a call for probation services to be more actively involved in assertive outreach and in the supervision of conditionally discharged patients.

Quality Assurance

The recommendations in this category include issues relating to guidelines, evidence-based practice, monitoring of the use of guidelines or protocols, and audit (see Table 6 and Box 3).

Predominantly, there are calls for guidance to be issued by the Department of Health, the Home Office, Central Government, and Social Services on a variety of topics. The most commonly mentioned topic is guidelines to improve interagency communication and liaison. Guidance is also called for in the procedures of CPA, risk assessments and assessments in general, record keeping, and the appropriate use of the sections in the Mental Health Act 1983. Other notable areas which require guidance are for staff dealing with violent patients, on the role and purpose of inquiries, on confidentiality of patient information, on involving carers in the care and treatment of patients, and on child protection issues.

As well as guidance there are recommendations to monitor the use of national guidance as a standard to determine proper implementation and following of procedures. Audits, which are examined in detail next, will form part of the monitoring procedure. Purchasers are asked to ensure that local agencies are adhering to guidelines issued for CPA, risk assessment and management, record keeping, discharge planning, and patient care.

The recommendations about audit include the need to involve collaboration with other agencies, such as Trusts, Social Services, and Health Authorities and for information ascertained from audits to be disseminated to other agencies involved in the care of patients with mental health problems. Clinical issues that have been highlighted in this section include auditing many of the areas highlighted in the improving routine mental health care practice section above. Mainly, audits should examine the quality of assessments, involvement of carers in care planning, proper implementation of CPA, discharge planning, record keeping practices, risk assessment and management, and application of the Mental Health Act 1983. These areas should be audited against Trust policies, national guidance, and standards set by professional bodies (e.g. UKCC or Royal College of Psychiatrists).

Finally, there are several calls for government agencies and professional organisations to issue guidelines based on evidence and to disseminate examples of good practice.

Staff Issues

The recommendations dealing with staff issues are listed in table 7 and the examples are listed in Box 4. The majority of training issues involve collaborating and communicating with other agencies. Another issue involves staff being trained in national and/or local guidelines and policies, which includes CPA procedures, and assessing and managing risk. Also, specialised training for working with particular client groups is recommended. These client groups include forensic patients, children, dual diagnosis, learning disabilities personality disorders, mood disorders, and substance use. Police, social workers, and General Practitioners also require more training in mental illness.

There are recommendations about clinical supervision. It is recognised that clinical supervision policies need to be reviewed or introduced to ensure that staff are supported through the guidance of more experienced clinicians. Supervisors should be trained in providing supervision and should be accessible to those they are supervising. Clinicians should be supervised when taking on new or specialist roles, especially patients subject to CPA. Supervision should also be fully recorded and audited to ensure needs are being met.

Also, staffing levels should be reviewed by Trusts and Health Authorities to ensure that numbers are adequate for the service provided, and that resources are available to meet staffing needs. Nearly half of these recommendations call for increases in number of consultants and other medical staff. There are also calls for adequate numbers of nurses, social workers, and support staff.

Other Staff Issues cover issues such as recruitment and retention, qualifications and competencies, and leave arrangements. Staff need to have appropriate qualifications, and sufficient experience for the particular post they hold. Clinicians should ensure appropriate cover for seeing patients is in place when on leave.

Mental Health Legislation

The recommendations under this heading are in table 8 and the examples are set out in Box 5. There are a number of recommendations calling for improvements to the use of powers of detention in general. Most importantly, the Mental Health Act 1983 should be part of the continuing education and training of medical, nursing, management and social services staff. It is recommended that the Mental Health Act commission should have a larger role in the monitoring of adherence to proper procedures involved in the application of the Mental Health Act. There should also be a full review of the Mental Health Act at the national level, making it easier to detain mentally ill persons, especially those with a history of violence.

Few specific sections are mentioned in the recommendations. Only Section 117 is mentioned enough times to warrant discussion. Recommendations about aftercare in general have been covered previously. For mentally disordered offenders, a representative from the police and/or probation should attend the Section 117 meeting in addition to the more typical members of a multidisciplinary team. It is recommended that the Department of Health should devise a standardised Section 117 form and that Section 117 documentation should be regularly reviewed and monitored by the Trust management and Mental Health Act Commission to ensure that it complies with national guidelines.

Lastly, recommendations are made for improvements to the process of independent inquiries. Agencies implicated in inquiries should acknowledge the findings and conclusions of inquiries, produce an action plan and monitor performance. A nationally agreed policy should be set up for handling inquiries possibly headed by the National Confidential Inquiry. The inquiry team of the Trust should reconvene in 6 to 12 months time to monitor the progress of implementing inquiries. Inquiries should be eligible for subpoena powers to ensure sharing of information. Inquiry recommendations should be collated and circulated widely perhaps by the National Confidential Inquiry, which may aid Inquiries findings to inform government policy.

Managing Specific Client Groups

There are recommendations dealing with how to improve the management of particular client groups which are listed in table 9 with examples listed in Box 6. Many of these recommendations are variations on the recommendations described in the section on improving routine mental health care practices. Therefore, only those recommendations which add to the present discussion will be included here.

In relation to violence it is recommended that risk assessment of the dangerousness of a patient must be carried out on admission, prior to discharge into the community, and regularly during treatment in the community. The conclusions of assessments of risk of violence must be communicated to all members of the team providing care and treatment for the patient, as well as to other agencies such as the police, and Social Services.

In the event of non-compliance, patients must either be re-assessed or readmitted to hospital. The recommendations regarding substance use, self-harm and suicide, and relapse of patients deal with improvements record keeping, the quality of assessments including risk assessments. The recommendations dealing with personality disorders ask Social Services, NHS Trusts, and Health Authorities to specify what services are available for appropriate assessment and treatment of personality disorders.

There are recommendations pertaining to restricted or conditionally discharged patients. Most notable of these recommendations is that probation officers and nurses should have special training before working with restricted or conditionally discharged patients. Any changes to the conditions of discharge must be notified to the Home Office for response. Finally, medical members of Mental Health Review Tribunals for restricted patients must be forensic psychiatrists.

The recommendations regarding children suggest that more attention should be paid to children of parents with mental health problems through training in the impact of parents mental illness for child protection workers and training for mental health professionals in child development and protection. Risk assessment and needs assessment of children of the patient should be conducted before the patient is discharged. Awareness of access to child mental health services should be raised for education and social services.

Discussion

The recommendations from the 79 Inquiries analysed and reported in this paper are wide ranging and encompass the totality of the mental health care system. The main thematic areas that the recommendations address include a) improving routine health care procedures, b) multi-agency working arrangements, c) quality assurance systems, d) staff issues, and e) the management of specific patient groups. Within these themes, the recurring issues are communication and collaboration between all the interested parties in the care of a patient. We believe that our qualitative analyses have exhausted the themes of the recommendations of the inquiries studied.

An observation of changes in mental health policy reveals that homicide committed by psychiatric patients and inquiries after homicide have influenced mental health policy in the UK. For example, the supervision register was introduced following the recommendation in the inquiry into the murder of Jonathan Zito by Christopher Clunis as a measure designed both to identify and register those patients most likely to pose a risk to others.¹⁵ In the same vein the addendum to Section 25 of the Mental Health Act 1983 as delineated in the Mental Health (Patients in the Community) Act 1995 allows doctors to manage potentially dangerous patients in the community by enforcing where they reside and where and when they attend for treatment.¹⁶

Furthermore, other current mental health policy appears to have taken on board many recommendations from inquiry reports after homicide has been committed by a mental health patient. In particular, changes to the Care Programme Approach as introduced in Effective Care Co-ordination in Mental Health Services¹⁷ and the National Service Framework¹⁸ reflect many of the recommendations of the inquiries.

The Care Programme Approach is conceived of as a systematic method for comprehensively assessing the needs of psychiatric patients with a view to developing a personalised care plan. Patients who require the services of a multiplicity of agencies are identified as in need of an enhanced level of CPA that should allow for the co-ordination their care across agencies and professional groups. One of the main findings of our study has been that many recommendations address improving the co-ordination of mental health care across the disparate agencies and professionals involved in the care of patients.

The National Service Framework set standards for the modernisation of mental health service in England and Wales. Several of these standards reiterate the findings of the current study. For example, standard three states that 'any individual with a common mental health problem should be able to make contact round the clock with local services.'¹⁹ Standard Four requires that all patients should have a copy of the written care plan which regularly reviewed by the care co-ordinator. Together with standard 5, these two standards provide the basis for the development of assertive outreach services across the country. These services are for patients who are the most difficult to engage and pose a danger to themselves or others. However, research findings on the

15 Nolan, P., Oyeboode, F. & Liburd, M. (1998). A survey of patients placed on the supervision register in one mental health trust. *International Journal of Nursing Studies*, 35, 65–71.

16 Mental Health (Patients in the Community) Act 1995. London: HMSO.

17 Department of Health (1999). *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*. London: NHS Executive.

18 Department of Health (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health.

19 *Ibid.*, p.8.

efficacy of assertive outreach have been inconclusive.²⁰ Thus, the NSF in setting these standards has sought to address the problems posed by some of the patients described in the homicide inquiries particularly those prone to disengage from services.

The inquiries into homicide committed by a person in contact with mental health services have greatly influenced public policy in mental health. However, the most recent inquiry in our collection which was published in July 2001, two years after publication of the NSF, still recommends that CPA should involve co-ordinated care across agencies and disciplines.²¹ This suggests either that government policy is yet to be fully implemented or that inquiries are likely to reveal the less than perfect world in which psychiatry is practised.

In the future, the National Patient Safety Agency (NSPA) will be responsible for changing the way adverse incidents are reported so that a culture of learning from mistakes may be encouraged.²² There is awareness that at present there is no systematic collation of data in order to improve our understanding of the nature and causes of adverse events in medicine. The new system set up by the NSPA endeavours to identify and record adverse events, report to local sites and the national system, analyse incidents and trends, learn lessons from analysis and research, disseminate findings and to implement change. In mental health, the homicide inquiries have been the response to the problem of adverse events. However, these inquiries are not systematic inquiries into the nature and causes of the adverse incidents. The inquiry reports have not been systematically collated to improve practice. Since adverse events in mental health services are a subset of adverse events in health care in general, it would be reasonable for adverse events in mental health to be dealt with under the same system as other adverse events. Therefore, it is right homicide committed by patients in contact with mental health services should be included under the terms of the new NSPA arrangements.

In more subtle ways the climate within which psychiatry is now practised has altered significantly to the degree that assessment of risk has become one of the principal tasks of clinicians. The Mental Health Bill, with its focus on risk to others and the control of mentally ill patients, is one of the changes evident in current psychiatric practice. It is the case that the public in Western countries is concerned with errors in medical arena and adverse effects of clinical interventions. However, errors and adverse events are the outcome of a complex interaction between the actions of individual practitioners, the systems of care, and the resources available to clinicians. Inquiries into adverse events should be concerned into failures of systems of care rather than attribute blame to individual practitioners.²³

20 Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders (Cochrane Review). In: *The Cochrane Library, Issue 4, 2002*. Oxford: Update Software.

21 Rassaby, E., Bull, D., McCollin, D. & Murray, K. (2001). *Report of the Independent Inquiry into the Care and Treatment of Kevin Hewitt*. Leicester, UK:

Leicestershire Health Authority.

22 Department of Health (2000). *Organisation with a memory: A report of an expert group on learning from adverse events in the NHS*. London: HMSO.

23 Reason (2000). *Human error: models and management*. *British Medical Journal*, 320, 768–770.

Table 1. Service Agencies

<i>Service Agency</i>	<i>Number</i>
NHS Trusts	558
Social Services	270
Health Authorities	233
Mental Health Services NOS	184
Housing Agencies	103
Police	90
Local Authorities	79
Prisons	61
Department of Health	59
Probation	58
Home Office	56
Judicial System	42
Voluntary Organisation	30
NHS Executive	26
Central Government	25
Health Care Agency NOS	22
Drug Misuse Agency	17
Primary Care Services	8
Regional Office	7
No Service Agency	707

Table 2. Staff Groups

<i>Staff Group</i>	<i>Number</i>
Psychiatrists	159
Managers and executives	144
Care co-ordinators	128
Nurses	120
Unspecified clinical staff	104
General Practitioners	84
Unspecified medical staff	67
Social workers	62
Psychologists	13

Table 3. Aspects of Mental Illness

<i>Target aspect</i>	<i>Number</i>
Violent behaviour	116
Substance use	53
Mentally disordered offenders	52
Personality disorder	19
Learning disability	12
Schizophrenia	8
Mood disorder	2

Table 4. Improving Routine Psychiatric Services

<i>Code</i>	<i>Number</i>	<i>Reports</i>
Admission	67	35
Aftercare	85	18
Assessment	183	56
Care planning	156	57
CPA	219	62
Confidentiality	47	32
Discharge	162	47
Documentation	365	71
Forensic	51	17
History taking	74	41
Incidents	44	31
Moving Patients	33	17
Out of Office Hours	23	16
Referral	69	37
Resources	96	44
Risk Assessment	155	61

Table 5. Multiagency Working		
<i>Code</i>	<i>Number</i>	<i>Reports</i>
Collaboration	159	52
Communication	543	75
Families and Carers	162	59
General Practitioners	84	44
Housing Services	103	28
Judiciary	42	14
Police	90	33
Prison	61	9
Probation	58	16

Table 6. Quality Assurance		
<i>Code</i>	<i>Number</i>	<i>Reports</i>
Audit	100	40
Evidence-Based Practice	23	13
Guidelines	140	51
Monitoring	120	51

Table 7. Staff Issues		
<i>Code</i>	<i>Number</i>	<i>Reports</i>
Clinical Supervision	71	44
Staffing Levels	32	19
Training and Professional Development	229	65
Other Staff Issues	97	45

Table 8. Mental Health Legislation		
<i>Code</i>	<i>Number</i>	<i>Reports</i>
Inquiries	76	35
Mental Health Law	53	21
Section 117	36	12

Table 9. Managing Specific Client Groups		
<i>Code</i>	<i>Number</i>	<i>Reports</i>
Children	63	11
Conditional discharge/ Restricted	29	5
Noncompliance	50	35
Personality Disorder	19	9
Relapse	23	12
Self harm or suicide	34	19
Substance use	53	22
Violence	116	43

Box 1. Improving Routine Psychiatric Services

Documentation. “Improve communication between those staff who care for patients by introducing ‘shared’ records into which all the health professionals involved in the care and treatment of an individual make entries in a single record in accordance with a broadly agreed local protocol”.²⁴

CPA. “We recommend that the Trust should ensure that all patients receiving enhanced CPA are subject to regular and audited multi-disciplinary review. CPA systems must reflect reality. In the light of difficulties evident in continuity of care, the Directorate should consider the use of mandatory rolling case summaries for all patients on enhanced CPA. If such a system is not developed, alternative methods of keeping track of patients’ care must be developed”.²⁵

Assessment. “The Milton Keynes Community NHS Trust should ensure that people with learning disability are automatically reassessed at regular intervals using the WHO recommended multi-axial system of diagnosis to record diagnoses in their psychiatric, developmental, intellectual, physical and psychosocial domains. Life events, changing clinical presentations (including frequent contact with services) and regular risk assessments should trigger a CPA review. The Department of Health and Royal College of Psychiatrists should consider issuing appropriate guidance to all Mental Health and Learning Disabilities Services on this issue of regular re-assessment”.²⁶

Risk Assessment and Management. “That Risk Assessment must not be considered as a ‘one off’ process at the time of admission into hospital or care. It must be seen as a continuing process and be reviewed at regular intervals to ensure that any revision and updating of care and treatment programmes can be implemented appropriately”.²⁷

Discharge. “Patients should not be discharged without an adequately prepared discharge plan or any outpatient or follow up appointments required after discharge being made and the details communicated to the patient. Discharge should be to an identified General Practitioner with whom the patient has already registered”.²⁸

Care Planning. “The Trust should ensure that, as part of the care plan, there are regular reviews of the progress of patients attending the Outpatients Clinic by senior doctors, if possible with other members of the multidisciplinary team, so that social and Psychological dimensions can be identified and dealt with”.²⁹

24 Williams, W. J., Campbell, A., Hayward, T. & Tallentire, P. (1997). *Inquiry into the Circumstances Surrounding the Deaths of Michael and Hazel Homer*. Nelson, UK: East Lancashire Health Authority

25 Mackay, J., Poole, R. & Sinclair, S. (2001). *The Report of the Independent Inquiry into the Care and Treatment of Paul Horrocks*. Birkenhead, UK. Wirral Health Authority.

26 Rubenstein, V., Lavin Smith, M., Lindsey, M., Richardson, D. & Roy, A. (2000). *Report of the Independent Inquiry into the Care and Treatment of Lorna Thomas and Nicholas Arnold*. Aylesbury, UK: Buckinghamshire Health Authority .

27 Brown, T., Fraser, K., Morley, A. & Swapp, G. (1999). *Report of the Inquiry into the Care and Treatment of Jonathan Crisp*. Middlesborough, UK: Tees Health Authority.

28 Adams, J., Douglas, P., McIntegart, J. & Mitchell, S. (1997). *Report of the Independent Inquiry into the Care and Treatment of James Ross Stemp*. Leicester, UK: Leicestershire Health Authority.

29 Hughes, J. Mason, L., Pinto, R. & Williams, P. (1995). *Report of the Independent Panel into the circumstances surrounding the deaths of Ellen and Alan Boland*. London: North West London Mental Health NHS Trust .

Aftercare. “The Aftercare Plan should be more than a list of discharge arrangements. It should include a plan for the patient’s rehabilitation and continued treatment within the community. The patient should be aware of the care plan and should be encouraged to adopt its aims and targets. The care plan is of little use without the patient’s active participation”.³⁰

History Taking. “On every admission the Ward Doctor and the Named Nurse should fully acquaint themselves with the patient’s previous clinical notes and detail any relevant information from the past medical history into a new case review which should then be recorded in the notes for the current admission”.³¹

Referral. “Any referral by a CPA care co-ordinator for a specific service from another agency should be confirmed in writing and a copy of any care plan should be made available”.³²

Forensic. “The Purchasing Authority should consider developing quality standards applicable to the care of patients with histories of violent offending. Such standards might include requiring Providers to ensure that a full range of assessment approaches, including access to forensic psychiatry services, is available to such patients”.³³

Incidents. “As soon as possible after an incident involving a homicide by a patient (including an outpatient) in the care of the psychiatric services, there should be: (a) a clinical audit at immediate service level under the management of a clinician not involved in providing care for the patient, and (b) an internal inquiry. The treating clinical staff (including any Community Psychiatric Nurses who have been involved in the care of the patient) should be interviewed and detailed statements taken from them”.³⁴

Transfer of Patients. “We recommend that where a patient is transferred from one hospital to another within the Trust before his/her care plan becomes operational, the plan must also be transferred with the patient and should be taken into account when a fresh plan is being devised. All the case notes in total must always accompany a patient who moves within the Trust to ensure continuity of care”.³⁵

30 Scotland, P., Kelly, H. & Devaux, M. (1998). *Report of the Luke Warm Luke Mental Health Inquiry*. London: Lambeth, Southwark and Lewisham Health Authority.

31 Mishcon, J., Mason, L., Stanner, S., Dick, D. & Mackay, I. (1997). *Report of the Independent Inquiry into the treatment and Care of Doris Walsh*. Coventry, UK: Coventry Health Authority.

32 Harbour, A., Brunning, I., Bolter, L. & Hally, H. (1996). *The Viner Report: The Report of the Independent Inquiry into the Circumstances Surrounding the Deaths of Robert and Muriel Viner*. Ferndown, UK: Dorset Health Commission.

33 Blom-Cooper, L., Grounds, A., Guinon, P., Parker, A. & Taylor, M. (1996). *The case of Jason Mitchell: Report of the Independent Panel of Inquiry*. London: Duckworth.

34 Mischon, J., Dick, D., Milne, I., Beard, P. & Mackay, J. (1996). *The Hampshire Report: Report of the Independent Inquiry into the Care and Treatment of Francis Hampshire*. Ilford, UK: Redbridge and Waltham Forest Health Authority.

35 Crawford, L., Devaux, M., Ferris, R. & Hayward, P. (1997). *The Report into the Care and Treatment of Martin Mursell*. London: Camden and Islington Health Authority.

Out of office hours. “That the Health Authority, [Social Service Department] and the Trust should together consider ways of developing an out of hours service for the use of those with mental health problems. Such a service should be set up involving all other relevant agencies, (including Primary Medical Health Care Services), and arrangements should be made to publicise the service and give information to potential users as to how the service may be accessed. The service could incorporate a 24 hour telephone helpline”.³⁶

Resources. “The panel recommends that priority be given and appropriate resources allocated to the establishment of sufficient mental health services and facilities in [the] District, which the panel considers is necessary to reduce the fragmentation and lack of co-ordination of services, to raise morale of those working in mental health care, and to encourage recruitment and retention of key staff”.³⁷

Confidentiality. “The limits of confidentiality between the various professionals concerned with a patients’ care should be carefully define indicating the circumstances in which others must be informed”.³⁸

Box 2. Multiagency Working

Carers and Families. “Written guidance should be given to all staff regarding the involvement of carers and other family members in the care and treatment of patients and so that their views are sought and recorded when Care Programme Approach plans are made and reviewed”.³⁹

Housing. “Action to improve communication and joint working between LMHTs and the Housing Department: Priority should be given to the further development of supported housing initiatives for mentally ill people based on an analysis of the current research being undertaken on housing need”.⁴⁰

GP. “The West Berkshire Priority Care Service NHS Trust should introduce a system to ensure the adequate involvement of general practitioners on discharge from inpatient care. In particular, it is essential to ensure that information is conveyed where possible to the general practitioner immediately, followed by a formal discharge summary within ten days”.⁴¹

36 Sedgman, J., Graham, M., Moran, J. & Wilkins, J. (1997). *Conclusions and Recommendations from: Report of the Inquiry into the Treatment and care of 5 individual patients by Oldham NHS Trust Mental Health Services commissioned by West Pennine Health Authority.* Oldham, UK: West Pennine Health Authority.

37 Galbraith, A., Simpson, C., Childs, A. & Parkin, D. (2000). *Report of the Independent Inquiry into the Care and Treatment of Patient R and Patient Y.* Durham, UK: County Durham and Darlington Health Authority.

38 Wood, I., Ashman, M., Davies, C., Lloyd, H. & Lockett, K. (1996). *Report of the Inquiry into the Care*

of Anthony Smith. Derby, UK: Southern Derbyshire Health Authority.

39 Lingham, R. & Candy, J. (1997). *Inquiry into the Treatment and Care of Damian Witts.* Gloucester, UK: Gloucestershire Health Authority.

40 Dimond, B., Carter, P., Jolley, A. & Watts, T. (2000). *Independent Inquiry into the Care and Treatment of Feza M.* London: East London and The City Health Authority.

41 Richardson, G., Chiswick, D. & Nutting, I. (1997). *Report of the Inquiry into the Treatment and Care of Darren Carr.* Reading, UK: Berkshire Health Authority.

Police. “The Mental Health Services of the Healthcare Trust and the Local Authority should establish an inter-agency working group to address the issue of the sharing of information between themselves and Police, Probation, Social Services and Housing. The Group should agree a policy for sharing information about mutual clients and for establishing a workable means of monitoring clients who may be involved with one or more of the services”.⁴²

Judiciary. “Multi-agency risk assessment and attendant communication is more formally established as a safeguard by the Family Courts. For example, there should be communication between relevant agencies in circumstances such as the discharge of a Family Assistance Order, where family members are known to be under the care of mental health services. In such circumstances, court decisions and their implications (assessed by the court welfare officer) should be communicated to the local statutory services involved in a given individual’s programme of care”.⁴³

Prison. “Forensic medical examiners should inform the medical officer of the local prison of any information which relates to a prisoner’s physical or mental health, and particularly of any assessment which has been carried out by a psychiatrist or approved social worker. (When the PER Form is introduced, such information should be in a sealed envelope attached to the Form”.⁴⁴

Probation. “Such an assessment should include gathering as much information about the patient from as many sources as possible. If the patient has been transferred from prison, the probation service should be contacted to provide any relevant information and a check should be made of his antecedents for convictions involving violence”.⁴⁵

Box 3. Quality Assurance.

Guidance. “That the Department of Health harmonise guidance Section 117 Registers, proposed supervision registers, and the care programme approach with community care assessment and care management in respect of people who have a severe mental illness and their carers. Such guidance should include clarification of clinical, management and practitioner responsibilities, and the importance of choice by the service user in who their psychiatrist or key worker is to be for purposes of sustaining a therapeutic relationship”.⁴⁶

42 Mishcon, J., Hayes, L., Lowe, M. & Talbot, M. (1997). *Report of the Independent Panel of Inquiry into the Treatment and Care of Paul Smith*. Peterborough, UK: North West Anglia Health Authority.

43 Williams, R., Hennessey, M. & Green, C. (1999). *Report of the Inquiry into the Care and Treatment of Anne Murrie*. Reading, UK: Berkshire Health Authority.

44 Coonan, K., Bluglass, R., Halliday, G., Jenkins, M. & Kelly, O. (1998). *Report of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford*. Witham, UK: North Essex Health Authority.

45 Mishcon, J., Dick, D., Welch, N., Sheehan, A. & Mackay, J. (1995). *The Grey Report: Report of the Independent Inquiry Team into the Care and Treatment of Kenneth Grey*. London: East London and The City Health Authority.

46 Woodley, L., Dixon, K., Lindow, V., Oyeboode, O., Sandford, T. & Simblet, S. (1995). *The Woodley Team Report: Report of the Independent Review Panel to East London and the City Health Authority and Newham Council*. London: East London and The City Health Authority.

Monitoring. “That the Trust should make it part of the task of each of its managers to identify whether its staff are carrying into actual effect its basic aims, like providing care in accordance with best practice. Wherever possible any monitoring carried out by managers should have, as a specific object, the identification of success or failure in such areas. Even though monitoring success or failure in these respects is not as easy as in some other aspects of the work of a hospital, because it is not as easily analysed in a statistical fashion, it must be recognised that they are the *raison d’être* of a hospital and must therefore be at the forefront of management’s concerns”.⁴⁷

Audit. “Clinical audit examines quality of out-patient assessments of previously detained patients and focuses on: the use of informants, in order to verify that informants have been seen; the range of issues considered within the assessment process (e.g. medical, social, employment, financial, family, forensic, substance misuse, etc.); the nexus between the treatment being provided and the needs which were identified; the way in which risks have been identified and managed”.⁴⁸

Evidence-based Practice. “The Department of Health should identify research-based interventions into families with histories of dysfunction and deprivation with a view to offering assistance at the earliest stage aimed at preventing and managing the development of early childhood conduct disorders and possible associated personality disorders”.⁴⁹

Box 4. Staff Issues.

Training and Professional Development. “The programme of in-service training for employed staff and for volunteers should be intensified and be better directed to the needs of the severely mentally ill and the staff caring for them. To be more specific, without implying their relative importance or the amount of time that should be spent on each, the following should be considered: i. The signs and symptoms of major mental illness, ii. Understanding and learning to talk with severely mentally ill people, iii. Substance abuse and its management: alcohol and drugs, iv. Treatment and management of mental illness: physical, psychological and social, v. Mental Health Act and its application, vi. Care Programme Approach: Supervision Registers; power of supervised discharge. vii. Risk assessment; viii. Emergency assessment and admission procedures; ix. Record keeping”.⁵⁰

47 Barlow, R., Crook, J., Kingdon, D. & McGinnis, P. (1996). *Caring for the Carer: Report of the Inquiry into the Care of Keith Taylor*. Middlesborough, UK: Tees Health Authority.

48 Eldergill, A., Bowden, P., Murdoch, C. & Sheppard, D. (2000). *Report of the Independent Inquiry Panel into the Care and Treatment of Stephen Allum*. Reading, UK: Berkshire Health Authority, and Eldergill, A., Kelly, H. & Sheppard, D. (2000). *Report of the Independent Inquiry into the Care and Treatment of*

Alexander Cameron. Reading, UK: Berkshire Health Authority.

49 Weeraratne, A., Hunter, C. & Newland, A. (2000). *Report of the Independent Inquiry into the Care and Treatment of Shane Bath*. Ferndown, UK: Dorset Health Authority.

50 Davies, N., Lingham, R., Prior, C. & Sims, A. (1995). *Report of the Inquiry into the Circumstances Leading to the Death of Jonathan New by (a Volunteer Worker)*. Oxford: Oxfordshire Health Authority.

Clinical Supervision. “An effective and efficient system should be in place to ensure all professional staff receive appropriate supervision of their work and have their work regularly reviewed. Independent practitioners should operate to the same standards. The system should balance managerial, educational and clinical supervision of staff and provide an opportunity to reflect on and explore clinical standards, case analysis and staff workloads”.⁵¹

Staff Levels. “There need to be more Consultant Psychiatrists and other CMHT members employed, to enable more detailed assessments and documentation to be implemented”.⁵²

Other staff Issues. “The Panel recommends that Brent Social Services Department should be asked to give careful consideration to the deployment, training and support of social workers and ensure that the most able and experienced staff are allocated to difficult and demanding patients [...]”.⁵³

Box 5. Mental Health Law and Inquiries.

Mental Health Law. “It is essential that anyone in the mental health system should have had some tuition in the Act and the Code of Practice. Anyone exercising the powers and duties derived from statute must be aware of their nature and extent. It is the primary task of management to ensure that practitioners are adequately versed in the law and practice in mental health and, further, that policies and procedures are properly formulated to instruct and guide all practitioners”.⁵⁴

Section 117. “We would recommend that where a person with a severe and enduring mental illness, who comes within the remit of s.117 of the Mental Health Act 1983, moves away from the area of the local Health and Social Services, then the following principles should apply: The need for on-going monitoring of that person’s progress in the community should be recognised by both Health Services and Social Services (by means of a care programme or care management). Responsibility should be retained until the s.117 statutory after-duty is properly transferred to the local Health and Social Services in the area to which the individual has moved. A document that would contain all pertinent information, including any history of violence and risk assessment should be passed to the local Health and Social Services to whom s.117 duties are conferred”.⁵⁵

Inquiries. “The Inquiry Panel should be invited to reconvene one year after the publication of this Report to consider and report on the progress made in implementing these Recommendations”.⁵⁶

51 Laming, H., Claydon, D., Davies, C. & Womack, J. (2000). *Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings*. Taunton, UK: Somerset Health Authority and Somerset Social Services.

52 Taylor, J., Longhurst, N., Oldridge, P. & Brown, T. (2000). *Mental Health Inquiry: Mrs Marie Alawode*. Huntington, UK: Cambridgeshire Health Authority.

53 Heginbotham, C., Carr, I., Hale, R., Walsh, T. & Warren, L. (1994). *Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan*. London: North West London Mental Health NHS Trust.

54 Blom-Cooper, L., Hally, H. & Murphy, E. (1995). *The Falling Shadow: One Patient’s Mental Health Care 1978–1993*. London: Duckworth.

55 Dixon, K., Herbert, P., Marshall, S. & Pinto, R. (1999). *The Dixon Team Inquiry Report*. London: Kensington and Chelsea and Westminster Health Authority.

56 Mishcon, J., Sensky, T., Lindsey, M. & Cook, S. (2000). *Report of the Independent Inquiry Team into the Care and Treatment of Daniel Joseph*. London: Lambeth, Southwark and Lewisham Health Authority.

Box 6. Patient Variables

Violence. “We recommend that within the multi-agency approach there must be mutually consistent systems of assessment of risk to the mentally disordered offender, him or herself; the community, or any significant individual likely to be targeted. Such a system must adopt mutually consistent assessments covering the propensity for violence to people and property, threats uttered, previous offending behaviour, and the likely threshold at which the risk assessment/dangerousness is likely to enter a higher risk category”.⁵⁷

Non-compliance. “The Trust and Health Authority should agree guidelines for ensuring regular contact is maintained with non-compliant or unco-operative patients by whatever measures are deemed appropriate in individual circumstances”.⁵⁸

Personality disorder. “the Authority and the Trust give specific consideration to the peculiar problems presented by people with personality disorder and arrive at an agreed position on what, if any, services are to be offered locally and what action local professionals should take when presented with the case of a person with personality disorder, which can include referral to other agencies”.⁵⁹

Conditional discharge or restricted. “Where there is such a case in which a conditionally discharged patient with this type of background is placed in the care and management of a multidisciplinary team it is, in our view, important that members of that care team have the training, experience and background which suits them for such a role – and we refer particularly to the training recommendations and requirements for Probation Officers and Community Psychiatric Nurses who have to fill a role in such a Care Team and the need for the Consultant Psychiatrist to be an appropriately placed and experienced person”.⁶⁰

Children. “The Chair [of the Area Child Protection Committee] should routinely ask for the children’s views on the situation under discussion and be informed of the efforts made to gain their views... The difficulties for social workers visiting families in child protection cases where adult needs can dominate are appreciated but time should be set aside to engage the children separately. In this case it would have been appropriate to refer the children for more specialist help [...]. The child’s right to be heard and his/her wishes taken into consideration is a duty laid on the local authority in the Children Act 1989”.⁶¹

57 Herbert, P., Ghosh, C. & Walters, I. (1999). *Report of the Inquiry into the Care and Treatment of Michael Donnelly*. Witham, UK: North Essex Health Authority.

58 Branthwaite, M., Fisher, N., Milne, I. & Mackay, J. (2000). *Report of the Independent Inquiry into the Treatment and Care of Richard Allott*. Warwick, UK: Warwickshire Health Authority

59 Gunn, M., Daniels, G., Foster, T. & Middleton, H. (1999). *Report of the Independent Inquiry into the*

Treatment and Care of Bradley Sears-Prince. Leicester, UK: Leicestershire Health Authority

60 Brown, A., Harrop, F., Cronin, H. & Harman, J. (1996). *Report of the Independent Inquiry into the Care and Treatment of Richard Stoker*. Northumberland Health Authority

61 Gabbott, J. & Hill, O. (1994). *Inquiry into the deaths of Jason and Natalia Henry*. London: Haringey Child Protection Committee.

Claiming Damages for Workplace Stress

By Edward Myers*

Introduction

British workers are reported as having the highest levels of stress in Europe; indeed 1 in 5 workers (around 5 million people) is affected by stress.¹ The cost to Britain's economy is broadly estimated at approximately 6.7 million working days lost each year – valued at between £3.7–£3.8 billion.² As recently as 14th October 2002 the TUC launched a campaign “Tackle the Hassle” designed to focus on the 270,000 people per year who go sick, and the cost to British Companies of around £538 per employee.

Along with these startling statistics has come an increased understanding of the nature and extent of occupational stress. The Health Education Authority in their report “Stress in the Public Sector” (1988) helpfully defines stress as an “excess of demand upon an individual in excess of their ability to cope”. Similarly, the Health and Safety Commission report, “Managing occupational stress; a guide for managers and teachers in the schools sector” (1990), identified stress as “...an unresolved mismatch between the perceived pressures of the work situation and an individual's ability to cope”. (The report concluded unremarkably, although interestingly in the light of subsequent case law, that teaching could be a stressful profession...).

More recently the Health and Safety Executive in their publication “Stress at Work” (1995) adopted a more illuminating approach. Referring to stress as “...the reaction people have to excessive pressures or other types of demands placed upon them”, they distinguish stress from both pressure, and the psychiatric consequences of this. Pressure at work can in some cases cause stress – i.e. an individual response to pressure. The HSE report continues

“Stress is not therefore the same as ill health. But in some cases particularly where pressures are intense and continue for some time, the effect of stress can be more sustained and far more damaging, leading to longer term psychological problems...”.

As any student of this area of law will know, damages are only recoverable for a recognised psychological condition; stress may be the midwife of such a condition³ but does not of itself sound in damages.

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1 Health & Safety Executive Press Release E206: 00 – 1st November 2000

2 *ibid*

3 *Hinz v Berry* [1970] 2 QB 40; *McLaughlin v O'Brian* [1983] 1AC 410; *Alcock v Chief Constable of South Yorkshire Police* [1992] 1AC 310;

The TUC (Trade Union Congress) recognised the European Week for Health and Safety 2002 by prescribing a TUC stress MOT for use by employees. They have indicated that workplace stress claims have increased by a factor of 12 in the period 1999 to 2000.⁴ The Health and Safety Executive have developed some criteria for the identification and reduction of workplace stress. Reasonable employers should be aware of this research and should take into account in taking measures pursuant to risk assessments.⁵ Further, the Working Time Directive 93/104/EC should in the future assist workers injured through stress from long hours of work. Against this background what right of action does an employee suffering from occupationally related stress have?

In order to fully understand the current legal situation and the position of employees considering bringing an action for occupationally related stress, it is necessary to consider the two seminal cases. The first reported decision was *Walker v Northumberland County Council*.⁶ Whilst this set a marker for cases of this nature there was some uncertainty as to the scope of the decision and its implication for future claims. Thereafter, in *Hatton v Sutherland* (and three other cases heard at the same time)⁷ the Court of Appeal, in the first reported decision of that Court which dealt with this issue, helpfully clarified the law post-*Walker*. As will be made clear below, although some practitioners interpreted this decision as a change in the law, or a raising of the bar for potential Claimants, in reality it was a consolidation of the common-law position as set out in *Walker*.

Walker v Northumberland County Council

Whilst claims for occupational stress have long been recognised by other common law jurisdictions, especially USA and Australia, it was not until *Walker v Northumberland County Council* that a marker was first put down in this jurisdiction. The Claimant was an experienced Area Social Services Officer with responsibility for the management of four teams of Social Services field workers in an area with a large number of childcare problems. In the 1980s an increase in population brought a significant increase in the number of cases referred to him. He repeatedly sought assistance from management in the form of extra staff or guidance on work distribution; however neither was forthcoming. In November 1986 he suffered a mental breakdown and under medical advice remained off work until March 1987. On his return to work it was agreed that an assistant would be made available. However this agreement was not adhered to. Consequently the Claimant was exposed to a rapidly increasing workload, and the responsibility for dealing with a substantial backlog of paperwork. In September 1987, some six months after returning to work, he suffered a second nervous breakdown. In February 1988 he was dismissed by his employers on the grounds of ill health.

He claimed damages against his former employer for breach of their duty of care as his employer, in failing to take reasonable steps to avoid exposing him to a health endangering workload. He contended that his immediate superiors knew that social work was particularly stressful, that such stress could give rise to mental illness, and his workload was such as to impose increasing stress on him, and that his employers ought reasonably to have foreseen that unless they took steps to alleviate the impact of that workload, there was a real risk of him becoming mentally ill.

Colman J, hearing the case at first instance, found for the Claimant. In giving judgment he

4 TUC Briefing Document Issue 25th September 2002.

No. 61/1993.

5 See HSE Stress Research and Stress Management; Putting Theory to Work, HSE Contract Research Report

6 [1995] 1AER 737

7 [2002] EWCA Civ 76

acknowledged that although the first breakdown was caused by his employers' failure to provide adequate resources, it was **not** reasonably foreseeable at that time that the workload to which he was exposed gave rise to a material risk of mental illness. However so far as the second breakdown was concerned, the Court found that it **was** foreseeable that if the Claimant was exposed to the same or a similar workload, there was a risk of him once more becoming mentally ill. He concluded :-

“The standard of care to be expected of a reasonable local authority required that in March 1987, such additional assistance should be provided... and the workload on Mr Walker thereby permanently reduced... notwithstanding that it could be expected to have some disruptive effect on the Council's provision of services to the public. It chose to continue to employ him but provided no effective help. In so doing, it was in my judgement acting unreasonably and therefore in breach of its duty of care”.

In reaching their decision, the Court in *Walker* felt it necessary to review the fundamentals of the law on negligence – especially in so far as it related to psychiatric injury.

The elements of negligence

Although the precise scenario had not previously received judicial consideration, it is clear from the judgment of Colman J that the approach to be adopted in determining negligence is not new. It is the “ordinary principles of employers' liability” which are to be applied (per Lord Steyn in *Frost v Chief Constable of South Yorkshire*⁸). These are of course proof of the existence of a duty of care, breach of such duty, and damage suffered as a result. In order to succeed, the successful Claimant will have to show foreseeability of what might happen if care is not taken. This foreseeability requirement whether construed as a component of the existence of a duty, or of its breach, has been most succinctly set out by Simon Brown LJ in *Garrett v London Borough of Camden*.⁹ In considering the huge variety of causes of psychological illness he (Simon Brown LJ) concludes:-

“Many suffer breakdowns and depressive illnesses and a significant proportion could doubtless ascribe some of their problems to the strains and stresses of their work situation. Unless however there was a real risk of breakdown which the Claimant's employers ought reasonably to have foreseen and which they ought properly to have averted, there can be no liability”.

It is readily recognised that because of the very nature of psychiatric disorder it is bound to be harder to foresee than physical injury. The approach to reasonable foreseeability of the risk of work engendered psychiatric injury is helpfully illustrated by the judgment of Miles CJ in *Gillespie v Commonwealth of Australia*.¹⁰ That case involved a claim by a former Australian diplomat against the Australian Foreign Affairs and Trade Department in respect of a mental breakdown which he suffered in consequence of stresses created by the living conditions in Caracas, Venezuela where he had been posted. The Claimant contended that such stress and therefore his injury would have

8 [1999] 2 AC 455

10 [1991] ACTR 1

9 [2001] EWCA Civ 395

been avoided or reduced if the Defendants had before sending him to Caracas, prepared him (by a course of training) for the severely stressful conditions likely to be encountered. Miles CJ observed at page 15:-

“In the present case it is not necessary to consider foreseeability with respect to the existence of a duty of care, because the relationship of employer and employee itself gives rise to that duty of care. Foreseeability for the present purposes is to be considered only in so far as the degree of remoteness of the harm sustained by the Plaintiff set the parameters of the steps that a reasonable person in the position of the Defendant would have taken to reduce the risk to the extent that any “unnecessary” risk was eliminated. In practical terms this means that the Plaintiff must show that the Defendant unreasonably failed to take such steps as would reduce the risk to what was a reasonable, that is a socially acceptable, level. It may be that this takes the Court into an area of value judgement for which the inscrutability of a jury verdict may provide a more appropriate means of expression.”

In *Walker* once the first breakdown had alerted the Defendants to the problem, it was much easier for the Claimant to persuade the court that, at least from that point, it was foreseeable that exposure to similar stresses would cause a similar psychological injury. As Colman J put it:-

“...the question is whether it ought to have been foreseen that Mr Walker was exposed to a risk of mental illness materially higher than that which would ordinarily affect a social services middle manager in the position with a really heavy workload.”

The extent to which a reasonable employer should foresee a harmful reaction to workplace pressures depends on the interplay between a number of relevant factors. These of course include the nature and extent of the work being done by the employee, and any manifest signs from the employee himself. So far as the nature and extent of the work being done by the employee is concerned a court is more likely to consider an adverse psychological reaction to be foreseeable if others have already suffered injury to their health arising from such work. (See in particular the observation of Hale LJ in *Sutherland v Hatton*¹¹ from para 23). Abnormal levels of sickness and absence amongst others would be relevant evidence.

Probably more important are the signs from the employee himself. It is not sufficient for a Claimant to show that it was reasonably foreseeable that the working environment would lead to stress. He must go beyond this – and show that it was reasonably foreseeable that the working environment would lead to damage to his health. This will clearly depend on the circumstances. In *Walker* the court found that although the Claimant complained about his workload prior to his first breakdown, this was not sufficient to render it foreseeable that he would develop a psychological illness. Clearly medical evidence in the form of a GP's sick notes or letters would place the employer on notice. Similarly uncharacteristically prolonged absences from work would place the employer on notice. However the employer must have good reason to think that the underlying cause is occupational stress rather than other factors.

Having established foreseeability, the successful Claimant will also have to show a breach of the duty to take reasonable care. Once again, when assessing whether a breach has taken place, the Court will consider in addition to the foreseeability of harm, the magnitude of the risk of that

¹¹ See footnote 7 *supra*

harm occurring, the gravity of the harm which may take place, the cost and practicability of preventing it, and the justifications for running the risk.¹² This duty was most succinctly encapsulated by Swanwick J in *Stokes v Guest Keane Nettleford (Nuts & Bolts) Ltd*.¹³ Although dealing with an action for damages for scrotal cancer caused by mineral soaked clothing, the dictum applies equally to cases involving psychological injury. He maintained:-

“the overall test is still the conduct of a reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of commonsense or newer knowledge it is clearly bad; but where there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it; and where he has in fact greater than average knowledge of the risks he may be therefore obliged to take more than the average or standard precaution. He must weigh up the risk in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probable effectiveness of the precautions that can be taken to meet it and the expense and inconvenience they involve. If he is found to have fallen below the standard to be properly expected of a reasonable and prudent employer in these respects, he is negligent.”

Although it may be tempting, having determined that harm was foreseeable and such harm had taken place, to conclude that the employer was in breach of his duty, this is not the case. It is always necessary to consider what the employer not only could but should have done. Moreover the employer can only be reasonably expected to take steps which are likely to do some good. This yet again involves notions of reasonableness and the Court will take into account the size and scope of the employer’s operation – and the interests of other employees in the workplace.¹⁴

Lastly the Claimant will have to establish causation – in other words that the particular breach of duty caused the harm. Whereas in many cases this may be straight forward, this will be a matter of expert medical evidence. Any Claimant who brings such a claim must expect his past medical history to be scrutinised in detail so as to determine the extent to which any psychological ill health preceded his absence from work, or was linked to non-work related stressors. Whilst the Defendant must take the Claimant as he finds him (the “egg shell skull rule”)¹⁵, a Defendant will successfully defeat a claim for damages for psychological illness if he can show that the same would have happened irrespective of the Defendant’s negligence.

There has been little judicial authority on the extent to which an employer owes to his employees a duty not to cause them psychiatric damage by the volume or character of the work which the employees are required to perform. Whereas it is clear law that an employer has a duty to provide his employee with a reasonably safe system of work and to take reasonable steps to protect him from risks which are reasonably foreseeable such law has developed almost exclusively in cases

12 See Dicta of Lord Reid in *Overseas Tank Ship (UK) Ltd v The Miller Steamship Company Ltd* [1967] AC 617 at page 642. He said: “It does not follow that, no matter what the circumstances may be, it is justifiable to neglect a risk of such a small magnitude. A reasonable man would only neglect such a risk if he had some valid reason for doing so, eg that it would involve considerable expense to eliminate the risk. He would weigh the risk against the difficulty of eliminating it”.

13 [1968] 1WLR 1776

14 See *British Railways Board v Herrington* [1972] AC 877 per Lord Reid at page 899 and *Watt v Herefordshire County Council* [1954] 1WLR 835 per Denning LJ at page 838.

15 Lord Parker CJ in *The Wagon Mound (No. 1)* [1961] 1ACR 388 at page 414.

involving physical injury to the employee as distinct from injury to his mental health. However as *Walker* illustrates, there is no logical reason why risk of psychiatric damage should be excluded from the scope of an employer's duty of care or from the co-extensive implied term in a contract of employment. That said there can be no doubt that the circumstances in which claims based on such damage are likely to arise will often give rise to extremely difficult evidential problems of foreseeability and causation. This is particularly so in the environment of the professions where the Claimant may be ambitious and dedicated, determined to succeed in his career in which he knows the work to be demanding, and may have a measure of discretion as to how and when and for how long he works, but where the character or volume of the work given to him eventually drives him to breaking point. Given that professional work is often demanding and stressful, at what point is the employer's duty to take protective steps engaged? What assumption is he entitled to make about the employee's resilience, mental toughness and stability of character given that people of clinically normal personality may have a widely differing ability to absorb stress attributable to their work?

Whilst in *Walker* the Court broke new ground in finding for a Claimant who had suffered psychiatric injury as a result of stress at work, the tools used by the Court to determine the issue of negligence were those honed over the years in dealing with cases of physical injury. What is clear however from *Walker* is that damages for psychiatric injury following stress at work are merely a development, or an extension of the law of negligence. Whilst there will be new evidential difficulties and problems of foreseeability and causation, there was no indication that a wholesale review of the common-law of employers' liability was to be considered. However the increase in stress at work, combined with growing awareness of the possibilities of successful litigation have led to an increasing willingness to litigate. Not surprisingly many of the cases involve public servants, and in particular teachers.

A number of these cases involving appeals against first instance decisions came before the Court of Appeal in early 2002. They provided the Appellate Court with an opportunity to reconsider both the case of *Walker* itself, and a review of the common-law of negligence as it pertained to stress related psychiatric damage suffered in the workplace.

Hatton v Sutherland & Others

In February 2002 the Court of Appeal (Brooke, Hale and Kaye LLJ) handed down Judgment in *Hatton v Sutherland*, *Barber v Somerset County Council*, *Jones v Sandwell Metropolitan Borough Council*, and *Bishop v Baker Refractories Ltd.*¹⁶ These four separate appeals, heard together, provided the Court with an opportunity to revisit the principles set out in *Walker* in an effort to clarify this difficult area of law. In each case the appellants were the employer Defendants who failed at first instance. The circumstances of each appeal are as follows.

Penelope Hatton was employed as a French teacher in a comprehensive school in Liverpool from 1980 until 1995. In January 1994 she was off work for a month following an attack in the street, and later that year her son was admitted to hospital for a considerable time. She remained away for the rest of the term with medical certificates identifying depression and debility. On her return to work in September 1994 she attributed her absence to her son's illness. Finally, in October 1995 she was signed off work with depression and debility and never returned.

¹⁶ [2002] EWCA Civ 76.

His Honour Judge Trigger sitting in Liverpool County Court accepted that one of the major precipitating factors contributing to the Claimant's stress was the increase in her duties and pressures at school. He found against the school on the basis that by September 1995 it was clear that the Claimant was suffering from a stress-induced illness. The Court of Appeal however accepted that although the Claimant had an increased workload, it was no greater than any other teacher in a similar school. Moreover the Claimant had never complained about this, rather relying on her son's illness as the cause of her absence from work. The court accepted that it was not reasonably foreseeable to the employer that the psychological harm experienced by the Claimant was attributable to her school-work. (Interestingly, had the Claimant been able to satisfy the test of foreseeability she would then have had to show that the school could have managed affairs in such a way as to have made a difference).

Leon Barber was an experienced head of maths at Bridgewater Community School in Somerset. Because of declining rolls, his responsibilities as a maths teacher fell, and in order to keep his former salary he took on additional publicity and marketing responsibilities resulting in an increased workload. With no previous history of psychiatric illness he first developed depressive symptoms in autumn 1995 but told no one at school about these. After periods of absence from work he eventually in July 1996 revealed to his superiors the detrimental effect his work situation was having on his health. Notwithstanding the deterioration of his condition he continued to work but in November 1996 lost control of a classroom and was advised to stop work immediately. His Honour Judge Roach sitting at Exeter County Court found for the Claimant, concluding that the illness was caused by stress at work. On appeal however the court refused to accept that the Defendant education authority was in breach of its duty of care to the Claimant. The three appeal judges took the view that although the Claimant had mentioned just before the summer holidays that he was suffering from ill health, he returned and made no such complaints. Had he approached the Deputy Head at the beginning of the autumn term and explained that things had not improved, the Court may have considered the matter differently.

Olwyn Jones was employed as an administrative assistant at a local authority training centre from August 1992. The evidence at first instance was that she was required to work grossly excessive hours and expected to perform variously the work of 2 – 3 people. Notwithstanding repeated complaints to her managers of excessive work, nothing was done. In mid 1994 she addressed her problems in a detailed document submitted to her employers but nothing further happened. By the end of 1994, in the absence of any response she invoked the grievance procedure. However before the hearing of her complaint took place she went off sick and never returned. At first instance his Honour Judge Nicholl sitting at Birmingham County Court found for the Claimant. The Court of Appeal upheld this decision albeit not "without hesitation". They accepted that damage to the employee's health was foreseeable and that obvious steps could have been taken to avoid the employer being in breach of duty to their employee. The Claimant's case was strengthened by the acknowledgement by senior management that there were steps which they could have taken, but which they failed to do.

The last of the four cases involved **Melvyn Bishop** a raw materials operative at a factory in West Yorkshire. He worked for his employers from 1979 until 1994 without difficulty. However following a re-organisation of workloads he found difficulties and complained unsuccessfully to his manager. Finally he attended his GP who provided the Claimant with sick notes. Shortly after he suffered a nervous breakdown. At first instance his Honour Judge Kent-Jones sitting at Leeds County Court found for the Claimant. In his view the history should have prompted the employers to investigate the situation immediately. Either he should have been given a job he could do or his employment terminated. Accordingly the Defendant was liable for the Claimant's breakdown. Not surprisingly perhaps the Court of Appeal overturned this decision. They found that the appellant had no notice that the Claimant was likely to suffer psychiatric illness if he continued in his job – especially as Mr Bishop had concealed from his employer the advice that his doctor had given to him to change jobs. It was he, Mr Bishop who chose to go back to work but there was little evidence to satisfy a court that a breakdown was reasonably foreseeable. In short there was nothing the employer could have done to enable Mr Bishop's employment to continue – especially against a background of the majority of employees welcoming the re-organised work shifts.

Having considered the legal principles to be adopted in considering claims for occupational stress, but before adjudicating on each case, the Court of Appeal took the opportunity of setting out a number of principles to be adopted when considering such cases. The 16 “practical propositions” which emerge from the Court's analysis of existing case law are:–

- (1) There are no special control mechanisms applying to claims for psychiatric (or physical) illness or injury arising from the stress of doing the work the employee is required to do. The ordinary principles of employer's liability apply.
- (2) The threshold question is whether this kind of harm suffered by this particular employee was reasonably foreseeable; this has two components (a) an injury to health (as distinct from occupational stress) which (b) is attributable to stress at work (as distinct from other factors).
- (3) Foreseeability depends upon what the employer knows (or ought reasonably to know) about the individual employee. Because of the nature of mental disorder, it is harder to foresee than physical injury, but may be easier to foresee in a known individual than in the population at large. An employer is usually entitled to assume that the employee can withstand the normal pressures of the job unless he knows of some particular problem or vulnerability.
- (4) The test is the same whatever the employment; there are no occupations which should be regarded as intrinsically dangerous to mental health.
- (5) Factors likely to be relevant in answering the threshold question include:–
 - (a) The nature and extent of the work done by the employee. Is the workload much more than is normal for the particular job? Is the work particularly intellectually or emotionally demanding for this employee? Are demands being made of this employee unreasonable when compared with the demands made of others in the same or comparable jobs? Or are there signs that other doing this job are suffering from harmful levels of stress? Is there an abnormal level of sickness or absenteeism in the same job or the same department?
 - (b) Signs from the employee of impending harm to health. Has he a particular problem or vulnerability? Has he already suffered from illness attributable to stress at work? Have there

recently been frequent or prolonged absences which are uncharacteristic of him? Is there reason to think that these are attributable to stress at work, for example because of complaints or warnings from him or others?

- (6) The employer is generally entitled to take what he is told by his employee at face value, unless he has good reason to think to the contrary. He does not generally have to make searching enquiries of the employee or seek permission to make further enquiries of his medical advisers.
- (7) To trigger a duty to take steps, the indications of impending harm to health arising from stress at work must be plain enough for any reasonable employer to realise that he should do something about it.
- (8) The employer is only in breach of duty if he has failed to take the steps which are reasonable in the circumstances, bearing in mind the magnitude of the risk of harm occurring, the gravity of the harm which may occur, the costs and practicability of preventing it, and the justifications for running the risk.
- (9) The size and scope of the employer's operations, its resources and the demands it faces are relevant in deciding what is reasonable; these include the interests of other employees and the need to treat them fairly, for example, in any redistribution of duties.
- (10) An employer can only reasonably be expected to take steps which are likely to do some good; the court is likely to need expert evidence on this.
- (11) An employer who offers a confidential advice service, with referral to appropriate counselling or treatment services, is unlikely to be found in breach of duty.
- (12) If the only reasonable and effective step would have been to dismiss or demote the employee, the employer will not be in breach of duty in allowing a willing employee to continue in the job.
- (13) In all cases, therefore, it is necessary to identify the steps which the employer both could and should have taken before finding him in breach of his duty of care.
- (14) The Claimant must show that the breach of duty has caused or materially contributed to the harm suffered. It is not enough to show that occupational stress has caused the harm.
- (15) Where the harm suffered has more than one cause, the employer should only pay for that proportion of the harm suffered which is attributable to his wrongdoing, unless the harm is truly indivisible. It is for the Defendant to raise the question of apportionment.
- (16) The assessment of damages will take account of any pre-existing disorder or vulnerability and of the chance that the Claimant would have succumbed to a stress related disorder in any event.

Whilst a welcome clarification of the law, many practitioners¹⁷ have taken the view that the judgment is unlikely to have a significant impact upon the number of occupational stress claims reaching the civil courts in future. Whilst the publicity surrounding these cases has dwelt on the failure of (three of) these appeals it would be wrong to suggest that *Hatton* had changed the law. The Court of Appeal has done a valuable job in clarifying the principles to be adopted when assessing such a case. However these principles are merely developments of the existing common law and include no radical departure. Whilst some Claimants (and their lawyers) may be deterred from bringing claims, the duty of care of an employer has not been altered. Clearly from this judgment

17 Judging from the many discussions the writer has had with other specialist personal injury lawyers.

a duty is placed on the employee to convey stress and the consequences of such stress to his employer. Similarly an employer is entitled to take what is told to him by his employee, at face value without an inquisition. However the Court of Appeal has very firmly closed the door on the argument that certain forms of employment are so stressful that they could endanger the mental health of those involved in those particular forms of employment (an argument that has been put forward by such groups as teachers, social workers and prison officers). It is clear from the judgment that where an employee is suffering from work-related stress he or she must inform his employer. Of the three unsuccessful respondents to the appeals, Mrs Hatton and Mr Barber failed to inform their employers that they were being put under pressure as a consequence of their work. The employers argued that they were therefore not given notice that problems were arising as a consequence of work and were not in breach of duty for having failed to take any steps to deal with this. This of course is precisely the position in *Walker* and why Mr Walker failed in respect of his first breakdown. If there is no history of psychiatric illness arising as a direct consequence of the employment, an employee is now less likely to succeed.

The Court of Appeal has in effect, upheld the decision of Colman J in *Walker* but in doing so has indicated in very clear terms that there is to be no dilution of the *Walker* test. Whilst the 16 propositions may well serve to reduce the number of claims that can be successfully pursued, *Hatton* has certainly not sounded the death knell for individuals suffering from psychological injury as a result of work-related stress.

Mental disability law in central and eastern Europe: paper, practice, promise

*Oliver Lewis**

This paper explores socio-legal issues within mental disability systems in central and eastern Europe, focusing on the ten countries which have entered into an accession partnership with the European Union (EU) and will become members within the next few years, namely (starting from the north): Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Hungary, Slovenia, Romania and Bulgaria,¹ countries with a combined population of almost 100 million people.² These EU accession countries share a recent history of either being parts of the Soviet Union (Estonia, Latvia, Lithuania), part of the Socialist Republic of Yugoslavia (Slovenia) or ruled from communist Moscow (the others).

To assert that these countries share the same political, social, cultural, linguistic or economic situation, would be as foolish as to think that countries in western Europe can be thought of in the same manner. For example, Bulgaria's gross domestic product per head is around six times lower than Slovenia's. Notwithstanding the near-impossibility of making broad-brush statements about "the region" (as I will refer to these countries), and whilst this paper does not attempt to be an academic comparative analysis or a comparison with (better?) mental disability systems in other parts of the world, what follows will attempt to draw out important themes in mental disability law and practice. The sources of information presented here come from a combination of site visits by the author in all 10 countries to institutions delivering services to people with mental disabilities,³ interviews with users and ex-users of mental health services, with lawyers, psychiatrists and other professionals, and from delivering human rights training seminars in each of the countries with support from the

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1 It is envisaged that eight countries will join the EU in May 2004, whilst Romania and Bulgaria have been told that 2007 is the indicative date for their accession.

2 For more on EU enlargement, see www.europa.eu.int/comm/enlargement/index.htm

3 Institutions visited include psychiatric hospitals, long stay institutions (otherwise known as social care homes) for adults and children, children's hospitals, prisons and day care centres.

Council of Europe.⁴ Facts presented here as a pastiche are either first hand testimony, or have appeared in writing elsewhere and are therefore referenced. Whilst I will not refrain from describing systemic violations of basic human rights in all of the countries mentioned above, I would like to emphasize the immense dedication and warmth of many staff members, working with limited resources in institutions which vary from the basic to places unfit for human habitation. A note on terminology: “mental disabilities” is used here to refer to children and adults who have been diagnosed as having mental health problems (“mental illness”) and/or intellectual disabilities.⁵

The main source of law in the accession countries is each country’s Constitution, which usually specifies the inherent and inalienable dignity of the person, the right to life, the right to be free from torture, inhuman and degrading treatment, and the (limited) right to liberty. Crucially, most Constitutions provide that binding international law shall be respected by courts, and in some cases, shall take precedence over domestic law.⁶ All of the EU accession countries have ratified the European Convention on Human Rights (ECHR), so Convention points can – theoretically at least – be argued in domestic courts, in a similar fashion to the situation now in England and Wales, and cases can be taken to the European Court of Human Rights in Strasbourg. However, it is rare for lawyers to raise ECHR points domestically, partly because human rights training in law schools is new, and partly for the fear that judges will not know what to do with international legal arguments. All countries in the region now have specific post-communist mental health legislation, whose compliance with the ECHR,⁷ and international “soft law”⁸ varies enormously.

A note on the recent historical context. During the holocaust thousands of adults and children with mental health problems and intellectual disabilities were sterilized, tortured and murdered by the Nazi regime. Appalling human rights abuses continued during the soviet/communist era. For half a century hundreds of remote and closed institutions were built across the region, satisfying the socialist ideology of making non-“normal” people disappear, which meant isolating people with mental disabilities, and fuelling prejudices and discrimination against them. Such institutions ranged from army barracks to architecturally stunning nationalized nineteenth century aristocratic homes. Rarely were institutions built for the purpose of providing specialized care. The practice of detaining people in such institutions for political reasons during the communist times has been well documented, but for each political prisoner there were hundreds of people *with* mental disabilities languishing in the same institutional regime and suffering the same discipline and abuse. Countries in the region therefore have inherited a mental health service which has for 50 years been based in institutions where things that happened inside were largely unknown. The majority of the institutions used during the communist regime are still in operation. Due to monetary cut-backs in most countries’ health and social care budgets, some people endure worse conditions now than they did at the fall of communism.⁹

4 For more information see www.mdac.info

5 For a review of the special problems faced by people with intellectual disabilities, see the 2002 reports produced on some of the accession countries by Inclusion Europe, available at www.inclusion-europe.org

6 For texts of many constitutions, see <http://www.uni-wuerzburg.de/law/>

7 For a review of ECHR and mental disability, see Lewis, O., “Protecting the rights of people with mental disabilities: the European Convention on Human

Rights”, (2002) *European Journal of Health Law* 9(4), 293–321

8 Such as the Principles for the Protection of Persons with Mental Illness, adopted by the United Nations General Assembly resolution 46/119 of 17 December 1991, and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly in 1993 (A/RES/48/96)

9 See Hayward, R. and Nica, R. *Gaining Ground*, Hamlet Trust 2000 www.hamlet-trust.org.uk

Detention

Psychiatric detention under Article 5 of the ECHR is regulated in all countries by domestic mental health legislation. The legislation usually provides for a detention of a person with mental disability of such nature or degree that s/he needs to be detained and treated as an inpatient. Emergency procedures which provide fewer safeguards are more frequently used than non-emergency routes. There are concerns across the region of the lax entry criteria into involuntary detention, so that someone can be detained and involuntarily treated by the decision of a single doctor, on the say of an irritated family member. The heavy-handedness of police officers taking people from their homes is cause for concern.¹⁰ In some countries prosecutors still enjoy the Stalin-esque power to order detention in a psychiatric institution without a prior medical opinion. Thanks to successful Strasbourg litigation against Bulgaria the government have conceded that the legislation must be amended.¹¹

When people are detained information is scarce. There are no national information leaflets or posters in any of the countries. Testimony from users/survivors indicates that verbal explanations are rarely given by staff, and if they are given, are inadequate. In Latvia, for example, it is the practice for patients not to be informed about their diagnosis, treatment or prognosis; for fear that this would increase the stigma in society against people with mental disabilities.¹² In many countries psychiatrists and nurses do not share the opinion that information provision is therapeutic in itself, and either are not aware of, or do not follow, provisions in domestic legislation, or Article 5(2) of the ECHR. In most countries (and this is no surprise) there is a hazy distinction between those detained compulsorily and voluntary patients. So-called voluntary patients are sometimes forced to sign admission papers under coercion. Patients remain largely unaware of their legal status and unaware of their legal rights, unequipped to raise concerns about their detention or treatment. Patients' advocates in hospitals are uncommon, as are adequate complaint mechanisms within institutions and inspectorate bodies to supervise and monitor conditions and treatment.

Court review of detention

After a person has been detained by a psychiatrist, most countries' legislation provide for a review by a judge, as required by Article 5(4) ECHR, which provides that "[e]veryone who is deprived of his liberty [...] shall be entitled to take proceedings by which the lawfulness of detention shall be decided speedily by a court and his release ordered if the detention is not lawful". However, no country in the region is in compliance with Article 5(4). In Estonia, the psychiatrist sends the judge a psychiatric opinion, and the judge decides on the case "without a hearing" (the patient playing no part in the proceedings).¹³ In Slovakia, the judge sends a rapporteur to the hospital who interviews the psychiatrist and the patient, reporting back to the judge who makes the decision.¹⁴ In Lithuania, the hospital either sends a fax to the court, or the psychiatrist personally goes to the

10 See *International Helsinki Federation, Human Rights in the OSCE Region Report 2002*, p.118 on Estonia

11 See *Varbanov v. Bulgaria*, Application no. 31365/96, judgment 5 October 2000. Also *Amnesty International (2002) Bulgaria: Far from the Eyes of Society*, AI Index: EUR 15/005/2002, p.16

12 *Personal communication with psychiatrists, Latvia*, May 2002.

13 Section 13(4) *Estonian Mental Health Act 1997*

14 *Personal communication with psychiatrists and user/survivors during a visit to Slovakia*, May 2002.

court (without the patient) to ask for a court decision regarding detention.¹⁵ In Poland, the judge visits the hospital and speaks with the psychiatrist and (sometimes) with the patient, but no representative is provided.¹⁶ In Hungary, there are court hearings at the hospital, where patients are provided with legal representation. However, patients rarely know who the people are in the room, the patient's representative routinely does not meet the patient before the hearing, and hearings commonly take less than five minutes.¹⁷ In those countries where there is a hearing of sorts, it is common for the patient not to be afforded (in Strasbourg language) "equality of arms", that is, to be on an equal footing with the detaining authority so that the patient can fairly test the lawfulness of detention. Medical records and psychiatric reports are rarely disclosed. Lawyers act in a manner which would be regarded by many as unethical and negligent. Lawyers do not meet clients before the hearing and by they make representations to the court not based on client's instructions, but on the lawyer's interpretation of what is in the client's "best interests". The lack of legal and judicial training in human rights as a whole and mental disability law more particularly results in lawyers and judges being role-less. The participation of judges and lawyers in review of mental disability detention is not so much a procedural *safeguard*, but a passive *presence* in a rubber-stamping exercise.¹⁸ Article 5(4) ECHR rights are largely observed on paper across the region, but an examination of the practice reveals many violations of international law.

In all jurisdictions the court review takes place after a very short period of time after compulsory admission. In Hungary for example the hospital must notify the court within 24 hours of admission, and the court must make a decision within the next 72 hours. If the hearings were meaningful (which they are not) a court review of detention within a week of admission (if the patient and the lawyer act quickly to prepare the case) is clearly beneficial to those who feel their detention is unjustified system. Having said that, the hearing would be more like a bail hearing than a full trial.

Owing to pressure from state health insurance systems in the region, people detained in psychiatric hospitals are held under compulsion for a remarkably short period compared with other jurisdictions. The state pays for the bed at a lower rate after a specified length of inpatient stay (anything from 20 to 60 days). Patients are therefore routinely treated with high doses of medication, then discharged, sometimes of course still suffering from acute mental health problems. It is virtually unheard of for a person to be civilly detained (under the equivalent of a section 3 of the English and Welsh Mental Health Act 1983) for more than two months. Query whether the difference between practice reveals more about the tendency by English and Welsh psychiatrists to be cautious when making discharge decisions than it does about psychiatric speediness in central and eastern Europe.

15 Personal communication with psychiatrists, a director of a psychiatric hospital and users and ex-users of psychiatric services, Lithuania, June 2002.

16 Personal communication with psychiatrists, lawyers and user/survivors, Poland, September 2002.

17 Mental Disability Advocacy Center, (2003) *Liberty Denied: mental disability detention in Hungary* (forthcoming)

18 For more on the role of lawyers in court hearings under Article 5(4) European Convention on Human Rights, see Lewis (2002), *op cit*.

Forensic detention

More worrying from a length-of-detention point of view is detention via the criminal courts. Those who are found not criminally responsible for criminal offences are sent to high security hospitals. In some countries these are so-called hospitals within prison confines (Hungary); in others on locked wards of psychiatric hospitals (Czech Republic); in others, open long stay-homes for people with mental disabilities (Slovakia). In most jurisdictions in the region, as in the UK, the criminal court sentences the patient-offender for an indefinite period of detention and treatment. Detention is reviewed in most jurisdictions annually, but patients in some countries (eg. Poland) have no opportunity to participate in the process, as the judge decides on papers sent by the treating psychiatrist and an “independent” psychiatrist (who may be employed by the same institution).

In Hungary, the equivalent of an English mental health review tribunal hearing for a “restricted” patient takes place annually at the Budapest criminal court. Proceedings are over in less than 5 minutes, and the issues remain untested: similar to detention hearings under civil law, lawyers do not meet their clients or take instructions. Forensic patients across the region are detained at the will of psychiatrists and do not have adequate access to a court, contrary to Article 5(4) ECHR. Mental disability hearings have been overlooked by the many judicial training seminars focusing on criminal law organized by international organizations. International studies have been conducted on court-appointed lawyers in criminal proceedings, but not in mental disability hearings.

Social care homes

Hundreds of thousands of people with mental health problems, intellectual disabilities, alcohol problems, drug addiction (and people with no health problems at all, so-called “social cases”) are housed together in what have become known as “social care homes”. These are large residential institutions which house any number between around thirty and over 700 residents.¹⁹ Residents are rarely discharged. Apart from Hungary and Bulgaria, the human rights torch has not shone inside social care homes.²⁰ Social care homes are both geographically and metaphorically far from the common consciousness. They usually fall within the responsibility of the ministry of social affairs – not health – which makes them politically more mundane. In violation of international standards,²¹ social care homes remain the breeding ground of human rights abuses and their residents the overlooked victims of systemic ill-treatment, degradation and boredom until death. In some cases social care homes are the very cause of death.

These institutions contain mostly overcrowded bedrooms, some devoid of bedside cabinets, wardrobes or any kind of visual stimulation. In some homes residents share clothes, in others they are dressed in old military uniforms to save money. In some homes residents share toothbrushes if they are provided with any form of dental care at all. Many residents have no teeth: the result of dental care neglect and inadequate diet. Washing ranges from a single shower in an unheated room

19 It is believed that the largest social care home in the region is in south west Hungary.

20 Although the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has visited social care homes in Estonia (unpublished), Slovak Republic, Hungary, Romania and Bulgaria (see www.cpt.coe.int), only Hungary and Bulgaria have received international NGO focus – see *Mental Disability Rights International Mental*

Disability and Human Rights: Hungary (1997 and 2003) www.mdri.org, *Mental Disability Advocacy Center (2003)* www.mdac.info, *Amnesty International (2002)* *op cit*

21 See *Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) “Substantive Sections”*, available from www.cpt.coe.int

(which means that residents are unable to wash regularly in the winter), to mass bathing in front of staff and other residents. In some institutions toilets have no divisions between them, and in others toilets consist of a hole in the ground in the garden, forcing residents to defecate in their bedrooms.

Food is served usually in a central dining room *en masse*. There is no choice in the menu, and as a result of mass catering and budget constrictions, food in some institutions in some countries consists of “soup”. In some institutions there is no need for a knife and fork, for the dual reasons that the residents do not have teeth, and because nothing other than liquid is served. Residents in some institutions eat from metal spoons and metal bowls for every meal.

Residents of social care homes are subject to arbitrary detention. Although social care homes are not places where people are detained by law, *de facto* detention can take a number of forms: residents are not allowed out during first month; residents are allowed out on certain days of the week; residents are not allowed to go to church (too disruptive); residents have to seek the permission of the director to leave – even to go to the local shops. In a study on all of Hungary’s 52 social care homes, researchers found that liberty was restricted in all of them.²²

The right to sexual relations is restricted, and in some institutions people are punished for making consensual attempts. It is not unknown for married couples to be separated. In single sex social care homes, there is an even greater taboo surrounding same-sex relationships than in the wider community. The right to communicate with the outside world is often restricted, with permission having to be sought from staff to make telephone calls. In some institutions, staff enquire into the nature of the conversations before a resident is allowed to make a call. If the resident is under guardianship (see below) and the guardian does not agree to the resident making phone calls, this decision is enforced by the institution. Relatives or friends of residents who want to visit the institution are sometimes forced to visit within certain times on certain days. Bearing in mind the remote locations of institutions, restrictive visiting times may constitute an unjustifiable infringement on communication.

Staff

Psychiatric hospitals are chronically understaffed, as nurses leave poorly-paid jobs in search for employment in other areas. There are also chronic staff shortages in social care homes for adults and children across the region. During the night there are often perilously few staff on duty, forcing residents to intervene (restraining a fellow resident, for example, if that person becomes agitated). Staff are under-qualified and there is rarely any pre-employment screening. Once in the job staff rarely receive ongoing training. The shortage or lack of professionals trained in nursing, social work, psychology, occupational therapy, art therapy, speech therapy, as well as educationalists (sometimes called “defectologists”) seriously undermine effective psycho-social rehabilitative care and treatment. As the European Committee for the Prevention of Torture has pointed out, “greater emphasis on social therapy would have a considerable impact upon the quality of care. In particular, [it] would lead to the emergence of a therapeutic milieu less centered on drug-based therapy and physical treatments”.²³

22 Gombos, G., Kismödi, E., Pető, K., *The human rights of patients in social care homes for the mentally ill*

(Budapest, Hungarian Mental Health Interest Forum, September 2001).

23 See para.43, CPT “Substantive Sections”, *op cit*

Treatment

In social care homes, psychiatrists tend to visit every week or every two weeks. In large institutions patients can go un-assessed for years. In the majority of homes patients are overly medicated: it is not uncommon for residents with intellectual disabilities without a concurrent mental illness to be prescribed strong anti-psychotics in order to curb “challenging behaviour” which otherwise would be unmanageable by the few staff. Residents with mental health problems are routinely over-medicated using old anti-psychotic medication – classic side-effects are obvious even to medically untrained visitors. People suffering from alcoholism sometimes receive no treatment, and are punished when they drink. In short, care and treatment in social care homes sometimes amounts to no more than medication, television and a bed.

Consent to treatment is routinely ignored – medical paternalism rules across the region, not just in psychiatry. In some parts of the region, notably Bulgaria and Romania, electro-convulsive therapy is sometimes given in its barbaric “unmodified” form, that is, without anaesthesia or muscle relaxants, and/or given in front of other patients, contrary to international medical and human rights standards.²⁴ There are credible reports that clinical drugs trials on people in psychiatric hospitals proceed without adequate ethical scrutiny, leaving underpaid doctors open to accept money for providing “subjects”. Free and informed consent in clinical trials is often lacking.

Restraint and seclusion

The use of (physical and chemical) restraint and seclusion in social care homes and psychiatric hospitals is cause for concern. Throughout the region instruments of physical restraint are used – fixation to a hospital bed with leather straps, tying a person to a chair using a bed sheet, restraint using a straightjacket. Sometimes there is no clear policy about when restraint can be used, patients remain un-monitored, and instances of restraint are not documented. Similarly, seclusion is used in some institutions, but others – particularly old buildings which were never designed as hospitals – there is no seclusion room, forcing staff to resort to restraints. Both restraints²⁵ and seclusion²⁶ are sometimes used as punishment. Sometimes chemical restraints are used instead of or as well as physical restraints.

In Hungary, Slovakia, the Czech Republic and Slovenia “caged-beds” are used in hospitals and social care homes. Caged-beds have been described as “metal frames built approximately 2 to 3 feet over a bed with a wire or net mesh enclosing all sides and the top. The cage permits a person to roll over or sit up but not stand up. The side of the cage can slide open or can be shut with a padlock.”²⁷ In some cases people are placed in a caged-bed if they become agitated. The author observed the long-term use of caged beds in one Slovak home:²⁸ seven women were each placed in a caged-bed for most of the day. The reasons given for using a cage bed on a 21-year-old woman

24 See para.39, CPT “Substantive Sections” *op cit.* Also *Inpatient psychiatric care in Bulgaria and human rights* (Sofia, Bulgarian Helsinki Committee, 2001)

25 Amnesty International (2002) *op cit.* p.44

26 For example, in some Hungarian social care homes if a person has broken the house rules of the institution, the individual may be forced to undergo a lengthy period in seclusion. (source: personal communication with staff members and residents in two social care homes)

27 *Mental Disability Rights International* (1997) *op cit*

28 Personal communication at Ve_k_ Biel social care home, Slovak Republic. This social care home has been visited by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. See the report to the Government of the Slovak Republic on the visit to Slovakia carried out by the CPT from 9 to 18 October 2000 (CPT/Inf (2001) 29), available at www.cpt.coe.int

with intellectual disabilities was that “she is aggressive”. When asked whether it was surprising that a person caged for long periods of time would become aggressive, staff maintained that in any case she was easier to handle. The reason given for another woman’s placement in a cage bed was that she had high blood pressure: “she might fall out of bed.” Arguments based on lack-of-resources are used by staff as an attempt (unwittingly?) to excuse and rationalize human rights violations. In its response to international criticism on the use of caged-beds, the Slovak government stated that their use was necessary because of staffing shortages. Given that there can be no justification for torture, inhuman or degrading treatment or punishment under international law, the government itself has provided the solution for their eradication: employ more staff.²⁹

Caged-beds do result not merely in ill-treatment which in some cases verges on torture, but also tragedy. In November 2000 a man in a caged-bed in a Hungarian social care home was trapped during a fire: staff were not present in his room, his caged-bed was locked, there were no fire alarms. He died from major burns and smoke inhalation. In violation of the procedural requirements under Article 2 of the ECHR, there has been no adequate investigation of his death.

Research recently conducted by Amnesty International in Bulgaria has revealed the worst human rights abuses in the region. In 2001 Amnesty International documented women locked in a cage outside one institution. The cage was full of urine and feces and the women covered in filth. One woman was unclothed on the lower half of her body and many sores were visible on her skin.³⁰ In a move welcomed by disability rights activists across the world, Amnesty International has now included within its work the human rights of people with a mental disability. In its first major report in this field released in October 2002 on Bulgaria, severe and systemic abuses are reported.³¹

Guardianship

The lives of thousands of people in the region are affected in a fundamental way by guardianship. Regulated by Civil Codes largely unchanged since Soviet times, guardianship attracts a low priority for legislators pressed by the international community to reform more visible areas of the legal system. Pivotal in the whole mental disability system in central and eastern Europe, human rights abuses pervade guardianship: from judicial enquiry into incapacity, appointment of the guardian, the guardian’s powers, oversight of the guardian and review of necessity of guardianship.³²

Families commonly ask the court to declare their relative incompetent because of financial reasons: “I want to sell his summer house”, said a relative in a court hearing observed in Estonia.³³ If a person has no relatives the State applies for guardianship, and if granted, a local authority, or a so-called “professional” guardian is appointed as guardian. The person whose capacity is in question is sometimes not informed of the application against them. Commonly the person whose capacity is in question is not legally represented. When there is a court hearing the doctor is given the power to advise the judge that the person’s presence is not required. Sometimes there is a court-appointed representative who rarely meets or takes instructions from the client. There are often no live witnesses, and similar to detention cases, a brief written psychiatric opinion is accepted as unquestionable scientific truth. Sometimes the person now under guardianship is not informed of

29 See the response of the government of the Slovak Republic to the CPT report (*op cit*), (CPT/Inf (2001) 30), available at www.cpt.coe.int

30 Amnesty International press release “Bulgaria: Disabled women condemned to ‘slow death’”, AI-index:

EUR 15/002/2001

31 Amnesty International (2002), *op cit*

32 Mental Disability Advocacy Center (2003) *op cit*

33 Tallinn City Court, November 2001.

the court's decision. In most jurisdictions the legal test of incapacity is not defined in law thus few applications for guardianship are refused. In some countries a person can be involuntarily detained in an institution to assess his capacity.

Conflicts of interests are common where a family member is appointed as guardian and has control over finances. Different issues arise where directors or staff of institutions are the guardian of residents. If no family member is willing to be guardian, the guardianship office (an administrative body) will appoint someone who is paid per person under his or her control. In many countries there is a pool of "professional" guardians, who are often the guardian of more than 100 people.³⁴

The powers of guardians across the region are immense. The State often divests its responsibility to protect its most vulnerable citizens by handing a bundle of personal rights to one individual. A guardian can decide where the individual should live. In practice, this means that a guardian can force placement into a social care home, and can block discharge. A guardian sometimes has the authority to decide when a person can leave an institution, for example to visit friends or family on the weekend. Crucially, guardians control the individual's finances. They are often given the unchecked authority to sell real estate and personal possessions; sole access to bank accounts; disposal of old-age or disability pension.

In some countries, a guardian consents to or overrides refusal of medical (including psychiatric) treatment. In the example given above, the 21-year-old Slovak woman's father, who is also her guardian, approved her placement in the social care home and also the use of the caged-bed.

In many countries, the fact that someone has been deemed incapable means that s/he is stripped of legal personality. Access to a lawyer is therefore restricted, as the lawyer will not get paid. Access to a court is impossible, as the person is no longer deemed to be a person. In some countries, the Constitution blocks an "incapable" person from participating in elections and civic life, and takes away the person's right to have a national identity card, essential for interaction with a number of organs of the state.

Often the powers of the guardian are inadequately regulated. There is no duty on a guardian to meet with the person under guardianship or to take their (often capacious) opinions into account when making decisions about that person's life. In most countries the local government's guardianship office is charged with the regulation of guardians, but frequently there is a lack of criteria for evaluating guardians, and a one-paragraph annual report blandly stating that "there were no problems this year" is adequate. Financial accounts are rarely checked. Only in Hungary is there a regular review of a person's status as incapable. In all other countries both the displacement of a guardian and the overturning of a judicial finding of incapacity are lengthy and difficult procedures. The issues within the guardianship system described here engage many articles of the ECHR, but remain under-reported and under-litigated.

Death

The numbers of deaths in some institutions is alarmingly high. When the Committee for the Prevention of Torture (CPT) visited Poiana Mare Psychiatric Hospital in Romania in 1995 they examined the record of deaths and found that 25 out of 61 deaths in an 8 month period were explicitly attributed to "severe protein and calorific malnutrition". The overall mortality rate was

³⁴ The author has met a person in Hungary who is the guardian to 158 individuals

in excess of 20% per annum.³⁵ In a visit to the Terter Social Care Home in Bulgaria in 1999 the CPT noted an increase in deaths at the home, running to an annual mortality rate of 33%. Causes of death included asphyxia and hypothermia.³⁶ Amnesty International's 2002 report reveals that records of deaths in Bulgarian social care homes are unreliable; post mortem examinations are rare, as are police investigations of suspicious deaths in social care homes.³⁷ Across the region "cardiac insufficiency" is commonly the official cause of death, even in young people with no previous heart abnormalities. Deaths from pneumonia and hypothermia in some psychiatric institutions in the winter are grossly disproportional to deaths from those causes outside institutions. There are no countries with adequate state machinery for questions to be posed, let alone answered in a manner compatible with the now stringent requirements of Article 2 ECHR – the right to life.

Promise?

Within the EU accession region there is an expectation that things will change after membership to the EU. Twelve years after the establishment of democracy, the locus of psychiatric and social care remains largely institutional. A growing network of non-governmental organizations providing innovative services based on the principles of inclusion, and constituting alternatives to long-term institutionalization, battle against some governments who are not moving forward with a strategy of closing of large institutions and establishing community-based psychiatric and social services.³⁸ Governments are slow to realize that large institutions are morally and economically costly.³⁹ In the meantime, children are given little state support and are segregated in special schools, whilst institutionalized children with intellectual disabilities, receiving inadequate education, leave children's homes to adult institutions. People with mental disabilities living in the community face profound difficulties in societies with few support-structures beyond those provided by the few non-governmental organizations. These difficulties include getting and holding down a job in the absence of regulations prohibiting discrimination in employment, with social security payments barely enough to survive.

The ECHR and international soft law standards are valuable weapons with which advocacy groups can campaign, but without political will to invest money in the right places, without diplomatic pressure from the EU and existing Member States, without intense domestic and international advocacy efforts, and without the willingness of professional groups to recognize the inherent value of respecting human rights, the prospect of change remains low. Rights and safeguards exist largely on paper. Governments appear to be satisfied to enact human rights compliant mental health legislation, whilst ignoring mechanisms to ensure enforcement of the law in practice. The lack of state legal aid systems, the problems of access-to-justice by those under guardianship housed in remote institutions, the few lawyers willing to represent people with mental disabilities, coupled with the unwillingness of domestic courts to hear ECHR points and the grinding slowness of the Strasbourg Court all combine to produce a pessimistic situation in which the realization of human rights seems a long way off. It is hoped that the non-governmental organizations such as the

35 CPT report on 1995 visit to Romania, published 19 February 1998, (ref CPT/Inf (98)5)

36 CPT report on 1997 visit to Bulgaria, published 28 January 2002, (ref CPT/Inf (2002)1)

37 Amnesty International (2002), *op cit*

38 For networks of NGOs in the region, see the Mental

Disability Advocacy Program www.osi.hu/mdap and Hamlet Trust www.hamlet-trust.org.uk

39 World Bank (2000), *Moving from Residential Institutions to Community-Based Social Services in Central and Eastern Europe and the Former Soviet Union*

regional Mental Disability Advocacy Center will assist lawyers and activists to improve the situation of people with mental disabilities across the region.

It is doubtful that the human rights of people with mental disabilities will be better respected once accession countries join the EU. With the exception of Turkey, human rights are not a key priority for the largely *economic* European Union, despite its mantra of “respecting the principles of liberty, democracy, respect for human rights and the rule of law”.⁴⁰ Although professing to take into account a country’s human rights record prior to accession, the EU has already indicated that all central and eastern European candidate countries have ticked the necessary human rights boxes. The EU has failed to assert adequate pressure on accession countries to reform their mental health systems – perhaps, because mental health services are thought of purely as a health issue and not a human rights issue. Despite the efforts of inter-governmental and non-governmental organizations, the accession countries look set to become EU Member States whilst continuing to violate the most basic human rights of people with mental disabilities.

⁴⁰ http://www.europa.eu.int/comm/external_relations/human_rights/intro/index.htm

Should we allow compulsory mental health treatment in prisons?

Mat Kinton*

In my more grandiose moments, it occurs to me that the various reports and policy documents that we deal with every day will form part of the source materials for future historians. It would be nice to think that our own age will be studied by someone as indefatigable and brilliant as Roy Porter, whose death earlier this year robbed us of our best commentator to date on the social history of psychiatry. I looked forward to each of his books and it is sad that there will be no more.¹

I have a tip for the future scholars who unearth dusty copies of this journal. Assuming that future generations remember that one of the best ways to examine a society is through its treatment of its most vulnerable members, they could do worse than to turn their attention to one report, already two years old, called *Nursing in Prisons*.²

They should turn to the concise and restrained Chapter 18, entitled “Concerns about Secondary Mental Health Care in Prisons”. While acknowledging that nurses and healthcare officers do their best within current arrangements, this chapter states that “prison health care does not and can not provide” adequate secondary level mental health care (para 85). The report’s description of what actually happens to mentally disordered prisoners falls between the lines of the same paragraph: “we are concerned about the practice of keeping disturbed prisoners with mental health problems alone in their cells for long periods of time. We are particularly concerned about the level of care provided at night... in the NHS, seclusion is used only as a last resort under the direction of a psychiatrist following strict protocols”.

What is being tacitly acknowledged in the above is that some seriously disturbed prisoners with mental disorder are routinely subject to conditions of isolation and standards of care that would be considered unethical and scandalous outside prison. Our future historians will not be kind to us on that score.

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1 I particularly recommend ‘Mind-Forg’d Manacles: A history of madness in England from the Restoration to the Regency’ (1987), ‘A Social History of Madness’ (1996) and ‘Madness: A brief history’ (2002).

2 *Nursing in Prisons: Report by the Working Group considering the development of prison nursing, with particular reference to health care officers. Department of Health 2000.* This document, alongside most of the others relating to prison healthcare mentioned below, is available online at www.doh.gov.uk/prisonhealth.

The *Nursing in Prisons* working group recommended that the management of prisoners with significant mental health problems should accord with the strict guidelines that pertain in the NHS, whether this takes place on the prison premises or through transfer to NHS facilities outside.³ Previous official statements had already recognised that the historic isolation of prison healthcare from the NHS had raised questions of equity and standards of care.⁴ The *Nursing in Prisons* report found that facilities within prison healthcare centres were not equivalent to those outside because of lack of staff and expertise, unsuitable environments and inadequate levels of observation and treatment.⁵

Developments in Prison Health Care.

At the time of the *Nursing in Prisons* report there was already a policy shift towards formal partnership between the NHS and the Prison Service for the provision of prison healthcare as a whole. This partnership is now set to evolve into the wholesale transfer of prison health into the NHS over the next five years.⁶ In the meantime various measures are intended to develop far more sophisticated mental health services in prisons than are generally available at present. The NHS Plan promises additional staff and more comprehensive treatment.⁷ The National Service Frameworks for Mental Health operative in England and Wales encompass the care of prisoners.⁸ By 2004, upon release all prisoners with serious mental disorders should have in place care plans overseen by care co-ordinators. By the time this article is published, all prisons should have completed a service review in collaboration with local NHS services and should have action plans in place for identified needs.⁹

The basic principle underlying the changes in prison healthcare is that, allowing for the prison context, services should be provided as far as possible in the same way as they are in the wider community.¹⁰ Therefore, just as the focus of service development outside prisons is on community-based services, so the focus within prisons is on mental health promotion and “wing-based” mental health interventions. A key target over the next 3 – 5 years has been set as reducing the numbers of prisoners resident in prison-based health care centres, with resources re-deployed to day care and wing-based services.¹¹

One way of managing this, and perhaps the most dramatic change in service provision within prisons, will be the establishment of NHS managed “in-reach” teams in around half (60–70 out of 137) of the prisons in England and Wales over the next two years.¹² By 2006 all prisons should have some form of in-reach services.¹³ “In-reach” services for prisons are likely to play a broader role than their community-based “out-reach” counterparts. Whereas out-reach services’ role is to help those with

3 *Ibid*, para 86

4 ‘The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group’. HM Prison Service & NHS Executive 1999.

5 ‘Nursing in Prisons’, para 86

6 ‘Prison Health Transferred to Department of Health’, Department of Health Press Release 64N/02 (24 September 2002)

7 ‘The NHS Plan: a plan for investment, a plan for reform’ Cm 4818-I. Department of Health 2000.

8 ‘National Service Framework for Mental Health.

Modern standards and service models’ Department of Health 1999; ‘Adult Mental Health: a National Service Framework’ National Assembly for Wales 2002.

9 ‘Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons’ Department of Health, HM Prison Service & The National Assembly for Wales 2001, para 6.

10 *ibid*, para 4.7

11 *ibid*, para 10

12 *ibid*, para 4.8

13 ‘Mental Health Bill Consultation Document’ Cmnd 5538-III. Department of Health 2002, para 3.34.

serious mental illness stay in contact with specialist services, “in-reach” services will eventually be expected to provide general mental health services suited to all patients with mental health needs.¹⁴

Extending compulsory powers into prison

At present, the powers to provide compulsory treatment under the Mental Health Act 1983 are not applicable inside prisons, where any treatment without consent must be justified under the common law. The Department of Health has produced guidance on the use of such common law powers in prison.¹⁵ The only power available in respect of prisoners under the Mental Health Act 1983 is that which allows their transfer from the prison environment to hospital facilities where compulsory care and treatment under the Act’s powers are applicable.¹⁶ There are often delays in the transfer process, particularly while a suitable bed is identified and made available. The Prison Health Policy Unit now has a protocol for transfer delays of longer than three months.¹⁷ Three months is a long time to provide inadequate care to an acutely disturbed person.

Perhaps unsurprisingly, the government has questioned whether it is time to consider extending powers of compulsion to prison environments. The government’s consultation document on its draft Mental Health Bill set out a simple argument for such an extension. It reasoned that, just as the draft Bill would provide a framework for the compulsory treatment in the community, thus severing the present law’s link between compulsion and detention in hospital, so “there should be similar flexibility for patients to receive compulsory treatment in prison”.¹⁸ Community treatment orders, in this model, would be allowed through the prison gates, so that prisoners could be made subject to them “just as if [they] were not in prison”.¹⁹

The consultation document did allow that “NHS services for prisoners still have some way to go before compulsory treatment as outlined here could be provided in every prison”. Therefore, the law would allow for compulsion only when appropriate services are in place and conditions are right.²⁰ It did not set out what such conditions should be, but the parallel drawn between the use of compulsion in the community and prison, and the specific mention of in-reach service development, gave a broad hint at some sort of “wing-based” service.

In its response to the draft Mental Health Bill,²¹ the Mental Health Act Commission has challenged the view that powers equivalent to “community treatment orders” should be used within prisons. It is clear that, for compulsory treatment within prisons to be legally or ethically justifiable, the level of service provision and support available to prisoner-patients should be at least equivalent to that which would be available elsewhere. It is less clear that in-reach services of any kind can provide the levels of service appropriate to provide compulsory mental health treatment. The prison “community” cannot offer any real equivalent to the support and care available outside prison, and any assumed equivalence between prison and the community outside greatly underestimates the isolation of the mentally ill in prison, the stigma of mental illness in such a situation and the bullying that can go on.

14 ‘Changing the Outlook’ para 4.7

15 ‘Seeking Consent: Working with People in Prison’ Department of Health & HM Prison Service 2002.

16 Mental Health Act 1983, sections 47 – 53.

17 ‘Prison Health Newsletter, Summer 2002’ Department of Health, HM Prison Service & The National Assembly for Wales 2002, page 10

18 Mental Health Bill Consultation Document para 3.35

19 *ibid*, para 3.36

20 *ibid*, para 3.40

21 Response to the Draft Mental Health Bill. Mental Health Act Commission 2002. Available online at www.mhac.trent.nhs.uk

The Commission was therefore concerned that some form of dispensary-style system of compulsion in prisons was being considered by the Government. We took the view that, if a prisoner-patient is suffering with a mental disorder to a degree that requires intervention without consent, a higher priority should be to ensure that he or she is cared for in proper surroundings and is not spending every night, and perhaps most of every day, in effective seclusion in a cell.

This is not to say that the use of compulsion should not be contemplated within the prison environment. If appropriate treatment units were available within prisons, it would make sense to allow compulsory treatment there. Such units should, in the Commission's view, be equivalent facilities to in-patient units outside of prison. They should be separate from the normal residential accommodation, staffed at all times with NHS professionals and able to provide the necessary treatment under the same quality-assurance arrangements (such as professional regulation and inspection of services) as exist elsewhere in the NHS. We would also expect the same safeguards to be available to prisoner-patients as would be available to patients subject to compulsion outside prison, such as the oversight of a monitoring body, access to advocacy, ability to appeal against compulsion to a tribunal and to have tribunal oversight and safeguards applied to the treatment itself.

Even if this infrastructure was in place, there should still be a requirement that transfer to an outside hospital should be considered if that would be in the prisoner-patient's best interests. The provision of compulsory treatment in prisons should not be allowed to create a disincentive for transfers to NHS care in hospitals outside where this is clinically or socially appropriate.

The conditions determining a clinical threshold for the use of compulsion under a Mental Health Act in prison need be no different to those that operate outside, but the overriding condition for the use of compulsion should be the removal of the prisoner-patient to a designated treatment environment for the duration of that treatment. Such placement would, in our view, be appropriate irrespective of whether the patient would, if outside of prison, have been assessed as requiring a residential or non-residential treatment order. The particular conditions of prison life are such that we feel this difference in approach would be justified, even though it means that the same presentation that, outside prison, would warrant only a non-residential order would, in prison, warrant residential care. The issue at stake in prison is the invasion of bodily autonomy, rather than the deprivation of liberty.

We feel that such a solution would provide a welcome extension of legal safeguards across this relatively unregulated area of medical care and *de facto* compulsion. It is not, however, a quick fix, and it does not sit comfortably with the Government's very understandable priorities around primary care in prisons.²² This undoubtedly means, in the Commission's view, that transfer from prison to a hospital environment must remain the primary and preferred option for all prisoners who would, if outside prison, fall within the criteria of the 1983 Act or subsequent legislation. The alternative, which is the introduction of compulsory powers into an ill-prepared healthcare system, would be an irresponsible wielding of power and would be unlikely to benefit the prisoner-patients concerned. And posterity will be watching.

²² 'Developing and Modernising Primary Care in Prisons'. Department of Health, HM Prison Service & The National Assembly for Wales 2002.

Casenotes

The Home Secretary's Tribunal Referral Powers Following IH

David Mylan

R (on the application of C) v Secretary of State for the Home Department

[2002] EWCA Civ 647

Court of Appeal (15th May 2002) Lord Phillips MR, Dyson LJ, and Jonathan Parker LJ

The Facts

C, a patient detained in Broadmoor High Security Hospital pursuant to an order made under section 37/41 of the Mental Health Act 1983 (MHA) applied to the Mental Health Review Tribunal ("the tribunal") for a discharge from hospital. The tribunal met on the 10th February 2000 and adjourned the application for a possible care plan to be formulated and for a further report from the patient's Responsible Medical Officer ("RMO").

The hearing resumed on the 11th and 12th October 2000, when it had the benefit of further reports from the RMO, the hospital social worker and the local authority social worker. There was a difference of views expressed both as to the suitability of discharge, and in the event that a conditional discharge¹ was considered appropriate the conditions that should be imposed.

Crucially part of the written evidence that the local authority social worker had prepared for the tribunal, consisting of her assessment of the needs of the patient should he be discharged, was not submitted as part of the written evidence. She was not present at the hearing to give oral evidence.

The tribunal after hearing all the evidence decided that the patient should be conditionally discharged, and that the discharge should be deferred² until the resources necessary to meet the conditions were assembled. In reaching this decision it appears that the tribunal had preferred the evidence of the hospital social worker to that of the RMO. The tribunal imposed a condition that:-

"The patient has access to such psychiatric treatment as he may need from time to time."

They imposed this condition rather than the more usual condition that a psychiatrist in the community should supervise the patient.

The reasons given by the tribunal to support the decision were most probably defective. As Mr. Justice Collins stated in the Administrative Court: -

"With great respect to the Tribunal, those are no reasons at all. It may well be that that deficiency could, had the Secretary of State so wished have justified an application for judicial review. I have no doubt whatever that those reasons were entirely defective."³

1 Section 73(2) MHA.

2 Section 73(7) MHA.

3 Paragraph 26 of the judgment in the Administrative Court [2001] EWHC Admin 501.

The community-based local authority social worker learnt that the statement of needs she had prepared in May 2000, had not been before the tribunal, and on the 30th October wrote enclosing a copy of the statement, and highlighting the differences between her view and that of the hospital social worker.

The Secretary of State (S of S) who had opposed C's discharge then exercised his power to refer⁴ his case to a new tribunal on the basis that:–

“Apparent confusion over the documentation was very important because of the extreme rarity of a restricted patient being discharged without a condition of psychiatric supervision and the problems that this presents.”⁵

The effect of such a referral back to the tribunal is to deprive the patient of the deferred conditional discharge that he had obtained⁶.

The Patient sought Judicial Review of the reference by the S of S and on the 19th June 2001 in the Administrative Court, Mr. Justice Collins gave judgment in favour of “C” and quashed the decision of the S of S to refer “C's” detention to the tribunal.

The consequence of this decision was to introduce a fetter on the power under Section 71(1) of the MHA, and as Counsel for the S of S put it when making her application for leave to appeal:–

“ Your Lordship is well aware that there are no previous authorities on the extent of the section 71 power, only authorities that give examples of that power. This case does therefore break new ground”.

Leave to appeal was granted and the case came before the Court of Appeal on the 10th December 2001. After hearing argument but before judgment was delivered, the appeal in the case of *IH*⁷ was lodged, and the Court of Appeal of its own motion decided that: –

“Having reserved judgment, we learned that Bell J's decision in *IH* was to be the subject of appeal. Because of the obvious impact that this appeal might have on the present case, we arranged for the appeal of *IH* to come before us and directed that this appeal should be restored for further argument at the same time.”⁸

The Law

The power of the tribunal to discharge a restricted patient is contained within S 73 MHA, which imports the tests set out in S 72(1)(b)(i) & (ii) MHA. If either of these tests is satisfied and “it is not appropriate for the patient to remain liable to recall to hospital for further treatment”⁹ then the patient must be absolutely discharged.¹⁰ If the tribunal considers that it is appropriate that the patient remains liable to be recalled then the patient must be conditionally discharged.¹¹

4 Section 71(1) MHA.

5 Paragraph 11 of the judgment quoting from the witness statement of the Home Office Civil Servant explaining why the reference was made.

6 Section 73(7) MHA.

7 *R (IH) v Nottinghamshire Healthcare Trust & Ors* [2001] EWHC Admin 1037. *R on the Application of IH v Secretary of State for the Home Department & Ors* [2002] EWCA Civ 646. For a discussion of this highly

significant case, see ‘Deferred Conditional Discharges’ by David Mylan, *Journal of Mental Health Law* July 2002 pp 208 – 218.

8 Paragraph 27 of the judgment.

9 Section 73(1)(b) MHA as amended.

10 Section 73 (1) MHA.

11 Section 73 (2) MHA.

Should the patient be conditionally discharged then “the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.”¹²

If on the day of the hearing it is not possible to fulfil any conditions that the tribunal considers it appropriate to impose: –

“A tribunal may defer a direction for the conditional discharge of a patient until such arrangements as appear to the tribunal to be necessary for the purpose have been made to their satisfaction.”¹³

The S of S may at any time refer the case of a restricted patient to a Mental Health Review Tribunal.¹⁴

Should the S of S exercise this power in respect of a restricted patient whose conditional discharge has been deferred, the effect is to place the patient in the same position he was before his case was considered by the tribunal. The relevant statutory provision states as follows:

“ where by virtue of any of any such deferment no direction has been given on an application or reference before the time when the patient’s case comes before the tribunal on a subsequent application or reference, the previous application or reference shall be treated as one on which no direction under this section can be given.”¹⁵

Where difficulties arise in respect of meeting the conditions, the decision of the House of Lords in the case of *Campbell*¹⁶ precluded any reconsideration by the tribunal of its decision.

In the event that subsequent events indicate that the discharge should not take place or new information suggests the proposed conditions may be inappropriate, the only function that remained to the tribunal was to direct the conditional discharge as and when the necessary arrangements had been made.

The objections made by C to the exercise of the power of referral to a new tribunal by the S of S is concisely set out in the judgment of the Court of Appeal:

“Under the Act the role of a Tribunal is to decide the lawfulness of a patient’s detention in accordance with Article 5(4) of the Convention. The Tribunal had decided that C’s detention was unlawful and that C was entitled to be discharged, albeit subject to conditions. The Secretary of State was bound to observe that decision. It was not open to him to abrogate it by making a fresh reference without good reason. The fact that the Tribunal had reached its decision without knowledge of Ms. Roden’s views did not constitute a good reason.”¹⁷

The Judgment

As noted above, C’s application to have the S of S’s referral to a new Tribunal quashed was upheld at first instance in the Administrative Court. The S of S appealed. The appeal failed and the referral remained quashed. Although the decision of both Courts was the same, the reasoning was totally different. In the Administrative Court the case went against the S of S because the Judge found that the S of S had misdirected himself as to the test that he should apply before making a Section 71(1)

12 Section 73(4)(b) MHA.

13 Section 73(7) MHA.

14 Section 71(1) MHA.

15 Section 73(7) MHA.

16 *Campbell v Secretary of State for the Home Department* [1988] 1 AC 120.

17 Paragraph 19 of the judgment.

reference. It was held that the mere existence of new information or the fact that there had been an omission in respect of facts or opinions that should have been before the tribunal, was insufficient. The S of S: –

“ must form the view that it is probable that the material in question would have affected the result in that it would have decided either that a more onerous condition be imposed or that a conditional discharge would not have been ordered.”¹⁸

The Court of Appeal, having indicated that it did not find it easy to follow the reasoning of the Administrative Court judgment, did not consider: –

“ that it would be profitable to conduct a detailed analysis of the judgment below.”

The reason for this was because immediately before giving judgement, they had given judgment in *IH* and had overruled *Campbell* on the grounds that it could not stand with Article 5(4) of the Convention. In consequence the Court of Appeal was able to dismiss the appeal on the grounds that: –

“This departure from the decision in *Campbell* leaves no doubt as to what the S of S should have done on the facts of this case. He should have invited the Tribunal to reconsider its decision, taking into account the views of Ms. Roden, which should have been before it at the time of its original decision. There was no justification for his making a fresh referral and, thereby, removing the matter from the jurisdiction of the Tribunal altogether.”¹⁹

Discussion

The significance of *C* is perhaps in the judgment at first instance rather than that of the Court of Appeal. Once *Campbell* had been reversed and the Court in *IH* set out the “New Regime” for the way in which tribunals should approach the implementation of the conditional discharge of a patient, in circumstances where the discharge cannot be immediately implemented and in consequence has to be deferred, the outcome of the appeal was a foregone conclusion. *IH* makes it clear that the decision of a tribunal to make a conditional discharge and then to defer, is a provisional decision²⁰ and not a final decision. The tribunal can then re-consider as many times as it considers appropriate. With this power, there is obviously no necessity for a Section 71(1) reference as the S of S can request the original tribunal panel, which has already acquired knowledge of the facts of the detention, to reconsider its decision.

Counsel for the S of S argued unsuccessfully before the Court of Appeal that the appeal should be allowed because at the time the S of S had no option but to proceed on the basis that *Campbell* was good law. The Court rejected this on the basis that: –

“What is in issue is not whether the S of S is to be criticised for the course that he took, but whether his decision was lawful. For the reasons that we have given, we have held that it was not”.

It was unfortunate that the Court of Appeal did not conduct a detailed analysis of the judgment below because the reasoning of Mr. Justice Collins in the Administrative Court quite clearly introduced a fetter to a power of the S of S. This is a power that is explicitly provided in primary legislation and which is not fettered by any provision within the MHA.

18 Paragraph 60 of the judgment in the Administrative Court quoted at paragraph 22 of the judgment in the Court of Appeal.

19 Paragraph 29 of the judgment.

20 Rule 2 of the Mental Health Review Tribunal Rules 1983 (S.I. 1983 No.942)

The powers of the S of S in relation to restricted patients arise as a consequence of *Hadfield's Case*²¹ which prompted the passing of two Statutes²² to create a system for dealing with criminal lunatics. The system precluded discharge without the consent of the Crown and reserved to the Crown further powers in respect of the treatment of such patients.

The powers have remained substantially intact for over 200 years. The major modification arose as a consequence of the European case of *X v UK*²³ which led to the provision within the MHA of a new power for the Mental Health Review Tribunal to discharge restricted patients in place of the advisory function they previously had under the Mental Health Act 1959.

This has so far been the primary statutory modification to the powers of the S of S in 200 years, and is not so much a restriction on the power of the State because the S of S retains the power to discharge²⁴, but rather a sharing of the power with a judicial body.

Various other powers are not shared. These include the power to restrict the grant of leave of absence under section 17 MHA²⁵; the power to restrict the transfer of the patient to another hospital²⁶; and the power to restrict the discharge of the patient by the RMO from detention.²⁷

The S of S has the sole power to recall the conditionally discharged patient to hospital²⁸ although the case of the recalled patient must then be referred to a tribunal.²⁹

The Administrative Court judgment introduced in certain specific circumstances a fetter on the S of S's power to refer a restricted patient to a tribunal. Because post-*IH*, the decision of the tribunal to order a conditional discharge deferred is now a provisional decision, it is now unlikely that the S of S would ever again seek to use the Section 71(1) power in such circumstances. The judgment can however be seen as introducing a further Human Rights Act-inspired chink into the power of the State in respect of restricted patients. It remains to be seen to what extent, if any, the judgment can be used in relation to any of the continuing powers.

21 *Hadfield's Case* (1800) 27 Howell's St. Tr.

22 39 & 40 George III Chapter 93 "An Act for regulating Trials for High Treason and Misprision of High Treason, in certain Cases" and 39 & 40 George III Chapter 94 "An Act for the Safe Custody of Insane Persons charged with Offences".

23 *X v United Kingdom (Detention of a Mental Patient)* (1982) 4 E.H.R.R. 188

24 Section 42(2) MHA.

25 Section 41(3)(e)(i) MHA.

26 Section 41(3)(e)(ii) MHA.

27 Section 41(3)(e)(iii) MHA.

28 Section 42(3) MHA.

29 Section 75(1)(a) MHA.

Charging for After-care Services under Section 117 of the Mental Health Act 1983 – The Final Word?

*Nicolette Priaulx**

R v Manchester City Council, ex parte Stennett, R v Redcar and Cleveland Borough Council, ex parte Armstrong, R v Harrow London Borough Council, ex parte Cobham [2002] UKHL 34; [2002] 3 W.L.R. 584; [2002] 4 All E.R. 124.

House of Lords (13, 14 May, 25 July 2002) Lord Slynn of Hadley, Lord Mackay of Clashfern, Lord Steyn, Lord Hutton and Lord Millett.

Introduction

With this important decision, the House of Lords confirmed that the services provided under section 117 of the Mental Health Act 1983 are provided as a consequence of a free-standing obligation on the authorities, and are free of charge.

Nearly two decades since section 117 of the Mental Health Act 1983 came onto the statute books, around two-thirds of authorities have been continuing to charge for after-care services in the absence of an express entitlement under s.117.¹ It is perhaps somewhat surprising that their actions were not subject to legal scrutiny much earlier than the summer of 1999, when the cases considered by the House of Lords first came before the High Court.²

While great confusion appears to have existed as to the scope and interpretation of s.117, guidance had in fact been provided on the matter some time ago. In January 1994 the Department of Health firmly adopted the position that s.117 imposed a duty on authorities to provide after-care services, including home care services, and that these services were not to be subject to charging.³ This position was confirmed by the Government when responding to a Parliamentary question in July 1998.⁴ Furthermore, the decision of the High Court in 1999 (which provided the first judicial confirmation of the position) led to a later Department of Health Circular which warned that 'social services authorities still charging for after-care services provided under section 117 should

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1 *Paragraph 4 of the judgment of Lord Steyn who gave the only detailed judgment in the case.*

2 *[1999] 2 CCLR 402*

3 *Advice Note for use by Social Security Inspectorate – Discretionary Charges for Adult Social Services (January 1994), para 2. This position is also reflected in*

various decisions of the Local Government Ombudsman, see for example Investigation into Complaint Nos 97/0177 and 97/0755 against the former Clwyd CC and Conwy County BC, 19 September 1997, 1 CCLR December 1998, (Legal Action Group); Investigation into Complaint No 98/B/0341 against Wiltshire CC, 14 December 1999, 3 CCLR March 2000, (Legal Action Group).

4 *Vol. 317 HC Official Report (July, 1998).*

immediately cease charging since there is no power to do so.⁵ And after the Court of Appeal⁶ upheld the High Court's decision, the Chairman of the Mental Health Strategy Group of the Association of Directors of Social Services wrote to all Directors of Social Services confirming that 'it was not lawful to charge for [section 117] services'.⁷

Therefore, one can hold little sympathy for authorities, which, despite such unequivocal guidance, have continued to charge some of the most vulnerable individuals in society for after-care services. Of course, one concern yet to be addressed, is the potential knock-on effect of this judgment, it being estimated that if repayment of charges levied since 1993 had to be made, the sum would sit at around £80 million.⁸ However, while the House of Lords recognised that this judgment held significant resource implications, Lord Steyn commented that "behind these figures lie, no doubt, innumerable tragic personal stories of mentally-ill individuals who were charged for after-care services."⁹

Facts

The respondents¹⁰ had been formally admitted to hospital under section 3 of the Mental Health Act 1983 ("the 1983 Act"). Following discharge they were placed into caring residential accommodation which constituted 'after-care services' falling within the meaning of s.117(2) of the 1983 Act. Under s.117(2) local authorities are under a duty to provide such services to persons to whom s.117 applies, such as the respondents. While s.117(2A)(a) refers to after-care services provided 'under this section', other provisions of the 1983 Act refer to after-care services provided 'under' section 117. Despite the fact that this section contains no charging provision, the appellants local social services authorities charged the respondents for the provision of after-care services. The respondents challenged the lawfulness of the decisions to charge for after-care services in judicial review proceedings. On 28th July 1999, in the High Court¹¹ Mr Justice Sullivan held that there was no right to charge for such after-care services. A year almost to the day later (27th July 2000), his decision was affirmed by the Court of Appeal (Otton, Buxton LJ and Hooper J).¹²

The authorities appealed to the House of Lords. The central question was whether section 117 is a 'free standing' provision which authorises and requires the provision of after-care services or whether it operates merely as a 'gateway' section to trigger provisions under other statutory provisions, such as s.21 of the National Assistance Act 1948. If the former view were taken, then there would be no right to charge for after-care services owing to the absence of a charging provision under s.117. However, if the latter view were adopted, the authorities would be entitled to charge under various statutory provisions even in cases covered by s.117.

5 HSC 2000/003: LAC (2000) 3, 10 February 2000, p.3.

6 [2000] 3 CCLR 276

7 Letter dated 30th October 2000

8 Lord Steyn illustrated some scepticism when addressing these 'unverified' figures, owing to different (and higher) estimates that had been presented to the Court of Appeal.

9 Paragraph 4 of Lord Steyn's judgment.

10 During the progression of these proceedings, this case

has been widely referred to as the 'Watson' ruling. Mary Watson, who was the first applicant in the High Court proceedings and the first respondent in the Court of Appeal, died before the hearing of the Appeal in the House of Lords. The authority in her case, Richmond London Borough Council, was not a party to the proceedings in the House of Lords but continued to act as an agent for the remaining authorities.

11 See footnote 2 above

12 See footnote 6 above.

Relevant Legal Provisions

The National Health Service and Community Care Act 1990 (“the NHSCCA 1990”) places responsibility onto local authorities for the effective delivery of community care services. Under the NHSCCA 1990, local authorities are required to prepare, publish and keep under review a plan for community care services in its area,¹³ in co-operation with housing authorities, health authorities and voluntary agencies. Community care services include those social care services provided under Part III of the National Assistance Act 1948¹⁴ and s.117 of the Mental Health Act 1983.¹⁵ Under section 47 of the NHSCCA 1990, local authorities are required to assess the needs of anyone who may be in need of community care services,¹⁶ and must determine in the light of that assessment whether such needs require the provision of such services.¹⁷ While a right to assessment exists under the NHSCCA 1990, it does not confer a guarantee that services will be provided. Those requiring community care services must look elsewhere amongst ‘a hotchpotch of conflicting statutes’¹⁸ for practical assistance.

Section 117 places a duty upon health and local authorities, in conjunction with voluntary agencies,¹⁹ to make arrangements for the continuing support and care of those former compulsorily detained patients to whom s.117 applies. Therefore, this section applies to individuals who have been detained for treatment under s.3 of the 1983 Act and are then discharged.²⁰ It also applies to persons who have been convicted of offences and have been made subject to a hospital order or a hospital direction or have been transferred from prison to hospital (under sections 37, 45A, 47 and 48 of the 1983 Act respectively) and who then cease to be detained.²¹ Section 117 requires both the health and social services authorities to provide after-care services until such time as they are satisfied that the individual is no longer in need of the services. The obligation under s.117 cannot be ended except by a joint decision of the health authority and social services, based on a proper assessment, that the person no longer needs the services. As acknowledged by the Mental Health Strategy Group of the Association of Directors of Social Services,²² ‘one of the key issues is determining the point a person might reasonably be deemed to no longer require services provided under section 117’.

While after-care services are not defined in the 1983 Act, in an earlier case in the Court of Appeal, Beldam LJ observed that they would “normally include social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities”.²³ It was common ground in the House of Lords that this was a correct description.²⁴

13 Section 46(1) NHSCCA 1990

14 Section 46(3)(a) NHSCCA 1990

15 Under section 46(3)(d) NHSCCA 1990. See also s.45 of the Health Services and Public Health Act 1968 and s.21 and schedule 8 of the National Health Service Act 1977: see s. 46(3) NHSCCA 1990.

16 Section 47(1)(a) NHSCCA 1990.

17 Section 47(1)(b) NHSCCA 1990.

18 Clements, L., (2000) *Community Care and the Law*, Legal Action Group. The quotation is taken from page 9 of the introduction to this comprehensive book about the legal basis of community care services.

19 Under section 117(2) of the 1983 Act

20 Section 117 also extends to patients who having been detained under section 3, are granted leave of absence under section 17, *R v Richmond L.B.C., ex parte Watson and other appeals* [2001] 1 All E.R. 436, and to those patients who have been conditionally discharged under section 73(2) (see Code of Practice para. 27.3.)

21 Under section 117(1) of the 1983 Act.

22 See footnote 7 above.

23 *Clunis v Camden and Islington Health Authority* [1998] 3 All ER 180 at 191, [1998] QB 978 at 992.

24 Paragraph 9 of Lord Steyn’s judgment

For those who do not fall within the scope of s.117 of the 1983, entitlement to the provision of accommodation may be found in s.21(1) of the National Assistance Act 1948 (“the 1948 Act”). Under this section, local authorities have a duty to provide residential accommodation²⁵ for those in their area aged eighteen years or over who by reason of age, illness or disability or any other circumstances are in need of care and attention which is not otherwise available to them. Once accommodation has been provided under s.21, the recipient of such accommodation is subject to a means-tested charge by reason of the provisions of s.22 of the 1948 Act, although the amount of capital that may be taken into account by local authorities is restricted under the Community Care (Residential Accommodation) Act 1998.²⁶

Judgment

Local social services authorities are not entitled to charge for after-care services provided as a consequence of their duty under s.117 of the 1983 Act. Had Parliament intended s.117(2) to be a gateway provision so that after-care services would be provided under other statutory provisions, it could be expected that s.117(2) would have specified those statutory provisions with appropriate wording. Section 117 is a freestanding provision, and s.117(2) was incapable of being interpreted as imposing a duty to secure the provision of such services under other unnamed enactments. The express references in s.117(2A)(a) to ‘after-care services provided...under this section’ and in other provisions of the 1983 Act to after-care services provided ‘under’ s.117 was inconsistent with the services being provided under any other statutory provisions. Contrary to the submission made on behalf of the appellants, their Lordships were of the view that the natural and obvious interpretation of s.117(2) is that the duty to provide services, by necessary implication imports a concomitant power to carry out the duty. According the appeal was dismissed.

Comment

The High Court and Court of Appeal had already provided a rather thorough treatment of the issues arising in this action.²⁷ For this reason, the unanimous decision of the House of Lords adds little more than the note of finality in confirming that individuals falling within the scope of s.117 of the 1983 Act may not be charged for the provision of after-care services. While on appeal to the House, counsel for the authorities put forward a slightly different argument and suggested that s.117(2) simply contained a general duty on authorities to co-operate about discharged patients, this matter was quickly disposed of. Lord Steyn rejected counsel’s argument as “untenable” owing to the imperative language providing that the authorities ‘shall...provide...after-care services’ until ‘the person concerned is no longer in need of such services’. His Lordship noted that as s.22 of the National Health Service Act 1977 Act already provided for such co-operation between health authorities and local authorities, it was unnecessary to enact s.117(2) for the ‘limited’ purpose of creating a duty to co-operate.

25 Other aspects of after-care (welfare services) are dealt with under section 29 of the 1948 Act.

26 For a detailed account of the various community care service provisions see (1) Clements, L (see footnote 18 above); (2) Bartlett, P. and Sandland, R. (2000) *Mental Health Law, Policy & Practice*, London: Blackstone

Press, pp. 298–323.

27 For an informative discussion of the proceedings in the High Court and Court of Appeal, see Mackintosh, N (2000) *Charges for Services Provided Under S.117 Mental Health Act 1983*, *Journal of Mental Health Law*, pp. 166–171.

Nevertheless, while the House of Lords has conclusively disposed of the central issues concerning s.117 and the funding of after-care services, a number of significant issues related to after-care provision remain on the legal landscape.

‘The Anomaly of the Compliant and Non-Compliant Patients in Adjacent Beds’

Counsel for the authorities referred the House to a comment made by Richard Jones in his influential ‘Mental Health Act Manual’²⁸ on the consequences of the Court of Appeal decision. He contrasts the situations of two men with pre-senile dementia, both being assessed as requiring accommodation for the rest of their lives, the crucial difference between the two being that the first was admitted *informally* to hospital as a compliant patient and the second under section 3 of the 1983 Act as he ‘happened not to be compliant when the crisis in his mental health occurred’.²⁹ Citing Jones, Counsel stated that the natural consequence of the Court of Appeal decision would be that the first would be charged for accommodation provision under s.22 of the 1948 Act, while the second individual would receive such services without charge, by virtue of falling within the ambit of s.117 of the 1983 Act. Counsel summed this up as ‘the anomaly of the compliant and non-compliant patients in adjacent beds’.

Nevertheless, Lord Steyn, describing this as Counsel’s ‘trump card’,³⁰ thought this view “too simplistic”, and noted that a reasonable view might be that patients compulsorily admitted under sections 3 and 37 pose a greater risk upon discharge to themselves and others than compliant patients, and highlighted that Parliament necessarily legislates for the generality of cases.³¹ Referring to certain paragraphs in the Code of Practice, Lord Steyn also took care to point out, ‘compulsory admission powers should be exercised in the last resort’, and that the principal factor in reaching a decision to admit is ‘the danger the patient presents to him or herself or others’.³²

But the ‘anomaly of the compliant and non-compliant patients in adjacent beds’, in itself, is far from ‘simplistic’ – it highlights the manifest unfairness which can arise from differential treatment in circumstances where the ‘needs’ of patients are objectively no different at all. Although such a consequentialist argument provides no good reason to deny **all** persons suffering from mental illness free after-care (the approach adopted by their Lordships), it does render a more sustainable argument that there should be a *similar provision* of services for everyone with *similar needs*.

On this latter point, Jones notes that it is certainly open to argument that an informal patient, who has been discharged from a psychiatric institution and is being charged for accommodation provided for his mental health needs, would have a valid claim under Article 14 ECHR.³³ In these circumstances, he suggests that it is arguable that Article 8 rights are invoked and such patients suffer discrimination as a result of their non-detained status.³⁴

It is perhaps understandable that their Lordships refrained from providing comment in relation to the position of the informal patient, for two reasons. Firstly, the role of the court was to deal with those to whom section 117(1) applies and the question here was whether local authorities could

28 Jones Richard (2001) *Mental Health Act Manual* 7th edition, London, Sweet & Maxwell

29 See footnote 28 above, para 1–967, p. 400.

30 Paragraph 13 of his judgment

31 See footnote 30 above.

32 Paragraph 2.7 of the Code of Practice. His lordship did

not comment in passing as he might have done, that this is not in fact the test laid down in the 1983 Act.

33 As confirmed by *Petrovic v Austria* (1998) 4 BHRC 232, even the most tenuous link with another provision of the ECHR would be sufficient in order to invoke Article 14.

34 See footnote 29 above.

legitimately charge for after-care services under s.117. As all of the respondents had previously been formally detained, an extended discussion of the unfairness that s.117 gives rise to in relation to the informally detained patient would be merely hypothetical. And secondly, section 117(1) is unambiguous as to which classes of individual fall within its scope – therefore, until the point is raised in a separate action, in the form described by Richard Jones, such a matter would seem to fall more appropriately to the legislature rather than the courts.

To charge or not to charge?

But for the purposes of ascertaining whether those falling within the scope of s.117 should be subject to charges for after-care services, perhaps there is a further crucial difference between the informal patient and section 3 patient described above. By comparison with those in need of care under the National Assistance Act 1948 who have the right to choose accommodation where the conditions specified in the National Assistance Act 1948 (Choice of Accommodation Directions) 1992 are satisfied, those patients subject to s.117 are deprived of any choice. This factor, combined with the continuing compliance required by some patients, clearly influenced Lord Steyn when contemplating the ‘far-reaching’ implications of acceding to the arguments of the appellants.

Lord Steyn noted that when a detained patient applies to a mental health review tribunal for discharge under s.72 of the 1983 Act, that on discharge pursuant to a direction by a tribunal, a patient might still require medical and other care. In these circumstances, caring residential care may be essential and would take the place of the hospital environment. Emphasising that the patient does not freely choose accommodation, Lord Steyn suggested that charging individuals for such accommodation in these circumstances would be surprising. His Lordship also noted that in the case of restricted patients (i.e. those patients made subject to a restriction order under s.41 of the 1983 Act) not only is the tribunal empowered under s.73 of the 1983 Act to impose conditions of discharge with which the patient is obliged to comply, but the Home Secretary also holds the power to impose conditions on the patient at any time (s. 42 of the 1983 Act). Lord Steyn suggested that:

“Plainly in such cases the patients do not voluntarily avail themselves of the after-care services. If the argument of the authorities is accepted that there is a power to charge these patients such a view of the law would not be testimony to our society attaching a high value to the need to care after the exceptionally vulnerable.”³⁵

Recovery of Charges³⁶

Where charges have been made for after-care services, authorities will now be subject to restitutionary claims on behalf of service recipients, which are unlikely to be defeated other than through the operation of a Limitation Act defence.³⁷ In addition, questions seem likely to arise in the future where decisions have been made to discharge individuals from section 117, the knee-jerk

35 Paragraph 15 of his judgment

36 In response to the House of Lords’ decision, the Bulletin of the Chief Executive of the Department of Health states ‘Those authorities that have made such a charge will no doubt now wish to address that issue and will each wish to seek their own advice as to the extent of their

liability’, Issue 135, 13th – 19th September 2002, DoH.

37 Different considerations apply to those who continue to suffer from a disability under the Limitation Act 1980. Under section 28(1) of the 1980 Act, the six-year period applicable to monetary claims, will not commence until he or she ceases to be under a disability or has died.

reaction of some local authorities to the initial stages of the *Watson* ruling. Where the provision of aftercare has been terminated in this way, and services have been provided under section 21 of the 1948 Act instead,³⁸ such decisions should be subjected to serious scrutiny.

It is abundantly clear that local authorities may not make charges unless there has been a proper assessment, resulting in a decision that the individual no longer needs aftercare.³⁹ Therefore the legality of decisions to discharge such individuals from s.117 should be doubted, in particular where the need for such services arises from the same mental health condition which led to detention for treatment initially.

Certainly the s.117 duty to provide after-care free of charge will be costly in terms of NHS and social services budgets. As the government has previously emphasised, social services and health agencies should establish joint policies on s.117.⁴⁰ The requirement for effective joint working arrangements cannot be overstated. These will not only need to contend with the provision of future aftercare, but following this judgment, for the sharing and apportioning of responsibility for restitutionary claims made by service recipients. In this respect, Rowley advises that some relief should be gained from the Health Service Act 1999 which enables both the pooling of budgets particularly where NHS and social care provisions overlap, and the ability to reach agreements as to the appropriate apportionment of funding responsibilities.⁴¹

Entitlement, Rights and the Draft Mental Health Bill 2002

‘Above all, legal reform must enshrine the principle of reciprocity...A new mental health act should continue legal provision for compulsion or persuasion of patients, whether in hospital or the community, only if the State also offers specific rights to treatment that go beyond the ineffective general rights to treatment offered by primary NHS legislation...Infringement of individual rights requires acceptance of social duties.’⁴²

As Fennell suggests, ‘mentally disordered patients may be said to have rights in two senses: negative rights to freedom from arbitrary detention or interference with their person; and positive rights to expect a certain minimum standard of service.’⁴³ He notes that s.117 is the one provision of the 1983 Act that actually reflects ‘positive rights in terms of entitlement to services’.⁴⁴ But the nature of that right is unquestionably qualified. Firstly, the 1983 Act is more intent on imposing a *duty* on health and social service authorities in circumstances where an individual is assessed as being in ‘need’.⁴⁵ Secondly, the extent and provision of aftercare remains a matter of medical discretion,

38 For which a charge is compulsory under s.22 of the National Assistance Act 1948.

39 As confirmed from *R v Ealing District Health Authority ex parte Fox* [1993] 1 WLR 393, the duty of Health Authorities to provide after-care services lasts as long as the patients needs it. Therefore, in these circumstances, patients have a continuing entitlement to the provision of after-care services.

40 See footnote 5 above.

41 Rowley, L (2002) *Mental Health News Brief, Issue Summer 2002*, London: Hempsons Solicitors, p.4. For a detailed assessment of the legal and financial implications of this judgment, see further, ‘Legal implications of the House of Lords’ s117 Mental Health Act aftercare decision in *Stennett v Manchester*

City Council and other conjoined cases’ (2002) *Public Law Health Check Issue 4*, Mayer Brown Rowe & Maw, pp. 12–15.

42 Eastman, N. (1994) *Mental health law: civil liberties and the principle of reciprocity*, *BMJ* 1994; 308: 43.

43 Fennell, P. (1999) ‘The Third Way in Mental Health Policy: Negative Rights, Positive Rights, and the Convention 26’ *Journal of Law and Society* 1, pp. 103–127, 103.

44 Footnote 43 above, page 106.

45 Hatfield, B and Antcliff, V. (2001) *Detention under the Mental Health Act: balancing rights, risks and need for services*, *Journal of Social Welfare and Family Law*, 23(2), pp. 135–153, 149.

and resource considerations may be taken into account when making the decision as to the after-care to be provided.⁴⁶ And thirdly, few effective means are open to a patient seeking to enforce such a 'right'.

However, this House of Lords decision provides room for optimism in adopting a proactive approach towards protecting one of the cornerstones of community care policy. As those subject to s.117 are some of the most vulnerable individuals in society, access to much-needed health and community care should be unencumbered by financial obstacles. Therefore, while this decision provides a welcome confirmation of the duties of local authorities and rights of formally detained patients, will this measure be sufficient to ensure a **continued** protection of the entitlement to free after-care services?

The White Paper, *Reforming the Mental Health Act* stated that patients subject to a care and treatment order outside hospital will not be charged for the provision of any service that is specified as compulsory.⁴⁷ However, no section 117 equivalent has been included in the Draft Mental Health Bill 2000 ("the Draft Bill"),⁴⁸ nor any mention as to whether these services will be provided free of charge. Although the Consultation Document (published alongside the Draft Bill) states that the Draft Bill does not cover everything that will be included in the final Bill, taking into account the high profile of s.117 in recent years and benefit of lower court jurisprudence, one might have anticipated that after-care services would have featured more prominently. Instead, 'providing care for patients in the community' falls under 'additional issues' which will be considered in line with discussion with interested organisations including patients groups and local government representatives.⁴⁹ Related issues covered in the Draft Bill however are more promising. The Draft Bill confirms that the clinical supervisor will hold the power to discharge a patient from a care and treatment order only on the basis of an agreed written plan which sets out what continued care and treatment will be provided and when the plan will be reviewed. In addition, before a Tribunal discharges a patient, they will have to be satisfied that there are adequate after-care arrangements.

The absence of a proposed statutory duty as that provided under section 117 has attracted particularly severe criticism from numerous groups providing responses during the Consultation Period. The existence of a care plan, while unquestionably central to targeting the needs of individuals is, in itself, insufficient to ensure that 'the needs of vulnerable individuals will be met in the absence of a duty to provide what is set out in the plan'.⁵⁰ In this respect, the Mental Health Lawyers Association warns that the removal of such a duty will lead to:

46 *R v Somerset County Council ex parte Fewings* [1995] 1 W.L.R. 1037. See also *R v Camden and Islington Health Authority, ex parte K* [2001] EWHC Admin 353, (2001) BMLR 192, in which the Court held that the obligation to provide after-care under s.117 was not absolute where the Health Authority, despite 'reasonable endeavours', was unable to arrange specific care and treatment in the community attached as conditions of discharge. Here section 117's scope was considered a matter of discretion limited by budgetary constraints.

47 Department of Health (2000) *Reforming the Mental*

Health Act, Part I, The new legal framework, Cm 5015 – I, London: TSO at para 3.58.

48 Department of Health (2002) *Draft Mental Health Bill*, Cm 5538 – I, London: TSO

49 Department of Health/Home Office (2002) *Mental Health Bill Consultation Document*, Cm 5538 – III, London: TSO at para 4.4.

50 Mental Health Lawyers Association (2002) *Consultation Submission in Respect of the Draft Mental Health Bill 2002* (September 2002) p.7.

- (a) Patients spending longer in hospital whilst statutory duties and payment obligations are confirmed⁵¹;
- (b) Less critical support for patients in the community;
- (c) A greater risk of relapse;
- (d) The greater use of compulsory powers against the mentally unwell.⁵²

And questions must certainly arise in relation to the funding of after-care services. As Mind contends:

“Aftercare services must be available free of charge...Not only does this flow from the principle of reciprocity, it is implicit in human rights principles that a person’s freedom should not depend on whether s/he can afford the services on which it is based.”⁵³

Responses to the Consultation Period emphasise the need to address further issues correlated to after-care provision. Despite the Draft Bill confirming that the Tribunal will have an increased role in overseeing the provision of after-care, the concern which many share is whether such a function is accompanied by powers to enforce any apparent shortfall in the after-care package. In addition, the ‘rights’ afforded to patients in these circumstances, are clearly insufficient. At present, if there is an apparent shortfall in the after-care package, the tribunal does not have any power to police the work of the authorities.⁵⁴ And nor does it appear that the patient has a right to reparation where she/he has been subject to the provision of inadequate support.⁵⁵ However, a decision by a district health authority or a local social services authority under s.117 may be liable to judicial review at the instance of the patient.⁵⁶ But, the primary method of enforcement of the duty is by complaint to the Secretary of State.⁵⁷ As Mind suggests, a suitable means of enforcing this duty would be via a section 117 equivalent, alongside an enforcement mechanism available to individuals via the routes of the Tribunal or judicial review.

51 Nevertheless, it could be argued that if there is ‘excessive delay’, owing to the absence of safeguards to protect an individual’s right to liberty and security, this would violate Article 5. It would be necessary to show that the individual in question no longer requires detention in hospital and is insufficiently mentally disordered to be detained under the 1983 Act. Under these circumstances it would seem likely that the authorities would be in breach of Article 5(1)(e) ECHR (see *Johnson v United Kingdom* (1997) 27 EHRR 296).

52 See footnote 50 above, p.8.

53 MIND (2002) Mind Response to the Draft Mental Health Bill Consultation Document, Briefing on Proposed Mental Health Act Reforms (September 2002) at p.18.

54 *R v Mental Health Review Tribunal, ex parte Hall* (1999) 2 CCLR 383.

55 *Clunis v Camden and Islington Health Authority* [1998] 3 All E.R. 180: in which Clunis attempted to sue for the failure of authorities to provide after-care services under section 117 of the 1983 Act. The Court

of Appeal refused to allow his appeal. His case was recently declared as inadmissible in the European Court of Human Rights (*Clunis v United Kingdom* (App. No. 45049/98) ECtHR 11 September 2001. For an argument that suggests that a failure to provide after-care services might form the basis of an action for breach of statutory duty, see Montgomery, J. (2002) *Health Care Law*, Second Edition, Oxford: Oxford University Press, pp.75, 320–321.

56 *R v Ealing District Health Authority, ex parte Fox* [1993] 3 All ER 170.

57 See note 47 above. Section 124 of the 1983 Act provides for the Secretary of State to exercise enforcement powers where an authority is in default. Section 124(1) provides: ‘Where the Secretary of State is of opinion or otherwise that a local social services authority have failed to carry out functions conferred or imposed on the authority by or under this Act or have in carrying out the functions failed to comply with any regulations relating to those functions, he may after such enquiry as he thinks fit make an order declaring the authority to be in default.’

Conclusion

Section 117 is widely regarded as a provision ‘designed to promote the social welfare of a class of individuals and ensure that the services were made available’.⁵⁸ An important aspect of this section is the positive duty placed upon authorities to provide aftercare services to facilitate a patient’s speedy return to the community. As Glover-Thomas asserts, ‘the intention behind section 117 is clear...patients should be cared for in the least restrictive environment possible, and if they are suitable candidates for community care, after-care should be provided under the 1983 Act s.117 free of charge.’⁵⁹

Underpinning the unanimous decision of the House of Lords, is the notion that special provision should be made for those to whom s.117 applies. The rationale behind this statutory provision is well elucidated by Buxton LJ in the Court of Appeal:

“The persons referred to in s.117(1) are an identifiable and exceptionally vulnerable class. To their inherent vulnerability they add the burden, and the responsibility for the medical and social service authorities, of having been compulsorily detained. It is entirely proper that special provision should be made for them to receive after-care, and it would be surprising, rather than the reverse, if they were required to pay for what is essentially a health-related form of care and treatment.”⁶⁰

Seen in this light, the absence of a duty to provide free after-care services is indeed a ‘retrogressive step.’⁶¹ For this reason, it is doubted whether the House of Lords has provided the final word in relation to the funding of and duty to provide after-care. The Draft Bill in its current form threatens to undermine the future benefits to be gained from this judgment, and deprives individuals in receipt of after-care services of the ability to arrange their affairs accordingly.

And, as discussed earlier, Jones’ illustration highlights the dangers of limiting the scope of s.117 to those who have been subject to compulsory detention alone. The ‘theoretical’ demarcation between patients detained under the 1983 Act and those informally admitted, is no longer as clear following the *Bournewood*⁶² decision. For most purposes this means that while informal patients are effectively *de facto* detained, they continue to sit outside the protective mechanisms afforded for the formally detained⁶³ – this is certainly true in relation to after-care provision. In this regard, the legislature should endeavour to avoid ‘generality’ in marking out the boundaries of entitlement to after-care services. Such under-privileging of the informally detained is not only unsustainable in a mental health climate that seeks to promote a patient’s speedy return to the community life, but is an approach that appears highly vulnerable in the light of the Human Rights Act 1998.

58 See footnote 56 above.

59 Glover-Thomas, N. (2002) *Reconstructing Mental Health Law and Policy*, London: LexisNexis Butterworths Tolley, p. 91.

60 See footnote 6 above.

61 See note 50 above, p.8.

62 *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1998] 3 WLR 107.

63 See *Bartlett & Sandland op. cit.* at footnote 26 above.

Nearest Relatives of Gay and Lesbian Patients

Nicola Cho*

R (on the application of SSG) v Liverpool City Council (1) Secretary of State for Health (2) and LS (Interested Party).

Administrative Court (22nd October 2002) – Mr. Justice Maurice Kay

Introduction

In this case the Administrative Court approved the naming of gay and lesbian partners of mental health patients as nearest relatives under Section 26 of the Mental Health Act 1983. An agreement was reached between the parties which brought an end to the discrimination faced by those in same sex relationships. Although the resulting order is limited to a nearest relative case, the principles are of much wider application and reflective of recent developments both in the Courts and in the corridors of Government.

The facts

Ms. SSG had lived with her female partner, Ms. ESG, in a stable sexual relationship since August 1999. She had a diagnosis of paranoid schizophrenia and depression, which she had suffered from for a number of years and which required treatment. She received that treatment in the community. This consisted of prescribed medication, outpatients appointments with a consultant psychiatrist and regular visits from a community psychiatric nurse.

Ms. SSG had been detained under the provisions of Section 2 of the Mental Health Act 1983 on one occasion in the past. She was subsequently discharged from hospital on 31st December 1997. Although she had not been admitted to hospital since that time, it was accepted that the chronic nature of her condition could result in her being admitted in the future.

The person thought to be Ms. SSG's nearest relative was her mother, LS, the interested party in the proceedings. Ms. SSG no longer had a good relationship with her mother and had effectively been estranged from her since October 2000. She did not feel that her mother would ever give due consideration to exercising her power of discharge¹ should she be detained under the Mental Health Act 1983 at some time in the future. She would have preferred her partner, Ms. ESG, to be informed or consulted about any admission for treatment, assessment or other care. Ms. SSG contended that whilst she and her partner were not free to marry, they had lived together as spouses since August 1999 and the fact that they were not afforded the same rights and recognition as unmarried heterosexual couples was discriminatory.

* Solicitor and partner with Jackson & Canter (Liverpool). Solicitor instructed by the Applicant in the case under review.

1 The nearest relative's power of discharge is contained in section 23(2) Mental Health act 1983, and is subject to the restrictions set out in section 25(1)

Solicitors correspondence was sent to the First Defendant, (Liverpool City Council), asking for it to amend its records and to treat Ms. ESG as Ms. SSG's nearest relative. Their Executive Director initially acceded to this request but the First Defendant then confirmed that it could not grant Ms. SSG's request after all as the legislation did not permit a patient to choose a nearest relative. The First Defendant pointed out that a nearest relative could authorise another person to perform the functions of nearest relative² or that an application could be made to the County Court to displace the nearest relative, in accordance with the provisions of Section 29 Mental Health Act 1983. Unfortunately, although LS was invited to delegate her powers of nearest relative to Ms. ESG, no response was received, and none of the four grounds provided for in Section 29(3) of the Act applied to Ms. SSG's case.

Ms. SSG therefore applied for judicial review of the First Defendant's determination that it would not treat her partner, Ms. ESG, as her nearest relative. The Secretary of State for Health was brought into the proceedings as Second Defendant, in view of the implications of the case beyond its own particular facts.

The Law

Nearest Relative

The nearest relative has a number of important functions in respect of certain patients subject to the compulsory provisions of the Mental Health Act 1983 namely unrestricted patients³ and those patients subject to guardianship or supervised discharge. These include:

- (i) The Approved Social Worker is required to consult with the nearest relative before any application for admission for treatment under Section 3 or for guardianship under Section 7 is made (unless such consultation is not reasonably practicable or would involve unreasonable delay) (Section 11 (4));
- (ii) If practicable, the nearest relative must be informed of an admission for assessment under Section 2 (Section 11 (3));
- (iii) The nearest relative can apply for admission for assessment, treatment or for guardianship (Section 11 (1));
- (iv) The nearest relative can require a Social Services Authority to direct an Approved Social Worker to consider making an application for admission into hospital and is entitled to written reasons if no such application is made (Section 13 (4));
- (v) Decisions not to make applications for admission to hospital must be discussed with the nearest relative (Code of Practice, paragraph 2.32);
- (vi) The nearest relative can direct the discharge of certain patients from detention or guardianship (Section 23 (2)) (although the discharge from hospital detention may be barred by the Responsible Medical Officer (Section 25 (1)));
- (vii) The nearest relative has certain rights in respect of applications to the Mental Health Review Tribunal (Section 66 (1));

2 In accordance with the provisions of Regulation 14 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulation 1983

3 In effect the nearest relative does not have any functions

in relation to restricted patients. See *R (on the application of H) v Mental Health Review Tribunal for the West Midlands and North West Region* [2000] MHLR 203.

Identifying the Nearest Relative

Section 26 contains complex provisions for identifying the nearest relative. Section 26(1) provides a list of relationships to the patient which determine whether someone is a 'relative' of the patient. Section 26(3) in effect confirms that subject to the effect of other sub-sections, the list is a pecking-order for determining which of the patient's relatives is deemed the 'nearest relative'. Top of the list is 'husband or wife'. Section 26(6) ensures that this phrase extends beyond marriage to include a person who has been living with the patient 'as husband or wife' for six months or more (provided the spouse of a married patient can be disregarded by reason of Section 26(5) on the grounds of desertion or separation). Provision is also made for a person who has been residing with the patient for not less than five years to become a relative (Section 26(7)), and indeed by reason of Section 26(4), to become the nearest relative.

Further, Regulation 14 of the Mental Health Regulations 1983 allows a nearest relative to delegate his or her powers to another person thus authorising that person to exercise the functions of nearest relative. However, any delegation of authority is not final and can be revoked in writing and further the authorisation lapses on the death of the original nearest relative so that the statutory pecking order in Section 26 must be invoked once more.⁴ An application can also be made to the County Court under Section 29 of the 1983 Act for a person to be displaced as nearest relative and for someone else to be appointed. Such an application may only be made on one of four specific grounds, set out in Section 29(3) namely

- (i) That the patient has no nearest relative or it is not reasonably practicable to ascertain whether there is such a relative or who that relative is;
- (ii) That the nearest relative is incapable of acting by reason of mental disorder or other illness;
- (iii) That the nearest relative unreasonably objects to the making of an application for admission for treatment or guardianship;
- (iv) That the nearest relative has exercised without due regard to the welfare of the patient or the interests of the public his or her power to discharge the patient from detention or guardianship or is likely to do so.

Human Rights

It was accepted that the functions of the nearest relative brought this case within the ambit of Article 8 of the European Convention on Human Rights, by which everyone has the right to respect for his or her private and family life. Any interference by a public authority with the exercise of these rights is prohibited unless it is for a legitimate purpose and is proportionate.

It was submitted on behalf of Ms. SSG that not only do issues of personal choice and identity fall within Article 8, but that a patient should be able to choose his or her own nearest relative (although this point was not central to her case). This was supported by the European Court of Human Rights decision on 30th March 2000, in the case of *J.T. v United Kingdom*,⁵ in which the Commission had declared admissible a complaint that the absence of any power enabling the

⁴ In Ms. SSG's case, it was subsequently discovered by the First Defendant that Ms. SSG's father was in fact her correct nearest relative and he went on to delegate his powers to Ms. ESG. Ms. SSG was estranged from him also which highlights the difficulties involved in

identifying nearest relatives and raises questions as to whether they can perform any useful function if they are no longer in touch with the patient.

⁵ [2000] 1 FLR 909

patient to specify a nearest relative whom the patient liked and trusted, was a potential breach of Article 8. That case was ultimately dealt with by way of friendly settlement on the understanding that the legislation would be changed. Nearly three years later, no amending legislation has been passed, and indeed it would appear that none is planned prior to the proposed wide-reaching mental health law reforms. The Government's proposals for the replacement of a "nearest relative" with a "nominated person", appointed in accordance with the patient's wishes but subject to certain safeguards, are of course set out in the Draft Mental Health Bill.⁶

In the light of the fact that the case fell within the ambit of Article 8, it was also accepted that Article 14 was engaged. This Article prohibits discrimination in the manner in which Convention rights are afforded. It was acknowledged that sexual orientation was a ground covered by Article 14.

The Secretary of State for Health as Second Defendant accepted that there was a difference in treatment by the 1983 Act between non-married heterosexual couples who had been living together for six months and same sex couples who had been living together for the same length of time. The heterosexual partner would be the nearest relative on the basis of six months residence (provided the married patient's spouse could be disregarded on grounds of separation or desertion) but the homosexual partner would not. For a partner to be recognised as a nearest relative, same sex couples would have to live together for a minimum period of five years. There was no recognition within the statutory provisions of their actual relationship and in effect they were treated no differently than flatmates. It was accepted that this difference in treatment could not be justified.

Compatibility

The question remained, was it possible to interpret Section 26 of The Mental Health Act 1983 in a manner which avoided incompatibility, pursuant to Section 3 of the Human Rights Act 1998?⁷ If not, then a declaration of incompatibility would be appropriate.⁸ It was submitted by the parties that Section 26 (6) could be so interpreted and compatibility thus achieved.

It was accepted by the Second Defendant that factors such as the closeness of relationship, degree of stability and permanence were just as capable of being present in a same sex couple as in an unmarried heterosexual couple. There was nothing to suggest that a same sex partner who had been living with the patient for six months would not be as capable as a heterosexual partner in performing the functions of the nearest relative. The Second Defendant submitted that there were no major practical repercussions or policy issues in interpreting Section 26 (6) so as to include same sex partners living with the patient for six months within its scope.

6 See clauses 148–156 of the Draft Mental Health Bill, Department of Health 2002. Cm 5538-1.

7 Section 3(1) Human Rights Act 1998 states that 'so far as it is possible to do so, primary legislation and

subordinate legislation must be read and given effect in a way which is compatible with the Convention rights'.

8 Section 4 Human Rights Act 1998

Order

The matter was dealt with by consent and the subsequent order was pronounced in open court on 22nd October 2002.

The order provided for the following:–

- (1) The determination by the First Defendant that it would not treat the partner of Ms. SSG as her nearest relative within the meaning of Section 26 of the Mental Health Act 1983 was quashed;
- (2) It was declared that the same sex partner of a patient could be treated as a “relative” within Section 26 (1) of the Mental Health Act 1983, and that having regard to the specific statutory context and applying Section 3 of the Human Rights Act 1998, the same sex partner could be treated as falling within the phrase “living with the patient as the patient’s husband or wife as the case may be” in Section 26 (6) and accordingly as a relative within Section 26 (1) of The Mental Health Act 1983;
- (3) It was declared that, having regard to the length of her cohabitation with Ms. SSG, that Ms. ESG was her nearest relative for all purposes under the MHA 1983; and finally that
- (4) The First Defendant was ordered to treat Ms. ESG as Ms. SSG’s nearest relative for all relevant purposes under 1983 Act and to record that she was the nearest relative and to inform any hospital authority or other relevant body with whom it might have to deal in regard to Ms. SSG’s condition that Ms. ESG was the nearest relative.

Comment

This is a case of immense importance to patients in same sex relationships. They can now be assured that their partners will be involved in making decisions regarding their treatment and care and will be consulted about and advised of appropriate applications made by Approved Social Workers, provided of course firstly they have lived together for six months or more, and secondly (in the case of married patients) their spouse can be disregarded because of separation or desertion.

Although the concession by the Second Defendant was limited to the specific statutory context of nearest relatives under The Mental Health Act 1983, it is another step towards full legal recognition of the rights of gay and lesbian couples. Since the consent order was made, there have been two other particularly significant developments in this area of human rights. Firstly the Court of Appeal on 5th November 2002, in a housing case (*Antonio Mendoza v Ahmed Raja Ghaidan*⁹) declared that a gay man could succeed to a statutory tenancy on his partner’s death. Secondly on 6th December 2002, Barbara Roche, the Minister for Social Exclusion, announced proposals to allow same-sex couples to register their unions as ‘civil partnerships’, giving them property and inheritance rights and recognition as next-of-kin.¹⁰ The Secretary of State for Health would clearly have been flying in the face not just of the judiciary (both here and at Strasbourg) but also his own Government colleagues if he had done anything in this case other than make the concession which he did. That said, his attitude must be welcomed and applauded. It stands in marked contrast to the inertia which has followed the undertaking given in *JT v United Kingdom*.¹¹

⁹ [2002] EWCA Civ 1533

¹¹ See footnote 5, above.

¹⁰ Reported in the *Guardian* newspaper 7th December 2002

Book Review

Neither Mad nor Bad. The Competing Discourses of Psychiatry, Law and Politics

Deirdre N. Greig. Jessica Kinglsey Publishers 2002.

The title of this book, as the author reminds us, is derived from Lady Caroline Lamb's description of Lord Byron as "mad, bad and dangerous to know". The phrase serves neatly to encapsulate a central problem faced by law and psychiatry explored in the book and (the timing of publication is fortuitous) faced by the government's draft mental health bill; how to distinguish between madness, badness and dangerousness?

Greig's book focuses in detail on the history of one man in the state of Victoria, Australia and the responses of the law, psychiatry, politicians and the community to the "problems" presented both by his behaviour and by his diagnosis of severe personality disorder.

By the age of eighteen, Garry David had accumulated a large number of convictions for separate offences, mainly of theft. His major term in prison, 14 years for wounding and attempted murder, came in 1980 when, aged 27, he attempted to ambush police with, it would seem, the desire to be killed in a dramatic shoot out. Even including this latter drug fuelled incident, David's criminal career could not be regarded as exceptional. Yet, as he was approaching the end of his custodial sentence and was appealing his continued detention as a security patient, the government moved to pass "one-person" legislation, the Community Protection Act 1990, requiring the Supreme Court to assess expert evidence of his dangerousness as a basis for his continued incarceration.

That the state reacted so dramatically and in a way that, arguably, led to David's death from injuries inflicted upon himself as part of a campaign of resistance, was not, Greig argues, attributable to proven criminality or a diagnosed mental illness but rather the use, as a form of professional knowledge and a basis for policy, of the concept of "dangerousness"; a concept that "signals a self-fulfilling prophecy of incontrovertible evidence that a dangerous propensity exists" thereby demonising the subject, arousing public fear and inviting political intervention.

Although an unexceptional criminal, it must be said that David was a highly unusual prison inmate who was to develop a broad range of tactics to destabilise both the psychiatric and penal authorities. This ability was demonstrated first at his trial in 1980 where his disruptive behaviour ranged from disdain for the court by refusing to stand, to threats of violence, including those of self-mutilation which resulted in the need for a daily x-ray to guard against his proven ability to swallow sharp objects and regurgitate them at will.

This pattern, with inventive variations, continued in custody where David developed and mastered the arts of prison anarchy; hunger strikes, cell barricades, threats, physical violence, self-mutilation and the inciting of other prisoners to resist. These cruder activities were accompanied by a written

campaign and an extraordinary and sometimes highly subtle ability to undermine and create conflict amongst the prison staff, particularly his treating doctors and nurses. The dimensions of David's public persona were amplified by the leaking of official documents to the sensationalist press detailing, among other things, his puerile and fantastic plans for a war on the public when released. Such fantasies might have been dismissed were it not for the image that the public were forming, chiefly through David's own writing to the press, of a man with extraordinary capacity for self-harm, of someone beyond pain, lost to himself and capable of anything, of somebody who must be mad.

Greig traces how David's strategies opened up a divide both practically, professionally and theoretically between the criminal justice and mental health authorities. The difficulty of "placing" him within a suitable structure of care and containment made the establishment of a suitable treatment regime impossible. The problem of locating him managerially was in part a product of the diagnosis of severe personality disorder and the ambiguities this raised as to the appropriateness and efficacy of treatment. The superadded notion of dangerousness, Greig argues, was useful because it removed the need for a complete understanding of David's condition, serving both as a bridge between criminality and mental illness, making continued incarceration an acceptable goal, and as a signal of the potential rather than the actual, something seized upon by the media who distorted David into a "Hannibal Lecter" figure in the minds of the public and politicians.

Greig's description of the frenzied way in which the options for Garry David were explored by the authorities is disturbing because they strongly suggest the issue had been pre-decided. These included the possibilities of certification, provided psychiatrists would recognise David as mentally ill, the recommendation, by a special committee set up for the purpose, that personality disorder be viewed as a mental illness and the enjoining by the Attorney General of the Law Reform Commission to focus its attentions on that part of the Mental Health Act which specifically excluded certification of those with an "anti-social personality". Whilst the government pursued options for confinement, a specially formed group of four psychiatrists delivered their, no doubt, unwelcome view that David was not mentally ill for the purposes of commitment.

The culmination of these efforts was the Community Protection Bill 1990 which, hastily drafted as it was, did nothing to disguise the government's central aim of preventing David's release, the purposes being, "to provide for the safety of members of the public and the care and treatment of Garry David ... and to provide for proceedings to be instituted in the Supreme Court for an Order for the detention of Garry David." The Bill thus shifted the burden of making a decision and the blame for the outcome to the judiciary. Whether prisoner or psychiatric patient, the court was empowered, on the finding of a serious risk to the public or likelihood of violence, to order preventive detention. But the finding of such a risk or likelihood was to be based upon evidence by experts who had previously been unable to resolve how David should be managed or clarify their views on his condition. The order for preventive detention which almost inevitably followed allowed David further opportunities to highlight the conflicts between the law and psychiatry which had been exposed at the hearings by styling himself a "psychiatric prisoner". David died in 1993 from complications of his self-inflicted injuries while still engaged in legal testing of the legislation which kept him a prisoner and the attacks on his body which were, Greig suggests, a way of demonstrating power over himself of a kind denied to the authorities.

Throughout, the charting of David's convoluted history at the hands of the state, the competition and contradictions between psychiatry and law and the reactions of politicians to public and media pressure is done with care and facility. The picture that emerges is that of guild like structures, each concerned to protect its interests but confronted by the impossible task of overcoming the incompatibilities. Psychiatrists could agree on a personality disorder but not its type whilst lawyers struggled with their need for precise meanings requiring of the psychiatrists discriminations they were not prepared or able to give. The accounts of the Mental Health Review Board hearings on the arguments as to whether David's personality disorder was borderline or anti-social are particularly interesting if unedifying.

The sub-title, the *Competing Discourses of Psychiatry, Law and Politics*, hints at the author's application of arguments and insights from less traditional sources. This accords with the Forensic Focus series of which this book is part and its intention of embracing such other disciplines as "language, literature, criminology, ethics and philosophy as well as psychiatry and psychology". My feeling is that Greig's use of, for example, commentators such as Foucault, Gusfield and Ignatieff is a little coy – these authors might have been mined more substantially, they tend to appear suddenly as if slotted in rather than contextualised.

This minor and rather personal quibble aside, this is a book I thoroughly recommend. It has much of importance to say to anyone in the wide field of subjects touched upon by the series but most especially to those concerned with the current debate on dangerousness and severe personality disorder. For politicians who share the concerns over the moves to legislate for broad criteria for the detention of those with diagnosed DPSD, it should be required reading. The history of Garry David as told in the book might have been the origin of the phrase "hard cases make bad law" but what politicians might also learn is that hard law has a nasty propensity for making bad cases.

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IS ANYONE SAFE? Civil Compulsion under the Draft Mental Health Bill*

Anselm Eldergill**

Introduction

The British Government published a draft Mental Health Bill for England and Wales on 26 June 2002.¹ Its publication was preceded by a White Paper in December 2000,² a Green Paper in November 1999,³ and a report prepared by a committee chaired by Professor Genevra Richardson.⁴

The focus of the Bill is on risk management and compulsion in the community. It has been widely condemned by professional bodies, and by carers and patient groups. The nature of the criticism is that the proposals are unprincipled and impractical.

It is important to establish whether this is so. The purpose of this paper is to analyse the Government's case for change and, having done that, to analyse the new civil powers of detention and compulsory treatment.

* *Inaugural Professorial Lecture delivered on 13 November 2002 at Northumbria University, Newcastle upon Tyne.*

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1 *Draft Mental Health Bill, Department of Health, Cm 5538-I, June 2002. The Bill's publication was accompanied by the publication of two associated documents: Mental Health Bill Consultation Document, Department of Health, Cm 5538-III, 2002 and the Draft Mental Health Bill Explanatory Notes, Department of Health, Cm 5538-II, June 2002.*

2 *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-I); Part II: High-risk patients (Department of Health/Home Office, December 2000, Cm 5016-II).*

3 *Reform of the Mental Health Act 1983. Proposals for Consultation (Department of Health, 1999, Cm 4480, November 1999).*

4 *Review of the Expert Committee: Review of the Mental Health Act 1983 (Department of Health, November 1999). The committee, which was established by the Department of Health in October 1998, also published its outline proposals: Review of the Mental Health Act 1983, Draft Outline Proposals by Scoping Study Group, April 1999.*

The Government's case

According to the Government, the existing Mental Health Act does not adequately protect people from the significant risk posed by a minority of patients. In particular, it remains based on treatment in hospital, and too often has allowed severely ill people outside hospital to drift out of contact with services.⁵

The Government was therefore concerned that this state of affairs might be true and require a remedy; later concluded that it was true; and invented the hypothesis that existing legislation contributes to this state of affairs. It has now identified a solution, the Mental Health Bill. It believes this is a reasonable solution that does not violate other established principles, and it intends to apply this solution to the facts that constitute the problem.

The Government's proposition may or may not be true.

In order to determine whether it is true, it is necessary to define who within the population is 'mentally disordered', the extent of their violence, what constitutes adequate protection from such violence, and, if people are inadequately protected, whether this is because of our laws. If the Government's proposition is sound, it is still necessary to examine the proposed solution: is it likely to solve the problem, and is it an acceptable solution if its implementation will violate other cherished convictions, such as liberty and justice?

This analytical approach, called pragmatism, seeks to secure a proper regard for the future practical consequences of our actions; to reduce the dangerous influence of subjective egoism; and to encourage the adoption of a reasonable, modest fallibilism with respect to our moral precepts. The best outcome we can legitimately hope for is that we are warranted in asserting a belief upon which we may successfully act, without any presumption of its independent, universal, or timeless truth.⁶

Who is mentally disordered?

It is necessary to define or describe who within a population is mentally disordered before it is possible to estimate the level of violence for which they are collectively responsible.

If persons with anti-social or psychopathic personalities are categorised as mentally disordered, it is necessarily true that other people are relatively more at risk from the mentally disordered than if they are excluded. Furthermore, if our definition of a psychopathic disorder requires abnormally aggressive or seriously irresponsible conduct, as it does under the 1983 Act, it is inevitable that people within the definition will often have been violent. Such a concept is bound to produce such a statistical finding, the whole aim being to detain those who, though not mentally ill, put others at significant risk. Conversely, if such people are excluded, the level of violence committed by what may be called the anti-social element in society will be that much greater, and the contribution of the mentally disordered that much less.

The definition of mental disorder in the 1983 Act includes people categorized as having a psychopathic disorder, but does not include people by reason only of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. It is clear from the draft Bill, however, that the Government considers that such persons have a mental disorder. By implication,

5 *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-I), p. xxx. (The 'White Paper').*

6 *See Dewey, J, Logic: The Theory of Inquiry (1938).*

it counts them as part of the group of mentally disordered persons who commit violence, violence from which the public are inadequately protected. It will later be argued that this all-inclusive approach is artificial and unjustified.

The level of violence to others

There are about forty homicides per 100,000 psychiatric admissions.⁷ In statistical terms, the risk that a mentally ill individual will kill themselves is substantially higher than the risk of homicide. According to one study, people suffering from schizophrenia are one hundred times more likely to kill themselves than someone else, and those with a mood disorder are one thousand times more likely.⁸

Research findings do tend to demonstrate a positive relationship between mental illness and violence, although there is some evidence that violence by people with mental disorder is not increasing.⁹ The risk of violent behaviour is modestly increased in people with psychotic illness alone. The greatest risk is associated with personality disorder, substance misuse, and conditions where substance abuse is combined with severe mental illness.

Whether people are adequately protected

Different people have different levels of anxiety. As a result, trying to determine what is an acceptable risk, what constitutes adequate protection, and whether a particular system is 'unsafe', is partly subjective. It is, nevertheless, important to try to establish whether violence associated with mental disorder is increasing, and to make comparisons between different kinds of violence.

The criminal statistics for England and Wales between 1957 and 1995 reveal little fluctuation in the number of mentally ill people who committed criminal homicide during this 38 year period, and a three per cent annual decline in their contribution to the official statistics. The number of homicides committed by them peaked at 130 in 1972, and then fell steadily to 60 in 1995. People are more likely to win the National Lottery jackpot than they are to die at the hand of a stranger with a mental illness.¹⁰

Although there appears to be a positive relationship between mental illness and violence, people with drug misuse or substance dependence disorders present the highest risk. Furthermore, variables such as male sex, young age, and lower socio-economic status proportionately make a much higher contribution to violence in society than the modest amount attributable to mental illness. In a large United States study, 16% of 18–24-year-old men from low socio-economic classes were found to be violent, and they represented a far greater risk than the people with schizophrenia.¹¹

7 Tidmarsh, D, *Psychiatric risk, safety cultures and homicide inquiries*, *The Journal of Forensic Psychiatry* (1997) 8(1): 138–151.

8 Häfner, H., and Böker, W., (1973) (translated by H. Marshall, 1982). *Crimes of Violence by Mentally Abnormal Offenders*. Cambridge: Cambridge University Press.

9 Mullen, PE, et al., *Community care and criminal*

offending in schizophrenia. *Lancet* (2000) 355:614–617.

10 Taylor PJ and Gunn J (1999), 'Homicides by people with mental illness: myth and reality' *British Journal of Psychiatry* 174: 9–14.

11 Swanson JW, et al., (1990). *Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys*. *Hospital and Community Psychiatry*, 41:761–770.

The available evidence suggests therefore that the closure of the old asylums, and the movement to providing care in the community, has not led to an increase in the level of violence committed by the mentally ill. The proportion of violence in society attributable to mental illness remains low, and people are better protected from violence of this kind than from most other kinds. Violence has much more to do with education, upbringing, alcohol, drugs and testosterone than mental illness. That is not to say, of course, that it is appropriate to detain and treat people in these classes under mental health laws.

The facts do not support the Government's proposition.

That this is so leads to a supplementary point, which is the need to encourage people to be realistic about risks and their management. It is impossible for mental health services to be totally safe, and Governments should take account of the natural limits of practice before they introduce legislation:

- Risk cannot be avoided and even a very low risk from time to time becomes an actuality. However careful the assessment, it is inevitable that some patients will later take their own lives or commit a serious offence.
- Any decision to detain an individual, or to compel them to have treatment, involves balancing competing risks, of which the risk that others may suffer physical harm is but one. For example, detention and compulsory treatment risk loss of employment, family contact, self-esteem and dignity; unnecessary or unjustified deprivation of liberty; institutionalisation, and disabling side-effects.
- The purpose of compulsory powers is not to eliminate that element of risk in human life which is a consequence of being free to act, and to make choices and decisions; it is to protect the individual and others from risks that arise when a person's judgement of risk, or their capacity to control behaviour associated with serious risk, is significantly impaired by mental disorder.
- Good practice relies on good morale and a feeling amongst practitioners that they will be supported if they act reasonably; it is unjust to criticise them when decisions properly made have unfortunate, even catastrophic, consequences.
- The occurrence of such tragedies does not per se demonstrate any error of judgement on the part of those who decided that allowing the patient their liberty did not involve unacceptable risks.
- An outcome is often the result of a complex series of events, and the choice of one particular causal factor may be arbitrary.
- Small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.
- All violence takes place in the present, and the past is a past, and so unreliable, guide to present and future events.
- Understanding the situations in which a person has previously been dangerous, and avoiding their repetition, can give a false sense of security about the future. Although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction

is significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

- Unless the individual's propensity for violence has a simple and readily understandable trigger, it is impossible to identify all of the relevant situations; some of them lie in the future, and will not yet have been encountered by the patient.
- Predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').
- A risk can in theory be measured and is the basis of actuarial prediction – in theory because in practice all of the critical variables never are known. The risk depends on the situation but the situations in which the patient may find themselves in the future can only be speculated upon.
- Because future events can never be predicted, it is important to put in place an adequate system for supervising an individual whose own safety may potentially be at risk or who may pose a threat to the safety of others. However, this approach is not fail-safe: it is based on the assumption that most attacks do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.
- All human beings, regardless of their skills, abilities and specialist knowledge, make fallible decisions and commit unsafe acts, and this human propensity for committing errors and violating safety procedures can be moderated but never entirely eliminated.

Whether our laws are at fault

Even if people are inadequately protected from the actions of people who suffer from mental disorder, this may not be a fault of our laws. It may be due to insufficient resources, poor government, poor service management, poor risk management, faulty practice, a faulty understanding of the law, or simply part of the human condition. In other words, a problem or limitation that is to a significant extent replicated across a world full of different mental health laws. Implicit in any discussion about the need for new laws is the assumption that modifying their content modifies outcomes. However, the extent to which this is true is unclear. Legislation is actually a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear from recent homicide inquiry reports. Had the professional carers foreseen what was about to happen, they already had power under the present law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of new legislation can improve foresight. Nor can it improve insight, for 'he that complies against his will, Is of his own opinion still.'¹²

The key to progress rests with improving government, resources, diagnostic tools, treatments and training, and, most fundamentally of all, with education:

'I believe that education is the fundamental method of social progress and reform. All reforms which rest simply upon the law, or the threatening of certain penalties, or upon changes in mechanical or outward arrangements, are transitory and futile.... But through education society

¹² Butler, *Hudibras* (1663), Part 3, Canto 3.

can formulate its own purposes, can organize its own means and resources, and thus shape itself with definiteness and economy in the direction in which it wishes to move.... Education thus conceived marks the most perfect and intimate union of science and art conceivable in human experience.¹³

The importance of our other convictions

A pragmatic approach to law-making involves considering whether the Government's solution violates other important convictions. Does it show adequate regard for those principles that have been demonstrated to have value? Even if there is benefit in the proposals, what is the cost?

Some of the most important, established, principles concerning the formulation of mental health laws may be restated here:¹⁴

1. It is unsatisfactory to seek to determine principles by reason only, without regard for human experience of the world within which principles are formulated and applied. Our value judgments are judgments about experienced objects.
2. There are many reasons to limit state intervention in people's lives: errors in law spread their negative effects throughout the nation as opposed to individual errors that are limited in scope; the damage of erroneous laws affect citizens more than legislators, who are thus less inclined to repeal them; it takes longer to repair the damage done by legislation than the damage done by individuals by their own private choices; because of the constant watch of critics, politicians are less inclined to publicly admit error and undo the damage done; politicians are more inclined than citizens to make decisions based on political gain and prejudice, rather than principle.¹⁵
3. The British constitution separates powers, the aim being to keep executive powers in check and under proper scrutiny, and so to secure good government. This is necessary because the 'whole art of government consists in the art of being honest',¹⁶ and 'it is not by the consolidation, or concentration of powers, but by their distribution, that good government is effected.'¹⁷
4. Promoting liberty, protecting individuals from harm caused by those at liberty, and those not at liberty from abuse by those who are, alleviating suffering, and restoring to health those whose health has declined, are all legitimate objectives, in that they reflect values embraced by virtually all members of our society.¹⁸
5. We are, however, 'faced with choices between ends equally ultimate, and claims equally absolute, the realisation of some of which must inevitably involve the sacrifice of others.'¹⁹ Whether individuals 'should be allowed certain liberties at all depends on the priority given

13 Dewey, J, *My Pedagogic Creed* (1897), in *The Essential Dewey, Volume 1* (ed. Hickman L and Alexander TM), Indiana University Press, Bloomington & Indianapolis, 1998, p.234.

14 Some of these principles were previously stated in Eldergill, A, *Reforming the Mental Health Act*, *Journal of Forensic Psychiatry*, Vol. 12, No. 2, 379-397.

15 Benjamin Constant: *Political Writings* (trans. and ed. Biancamaria Fontana), Cambridge University Press 1988.

16 Thomas Jefferson: *Rights of British America, 1774. The Writings of Thomas Jefferson, Memorial Edition* (ed., Lipscomb & Bergh), Washington, DC, 1903-04.

17 Thomas Jefferson: *Autobiography, 1821. The Writings of Thomas Jefferson, Memorial Edition* (ed., Lipscomb & Bergh), Washington, DC, 1903-04, 1:122.

18 Eldergill, AC, *Mental Health Review Tribunals - Law and Practice* (Sweet & Maxwell, 1997), p.45.

19 Berlin, Sir I, *Four Essays on Liberty* (Oxford University Press, 1969), p.168.

by society to different values, and the crucial point is the criterion by which it is decided that a particular liberty should or should not be allowed, or that its exercise is in need of restraint.²⁰

6. When enacting mental health legislation, Parliament has generally sought to erect a balanced legal structure that harmonises three things: individual liberty; bringing treatment to bear where treatment is necessary and can be beneficial; the protection of the public.²¹ Those we describe as ‘patients’ are themselves members of the public, so that the law must seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.
7. The use of compulsion has been permitted when significant harm is foreseeable if an individual remains at liberty. Its purpose is to protect the individual or others from those risks that arise when a person’s capacity to judge risks, or to control the behaviour giving rise to them, is impaired by mental disorder.
8. Other risks are, constitutionally, matters for citizens to weigh in their own minds. The purpose of compulsion is not to eliminate that element of risk in human life that is simply part of being free to act and to make choices and decisions. A person who obeys our laws is entitled to place a high premium on their liberty, even to value it more highly than their health. Subject to the stated limits, people are entitled to make what others regard as errors of judgement, and to behave in a manner which a doctor regards as not in their best interests, in the sense that it does not best promote health.
9. This desire to determine one’s own interests is common to human beings, and so not to be portrayed as an abuse of liberty. On the one hand stands liberty, a right which Parliament and the law should always favour and guard, on the other licence, a wilful use of liberty to contravene the law, which the law must of necessity always punish.
10. Any power given to one person over another is capable of being abused. No legislative body should be deluded by the integrity of their own purposes, and conclude that unlimited powers will never be abused because they themselves are not disposed to abuse them.²² Mankind soon learns to make interested uses of every right and power which they possess or may assume.²³
11. This risk of abuse is multiplied if the individual is not free to escape abuse, is incapacitated or otherwise vulnerable, or their word is not given the same weight as that of others. Children and adults with mental health problems are particularly at risk, and the law has usually afforded them special protection.
12. This protection involves imposing legal duties on those with power, conferring legal rights on those in their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed.
13. This is a matter of constitutional importance, for the observance of legal rights and the rule of law are the cornerstones of all liberal democracies. The rule of law ‘implies the subordination of all authorities, legislative, executive [and] judicial ... to certain principles

20 *Dias, RWM., Jurisprudence (Butterworths, 5th ed., 1985), p.109.*

21 *Hansard, H.C. Vol. 605, col. 276.*

22 *Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.*

23 *Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.*

which would generally be accepted as characteristic of law, such as the ideas of the fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual.²⁴

14. In any legal system, 'it implies limitations on legislative power, safeguards against abuse of executive power, adequate and equal opportunities of access to legal advice and assistance, ... proper protection of the individual and group rights and liberties, and equality before the law ... It means more than that the government maintains and enforces law and order, but that the government is, itself, subject to rules of law and cannot itself disregard the law or remake it to suit itself.'²⁵
15. In framing these principles and laws, Parliament has sought to be just, justice being 'a firm and continuous desire to render to everyone that which is his due.'²⁶
16. If new laws are necessary, they should impose minimum powers, duties and rights; provide mechanisms for enforcing duties and remedies for abuse of powers; be unambiguous, just, in plain English, and as short as possible.
17. Because there is a long record of experimentation in human conduct, cumulative verifications give these principles a well-earned prestige. Lightly to disregard them is the height of foolishness.²⁷

The Government's solution

Having considered the case for change, and some of the principles that should govern the drafting of mental health legislation, it is time to examine the proposed solution.

The draft Bill comprises 180 clauses divided into 11 parts, and nine schedules. Some parts of the Bill are sub-divided into chapters, in order to make the document more readable.

As with the 1983 Act, Part 1 is concerned with introductory matters, such as defining mental disorder, Part 2 with civil compulsion, Part 3 with patients involved in criminal proceedings, and Part 4 with medical treatment. Part 5 then sets out a new statutory scheme for incapacitated patients, while the remainder of the Act deals with matters such as powers of entry and conveyance, patient representation, appeals and statutory offences.

A new compulsory assessment power replaces section 2 of the 1983 Act, and all patients must first be assessed under this 28-day procedure. A person subject to it may be detained in hospital as a resident patient or assessed in the community as a non-resident patient. Further compulsion requires a tribunal order. The professional responsible for the patient's assessment and medical treatment is known as their 'clinical supervisor', and this person replaces the 'responsible medical officer'.

Mental disorder

The Bill's definition of mental disorder, taken from the Richardson Report, is meaningless: 'mental disorder' means 'any ... disorder of mind ... which results in a ... disturbance of mental functioning.' In short, 'mental disorder' means any mental disorder which results in a mental disorder.

24 David M Walker, *The Oxford Companion to Law* (Clarendon Press, Oxford, 1980), p.1093.

25 *Ibid.*

26 Justinian, *Inst.*, 1, 1.

27 Dewey, J, *Human Nature and Conduct* (Allen & Unwin, 1922).

The general purpose of any definition of a class is to state its boundary but here no one is excluded. The definition is not a definition at all.

The constitutional purpose of defining ‘mental disorder,’ and dividing disorders into different classes, is to define, as far as practicable, the group of citizens to whom the statute applies, and the circumstances in which resort may be made to compulsory powers. By the use of such mechanisms Parliament has usually sought to ensure that the liberty of individuals is not unnecessarily, or unjustifiably, infringed.

The comprehensive nature of the definition is significant because the four statutory forms of mental disorder are to be abolished. If an individual comes within this ‘definition’ of mental disorder – and, as drafted, no one is outside it – they may be detained or supervised by other individuals, provided they meet the loose criteria for compulsion in the Bill.

Section 1(3) of the present Act is not reproduced. This provides that no one may be dealt with as mentally disordered by reason solely of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. The statutory bar on using mental health laws to detain or compel people who depend on drugs or alcohol, or who sexually offend against children, but whose conduct is not otherwise abnormal or harmful, is therefore abolished.

By removing existing exclusions and limitations, the new scheme renders an extensive new population of people liable to compulsory treatment: people who depend on alcohol or drugs, where their dependence is the only justification for a finding that they are mentally disordered; people whose sexual behaviour is considered to be deviant, where their behaviour is the only justification for a finding that they are mentally disordered; people with a ‘disordered personality’ or a learning disability, even though their conditions are untreatable, and their behaviour is not abnormally aggressive or seriously irresponsible; non-compliant out-patients; conditionally discharged restricted patients; and those now subject to guardianship or after-care under supervision.

Alcohol and drug dependency services will be drawn into implementing mental health laws, and the patient population will change if psychiatric services are used to contain people who exhibit socially deviant behaviour. The public’s fear of the mentally disordered will then increase.²⁸

Persons who may only be treated compulsorily

The Bill goes further, and provides that some people with a mental disorder may *only* be treated under a compulsory order. Urgent treatment aside, in two situations an incapacitated patient may not be treated by their clinical supervisor unless the treatment is authorised under Part 2.

The first situation is where an incapacitated person would resist the proposed treatment. Here, it is to be assumed that a person who has indicated that s/he does not want to receive treatment, or a particular treatment, would resist it. Thus, we arrive at the rather Einstein-looking formula, ‘incapacity + resistance = compulsion.’

The second situation is where there is a substantial risk that an incapacitated patient will commit suicide or cause serious harm to others.

It seems to be assumed that an incapacitated person who resists treatment necessarily meets the statutory conditions for compulsory treatment. Otherwise, the patient cannot be treated by specialist mental health services.

²⁸ Rabkin, JG, ‘Criminal Behaviour of Discharged Mental Patients: A Critical Appraisal of the Research,’ *Psychological Bulletin* (1989, 86, 1–27).

These requirements must be read with the new incapacity scheme set out in Part 5. The effect is that incapacitated patients who resist treatment, or are at substantial risk, may only be treated by their clinical supervisor under Part 2, whilst other incapacitated people may be treated under Part 5, without being 'sectioned', provided they qualify for its safeguards. Broadly speaking, they qualify for this less formal scheme if they are in-patients, and their incapacity and need for in-patient treatment are likely to last more than 28 days.

Because people 'who are not capable of consenting to treatment' must sometimes be 'sectioned' or not treated, it is crucially important to know who these people are. However, the Bill does not include a definition, and is of no assistance.

It might be assumed that the provisions mainly affect people who cannot consent to treatment because they have a learning disability or suffer from a form of dementia. In other words, the test is a cognitive test based on the individual's capacity to understand the nature, purpose and likely effects of the proposed treatment, and also perhaps the alternatives and likely consequences of no treatment.

However, the Richardson Report and the Lord Chancellor's paper on incapacity, *Who Decides?*, adopted the Law Commission's recommendation that an individual who is able to understand and retain information relevant to a treatment decision is still incapacitated if s/he is unable to make a decision based on that information.²⁹

The Law Commission gave an example of what it meant by this, which the Lord Chancellor's paper refers to:

'Some people may be unable to exert their will ... because of delusions or compulsions or [some] other reason connected with their disability. The schizophrenic who cannot believe what his doctors or financial advisors tell him is one example; the manic depressive whose impulses override his understanding is another ... The Law Commission thus recommended that a person should be regarded as unable to make a decision by reason of mental disability if the disability is such that, at the time when the decision needs to be made, the person is:

- unable to understand or retain the information relevant to the decision or
- unable to make a decision based on that information.'³⁰

Many in-patients with diagnoses of chronic schizophrenia or a mood disorder come within this class, and some out-patients. If a 'cognitive + conative' approach of this kind is adopted by Parliament or the courts then many people who have a severe mental illness may only be given treatment on a compulsory basis.

This approach to capacity is grounded in Kant's notion of the autonomous individual, and in his distinction between autonomy and heteronomy of the will. The heteronomous person derives principles of action from outside her or himself, for example by considering the objects or consequences of their choices, or by acting in accordance with the commands of the state or society. The autonomous individual derives principles of action from within, what they will be in accordance with reason. Those incapable of acting in accordance with reason are incapable of autonomy. They are not part of the Enlightenment.

29 'Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults', Lord Chancellor's

Department, London, December 1997, pp.12-13.

30 *Ibid.*, p.13. See Law Com 231, para. 3.21.

When applied to the making of decisions by, or concerning, people who have a mental disorder, this ‘people are unable to exert their will’ approach results in a perverted concept of capacity. Rather than honestly say, ‘I know you don’t will this but I sincerely believe that it is in your best interests’, it involves the professional saying, ‘You may think you know what you wish but you lack reason and you are unable to exert your will. I actually know what you will, what you wish, better than you. The rational you wishes me to do this, to compel you to have this treatment that you appear to resent.’

It is an approach that brings to mind the warning of Sir Isaiah Berlin:

‘Even though men suffer ... in the process, they are lifted by it to a height to which they could never have risen without my coercive – but creative – violation of their lives. This is the argument used by every dictator, inquisitor, and bully who seeks some moral, and even aesthetic, justification for his conduct. I must do for men (or with them) what they cannot do for themselves, and I cannot ask their permission or consent, because they are in no condition to know what is best for them.’³¹

This is, Berlin suggests, a form of thinking to which the scientist may be especially prone, and he reminds us that Auguste Comte asked, ‘If we do not allow free thinking in chemistry or biology, why should we allow it in morals or politics?’ For if, as Comte believed, scientific method will in due course reveal all truths then what case is there for freedom of opinion or action, at least as an end in itself, and why should any conduct be tolerated that is not authorized by appropriate experts?³²

Such a dehumanising approach is totalitarian in nature, and an awareness of the suffering it has caused, and causes – leading to its emphatic rejection – ought to be the great lesson of the twentieth century.

What each individual wishes, whether ill or not at the time, is at that time their will. They have expressed their preference and, in doing so, the decision they would make if left free to decide. It may be that their choice is founded upon a belief that facts exist which do not exist, or is profoundly affected by an abnormal mood, but what they wish is, nevertheless, still truly what they wish, and a true expression of their mind and the world within which they move.

What each person wills for herself must therefore never be denied or reinvented by those who do not will it for them. The human will is the essence of human dignity, and one must treat people in such a position as capable human beings who refuse their consent. If their wishes are overridden, the justification for compulsion must be the risks associated with their decision, not that they are incapable of making a decision.

It may be contended that this is simply another kind of incapacity, namely incapacity by reason of mental disorder to understand, appreciate or control the significant risks associated with the individual’s decision. Hence, the distinction is academic. There is, however, a difference. Whilst it is always necessary to make a decision for a person who is incapable of making a decision for themselves, the approach advocated here is that most people with a severe mental illness are capable of making their own decision. They must therefore be allowed to decide for themselves unless it can be demonstrated that their decision gives rise to significant risks. To this extent they retain their autonomy.

31 Berlin, *Sir I, supra*.

32 Berlin, *Sir I, supra*, p.151.

It is a risk approach, and one which gives rise to a moral duty on the part of others to provide safe care once significant risks are established. This care must accord with the principle of beneficence, which asserts an obligation to help others further *their own* important and legitimate interests.

Proceeding in this way gives proper recognition to the importance of individual liberty and autonomy in English society. It recognises the sanctity of the individual – the fact that no person is a means to another’s end – and the fact that, though much is taken, much remains.

Whether the human personality is a proper subject for medicine

The Home Office and the Department of Health have for some time now been considering the introduction of new laws aimed at protecting the public from individuals who have a ‘dangerous severe personality disorder’.

In July 1999, the two departments published a consultation document, setting out proposals intended to ensure ‘that DSPD people are kept in detention for as long as they pose a high risk. The approach the Government has developed ... involves the idea of detention based on the serious risk such people present to the public.’³³

The Government was therefore advocating that risk alone, as well as mental disorder and criminal punishment, can justify detention. As a result, consideration was given to detaining such people in ‘third units’, in essence adult secure accommodation of the kind presently provided for some behaviourally-disturbed children.

This is a quarantine argument; one which holds that, subject to problems of identification, the civil detention of dangerous people is justified even if they have not committed any violent offences. The contrary argument is that the civil detention of dangerous non-offenders is never warranted, because it is a fundamental principle that citizens who obey our laws have a right to be at liberty. To imprison a person who has not yet committed the offence one fears is the criminal justice system of Alice’s Wonderland: “No, no!” said the Queen. “Sentence first – verdict afterwards.”

The ‘third-unit’ option seems to have been abandoned, probably because it was thought that indefinitely detaining non-offenders in civilian accommodation risks infringing the European Convention on Human Rights. Article 5(1) permits the detention of convicted persons and those of unsound mind in appropriate facilities (prisons and hospitals, respectively), but does not in clear terms permit the detention of citizens who have not offended merely because there is a risk they will do so in future. Detention in secure non-hospital accommodation rather rules out pleading mental disorder, and a need for treatment, as the justification, and nor can punishment or lawful sentence be pleaded, because the individuals are not serving a term of imprisonment.

Probably for these reasons, therefore, the Government seems to have retreated, at least for the present, to the justification that such people are mentally disordered: they require medical treatment in hospital or medical treatment under supervision in the community.

It is, no doubt, with the anti-social in mind that the criteria for compulsion, and various key statutory terms – such as mental disorder, medical treatment, hospital and clinical supervisor – are defined as they are. Indeed, the proposals for the compulsion of civilians seem designed to deal with people who habitually threaten, harm or alarm others, whatever the cause. It is in effect a ‘well

³³ Home Office/Department of Health, *Managing Dangerous People with Severe Personality Disorder, Proposals for Policy Development, July 1999.*

dodgy' Act, designed to sweep from the streets, or to supervise and control, anyone whose conduct causes the public significant concern, but whose behaviour – in the absence of actual evidence or proof of serious offending – does not allow the police or the courts to place them in custody.

Much of the recent debate has centred on whether or not the NHS and other agencies are resourced to provide such an extensive service. However, this assumes that such people should be dealt with on the basis that their conduct is evidence of a medical condition that requires medical intervention. The arguments for not permitting this are compelling.

Kurt Schneider defined personality as, 'the unique quality of the individual, his feelings and personal goals; the sum of his traits, habits and experiences and the whole system of relatively permanent tendencies, physical and mental, which are distinctive of a given individual.'³⁴ In short, personality is what makes one individual different from another. It is who I am.

This observation immediately gives rise to two important questions: Are people said to have disordered personalities injured, ill or diseased? And, is the human personality a proper subject for medicine?

The evidence suggests that present medical interventions have, like liberal prison regimes, the reformation of the individual as their aim. This is unacceptable because the proper function of medical science and practice is to treat individual suffering attributable to disease or injury, not to alleviate the suffering of society; and, in the field of mental health, to treat those diseases or injuries which interfere with the development or expression of an individual's personality, not to reform her or his personality by reference to some social or political norm.

The mental state and behaviour of an individual said to have a personality disorder is abnormal, in the sense that it deviates from the social norm, but normal in relation to their own individual norm: that is, it is consistent with what is known about their development and functioning over time. Here then, the individual is only abnormal by reference to a social norm, and such a deviation cannot be said to constitute a disease because mere social deviation is not evidence of biological disorder. This requires evidence of injury or deviation from the individual norm. If there is no evidence of either then one is simply confusing individuality with ill-health: treating as biologically abnormal an undiseased, uninjured, creature living its natural life, so that medicines are pesticides.

The motivation for this social control is transparent. People want to live in a cultivated society, and they cultivate society in much the same way they cultivate nature in their gardens. This involves eradicating disease in the garden, but also weeding it and controlling pests, that is containing or destroying organisms which are doing nothing more than expressing their natures. There is nothing unique in this, for the same power is claimed over animals and unborn life, and most other things that interfere with personal survival or fulfilment. But it is why CS Lewis wrote that, 'To be cured against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles and domestic animals. But to be punished ... because we have deserved it ... is to be treated as a human person made in God's image.'³⁵

³⁴ Schneider, K, *Clinical Psychopathology* (5th ed., trans. Hamilton MW, Grune & Stratton, 1958).

³⁵ Lewis, CS, *The Humanitarian Theory of Punishment*, *University of Melbourne Law Review* (1953) 228.

Although many people would not today understand the issue in religious terms, the argument retains its inner strength: there is more human dignity in punishment than in medicalizing anti-social or violent behaviour.

This is an uncomfortable message for an age that is uncomfortable with the notion of punishment, the more so when the debate involves issues of responsibility and free will, and the extent to which some people's personalities do not enable them to refrain from anti-social behaviour. However, our conscious thinking and deciding are embodied in the workings of our brains, and consequently *our* behaviour is determined by *our* thinking and choosing. While determinism provides an explanation for our choices and actions, it is humans beings, not deterministic rules, that cause events. The fact that an individual's personality, as determined by their genes and previous experiences, dictates the choice s/he makes does not mean that s/he has not chosen between alternatives. Furthermore, whilst not everyone has the same capacity to eschew the wrong, this does not preclude us from judging their actions, because whether an action is harmful is not affected by its antecedents. In short, our conscious decisions and actions are matters of personal choice: each chooses what suits their personality, not that of others, and must be accountable to others for their choice. The counterpart of freedom and autonomy is accountability for acts freely and autonomously done.

The view presented here therefore is that those persons presently categorized as psychopaths are not mentally disordered, and they should be excluded from mental health legislation. We are simply medicalizing 'deviant behaviour'.³⁶ Believing this, there is no inhumanity in holding that they should be imprisoned if their offence and forensic history merits it. If we are satisfied that our prison system is the best that can be devised for the prevention of crime, and the reformation of the criminal, then we may rest satisfied that it is the best treatment for the sort of insanity from which criminals suffer. If, on the other hand, we are not satisfied that prisons are reformatory then why this is so needs to be the principal focus of our attention.³⁷

What cannot be justified are mental health or social protection laws that permit the preventive detention of law-abiding citizens who are free of injury or disease. It would be unjust to detain them for crimes they have not committed and are actuarially unlikely to commit. It would be immoral, because the old maxim that 'you shall not do evil that good may come' is applicable in law as well as in morals. It would be inutile, because any impact on the rates at which serious offences are committed is likely to be marginal. There is little gain in detaining a handful of notionally dangerous civilians each year when guilt in criminal proceedings must be proved beyond all reasonable doubt, because every year we release without penalty thousands of rapists and other violent offenders. Lastly, it would be unwise. For, when the public perceives that they are no safer despite such a reform, rather than realise and learn from their folly, they will demand that basic freedoms be further curtailed and the penalties made more severe.

36 In Conrad's opinion, the conditions for the medicalization of deviance are that: (1) a behaviour or set of behaviours must be defined as deviant and as a problem in need of remedy by some segment of society; (2) previous or traditional forms of social control must be seen as inefficient or unacceptable, e.g. corporal punishment or penal servitude; (3) some medical form of social control must be available; (4) ambiguous organic data as to the source of the problem must exist; and (5)

the medical profession must be willing to accept the deviant behaviour as within their jurisdiction. Conrad, P, *On the Medicalization of Deviance and Social Control*, in *Critical Psychiatry: The Politics of Mental Health* (ed. D. Ingleby, Penguin Books, 1981), pp. 111-118.

37 Maudsley, H, *Responsibility in Mental Disease*, 4th ed, 1885, Kegan Paul, Trench & Co., London, p.27.

Such demands misunderstand the functions of the law and its natural limits. It is not within the power of the law, given the venality of the times, to cleanse the Augean stable. As Montesquieu observed, in 'moderate governments, the love of one's country, shame, and the fear of blame are restraining motives, capable of preventing a multitude of crimes. Here, the greatest punishment of a bad action is conviction ... In those states a good legislator is ... more attentive to inspire good morals than to inflict penalties.'³⁸

Only those who know the cost but not the value of our freedoms would embark upon such a journey. Nothing which has great value is without cost, and the value of anything is what one is prepared to sacrifice for it. The value attached to trial by one's peers is the financial cost of the jury system; the value of justice is demonstrated by a willingness to see the guilty go free rather than risk convicting the innocent; and the value of liberty is demonstrated by stoically bearing the many evils which liberty permits. If the defence of these freedoms was worth the sacrifice of millions during two wars then, unless society has become wholly degraded, it must withstand the death of a few during peacetime. Such a scheme has no utility which can justify its innate immorality and the infliction of such great injustice; and it would be highly imprudent to interfere with public liberties in the name of public safety when the necessity of such a scheme has not been firmly established.³⁹

The relevant conditions for compulsion

The new statutory criteria for compulsion are called 'the relevant conditions', of which there are four. The same criteria are used for compulsory assessment and treatment, and the short-term detention of informal in-patients requires that these conditions appear to be met.

The first two conditions for compulsion

The first two conditions are duplicitous, and read more properly as a single condition; one which requires that 'the patient is suffering from [a] mental disorder ... of such a nature or degree as to warrant the provision of medical treatment ...'

This condition is easily satisfied because the nature or degree of the individual's disorder need no longer be of a severity that warrants detention, compulsion or treatment. If s/he has a mental disorder, all that is required is that it is of a kind that warrants providing medical treatment. The Bill provides that 'medical treatment' means,

'treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose 'treatment' includes

- (a) nursing,
- (b) care,
- (c) habilitation (including education, and training in work, social and independent living skills),
and
- (d) rehabilitation (read in accordance with paragraph (c)).'

38 Montesquieu, *Baron de, The Spirit of the Laws* (Cambridge University Press, 1989).

39 This passage is taken from Eldergill, A, *Psychopathy, the Law and Individual Rights*, Princeton University

Law Journal, Volume III, Issue 2, Spring 1999. Reproduced in Eldergill, A, *A Greater Evil*, *The Guardian*, 20 July 1999.

This definition differs from that in the 1983 Act in two respects.

Firstly, treatments of the kind described constitute medical treatment if they are provided under the supervision of an approved clinician. Who is an approved clinician is left to regulations. However, according to the explanatory notes, it is expected that the term will refer to medical practitioners and psychologists of consultant status. Under the current statute, the listed interventions only count as medical treatments if they are provided under medical supervision.

When regulations are made, the Minister may seek to preserve the breadth of the existing definition, by describing all medical practitioners as approved clinicians. Alternatively, he may adhere to the intention expressed in the explanatory notes, by limiting the term to treatments provided under the supervision of a consultant.

If the Minister includes all doctors within the term, the first condition for compulsion is met by people who require treatment for anxiety or depression from their family doctor.

If the Minister restricts the term to consultants, the first condition is that the person has a mental disorder serious enough to warrant treatment by specialist mental health services. At its most stringent, therefore, people who experience depression or acute anxiety meet the condition if they require an out-patient appointment or a referral to mental health services.

It can be seen that who meets the test for detention in the primary legislation (the Parliamentary Act) depends on the secondary legislation made by the Minister (the regulations). This is unsatisfactory, and may be unlawful. For example, because it enables the conditions for compulsion to be periodically varied by Ministers without going back to Parliament.

The second difference relates to the words in parentheses, which are new: 'including education, and training in work, social and independent living skills'. The use of the word 'including' indicates that the list is not exhaustive, and that the interventions referred to are examples. Other supervised measures appropriate to a person's social habilitation or rehabilitation can constitute medical treatment.

The effect of the revisions is that social interventions which most people would not think of as forms of medical treatment are medical treatments for legal purposes. For example, work training or training in social skills under the supervision of a psychologist is medical treatment, even though no medical practitioner is involved in providing it.

Thus, a person who takes street drugs, and whose behaviour is anti-social and alarming, may be said to have a mental disorder that warrants providing them with medical treatment, in the form of work training, and training in social skills, under psychological supervision. This is social compulsion dressed up as medical compulsion.

The second condition for compulsion

When a person is described as suffering from a psychopathic disorder or mental impairment, the current Act makes it a precondition of long-term detention for treatment that treatment will alleviate their condition or prevent its deterioration.

The equivalent condition of compulsion in the draft Bill is that 'appropriate medical treatment is available in the patient's case'.

'Appropriate' is a very general word, and what is appropriate to a situation depends on the situation and all of the circumstances. The Bill deliberately does not say that treatment is only

appropriate if it alleviates the patient's condition or prevents its deterioration, and this is not a treatability test. By analogy, where a person has an incurable cancer, treatment which alleviates pain may be appropriate, even though it has no curative value.

The previous example helps to make this clear. This involved training in social skills under psychological supervision. These available 'medical treatments' can be described as an appropriate way of treating the individual's anti-social behaviour, in which case it is not formally necessary to determine that the interventions are likely to alleviate or stabilise any underlying disorder.

Likewise, where an individual's violent behaviour places other people at significant risk, supervised social interventions of the kind imposed on restricted patients may be an appropriate way of managing the risks. Indeed, the very fact that the individual's violent propensities are untreatable may make it particularly appropriate to ensure that s/he is subject to habilitation under supervision.

Again, therefore, the wording is designed to permit the compulsion under mental health legislation of people whose behaviour is dangerous, threatening or alarming.

The final condition for compulsion

The final condition consists of alternative criteria, and which of them applies depends on whether other people are at substantial risk of serious harm.

In cases where there is a substantial risk that the patient will cause serious harm to others, the final condition is that 'it is necessary for the protection of those persons that medical treatment be provided to him'. It is not necessary to demonstrate that the treatment cannot be provided without compulsion.

Where no substantial risk of serious harm to others exists, the final condition is that it is necessary for the patient's health or safety, or the protection of others, that 'medical treatment' is provided, and this treatment cannot be provided unless the patient is subject to the provisions of the new Act.

This is a very lax condition, although how lax depends on who the Minister chooses to describe as an approved clinician, which will determine how medical treatment is defined. If treatment of any description suffices, a person meets all four conditions for compulsion if s/he requires but refuses treatment for mental disorder from a general practitioner. If only medical treatment provided under the supervision of a consultant suffices, a person meets the conditions if s/he refuses appropriate treatment from mental health or alcohol and drug dependency services, including measures such as work training and training in social skills.

Breadth of the conditions

It is important to emphasize the comprehensive nature of the conditions for compulsion:

- The definition of mental disorder in the Bill is meaningless, and no one is excluded from it;
- People may be dealt with as mentally disordered by reason solely of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs;
- Who meets the test for compulsory treatment in the Parliamentary Act depends on the regulations made by the Minister;

- Social interventions not provided under medical supervision, such as work training and training in social skills, are defined as medical treatments;
- A person satisfies the conditions for compulsion if s/he refuses appropriate treatment from mental health or alcohol and drug dependency services, including social measures of the kind just described.

Powers of detention and compulsion

There is not space here to describe every aspect of the new civil powers. Given the Government's intention to introduce the Bill during the current Parliamentary session, the overriding need is to ensure a full and proper debate of its terms, by exposing the most significant ways in which existing powers are increased.

Short-term powers

The 1983 Act contains a number of short-term powers which enable a person to be detained for up to 72 hours. The Bill retains these short-term powers but with some modifications.

Under the Bill, a doctor may authorize the detention for up to 72 hours of an informal in-patient who appears to require compulsory assessment *in the community*. An 'authorised person' may likewise detain such a person for up to six hours. Who is authorized to use this power will be determined by the Minister after Parliament has enacted the legislation. It may be that the power will remain reserved to suitably qualified nurses. However, the Bill does not require this. As a matter of law, the Minister could empower other people, either now or at a later date. For example, approved mental health professionals or the person registered in respect of an independent hospital. The new section 135(1) power adopts the existing statutory grounds. Because the criteria remain unchanged so they remain defective in the same respects. The power is mostly used, and the criteria stretched, in order to enable professionals to remove and assess a person who refuses entry to their home. However, reason to suspect that an individual meets the criteria for admission and detention under the Act is not a ground for issuing the warrant. Whether a person can care for themselves, or is being ill-treated or neglected, is not the same issue as whether the only way in which a statutory assessment can be undertaken is by forced entry and removal.

The most controversial short-term provision is the urgent removal power in Clause 143. This authorises a constable acting on information from an approved mental health professional to force entry to private premises without a warrant. The constable must have reasonable grounds for believing two things: that an occupant believed to suffer from mental disorder is in urgent need of care or control in order to prevent serious harm to themselves or others; and that the urgency of the situation makes their removal under a warrant impracticable.

Necessarily, this power, as with all others, extends to people who are alcohol or drug dependant, or 'sexually deviant'.

Although the clause initially seems to be an emergency section 135(1) power, it is in fact much wider. It may be used if a patient is absent from hospital or their place of residence, or to effect the speedy recall to hospital of a restricted patient. It could also be used when a non-resident patient does not attend hospital for medication, if a constable is advised that the person is thereby in urgent need of care or control. If the patient is removed to hospital (which is a place of safety),

and their non-residency status is revoked within six hours, there will be no need to apply retrospectively to a court for a warrant.

The new 'section 4' emergency admission procedure may be invoked where a registered doctor and an approved mental health professional determine that the relevant conditions for compulsion are met. It provides that the patient shall be admitted to hospital if the doctor – rather than both professionals, as at present – determines that their assessment is an urgent necessity, and that awaiting a second medical examination would involve undesirable delay.

This is unsatisfactory. The fact that the relevant conditions for compulsion exist signifies only that compulsion is warranted, either as a resident or as a non-resident patient. Although the approved professional's opinion is that the conditions are met, it may also be their opinion that admission and detention are inappropriate. If so, the individual's detention is then founded on one medical opinion with which the approved professional disagrees, and that possibly from a general practitioner, or a doctor with no previous acquaintance of the patient. Furthermore, even if the approved professional believes that detention is appropriate, s/he may not agree that detention or assessment is urgently necessary, or that it is undesirable to await the second medical examination, for example from a consultant psychiatrist.

Preliminary examinations

Formal assessments of the need to invoke compulsory powers are currently undertaken by an approved social worker and two doctors. These assessments are referred to as 'preliminary examinations' in the Bill, and they will be conducted by two doctors and 'an approved mental health professional'.

The present intention is that this latter figure may be a trained and accredited social worker or health service professional. The involvement of a social worker will therefore no longer be essential, and the existing separation of powers, which requires that the applicant is independent of the doctors recommending compulsion, is abolished. In future, assessments may be conducted by three health service colleagues, all employees of the same detaining body.

Dealing with requests for a preliminary examination will also be an NHS function, and this is a further indication of the Government's desire to transfer mental health social workers to NHS care trusts.

The terminology emphasises that the statutory purpose of preliminary examinations is simply to determine whether a person meets the Government's conditions for compulsory medical treatment, not to assess their overall situation, including their social circumstances. More particularly, those examining the patient must determine three things:

- 1 Are the relevant conditions for compulsion met?
- 2 If so, is detention in a hospital appropriate?
- 3 If it is not, what requirements should be imposed on a non-resident patient?

Liability to compulsion is automatic if the three examiners agree that the relevant conditions for compulsion are met. None of them is given any discretion to consider matters not included in the Government's test for compulsion, such as the likely effect on the citizen's employment prospects and family life, or on the therapeutic relationship. Not only is the patient being compelled, the professionals are being compelled to use compulsion.

It can be seen that the approved mental health professional's role differs from that of an approved social worker. The latter is not required to determine whether an individual satisfies the medical grounds for compulsion. If two doctors certify that the medical conditions are met, their duty is to consider these recommendations together with any 'other relevant circumstances', and then to decide whether compulsion is necessary and proper, and an application ought to be made. No duty to apply arises if their professional opinion is that compulsion ought not to be used.

This professional discretion is entirely lacking from the new scheme. The approved professional's role is the same as that of the doctors: simply to examine the patient, and to determine and record whether or not the relevant conditions are met, compulsion being automatic if they are. Examiners must also now record determinations that a person does not meet the relevant conditions, together with the reasons for that finding. At present, it is only necessary to complete prescribed statutory forms when compulsory powers are either recommended or used.

A person who meets the conditions for compulsion may be detained in hospital if a nurse or social worker and one doctor consider it 'appropriate', notwithstanding that the other doctor, who may have special expertise in psychiatry, considers it to be inappropriate. Thus, the individual's detention is authorised even though the medical opinion is evenly split, with the expert opinion being against detention.

The test for detention is as subjective as such tests can be. Not 'is the individual's mental disorder sufficiently severe to warrant deprivation of liberty?', or 'is depriving this individual of their liberty justified by the risk of harm?', but 'does a professional person think it is appropriate to detain them while an assessment is carried out?'

This is not a proper constitutional basis on which to deprive a citizen of their liberty. The test ought not to be whether detention is appropriate but whether it is necessary – necessary because of the severity of the disorder and the consequential significant risk to the person's own health or safety or that of others.

It is unlikely that these provisions satisfy Article 5 of the European Convention on Human Rights. According to *Winterwerp*, detention on the grounds of unsoundness of mind must be founded on objective medical evidence, not divided medical evidence based on a statutory test devoid of any proper limitations on the power.⁴⁰

When detention is not appropriate, the requirements that may be imposed on a non-resident patient include that s/he does not engage in specified conduct. Presumably, this condition is directed in particular at those who depend on alcohol or drugs, are 'sexually deviant', or otherwise engage in anti-social behaviour. The fact that the requirements which may be imposed 'include' those specified in the Bill leaves open, and unclear, what other requirements may lawfully be imposed.

According to the Bill, a patient is subject to those requirements specified by all or the majority of the examiners. However, the Bill only requires an examiner to specify requirements if s/he determines that detention is not appropriate. Where the approved professional is the only examiner to determine that detention is inappropriate, the patient will be a non-resident patient but the requirements s/he specifies have not been specified by all or the majority of the examiners.

40 *Winterwerp v. The Netherlands* (1979) 2 EHRR 387.

Consent and treatment issues

The Bill provides that a Part 2 patient's consent is not required for any medication specified in their care plan provided that it is administered in a hospital.

By implication, a patient who has capacity to consent to treatment may consent to it being given at home. Conversely, whenever an incapacitated person is given medicine at home that medication is, by definition, given without their consent.

The drafting raises four key questions: What constitutes capacity? What constitutes consent? What is a hospital? What rights do patients have to a binding, independent, second-opinion?

The first question has already been considered, and it was noted that many mentally ill patients may be incapacitated according to one common interpretation.

The fact that home treatment teams have no statutory authority to treat incapacitated patients at home may tempt professionals to invoke the common law in an attempt to plug this gap. When challenged, it will be argued that it is a common-law duty to treat an incapacitated patient whenever treatment is necessary to preserve their life, health or well-being, and treatment is in their best interests.⁴¹ Attempting to justify under common law the administration of medicines authorised under statute is, however, artificial.

An alternative position may be to argue that any oral medication authorised under the statute is being self-administered, even though it has been dispensed by a home treatment nurse *in situ*, and the nurse is standing over the patient. The Government needs to clarify its intention in precise, unambiguous, terms.

On the answer to the second question – what constitutes consent? – hangs the practical consequence of how many patients with capacity may end up being given medication at home.

In practice, consultants or tribunals will no doubt impose a requirement or condition that the patient takes prescribed medication, in addition to a requirement that s/he attends hospital as required. It will be pointed out that there will be no need to require the patient to attend hospital, or to convey them there, if an injection can be given at home. The patient has this option.

It may be objected that any medicines given in such circumstances are not given with consent, for if the person truly consented to their administration a compulsory treatment order would be unnecessary. Against this, the procedures for patients liable to compulsory treatment under the 1983 Act provide for medicines being given with or without consent. The current statutory position is therefore that a patient may give a valid consent to medication notwithstanding that a refusal may result in administration by force.

If this is the case, home treatment and assertive outreach teams will be giving medication within the home to people who would refuse it if free to decide. It is then only a matter of time before a patient dies at home following the administration of medication, with such incidents eventually leading to public concern for patients, in place of concern for their own safety. And so, in the absence of balanced legislation, the laws shift periodically from one pole to the other, ending with the future re-establishment of a Mental Health Commission to monitor the use of these powers.

The answer to the third question – what is a hospital? – will determine the range of places within which medication may be given by force, and to which patients may be conveyed for that purpose.

⁴¹ *Re F* [1990] 2 AC 1.

When the Government says that medication may only be administered without consent in a hospital, this assurance must be understood in the context of how it has chosen to define a hospital. Medication may be given without consent in any NHS clinic or out-patient department, and in small 'mental nursing homes' that are willing to provide the service. Furthermore, non-resident patients may be required to reside at these small homes, in which case they may be treated on the premises without their consent.

The definition of a hospital also leaves open the possibility of 'third units' being developed 'through the back door'. Any private establishment that provides treatment for people who are liable to detention under the Mental Health Act is a hospital. Similarly, a private establishment is a hospital if its main purpose is to provide medical treatment for mental disorder. Because people with personality disorders, substance abuse problems or sexual deviancy now have a mental disorder, and social interventions under psychological supervision constitute medical treatment, an establishment which offers such a service is a 'hospital'. Provided it is suitably registered, it may where 'appropriate' detain people who meet the conditions for compulsion. Establishments which do not register to receive detained patients may still accept non-resident patients, who can be required to reside there and be given medication on the premises without consent. These people are being contained, not detained.

Defining anti-social people as mentally disordered, supervised social interventions as medical treatments, and establishments which detain such people or provide social services as hospitals, therefore enables adult secure accommodation to be dressed up for Convention purposes as hospital treatment for persons of unsound mind.

The final question concerns the right to a second-opinion. Fairness and commonsense dictate that decisions to prescribe treatments that can be administered by force should be subject to safeguards. However, the new Mental Health Tribunal will not perform the functions performed by Mental Health Act Commission second-opinion doctors. Whenever the tribunal decides that a person meets the relevant conditions for compulsion, its order must state either that the care plan submitted to it is approved for the medical treatment of the patient or that it is approved with such modifications as are agreed with the clinical supervisor. In other words, the care plan must be approved if the patient meets the criteria for compulsion and the patient's consultant is unwilling to modify it. It may only be modified with her or his consent. The practical effect is that patients subject to compulsion will no longer have a right to an independent, binding, second-opinion concerning the necessity or appropriateness of the medication they are forced to take.

Likewise, people subject to compulsion will no longer have a right to an independent adjudication of the need to administer ECT. Under the Bill, the clinical supervisor must apply to the tribunal for it to authorize ECT, and the attached care plan must specify that ECT is to be administered. However, provided that the patient meets the conditions for compulsion, here too the tribunal must approve this plan unless the patient's consultant is willing to modify it. All that Clause 38(4) adds is that the tribunal's 'order must state that that treatment [ECT] is authorised'. Tribunals must therefore authorize treatments which the patient's consultant insists upon.

Enforcement provisions

The Bill provides that the consultant of a non-resident patient may sign a pink statutory form, upon the completion of which the patient is liable to detention. Although a warrant is required if the patient refuses entry to their home, for the purpose of removing them to hospital, the balance of power and personal convenience is shifted. If the patient refuses to comply with their consultant's requirements, and a warrant is then obtained, s/he faces detention during the remainder of the assessment or treatment period, which may be weeks or months. Non-compliance leads not to the particular requirement being enforced on a single occasion, but to termination of the individual's right to be at home and to move about in their community.

The consultant therefore has a considerable stick to wield if the patient fails to comply with conditions or requirements, even allowing for the fact that hospital beds are in short supply. The patient will be told that admission will be the result of any failure to take medication at home, to attend hospital for injections, or to comply with requirements. The patient will know that their detention lies wholly in the consultant's hands, because it does not depend on a fresh preliminary examination, or on obtaining the consent of an approved mental health professional to admission.

Although the Bill's usual safeguards require that an appropriate mental health professional agrees that detention is appropriate, here detention is founded on one medical opinion, an opinion which conflicts with, and overturns, the decision of three examiners or the tribunal as to its inappropriateness.

Mental Health Tribunals

The existing Mental Health Review Tribunals are to be abolished, and the functions of the new Mental Health Tribunal are significantly different. It is not only the body that reviews the need for compulsion; it is also the body that authorizes compulsion beyond the initial 28-day period.

The powers of the new tribunal are limited. In particular, it has no discretion to discharge a person who meets the relevant conditions for compulsion. Here too, practitioners are prohibited from taking into account matters not referred to in the Government's test. As a result, more patients will be subject to perennial compulsion, because some people with chronic illnesses never satisfy the statutory test for discharge. That is not to say that they ought not to be discharged once they are functioning at their optimum level, provided that neither they nor anyone else is at significant risk.

Under the Bill, hospitals will no longer have to prove that the legal grounds for compulsion are met. The drafting is very clever or too clever: 'A tribunal must discharge the patient if it determines that not all of the conditions for compulsion are met' is uncomfortably close to the old, unlawful, test: 'A tribunal must discharge the patient if it is satisfied that not all of the conditions for compulsion are met.'

Reliability is the cornerstone. The Convention test is whether it can be 'reliably shown' that the person suffers from a mental disorder sufficiently serious to warrant detention. It is, of course, always possible to make a decision one way or the other if legislation forces one to do so. However, if the evidence is finely balanced, has it been reliably shown that the conditions for compulsion exist? It may be that the Convention requires a burden of proof.

Whether a patient who meets the conditions for compulsion is released from detention is left entirely to the tribunal's discretion, there being no grounds which qualify when detention is justified.

Furthermore, when a person who has been detained for up to 28 days asks the tribunal to review the grounds for the detention, it can extend the period of compulsion by up to six months. Necessarily, many patients will be wary of challenging their detention, given the purpose and possible consequences of independent review. This wariness is likely to be reinforced by the fact that their perception of tribunals will change. Instead of being the independent body that can order their release, it will be seen as the authority that imposes long-term compulsion. It must still be doubtful that these provisions satisfy Article 5.

A notable feature of the new scheme is that people who have not committed an offence may be placed under restrictions on discharge, transfer and leave of the kind now imposed by the Crown Court on offenders who pose a risk of serious harm to the public. The effect is that some resident Part 2 patients will be subject to restrictions but with control being exercised by the tribunal rather than the Home Office. It is no doubt hoped that these provisions will in particular be used for 'sexual deviants' and persons said to have 'dangerous severe personality disorders'.

Safeguards

The White Paper stated that, 'removing an individual's liberty against their will is a very serious step ... so the White Paper outlines how safeguards will be improved.'⁴² It is, however, commonsense to look at what is done, and not to what is said, and to judge intentions by acts.

The detail is different, and many important safeguards against the poor or inappropriate use of compulsion are swept away. In addition to those already mentioned, the Bill takes away the powers of a patient's nearest relative; abolishes the statutory duty to provide after-care; provides that the guidance in the Code of Practice may be qualified; revokes the discharge powers of NHS bodies and local authorities; and makes no provision for a Mental Health Commission.

No nearest relative

A person's nearest relative has several important powers under the present Act, two of which protect patients against the inappropriate use of compulsory powers.

At the end of the assessment period, the patient's nearest relative may veto further compulsory treatment unless a judge rules that their objections are unreasonable. In addition, unless the patient is likely to be dangerous, a patient's nearest relative may discharge them from hospital and compulsory treatment. Provided that their objections to compulsion are not unreasonable, and no one is in danger, a patient's spouse, partner or child therefore has a right to insist on caring for them at home.

These powers recognise the importance of the family in people's lives, and the need to limit the circumstances in which the state may interfere with individual and family life. A balance is achieved between the state's claim to provide protective compulsory care and the right claimed by families to care for their loved ones, and to cope with and manage behaviour that mostly affects only them. As Mill once beautifully put it, to individuality should belong the part of life in which it is chiefly the individual that is interested; to society, the part which chiefly interests society.

The Bill abolishes the nearest relative as a legal entity, and with it the family's right to these protective powers. The proposals weaken, indeed largely illegitimize, the role of the family.

⁴² *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-1).*

A new 'nominated person' replaces the nearest relative. This person, who is usually chosen by the patient, has a right to be consulted about most decisions concerning treatment or compulsion. S/he must then say what the patient's ascertainable wishes and feelings are. However, a right to be consulted, and a duty to help express the patient's wishes, confers no power. The nominated person has but one power, which is to apply to the tribunal for the patient's discharge.

Patients and nominated persons have a right to help under the Bill's new advocacy provisions. 'Mental health advocates' must, where practicable, be independent of the hospital that is responsible for the patient's treatment. They must help patients and their nominated persons to obtain, and understand, information about the patient's treatment; why it is being provided and under what legal authority; what statutory requirements apply to the patient; and the patient's statutory rights. The White Paper indicates that they will be unqualified, and act as independent facilitators to handle patient and family concerns. Their role has as much to do with explaining the consultant's treatment, and why the patient must comply with it, as it does with protecting the person's legal rights.

Carers who provide regular and substantial care must also be consulted about some decisions. These rights are, by definition, carers' rights, and their advice may be that the patient should remain subject to detention or compulsion.

No duty to provide after-care

The Government indicated in the White Paper that patients would not be charged for services they must comply with, but the Bill makes no such provision. It removes the existing statutory duty on the NHS and local authorities to provide after-care to people who have been detained for treatment.

Qualified Code of Practice

The new Code of Practice must set out general principles to which a professional must have regard whenever coming to a decision under the Act. However, the code may now provide that one or more general principles shall not apply in circumstances in which its application would be 'inappropriate', or in relation to specified decisions or persons.

The code must also give further guidance concerning the discharge of statutory functions, but likewise it may provide that the guidance is not to apply to specified persons.

Powers of NHS bodies and local authorities

Hospital managers, Health Authorities, NHS trusts, and local authorities will all lose their powers to discharge individuals from compulsion. Only the patient's clinical supervisor or the tribunal may discharge a patient.

No Mental Health Commission

When vulnerable people are subject to detention in psychiatric facilities, the law has usually sought to protect them by requiring an independent legal body to visit them, in order to ensure that the powers are not being abused. The Mental Health Act Commission presently performs this essential function.

The history of the Commission is that it has experienced the same difficulties as other health service bodies: tight political control of what ought to be a process of independent scrutiny; fear that constructive, sensible, criticism which is evidence-based will lead to non-reappointment; a non-professional management board directing the activities of expert members; significant under-funding; low rates of pay; a failure to recruit or engage leading experts; casualisation of labour in order to increase output, resulting in diminished professional standing; failure to adhere to statutory remit; and bureaucratic processes devised for health service bodies, a class to which the Commission belongs in name only.

Although the Department of Health is mostly to blame for the Commission's well-known shortcomings, it is the Commission which is being abolished.

The future arrangements for monitoring the use of mental health powers are described in the consultation document that accompanied the Bill's publication. A specially established division within the Government's 'new health care inspectorate' will scrutinize the way in which powers are applied. This refers to the Government's intention to establish a new Commission for Healthcare Audit and Inspection (CHAI).

The new 'super-commission' will take over the work of the Commission for Health Improvement, the Audit Commission's work on value for money, and the National Care Standards Commission's remit to inspect private hospitals. It will be responsible for inspecting NHS hospitals, the Government's star rating system, the imposition of special measures for failing organisations, the licensing of private hospitals, the conduct of NHS value for money audits, the scrutiny of patient complaints, and the way in which Mental Health Act powers are used.

Ensuring that compulsory treatment powers are not abused thus forms a relatively small part of an extensive remit, the remainder of which is concerned with ensuring that trusts implement the Government's NHS Plan and modernisation agenda. Here, it may be observed that the attention of public bodies which monitor standards focuses on one of two things:

- Quality standards (setting, monitoring and enforcing quality standards; patient safety; implementing service reforms designed to improve quality).
- Legal standards (including the maintenance of ethical standards that may not be legally enforceable).

Almost all of the public bodies that the Department of Health has created, and for which it is responsible, exist in order to ensure or improve the quality of care. They have been created, not to ensure compliance with constitutional rights, but to drive forward the Government's NHS agenda. In 1999/2000, its 64 non-departmental and non-provider public bodies employed 14,780 staff and received £715m in public funding. The Mental Health Act Commission employed 32 of the 14,780 staff, and received just over £3m (or 0.4%) of this £715m.

The Government's justification for what amounts to a take-over of the MHAC by the Commission for Health Improvement is that it has 'been considering generally the number of external bodies that subject the NHS, and front line staff in particular, to scrutiny, and the way in which these functions are exercised'.

It is, of course, true that the creation of too many quality-assurance commissions and public bodies has disadvantages: too much top-down guidance, too many codes of practice, confusion on the ground about what to prioritise, a feeling amongst staff that they are drowning in paper, the impossibility of meeting all targets, leading to demoralisation, and so on.

It is, however, this very Government that has created these quangos, and which is responsible for the problem. Rather than abolish some quangos it has established to implement the NHS programme, the Government now proposes getting rid of the small, semi-independent, Mental Health Act Commission established in 1983.

This will do enormous harm, and no good. The fact that quangos are merged so that they exercise their functions as divisions of one super-quango does not reduce bureaucratic regulation. This requires reducing the range of functions performed. Furthermore, one can only successfully join institutions that perform similar functions. Merging the Mental Health Act Commission and CHI, simply because they both monitor the health service, is like merging Boots and Currys, simply because they both retail goods on the High Street. You still have two separate businesses: enforcing the Government's NHS agenda/protecting individuals' constitutional rights; selling toiletries/selling electrical equipment. Merging them does not change that, and the Government's proposals are little more than the ill-considered expression of an in-cliché about 'joined-up working'. Why should patients – that is members of the public – want their constitutional rights, their liberty and the use of force against them 'joined up' with the Government's NHS modernisation and 'quality assurance' agenda?

This is the most poisonous of all the proposals in the Bill. What will happen is what has always happened. As one small division within a super-Commission dedicated to monitoring compliance with the NHS programme, the constitutional imperative will be consumed by the larger political imperatives. When CHAI budgets are set, 'mental health legal money' will compete with Ministerial performance-targets, and be diverted to the inspection of acute care – in the same way that funds announced for mental health initiatives are now diverted by Health Authorities to reducing waiting list times, or whatever the current political agenda dictates.

A separate Commission is therefore essential, given the number and range of people who will be liable to compulsion; the fact that compulsion will now take place in the community; the position of incapacitated people; and the overall reduction in safeguards for those subject to compulsion.

The functions performed by this Commission should meet common international standards. These are the minimum standards agreed by nations as being the baseline for countries that wish to be considered civilised in this respect.

The observance of standards agreed by the United Nations – that is by all nations meeting in general assembly – requires that every mental health facility is inspected by a competent and independent authority prescribed by domestic law. Such inspections must be sufficiently frequent to ensure that the conditions, treatment and care of patients comply with international principles.⁴³

Observance of draft recommendations agreed by the Committee of Ministers will (unless amended) require the existence of an independent and adequately funded authority with responsibility for the implementation of mental health legislation. The functions of this authority should include setting and monitoring standards in relation to the implementation of the legislation; visiting and inspecting premises used to care for people suffering from mental disorder;

43 *Principles for the protection of persons with mental illness and the improvement of mental health care, Adopted by General Assembly resolution 46/119 of 17 December 1991; Declaration on the Rights of Mentally Retarded Persons, Proclaimed by General Assembly*

resolution 2856 (XXVI) of 20 December 1971; Declaration on the Rights of Disabled Persons, Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975.

to establish their suitability; meeting privately with patients subject to mental health legislation; having access to their medical and clinical files; receiving complaints and ensuring that they are dealt with appropriately; reviewing any restrictions on rights of communication; ensuring that relevant professional obligations and standards are met; ensuring that statistics on the use of the legislation are collected systematically; providing an annual report to the relevant Minister; advising her/him on the conditions and facilities appropriate for such care; ensuring that the Minister and those responsible for patients respond to reports and questions raised during visits; ensuring that follow-up action is taken. The authority should be notified of the deaths of persons subject to involuntary placement or treatment, and have power to undertake or order their independent investigation.⁴⁴

This last function is an important one because the present requirement to hold independent homicide inquiries is being abolished by stealth, notwithstanding the recent decision of the European Court of Human Rights in *Edwards*. In that case, the court held that the standard procedures used to conduct independent homicide inquiries under NHS guidelines do not satisfy the requirements of the Convention. The inquiry panel had no power to compel witnesses; sat in private during its hearing of evidence; the deceased's family were not represented, and were unable to put any questions to witnesses; and they had to wait until the report's publication to discover the substance of the evidence about what occurred. Accordingly, the procedures did not comply with the requirements of Article 2 to hold an effective investigation into the individual's death.⁴⁵

The Department of Health's decision to replacing the existing independent homicide inquiries with short internal reviews not only does not address the requirements set down in the *Edwards* judgment, it significantly reduces the existing requirements which were held not to comply with the Convention. That may be why the new procedures are being introduced by e-mail to chief executives, rather than by publicly withdrawing the existing guidelines.

To summarise, the Government's intention is that there will no longer be a separate Commission the sole function of which is to monitor the use of compulsory powers.

In 1982, Parliament amended the last Mental Health Bill by strengthening the role of what was to be the new Mental Health Act Commission. It must be hoped that it will again perform a similar valuable service. If it does, there is much to be said for placing the new Mental Health Commission on the same footing as the Health Service Commissioner: that is, accountable to and funded by Parliament, not the Department of Health. There is now ample evidence that the Department of Health does not attach sufficient value to these important legal functions.

44 *European Union Charter of Fundamental Rights; Draft Recommendation of the Committee of Ministers to member States to ensure the protection of the human rights and dignity of people with mental disorder, especially those placed as involuntary patients in a psychiatric establishment.*

45 *Edwards and Another v United Kingdom, Application No 46477/99, European Court of Human Rights, 14 March 2002.*

Summary and concluding remarks

The maintenance of legal standards, and in particular observance of the rule of law, is a matter of great importance for many people.

Patients are themselves members of the public, so the law must ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.

The rule of law implies the subordination of all authorities to certain principles which would generally be accepted as characteristic of law, such as ideas of the fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual.

The Government is concerned that existing legislation remains based on treatment in hospital, and too often has allowed severely ill people outside hospital to drift out of contact with services. It does not adequately protect people from the significant risk posed by a minority of patients.

This proposition may or may not be true, and in fact the existing evidence does not support the Government's proposition. The closure of the asylums has not led to an increase in the level of violence committed by the mentally ill, and people are rather better protected from violence associated with mental illness than they are from other forms of violence.

The problem of violence in society is one that has much more to do with education, upbringing, alcohol, drugs and testosterone than mental illness. That is not to say that it is appropriate to detain and medically treat people in these classes under mental health laws.

Legislation is, in any case, a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks.

The draft legislation seems designed to sweep from the streets, or to supervise and control, anyone whose behaviour causes the public significant concern, but whose behaviour does not allow the police or the courts to place them in custody in the absence of any evidence or proof of serious offending. In many respects, it does not comply with the European Convention on Human Rights, or with the minimum international standards agreed by nations as being the baseline for countries that wish to be considered civilised in this respect.

No rational, humane, person can support such a set of proposals. A moral case can be made for allowing some people in the community who have a severe mental illness to be treated without their consent, for example where they would otherwise be detained and treated without consent in hospital. Any statutory scheme of this kind must, however, be carefully defined, and subject to rigorous restrictions and safeguards. Patently, the Government has chosen not to argue this case, and its proposals are immoral and, without professional support, by definition impractical.

Given the universal opposition, the problem for the Department of Health now is how it can regain the confidence of professional, patient and carers' organisations. Doing that must necessitate moving those persons responsible for the proposals, and then seeking to achieve a reasonable and fair consensus of opinion.

Not all democracies are liberal democracies. Should the Government choose to push on regardless, it will soon enough learn the limits of force and the benefits of compromise, and the truth of Abraham Lincoln's observation that nothing is settled finally unless it is settled justly.

Some thoughts on the proposed Mental Health Act

Michael Gunn* and Tony Holland**

Our thoughts on the proposed Mental Health Act are a product of us working together for a considerable period of time and feeling that we have something to offer jointly by bringing together our legal and psychiatric perspectives.

Main concern with the basis of the proposed Mental Health Act

The main thrust of our thoughts is that we have a fundamental problem with the reform of mental health law as proposed.¹ We are beginning to question whether there is any need for a mental health act at all.² In any case, legislation which interferes with the freedoms of others should, we believe, be predicated on the libertarian model as espoused by John Stuart Mill. He stated, in his essay *On Liberty*, that.

“... the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.”

This is a philosophical statement that is echoed in the most famous legal version by Cardozo CJ in *Schloendorff v New York Hospital*³:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault...”

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1 Despite its omission from the Queen’s Speech at the commencement of the Parliamentary Session 2002–3 (The Times 14th November, pp. 42 and 15), a Bill is to be introduced (The Times 15th November, p. 12).

2 This is a line of thought that we intend to pursue further.

3 (1914)105 N.E. 92. The same position is taken by the English courts, see Lord Goff in *Re F* [1990] 2 A.C. 1 at p. 72; Lords, Keith, Goff, Browne-Wilkinson and Mustill in *Airedale NHS Trust v Bland* [1993] A.C. 789 at pp. 864, 857, 882 and 891 respectively; Lord Reid in *W v W* [1972] A.C. 24, at p. 43; and Judge L.J. in *St George’s Healthcare NHS Trust v S* [1999] Fam 26, at pp. 43–50.

Therefore, the first requirement is to determine whether a person is capable of making their own decisions (i.e. is not of “sound mind”). If capable, they make their own decisions, unless an interference is warranted as above. If not capable, decisions must be made on their behalf. Whilst the law has developed since the decision in *Re F*⁴ to produce a test for incapacity⁵ and to expand the types of factors to be taken into account when declaring the legal position in relation to an incapacitated adult,⁶ we firmly hold to the view that there is still a requirement for legislation. The introduction of a Mental Incapacity Act would provide still needed clarity and ensure that decisions can unequivocally be made⁷ in all areas⁸ when needed.⁹ This legislation should come first.¹⁰ Thus, where a person has a mental disorder that impairs their decision-making capacity, the first requirement would be to determine if they were capable of making their own decisions. If not, such decisions would be made under the auspices of a Mental Incapacity Act which would produce decisions in the best interests of the incapacitated adult.¹¹ If someone is capable of making the decision, that must then be binding and advanced refusals should, where valid, be binding.¹²

4 [1990] 2 A.C. 1. Subsequently, it has become clear that (a) the courts are looking for there to be a “serious justiciable issue” to trigger the jurisdiction of the High Court to make a declaration; this may be no different from the need to look for a civil wrong to which a defence, such as necessity, was required, as was the analysis by the House of Lords in *Re F*, but it is open to a broader interpretation. In fact, in all the subsequent decisions it is possible to identify a civil wrong; (b) the jurisdiction to issue the declaration is not limited to an assessment of best medical or scientific interests, but best interests “encompasses medical, emotional and all other welfare issues”, per Butler Sloss P. in *Re A* (medical treatment: male sterilisation) [2000] 1 F.C.R. 193, and see *Re F* (adult: court’s jurisdiction) [2000] 3 F.C.R. 30; and (c) it is for the court to determine what is in the incapacitated adult’s best interests on the basis that there can only be one option that is in her/his best interests: *Re S* (Adult Patient: Sterilisation) [2001] Fam 15.

5 See, now, *Re MB* [1997] 2 F.L.R. 426; and see *Re C* [1994] 1 All E.R. 819 and *Re T* [1993] Fam 95.

6 See above, n. 4.

7 So the jurisdiction would not be merely declaratory. Even though the distinction between the declaratory nature of English law and the old Scottish law based on *parens patriae* is minimal (see *Law Hospital NHS Hospital Trust v Lord Advocate* 1996 SLT 848), it could have significant effects not least in requiring cases to be taken to court. Further, see n. 8 below.

8 Subject to the caveat that some decisions are so personal that no one should ever be able to make them on behalf of an incapacitated adult, such as the decision to marry. See, further, Law Commission (1995) *Mental Incapacity* (Report no. 231) at para. 4.29, and the accompanying Draft Mental Incapacity Bill, clause 30.

9 Technically a declaration is only applicable between the parties before the court, though they tend to have wider application in fact. Decisions made under a Mental Incapacity Act would have general applicability. On

declarations, see Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity) [2001] 2 F.L.R. 158.

10 We are not the first to make this sort of proposal, see Price, D.P.T., “Civil Commitment of the Mentally Ill” (1994) 2 *Medical Law Review* 321, but we have propounded it before, see Zigmund, A. and Holland, A.J., “Unethical Mental Health Law: History Repeats Itself” (2000) 3 *Journal of Mental Health Law* 49, and Gunn, M., “Reforms of the Mental Health Act 1983: The relevance of capacity to make decisions” (2000) 3 *Journal of Mental Health Law* 39. For a different perspective, see Robinson, R., “Capacity as the Gateway: an alternative view” (2000) 3 *Journal of Mental Health Law* 44.

11 Best interests as a concept has presented some problems, e.g. to Lord Mustill in *Airedale NHS Trust v Bland* [1993] A.C. 789, at p. 897 where he thought that *Bland* had no interests. In Scotland, the approach has been to avoid use of the concept of best interests and, instead, to provide a set of general principles to assist in decision-making on behalf of an incapacitated adult, see *Adults with Incapacity (Scotland) Act 2000*, s. 1.

12 Of course, establishing validity and applicability is never easy but assuming those requirements are present, such advance refusals should apply to all forms of treatment including treatments for mental disorder. It is for reason of the practical problems and some concern that its presence might make passage of any Mental Incapacity Bill through Parliament difficult (which are the reasons for not codifying the *Bland* rules and for not introducing statutory rules on research and people with incapacity) that the Government, in its consultation process, has not decided whether to have advanced refusals within any future Mental Incapacity Act, see Lord Chancellor’s Department, *Making Decisions: The Government’s proposals for making decisions on behalf of mentally incapacitated adults* (1999, Cm 4465), at paras. 13–20.

A Mental Health Act would exist only to cover those circumstances where the person presented a danger to others and so interference could be justified on that basis, notwithstanding the person's capacity to make decisions or even their refusal to accept treatment. Once detained, the logic would suggest that treatment could only be provided for the reason that permitted the initial detention, so any treatment falling outside that justification would have to be authorised either with a capable person's consent or through the Mental Incapacity Act for an incapable person. So, treatments to reduce the risks presented to others would be the only treatments for mental disorder that would be permissible.¹³ The Mental Health Act would not permit interference where it was for the interests of the person affected. Therefore, we would fundamentally restructure the legislation package. For the draft Mental Health Bill this would mean no ability to admit, detain and treat any person on the basis of their own health and safety. Thus, any future Mental Health Act would be considerably narrower in scope than at present or as proposed. Most decisions affecting people not capable of decision-making would fall within a Mental Incapacity Act, subject to the possibility (as with people capable of decision-making) of that procedure being overridden by use a Mental Health Act.¹⁴ Whilst we recognise that the draft Mental Health Bill does, to some extent, endeavour to take capacity and autonomy more seriously,¹⁵ we feel that it does not go far enough.

Dangerous and severe personality disorder

What would this say for the proposals for dangerous and severe personality disorder? Provided there was evidence to establish that there is such a diagnosable condition and that the consequences of it in terms of harm to others could be predicted, there is no reason why such proposals should not be introduced subject to the requirement that there be serious attempts to ameliorate the condition and to avoid incarceration wherever possible. However, the significant problems are

13 Currently, the treatments may not effectively be even limited to treatment for the mental disorder because of the extended meaning provided for section 63 in *B v Croydon H.A.* [1995] Fam 133. Hoffmann L.J., at p. 138, interpreted s. 63 to extend to treatment that was "ancillary to the core treatment" (authors' underlining) and the latter being the treatment that warranted compulsory admission to hospital under the Mental Health Act). He went on later on the same page to expand upon when treatment might be ancillary. Bartlett, P. and Sandland, R., *Mental Health Law: Policy and Practice* (2000), at pp. 220–227, make the interesting point that, where a patient's life is at risk, the extended definition of s. 63 more readily is applied. Probably, the law now, rather, is that there must be a sufficient connection to warrant the application of section 63. Such a sufficient connection was to be found in *B v Croydon H.A.* and in *Tameside and Glossop Acute Services Trust v CH* [1996] 1 F.L.R. 762 (though this case can alternatively be viewed as a bad decision), but not in *Re C* (adult: refusal of medical treatment) [1994] 1 All E.R. 819 nor in *Re JT* (Adult: Refusal of Medical Treatment) [1998] 1 F.L.R. 48. Support for this approach is to be found in *St. George's Healthcare N.H.S. Trust v S* [1999] Fam. 26 where Judge L.J., at p. 52, stated that "Section 63 may apply to the treatment of any condition which is integral to the mental disorder" (authors' underlining). Whilst Judge L.J. purported to be following *B v Croydon H.A.*, it seems more likely that this has

limited its extent in a manner that will receive approval and be followed in the future. Further Judge L.J. in that case thought that there would not have been a sufficient connection for s. 63 to apply.

14 Implicit here is the proposition that, where a capable person (because of their risk to others) would be detained under a Mental Health Act, so also should an incapable person, even if the Mental Incapacity Act might apply. Thus the legislation would be more readily compatible with the non-discrimination principle most clearly propounded by the Richardson Committee (Expert Committee, *Review of the Mental Health Act 1983* (Department of Health, 1999) available at www.doh.gov.uk/mhar.report.htm; and see the February 2000 issue of the *Journal of Mental Health Law*).

15 For example, there is a commitment that the Code of Practice should set out general principles to further patients' autonomy, however, "the draft Bill does not spell out the central role of these considerations, and would not impose a statutory obligation on decision-makers to give effect to them: breach of the Code would not seem to make a decision or action unlawful...." (The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill* (25th Report of the Session 2001–02; HL Paper 181; HC 1294), at para. 21). And so the matter should not be left to a Code (para. 22).

whether it is indeed diagnosable with sufficient accuracy and, more tellingly, whether the requisite level of harm can be predicted in an individual case.¹⁶ In particular because of weakness in the latter, it is not likely to reach the level of certainty necessary for interference with freedoms on the basis of anticipated harm and so incarceration must be based upon the commission of harm to others and it being a response to that actual harm and its future prevention.¹⁷ What the draft Bill contains is the facility to be able to detain people where they need treatment, but that treatment does not involve relieving their disorder. This is clarified by the more extended definition of “medical treatment”, which now explicitly covers “education, and training in work, social and independent living skills.”¹⁸ Further, there is no equivalent of the treatability requirement that appears in the 1983 Act. Thus, “the effect of [the relevant conditions] taken together with the broad definitions of ‘mental disorder’ and ‘medical treatment’ ... would be to permit the compulsory detention and care of people for the protection of others when the people detained have never been charged with any criminal offence and nothing can be done to alleviate the mental disorder from which they are suffering. This raises human rights issues, flowing mainly from the breadth of the circumstances in which a patient could be subjected to compulsory, non-consensual, treatment.”¹⁹ This more eloquently puts our point. Whilst the proposal is compliant with the European Convention on Human Rights even though the detained patient may not be truly treatable,²⁰ this is an example where ECHR compliance does not produce a good or proper result.²¹

16 This latter point is also strongly made by the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at paras. 43 – 47.

17 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 35.

18 *Draft Mental Health Bill*, clause 2(5). This may be regarded as a clarification rather than an extension of the meaning of “habilitation” which appears also in the definition of medical treatment in the *Mental Health Act 1983*, s. 145.

19 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 37.

20 *A v Scottish Ministers* [2001] S.L.T. 1331. The view of the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181;

HC 1294), at para. 34, is that there are signs, which really are not very clear at all, that a treatability requirement will be introduced by the European Court. That is a proposition with which we would agree, but, like the Committee, find it hard to make the case a convincing one on the basis of the existing jurisprudence. The other approach is to argue that in some cases the failure to treat might involve a breach of Article 3 as there is inhuman or degrading treatment or punishment. Owing to the high threshold before breach is established, this will not be an easy argument, but, using *Kudla v Poland* (2000) application no. 302190/96, the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 35, makes the case.

21 Further, the judgments are relatively old and “it would in our view be a mistake to restrict attention to judgments delivered as long ago as 1979 and 1985:” *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 34.

The Bournemouth gap

A further consequence of our approach is that there is no need for Part 5, i.e. the proposals for dealing with the so-called *Bournemouth* gap.²² If a person is not capable of making a decision to be a voluntary patient, such a decision should be made under a Mental Incapacity Act. Admission would be possible, but only if it were in the best interests of the incapacitated adult. As there would be measures for protection from exploitation and abuse within a Mental Incapacity Act, no need for Part 5 arises. It is perhaps only in the proposed Bill because a Mental Incapacity Act is not currently in the Parliamentary timetable. The Government accepts the need to introduce one when Parliamentary time allows.²³ On some of the particular points made in Part 5, one interesting comparison is with the approach that the Government proposes to take with regard to children. The two appear to be inconsistent when the differences between the two groups do not support such a markedly different approach. It is the opinion of the House of Lords and House of Commons Joint Committee on Human Rights, that children are inadequately protected by the draft Mental Health Bill and that a preferable approach would be to apply the system in Part 5 also to children.²⁴ What Part 5 of the draft Mental Health Bill provides is (a) a statement of those cases where informal treatment is not available, that is where an incapable patient either would resist treatment or “is at substantial risk of committing suicide or causing serious harm to other persons;”²⁵ And (b) provisions whereby the status of a “qualifying patient” is created.²⁶

22 *The House of Lords in R v Bournemouth Community and Mental Health N.H.S. Trust, ex parte L* [1999] 1 A.C. 458 decided that an informal patient, under the Mental Health Act 1983, s.131, is someone who is incapable and compliant. Section 131 permits their admission to hospital notwithstanding that they are not capable of decision-making (those patients going into hospital after consenting are voluntary rather than informal admissions). The gap that this leaves is obvious. There is no protection for informal patients as, if they are not competent to decide whether to enter hospital, they are not in a position to exercise the normal protections (leaving hospital, saying no to treatment, and seeking legal advice). However, neither are there any agencies designated with oversight of their condition (the remit of the Mental Health Act Commission to informal patients has never been introduced as the Mental Health Act 1983, s. 121(4) has never been implemented). Whilst it is entirely possible that the vast majority of such patients will be properly cared for, because the staff will act properly and appropriately, there is no mechanism to ensure that the compliant, incapacitated patient's interests are properly preserved and protected.

23 Indeed the signs from the Lord Chancellor's Department through its Mental Incapacity Consultative Forum (of which Gunn is a member) are that this is a serious commitment, but any Bill will not be before Parliament before the 2003–04 Parliamentary session at the very

earliest, see LCD Press Statement, “Government Proposals to Codify Law on Mental Incapacity” 16th December 2002.

24 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 80.* The Committee is of the view that the proposed approach in relation to children under 16 “leaves them under-protected compared to adults, and may lead to violations of their rights under the ECHR and under Article 25 of the [Convention on the Rights of the Child]” as “[d]ecision-making for these child patients would be left to parents or guardians and the professionals, without the need for independent scrutiny or review of treatment decisions.” However, that accords with the current system for decisions in other areas, and so the question is whether the fact that it is mental health problems that are involved is a sufficient reason to vary the system. If the Mental Incapacity Act takes priority, then there is no need to separate out this issue within a Mental Health Act, but it may be the case that more protections for children under 16 need to be considered for all types of decisions, whether involving mental health care or not.

25 Clause 121(1) - (3). Where a patient has at any time indicated that they would not want the treatment, it is to be presumed that they would resist that treatment: clause 121(4).

26 Clause 122.

A qualifying patient is someone who satisfies certain criteria²⁷ and for whom a clinical supervisor is appointed.²⁸ The relevant criteria are:

- (a) the patient is 16 or more
- (b) the patient is suffering from mental disorder
- (c) that mental disorder is of such a nature or degree as to warrant the provisions of medical treatment to the patient
- (d) it is necessary for the patient to be resident at a hospital for the treatment and that requirement is likely to continue for at least 28 days
- (e) the patient is incapable of consenting to the treatment and that condition is likely to continue for at least 28 days
- (f) the treatment can lawfully be provided without the need for Part 2.

Putting the proposals together means that the treatment will be administered in accordance with the common law.²⁹ Quite clearly, this is, therefore, in the wrong piece of legislation. What Part 5 does endeavour to do is to provide some safeguards for such patients. Before examining them, it is worth recognising that one of the weaknesses with the current proposed Mental Incapacity Act is the reliance on the general authority to act reasonably in relation to an incapacitated adult without the need for special procedures (except in certain specified cases). The ultimate protection is the ability to have disputes resolved by a judicial forum, but disputes only arise where there are two parties at odds. This may not occur when it is the carer or a professional, etc making decisions about an incapacitated adult. It is possible that the safeguards in the draft Mental Health Bill might be worthy of introduction to the general authority so as to preserve it as an essential element of any Mental Incapacity Act. Under the draft Bill, it will be the responsibility of social services (having been notified by the hospital) to “notify the patient of the help available from mental health advocates,” “to appoint a person to act as the patient’s nominated person” and “to notify the nominated person of the help so available.”³⁰ The nominated person will have a key role as they should be involved in treatment decisions and, if it appears to him or her that the patient would not have consented to the treatment, the clinical supervisor is to be informed and the treatment is not to go ahead “except in a case of urgency.”³¹ Why urgency should be a sufficient reason to override what is a form of advance refusal is mysterious. There may be criteria to be introduced here, though we would have thought that an advanced refusal should take priority since the English courts do not recognise any state interests as being sufficient to override the decision of a competent adult.³² However, this Part operates on a more paternalistic basis, but even then simply a case of urgency would not be sufficient warrant to interfere with the patient’s wishes. What might be sufficient, if a paternalistic approach is accepted, might be a treatment that is life-saving or preventing a serious deterioration in their condition. Any treatment will need to fall within the care plan that must be drafted by the clinical supervisor within 28 days of his or her appointment.³³

27 Clause 125.

28 Clause 123.

29 See above, n. 4.

30 Clause 127(2)

31 Clause 128.

32 See *Secretary of State for the Home Department v Robb* [1955] 1 All E.R. 677, and *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95. The apparently contrary decision in *Re S (Adult: Refusal of Treatment)* [1993] Fam. 123 was properly overruled in *Re MB (Medical Treatment)* [1997] 2 F.L.R. 426.

33 Clause 129(2).

The clinical supervisor is obliged to consult the patient and the nominated person, if practicable.³⁴ That care plan must then be approved by a medical adviser.³⁵ The care plan must be reviewed every 12 months.³⁶ Finally, the patient and his/her nominated person has a right of application to the Mental Health Tribunal to seek their discharge, despite not being detained.³⁷ The tribunal will discharge the patient if “satisfied that [they are] being unlawfully detained at the hospital.”³⁸ We would agree with the following overall assessment of the House of Lords and House of Commons Joint Committee on Human Rights, although the Committee is concerned that the system does not apply to non-resident patients or patients in residential homes. The latter is clearly impossible to justify, since the only difference is type of venue,³⁹ the former is hard to justify, especially when account is taken of the fact that, under the Mental Incapacity Act it is the decision and its effect that matters not where someone happens to be. If the regime is to exist at all, it should apply to all compliant, incapable patients.⁴⁰

“We welcome the clear structure for decision-making which the draft Bill would introduce in relation to the treatment of ... informal patients. We also welcome the element of independent review by medical adviser and MHT, and the ability of the nominated person to trigger those mechanisms. We consider that these steps constitute major protections for the human rights of patients who are unable to consent to treatment but do not require compulsory treatment.”⁴¹

34 Clause 129(5). “Consult” does not provide the consultees with a power of veto.

35 Clause 130. The medical adviser will be a member of the Expert Panel and must examine the patient, satisfy him/herself that the consultation took place and discuss the treatment specified in the plan with the clinical supervisor before approving the plan, if at all: clause 130.

36 Clause 133.

37 Clause 136.

38 Clause 136(2).

39 The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 81.

40 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 81.

41 The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 78.

Compliance with the European Convention on Human Rights

Compliance with the European Convention on Human Rights is a laudable objective for the Mental Health Act, and is required by the Human Rights Act 1998. It produces some important and welcome changes, such as the need to involve an independent organisation, the Mental Health Tribunal, prior to longer term admission,⁴² the provision of a right of appeal to a Mental Health Appeal Tribunal on a point of law, and the burden of proof lying on those alleging the need for detention rather than on the patient.⁴³ Further, the legislation underlines the need for the continued presence of the criteria that warranted original detention and to require release when the patient's condition gets better.⁴⁴ But, the power of professionals other than the Tribunal to discharge a patient (and in particular the patient's clinical supervisor⁴⁵) appears to have been removed, and so there may be a longer delay than is necessary before someone is indeed discharged, which would be contrary to the ECHR. In any case, compliance with the ECHR should never be regarded as sufficient. The Convention does not cover all human rights issues and is time-framed, despite the commitment to its dynamic interpretation, by its ratification in the 1950s. Thus, simply because a proposal is Convention compliant does not necessarily mean that it is right. It is Convention compliant to detain a person as a "person of unsound mind"⁴⁶ without treating them, as the requirements of Article 5(1)(e) of the Convention do not demand treatment.⁴⁷ It is entirely possible that the detention of an untreatable person of unsound mind could eventually be held to fall outside the Convention. Because of the European Court's commitment to a dynamic interpretation of the Convention, no interpretation is set in stone. The logic of the detention would, we submit, rely upon the person detained being treatable. Further, it might

42 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181, HC 1294)*, which states, at para. 23, that "[t]he new arrangements have the potential to address concerns [that MHRTs do not adequately protect patients from arbitrary detention under Art 5, ECHR], and so are of great significance in the drive to safeguard patients' rights." The Committee thinks that the availability of independent experts from the Expert Panel will contribute to such safeguards (para. 24). But the Committee does have a concern about independence because the qualifications of members are to be dealt with by regulations rather than the primary legislation (para. 26). One significant concern is that the success of the new system relies on the ability to appoint sufficient people of sufficient quality and "there might not be enough available people" (para. 25). On the other hand, the Royal College of Psychiatrists has deep concerns about the Tribunals because (i) medically resourcing both the Tribunals and the Expert Panel for an increased numbers of hearings will be problematic; (ii) a deep concern that there will be a consequential lengthening of the period before a hearing, which will eventually contravene the ECHR; (iii) doctors will not always be on Tribunals and so the work of the Tribunal may be poor (especially with regard to analysing care plans and whether psychologists can adequately review cases for review of on-going detention as opposed to psychiatrists, as well as the overall decision-making in relation to detention and continued detention),

especially if also the medical member of the Expert Panel does not have to be present at the hearing (Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: Response to the draft Mental Health Bill and consultation document – Points on which consultation is not requested* (2002).

43 *R (on the application of H) v Mental Health Review Tribunal North and East London Region (Secretary of State for Health intervening)* [2002] Q.B. 1 which resulted in a change to the Mental Health Act introduced by the Mental Health Act 1983 (Remedial) Order 2001 (S.I. 2001 No. 3712) passed under the Human Rights Act 1998 provisions on amending legislation incompatible with the European Convention on Human Rights. See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294)*, at para. 59.

44 *Johnson v United Kingdom* (1997) 27 E.H.R.R. 196, and see *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387 and *Luberti v Italy* (1984) 6 E.H.R.R. 440.

45 Under the Mental Health Act 1983, s. 23, the patient's responsible medical officer, amongst others, has the power to order discharge, and frequently does.

46 There is no definition of this phrase and, therefore, the wide definitional approach adopted in the proposed Mental Health Act is Convention compliant as it does rely upon the availability of medical evidence.

47 *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387.

eventually be decided that the failure to treat someone detained in hospital might fall foul of the prevention of inhuman or degrading treatment or punishment in Article 3⁴⁸ or of the prevention on improper interferences with privacy under Article 8. It is Convention compliant not to have a detailed definition of “person of unsound mind”, but does that warrant not attempting to provide definitions where available and exclusions where possible? Any comparison with the width of the DSM or ICD and the exclusions under the Mental Health Act 1983, s. 1(3) will demonstrate the risks associated with losing the exclusions, and we consider this further below.

Definition of mental disorder and conditions for detention

One of the relevant conditions for compulsory admission to hospital is the presence of a mental disorder.⁴⁹ This is very widely defined in the proposed Act in clause 2:

“‘Mental disorder’ means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning...”

Further, there is no equivalent to the Mental Health Act 1983, section 1(3), which excludes some things from being a mental disorder.⁵⁰ The argument for the change is⁵¹ that some clinicians have mistakenly assumed that it means that someone who is dual diagnosed as an alcoholic and with mental illness or someone whose alcoholism has caused mental illness does not have a mental disorder. This interpretation of the current s. 1(3) is plain wrong and it is completely unsustainable. The better solution, therefore, is either to educate or guide the practitioners better or to clarify the provision. The approach of removing the exclusions is not justified for the reason given. What is proposed is extraordinarily wide, but it is the view of the Government that its application is limited by the need for the other relevant conditions to be present⁵² and the need for the professionals to develop a care plan. The relevant conditions are stated at clause 6 as being the following.

“(3) The second condition is that that mental disorder is of such a nature or degree⁵³ as to warrant the provision of medical treatment to him.”⁵⁴

48 A line into this possible development is provided by the decision of the European Court in *Aerts v Belgium* (2000) 29 E.H.R.R. 50 whereby detaining someone in a completely inappropriate environment may be a breach of Article 3. However, it is some way from there to the argument that detention of the mentally disordered without the provision of treatment is a breach of Article 3, especially when the Court has given precedence to compliance with current medical thinking (*Herczegfalvy v Austria* (1992) 15 E.H.R.R. 437 in relation to consideration of Article 8), and a significant proportion of the medical profession would support the detention of persons with serious personality disorder who were not treatable but who might be aided in being present in an ordered or environment or whose potential for violence might be curbed by such detention. Article 8 is less likely to provide the need for treatment as the prevention of crime and the protection of the interests of others being served by such detention would permit such interferences with privacy under Article 8(2) assuming that the failure to provide treatment could be regarded as *prima facie* an interference with privacy.

49 Draft Mental Health Act, cl. 6(2).

50 So no one can be diagnosed under the Act as having any form of mental disorder “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.”

51 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at paras. 3.18 – 3.19.

52 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at para. 3.21.

53 As this is the same phrase as currently appears in the Mental Health Act 1983, s. 3(2)(a), the same interpretation will apply as was given by Poplewell J. in *R v Mental Health Review Tribunal for the South Thames Region, ex parte Smith* [1997] C.O.D. 148 where he recognised that the phrase is disjunctive and that nature and degree each have their own different meaning and so, whilst often detention will be based upon the presence of both, only one condition need be satisfied.

54 Sadly, legislation still is structured in the male only gender, though applying to people of either.

- (4) The third condition is –
- (a) in the case of a patient who is at substantial risk of causing serious harm to other persons, that it is necessary for the protection of those persons that medical treatment be provided to him, and
 - (b) in any other case, that –
 - (i) it is necessary for the health or safety of the patient or the protection of others persons that medical treatment be provided to him, and
 - (ii) that treatment cannot be provided to him unless he is subject to the provisions of this Act.
- (5) The fourth condition is that appropriate medical treatment is available in the patient’s case.”

The question, therefore, is whether the draft Bill will have much wider application through a different approach to the definition of mental disorder.⁵⁵ The Government does not expect it to be “used as a means of social control, nor to detain anyone simply because their sexual preferences diverge from the norms of society, nor to detain anyone who does not have a mental disorder.”⁵⁶ However, concerns have been expressed that it could be applied to people who should not be regarded as potential subjects for mental health legislation. Any swift review of the international classifications of mental disorder will reveal that a number of conditions appear in either or both of the American Psychiatric Association’s Diagnostic Statistical Manual or the World Health Organisation’s International Classification of Diseases and Disorders that cannot credibly be argued to be a mental disorder at all or that could warrant compulsory admission to hospital. Under the criminal law, it is the case that any internal cause of an inability to know what one is doing or to know that it is legally wrong raises the defence of insanity,⁵⁷ such that a person attacking another when suffering an epileptic fit is claiming that defence when saying that they did not know what they were doing,⁵⁸ similarly a person with diabetes who has not taken their insulin.⁵⁹ “The prospect of a Mental Health Act being used to authorise compulsory treatment of people suffering from diabetes or epilepsy is unattractive.”⁶⁰ It is much worse than that! Further, could the new approach lead, as has been suggested, presumably more credibly by Zigmond,⁶¹ to people with multiple sclerosis or Parkinson’s disease or mild anxiety being compulsorily detained under the draft Bill?

Even if doctors might view these as a mental disorder within the proposed definition, it is hard to see on what basis all the other conditions would be satisfied. But the warning is worthy of recognition and rather than rely upon the appropriate use of the Act by clinicians and the work

55 *Under the Mental Health Act 1983, a broad concept of mental disorder only applies to admission to section 2 and the emergency sections, and greater certainty of diagnosis is required for admission under section 3 or the imposition of a hospital order under section 37.*

56 *Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.22.*

57 *M’Naghten’s case (1843) 10 Cl. & Fin. 200; Bratty v Attorney General for Northern Ireland [1963] A.C. 386; R v Sullivan [1984] A.C. 156.*

58 *R v Sullivan [1984] A.C. 156.*

59 *R v Hennessy [1989] 2 All E.R. 9. The sleepwalker also raises the defence of insanity because the cause of not knowing what they are doing is an internal cause: R v Burgess [1991] 2 Q.B. 92.*

60 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 29.*

61 *The Times November 14th 2002, at p. 15.*

and its effect on general practice of Mental Health Tribunals, would it not be better to prevent the problem by improved definitions? The difficulty is with the lesson that derives from the passage of the Mental Health Act 1983. In that Act only three of the four specific conditions of mental disorder are defined.⁶² Attempts to define “mental illness” were considered,⁶³ but no generally acceptable definition was discovered.⁶⁴ Therefore, the condition with which the vast majority of compulsorily detained patients are diagnosed is not defined in the Act. The only legal definition is that to be found in a decision on the Mental Health Act 1959, where Lawton L.J. stated that the words “mental illness” are “ordinary words of the English language. They have no particular medical significance. They have no particular legal significance.... [O]rdinary words of the English language should be construed in the way that ordinary sensible people would construe them.... In my judgment [an ordinary sensible person] would have said, ‘Well, the fellow is obviously mentally ill.’”⁶⁵ Despite Lawton L.J.’s requirement that there would have to be a medical basis for the view reached, it was memorably and derogatorily termed “the-man-must-be-mad” test.⁶⁶ The lesson seems to be that the concept could not be defined before the 1983 Act, and it has not created any major problems, so the task is not worth pursuing now. Some support is derived from the E.C.H.R. jurisprudence as there the courts have shied away from attempting to define what is a “person of unsound mind.”

One particular consequence flowing from the changes represents a very significant change in policy. Under the 1983 Act strenuous efforts were made to exclude people with learning disability from the potential for compulsory admission to hospital. The introduction of the concepts of mental impairment and severe mental impairment had the unfortunate consequence that not only could few people with learning disability be admitted compulsorily to hospital (which received general approval at the time) but also they could not be received into guardianship, which is a major reason for the poor take up of guardianship.⁶⁷ The consequence of the change in policy is that many more people with learning disability will potentially fall within the purview of the draft Mental Health Act than of the 1983 Act. This is a further argument for a Mental Incapacity Act to be the primary piece of legislation as some people now falling within the purview of the Act (which includes not only residential orders in hospitals but also non-residential orders for people living in the community⁶⁸) will be incapable of making decisions for themselves. However, the draft Bill leaves us with, effectively, undefined concepts or, rather, broadly defined concepts when some attempts could have been made to provide exclusions and examples of inclusion. Heavy reliance will, therefore, be placed on the propriety of clinicians’ actions and the quality of their education and continuing professional development.

62 In s.1(2), definitions are provided for mental impairment, severe mental impairment and psychopathic disorder.

63 D.H.S.S., *A Review of the Mental Health Act 1959* (1976), building upon a recommendation in the Report of the Committee on Mentally Abnormal Offenders (1975, Cmnd. 6244; the Butler Report).

64 D.H.S.S., *The Review of the Mental Health Act 1959* (1978, Cmnd. 7320; the White Paper).

65 *W v L* [1974] Q.B. 711, at p. 719. As it happens this

was obiter dictum, but has nevertheless moved into the accepted interpretation of the legislation.

66 Hoggett, B., *Mental Health Law* (4th ed., 1996), at p. 32.

67 Gunn, M., “Mental Health Act Guardianship: where now?” [1986] *J.S.W.L.* 144.

68 We have chosen not directly to address issues arising from the possibility of compulsory community provision, though the general themes are directly applicable.

Replacement of the Mental Health Act Commission

The introduction of a form of inspectorate by the Mental Health Act 1983, the Mental Health Act Commission, was an important contribution to ensuring that the legislation was used appropriately. However, the Commission tended to be confused as to its remit, often wandering away from it into areas that were the remit of other organisations and that often at the expense of its primary remit which was to “visit and interview” patients and to “require the production of and inspect any records relating to the treatment of any person who is or has been a patient.”⁶⁹ This remit would ensure that there was some inspection function in relation to compliance with the Act in relation to detained patients and a facility for patients to raise concerns about the way in which they were being treated. Separating this from functions such as examining the environment was always difficult and, despite what has been said, contentious in the sense that some would argue that it did fall within the Commission’s remit. Thus, the introduction of a new health care inspectorate, which will not only have the remit to provide “scrutiny of the proper application of the new Mental Health Act,”⁷⁰ but also have the remit to provide “a single point of access on quality issues for service users, service providers and the Government,”⁷¹ is to be welcomed as providing what is indeed likely to be a more influential and effective body. Its success will depend upon those appointed to be inspectors and will require a range of skills, not always available in one individual, to ensure that the width of the remit can properly be delivered.⁷² Intriguingly, the Inspectorate will have the power to refer an individual’s case to a Mental Health Tribunal on a point of law. This has interesting potential since inspections sometimes do reveal difficult areas of law that demand resolution for the individual concerned and sometimes that has significant general effect. This ability is a sound proposal and is likely to assist in providing the Inspectorate with the teeth that it needs to ensure that it delivers.⁷³

Limited reform of the Mental Health Act 1983, section 139

Sadly, there is no clear proposal to abolish what is currently the Mental Health Act 1983, s. 139. As currently structured this has two elements to it (a) restrictions on the freedom to instigate litigation and (b) defences available to individual members of staff acting or purporting to act under the 1983 Act. The former is unsustainable as an improper restriction on freedom of access to the court. There is no reliable evidence that detained patients endeavour to sue inappropriately more often than anyone else. Indeed, it has been said that “mental health patients are a particularly vulnerable group.... Compared with most other people, they are less likely to be able to action to protect their own rights.”⁷⁴ Although not made in the context of s. 139, this suggests that there is no good reason for additional hurdles to be placed in the way of seeking to resolve issues by way

69 *Mental Health Act 1983, s. 121(5).*

70 *This will include: collecting information; investigating and visiting for cause and certain related responsibilities and powers: Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.4.*

71 *Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.2. The scrutiny function will be exercised by a special division of the inspectorate.*

72 *See also the House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 89.*

73 *Lack of teeth was a criticism of the Mental Health Act Commission though the Commission often contributed to its weakness by sending mixed messages about practices.*

74 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 5.*

of legal action. In any case, those who, by their actions, have proved themselves to be vexatious litigants can have their freedom to instigate further litigation limited. This operates not on any generalised assumptions about a class of people but on the particular activities of an individual. Whilst a challenge to this part of the section was unsuccessful in *Ashingdane v U.K.*⁷⁵, it is submitted that the restriction is indeed a breach of Article 6 as an improper restriction on the right of access to a court. The Government understands “that [abolition] would make many staff feel vulnerable even when exercising their legal duties responsibly”. Therefore, it proposes that the onus of proof should be reversed, such that “the person complained against will have a defence of good faith and reasonable care.”⁷⁶ One difficulty here is that there appears to be a conflation between the right of access to the courts and whether to continue an obstacle to it and the existence of a special defence when sued. The Government appears to be addressing the right of access to a court and so the burden of proof switches to the defendant in pre-hearing proceedings. This does not make sense. Clarity on this is required, and there is no provision in the draft Bill. What is required is a separation, as explained above. In this way the debate can be focussed on whether to have both a limitation on litigation and a special defence. We argue against the former. As regards the latter, there is a better argument for it, which is, in part, presented by the Government in the extracts above. However, no other professionals have any such special defences. Surely, the preferable approach is that acting in compliance with the Act is a defence to any action as indeed would be an honest and reasonable mistake about the powers available under the Act. There is no need for any special provision.

Sharing information

The need to share information is a common theme of many homicide inquiry reports. Whether the changes proposed through the draft Mental Health Bill are necessary is open to serious doubt. This is because the law on confidentiality is subject to exceptions which would apply where those caring for another who presents a risk to others need to share relevant and important information.

Final comment: a plea on drafting

One final plea would be for the drafting of the legislation to be reconsidered. It is accepted that drafting legislation is an extraordinarily difficult task. However, this proposed legislation is very difficult to follow. This is a particular problem for legislation such as Mental Health Acts as the size of their non-legal readership and user group vastly outweighs their legal readership and user group. It is difficult to imagine patients, doctors, nurses, carers, etc making much headway through its tangled web.⁷⁷

75 (1984) 7 E.H.R.R. 528.

76 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at para. 3.16.

77 See also Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: Response to the draft Mental Health Bill and consultation document* (2002).

Responses to the Draft Mental Health Bill

Law Society's Response to the Draft Mental Health Bill

Introduction

Mental illness and mental incapacity are two of the last great social taboos and that is why it is so important for people to have enough time to discuss and understand the implications of the Government's Mental Health Bill. This Bill is not now in the current legislative timetable, however, Ministers have indicated their commitment to legislative reform, and soon.

Widening the criteria for detention

The Bill appears to have been drafted in response to public concern about rare high profile cases where individuals suffering from severe personality disorders have committed serious crimes. Unfortunately, there are many dangerous people on the streets, only a small minority of whom suffer from mental illness. Many serious crimes are committed by people under the influence of alcohol but no-one suggests that anyone calling at their local pub for a drink is a potential criminal. Categorising people suffering from mental illness by way of potential risk is equally inappropriate.

The impression that streets will be made safer by this legislation is a myth. The Richardson Committee which advised the Government on the scope of new legislation, recommended the wider definition of mental illness and greater powers of detention only if there was a reciprocal right on the part of the patient to receive appropriate treatment. Psychiatric services have long been under-funded, many hospitals have been closed down. There are currently 400 consultant psychiatrist posts vacant nation-wide. The Government have announced increased funding to implement the proposals should the Bill be enacted but it is likely to be woefully inadequate to provide the services for all the people detained under the new definition. That, presumably, is the reason why the element of reciprocity stressed by the Richardson Committee is absent from the Bill; the Government does not want to create a statutory right to services it cannot provide.

The Royal College of Psychiatrists, one of a number of organisations who are working with the Law Society and who have assisted in resisting this Bill, has reported such a level of concern amongst its members about proposed legislation that it predicts the number of consultant vacancies will rise to 600 if the Bill became enacted. People with mental illness, many of whom have already been failed by the "care in the community" scheme, will be less, rather than more likely to engage with psychiatric services if the threshold to detention is lowered without the reciprocal guarantee of appropriate treatment. Disengaged from the services, their condition is likely to deteriorate and there will be more, not fewer, seriously ill people on the streets.

Human Rights Compliance

Far from bringing the process further into line with human rights best practice, the Bill appears to create a range of possible new areas of challenge. The Bill only partially addresses the problem in

the case of *Wilkinson*¹ which is a treatment case brought under Articles 2, 3 and 8. The position of an individual who does not wish to comply with treatment and has mental capacity is still not clear under the Bill.

The Bill suggests that prisoners who are subject to compulsion should receive their treatment in prison. This gives rise to a possible challenge under Article 5. In *Aerts v Belgium*² the ECHR held that detention of someone in a hospital wing of a prison violated 5(1)(e). The new criteria allows a person to be detained even if they are “untreatable”. If the detention does not achieve its legitimate purpose, the compulsion is challengeable on the grounds of proportionality.

In relation to Article 6, the Bill also introduces a two tier tribunal system. Although this is largely welcomed by the Society, the impact of the introduction of this system does present practical problems. Firstly, in the recruitment of extra members for the tribunals. Secondly, in settling an appropriate venue for additional sessions. Thirdly, in the increased administrative workload. If these issues are not properly addressed, continued serious delays will occur. Delays in tribunals have already seriously prejudiced patients’ interests. The Bill puts additional stress on a system which is already in ‘meltdown’.

Further, current law and practice allows for a tribunal hearing on an assessment to detention to be held within 7 days whereas the proposals under the Bill state that a routine referral will take place within 28 days. The Bill therefore represents an erosion of existing rights.

The concept of a nominated person introduced by the Bill to replace what is currently the nearest relative allows a patient to have some choice over the person appointed. Under existing law this omission breaches Article 8 and this has been partially addressed under the new Bill. However, the new “nominated person” has no right to apply to have a detained person discharged, they have also lost the right to object to treatment on behalf of a patient.

Lack of overarching principles

The Bill does not contain any overarching principle such as that in the Children Act 1989 which places the welfare of the child as being of paramount importance. This principle helps practitioners, judges and those advising, to keep in mind the main thrust of the legislation. Principles for mental health law are very important when dealing with vulnerable members of society. Principles which the Bill could contain are those of non-discrimination, self-determination and personal responsibility and most importantly the ‘least restrictive alternative’ principle. Only this way can we maintain the ethical standards required when considering depriving someone of their liberty for reasons of their health. The professions need overarching principles and ethical considerations. Law and psychiatry are very different disciplines each trying to apply their own principles in a manner so as not to cause injustice to the patient or to enhance their welfare. It is important to view “the relationship between law and psychiatry in terms of ethics since it is not only in relation to research that those who are inherently potentially less able to control their own destiny, such as many with mental disorders, who most merit scrupulous ethical investigation.... in spite of any apparent protection they may appear to receive from the law.It is not only

1 *R (Wilkinson) v (1) Responsible Medical Officer (2) Broadmoor Hospital Authority (3) Mental Health Act Commission (4) Secretary of State* [202] CA 1 Weekly

Law Report page 419
2 [1998] 29 EHRR page 50

psychiatry but also the law that is properly open to ethical scrutiny. Ethics is indeed above not only psychiatry but also the law".³

Therefore because of the differences between the two professions and the vulnerability of mental health patients, mental health law needs overarching principles and ethical considerations.

Interface with criminal law

The need for an overview of the impact of the Bill becomes imperative when looked at in conjunction with the development of criminal law.

It is a widely held view that early diagnosis and treatment is more likely to prevent offending behaviour and that once a person becomes part of the criminal system, it is less likely that their mental health problems will be appropriately treated. This is why the Society supports early engagement. Whilst the Law Society is keen to put into perspective offending behaviour and mental illness, it should be noted that the media increasingly report cases where persons with a mental disorder and violent behaviour re-offend (this becomes particularly newsworthy when children are involved). Mental health issues and serious crime are inextricably linked.

The Government in their attempt to restore public confidence both in the criminal justice system and mental health have shifted their focus from one of rights to the individual to that of protecting "decent citizens" or "innocent members of the public". Use of this language polarises "decent society" whom it would appear are the victims of those who are "threat to society". There appears to be little acceptance that members of the public can be victims one day and defendants the next. This is the case especially with mental health problems. Such rhetoric is simplistic and divisive differentiating deserving citizens from the undeserving. The shift towards public protection can be seen in other areas of law, particularly the criminal justice system. The challenge to the Law Society is to alert the public to this shift and to examine the issues carefully. We need to ask on what policy grounds can such a development in mental health law be justified.

Public understanding of mental illness has come a long way in recent years. The Mental Health Bill which was proposed by the Government with its emphasis on risk reintroduced stigma to mental illness. If the Bill remains unchanged it will serve patients badly by eroding their rights and serve society badly by driving patients away from the treatment they need. This view is shared by all major interest groups dealing with mental illness.

The Law Society welcomes the withdrawal of this Bill from the legislative timetable and hopes the time can be used for constructive dialogue with a view to addressing the problems we have raised in this article.

The Law Society

3 Nigel Eastman, *Criminal Behaviour and Mental Health*, Volume 2 No. 1 2001 page 124

This Commentary is made on behalf of the Royal College of Psychiatrists in response to the Draft Mental Health Bill

Introduction

The Royal College of Psychiatrists is gravely concerned about the deleterious effects of the Government's Mental Health Bill upon patients' civil rights and the professional and public perception of the role of psychiatry. In addition it will seriously harm recruitment into a medical specialty which is already heavily under-recruited. The resulting damage to mental health services will make the Bill self-defeating in relation to its core objectives.

Before discussing this Bill it must be emphasised that the proper content of a Mental Health Act can only be determined after the passage of an Incapacity Act. The new Mental Health Act should be drafted with direct and explicit reference to the interface between that Act and an Incapacity Act. The lack of a 'joined-up approach' to legislation is very regrettable.

The Potentially Positive Aspects of the Bill:

1. The use of Tribunals to authorise longer term compulsion is welcomed. However the number of hearings will increase substantially. This has implications for medically resourcing the clinical service in addition to the Tribunals and the Expert Panel. Also, the Courts, not just the Tribunals, will have access to the Expert Panel and this will increase the burden on doctors. Furthermore, given that the Tribunal is effectively a 'judicial' decision on 'the care plan' it is crucial that the patient's lawyer has an opportunity to cross-examine both the clinical supervisor and the Expert Panel doctor. This is made more important by the right of the patient to his/her own expert and it would be wrong for one to be questioned in the hearing and not the other. Given that increasing the numbers of psychiatrists is not possible, other than as a long term objective, more time given to legal work means less time with patients.
2. The right to independent advocacy is also welcomed, although there are concerns as to how the services are to be developed given the current available skills and resources.
3. We strongly support the importance of good quality information being available. There may well also be advantages in the monitoring system being part of a much larger organisation such as the Commission of Health Improvement (CHI). There are however particular issues pertaining to detained patients. CHI appears to focus on monitoring systems occurring in hospitals, as opposed to visiting individual patients. This must be addressed.

The Definitely Negative Aspects of the Bill:

1. The absence of the Richardson Committee proposal for an Act based upon stated and incorporated principles.

Criteria for Compulsion

2. The absence of a 'best interest test' in relation to patients posing no serious risk to others is likely, in some circumstances, to result in patient harm. In treating certain medical conditions, compulsion can be counter-therapeutic, namely where the essence of therapy is the acknowledgement of personal responsibility.
3. The absence of a requirement for 'therapeutic benefit' in relation to serious risk to others.
4. The requirement for a Trust to arrange an assessment for possible compulsion under the Act on request from anyone. It is clearly open to abuse by difficult neighbours or aggrieved partners. This is compounded by the lack of an independent applicant.
5. The breadth of the proposed criteria leading to compulsion. Patients suffering from multiple sclerosis, Parkinson's disease, learning disability or dependence on alcohol or nicotine, amongst many others are included. All of these are 'mental disorders' (in terms of the suggested definition) and all are susceptible to 'medical treatment'. The broad criteria, combined with lack of exclusions make it difficult to imagine many circumstances where a patient who suffered from 'mental disorder' for which there was 'appropriate medical treatment available' would not potentially be subject to compulsion. This is likely to be a particular problem for people with long-term mental health problems such as learning disability, dementia or personality disorder, who could be subject to compulsion at any time. There is not even a clear requirement in relation to severity of the disorder given the absence of an equivalent of the 'nature or degree' to require 'admission to hospital' of the current Act.
6. The lack of clinician discretion as to whether or not to use compulsion, combined with the broad definition of mental disorder, loose criteria and lack of exclusions means there is an 'automatic chain-reaction' which is initiated by a request to the Trust for an assessment and 'inevitably' ends with compulsion under the Act. The conditions for assessment being met leads to a duty to carry out such an assessment. If the conditions continue to be met then there is a duty to apply to the Tribunal for an order, either for the patient to be treated compulsorily in hospital or as a non-residential patient. If the conditions are still met then the Tribunal must make the order.

Much has been made of occasions when the 1983 Act has not been applied when it might have been, sometimes by virtue of misunderstanding of the legal effect of the exclusion criteria. This may have been the case particularly in relation to patients with dual diagnosis, or patients with drug induced psychosis. However, on many occasions where drug abusing patients have not been admitted, albeit when legally they could have been, this is likely to have been the result of inadequate physical resources (locked wards) and the absence of nursing staff sufficiently trained in dealing with difficult and sometimes violent patients. The proposed 'solution' to this problem in the Bill will merely substitute a different problem for the current one. Hence, the combination of lack of exclusions and loosely defined legal criteria for compulsion suggest that there is likely to be frequent medically and socially inappropriate use of the new Act, especially in the context of a 'blame culture'. Yet it will remain the case that in-patient services will continue to be so stretched and poorly resourced as to continue to make it inappropriate or dangerous to admit patients exhibiting violence alongside those who are (for example) profoundly depressed or elderly.

We would very much support the Scottish proposal of 'impaired decision making' as the core criterion for compulsion.

7. The term 'medical treatment' is defined far too broadly particularly in light of the looseness of the criteria.

Powers of Discharge

8. It is unacceptable for clinicians to lose the absolute right to discharge civilly detained or compelled patients who they believe should no longer be detained or compelled. It is hard to imagine the effect on medical care in circumstances when neither the patient nor their doctor believes the patient should be in hospital, or subject to compulsion, and yet discharge is prevented, despite the patient having committed no offence.
9. For civilly detained patients under the current Mental Health Act, there are four possible routes for discharge, whereas the draft Bill will potentially reduce these to one. This represents a serious diminution of civil liberties.
10. The exclusion of Clause 6 (4) ('the treatment cannot be provided unless he is subject to the...Act') in relation to those who present a 'substantial risk of serious harm to other persons', clearly contravenes the core notion of using 'the least restrictive alternative'.

Data Sharing

11. The proposals in relation to sharing information will discourage people from seeking assistance and is likely to do more harm than good. This may particularly be the case if they take illicit drugs, given their knowledge that the doctor treating them would have a duty to consider reporting them to the police. Clear guidance on sharing information when there is a serious risk to others is given by the General Medical Council and supported by the courts.

Cost Implications

12. The workforce and financial cost implications of the Bill will be considerable. There is therefore a high risk that, without major additional resources, the delivery of mental health services will suffer as a result of implementation of the Bill. This risks defeating many of the Government's intended purposes of the Bill, including enhancing public protection. We believe it is almost certain that the Bill will prove unworkable.
13. It is important to note that members of the College work in the other jurisdictions within the UK. The Scottish legislature first passed incapacity legislation and has then proposed a mental health bill which has been universally welcomed. It is highly likely that there will be patients who will be subject to compulsion in one jurisdiction but not in the other. Gretna Green may again become a place to which to run.

Conclusion

This Bill was introduced in response to a belief that drafting a new Mental Health Act in this way will protect the public from the (misconceived) dangerousness of the mentally ill. Even if this is a legitimate aim, the Government's approach is fundamentally in error, in that it is based upon 'individual case scenarios' rather than properly upon an 'aggregate public health model'. The Government assumes that, because there may be individual cases identified where the availability of the powers proposed in the Bill would be likely to produce increased public protection therefore the overall effect of the Bill will be to increase public safety. This reasoning is erroneous. Rather, it is necessary to attempt to predict the overall effect upon patients and services in the aggregate of introducing any new legislation. Hence, if patients overall are driven away from services by the fear of 'draconian legal powers over them', if the functioning of mental health services is distorted away from 'best practice', and if, in the long term, the practice of psychiatry is stigmatised as being too closely linked with public protection, so that medical recruitment into the specialty is further reduced, then overall the effect of such new law will be to reduce public protection and national mental health.

The College believes that the Draft Bill will, if enacted, result in poorer mental health care and reduced public safety, both being at the further expense of increased stigmatisation of mental illness, stigmatisation within medicine of psychiatry as a specialty and erosion of patients' civil rights. A Mental Health Act must be both consistent with the nature of services to which it relates and command support and respect from those directly concerned with its use. Neither condition is satisfied by the Draft Bill.

Tony Zigmond

**Consultant Psychiatrist, Leeds Community and Mental Health Service (Teaching) NHS Trust
RCPsych lead on mental health law reform.**

Liberty's* Response to the Draft Mental Health Bill

Introduction

1. The representations made in this paper begin with a consideration of the main points Liberty wishes to address, and concludes with further significant areas, among which are some of the points on which views have been specifically requested by the Consultation Document¹.
2. Before the final draft of the Mental Health Bill, Liberty made a number of representations as to the proposed content of that Bill. Whilst it welcomes the expressed intention to enact a measure more compliant with the obligations of the ECHR, Liberty is disappointed to note that a number of the matters that go to the heart of civil liberties have not been satisfactorily addressed in the current Draft Bill.
3. Liberty has previously made submissions to the Expert Committee chaired by Professor Genevra Richardson in 1999². We believe that there are matters addressed therein that still remain to be dealt with in manner consistent with the Government's obligations to patients and potential patients of the system.
4. The current main areas for Liberty's particular concern are the following:
 - The definition of mental disorder
 - Dangerous people with Severe Personality Disorder
 - The non-statutory status of the Code of Practice
 - The incapacitated patient
 - Compulsory treatment in the community
 - Scope of Review Tribunals
 - Data Sharing

The Definition of Mental Disorder

5. Liberty is concerned to note that the Bill has chosen a broad and unqualified definition of the main criterion for compulsory detention. The term "mental disorder", standing alone replaces the more complex definitions of the 1983 Act, which was generally accepted to be outdated for various good reasons.
6. The concern arises out of the fact that there is no statutory definition of the phrase mental disorder save for the following broad statement in clause 2(6) "*Mental disorder means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning...*". There are no protections in the form of exclusions for those suffering from, for example, alcohol or drug dependency. In fact the definition is drawn so broadly that minor

* Liberty (The National Council for Civil Liberties) is one of the UK's leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research.

It is the largest organisation of its kind in Europe and is democratically run.

1 CM5538III

2 www.liberty-human-rights.org.uk

disorders such as mild depressions or learning disabilities would fall into the definition in clause 2(6). Liberty is very concerned that there are no protections from the abuse of power on the face of the statute. The Explanatory Notes to the Bill explain that further materials and diagnostic criteria will be referred to in the Code of Practice. However, Liberty notes with concern that the Code of Practice has no statutory force.³

7. We believe the criteria by reference to which a person may be deprived of his or her liberty should be set out in, at the least, secondary legislation. It is clear from the face of Article 5 and from the earliest Strasbourg cases⁴ that detention must be “according to the law”; that law must be readily ascertainable and precise. Liberty queries whether that can properly be said of the current Bill as structured. As drafted the Act lays itself open to abuse and for the criteria for detention to be changed without the democratic safeguards of legislation.
8. The reason for the change of format is said⁵ to be the fact that Clinicians have misunderstood the old Act, not applying the Act to those with mental disorder overlaid with, for example, substance abuse. The remedy lies in education, or in more precise drafting. It does not lie in replacing the protections of the old Act with general, undefined terms, which are open to abuse.

Dangerous people with Severe Personality Disorder

9. Liberty recognises that the Government has expressed⁶ its intention to include within the scope of the new Act those with untreatable psychopathic disorder, sometimes referred to as dangerous people with severe personality disorder or DSPDs. That is to say, that it intends to change the definition of treatability as to effectively remove it as a criterion for admission for treatment for this class of person. It is accepted that the treatability criterion does not find a clear place in the Strasbourg jurisprudence as it has developed in the Strasbourg case law. We also recognise that the challenge mounted in the Scottish jurisdiction⁷ to provisions having similar effect, arguing principles of ECHR law, failed in the Privy Council on a devolution issue appeal. We nonetheless contend that the compulsory detention within a hospital (and thus, therapeutic) regime, of those who can receive no therapeutic benefit from that regime is wrong.
10. Liberty believes there are cogent arguments against the Privy Council’s conclusion that it is neither arbitrary nor disproportionate to detain a person in hospital who cannot be treated. Detention in the hospital system without treatment is mere containment. In *Ashingdane v United Kingdom* (1985) 7 EHRR 528 the court accepted there should be some relationship between the place of detention and the reasons for detention under Article 5(1)(e): there must exist suitable conditions or treatment to justify the detention.⁸ It is suggested that hospital detention is unsuitable for a person who cannot benefit from treatment. Irrespective of the potential benefits to public safety of containment of such persons, it is inappropriate for any such person to be, effectively, imprisoned within the hospital regime. It is also an

3 See below

4 *In Winterwerp v The Netherlands* (1979) 2 EHRR 387, 402-403 para 39 - 45 part of the reasoning included the proposition that the law must be sufficiently accessible to the individual and sufficiently precise for him to for see the consequences for himself, in order to be lawful.

5 *In Mental Health Bill, Consultation Document Cm 5538 III*

6 *Draft Mental Health Bill Department of Health 2002 Annexe A paragraph 4*

7 *Karl Anderson and Ors v The Scottish Ministers and Ors PC* (31st July 2000) [2001] UKPC D5

8 See also *Guzzardi v Italy* 3 EHRR 367

inappropriate use of hospitals and National Health Service resources. There are shortages of properly trained health professionals and secure beds in the NHS.

- 11 Liberty understands that the number of persons within the definition of dangerous personality disorder is around only 300 – 600 in England and Wales⁹. We contend that the disproportionate publicity attaching to the comparatively small number of incidents caused by this minute segment of the population has unduly influenced policy. Liberty acknowledges that the public interest in safety must also be an important consideration. However, in this instance, it is suggested that the balance between the interests of the public and those of the individual is wrong.
12. Hospital is an inappropriate venue for the containment of offenders who cannot be treated, and even more inappropriate for *potential* offenders who cannot be treated.

The Code of Practice

13. There were cogent submissions made regarding the Code of Practice to the Expert Committee¹⁰ to the effect that the Code should have statutory force. The Committee decided, on balance, after careful consideration, that the Code should not have statutory force. It urged, however, that there should be a statutory presumption of compliance expressed in the Draft Bill.¹¹ There is none.
14. Liberty is concerned at these omissions. Indeed, it is our contention that the Code must have statutory force. The Bill has expressly been drafted with the purpose of fulfilling the Government's obligations under the ECHR. This is presumably not least because the circumstances and treatment of the mentally disordered expose them to a risk of breaches of their human rights (*Keenan v UK (2001) 33 ECHR 38* at paras 110 and 112, *X v UK* Appn. No. 6840/74 followed by the DHSS Review of Special Hospitals Seclusion Procedures). The Code's express purpose is to set down the principles that underlie the Bill, and give guidance to those discharging functions under the Bill. It is plainly at the Bill's heart, and following a recommendation of the Expert Committee, reference to it is placed in clause 1 of the Bill.
15. The Code's ambit includes the care and treatment of persons subject to the Bill, for instance, their seclusion and restraint, or their compulsory treatment – all areas in which their fundamental human rights are engaged. However, as stated above, the Bill as currently drafted does not impose any obligation on those who compulsorily detain or treat the mentally disordered under the Bill to comply with the Code, or contain any presumption of compliance: despite the fact that it is intended as a safeguard against breaches of their human rights.
16. The same deficiency in the present Act has recently been exposed in the case of *R (Munjaz) v Ashworth Hospital and others (unreported, 5 July 2002, Sullivan J)*. In essence, the UK Government claims to safeguard the human rights of those subject to the present Act and the Bill by a Code which detaining authorities and professionals may ignore at their discretion.

9 Government Consultation Paper *Managing Dangerous People with Severe Personality Disorder* [ref]

Mental Health Act 1983, November 1999 (the "Richardson Report")

10 in *Report of the Expert Committee; review of the*

11 *Richardson report paragraph 2.30*

This code cannot be relied upon by patients in legal proceedings because it has no greater force than merely non-statutory Guidance.

17. Liberty understands a number of the considerations regarded by the Richardson Report as essential to the construction of a humanitarian and modern mental health statute, are relegated to this non-statutory document. Thus reference to consensual care, autonomy, reciprocity, respect for diversity etc¹² will only be made in the Code.
18. It is suggested that the unsatisfactory position of the Code reflects the character of the Draft Bill, which is wholly different from the character of the legislation proposed by the Expert Committee. In essence, the patient focused Richardson Report is being replaced by a bill where presumed public safety considerations are dominant.¹³
19. Liberty submits that the only way in which the Bill's avowed intention to fulfil obligations to individuals, particularly under Articles 2, 3, 5, 6 and 8 ECHR, is to give the Code statutory force either under the Bill or by the making of a Direction by the Secretary of State.

The Incapacitated Patient

20. The proposal that incapable patients should benefit from statutory safeguards is plainly necessary. However, Liberty is concerned that the positive potential of this part of the Bill is undermined by the absence of a statutory definition of incapacity. If it is proposed that the Code should supply the definition, the comments made above in relation to the Code are repeated. Liberty submits that the definition put forward by the Law Commission (in *Who Decides?*¹⁴) should be adopted and included in the Bill to promote certainty in the care and treatment of this group of patients newly included within the statutory framework.
21. Parliament should further consider whether, having made legislative provision in respect of this aspect of incapable adult's lives, it should enact the Mental Incapacity Bill so that decisions may be made about other areas such as social care, housing and all medical treatment, not just for mental disorder.

Compulsory Treatment in the Community

22. Liberty wishes to encourage a cautious approach to the delivery of compulsory medical treatment in the community. We are pleased to see that there are no provisions which allow the compulsory treatment of a person in their own home. Liberty is nonetheless concerned that compelling the capacitated to accept medication with the threat of confinement on failure (clause 117) is likely to discourage co-operation; and undermine if not destroy the therapeutic relationship in the community. This approach runs the risk of alienating and isolating the patients it is intended to serve, since collaborative relationships are generally considered to be the most beneficial. An additional element of coercion in the relationship between carers and patients will not assist the provision of care, or, ultimately, the protection of the public.
23. It has been suggested¹⁵ that compulsory treatment in the community should be coupled with

12 *see further the critique of the Green Paper by Jill Peay in "Reform of the Mental Act 1983: Squandering an Opportunity"*

13 *See further in this connection the comments upon*

DSPDs above

14 *CM 8303*

15 *by The Sainsbury Centre for Mental Health, among others*

the provision of intensive community support services. If adequate care is absent the powers are open to abuse. Liberty supports the suggestion that assertive outreach is a necessity if the proposals are to work to the benefit of patients in the community, and draws attention to the significant negative response it understands to have been received from professionals. However, we also recognise that there is also informed support for the principle¹⁶ of such compulsion if adequately supported within the community.

24. Liberty wishes to emphasise the necessity for a suitable location for the administration of any treatment that was not carried out in a hospital setting; an issue allied to the provision of sufficient community support generally for those discharged from hospital care.

The Scope of New Review Tribunals

25. There is provision in the Bill for a single member to sit and determine some matters brought to the Tribunal. While it may be appropriate for some matters to be dealt with by a Single Member, it is suggested that fairness requires that such Single Member sittings should take place only with the consent of the patient concerned, and that he should be entitled to request a full sitting of the Tribunal.
26. While the creation of a right of appeal to a specialist body is welcomed by Liberty, it is concerned that this right is limited to appeal on a point of law. This has two adverse consequences:
 - a. The limitation on the right of appeal undermines the positive effect of the creation of the right and the appeal body, namely that of determination by an expert body with specific experience of the area. Many issues before Mental Health Tribunals will turn upon difficult clinical questions of diagnosis, treatment and care. To deal with these issues, there should be a right of appeal, with leave of the chairman or the Tribunal.
 - b. This will involve preliminary consideration of cases that are likely to require adjudication by a higher court. In recent years a number of vital issues in the area of mental health (particularly since the coming into force of the ECHR) have required adjudication by the House of Lords and Court of Appeal. Such decisions, e.g. *Bournewood*, have had consequences for very many patients. A requirement that such issues must first be determined by the Appeal Tribunal is undesirable, resulting in the prolonging of potentially unlawful detention or treatment of many. Leapfrog provisions exist in other statutes where delay is to be avoided in order to protect both individual human rights and the public interest.¹⁷
 - c. Liberty is further concerned that the right of appeal may only be exercised by the chair of the Mental Health Tribunal, and that there is apparently no mechanism for challenging this refusal of appeal save by judicial review of his decision.

Data Sharing

27. Although some information sharing may be necessary for public protection, Liberty is concerned that information should only be shared with individuals or public authorities when it is necessary to do so. It is vital that there is clear Government guidance on this issue

¹⁶ *National Schizophrenia Fellowship*

¹⁷ *Compare the Immigration Act materials*

since there are currently a wide variety of local and inter agency practices which lack consistency.

28. Particular care should be exercised in considering whether victims, or relatives of victims, of mentally disordered patients should be informed of their discharge, or progress towards discharge. The giving of such information often comes close to providing information about the medical condition or treatment of the patient to others when no other individuals would have their medical confidentiality broken in this way. Liberty believes that extreme caution should be exercised when passing out information to ensure that patient confidentiality is protected to as great an extent as possible. Further, any guidance on the provision of information to victims or their relatives should require those considering the giving of information to have regard to the effect of the giving of information on the mental state of the patient, and to the risk that he may be subject to reprisals or other negative consequences.

Liberty would like to acknowledge the authors of this article Alison Foster QC and Fenella Morris, both of Chambers of Nigel Pleming QC, 39 Essex Street, London WC2R 3AT

Response by Guy Otten, MHRT Regional Chair for Trent, Yorkshire and Northern Region, to the Draft Mental Health Bill

Introduction

I support the broad aims of the draft Mental Health Bill. It is time to modernise the law to reflect the community focus of treatment for the mentally ill, and to improve the law's support for the work being done in the National Health Service, Social Services and private sector to help mentally ill people.

In particular I support the introduction of a measure of compulsion in the community, as the way of using the least restriction on liberty consistent with the need to help the patient recover and maintain his/her recovery. I also support the new 'Gateway' system for sectioning, the Nearest Relative reform, the strengthening of the protection for the Bournwood patients and children, and the greater provision for DSPD patients. However, I have some reservations and concerns over the proposed Bill; some of which go beyond the Consultation areas.

The following remarks focus on some of the issues that strike me as either particularly controversial or problematic; they do not constitute the views of the Mental Health Review Tribunal service or of the other Regional Chairs or Liaison Judge.

The proposed Mental Health Tribunals (MHT)

Resourcing Issues

The new Mental Health Tribunal will be busier, and will therefore cost more than the existing Mental Health Review Tribunal, and must be resourced properly.

The MHRT has for years suffered persistent and serious inadequacy of funding. I look to a permanent Government commitment to fund the MHT (and MHAT) fully, so that delays are a thing of the past, (which means more staff and more members) and members are valued by proper mileage rates, and annually reviewed and increased fees which are automatically linked to an appropriate scale. Also, full advantage should be taken of technology, for example, by means of a website (to promote openness and a better understanding of what MHT will do and expect from users), and the provision to all Tribunals of laptops on which the Tribunal Assistant can prepare typed up decisions on the spot. Computer software programmes should be installed that enable the operational side when empanelling Members, rationally and quickly to identify those Members who are nearest to the venues, who are free at the time needed, and to ensure panels are gender balanced.

Full-time chairs must be appointed in sufficient numbers to handle high quality training and appraisals as well as to form a leadership backbone of highly able and knowledgeable members. This last should start now as part of the lead up to new legislation. I argue that clerks should be appointed to support the hearings who will both take a full note of the evidence and type up the decision on a computer/laptop immediately after the decision is made and the Reasons settled.

Tribunal Independence and Convention Compliance

The independence of the MHT is a vital component of the success of the MHT. MHRTs have, of course, always asserted independence in practice, but the reality of independence may be thought to be undermined by the low funding status the MHRT has 'enjoyed' within the Department of Health (DoH). Both the reality and appearance of full independence are vital for any judicial body's acceptance and authority. But no provision giving the Mental Health Tribunal independence of the DoH appears in the draft Bill.

It is arguably a Convention breach that a Tribunal which decides on the issues of compulsion of patients is run and funded by the very same body, DoH which runs and funds the National Health service, who are responsible for detaining most of the patients concerned. The case of *Smith v Secretary of State for Trade and Industry* (Times 15/10/99) shows that this question is no longer a theoretical one.

To resolve this problem, it has for some years now been agreed by the Lord Chancellor's Department, the Regional Chairs and DoH that at the first legislative opportunity, provision would be made for the MHRT to be made independent of the DoH, either by transferring the MHRT to the Lord Chancellors Department, or by making the MHRT an independent non-departmental, government body, similar to the Parole Board. While the Leggatt reforms may resolve the problem, it is not yet clear if, how far or when the Leggatt reform proposals will be implemented. In the meantime, it is essential that the vital strengthening of MHRT independence is not lost.

Medical Members

I am anxious that we will be losing the Medical Member in its traditional form, and in the light of the recent case of *Dervis Said v MHRT* (CO/3084/2002) decided on 27th November 2002 by Burnton J, I do not now believe that change is necessary to safeguard the MHT from Convention challenge.

Even under the current Act, there are many cases where the basic medical evidence is not seriously disputed, or disputed at all. Instead the enquiry often centres on the meaning of the evidence as far as the tests in sections 72 and 73 MHA 83 are concerned. Although the participation of a Consultant is of enormous help to a Tribunal, such matters may be resolvable with the help of a 'clinical' member who is not a consultant. Under the draft Bill's regime there will also be such cases: some patients may not contest the 'gateway' section, or if they do, contest it on grounds that can be adjudged satisfactorily by non Consultant Members.

Given the shortage of senior Consultant Psychiatrists from whom existing Tribunal Medical Members are drawn, it seems inevitable that the use of such Consultants (and perhaps Consultant Psychologists) will have to be focussed on those cases for which there is a compelling reason for using one, for instance where there is a disputed diagnosis. In other cases, the Tribunal could use 'clinical' members who will be experienced and specially selected.

Interlocutory procedures and Rules will be needed to identify the types of case which justify the membership of a Consultant on the Tribunal panel.

The Tribunal administration would have to be funded much more generously than at present, because it would have to be more proactive not only in getting reports in early but also to identify

whether the case justified the use of a Consultant Psychiatrist on the panel. For this the administration would need to seek a high degree of advance disclosure about the areas of dispute from patient representatives. A full-time President could screen cases ahead of listing to allocate the cases correctly.

The default position if a patient were unable to give clear instructions on this to his/her solicitor would be not to use a Consultant, but if necessary, the Tribunal could direct a short adjournment for such a Consultant to be empanelled. The preliminary report should always be supplied by a Consultant Member.

More controversially some cases which are completely uncontested might be suitable to be dealt with on the papers, subject perhaps to the approval of the medical panel member's report and the patient's solicitor.

A further safeguard will be the possibility of an appeal to the MHAT.

Tribunal Rules.

I see two omissions in schedule 4 (which sets out the provisions which will generate Rules):

- (i) Regional Chairs/the National President need a power to make Practice Directions to encourage 'best practice' and regulate such matters as single member sitting and paper hearings.
- (ii) Paragraph 1 (s) of schedule 4 enables rules to be made for decisions to be set aside essentially for clerical errors. This provision is unduly restrictive. The power to set aside decisions should be extended to cases where the Regional Chair identifies illegality in the procedure or unlawfulness in the Reasons. See my comments on s 67(1) of the MHA 83 below.

The Regional Chairs and Liaison Judge should be involved in the drafting of the Rules to ensure they are practical and workable.

The Care Plan and Convention Compliance

No power is given to the MHT to deal with the situation where the clinical team fails to offer an acceptable Care Plan, particularly in those cases which cause the greatest problem now, where a restricted patient is ready to move on to lesser security or out of hospital to a 'non-residential' phase of his/her treatment.

If no teeth are given to the MHT, it is predictable that sooner or later the new legislation will be found wanting at Strasbourg. (The recent case of *R (on the application of IH) v Secretary of State for Home Department (1) Secretary of State for Health (2)* [2002] EWCA Civ 646 was an attempt to have the MHRT's powers declared inadequate in Convention terms on this point. See the discussion on *IH* by David Mylan in the July 2002 issue of this Journal (pp 208 - 218)).

One way forward would provide that where the clinical team and/or services, to which the patient is due to be transferred as a result of the MHT's decision, disagree with that decision and decline to execute it, a special review by the MHT or MHAT could be arranged at which the dissenting clinicians are represented. If then after hearing the arguments of these parties, the MHT/MHAT still upheld the decision, the dissenters would be required to execute it (as any Court order).

This reform would not only overcome the criticism that the Tribunal lacks the characteristics of a Court under the Convention, but also help to speed through the system cases which are currently subject to blockage, and so result in patients being wrongfully denied their liberty.

Compulsion in the Community

Patients understandably fear that under the proposals in the draft Bill, they might be subjected to more, not less, compulsion. This may be true because compulsion in the community will be used in cases where patients now escape compulsion – and regrettably then not infrequently relapse.

But the opportunities for challenging treatment decisions that affect patients will be greater in the draft Bill than they are under the present legislation, and indeed these challenges can be predicted to constitute the greater part of the business of the new Mental Health Tribunal (MHT).

And of course the MHT will inherit the central principle of upholding a culture of respect for the patient and of the use of the least restriction on the patient compatible with the maintenance of the patient's health and safety and the public's protection.

DSPD and no crime committed

A principal criticism of the draft Bill is that citizens could be sectioned when they have never committed any crime. This is a strange criticism as of course civil sectioning already applies in these circumstances. Public criticism is, I think, misplaced. This is because no person will be sectioned under this provision without serious evidence of the DSP disorder and of dangerousness, which will inevitably include proof of incidents which could have led to convictions, but have not done so perhaps only because the patient has for instance been diverted from the criminal justice system under Home Office circular no. 66/90 and its successor circulars.

However, I propose it would be prudent:

- (a) to reassure the public that one of the main objectives of this provision will be to catch paedophiles (and other violent offenders) who come to the end of a determinate sentence and have to be released when it is clear on the best available evidence that they have not engaged in treatment and remain very dangerous, and are very likely to re-offend, and that these people in effect have shown their dangerousness by their original crime, coupled with no evidence that they have reformed, and
- (b) to find a form of words that imposes clear tests of dangerousness in such circumstances. It may be necessary in some instances in all fairness to have detailed trials of the facts where no criminal conviction exists, perhaps with witnesses called to testify to the facts. Although Tribunals commonly do not call witnesses to investigate disputed facts, they always have the option to do so when necessary.

Racial Discrimination

Critics say that the draft Bill will do nothing to eliminate the over-representation of ethnic minorities among detained patients. It is doubtful whether this mischief is curable simply through legislative provisions. An alternative view is that the problem is slowly being addressed through greater cultural awareness and understanding, but the overall pressure on ethnic minority people caused by the nature of UK Society will take years of cultural change to ease.

Exclusions

The consultation on the exclusions to be written into the Bill rightly makes it clear that the exclusions still need to be clearly formulated.

The overwhelming number of patients who receive mental health services voluntarily consent to treatment. Of those who have to be sectioned, the majority pose little or no danger to others, but are themselves vulnerable. But the few who do pose a threat to others attract great public concern. It is surely the legitimate business of Government to promote the health and safety of all citizens, whether mentally ill or not, to search for a balanced form of words in the draft Bill to achieve this aim, and to eliminate the defects of the present system, which has at times released dangerous people.

For instance, disagreements about treatability have arguably both unnecessarily undermined public safety, and denied some patients the care and treatment which they desperately needed, and could eventually have benefited from. Attempts to argue untreatability have generally been associated with a failure to understand the broad definition of medical treatment in s 145 of the 1983 Act, (substantially repeated in the draft Bill).

Law and Order? Crime Prevention and Joined-up Government

Indeed the Government's proposals could logically have gone even further, and still be within the terms of Article 5 of the European Convention on Human Rights, for example by proposing the detention and specialised treatment of those long term alcoholics and drug addicts,

(a) who are severely and dangerously personality disordered, and

(b) who are habitually violent or commit serious offences as a result of drink or drugs.

Experience suggests that mental disorder (in a wide sense) is typically present among these groups and statistics show that they are a major source of crime.

Sharing Information on Patients

Difficulties have been experienced in a small number of hospitals over access to patients' medical records to solicitors, when they are urgently needed in connection with Tribunal representation. Regional Chairs have had to direct hospitals to afford access. Confidentiality concerns are misplaced here.

In clause 170 of the draft Bill, it would be helpful to impose on hospital managers a duty to supply access speedily to patients' solicitors.

Duty to Examine v Right to an Assessment

One of the criticisms of the Mental Health Act 1983 is that patients who ask for help are at times turned away for various reasons. The draft Bill (in clause 9) imposes on the 'appropriate Minister' a duty to arrange an examination if requested, but fails to provide any enforcement mechanism to ensure this duty is taken seriously by managers on the ground. It is therefore only enforceable by judicial review, which is not a readily available remedy for a potential patient!

The Bill could, it is suggested, give a patient a right to apply to the MHT if he/she is turned away in this way. Such a provision would make it more likely that managers focussed resources on the

delivery of this important service for patients. The hearing would have to be held within days to be of any use to the patient.

On a complaint that a request for an assessment was refused, the Tribunal could direct the examination (if it felt one was warranted). Without some teeth such a duty is likely to be weak.

Section 67(1) of the Mental Health Act 1983

This section gives the Secretary of State a power to refer to the Tribunal the case of an unrestricted patient (and those subject to guardianship) 'if he thinks fit'. This is interpreted essentially as an administrative power, to ensure patients get a hearing when they might otherwise not have one. But there are occasions when a judicial review, and the expense and delay that judicial review causes, could be avoided, and speedier (and cheaper) justice delivered, if the Regional Chairs had a judicial version of this power, namely to set aside a clearly unlawful decision and to order a fresh hearing, as do for instance the District Chairs in The Appeals Service. Regrettably there is no provision for such a power in the draft Bill.

Safeguards

I share the concerns of commentators who are nervous that the safeguards currently in place under the 1983 Act are to be abolished. The MHAC's role is I believe vital and should not be diluted in any way. However the abolition of the Nearest Relative's right to discharge is not so great a loss, as the Nominated Person (a person likely to be more acceptable to the patient than the Nearest Relative) will have a right to apply to the Tribunal for the patient's discharge under clauses 28 and 42 of the Draft Bill.

Conclusion

I recognise that the draft Bill still needs strengthening and clarifying, and that the definition of mental disorder needs tightening, but my greatest concern is that the successful fulfilment of the Draft Bill's admirable objectives will depend on the generosity of the level of Government financial commitment. For example, the ready availability of both a genuine right to an assessment and help when requested depends upon further increases in resources, person power and training, fresh commitments for which must be made ahead of time, i.e. now.

Response by Robert Brown, Independent trainer of Approved Social Workers and Mental Health Act Commissioner, to the Draft Mental Health Bill

THE CHANGING ROLE OF THE APPROVED SOCIAL WORKER

Key elements of this article were originally included in two separate lectures at conferences hosted by the Institute of Mental Health Act Practitioners on 7th February 2000 and on 7th March 2001. The material has been revisited in the light of the publication of the Draft Mental Health Bill.¹ Although a new Mental Health Bill was omitted from the Queen's Speech on the 13th November 2002, the Government has stated its intention to introduce one as soon as time allows.

Summary

There has been concern in social work circles that mental health law reform will lead to a dilution of the role of the Approved Social Worker (ASW). This is against a background of major changes in the way social workers are employed in the mental health field. The article considers: key issues affecting ASWs in recent proposals, the history of the ASW, their key tasks under the current Mental Health Act, and changes in the way ASWs are being employed. There is then some discussion of the potential future for Approved Social Workers.

Mental health law reform proposals of consequence for Approved Social Workers

The Green Paper² was published in November 1999 and asked the following question:

- Should the applicant for admission be an ASW or could they be a mental health professional with specialist training or recent knowledge of the patient?

The White Paper published in December 2000 stated that 'the third person [i.e. in addition to two doctors] will be a social worker or another approved mental health professional with special expertise in the care of people with serious mental disorder, and where relevant learning disability, who will be responsible under the new legislation for co-ordinating the preliminary examination process'.³

The Explanatory Notes⁴ published at the same time as the Draft Bill elaborates on Clause 2(9) of the Draft Bill (which defines 'an approved mental health professional' as a person who 'falls within a description specified by the appropriate Minister in regulations'). Note 11 says as follows:

1 *Draft Mental Health Bill. Cm 5538-I. Department of Health 2002*

2 *Reform of the Mental Health Act 1983. Cm 4480. Department of Health 1999*

3 *Reforming the Mental Health Act – Part 1 The new legal framework. Department of Health and the Home Office 2000. At para. 3.32.*

4 *Draft Mental Health Bill. Cm 5538-II. Department of Health 2002*

“AMHPs [i.e. Approved mental health professionals] are likely to be social workers and members of other professions such as mental health nurses. There will be a requirement for those who intend to carry out the role of AMHP to undergo training and have a set level of understanding of mental health legislation and in assessing the non-medical aspects of treatment. Only then will the mental health professional be “approved” and able to carry out this role.”

The main concern in this article is with the central role that has developed for the ASW in the use of civil compulsion. Awareness of this role, and the way it has developed, is essential before reaching any judgment on the clear Government intention to move from ‘ASWs’ to ‘AMHPs’.

The History of the ASW

The Approved Social Worker’s role in England and Wales grew from that of the Mental Welfare Officer (MWO) under the 1959 Mental Health Act. The MWO was often seen as a possible applicant when there was no relative available, as well as someone who could co-ordinate the process of admission. Over time it became the custom, rather than the exception, that the MWO would be the applicant. It is interesting to note that a similar process is now occurring in Northern Ireland where an increasing proportion of applications involves ASWs rather than relatives.

Reasons for the MWO being the applicant included:

- They developed a certain expertise (assessing social circumstances and their links with behaviour, mobilising resources and knowing the relevant personnel, ensuring any intervention was the least restrictive necessary in the circumstances, knowledge of the law and related procedures, and the ability to make a decision);
- It took the pressure off relatives if the MWO made the application; and
- After the Local Authority Social Services Act of 1970, the MWO could be seen clearly as independent from the medical profession as they worked for the new Social Services Departments rather than the local health authority.

There was a dilemma in 1974 when, apart from those based in Special Hospitals such as Broadmoor, hospital-based social workers became part of Social Services Departments. Such workers were allowed to become MWOs. This was based on the argument (put by Baroness Faithfull in the House of Lords) that their knowledge of patients and resources as well as their employment status outweighed any disadvantage that they might be seen as potentially collusive with the psychiatrist. A Secretary of State letter dealt with this concern by saying that where a hospital-based MWO feared that they would not be seen as independent, they could ask for the assessment to be made by another MWO.

Some concern was expressed in the 1970s about a loss of mental health expertise but the social worker remained as the usual applicant.

With the amendments to the Mental Health Act in 1982 there were tighter expectations of the new Approved Social Worker in terms of training, competence and specific duties (such as interviewing the patient in a suitable manner).

Statutory basis for employing ASWs

Section 114 of the Mental Health Act 1983 states the following:

- “(1) A local social services authority shall appoint a sufficient number of approved social workers for the purpose of discharging the functions conferred on them by this Act.
- (2) No person shall be appointed by a local social services authority as an approved social worker unless he is approved by the authority as having appropriate competence in dealing with persons who are suffering from mental disorder.
- (3) In approving a person for appointment as an approved social worker a local social services authority shall have regard to such matters as the Secretary of State may direct.”

The relevant circular,⁵ containing the Secretary of State’s directions, gives the General Social Care Council control over training requirements. From 1995 all ASW training programmes have needed to assess specific competences. Prior to this, the responsibility for assessing the competence of ASWs was left exclusively with local authorities. They still retain a responsibility as seen in section 114 but the development of the new courses has probably led to more consistency across authorities in terms of standards. The circular states:

“14. Approved social workers should have a wider role than reacting to requests for admission to hospital, making the necessary arrangements and ensuring compliance with the law. They should have the specialist knowledge and skills to make appropriate decisions in respect of both clients and their relatives and to gain the confidence of colleagues in the health services with whom they are required to collaborate. They must be familiar with the day to day working of an integrated mental health service and be able to assess what other services may be required and know how to mobilise them. They should have access to, consultation with and supervision from qualified and experienced senior officers. Their role is to prevent the necessity for compulsory admission to hospital as well as to make application where they decide this is appropriate.”

Approved social workers’ tasks (with section references)

As is apparent from the list which follows, ASWs have a number of statutory duties set out within the 1983 Act. Note that those tasks which are marked with an asterisk can only be performed by an ASW.

- ss6&137 If an application is made, the ASW has the powers of a constable to convey the patient to hospital (see chapter 11 of the Code of Practice).
- s8 The ASW may be asked to carry out the functions of guardian by the Local Authority.
- *s11(3) To take such steps as are practicable to inform the nearest relative that an application has, or is about to be, made, and inform them of their powers of discharge under section 23. This should include reference to s25 RMO blocking power regarding danger.
- *s11(4) If it is an application for admission for treatment or for guardianship, to ensure that the nearest relative does not object to the application being made, unless this is not practicable or would involve unreasonable delay.

⁵ LAC(86)15

- *s13(1) “It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him.” In carrying out this task the ASW must interview the patient in a “suitable manner”; consider “all the circumstances of the case”, including: past history of the patient’s mental disorder; the patient’s present condition; the effect on this of any social, family and personal factors; the wishes of the patient; medical opinion. The ASW should consider: informal admission; day care; out-patient treatment; Community Psychiatric Nursing support; crisis intervention centres; primary health care support; social services provision; friends, relatives, voluntary agencies. The ASW must then decide whether “detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need” (s13(2)). Although it is important to stress that the ASW is acting as an officer of the local authority who are accountable for the ASW’s actions, it should be noted that the ASW also carries a personal responsibility in making this decision.
- s13(4) If required to do so by the nearest relative, the Social Services Department must direct an ASW to assess whether to make an application for detention.
- *s13(4) If the ASW does not apply they must give reasons in writing to the nearest relative.
- s14 If the nearest relative applies for detention under section 2 or 3, a social worker must “interview the patient & produce a report on his social circumstances” for the hospital managers.
- *s25B Where appropriate and having regard to the patient’s history, to provide a written recommendation in the prescribed form for supervised discharge.
- *s29 In certain circumstances, to apply to the County Court for the displacement &/or appointment of a nearest relative for the patient.
- *s115 To enter and inspect premises where there is reasonable cause to believe that a patient is not under proper care.
- *s135(1) To apply for a warrant to search for and remove to a place of safety patients or persons living alone or in need of care.
- *s136 To interview a person arrested by the police under s136.
- s48 National Assistance Act 1948 If a patient is admitted to hospital or Part III accommodation, then the local authority must ensure that any moveable property of the patient is protected.

In addition, the Code of Practice (para 11.13) states that the ASW “should leave an outline report at the hospital when the patient is admitted, giving reasons for the admission and any practical matters about the patient’s circumstances which the hospital should know.” Subsequent advice⁶ states this should also include information about any children and possible arrangements for them to visit.

⁶ LAC(99)32

There were initial problems in making the arrangements for training and assessment of ASWs and they were not appointed as such until 1984. It then took a number of years for the job to be seen as one that would normally be undertaken by mental health specialists. Also, with the collapse of CCETSW's⁷ initial system of examination, the training courses were not formally required to assess trainee ASWs until 1993. Since that time I would suggest that there has been a better standard of work, increased knowledge of the legal issues and more consistency of approach. There are moves to standardise the arrangements for re-approval (which has to be at least every 5 years).

Why should these tasks be performed by ASWs?

The key areas for the purposes of this short article are those concerning the making of applications for detention or guardianship, and the making of recommendations for after-care under supervision. Apart from practical questions (such as who else would actually want to be involved in these processes) we need to look at the reasons for ASWs, rather than other professionals or, as currently, nearest relatives, taking on these tasks. It is the co-existence of these factors that seems to me to be an important safeguard.

The following seem to me are all legitimate views and they were noted to a greater or lesser extent in the Report of the Expert Committee:⁸

- (1) ASWs are independent from the medical profession in terms of employment base, accountability and training. In general the personal accountability for decisions has allowed them to achieve a "creative tension" with medical colleagues (an expression that I believe William Bingley first coined when he was MIND's Legal Director).
- (2) ASWs have developed an expertise in co-ordinating the assessment, in the process of conveyance to hospital, and in dealing with the family and social implications of detention or guardianship.
- (3) In their basic ASW training and refresher training they have developed a culture of seeking the least restrictive alternative based on an awareness of liberty issues, social models of mental disorder and relevant resources.
- (4) ASWs undergo specific post-qualifying training which lasts a minimum of four months and includes a detailed study of the Mental Health Act and a formal assessment of their knowledge. This is invaluable in working to the Act, and I believe it benefits service users, carers and professionals involved in the process.
- (5) While being independent, they are, nevertheless, familiar with resources because they are usually directly involved with mental health services.
- (6) They are not directly involved with the continuing consequences of the deprivation of liberty, such as preventing people from leaving a ward or the administration of unwanted treatments. (The exceptions to this last rule are rare but significant in the current context. For example some ASWs have been involved in making an application for guardianship and have then carried out the functions of guardian. Equally some have made a recommendation for supervised aftercare and then taken on the role of supervisor.)

7 *The Central Council for the Training and Education of Social Workers.*

8 *Report of the Expert Committee; Review of the Mental Health Act 1983, Department of Health 1999.*

The impact of joint working with Health on the independence of ASWs

There have been recent changes in the way that ASWs are being employed in England and Wales. I am currently involved with both basic and refresher training for ASWs in Somerset and I am also the External Assessor for the ASW programme in Northern Ireland. Northern Ireland ASWs are working to different legislation but there are some important parallels with the English and Welsh systems. Like the Trust system in Northern Ireland, the Somerset Partnership is a single health and social service agency and, although the ASWs are still technically employed by Somerset County Council, they are well integrated with health colleagues in day to day work. Similar developments have taken place in Wiltshire and elsewhere, and this is certainly the direction in which movement is expected across England and Wales.

While such systems have the benefit of involving ASWs in mental health services, they do raise important questions.

- How independent can the ASW be (or be seen to be)?
- How will the ASW link with other relevant services such as child care, disability (including learning disability) and old age?

The ability of the ASW to make their decisions in a way which preserves the ‘creative tension’ with doctors may depend less on their employers and more on maintaining a professional line of accountability and support for their role as in Northern Ireland. They may also be seen to have a positive role in maintaining links with social workers and social care colleagues in child care, disability services etc.

ASW to AMHP

Whatever happens to the Draft Bill, it looks as though professionals will still be able to detain an individual without first going to a court or tribunal. In these circumstances I am left with the view that there should be clear limitations on who could be the equivalent of the current applicant, and a clear expectation of their role.

There are a number of issues raised by the changes envisaged in the Draft Bill. For example, for independence reasons we may move to a position where an applicant comes from a team other than that which will be providing the compulsory 28 day assessment. The loss here would be, that it will be even more unlikely that the patient will know the applicant, especially for community based assessments; on the other hand the need for independence may outweigh this concern. I hope it does not lead to a roving crisis team approach. If most assessments are still undertaken in hospital it could well be that the applicant will know the patient, depending on how mental health teams are organised.

Effect of various professions taking on the AMHP role.

If other professionals are to be applicants, then knowledge of the patient would not seem to be enough. The strength of the current position is the balancing perspective and potential “creative tension” which is inherent in the ASW role. This is based on the six views identified above. It may well be that other professionals could achieve these as well as, or better than, current ASWs, and if this is the case I can see little objection to change. Indeed many of the original Mental Welfare Officers had nursing backgrounds and it may be that it is the essence of the role itself that leads

to the creative tension. But it is a big 'if' concerning the introduction of other professionals, and I am not sure that many service users would see nurses as providing an appropriate balance to the medical view of doctors. On balance I can see no major advantage in having anyone other than the ASW as applicant and several potential disadvantages if this were to be changed.

