ISSN 1466-2817

Journal of Mental Health Law

NORTHUMBRIA LAW • PRESS

June 2001 pages 1-110

Journal of Mental Health Law

June 2001 Edition No. 5. Pages 1-110

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Foreword

We begin this issue of the Journal by focusing on Parts I and II of the Government White Paper - Reforming the Mental Health Act, which was published in December last year.

Our first article by Philip Fennell takes a detailed look at the proposals contained in both volumes of the White Paper, which set out radical changes to our current legal framework of compulsory mental health care. The author argues that the proposals, which promote a closer working relationship between psychiatric and criminal justice systems, will result in adverse consequences for traditional medical values, and a shift in the balance of power between patients, family and state. Professor Herschel Prins provides further comments on the proposals for High Risk patients under Part II of the White Paper and questions whether the proposals give rise to unrealistic public expectations of risk assessment and management based on moral panic and the Government's need for political expedience.

Peter Bartlett, takes a critical look at English mental health reform and urges English analysts to look closely at the mental health law reforms which have occurred in Ontario and which reflect many of the concerns and issues currently being debated in the UK. The article draws a number of useful comparisons between the Ontario system and the proposed English one and suggests that English commentators and legislators would do well to look to the experience of mental health law reform in Ontario, which has much to teach us.

In our fourth article "Legal Knowledge of Mental Health Professionals: Report of a National Survey", Dr Nigel Eastman, Caroline Roberts and Jill Peay present findings from a national postal survey carried out to assess relative levels of legal knowledge within professional groups who hold key responsibilities under the Mental Health Act. The results of this important study are significant for those working and training professionals in the field of mental health and are of particular relevance for those deciding on the future roles of professionals under the proposed new Mental Health Act.

Professor Georg Hoyer and Dr Robert Ferris set out a detailed analysis of involuntary outpatient treatment of patients with mental disorders. They explore whether the introduction of broad outpatient commitment orders is warranted by empirical evidence about the efficacy and effectiveness of such orders in their article.

Finally, David Hewitt considers the use of placebo for therapeutic purposes in the treatment of patients with mental illness. The article examines the lawfulness of the practice under domestic law and the possible effect of the Human Rights Act 1998 upon therapeutic placebo administration.

In this issue we review four recent cases, three of which concern Mental Health Review Tribunals. In each of the cases, the effect of the implementation of the Human Rights Act 1998 is very apparent. Anselm Eldergill considers the Court of Appeal's decision in *The Queen (on the application of H) v Mental Health Review Tribunal North East & London Region and the Secretary of State for Health* (2001). The Court's conclusion that the burden of proof placed on patients at MHRTs is incompatible with Articles 5(1) and 5(4) of the European Convention on Human Rights, (and the consequent Declaration of Incompatibility), is of course of considerable interest beyond the confines of mental health law. In *R v Camden and Islington Health Authority ex parte K* (2001) the Court of Appeal considered the plight of those patients granted deferred conditional discharges,

but who have no reasonable prospects of discharge. In *The Queen (on the application of C) v London South and South West Region Mental Health Review Tribunal* (2000) the Administrative Court declined to view the standard 8 week period between an application by an unrestricted patient and the MHRT hearing itself, as failing to meet the requirement in Article 5(4) for a speedy review of detention. Kristina Stern and Rebecca Trowler have submitted interesting analyses of these two decisions. Finally, Philip Plowden considers the Court of Appeal's deliberations in *R v Offen, McGilliard, McKeown, Okwuegbunam, S* (2000), on mandatory life sentences for those convicted of a second 'serious' offence unless 'exceptional circumstances' apply, and looks at the implications of the Court's decision for those suffering from a mental disorder.

As always, we are very grateful to all the authors for their generous contributions to this issue of the Journal.

Charlotte Emmett
Editor

Reforming the Mental Health Act 1983: 'Joined Up Compulsion'

*Philip Fennell**

Introduction

This article discusses the two volume White Paper *Reforming the Mental Health Act* issued by the Government in December 2000.The two volumes are separately titled *The New Legal Framework*[1] and *High Risk Patients*[2]. The foreword to the White Paper appears above the signatures of the Secretary of State for Health, Alan Milburn, and the Home Secretary, Jack Straw. This is heralded as an example of 'joined up government', and indeed one of the themes of the White Paper is the need for closer working between the psychiatric and criminal justice systems. The primary policy goal of the proposals is the management of the risk posed to other people by people with mental disorder, perhaps best exemplified in Volume One of the White Paper which proclaims that 'Concerns of risk will always take precedence, but care and treatment should otherwise reflect the best interests of the patient.'[3] This is a clear reflection of the fact that the reforms are taking place against the background of a climate of concern about homicides by mentally disordered patients, whether mentally ill, learning disabled, or personality disordered.[4]

The Government has also had to ensure that their proposals comply with the requirements of the Human Rights Act 1998, and state that new legislation will be 'fully compliant' with the Human Rights Act.[5] The issue of Convention compliance is an important one. In terms of rights, the traditional concern of mental heath legislation has been to protect patients against arbitrary detention (Article 5) and to respect their right to protection against inhuman and degrading treatment (Article 3) or their right to respect for autonomy (Article 8). However, implicit, and sometimes explicit in the new proposals is a broader concept of rights, going beyond the notion of patients' liberty rights to embrace the right of the public to expect that the state will in certain circumstances protect them against threats to their right to life under Article 2. The classic case on this is of course *Osman v United Kingdom* where the European Court of Human Rights held that

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1 *Reforming the Mental Health Act: Part I The New Legal Framework TSO 2000 Cm 5016-l.*

2 *Reforming the Mental Health Act: Part II High Risk Patients TSO 2000 Cm 5016-ll.*

3 *Cm 5016-l, para. 2.16*

4 *Taylor, P.J. and Gunn, J., 'Homicides by People with Mental Illness: Myth and Reality' (1999) 174 Br. J. Psychiatry, 9-14,*

5 *Cm 5016 -ll para. 1.11*

there would be a breach of Article 2 if authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of identified individual or individuals from the criminal acts of a third party, and failed to take action within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.'[6] Clearly the Government has realised that it enjoys a certain margin of appreciation in balancing the rights of the patient not to be detained arbitrarily against the 'rights' of the public to be protected against violent conduct from mentally disordered people, and public protection clearly predominates the proposals.

The Government's primary concern is that too few rather than too many risky people are subject to compulsory intervention, as is evident from the following passage:

> The 1983 Act … fails to address the challenge posed by a minority of people with mental disorder who pose a significant risk to others as a result of their disorder. It has failed properly to protect the public, patients or staff. Severely mentally ill patients have been allowed to lose contact with services once they have been discharged into the community. Such patients have been able to refuse treatment in the community. And it is the community as well as those patients which has paid a heavy price. We also need to move away from the narrow concept of treatability which applies to certain categories of mental disorder in the 1983 Act. New legislation must be clearly framed so as to allow all those who pose a significant risk of serious harm to others as a result of their mental disorder to be detained in a therapeutic environment where they can be offered care and treatment to manage their behaviour.[7]

The Mental Health Act 1983 is described as 'outmoded, based on treatment within hospitals, complex, confusing and lacking in explicit statements of its underlying principles.' There are two primary policy goals behind the White Paper. The first is to introduce more effective compulsory community powers than guardianship or supervised discharge to ensure that patients in the community are subject to an effective undertaking to carry on with medication. The second main goal is to ensure that dangerous severely personality disordered patients can be subject to detention in the mental health system or in some intermediate system of 'third way' therapeutic institutions. In addition there are a number of subsidiary aims, one of which is the abolition of the nearest relative and their replacement by a nominated person with much more limited powers in relation to the patient's care and treatment, shifting the balance away from the rights of families towards the power of the state to intervene compulsorily. Another is the abolition of the review functions of hospital managers, which for the most part will be taken over by a new Mental Health Tribunal. In this article I shall argue that these proposals will bring about a convergence between the psychiatric and criminal justice systems, with adverse consequences for traditional medical values such as confidentiality, and a refocusing away from traditional due process rights of patients towards the rights of the community to be protected from mentally disordered people.

The White Paper Proposals

The White Paper begins by acknowledging that promoting and supporting good mental health services is a key responsibility of Government[8] and outlining the Government's investment programme. It then proceeds to list the Mental Health National Service Framework Standards which states the legitimate expectations of service users and carers to assessments of their needs,

6 *(1998) 29 EHRR 245 at 305.*

7 *Cm 5016-l, para. 1.15*

8 *Ibid., Para 1.1.*

to written care plans, to access the service, and to the benefit of suicide prevention strategies. After statements of the importance of social inclusion and non-discrimination, the Government then states 'the two aims of mental health legislation' in the following terms:

> First that those who are seriously ill get appropriate health care to meet their particular needs; and second, that the public is protected from the small minority of people with mental disorder who may pose a risk to their safety.[9]

The fixation on risk management is evident from the fact that a notable absentee from this list is the traditional aim of protecting patients against ill-treatment or arbitrary use of compulsory powers. The ascendency of risk management is further exemplified in the combination of broader powers to detain and treat compulsorily in the community, and there will be a single pathway to compulsion, a care and treatment order, which will allow either care and treatment under detention in hospital or compulsory care in the community.

Mental Disorder

In order to be subject to the new regime of compulsory powers the patient will have to be suffering from mental disorder which will be broadly defined as 'Any disability or disorder of mind or brain, whether permanent or temporary which results in an impairment or disturbance of mental functioning.'[10] The definition is drawn from the Law Commission Report on Mental Incapacity.

This represents a reversal of the 20th Century trend in mental health legislation towards developing legal sub-categories of mental disorder, and attaching different admission criteria to each. At the end of the 19th Century there was separate legislation dealing with lunatics and with idiots and imbeciles. The Idiots Acts were replaced by the Mental Deficiency Act 1913, which introduced the concept of mental deficiency, with several subcategories of 'mental defective' including moral imbeciles. Until the Mental Health Act 1959 these separate statutory frameworks continued to operate, subject to the overarching jurisdiction of the Board of Control, the successor body of the 19th Century Lunacy Commissioners. The 1959 Act brought all mental disorder under one framework. It allowed compulsory admission for up to 28 days based on the presence of mental disorder generally defined. Detention under the long-term power to detain for treatment had to be based on the presence of one of four statutory subcategories of mental disorder The so-called 'major disorders' were 'mental illness' (undefined) and 'severe subnormality'. The minor disorders were 'subnormality' and 'psychopathic disorder', and here there was a rudimentary treatability test, as well as an upper age limit on detention unless the patient was dangerous.[11]

The Mental Health Act 1983 abolished the age limit and relied solely on a treatability test for the 'minor disorders', now psychopathic disorder and mental impairment. The drawback of the treatability test from the Government's point of view is that it confers clinical discretion on psychiatrists, which means that doctors may refuse to detain those whom they consider untreatable. Adoption of the new broad definition of mental disorder is almost equivalent to using the catch all 'any other disorder or disability of mind' which appears at the end of the generic definition in s. 1 of the current Act. The Government is frank about its intentions:

> It is intended to ensure that the presence, or absence, of any one particular clinical condition does not limit the discretion of clinicians to consider whether a patient with mental disorder

9 *Cm 5016-I, para. 1.13.*

10 *Cm 5016-I, para. 3.3.*

11 *Mental Health Act 1983, s 26.*

> should be treated under compulsory powers. … This means that no particular clinical diagnosis will have the effect of limiting the way that the powers are used … It will also help to ensure that people who require care and treatment under mental health legislation are not excluded because of too narrow a definition of mental disorder.[12]

In addition to broadening the definition of mental disorder, it seems that the Government intends to abandon the limiting clause in s. 1(3) of the 1983 Act, which states that no-one shall be treated as suffering from mental disorder by reason only of sexual deviancy or addiction to alcohol or drugs. This reflected the desire to ensure that homosexuals were not subject to detention under mental health legislation, and the idea that there was little point in compelling addicts to accept treatment which they did not want. The effect of this has been that a person cannot be detained unless there is some accompanying mental disorder, such as Korsakoff's syndrome, in the case of alcoholism.

There is nothing in Article 5(1)(e), which authorises detention on grounds of unsoundness of mind, to inhibit such a broad definition. The well-known *Winterwerp* formula requires only that the unsoundness of mind must be a true mental disorder established by objective medical expertise, and that it must be of a nature or degree warranting confinement. Article 5(1)(e) of the European Convention on Human Rights allows detention on grounds of alcoholism or addiction to drugs, but the European Court of Human Rights was emphatic in *Winterwerp* that detention on grounds of unsoundness of mind under Article 5(1)(e) did not authorise detention on grounds of mere deviance from society's norms.'[13]

The broadening of the definition of mental disorder on its own will have the effect of narrowing the mesh of the net of compulsory powers, more people will be liable to detention, and more people to compulsory medication in the community. Before turning to the question of treatability, it is important to examine the new framework of compulsory assessment and treatment, 'the single pathway' to compulsion.

The Single Pathway

There will be a single pathway to compulsory care and treatment. What this means is that the same decision-making procedures will apply to compulsory treatment in hospital or in the community. Instead of separate procedures for detention (hospital based) and, supervised discharge (which requires a previous period of detention) and guardianship (local authority social services based) there will be one single pathway to either form of compulsion. This is based initially on powers very similar to the current s. 2 admission for assessment under the 1983 Act. The patient will be able to be subjected to compulsory assessment for up to 28 days on the authority of two doctors and a social worker or other 'mental health professional with specific training in the application of the new legislation.'[14] The major difference in personnel will be that the Government appears to be contemplating using community psychiatric nurses as applicants as well as the current Approved Social Workers. The current system is based on the fact that the application comes from an ASW who is specially trained in this work, who is employed independently of the hospital authorities, and who exercises individual statutory discretion as to whether it is necessary to make an application. The addition of 'another mental health professional' as a potential applicant is intended to involve community psychiatric nurses (CPNs). CPNs have traditionally worked under the direction of psychiatrists. ASWs currently undergo 60 days

12 *Cm 5016-l, paras. 3.3 – 3.5.*

13 *Winterwerp v the Netherlands (1979) 2 EHRR 387.*

14 *Cm 5016-1, para. 3.14.*

of specialist training to receive their warrant, and similar training will be needed for CPNs. The principle of independent checks and balances and the notion that admission is a much a social as a medical matter are both greatly diluted by these proposals.

The criteria for compulsory assessment are that: (a) the patient must be suffering from mental disorder that is sufficiently serious to warrant further assessment or urgent treatment by the specialist mental health services; and (b) without such intervention the patient is likely to be at significant risk of serious harm, including deterioration in health, or pose significant risk of serious harm to other people. The specialist mental health service is defined as care and treatment for mental disorder provided under the management of a clinical supervisor.[15] In contrast to the responsible medical officer under the 1983 Act, a clinical supervisor need not be a psychiatrist, he or she could be a clinical psychologist[16], and this may be more likely where the patient has a personality disorder or a learning disability. Currently the criteria for admission for assessment under s. 2 are that that person has mental disorder, in the general sense, of a nature or degree warranting assessment, and that the patient's detention for assessment is warranted in the interests of their health or safety or for the protection of others. The proposed new test will be that the mental disorder warrants assessment or urgent treatment by the specialist psychiatric service, in other words bad enough to see a consultant psychiatrist or clinical psychologist. Under the new criteria, the risk will have to be significant. This may be thought, and intended, to be a dilution of the 'substantial risk of serious harm' which appears in the supervised discharge criteria in ss 25A-H of the 1983 Act. But neither term refers to statistical probabilities. 'Substantial' means having substance, and significant means having 'significance'. How much substance or significance they have to have is a matter for the decision-maker, and presumably also for the Code of Practice to be issued to accompany the Act.

During the 28 day period no treatment without the consent of the patient, other than urgent treatment, can take place before a written care plan has been produced.[17] This is the equivalent under the existing Act of the provision that Part lV, which authorises treatment without consent, does not apply until the second medical opinion has been furnished to convert an emergency 72 hour admission into an admission for assessment under s. 2.[18] There will be a requirement to prepare a written care plan within three days unless there are exceptional circumstances making this impractical.[19] The treatment plan 'may in the initial stages be quite simple', but once there has been a full assessment it will have to set out in detail what is to be provided, in line with the Care Programme Approach, which means that there must be a key worker, a risk assessment, a needs assessment, a written care plan, and regular review.[20] There can be no compulsion beyond 28 days unless the Mental Health Tribunal (MHT) makes a compulsory care and treatment order or makes a further order for assessment, and patients have a 'fast track right of appeal' to the MHT during the first 28 days.

Care and Treatment Orders

One of the main changes proposed is in the role of the Mental Health Review Tribunal. Currently it reviews the need for continued detention, decisions to detain being made by mental health professionals, hospital managers and the courts. The new tribunal will be a Mental Health Tribunal (MHT), which will be the body which makes the decision to impose the care and treatment order

15 *Ibid., p. 62*
16 *Ibid., p. 58.*
17 *Ibid., para. 3.38.*
18 *Mental Health Act 1983, s. 56.*
19 *Cm 5016-l, para. 3.17.*
20 *Ibid., para. 3.19.*

which will be for a maximum period of six months in the first instance, renewable by the MHT for a further six months and thereafter at yearly intervals. Despite the disappearance of the word 'Review' from its title the MHT will have review functions. The patient has a 'fast track' right to apply to the MHT against detention for assessment and has the 'right to request that the tribunal reviews any order for compulsory care and treatment lasting longer than three months.'[21] If this means that the patient will be entitled to apply for a tribunal after three months, on current delay rates, the hearing will be happening within very few weeks of the next hearing to renew the order. And there will be problems of independence. Will the MHT panel which hears the review be differently constituted to the MHT which imposed the care and treatment order?

The MHT will consist of a legally qualified chair and two other members with experience of mental health services. One of the members will be a person with 'a clinical background' and the other will usually have a background in community or voluntary sector service provision.[22] When the clinical supervisor applies to the Tribunal for authority to continue the compulsory care and treatment beyond 28 days patient arrangements will be made for the patient to be seen by an independent doctor drawn from a panel of experts appointed by the Commission for Mental Health to give expert evidence to the tribunal. This task will have to be carried out by a doctor, but the expert panel will have a broad membership. The doctors will be drawn from a variety of backgrounds, general, old age, learning disability, child and forensic, and also from clinical psychology. The expert panel will also include people with experience in ethnic minority issues, social care, learning disability nursing, mental health nursing and, tellingly, the probation service.[23] The medical members of the panel will perform the role currently undertaken by medical members of tribunals, but they will be expert witnesses, no longer tribunal members. They will also take over the role undertaken by second opinion appointed doctors (SOADs) under Part lV of the 1983 Act. Moreover, they will have the function of visiting all patients who are assessed as long term incapable and in need of treatment from the specialist service.

At a 28 day review the MHT will have the option of discharging the patient, of authorising a further 28 days assessment, or of making a care and treatment order.[24] The criteria for the tribunal to make a care and treatment order will be: (a) a diagnosis of mental disorder of a nature or degree to warrant specialist treatment; and (b) that specialist treatment must be necessary in the best interests of the patient and/or because without care and treatment there is a significant risk of harm to other people; and (c) a plan of care and treatment is available to address the mental disorder.

A number of features of these criteria deserve comment. First of all this is a break with the approach of the 1959 and 1983 Act that detention under long term powers should require a more specific 'diagnosis'. The same broad concept of mental disorder applies to admission for assessment and to the longer term care and treatment order. Secondly the 'necessary in the interests of the patient's own health or safety' criterion is to be replaced by 'necessary in the best interests of the patient', and the 'or necessary for the protection of other persons' criterion by 'because without care and treatment there is a significant risk of harm to other people.'

The best interests criterion is presumably an attempt to introduce common law concepts into the Mental Health Act. The Green and White Papers have apparently rejected the idea of employing a test based on capacity, although at the time of writing there are suggestions that the Government may be considering introducing a test based on impaired judgment due to mental disorder.

21 Ibid, para. 3.61.

22 Ibid., para. 3.44

23 Ibid., paras. 3.45-3.47..

24 Ibid., para. 3.42.

At common law doctors have a power and a duty to give incapacitated patients treatment which is necessary in their best interests. At common law the gatekeeper concept is incapacity and best interests refers to the doctor's duty once there has been a finding of incapacity. It is the doctor's duty to consider a wider range of interests than the purely medical, including social interests. The doctor must then balance the certain and the possible gains against the certain and the possible losses, and only if the account is in significant credit should the treatment be viewed as being in the patient's best interests.[25] In Re SL the Court of Appeal held that 'the doctor ought not to make any decision about a patient that did not fall within the broad spectrum of the *Bolam*[26] test. This might give the doctor more than one option since there may well be more than one acceptable medical opinion. But then the doctor has to move on to consider the best interests of the patient, and this involves choosing the best option.[27]

It seems that there will be a statutory definition of best interests which will be at variance with the common law concept, and the White Paper sets out a number of considerations to be taken into account in deciding whether continuing care and treatment is in a patient's best interests. These include:

> The nature and degree of the disorder – what and how severe the symptoms are, how the disorder is likely to develop and what interventions are appropriate. The clinical team should take account of any information that is available about how the patient has responded to treatment in the past, whether they have complied with care and treatment and what are the risks of not treating them. This will include consideration of how the mental disorder may affect the patient's capacity to make decisions about treatment. Second the team should take account of the patient's expressed wishes and preferences supported, where appropriate, by an advocate. Thy also need to consider whether overriding the patient's wishes may make it more difficult to deliver effective care and treatment.[28]

Despite all this statutory guidance the fact remains that a concept which has not traditionally been used as a gatekeeper concept is being pressed into service as such by the White Paper, and it is difficult to see how this is an improvement on 'necessary in the interests of the patient's health.' Patients challenging care and treatment orders will be able to argue that the treatment plan is not in their best interests, and patients or representatives of patients who are not detained but who will be subject to the new procedures for patients with long term incapacity will have the right to seek a review of the care and treatment plan if there are concerns about the content or whether it is being delivered in the patient's best interests'[29] This will bring the tribunal for the first time into deliberations about the nature and quality of treatment offered to patients subject to compulsion. Hitherto their jurisdiction has been to decide whether or not to discharge patients.

The treatability test, although widely interpreted to include treatment of the symptoms and sequelae of mental disorder, and to include anger management in a structured environment, has been seen by the Government as a major 'fault line' in the legislation.[30] The White Paper applies different criteria of 'treatability' depending on whether compulsion is in the patient's best interests or because there is a significant risk of harm to other people. In cases where the use of compulsory

25 *Re A (Mental Patient: Sterilisation) (1999) 53 B.M.L.R. 66 at 77).*

26 *Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, [1957] 1 WLR 582.*

27 *Re SL (Adult Patient)(Medical Treatment [2000] 2 FCR 452..*

28 *Cm 5016-I, para. 3.24 - 3.25.*

29 *Cm 5016-I, para. 6.11.*

30 *B v Croydon District Health Authority [1995] 1 All ER 683; Reid v Secretary of State for Scotland [1999] 1 All ER 481.*

powers arises in the person's own best interests, the treatment plan must be anticipated to be of direct therapeutic benefit to the individual. Therapeutic benefit will cover 'improvement in the symptoms of mental disorder or slowing down deterioration and the management of behaviours arising from the disorder. This would include only behaviours which lead to significant adverse consequences *for the patient* such as suicide or serious self-harm, or serious deterioration in physical health.' (emphasis added).[31] In cases where the compulsory powers are sought primarily because of the risk the patient poses to others, the plan must be considered necessary directly to treat the underlying disorder or to manage behaviours arising from the disorder. In such a case the care plan must include the provision of interventions that are specifically designed to ameliorate the behaviours that cause them to be a risk.[32] Care and treatment for mental disorder will not be defined in new legislation. Instead, each plan of treatment must indicate what symptoms or behaviours arising from mental disorder it is intended to address, thus ensuring that 'the Tribunal considers any issues regarding the limits of care and treatment for mental disorder.'[33]

The purpose of this refined approach to treatability is to make it clear that people with personality disorders may be detained even if the only treatment available is addressed at the behaviour which causes them to be a risk to others rather than at the 'core disorder.' The net effect of these changes will be to make it clear that a much larger number of people will be liable to compulsion under mental health legislation, and the procedural changes contained in the White Paper are also aimed at ensuring the primacy of risk management. Transparency, uniformity and ownership of psychiatric decision-making are key themes in the White Paper. Discretionary powers to detain will be broadened through a widening of the definition of mental disorder, and the relevant trust will be required, when called upon to do so by the nominated person, the patient's General Practitioner (GP), the police or other criminal justice agencies to send mental health professionals to carry out an assessment of the need for compulsion. Under the current legislation an ASW who is called upon by the nearest relative to carry out an assessment must give reasons in writing when he or she does not make an application for admission[34], so it is likely that the mental health professionals will be required to give written reasons to GPs, police or other criminal justice agencies for not using those powers. This prompts the question whether those reasons, if inadequate, could be used to found a damages action based on Article 2 and the *Osman* principle brought by the family of a victim of a homicide by a mentally disordered person. In such a case, if the police or probation ask for an assessment and those carrying out the assessment decline to use compulsory powers, they give their reasons. If there was a risk to an identified individual or individuals, and the authorities failed to take action within the scope of their powers, which judged reasonably might have been expected to avoid the risk, the authorities would be liable under the *Osman* principle. This will inevitably lead to an expansion in defensive medicine and defensive practice from other professionals involved in the assessment process.

A further major change is the abolition of the statutory role of nearest relative and its replacement with the nominated person. Currently the nearest relative can ask for an assessment of the need for compulsory admission, can apply for compulsory admission, and has the right, where practicable to be consulted about an admission for treatment for up to six months. If the nearest relative objects, no application for admission for treatment may proceed, subject to displacement by the county court if the objection is unreasonable. This right of veto is not available in relation to

31 *Cm 5016-I, para. 3.21.*
32 *Cm 5016-I, para. 3.18.*
33 *Cm 5016-I, para. 3.20.*
34 *Mental Health Act 1983, s 13(4).*

admission for assessment under s 2. The nearest relative is also entitled to ask for the discharge of a patient detained under the non-offender provisions of the 1983 Act, and the patient must be discharged unless it is certified by the responsible medical officer (RMO) that the patient is dangerous to self or to others. The nearest relative can appeal to the Mental Health Review Tribunal against refusal of discharge, and is also entitled to notice of any tribunal application for discharge made by the patient, a provision which was challenged in *JT v United Kingdom*[35]. Here the patient objected to her mother being her nearest relative, given that she was living with the man who had allegedly abused her. This was held to be a breach of Article 8 of the Convention, in that the patient did not have any say in who could exercise the functions of nearest relative. The Government's response to this is that role of nearest relative and the powers attached will be removed by the new legislation to be replaced by nominated person who will be nominated by the mental health professional applying for compulsory powers, and the nominated person will have the right to be consulted over the exercise of compulsory powers, and will have the right to apply to the tribunal for review of the use of compulsory powers, but will have no power of veto or discharge.[36]

This is a major transfer of power from the family to the state, and a departure from the principle that the family is entitled to take care of their loved one's health needs, but the state may override that if the person is dangerous to self or to others. Nearest relatives have successfully challenged applications for admission, where the wrong relative has been consulted, and have successfully applied to tribunals for the patient's discharge on grounds that they were not dangerous.[37] To allow the very person whose actions might be challenged to nominate the nominated person, and to take away the family's express powers and replace them with a consultation duty, when added to all the other reforms, represents an almost complete dismantling of the delicate system of checks devised to reflect the balance of perspectives between the state, health and social care professionals and the family. The proposals for a legal framework for the care and treatment of non-offender patients will broaden considerably the scope of compulsion under mental health legislation, and will undoubtedly lead to a significant increase in the numbers of patients who are subject to compulsory powers. Before looking at the safeguards for patients, it is important to see the proposals in the context of the second volume of the White Paper, entitled *High Risk Patients*.

High Risk Patients

High Risk Patients sets the new legal framework for detaining non-offender patients in the context of the changes to the criminal justice system. The Volume begins with a statement that the majority of patients who are detained are detained in their own best interests and defines high risk as covering 'a smaller group characterised primarily by the risk which they pose to others. It includes both those detained under civil powers and offenders who have been given a mental health disposal and a restriction order.'[38] Although the Government acknowledges that no society can ever be totally free of the risk of serious harm. 'where there are deficiencies in the provision of specialist services, as in the case of DPSD, the public rightly expects the Government to take action, and the clear aim of the proposals is to remedy 'weaknesses in the law' which stand in the way of detention of dangerous people with severe personality disorders.[39]

35 *European Commission on Human Rights Decision as to Admissibility Application 26494/95 26 February 1997, (1997) EHRR CD 81.*

36 *Cm 5016-I, paras. 5.5 – 5.9.*

37 *Re S-C (Mental Patient: Habeas Corpus) [1996] 1 All ER 532.*

38 *Cm 5016-II, para. 1.3.*

39 *Ibid., para. 1.8.*

The proposals for high risk patients need to be understood in the context of what the Government calls 'the full package' of criminal justice reforms. These include the requirement that sex offenders register with the police on leaving prison under the Sex Offenders Act 1997, sex offender orders under the Crime and Disorder Act 1998, and automatic life sentences for a second serious violent or sexual offence under the Crime Sentences Act 1997. The Home Office has also introduced an Early Warning System' to alert the Home Office to the imminent release of potentially dangerous violent or sexual offenders and enable the risk management arrangements for those offenders to be monitored. Further measures are being developed to strengthen the effectiveness of child protection law, and to put police and probation service risk management strategies on a statutory basis to improve standards. Measures are also being taken to prevent sex or violent offenders against children from working with them on release, and to introduce electronic tagging as condition of licence.

High Risk Offender Patients

As for mentally disordered offenders, the new broad definition of mental disorder will apply, and the current range of remand powers for assessment and for treatment under ss. 35 and 36, and the interim hospital order under s. 38 will be replaced by a single power of remand for assessment or treatment based on a single medical recommendation. However, a second medical recommendation will be required before compulsory treatment can be given. The remand may be to detention in hospital or on bail, and will be available to both magistrates and higher courts. Remand will be for an initial period of 28 days renewable by Court for up to a year.

There are three provisions in English law for protective sentencing, life imprisonment, protective sentencing under sections 1(2)(b) and 2(2)(b) (longer than normal) of the Criminal Justice Act 1991, and the new procedures for mandatory minimum sentences in the Crime (Sentences) Act 1997, whereby conviction of a second serious violent or sexual offence attracts a mandatory life sentence. These comparatively recent developments are intended to bring about wider use of indeterminate sentencing in the penal system, although the Government is clearly disappointed that these powers are not being used as extensively as they had hoped. They are also concerned about the numbers of prisoners with personality disorders who are coming to the end of determinate sentences and will be entitled to release regardless of risk.

Where an offender is suffering from mental disorder in the new broad sense, it will be open to any criminal court to impose a care and treatment order which will last for six months before requiring to be continued by the Mental Health Tribunal. Where a mentally disordered offender poses a significant risk of serious harm to others or because of the nature of the offence or previous convictions, the court may impose a care and treatment order with restrictions. This will be applicable only where the care and treatment order is based on detention in hospital. The major disadvantage of hospital and restriction orders from the Government's point of view is that a patient may be entitled to discharge by a Mental Health Review Tribunal if no longer mentally disordered before he or she has served a period of detention proportionate to the gravity of the offence. The Government seeks to rectify this by extending the availability of the hospital and limitation direction, which currently applies only to offenders with psychopathic disorder, to all offenders suffering from mental disorder in the new broad sense. This will enable the court to have the option of combining criminal justice tariff with an order for care and treatment under the mental health legislation. Patients will be able to be transferred from prison as under current

legislation, but on expiry of their sentence, continued care and treatment will have to be authorised by the MHT.

The proposals for mentally disordered offenders show some small but significant changes to the current framework. These are broadening the definition of mental disorder which will form the basis of a hospital disposal, simplifying the remand powers for treatment and assessment, extending the hospital and limitation direction to all mentally disordered patients, and to comply with the Strasbourg decision in *James Kay v United Kingdom*[40] the introduction of express statutory criteria for recall of restricted patients to hospital. Unless it is an emergency the authorities must satisfy themselves that the patient continues to suffer from a mental disorder within the meaning of the new legislation and is failing to co-operate with care plan, and/or his continued presence in community poses risk of serious harm to others and/or the care and treatment needed cannot safely be provided in the community. The most significant changes are in the provision made for the involvement of criminal justice agencies in mental health care decisions, a development which is largely fuelled by the Government's desire to manage the problem of Dangerous People with Severe Personality Disorder.

High Risk Non-Offender Patients

The primary focus of the *High Risk Patients* proposals is on Dangerous People with Severe Personality Disorder (DPSPD patients). Having put forward two options, one involving the use of existing prison and health service institutions, the other involving the development of new specialist 'third way institutions'[41], the Government has not taken a final decision on how services will best be provided long-term. However, it will 'bring forward the legislative changes required' whichever option is chosen, and there will be a 'new framework for the detention of DPSPD in a therapeutic environment for as long as they pose a risk to others as a result of mental disorder.[42]

The new powers 'will apply to individuals in civil proceedings as well as those sentenced for an offence', that is, it will not be necessary to be convicted of an offence to be subject to detention. However, the Government assures us that in practice, the nature of the assessment process (12 weeks long) means that it is highly unlikely that any individual without a long track record of increasingly serious offending will be affected by these new powers.[43] Although the Government is worried about this group, they offer only a working definition. The person must show significant disorder of personality and present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover e.g. homicide, rape, or arson. The risk presented must appear to be functionally linked to his personality disorder. The Government intends to 'refine the definition during the pilot period as we develop a clearer picture of the nature and characteristics of this group.'[44] The 'treatability' requirement in the current legislation is described as 'unhelpful' as it has neither met the needs of patients nor helped to give the public the protection it needs. The new 'civil admission' procedures will in the Government's view provide the unambiguous authority to detain individuals who would fall within the DPSPD group where appropriate interventions are offered to tackle the individual's high risk behaviour. In all cases treatment will be delivered in an appropriate therapeutic environment.

40 *James Kay v United Kingdom (1998) 40 BMLR 20*

41 *Home Office and Department of Health, Managing Dangerous People with a Severe Personality Disorder July 1999.*

42 *Cm 5016-ll, para. 2.12.*

43 *Ibid., 2.13*

44 *Ibid., para. 2.18*

The important aspect of the new civil procedures is that they enable pressure to be exerted by criminal justice agencies on mental health professionals to assist in managing risk. We have already seen how police and criminal justice agencies will be able to request a mental health assessment and will be entitled to reasons if compulsory powers are not used. The Sex Offenders Act 1997 puts a duty on the police to monitor those offenders who are on the sex offender register, and MARPs have been set up to meet these requirements. The White Paper reports that 'Many panels have subsequently extended their remit to respond to the risks posed by other potentially dangerous offenders in their communities and a range of other agencies are now involved in local arrangements, led by police and probation services.'[45] The Criminal Justice and Court Services Act 2000 places a statutory duty on police and probation services to establish arrangements for the assessment and management of risks posed by relevant sexual or violent offenders in the community and to monitor those arrangements. The duty extends to patients who have been detained on a hospital order as well as those sentenced to imprisonment, so that information will have to be shared with police when violent or sex offenders are discharged from hospital.

If compulsory powers to assess non-offender patients are used at the request of criminal justice agencies, they, and other agencies involved in formal risk management arrangements in the community (i.e. Multi-Agency Risk Panels (MARPS)) will be able to provide evidence before the tribunal, independent of the assessment of the clinical team. This may include evidence of previous criminal behaviour. Tribunal will have a duty to consider such evidence in making its decision. When a tribunal orders supervision in the community, this may include involvement of MARPs.[46]

The White Paper also indicates the Government's intention to introduce a 'new statutory duty covering the disclosure of patient information between health and social services and other agencies for example housing and criminal justice agencies where it is justified, for example in the public interest.' The new duty is intended to 'support these new risk management arrangements led by the criminal justice system.'[47]

The purpose of these provisions is to bridge the information barriers between health and social services with their emphasis on individualistic health and social care values such as confidentiality, and the police, whose primary task is risk management. This necessarily entails the incorporation of the police into what previously were health and social care decisions. The right of privacy under Article 8 of the European Convention allows for exceptions to the confidentiality of medical records if it is in accordance with law and necessary in a democratic society for the prevention of crime, for health, or for the protection of the rights of others. Given the breadth of these exceptions, it is unlikely that the new statutory duty of disclosure would fall foul of Article 8, provided that those making decisions to share information without the consent of the subject observe the requirement to restrict this to a need to know basis, and to bear in mind the principle of proportionality, that the method chosen to achieve the protection of the public interest does not go beyond what is strictly necessary for that purpose. The provisions on information sharing are a classic example of risk management values justifying exceptions to the medical principle of confidentiality. It also shows a desire to limit clinical discretion by imposing a duty to share information, and it also opens up the possibility of a *Tarasoff* type action for breach of that statutory duty, if a person suffers damage as a result.[48]

45 *Ibid., paras. 5.4 - 5.6.*

46 *Ibid., paras. 3.22-3.23.*

47 *Ibid., para. 5.7.*

48 *Tarasoff v Regents of the University of California (1976) 551 P.2d 334 (Cal.Sup. Ct.).*

Safeguards

The current system of safeguards for patients rights is based on local review of the need for detention by hospital managers, formal review of detention by the Mental Health Review Tribunal and the supervisory role of the Mental Health Act Commssion which visits and interviews detained patients, reviews the handling of their complaints, and oversees the system of statutory second opinions under Part lV of the 1983 Act. The White Paper affords a central role to the new Mental Health Tribunal, and abolishes the review function of the hospital managers. The Mental Health Act Commission will be replaced by a Commission for Mental Health, which will consist of representatives of users, carers and the key professional bodies. Its remit is described as being 'similar to that of the existing Mental Health Act Commission but without its current responsibilities for visiting':

> Instead there will be a fresh emphasis on monitoring the implementation of the safeguards which ensure that compulsory powers are properly used. It will have significant new responsibilities for collecting and analysing information, and overseeing standards of professional advocacy and training for practitioners with key roles under the new legislation. It will also have an important role in overseeing the arrangements for the care of patients with long-term incapacity under the new legislation.[49]

Issues of quality and consistency of services will be matters for the Commission for Health Improvement or the National Care Standards Commission. The role of the Commission in relation to complaints will be taken on by the new specialist Patient Advocacy Liaison Service (PALS). The Commission will have a particular remit to advise the Secretary of State as to whether the powers in the Act are being used in a manner consistent with the principles, set out in Chapter 2 of the White Paper, which 'will be set out in a way that provides a clear context for decisions about when and how the new powers should be used.'[50] The principles are that the new legislation will be compatible with the Human Rights Act 1998, that decision-making will be conducted openly and fairly, with respect for patients individual characteristics such as age, gender, ethnicity and religion, that formal powers will not be used as an alternative to securing the agreement of people whose disabilities result in communication difficulties, that mentally disordered people will be treated in such a way as to promote to the greatest degree their self-determination and personal responsibility, that care and treatment will involve the least degree of restriction consistent with ensuring that the objectives of the treatment plan are met, and that formal powers should only be used with good cause and when alternatives have been considered.[51] None of these principles is new. They are all currently stated in the Mental Health Act Code of Practice.[52] It is not clear from the White Paper whether these will be specified in the legislation itself or in a new Code of Practice.

There will continue to be a statutory system of second opinions based largely on the existing system, but provided by doctors and others appointed by the Commission for Mental Health to give expert evidence to the MHT. 'The function of the second opinion doctor will be to consider whether the treatment is consistent with acceptable practice in the treatment of patients with mental disorder.'[53] The major difference will be that psychosurgery, which cannot currently be administered unless the patient is capable of consenting and has consented, will be able to be given

49 *Cm 5016-1, para. 7.8.*

50 *Ibid., para. 2.8.*

51 *Ibid., paras. 2.7 – 2.12.*

52 *Department of Health and the Welsh Office, Mental Health Act Code of Practice (1999), para. 1.1.*

53 *Cm 5016-l, para. 5.25.*

if approved by the High Court.[54] There will be guidance in the new Code of Practice on the administration of polypharmacy, and of drugs in excess of British National Formulary upper dose recommendations, and the tribunal, in considering the treatment plan, will consider how and to what extent the treatment plan takes account of any guidance in the code.[55]

The new Mental Health Tribunal will be the most important of the institutions providing safeguards. It will authorise compulsory care and treatment, and it will review the continued need for such compulsion. When a patient is admitted for assessment, his or her clinical supervisor will in an appropriate case, make a recommendation to the MHT for a care and treatment order. The MHT will then decide, on the basis of the evidence, whether the conditions for continuing care and treatment under compulsion are met. In making its decision the MHT is required to consider the proposed care and treatment plan and the report from the panel medical expert and any evidence put by the patient or his or her representative.[56]

It seems that the Government will reverse the notorious negative burden of proof in that the MHT will have to be satisfied that the criteria for compulsory care and treatment are met before initiating or renewing an order. However, there is some lack of clarity as to whether the MHT will have a power or a duty to make an order if so satisfied. Paragraph 3.43 says that 'If the MHT considers that the criteria are met and the care and treatment plan is appropriate it *will* make a care and treatment order.' Paragraph 3.49 says that 'If the tribunal is satisfied that the conditions for compulsory care and treatment are satisfied, it will have *the power* to approve a care and treatment order. If conditions are not met, the patient will be discharged.' Finally, Paragraph 3.50 states that the Tribunal will be '*required* to make a care and treatment order if care and treatment plan proposed by patient's clinical supervisor meets the criteria set out in the legislation, and is appropriate in all the circumstances. Legislation will include provision for the situation where care and treatment order is warranted but treatment plan is inappropriate.' Where the patient is not liable to detention following a court order (i.e. is a non-offender patient) he or she will have the right, to request that the MHT review any order for compulsory care and treatment lasting longer than three months. 'The purpose of the review will be to determine whether the current arrangements under compulsory powers are *appropriate*.'[57] Leaving aside the question of whether there will be a power or a duty to make an order when the criteria are satisfied, this will involve the tribunal in a whole new range of questions concerning the appropriateness of treatment, and will significantly increase the duration of tribunal hearings.

The MHT's powers will include the power to make 'flexible orders.' The care and treatment order will include a treatment plan, and the tribunal will be required to consider the appropriate location for treatment, and whether care under detention is necessary. It will have the power to specify duration up to the statutory maximum. Where the patient is not detained the treatment plan will specify which aspects of the care plan are compulsory, and the consequences of non-compliance. Where the patient subject to a care and treatment order outside hospital those responsible are required to ensure that services provided in a manner enabling the patient to comply. Patients will not be charged for service specified in the order as something they must comply with.[58] If the patient is detained, the plan will specify whether he or she may be granted leave or discharged by the clinical supervisor, or whether these powers will be reserved to the MHT.[59]

54 *Ibid., para. 5.19.*
55 *Ibid., para. 5.23.*
56 *Ibid., para. 3.48.*
57 *Ibid., para. 3.61.*
58 *Ibid., paras 3.56-3.58.*
59 *Ibid., para. 3.51.*

In each case involving a care and treatment order, the patient will be seen by a member of the expert panel prior to the hearing. The Government envisages that there will not necessarily be a hearing to approve a care and treatment order. A hearing will be required where the patient requests or there is a difference of opinion between clinical supervisor and expert panellist Otherwise the tribunal will review the case on the papers which must include the expert panellist's opinion.[60] A further important development is the introduction of rights for victims and their families to make representations to the MHT against an offender patient returning to the area of the index offence.

The Tribunal and the Commission for Mental Health will also play a key role in providing safeguards for people with long-term incapacity, filling the so-called '*Bournewood* Gap' identified by Lord Steyn in *R v Bournewood Community and Mental Health NHS Trust ex parte L*.[61] The new legislation will place a duty on clinical supervisors to carry out an assessment and obtain an independent second opinion from an expert panellist, where patients with long term incapacity are assessed as needing long-term care and treatment for serious mental disorder from specialist mental health services in their best interests. This will apply to patients admitted to hospital or residential care home, but not to those living at home.[62] The clinical supervisor will be required to arrange a full assessment and develop a care plan on the basis of the care programme approach and the Care Plan Guidance in Wales. This must cover all aspects of care and treatment including steps to restrict patients' freedom such as locking of doors or routine sedatives. All interventions must be in patient's best interests. The clinical supervisor must arrange for doctor from Tribunal Panel to examine the patient. The doctor from the panel will discuss the proposed care and treatment plan with supervisor and may suggest changes.

In drawing up the treatment plan the clinical supervisor must consult the patient's close relatives and carers, and consult the social care representative who nominates a person to represent the patient. The clinical supervisor must notify the Commission for Mental Health that a plan is being drawn up and, unless there are exceptional circumstances, finalise it within 28 days. Th supervisor must then place on record with the care and treatment plan a note that in his or her opinion the care and treatment plan is in the patient's best interests. The supervisor must also certify that the patient is not actively resisting treatment and does not pose a significant risk of serious harm to other people, otherwise it will be necessary to seek compulsory powers. The patient or his or her representative will be able to apply to the MHT either to challenge detention or to seek review of the care and treatment plan, for example on the grounds that it is not in the patient's best interests. MHT will commission new report from a member of its medical panel, and will also consider evidence from the clinical team, and, if appropriate, from carers and close relatives. The clinical supervisor will be required to take account of changes suggested by the MHT and if necessary submit a revised care plan to the MHT for formal approval. However the expectation is that any dispute would be resolved informally through discussion with the clinical team without recourse to the tribunal.[63] The Government has chosen to provide this form of safeguard in preference to an Incapacity Act, whereby care managers or health care attorneys could be appointed by a new locally based Court of Protection. The danger is that the Mental Health Tribunal will be overwhelmed by a vast increase in its case load. Between 1986 and 1998 the number of tribunal

60 *Ibid., para. 3.63.*

61 *[1998] 3 All ER 289. See further P. Fennell, 'Doctor Knows Best? Therapeutic detention under Common Law, the Mental Health Act, and the European Convention' (1998) 6 Med Law Rev 322-353.*

62 *Cm 5016-I, para. 6.5.*

63 *Ibid., paras 6.7 - 6.13.*

hearings held annually increased from 2972 to 9,057.[64] The new proposals are likely to lead to an even more dramatic increase in case load, even with the provisions for paper review rather than personal hearings, and will undoubtedly lead to longer hearings, since the tribunal will be looking not only at the need for compulsion, but also at the nature and quality of the treatment plan.

Conclusion

The proposals in the White Paper involve a radical change in the legal framework of compulsory mental health care. They place a premium on risk management with significant consequences for the psychiatric system, and the relations between psychiatrists, psychologists and the state. The Government appears to be just as worried about psychiatrists who will not co-operate in its risk management project as it is about uncooperative patients. A prime aim of the proposals is to introduce uniformity and accountability of psychiatric decision-making and to encourage the use of compulsory powers. It does this by broadening the discretionary powers to impose compulsory treatment and by removing any provisions which give clinicians discretion not to impose treatment under compulsion. It is for this reason that the Government is keen to avoid use of concepts like incapacity which are open to subjective judgment. The proposals will alter the relationship between psychiatrists and their patients in subtle and sometimes not so subtle ways, imposing duties to disclose information where a patient is thought to pose a risk of harm to others. They will also alter the balance between the rights of the family and the power of the state in relation to psychiatric compulsion by replacing nearest relatives with nominated persons with more limited powers.

The White Paper will also bring about a convergence, bordering on merger between the psychiatric system and the penal system and the legal status of prisoner and patient. With increasing use of life sentences, prisoners and patients will be subject to indeterminate detention and on release to indefinite supervision and liability to recall. Prisoners who are subject to determinate sentences may be referred by criminal justice agencies for assessment and possible detention under civil powers on expiry of their sentence if they pose a continued risk and are suffering from mental disorder in the new broad sense. Police, probation and other criminal justice personnel are to be given a role in clinical decision-making.[65] The Government's statement of its determination to challenge the distorted image of mental disorder and to combat the social exclusion that can result from it' is undoubtedly sincere. However, it must be said that the injection of criminal justice values, practices and personnel into psychiatric decision-making calls into question whether the new legal framework will help or hinder health and social services in meeting Standard One of the National Service Framework for Mental Health, when they seek to 'combat discrimination against individuals and groups with mental health problems and promote their social inclusion.'[66]

64 *Mental Health Review Tribunals for England and Wales Annual Report 1997-8, Department of Health 2000, p. 51.*

65 *This argument is more fully developed in P. Fennell and V. Yeates, To Serve Which Master? Criminal Justice Policy, Community Care and the Mentally Disordered Offender in A Buchanan, Community Care of the Mentally Disordered Offender (2001) Oxford University Press, Chapter 13.*

66 *Cm 5016-I, para. 1.12.*

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

Herschel Prins[1]

Introduction

The Government White Paper Reforming the Mental Health Act[2] follows closely on the heels of the Green Paper - Reform of the Mental Health Act, 1983 which derives from (but also departs from in many respects) the Report of the Expert Committee chaired by Professor Genevra Richardson.[3] One could say, with some justification, that mental health professionals have been 'deluged' with paper in this area in the past year or two, so that trying to discern trends has become very difficult. In particular, the material in the White Paper is somewhat closely written and needs to be read with a good deal of care (or, so it seemed to me). To complicate matters further, offender-patients are also discussed in Part I of the White Paper (The Legal Framework) whereas it would have been more logical to have dealt with the proposed provisions for them in Part II. For clarity, I propose to deal with all these matters under one heading.

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

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

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

High Risk Patients

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

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

(ii) Sentencing powers after assessment

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

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

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

Specific Matters (Part II)

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

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

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

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

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

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

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

7 *Department of Health and Home Office (1999)* Managing People With Severe Personality Disorder - Proposals for Policy Development. *The two options were Option A, amended criminal justice legislation to allow for greater use of discretionary life sentences, an amendment to the 1983 Mental Health Act, to remove the 'treatability' criterion for civil detainees. Services would continue to be provided in both prison and NHS facilities. Option B proposed new powers in civil and criminal proceedings for indeterminate detention of DSPD individuals (including powers for supervision and recall following detention). Individuals would be held in a new service separately managed from mainstream prison and health services - a 'third service'.*

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

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

Summary of Arrangements for Assessment and Treatment

(a) Civil Proceedings

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

(b) Criminal Proceedings

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

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

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

9 *See for example. Blom-Cooper, L.Q.C., Grounds, A., Guinan, P., Parker, A. and Taylor, M. (1996)* The Case of Jason Mitchell: Report of the Independent Panel of Inquiry. *Duckworth. For comment on the proposal to remove the medical member from the Tribunal see Rooth, G. (2001)* The Future (or not) of the Medical Member: An Aspect of the 1983 Mental Health Act Review. *Psychiatric Bulletin, 25, 8-9.*

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

Concluding Comment

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

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

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

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

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

English Mental Health Reform: Lessons from Ontario?

Peter Bartlett[1]

Reforms in areas related to mental disability are under debate in England to an extent unprecedented for almost half a century. The Law Commission's proposals on incapacity, following further consultation from the Lord Chancellor's Department, have now largely been accepted in principle by the government for legislative enactment at some time in the undetermined future.[2] A joint green paper from the Home Office and the Department of Health has established a policy agenda concerning the governance of people with serious personality disorders.[3] Proposals by an expert committee chaired by Professor Genevra Richardson on mental health reform have likewise been followed up by a government green paper,[4] and the two green papers have in turn resulted in a joint white paper on reform of the Mental Health Act 1983.[5] All this takes place as the Human Rights Act 1998 takes effect, with its guarantees relating to liberty and security of the person, standards for hearings, respect for private and family life, and protection from inhuman or degrading treatment. Throughout the development of the reforms, a number of similar themes have recurred, involving civil rights, the provision of appropriate legal processes, anti-discrimination, the respect for people with capacity, the extension of controls into the community, and the safety both of people with mental disabilities and of the public as a whole.

At least in the public arena, most of the debate has focussed on the English situation. The premise of this paper is that the situation in the rest of the world may have something to teach us. The paper examines the law of Ontario. While it focuses primarily on those issues related to the Richardson Report and its subsequent government response, Ontario legislation divides issues somewhat differently to English law, and thus overlap with the other reform proposals is inevitable.

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2 *Law Commission, Mental Incapacity, Law Com No. 231 (London: HMSO, 1995); Lord Chancellor's Department, Making Decisions, Cm. 4465 (London: TSO, 1999).*

3 *'Managing Dangerous People with Severe Personality Disorder - proposals for policy development'. (London: TSO, 1999).*

4 *Expert Committee, 'Review of the Mental Health Act 1983', chair: G. Richardson, (London: Department of Health, 1999); Department of Health and the Welsh Office, 'Reform of the Mental Health Act 1983: Proposals for Consultation' (London: TSO, 1999).*

5 *Department of Health and the Home Office, 'Reforming the Mental Health Act', 2 vols., Cm 5016-1 (London: TSO, 2000).*

Historical Overview

The contemporary history of mental health law in Ontario conveniently begins in 1967, with the passage of a new Mental Health Act.[6] In its general themes, it is comparable to the English Mental Health Act 1959. Both can be understood as broadly deferential to doctors' views, with admission criteria acknowledging a considerable degree of medical discretion, subject to review by an administrative tribunal. Both were silent on treatment issues. Unlike the English legislation, issues of incapacity were dealt with primarily under a separate statute, the Mental Incompetency Act. Nonetheless, where previously Ontario psychiatric inpatients had routinely lost the control of their estates, the 1967 act provided a system of routine assessments by the admitting physician of inpatient's capacity to manage their financial affairs, with the Public Trustee taking over management of the estates of those lacking such capacity, a system not reflected in the English legislation.

Significant revisions to the Ontario Mental Health Act were made in 1978. Where the 1967 act can be seen as reflecting developments in England, the 1978 act can be seen as anticipating them. Treatment provisions were introduced for the first time, on much the same model that would appear five years later in England: treatment of voluntary patients would be governed by common law, treatment of involuntary patients would be either by consent of the patient or else with a second opinion provided by a psychiatrist. Unlike the English system introduced in 1983, however, there was in Ontario no three-month grace period where treatment could be given without consent or second opinion, and the imposition of treatment without consent became subject to review by the administrative tribunal. Where the involuntary patient lacked capacity, consent could be provided by the patient's nearest relative as defined in the act, although no right of review was available to a doctor's decision regarding incapacity. Rights to view the clinical record were introduced at this time, although later strengthened considerably. A right to a tribunal review of the admitting physician's decision that the patient lacked financial capacity was introduced. More important for the body of this paper, amendments were made to the criteria for involuntary admission. Where the 1983 English act continued with vague criteria referring to the health or safety of the patient and the protection of others, the Ontario statute defined dangerousness in considerable detail.

To this point, the Ontario law had developed according to the evolution of political and professional thinking. The next set of amendments was forced by broader constitutional considerations. The Canadian Charter of Rights and Freedoms was introduced to the Canadian constitution in 1982. Along with enshrining rights for example to liberty and security of the person and to due process upon arrest or detention, section 15 of the Charter protected against non-discrimination on the basis, inter alia, of mental handicap. The implementation of section 15 was delayed until 1986, to allow the amendment of legislation to comply with the section. Amendment of the Mental Health Act was thus effectively forced upon the Ontario legislature. There was no consensus in the governing Liberal Party as to how to proceed: the Minister of Health, reflecting the perceived view of the medical establishment, did not favour major legislative amendment notwithstanding the introduction of the Charter provisions; the Attorney General, who would have had to defend the legislation in court, was much more open to changes. In the end, the matter was forced by amendments proposed and spearheaded by the opposition New Democratic Party.[7]

6 *S.O. 1967, c. 51, contained in the following decennial statutory consolidation as R.S.O.1970, c. 269.*

7 *The amendments were introduced by the Equality Rights Statute Law Amendment Act, 1986, S.O. 1986, c. 64 and the Mental Health Amendment Act, 1987, S.O. 1987, c. 37, both amending the Mental Health Act, R.S.O. 1980, c. 262.*

The 1986 amendments were significant for a number of reasons. Procedural protections were clarified and strengthened. Patients who had capacity to do so were given the right to appoint the person who would serve as their substitute decision-maker in the event that they later lost capacity. Children admitted on the consent of their guardians (called 'informal' patients following the amendments)[8] were given rights to tribunal review of their admissions. Most important for this paper, however, was the affirmation that a patient with capacity had the right to refuse treatment, whether that patient was voluntarily or involuntarily admitted to the hospital, and this refusal could not be overridden. The act further stipulated that patients lacking capacity could be treated on the consent of their substitute decision-maker, and detailed instructions were provided as to how this individual was to exercise that authority. The decision of the substitute would be based on the wishes of the patient when competent; or if none were known, best interests as defined by the statute.[9] For the first time, the decision of a treating physician that a patient lacked capacity could be appealed to the review board. A provision allowing the refusal of the substitute to be overridden in the best interests of the patient was struck out by litigation as contrary to the equality provisions of the Charter.[10] The result was that rights to consent to psychiatric treatment became entirely separate from admission status, although at this time both were still contained in the same legislation, the Mental Health Act.

This approach was taken a step further in 1992. Legislation regarding personal and financial guardianship had long been acknowledged in need of reform. The relevant legislation, the Mental Incompetency Act,[11] involved unwieldy court processes, and did not allow for partial guardianship arrangements beyond the distinction between financial and personal matters: an individual could manage all or none of their property and estate, and/or all or none of their personal affairs, but nothing in between. No more specific orders were possible. Some legislative tinkering had been done, such as the introduction of enduring powers of attorney for financial (but not personal) matters in 1983,[12] but no one was particularly satisfied with the state of the law. Various committees and inquiries had been struck,[13] but reform had languished in an absence of consensus and political will. A change of government in 1990 brought the political will, with the election of the New Democratic Party.

8 *Prior to 1996, Ontario law had followed the English style of categorising patients as involuntary (i.e., civilly confined) or informal (i.e., inpatients not civilly confined). Notwithstanding the legal definitions, the latter were generally referred to as 'voluntary', and the 1996 legislation amended the legal terminology to reflect this usage. 'Informal' became the term used for those aged from 12 to 16 who were admitted to the facility on the consent of another, usually the parent but sometimes a legal guardian or social services authority. For consistency, this paper will refer to adults not civilly confined as 'voluntary' even when the reference is prior to 1996, when 'informal' would technically have been the correct term.*

9 *Creating sections 1a(6) and 35(5) of the Mental Health Act then in force, reflected in the 1990 statutory consolidation as R.S.O. 1990, c. M.7, s. 2(6) and 49(5) respectively.*

10 *Fleming v. Reid (1991), 4 O.R. (3d) 74 (O.C.A.).*

11 *This was based in the 1909 Lunacy Act, 9 Edw. VII, c. 37 (Ont.), itself really a codification of Victorian law. Amendments in 1911 slightly expanded the definition of incapacity, and new terminology was introduced in 1937. Otherwise, the act remained largely unchanged until its repeal in 1992: see R.S.O. 1970, c. 271, R.S.O. 1980, c. 264, R.S.O. 1990, c. M-9. Like the corresponding portion of the English legislation (Mental Health Act 1959, 7/8 Eliz II, c. 72, pt. VIII), the Mental Incompetency Act was directed at people with mental disabilities generally, not merely people under psychiatric care in hospital.*

12 *S.O.1983, c. 74, s. 2.*

13 *Eg., Attorney General of Ontario, 'Interim Report on the Estates of Persons Incapable of Managing their Property' (August, 1985); Tri-ministerial Committee on Guardianship (Chair: G. Sharpe) (1986); Attorney General of Ontario, 'Report of the Committee on those Incapable of Managing their Affairs' (Chair: S. Fram) (1987); Ministry of Health, 'Report of the Enquiry on Mental Competence' (Chair: D. Weistub), (Toronto: Queen's Printer, 1990).*

For present purposes, the 1992 reforms extended the Mental Health Act approach to the remainder of health care decision-making. The Consent to Treatment Act 1992[14] provided a statutory right of competent patients to make treatment decisions, and the list of substitutes to make decisions in the case of incapable patients, without distinction between physical and mental disorders. The movement of these provisions from the Mental Health Act to the Consent to Treatment Act further articulated the division between treatment decision-making and institutional confinement, and emphasising a similar approach to mental and physical treatment. At the same time, new guardianship legislation covering financial and personal decisions other than health care and mental health confinement was passed as the Substitute Decisions Act 1992.[15] The government was acutely aware of the need for effective enforcement and administration of these statutes. As a result, these statutes in combination with yet another piece of legislation, the Advocacy Act 1992,[16] placed rights advice and advocacy on a statutory footing and created a bureaucracy run by a board to administer rights advice and advocacy services.

Advocacy Ontario was short-lived. Its establishment and initial operation had been controversial and problematic for a variety of reasons, and it was abolished following a change of government in 1995, although rights advice remains a part of the system, in a somewhat reduced form. The new government also replaced the Consent to Treatment Act 1992 with the Health Care Consent Act 1996.[17] That statute continued the broad structure of the previous statute, respecting the treatment decisions of capable patients regarding both psychiatric and physical treatment.

In Ontario, homicides by those with psychiatric difficulties have in recent years been high profile as they have been in England, and the government responded with Brian's Law (Mental Health Legislative Reform), 2000.[18] This law makes minor amendments to the existing confinement criteria, as well as adding a new ground of confinement concerning people who lack capacity to consent to treatment and whose mental illness is both of a recurring nature and has been shown amenable to treatment. As such, like the Richardson proposals, it would introduce a different standard of confinement for those incapable of consenting to treatment . It also introduces a new form of regulation of treatment outside the psychiatric facility, described as a 'community treatment order'. As will become clear below, this is more similar to a contract than a coercive order, as it requires the patient if competent (and otherwise the substitute decision-maker) to consent to the order. Consent can further be withdrawn on 72 hours notice. While the possibility of informal coercion is of course not to be underestimated,[19] this model appears to be particularly strong on patient autonomy and, once again, does not undercut the basic position in Ontario law that persons with capacity have a right to refuse treatment.

14 *S.O. 1992, c. 31.*

15 *S.O. 1992, c. 30.*

16 *S.O. 1992, c. 26.*

17 *S.O. 1996, c. 2, sch. A.*

18 *S.O. 2000, c. 9.*

19 *Regarding the prevalence of such informal coercion in the context of 'voluntary' admissions to psychiatric hospitals, see J. Gilboy and J. Schmidt ' "Voluntary" hospitalization of the mentally ill' 66* Northwestern Law Review *(1971) 429, V. A.Hiday. 'Coercion in Civil Commitment: Process, Preferences, and Outcome', 15* International Journal of Law and Psychiatry *(1992) 359. Particularly good in assessing J. Monahan et. al. 'Coercion and commitment: Understanding involuntary mental hospital admission' 18* International Journal of Law and Psychiatry *(1995) 249.*

Lessons for England?

The Ontario law orders the regulation of mental health in a very different way to its English counterpart. On its face, it appears to take into account many of the concerns raised regarding English reform proposals. The Ontario Mental Health Act is acknowledged to have a policing function: it is about public safety, reflecting similar concerns of the UK government, expressed in its green and white papers. There is no restriction on the range of mental disorders which are covered by the act. People with serious personality disorders are dealt with in the same way as persons with any other mental disorder: if they are dangerous within the meaning of the Act, they are locked up. This matches the concerns of the government contained in the proposals on people with serious personality disorder. While dangerous people with mental disorders are dealt with differently from dangerous people without mental disorders, a point suggesting some possible discrimination in approach, the Ontario legislation seems otherwise to be as close to non-discriminatory as is reasonably possible. Specifically, treatment decisions under the Health Care Consent Act and other decisions covered by the Substitute Decisions Act are made on the basis of ability to make the decision in question: people with psychiatric problems are dealt with in exactly the same way as people with non-psychiatric incapacity, and psychiatric treatments in essentially the same way as physical treatments.[20] Capacity and the desire to regulate mental disorders in the same way as physical disorders are thus given a central role as envisaged by the Richardson report, with no sacrifice to the safety of the community. Procedural safeguards in the form both of rights advice and review tribunals, are provided efficiently and in abundance, and human rights are acknowledged. This seems to represent the range of concerns in the current English debate. Closer examination of the Ontario proposals further provide guidance on how English legislation might appropriately balance the above concerns.

Criteria and Process for Involuntary Admission

If the government is to increase the role of public safety as a guiding principle of the English Mental Health Act, as the white paper claims,[21] it ought to do so responsibly. The risk with dangerousness criteria is that large numbers of non-dangerous people are falsely identified as dangerous and thus inappropriately confined.[22] The current English criteria, referring only to it being 'necessary for the health and safety of the patient or the protection of other persons' that the individual be admitted for treatment,[23] provide no guidance as to how the appropriate threshold of risk is to be determined and thus provides no check on the over-prediction of dangerousness. The Richardson Report, somewhat surprisingly, does not propose any alteration of

20 *The one exception is the new community treatment orders, which apply only to treatments for mental disorder. Even these, however, can be terminated by the competent patient or the substitute of the incompetent patient. The difference is thus one of notification: a doctor must be notified if a patient goes off treatment for mental disorder governed by the order, where no comparable rule applies to physical disorder.*

21 *In the government's words, '[E]xisting legislation also failed to provide adequate public protection from those whose risk to others arises from severe personality disorder. We are determined to remedy this.' White paper, p.1.*

22 *See for example, P. Bowden, 'Violence and Mental Disorder', in N. Walker (ed.),* Dangerous People, *(London: Blackstone Press, 1996); J. Monahan, 'Risk Assessment of Violence Among the Mentally Disordered: Generating Useful Knowledge', 11* International Journal of Law and Psychiatry *(1988), 249; J. Monahan and H. Steadman (eds),* Violence and mental disorder: developments in risk assessment, *(Chicago: University of Chicago Press, 1994).*

23 *Mental Health Act 1983, s. 3(2)(c); see also similar wording in section 2(2)(b) regarding admission for assessment.*

this wording. The white paper refers to 'risk of serious harm, including deterioration of health' or 'significant risk of serious harm to other people' as initial criteria for the imposition of a compulsory assessment, although the former criterion lapses into an ill-defined best interest test coupled with a treatability requirement when ongoing compulsion is at issue in the subsequent compulsory assessment.[24] Compare these to the 1978 Ontario criteria, contained in section 15(1) of the Mental Health Act:

> 15(1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
>
> (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
>
> (c) has shown or is showing a lack of competence to care for himself or herself
>
> and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
>
> (d) serious bodily harm to the person;
>
> (e) serious bodily harm to another person; or
>
> (f) imminent and serious physical impairment of the person
>
> the physician may make application in the prescribed form for a psychiatric assessment of the person.

Substantively similar provisions apply to allow police officers and Justices of the Peace to remove an individual to a psychiatric facility, where the section 15 examination takes place.

The provision makes a serious attempt to clarify what sort of behaviour will warrant confinement. Subsections (a) through (c) make it clear that the prediction cannot be based on pure speculation: a threat or attempt of bodily harm, violent behaviour or causing someone else to fear violent behaviour, or a demonstrated lack of competence to care for the self is required.[25] A standard of predicted behaviour is also required: *serious* bodily harm or physical impairment must be likely (not 'possibly') to occur. The word 'imminent' in subsection (f), removed by Brian's Law in 2000, suggested a time factor: things had to have reached or reasonably neared a crisis.[26]

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24 *White paper, para. 3.15, 3.18. The white paper contains no obvious enforcement mechanism for the former set of criteria, apart from judicial review.*

25 *The case law stops short of insisting that an 'overt act of commission' be committed for subsections (a) through (c) to take effect:* Azhar v. Anderson *(1985, Dist. Ct., unrep.), in obiter. This would seem to raise a variety of rather tedious word-games: are threats 'overt acts of commission'? Is living in sufficient squalor to place oneself at risk of serious bodily harm or serious physical impairment an overt act? Or is it merely an omission to care for self? If these are the sort of situation the case holds to be included in subsections (a) to (c), the point is unobjectionable, if unexciting. If instead the finding that 'overt acts' are not required is intended to imply that predictions need not be grounded in identifiable, actually existing prior conditions, the decision (from a lower level, non-Superior court) must be simply wrong on this point. It is difficult to see how the statute could be clearer.*

26 *The word 'imminent' was removed by Brian's Law, s. 3(1), for reasons not explained in the explanatory note to that statute. It would seem that one reason was that there was no consensus as to what the word meant. While it is an open question as to whether 'imminent' is the appropriate word, it does seem that some form of time frame should be understood as part of the predictive scheme. That said, there is no obvious reason why the risk of physical impairment should be treated differently than the serious bodily harm referred to in paragraphs 15(1)(d) and (e) in this respect.*

Section 3(2) of Brian's Law 2000 adds a new and distinct set of confinement criteria to section 15:

> 15(1.1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> (a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and
>
> (b) has shown clinical improvement as a result of the treatment,
>
> and if in addition the physician is of the opinion that the person,
>
> (c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
>
> (d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and
>
> (e) is apparently incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,
>
> the physician may make application in the prescribed form for a psychiatric assessment of the person.

While a marked departure from the 1978 clauses, it shows some parallel structure. For the behavioural criteria in the paragraphs 15(1)(a) to (c), this subsection substitutes specific experience of successful treatment for mental disorder now afflicting the individual. The dangerousness criteria of paragraph 15(1)(d) to (f) are reflected in paragraph (1.1)(d) of the new section, albeit with the additional ground of substantial mental or physical deterioration.

Significant for current discussion, the section applies only for persons incapable of consenting to the proposed treatment and where the consent of the substitute decision-maker has been obtained. Where section 15(1)(c) may have implicitly created a standard of confinement in which capacity was a relevant factor, the new subsection 15 (1.1) explicitly creates a standards of confinement based on the treatment capacity of the potential patient. This is a direct precedent for the Richardson proposals, which would create different criteria of compulsion based on capacity to consent to treatment. Effectively, the proposal allows slightly earlier intervention to ensure treatment of those lacking capacity to consent, where the substitute decision-maker consents and when there is a track record of successful treatment for the disorder. Here again, the right of competent patients to control their treatment is not affected: the provision applies only to those patients lacking capacity and does not in any way restrict the allegedly incapable person from applying for a review of his or her capacity in the usual way.

The initial admission provision allows confinement of an individual in a psychiatric facility for up to 72 hours. There is no review provided by the Act in this period, although judicial review by way of habeas corpus and civil actions for wrongful confinement are available, if not necessarily very

practical. In the 72 hour period, a more extensive examination is to occur pursuant to section 20 of the act, after which a further confinement may be permitted if the attending physician takes the view that the patient is indeed suffering from a mental disorder of a nature or quality which will likely result in one of the conditions in subsection 15(1)(d) to (f) or 15(1.1) above if the person does not remain in the facility, and the person is not suitable for voluntary admission. Section 20 confinements can be renewed as they approach their expiry.

The first of these section 20 confinements lasts for two weeks, the second for a month, the third for two months, and the fourth and subsequent for three months. These time periods are considerably shorter than the current English equivalents of twenty-eight days under a section 2 confinement, six months for the first two section 3 confinements, and one year thereafter.[27] These periods are significant both because they require the doctor to re-assess the case for confinement, a process which may result in the doctor taking the view that confinement is no longer justified, and also because in Ontario, as in England, the patient has a right to a review of detention by the tribunal once per certificate. There is much to be said for the Ontario approach here, which better reflects the time that psychiatric interventions require to take effect. A patient who opts for a hearing at the beginning of his or her confinement would thus have a right to a second one a couple of weeks later, as prescribed drugs are taking effect and when there may therefore be a real change in the applicability of the confinement criteria to the patient. In England, if hearings were held promptly (which of course they are not - more on that below), the condition of a patient opting for a hearing at the beginning of the confinement period could have changed markedly, to the point where the confinement criteria cease to be met, months before the patient would have the opportunity to apply for another hearing. The fact that this system works effectively in Ontario raises the question of whether the right to periodic review of detention established by *X v. United Kingdom*[28] ought to be interpreted considerably more strictly.

Informal/**Bournewood** *Patients*

The 1986 amendments to the Ontario Mental Health Act introduced the concept of an 'informal' patient. This is someone admitted on the authority of another, and thus bears some resemblance to *Bournewood* patients.[29] The Mental Health Act provision applied only to persons between the ages of twelve and sixteen years,[30] but in 1992, similar provisions were introduced regarding adults

27 *See Ontario Mental Health Act, s. 20(4), and English Mental Health Act 1983, s. 20(1) and (2). While the English white paper abolishes the distinction between section 2 and 3 admissions (for assessment and treatment respectively), it does not alter the length of compulsory orders. These will remain at 28 days for the first order, six months for the following two, and a year for each order thereafter: para 3.10.*

28 *(1981) 4 EHRR 188.*

29 *That is, patients of the sort at issue in* R. v. Bournewood Community and Mental Health NHS Trust, ex parte L *[1998] 3 WLR 107 (HL). These are adults who lack the mental capacity to decide where they will live, and merely acquiesce to remaining in hospital. At issue in the case was whether these persons were 'confined', and whether they could be admitted to psychiatric facilities as informal patients or whether instead civil confinement procedures needed to be applied. The House of Lords held that informal admission was acceptable, but the case has triggered discussion as to how such persons ought to be dealt with in law.*

30 *Mental Health Act, R.S.O. 1990, c. M.7, s. 13. Admission of minors as informal patients also occurs in England: see* R v. Kirklees Metropolitan Borough Council, ex parte C *[1993] 2 FLR 187 (CA), and Ralph Sandland, 'The Common law and the "informal" minor patient', 5:3* Journal of Forensic Psychiatry *(1994) 569. The need for a separate regime determining the appropriateness of children in this situation has not as yet formed part of the English debate. Again, the Ontario legislation may provide a model for consideration.*

in the Consent to Treatment Act and continued in the Health Care Consent Act 1996.[31] Even now, the parallel with Bournewood patients is not exact, as the Ontario legislation clearly has in mind individuals who are not acquiescing to their admission. The acts grant objecting patients who apparently lack the capacity to decide their own hospital admission the right to have their admission to the psychiatric facility reviewed by tribunal. Absent such application, review of the admission of minors under the Mental Health Act occurs automatically at the end of six months, but there is no such routine scrutiny for adults.

The Richardson Report argues for the importance of statutory regulation covering the voluntary admission of incompetent acquiescing patients, who cannot be expected actively to challenge their admissions. The government's response in the white paper suggests an approach similar to that of Ontario: applications by the patient or their representative will be possible to challenge de facto detentions.[32] The Ontario legislation may provide a model for the criteria which might be used to determine the appropriateness of such admissions:

> 34(5) In reviewing the decision to admit the person to the hospital, psychiatric facility or health facility for the purpose of treatment, the Board shall consider,
>
> (a) whether the hospital, psychiatric facility or health facility can provide the treatment;
>
> (b) whether the hospital, psychiatric facility or health facility is the least restrictive setting available in which the treatment can be administered;
>
> (c) whether the person's needs could more appropriately be met if the treatment were administered in another place and whether space is available for the person in the other place;
>
> (d) the person's views and wishes, if they can be reasonably ascertained; and
>
> (e) any other matter that the Board considers relevant.[33]

It is clear that the admission of those who lack capacity to decide where they will live should not be as limited in the same way as civilly confined patients. If the Law Commission proposals on incapacity are implemented in their present form, acquiescing Bournewood patients would be admittable on the basis of their best interests, although not confineable absent judicial intervention.[34] While the factors contained in the statutory test of best interests overlap with the Ontario criteria somewhat and would be appropriate additions to the above factors, it is at least arguable that the specific issues contained in the Ontario criteria ought to be specifically considered before the admission of a Bournewood patient.

Treatment Provisions

As noted above, the Health Care Consent Act concerns all medical treatment, not merely psychiatric treatment. The key provision for current purposes is contained in section 10, which provides that treatment may not be given unless the practitioner offering the treatment has ensured that the patient consents and is capable of doing so. Capacity is in turn defined by section 4(1) of that act:

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31 *See Consent to Treatment Act 1992, s. 19, 32, and Health Care Consent Act, s. 24, 34.*

32 *White paper, paras. 6.4, 6.11.*

33 *Health Care Consent Act, s. 34(5). Similar provisions may be found regarding children as informal patients in the Mental Health Act, s. 13(3).*

34 *Law Commission,* Mental Incapacity, *para. 4.30-33, 7.13.*

> 4(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

In this provision there is no express requirement of a mental illness or diagnosis. Unlike the English test in Re C,[35] there is no express requirement that the individual believe the information provided. This difference is largely illusory, however, given the requirement that the individual appreciate the reasonably foreseeable consequences of his or her choice. It would be an unusual, but not theoretically impossible case, where the individual appreciated the foreseeable consequences of the choice to be made, without believing the information provided.

Where the patient lacks capacity to consent, the prescribed substitute decision-maker has authority to give or withhold consent. The substitute will be, in order of preference, a court-appointed guardian, the holder of a power of attorney for personal care authorising the holder to make such decisions, an individual appointed by the review board to fulfil this role, or a family member according to a prescribed list of proximity or relationship.[36] The way in which the decision is to be made regarding treatment of the incapable patient is also closely defined by the legislation. Consistent with the respect accorded to patient capacity, wishes expressed by the patient while competent and over the age of sixteen years must be honoured, and only in the absence of such wishes may resort be had to the patient's best interests.[37] 'Best interests' is in turn defined by section 21(2):

> 21(2) In deciding what an incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,
>
> (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
>
> (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1) [i.e., the paragraph requiring competent wishes to be followed]
>
> (c) the following factors:
>
> 1. Whether the treatment is likely to,
>
> i. improve the incapable person's condition or well-being,
>
> ii. prevent the incapable person's condition or well-being from deteriorating, or
>
> iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
>
> 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

35 *[1994] 1 All ER 819.*

36 *See s. 20.*

37 *See s. 21(1). The right of a competent adult patient to refuse physical treatment and the enforceability during subsequent incapacity of wishes made regarding physical treatment while the patient had capacity are established in English law: see, eg., Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819. These rights also presumably apply in England to treatments for mental disorder for informal patients and those living in the community, but they cease to apply if the individual is civilly confined. In that event, the Mental Health Act allows most treatments to proceed without patient consent and without any formal scrutiny for three months, and allows patient consent to be overridden thereafter: s. 57, 58, 63.*

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

These criteria are binding on substitute decision-makers. While the Ontario legislation remains deferential to the wishes of the individual expressed while competent, some flexibility is accorded to the review tribunal within that framework:

> 36(3) The Board may give the substitute decision-maker permission to consent to the treatment despite the wish [i.e., the previously expressed refusal of the patient while competent] if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.

Under Ontario law, unlike the English situation following *F v. West Berkshire Health Authority*,[38] the doctor never makes the final decision as to whether treatment will be given, and the person making that decision on behalf of a person lacking capacity must decide according to a specific set of criteria. Once again, Ontario adopts an approach requiring specificity.

The intent of the Ontario system was to ensure that there would always be a second view of the doctor's proposal for treatment, a reality check serving a function analogous to informed consent by a competent patient, ensuring that the proposal was appropriate for the patient's particular circumstances. This second view has been the case for mental health in Ontario since 1978.[39] In the early years, the approach did not entirely fulfil this objective. The perception among patient rights advocates was that it was treated more as an obligation to inform family members of treatment rather than as scrutiny prior to consent, and in any event, it was thought that families tended to be too deferential to the medical views even when they conflicted with the patient's earlier, competent choices. For this reason, the closer guidance as to how consent should be given was included in the 1986 amendments. This, along with some administrative back-up to the provisions to inform substitutes of the criteria, has probably improved matters in this regard. It is difficult to see that it is sufficient to provide any real check on appropriateness of proposed treatments, however, as the person providing consent will in practice rely upon the advice provided by the doctor, advice which will normally point to the desirability of treatment. Appropriate audit structures may thus be a more effective mechanism of professional scrutiny, although one which is again likely to reflect medical values. That said, the Ontario provisions did introduce clearer guidance to doctors and substitute decision-makers as to how decisions regarding treatment are to be made.

One object of the 1986 reforms had been to force a second, non-medical opinion for the patient who was incapable, but was acquiescing to treatment. Treatment on this basis had been illegal without the consent of the substitute since 1978, but the experience of the patient rights bar was that such consent was nonetheless often not obtained. While publicity surrounding the law may have altered this to some degree, particularly in extreme cases, it is not clear that it has solved the problem. There remains anecdotal evidence that psychiatrists are negotiating treatment regimes with patients of at best marginal capacity, to avoid the perceived administrative hassle of

38 *[1989] 2 All ER 545 (HL).*

39 *Until Charter rights took effect, the refusal of the patient or substitute could be overruled by the review board. The board contained lay, legal and medical perspectives on it, however, so this did not in theory detract from the principle of scrutiny of the treatment proposals of the attending physician.*

approaching the nearest relatives. While a partial solution should not necessarily be criticised because it is not a total solution, the Ontario situation may here promise more than it delivers.

The difficulties of involving family members and carers formally in decision-making structures have received some discussion in England. Particularly when the list of substitutes is fixed, inappropriate results may occur. As an extreme case, a patient might quite reasonably not want a parent informed of the particulars of their treatment, if the parent has been abusing the patient. The Richardson proposals, reflected in the government white paper, proposes a system which would reduce the formal role of nearest relatives, and instead create a more informal role for nominated persons, appointed by the patient if competent and a review tribunal if not.[40] While the role in Ontario is more formal, the appointment system is much as the government and the Richardson Committee envisage. The green paper raises questions about the mechanics of appointment,[41] unanswered in the white paper; the government might do well to consult with the Ontario review tribunal regarding practicalities.

Community Treatment Orders

There has been no tradition of community treatment orders as such in Ontario. The approach of the Ontario legislation, which separates capacity and treatment from confinement, creates a markedly different environment for the consideration of such orders. At least theoretically, the provision of physical or mental treatment of an incapacitated person in the community has not posed problems, as it may be performed on the consent of a substitute. Further, when treatment cannot be enforced on a non-consenting competent patient in a psychiatric facility, it is unsurprising that it similarly cannot be enforced in the community.

Brian's Law introduced what it describes as a community treatment order, in 2000. In Ontario, as in England, political pressure had been towards further control of persons with mental health problems in the community, and in particular those ceasing prescribed treatment. The act itself was named in memory of Brian Smith, an individual killed by such a person.

Certainly, realities must be acknowledged: the act brings these patients into a new legal regime, subjecting them to particular professional scrutiny, and creating practical pressures to conform to treatment proposals. At least on paper, however, the Ontario model is not so much about enforcing a treatment programme on an unwilling patient, as it is about the provision of a coherent programme of after-care to those in particular need. There is no Ontario equivalent to the English right to after-care under section 117; if such care is to be required, the CTO is the only mechanism to do so. The intention in the drafting of the provisions seems to be to require doctors and the patient (or the patient's substitute decision-maker, if the patient lacks capacity) to reach an agreed solution embodied in a community treatment plan as to what treatment is appropriate in the community. It is available only if the patient has been an in-patient in a psychiatric facility on two or more separate occasions, or for a cumulative period of 30 days or more in the previous three years, or has previously been subject to a CTO in the previous three years. If the subject is not at the time of the order an in-patient, the physician must determine that the patient meets the criteria for compulsory admission under subsection 15(1) or 15(1.1), discussed above. In addition, it must be determined that the person is able to comply with the community treatment plan; that the care

40 *Richardson Report, para 12.17-23; white paper, para 5.5-9.*

41 *Green paper, para. 10.10.*

and treatment proposed is available in the community; and, in section 33.1(2)(c), that 'if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person'[42] If these conditions are met, so long as the subject agrees (or the subject's substitute, if the subject is incapable), the CTO takes effect. It runs for six months, and is subject to renewal if the above conditions are still applicable.

The statute is curiously silent about the scope of what may be included in a community treatment plan. Clearly, a regimen of medicine would be possible; but it is unclear how far the plan may extend outside the medical sphere and into the realms of social care, contact with services and accommodation.

The subject of the order may request a re-assessment of the situation at any time. Alternatively, consent of the subject or the substitute may be withdrawn on 72 hours notice. In either case, the attending physician may terminate the treatment order following a review of the individual's condition, if appropriate. If the physician believes that the subject is failing to comply with the order, an assessment may be ordered under section 15, the usual entry route to civil confinement, but only if the risks of bodily harm, physical or mental deterioration or physical impairment identified above are thought to exist, and if reasonable efforts have been made to assist the subject in complying with the order and warning of the possibility of admission if the order is not complied with.

The CTO also places responsibilities on the treatment providers named in the order. While the new section 33.6 of the Mental Health Act exempts treatment providers from liability for default of others in the provision of the treatment, it makes no such exception for treatment which the named treatment provider is charged with providing himself or herself under the order. This suggests quite a different approach from that of the English court in *Clunis v. Camden and Islington HA*,[43] where the court specifically denied any duty of care either in breach of statutory duty or in negligence for the supervision of a patient under section 117 aftercare. Such a duty of care would presumably be found in Ontario. As such, the Ontario CTO can be seen as enforcing standards of care from treatment providers as much as enforcing compliance in the patient population. This, again, is a step beyond what is proposed for England. The Richardson Report does propose that rights to assessment and to aftercare would exist, but there is no indication how these would be enforced. Certainly, there is no suggestion that the failure to assess or provide aftercare would lead to civil liability. After the decision in *Clunis*, it is difficult to see that such an amendment can be intended in the absence of express language. In the government white paper, even the formal right to an assessment has been removed.

The CTO is a sufficiently new mechanism in Ontario that it is not yet possible to suggest how successful it will be. There does seem to be considerable evidence that patient concordance with treatment is affected by the standard and availability of that treatment. If that is indeed the case, the Ontario approach may well be worth taking seriously.

42 *Brian's Law, s. 14, creating s. 33.1(2)(c) of the Mental Health Act.*

43 *[1998] 3 All ER 180.*

The Consent and Capacity Review Board and Due Process Protections

The Consent and Capacity Review Board hears applications relating to capacity to consent to treatment, financial capacity and challenging civil confinement. It also hears applications for review lodged by informal patients as discussed above, and similar applications from allegedly incapacitated adults objecting to being admitted by substitute decision-makers to nursing homes and similar institutions. It can appoint substitute decision-makers for treatment and care purposes when the patient lacks capacity and has not done so, and can provide directions as to the effect of wishes expressed by the patient regarding care and treatment. As in England, the board generally sits in panels of three: one psychiatrist, one lay person, and a lawyer as chair. Unlike the English tribunals, standards are contained in the legislation as to expeditiousness. Hearings must commence within seven days of the application unless all parties agree to a postponement. A decision must be communicated to the parties within one day of the completion of the hearing. The parties must be informed of their right to request reasons, and if requested, reasons must be handed down within two days.[44] Once again, the decisions of the European Court of Human Rights on speedy determination of rights begins to look extraordinarily feeble, particularly when the Ontario legislation is much more generous in the frequency of hearings to challenge confinement.

The review board system is supported by a fairly extensive system of rights advice. Major psychiatric facilities contain full-time rights advisors, and a network of part-time advisors exists in the broader community. These individuals make routine visits when decisions of significant legal import are made relating to the patient, such as a finding of incapacity, original civil confinement, or the renewal of civil confinement. They do not in their rights advisor role represent patients before the review board, although some of the part-time advisors in the community are lawyers who may take on briefs in that capacity. Instead, rights advisors generally put patients wishing to challenge decisions in contact with lawyers, who are funded through legal aid. This provision is in addition to the services in large psychiatric facilities of professional patient advocates, who assist patients with administrative matters outside the competence of review boards. While some rights advisors are part time, this is not an ad hoc programme. It shares with the patient advocate programme a small secretariat in Toronto. It is through this central office that the advisors are trained and employed; they may work in the psychiatric facilities, but they are not employed by them. This system has been in place for almost twenty years.

There was, briefly, a much more extensive and high-profile system of advocacy, Advocacy Ontario, created by legislation in 1992. This was a government office intended to provide rights advice and advocacy services to people with physical or mental disabilities, to act in the best interests of those incapable of instructing advocates when the health or safety of those individuals was at stake, to engage in public education, to press for systemic change to improve the situation of people with disabilities, and generally to promote respect for the rights, freedoms, autonomy and dignity of people with physical or mental disabilities.

Advocates employed by the agency had considerable power. They were for example to have access at all reasonable times to any place where a vulnerable person was thought on reasonable grounds to be, although entry to private dwelling houses would be only by warrant of a Justice of the Peace.[45] They had access to the health and other administrative records relating to an individual

44 *Health Care Consent Act 1996, s. 75.*

45 *Advocacy Act 1992, S.O. 1992, c. 26, s. 20-23.*

lacking capacity upon whose behalf they were acting, and otherwise by consent of the individual,[46] as well as a facility's administrative procedural manuals and records for the purposes of systemic advocacy.[47] The office was to be overseen by a board of commissioners. Eight of the twelve members of this board along with the chair were required by statute to be drawn from a list of individuals nominated by groups representing people with physical or mental disabilities, to ensure accountability to the users of advocacy services. To protect against potential co-option, Advocacy Ontario was placed under the Ministry of Citizenship, removed from the Attorney-General and Health Ministries which were responsible for the other legislation relating to mental health and incapacity.

One can readily understand the logic behind Advocacy Ontario. Rights advice supported by legal representation works in individual cases, with clients who have capacity to instruct. It is not efficient at creating systemic change, however, and it is not effective for clients lacking capacity to press for their own rights. When the rights in question are those relating to personal guardianship, invoked because of a perception that an individual lacks capacity, it is obvious that an ability to press for ones rights cannot be assumed. Further, it is simply not true that all carers are good carers. Canadian estimates are that seven to ten per cent of elderly people suffer some form of physical, mental, or financial abuse, generally at the hands of their families. One cannot assume that other vulnerable people fare better. If the principles behind the Ontario reforms of the early 1990s were to be meaningful, the logic goes, appropriate support services had to be put in place.

Sadly, Advocacy Ontario was not a success. The reasons are manifold. It became a political issue, associated in the public mind with a government which had become deeply unpopular by the time Advocacy Ontario was up and running. The unpopularity was articulated in a variety of ways. It was perceived as over-funded and profligate. It was perceived as overly interfering in the private lives of Ontario's families, caring for their loved ones. While it is true that the powers accorded were significant, it is not in fact obvious that they were excessive. If the people at risk in the community were to be protected from abuse, for example, a process to get a warrant to enter a private dwelling seems to be a necessity, but in Ontario, as in England, the risks to which vulnerable people are subjected in the family and in other 'safe' environments are not something that many politicians are prepared to tackle. The first chair of Advocacy Ontario, a former shadow health minister and former user of psychiatric services, was hailed with broad enthusiasm upon his appointment. As the stock of the government in general and Advocacy Ontario in particular fell, he became perceived as a purely political appointment. The problems were not all perceptual, however. Appointments to the advisory board and to the Commission were apparently chosen to reflect the diversity of views relating to advocacy and patient rights issues. While this might have been effective in other circumstances, the board sadly seemed incapable of working together. Under these stresses, Advocacy Ontario had largely imploded before a new government finally abolished it, shortly after an election in 1995.[48]

The result is problematic. There is now in Ontario no systemic mechanism in place to ensure that the law is being followed. As rights advisors act only on competent instructions, they have little effect for persons unable to provide such instructions. For those persons, advocacy services are largely absent, and the honour system seems to be relied upon for the application of the law.

46 *Advocacy Act 1992, s. 24.*

47 *Advocacy Act 1992, s. 26.*

48 *See S.O. 1996, c. 2, s. 72.*

The English government has in the green paper agreed to consider the provision of advocacy in a mental health context. The existing Ontario model, and Advocacy Ontario, provide a mixture of success and failure. We might well learn from more detailed study of this experience.

Problems

From the foregoing, it will be clear that there is much for English analysts to consider. The overarching structure of the Ontario legislation is designed to take into account both patient rights and safety of the public and the patient. These are central to the concerns of the government in its green paper and of the Richardson Committee. While there may still be some problems with enforcement mechanisms, the presence and efficacy of the Ontario rights advice and review board structure does provide the English onlooker with cause for pause.

There are, of course problems, real and apparent. The major theoretical difficulty with applying the Ontario system to England is that Ontario's Mental Health Act expressly acknowledges a policing role of psychiatric confinement, based on dangerousness rather than the need for or availability of treatment. Theoretically, it would be possible for patients to be detained in psychiatric facilities ad infinitem, untreated because there is no effective treatment, or because they are competent and refuse consent, or because they lack capacity and refused the required treatment prospectively. The concern is that the ethos of the facility would change from hospital to patient warehouse.

Certainly, the express acknowledgement of dangerousness rather than treatability as the criterion for confinement does have a symbolic importance, but it is easy to overstate the difference with the current English system. After all, English statute law allows confinement not just on health grounds, but also for the 'safety of the patient or for the protection of other persons', a dangerousness criterion, albeit coupled with the alternative best interest criterion of 'health'. There is further no express treatability requirement for either severe mental impairment or mental illness, but only for the small minority of cases which are categorised as psychopathic disorder or (non-serious) mental impairment. The requirement of treatability rather than dangerousness as a prerequisite for involuntary admission in England is thus already largely a myth. The Ontario legislation is more specific in its articulation of how dangerousness is to be determined, but it is not obviously theoretically different for that.

In practice, the concern seems ill-founded, since virtually no competent patients in Ontario psychiatric facilities refuse all treatment. Ontario facilities have simply not become warehouses of patients 'rotting with their rights on', any more than their English counterparts. Certainly, some patients refuse some treatments, requiring negotiation between doctor and patient towards an agreed treatment regime. While this may result in some compromise on what are perceived by the doctors as medical best interests, the increased communication between doctor and patient which is implied has its own advantages. It ensures that the patient is more involved in the development of the treatment plan, at least in theory meaning that the patient has a greater emotional stake in the resulting deal. This should in turn mean better rates of treatment continuation – a desirable medical result.

The cost of the review board structure is an obvious area of curiosity, but it does not seem exorbitant. The Ontario Consent and Capacity Review Board received 3091 applications in 1998-9, resulting in 1785 hearings. The cost of this to the taxpayer was just over $CDN 2 million, or about £900,000.[49] In this period, roughly 15,000 people (excluding criminal confinements) were involuntarily admitted to psychiatric facilities in the province. The higher number of confinements in England would militate towards an increase in this figure,[50] but the higher population density would counteract this to some degree, as transportation costs to get board members to hearings would be reduced. The cost hardly seems excessive, for provision of an efficient tribunal structure.

The more severe criticisms relate to the key terms of the legislation. It is all very well to focus on dangerousness as the criterion of confinement, but even after the closer criteria of the Ontario legislation, dangerousness is notoriously unpredictable. Studies generally find that between half and three quarters of those predicted to be dangerous by psychiatric professionals do not in the end turn out to be violent.[51] Capacity is similarly an extremely slippery concept. And while the standards in the legislation appear to provide considerable power to patients, the effect of informal coercion is not to be underestimated. In what sense, for example, is consent to treatment 'voluntary' as required by the Health Care Consent Act,[52] if it is provided after the doctor explains (perhaps quite accurately) that the treatment is the patient's only hope of recovering far enough to be released from the psychiatric facility, or if carers in the community will only accept the patient if he or she agrees to medication? These problems exist equally in the current and proposed English systems, however, and the closer wording and clearer structuring of the Ontario acts at least provides an improvement on the vague English legislation in these regards. The fact that it is only a partial solution does not necessarily justify extreme criticism, given what else is on offer.

Conclusion

Admittedly, the Ontario acts have their problems. At the same time, they do seem to provide a coherent system, which takes into account the variety of interests and concerns under discussion in the current reform debate. The risk is not merely that the government may re-invent the wheel in the to-ing and fro-ing leading up to mental health reform, but perhaps more important, that they may not re-invent it very well. The Ontario example provides a wealth of experience which should be tapped. The English commentators and legislators would do well to give it further heed.

49 *My thanks to David Hoff of the Ontario Consent and Capacity Review Board for providing this information.*

50 *In England, just over 25,000 people were civilly confined under part II of the Mental Health Act.*

51 *For surveys of the relevant literature, see P. Bowden, 'Violence and Mental Disorder', in N. Walker (ed),* Dangerous People, *(London: Blackstone, 1996), J. Monahan, 'Risk Assessment of Violence among the Mentally Disordered: Generating Useful Knowledge', 11* International Journal of Law and Mental Health *(1988) 249, J. Monahan, 'The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy', 141* American Journal of Psychiatry *(1984) 10. Further, factors such as race, sex and class appear to be among the best predictors of dangerousness, raising profound discrimination questions as to how dangerousness can or should be used in social policy relating to mental illness: see S. Wessely, 'The Epidemiology of Crime, Violence and Schizophrenia', 170 (supp. 32)* British Journal of Psychiatry *(1997)* 8.

52 *Section 11(1).*

Legal Knowledge of Mental Health Professionals: Report of a National Survey

Jill Peay, Caroline Roberts** and Nigel Eastman****

Summary

This article presents findings from a national postal survey of knowledge of mental health law amongst psychiatrists, GPs, approved social workers and Mental Health Act Commissioners, conducted in England and Wales. The study was designed to assess (amongst other matters) the relative levels of legal knowledge between and within these professional groups. Data from 2022 respondents revealed considerable discrepancies in knowledge scores. Commissioners, approved psychiatrists and approved social workers achieved the highest scores, and non-approved GPs the lowest scores. Within-group differences, for doctors, were correlated with levels of day-to-day experience in using the Mental Health Act and, for approved social workers, with training. The article concludes that the advisability of maintaining the statutory role of GPs in its current form is questionable, given the preponderance of poorly performing GPs. Both use of the Act and training were important in sustaining practitioners' legal knowledge.

Introduction

It is paradoxical that whilst the legal provisions governing the detention (and subsequent treatment) of those suffering from mental disorder are widely thought to be tightly constrained, the wording of the Mental Health Act 1983 (MHA) makes its application highly discretionary. The MHA is, in practice, reliant for its clinical and civil rights effects upon the interpretation and judgement of the practitioners who are required to apply it.[1] Moreover, whether and how the law is applied, and whether it is applied consistently, depends substantially upon the legal knowledge

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1 *Eastman, N. & Peay, J. (eds) (1999)* Law Without Enforcement: Integrating Mental Health and Justice. *Oxford: Hart Publications; Hoggett, B. (1996)* Mental Health Law *(4th Ed) London: Sweet and Maxwell*

of those practitioners;[2] impoverished knowledge can lead both to patients being denied treatment from which they might have benefited, and to patients being inappropriately treated. Yet, research concerning what is known by UK practitioners about mental health law is scant. Previous studies have been interview based, relatively small scale and confined to doctors,[3] or based on doctors' understanding of the common law.[4]

Methods

A postal survey was conducted in England and Wales using a purposely designed and piloted self-completion questionnaire of mental health practitioners with key responsibilities under the MHA. The surveyed groups were psychiatrists approved under s.12(2) of the MHA as having "special experience in the diagnosis or treatment of mental disorder", non-approved psychiatrists and general practitioners (GPs), as well as approved social workers (ASWs). In addition, all 476 s.12(2) approved GPs on the Regional Health Authority registers and all 147 Mental Health Act Commissioners (MHACs) then active were included. The survey was conducted between February and July 1999, with two re-mailings to non-responders. Response was also encouraged through participation in a prize draw for a week-end for two in Paris.

For the sampled groups, representative samples (proportionately stratified according to region) of 700 non-approved GPs and 600 ASWs were approached, using a 'random start and fixed interval' method. The GP sample was obtained from a commercial NHS database company and the ASW sample from lists of those active on the duty rotas of sixty local authorities (representative in terms of population density and the proportion of households in social classes I and II). A sample of 1500 psychiatrists (including those with and without s.12(2) approval) was taken from membership lists of the Royal College of Psychiatrists. Psychiatrists were 'over-sampled' in order to ensure adequate numbers of s.12(2) and non-approved practitioners were obtained of those specialising in areas of psychiatry requiring regular use of the MHA. Returned questionnaires from psychiatrists were filtered in order to exclude those not fulfilling the sampling criteria. Further details of the sampling procedures, selection criteria and other aspects of the methodology are available elsewhere.[5]

The questionnaire was in three parts. Whilst part 1 concerned attitudes towards mental health issues, this article describes and analyses data from parts 2 and 3. These addressed knowledge of the MHA and the 1993 Code of Practice, and assessed various demographic items including professional experience and training.

2 *Hawkins, K. (1986) On Legal Decision-Making.* Washington and Lee Law Review. *43: 1161-1242; Hogarth, J. (1971)* Sentencing as a Human Process. *Toronto: University of Toronto Press*

3 *Humphreys, M. (1994) Junior Psychiatrists and Emergency Compulsory Detention in Scotland.* International Journal of Law and Psychiatry *17, 421-429; Humphreys, M (1997) Non-consultant psychiatrists' knowledge of emergency detention procedures in Scotland. A national survey.* Psychiatric Bulletin *21, 631-635; Humphreys, M. (1998) Consultant Psychiatrists' Knowledge of Mental Health Legislation in Scotland.* Medicine, Science and Law *38, 237-241; Humphreys, M. & Ryman, A. (1996) Knowledge of emergency compulsory detention procedures among general practitioners in Edinburgh: sample survey.* British Medical Journal *312, 1426-3; Bhatti, V., Kenney-Herbert, J., Cope R.,* et al *(1999) Knowledge of current mental health legislation among medical practitioners approved under section 12(2) of the Mental Health Act 1983 in the West Midlands.* Health Trends *30, 106-108*

4 *Hassan, T., MacNamara, A., Davy,* A., et al *(1999) Managing patients with deliberate self-harm who refuse treatment in the accident and emergency department.* British Medical Journal *319: 107-9*

5 *Roberts, C., Eastman, N. & Peay, J. (2000) A study of the attitudes and legal knowledge of professionals with responsibilities under the Mental Health Act 1983: Report of a national postal survey. London: LSE and St George's Hospital Medical School*

Measuring knowledge of mental health law

The knowledge part of the questionnaire consisted of 27 true or false statements. The items were intended to vary in difficulty, allowing even those with relatively little experience of using the MHA (namely, non-s.12(2) approved GPs) the opportunity to demonstrate knowledge. The items were presented in a random order with respect to their predicted levels of difficulty. Respondents were asked to indicate whether the item was 'true', 'false' or, if they were unsure of the correct response, that they 'would need to look it up'. Guessing was discouraged.

Given that it would be possible to 'look up' the correct answer to most questions, either in the MHA itself or in a relevant manual, a number of potential validity problems needed to be resolved. A range of approaches was developed in the design phase, including some aimed at easing respondents' anxiety about demonstrating any possibly limited knowledge. However, the most innovative approach adopted was the inclusion of six items designed specifically as 'validity checks'. These allowed both the identification of respondents who had most likely ignored our instructions and referred to materials during completion of the survey and provided a means of evaluating the methodology employed.

Validity questions were of two types. First, 'difficult obscure' statements, where only respondents with a very good general knowledge of mental health law (including knowledge of recent case law, Department of Health guidelines and their relationship) would be likely to know the correct response, since there would be no obvious source for 'looking up'. Secondly, 'difficult technical' statements were included. In order to give the right answer to these it was postulated that resort to the MHA or to a manual *would* be necessary for those respondents unable successfully to guess correctly. Even someone with extremely good knowledge would be very likely to have to look up such answers. Accordingly, a better performance on the former type of validity question than on the latter type was hypothesised. Those who gave correct answers to the technical questions, but not to the obscure questions, were most likely to have referred to a legal source despite exhortations not to do so.

Developing true/false statements

The 27 true/false items developed included both those addressing knowledge of the most basic kind, for example, item 2.4 "mental illness is defined within the MHA 1983" and the six 'validity' questions. Whilst the questionnaire was extensively piloted the selection of items included in the final version required few adjustments beyond changes to wording and better balancing of the number of true and false statements. Table 1 below illustrates answers to seven of the knowledge items by professional group, based on a sample of 2022 questionnaires.

Knowledge Item	Proportion of respondents giving correct (C), incorrect (I) and 'I would need to look it up' (DK) responses (percentages %)																	
	Mental Health Act Commissioners			s.12(2) Psychiatrists			ASWs			Non-approved Psychiatrists			s.12(2) GPs			Non-approved GPs		
	C	I	DK	C	I	DK	C	I	DK	C	I	DK	C	I	DK	C	I	DK
2.3 Under the MHA a General Practitioner can only make a medical recommendation for detention in hospital if the patient has been on his or her list for at least three months. (False)	85	4	11	83	3	15	89	3	9	65	6	30	84	7	9	64	9	27
2.4 Mental illness is defined within the MHA 1983. (False)	77	19	3	78	18	4	72	26	2	67	26	8	42	44	14	27	33	41
2.19 The legal criteria for compulsory admission to a hospital under the MHA include that the person is unable to consent to treatment. (False)	89	7	4	81	13	6	89	9	3	67	22	11	59	29	13	67	22	11
2.20 Drug treatments above the British National Formulary (BNF) limits always require a second opinion from a doctor appointed by the Mental Health Act Commission (SOAD). (False)	80	10	10	79	11	11	25	28	47	64	14	22	47	11	42	37	10	53
2.23 Under the Mental Health (Patients in the Community) Act 1995 there is a power to convey but not to treat the patient without consent. (True)	81	6	14	78	3	20	74	2	24	59	7	34	39	9	52	20	8	71
2.25 A patient's 'nearest relative' for the purposes of the MHA can be nominated by the patient. (False)	79	16	5	66	13	21	88	7	5	53	22	25	57	19	24	27	23	50
2.27 The legal criteria for admission to a hospital for treatment under Section 3 of the MHA include that the person is in need of detention in the interests of their health. (True)	81	16	3	87	10	4	84	13	3	79	12	9	67	22	11	51	14	35

Table 1 - showing mean responses to seven knowledge items for each professional group

Statistical Analysis

Key comparisons between professional groups were carried out on the basis of mean knowledge scores using Analysis of Variance, and the Scheffé post hoc range procedure (in ANOVA), which allows simultaneous pairwise comparisons of means for all possible multiple-group comparisons. The Scheffé procedure produces more conservative estimates for p-values, thus reducing the probability of making Type I errors.

Calculating the 'adjusted knowledge' score

It was necessary to decide the most appropriate measure of knowledge to use for both between- and within-group comparisons. This involved two processes. First, the generation of descriptive statistics for the items included as validity checks, in order to ensure that respondents had not referred to the Act or a manual whilst completing the true/ false statements. As hypothesised, the majority of respondents performed poorly on these items compared with the other items. The 'difficult technical' items produced the highest number of 'I would need to look it up' responses, as had been predicted would happen if respondents followed our instructions. We also cross-checked to ensure that those respondents who scored well on the 'difficult obscure' items did indeed perform well overall on the knowledge items. Combining these responses gave us confidence in the robustness of our validity items as a method of detecting possible 'looking-up' offenders. Whilst it had been intended that data from such 'errant souls' would be excluded from the analysis, in the event less than ten respondents were considered likely to have breached our exhortations. Since they were distributed across all the professional groups we decided not to exclude them. On the basis of these analyses, however, it was decided that the validity items would be *excluded* from the computation of knowledge score, on the grounds that they did not provide a fair test of actual knowledge. By removing them, overall mean scores substantially increased across all professional groups.

Secondly, an exploratory analysis using Item Response Theory was carried out to determine whether particular items appeared to be differentially difficult for the professional groups.[6] This involved a logistic test item analysis (using a two-parameter model) using the SYSTAT package (version 5.03 for Windows) to produce Latent Trait Models for each item within each of the four professional groups. Item Response Theory allows an examination of the relative difficulty of each item given a postulated 'ability' level for all respondents. Thus, item difficulty is determined not simply by the proportion of respondents obtaining a correct response, but rather by focusing on the specific characteristics of each item.

Three items (relating to treatment and consent issues) were found to differentiate particularly poorly between psychiatrists (with a high proportion responding correctly across the range of ability) and one item was found to be particularly 'easy' for ASWs (pertaining to their role with respect to the nearest relative). Excluding these items from the computation of the score for knowledge, however, did not affect the overall ranking of the professional groups, nor did it significantly affect the mean scores for each group, and so the items were *retained*. The final knowledge score, therefore, was calculated on the basis of 21 items (i.e. a total of 27 minus the 6 validity items).

6 *Hambleton, R.K., Swaminathan, H. & Jane Rogers, H. (1991)* Fundamentals of Item Response Theory. *Sage Publications*

It should be noted that, for the purpose of the analyses reported below, data from 169 respondents who had either a high number of 'don't know' responses (10 or more) or for whom there were 10 or more missing values (indicating that they had made no attempt to respond to the items) were excluded; this produced a sample of 1,853 respondents for the comparisons of 'knowledge' score (see Table 2 below). Using this most 'conservative' score of knowledge (that is, the one which places respondents in the best possible light in terms of their group's mean legal knowledge) has the advantage of minimising any bias that might otherwise be introduced as between the professional groups due to their differential preponderance to guess correct answers. As might be expected, of the 169 excluded respondents, 123 were non-approved GPs; accordingly, any observations offered below about the lack of knowledge of GPs is based on a sample that has already excluded a significant number of their most poorly performing members.

The final adjustment made to produce as fair a measure of knowledge as was possible involved calculating for each included respondent the number of correct responses, minus the number of incorrect responses. Since we had discouraged 'guessing', confidently made incorrect responses were deducted from correct responses, thus penalising inaccurate responses whilst giving appropriate credit for correct ones. Since the view was taken that it was acceptable, in practice, to admit the need to look up information, but unacceptable to give incorrect answers, the 'I would need to look it up' responses played no part in the calculation of 'adjusted knowledge' score.

Within-group differences in knowledge

Within-group differences in knowledge were explored using multiple regression analyses (Stepwise procedure in SPSS), whereby only those regressors that *significantly* predicted the dependent variable were retained in the model. Thus, regression models were selected not simply on the basis of the magnitude of the R square. Rather, the emphasis of the procedure was on identifying those factors most influential in determining knowledge score. Some further Analyses of Variance were carried out to explore within-group differences where appropriate.

Results

The number of returned questionnaires included in the study was as follows: 125 Mental Health Act Commissioners (85% response rate for included questionnaires), 266 s.12(2) GPs (56%), 306 non-approved GPs (44%), 425 ASWs (71%) and 900 psychiatrists (60%). Of the latter, 716 had s.12(2) approval. The prevalence of s.12(2) approval was greater than anticipated and this, in addition to increased non-response amongst those without approval, led to the under-representation in the survey sample of psychiatrists who had not gained s.12(2) approval (predominantly those who had only recently passed the Membership exam).

Between-group differences

On the basis of the 'adjusted knowledge' score described above, the pattern of knowledge levels which emerged was that MHACs had the highest mean scores, followed by s.12(2) psychiatrists and then ASWs (although only by a few percentage points), with non-approved psychiatrists and GPs at the lower end of the scale.

Professional Group	Mean Adjusted Knowledge Score	Standard Deviation	N
Mental Health Act Commissioners	76.9	16.7	121
s.12(2) psychiatrists	76.4	12.8	709
Approved Social Workers	71.5	13.5	421
Non-approved psychiatrists	66.4	15.0	174
s.12(2) GPs	54.5	16.4	245
Non-approved GPs	45.3	14.4	183
TOTAL	**68.4**	**17.6**	**1853**

Table 2 Mean knowledge score for all professional groups (calculated for all 21 items (excluding 'validity items', as total correct - total incorrect). Scores are shown as percentages.

Table 3 below shows the distribution by professional group across six unequal percentiles (based, for the purposes of analogy, on University degree classifications) using the adjusted knowledge scores. It notably demonstrates first, that there were representatives in all the professional groups who scored in the highest percentiles, supporting our argument that the knowledge test was not impossibly difficult for even GPs to obtain good scores. Secondly, the preponderance of MHACs (76%) in the highest percentile is a reassuring reflection of their overall high quality. MHACs, of course, are not only appointed on the basis of their working experience (including lawyers, doctors and social workers) but also receive extensive in-house training. Third, the difference between, on the one hand, ASWs and s.12(2) approved psychiatrists, and on the other GPs (whether approved or not), is most marked at the bottom end of the range. Using a score of less than 40% as a measure of poor performance, not more than 2% of ASWs or s.12(2) psychiatrists fell into this category, but 15% of approved GPs and 30% of non-approved GPs were located in this range.

Within-group differences

First, for all respondents a positive, significant correlation between knowledge and training received in the year preceding the research was found (Pearson's $r = 0.28$, $p_{2\text{-tailed}}<0.01$). Secondly, however, the multivariate analyses (multiple regression) revealed the complexity of the relationship between knowledge, training and the various demographic and professional experience measures. For example, for psychiatrists (approved and non-approved), levels of knowledge were significantly influenced by their experience of using the MHA (significant variables included attending Mental Health Review Tribunals, writing court reports and participation in MHA assessments during the past year - all of which imply *active* use of the Act). For GPs, the best single predictor of variance in knowledge was participation in MHA assessments during the previous year. Only 22 GPs had *never* participated in such an assessment and their mean knowledge score was significantly lower than for those attending 20 or more assessments in 1998 ($t_{103} = -3.18$, $p_{2\text{-tailed}}<0.01$). For MHACs one of the greatest influences on knowledge scores was experience of teaching mental health law

Adjusted Knowledge Score (Degree Class)	MHA Commissioners (n=121)		s.12(2) Psychiatrists (n=709)		Approved Social Workers (n=421)		Non-approved Psychiatrists (n=174)		s.12(2) GPs (n=245)		Non-approved GPs (n=183)		Total (n=1853)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
First Class (70%+)	92	76	557	78.6	247	58.7	81	46.6	52	21.2	8	4.4	1037	56.0
Upper Second (60-69%)	14	11.6	83	11.7	104	24.7	39	22.4	55	22.4	24	13.1	319	17.2
Lower Second (50-59%)	7	5.8	43	6.1	52	12.4	30	17.2	58	23.7	41	22.4	231	12.5
Third Class (45-49%)	3	2.5	11	1.6	9	2.1	7	4.0	14	5.7	17	9.3	61	3.3
Pass (40-44%)	2	1.7	8	1.1	3	0.7	12	6.9	30	12.2	39	21.3	94	5.1
Fail (under 40%)	3	2.5	7	1.0	6	1.4	5	2.9	36	14.7	54	29.5	111	6.0

Table 3 Adjusted knowledge score divided into degree classifications – Professional Group Crosstabulation

to others. For ASWs however, the association of greatest significance appears to be that between training and knowledge levels. For, whilst use of the MHA was important, the clearest associations were between numbers of days of training (whether ASW qualification training or days of training received in 1998) and knowledge score.

Discussion

Methodological limitations

Assessing knowledge is fraught with problems and, whatever methodology is adopted, the measures of knowledge produced will have their limitations. For example, the interview based methodology of the studies cited above require respondents to construct or recall an answer. This is likely to be more difficult, particularly when an interview is conducted face to face, than an anonymous postal survey that merely requires the respondent to recognise the correct answer. These earlier studies may thus *underestimate* knowledge. In contrast, a postal survey necessarily risks *overestimating* knowledge levels.

Whilst we are reasonably confident that the validity measures employed in this study enable us to refute that possibility, the very *poor* scores obtained by some respondents confirm that our methodology could reflect real areas of 'ignorance'. Such ignorance would replicate the universally depressing picture of knowledge painted by the earlier studies. For example, in a study of non-consultant psychiatrists in Scotland, it was found that, "none of the individuals interviewed was able to give an accurate description of all the conditions which must be fulfilled in order to detain

a patient in an emergency".[7] Moreover, as Humphreys further observed, some consultants "seemed unashamed or even unaware of their lack of knowledge".[8]

However, it is important to emphasise that our study was primarily designed not to assess absolute knowledge, but *comparative* levels of knowledge amongst *all* practitioners who have responsibilities under the MHA. It thereby sought to redress the emphasis of the earlier studies on *doctors'* knowledge. Indeed, MHA's multi-disciplinary framework may ensure that where doctors are deficient in their knowledge, ASWs can serve as a brake, or a spur, where inappropriate action, or inaction, might otherwise result. Whilst these 'checks and balances' do not invariably redress any deficiencies in medical legal knowledge,[9] the 'structured' nature of real life multi-disciplinary decision-making does highlight a further limitation of our study. In practice, mental health professionals may both resort to written materials and have access to one another and to other parties, such as family members, who may have no statutory role under the MHA. Whether these individual contributions are likely to be more or less informative is an open question, but this study does indicate that doctors are unlikely to encounter a very poorly informed ASW. The same cannot be said of ASWs' encounters with GPs.

A third limitation of our study is the relatively lower response rate from non-approved GPs (44%). Whilst this can be attributed to the lesser degree of salience of mental health law issues to general practice, low levels of knowledge remain of concern where all GPs potentially have a statutory role in the process of compulsory admission under the MHA.

Knowledge scores - the order of merit

Whilst there are problems in the interpretation of our findings, a number of points emerge with clarity. The first is relatively positive; namely, those with key responsibilities under the MHA did not perform on the knowledge items as badly as the previous literature specifically concerning doctors might have led us to expect. Indeed, a significant number of individuals in all of the practitioner groups (with the exception of GPs) obtained impressively high scores, reflecting a minimal ability at least to recognise correct answers.

On the negative side, there was also a significant number of individuals who performed poorly, worryingly including some MHACs (although it is notable that MHACs, as a group, performed in the highest percentiles). Also, the *mean* percentage scores (77% for MHACs ranging down to 45% for non s.12(2) GPs) are not particularly impressive overall. To use an academic analogy, three *groups* performed in the first class bracket (MHACs, approved psychiatrists and ASWs); non-approved psychiatrists obtained a middling 2:1 (66%); s.12(2) approved GPs fell in the lower second class bracket (55%), whilst non-approved GPs scraped a third class pass (45%). However, it should be recalled that 123 non-approved GPs were excluded from the analysis, on the basis that, again by analogy, they had turned up at the examination room but had not made a serious attempt at the paper (having had 10 or more 'don't knows' or 10 or more missing values). Whatever their mitigating (medical or not) circumstances this sort of performance should not be condoned. Moreover, while it could be argued that GPs have very limited roles in terms of the frequency of their actual use of the MHA, that cannot be a justification for such ignorance. The MHA gives

7 *See Humphreys (above) 1997 at p.632.*

8 *See Humphreys (above) 1998 at p.239*

9 *Peay, J. & Eastman, N. (2000) A study of the decision processes and decision outcomes of professionals with responsibilities under the Mental Health Act 1983: Report of a vignette study. London: LSE and St George's Hospital Medical School*

them authority and for those many individuals who are sectioned by GPs, inexperience, and even understandable ignorance can be no consolation.

The order of merit described above also reveals a counter-intuitive finding, namely that approved psychiatrists just outperformed ASWs. We describe it as counter-intuitive because such psychiatrists are required, in order to achieve their 'approved' status, to undergo an average of only one to two days of training in mental health law[10] whereas ASWs undergo three months of training, albeit in mental health generally as well as mental health law.[11] It was also notable that, when asked to rate their own confidence in mental health law, ASWs *rated* themselves as *more* confident than did the psychiatrists. To conclude that s.12(2) psychiatrists *are* generally better informed on the knowledge items, whilst ASWs *think* that they are better informed and that no amount of training makes a difference to their knowledge, would be harsh since the difference in their scores is so marginal. However, it is notable that, looking percentile by percentile, approved psychiatrists did outperform ASWs in each percentile. Interpreting these findings is difficult, particularly since the ASW sample was relatively homogenous, whilst the s.12(2) psychiatrist sample was heterogeneous by comparison and the two groups will have had differing training and work experiences. Yet, looking at the differences of the *spread* of scores between *all* the groups, the ASWs' three months training seems to have the advantage that one can rely upon most ASWs being 'quality assured'. Put at its simplest, a patient is relatively unlikely to encounter an ASW or s.12(2) psychiatrist with poor legal knowledge.

Training, refresher training and 'active' training

An important question concerns the amount and nature of training which best serves to ensure that knowledge is both acquired and retained. Should our finding that s.12(2) psychiatrists (with their two days of training) outperform ASWs (with three months of training) lead us to conclude that two days is enough and three months more than enough? Given our reflections above, quite the reverse. However, whilst the ASWs' training may protect them from unacceptably low levels of knowledge, the fact that the approved psychiatrists' knowledge is associated with *active use* of the MHA may indicate that mere *passive training* is not the best method for ensuring that knowledge is retained. Whilst it is possible that ASWs and psychiatrists as groups respond better to differing training regimes, a more plausible explanation is that retention of knowledge, and even its acquisition, is best achieved through active use of the MHA. Thus, one improvement to the training regime in mental health law might be to ensure that it has a more 'experiential' element.[12]

GPs - reasons for concern

What remains of concern however is the relatively low levels of knowledge shown by those who only use the MHA infrequently, and yet who potentially enjoy day-to-day responsibilities and powers under it. The argument is most acute with respect to GPs. GPs had the lowest knowledge scores, yet, for our sample of 572 GPs, only 22 of them had *never* participated in a MHA

10 *NHS Executive (1996) Approval of doctors under section 12 of the Mental Health Act 1983. HSG(96)3.*

11 *Central Council for Education and Training in Social Work (1992) Requirements and guidance for the training of social workers to be considered for approval in England and Wales under the Mental Health Act 1983. Rev ed London: CCETSW 1003, (CCETSW paper: no 19.19)*

12 *Harrison, J. (1996) Training in the Mental Health Act: see one, do one, teach one?* Psychiatric Bulletin *20, 160-161*

assessment. It is also notable that GPs, having tackled the knowledge items, showed a marked decrease in confidence, demonstrating that as a group, they at least recognised that they did not know that which perhaps they ought to have known.

How might these findings be judged in a broader medical context? Modern thinking about regulating medical practice has increasingly sought to control practice on the basis of specific experience; thus, surgeons, for example, are allowed to undertake particular procedures, such as mastectomies, only if they perform more than a given number per year. Unfortunately, ignorance of the law is no impediment to its initial application. Quality assurance in maintaining patients' civil rights would, therefore, seem to demand that only doctors who can demonstrate a given level of annual experience (and/or knowledge) in using the MHA, on a number of measures, should be *allowed* to use it. Whilst the Government's Green Paper asserts "(A) key aim of our proposals is to ensure that the provisions of a new Mental Health Act are fairly and consistently implemented"[13] and the later White Paper confirms that "Practitioners who are responsible for using the powers in mental health legislation need to have a thorough understanding of its scope and purpose"[14] neither of these objectives seem likely to be easily achieved. The existing wide disparity in basic knowledge amongst key practitioner groups is unlikely to be remedied for, whilst the White Paper asserts[15] "Specialist training will be provided for all professional staff authorised to undertake specific functions under the new legislation. Training and regular updating will be statutory requirements for those who are responsible for taking key decisions" there is no assurance that all GPs will be included in this training. Yet GPs are seemingly to retain a statutory role in the decision to assess patients (a process which may last up to 28 days), and, as at present, may be the only doctor involved in an emergency admission.[16] We would suggest, on the basis of this study, that whilst GPs might properly be *consulted* about their patients clinically and in relation to decisions to detain, they arguably should not retain the legal authority to *make* that decision. This more limited approach would contrast with the recommendation of the Richardson Committee,[17] now taken up in the White Paper[18] for potentially expanding the range of specialist mental health practitioners who might *have* such authority. Notably, however, the Richardson recommendation was premised on the crucial importance of adequate training for those specifically empowered under legislation.

Further analysis could be undertaken on the comparative disparities in understanding and non-understanding of the law. Here, we merely observe that misapprehensions about the law, especially in the context of high levels of expressed confidence, may result in unlawful use or unnecessary overuse of the MHA. Equally, the law may be underused. Lest these descriptions be thought anodyne, it is worth stressing that they may disguise what in practice can amount to unjustified loss of liberty for some patients and/or a failure properly to be treated, via detention, for others.

13 *Department of Health (1999)* Reform of the Mental Health Act 1983. Proposals for Consultation. *Cm 4480 London: The Stationery Office Ltd, at p.10*

14 *Department of Health/ Home Office (2000)* Reforming the Mental Health Act. Part I: The new legal framework *Cm 5016-I London: The Stationery Office Ltd, at para 2.30*

15 *Ibid*

16 *Ibid at para 3.75*

17 *DoH op. cit., n.13 at p. 48,*

18 *DoH/Home Office, op.cit., n. 14 at para 3.14)*

Conclusion

This study, based on a national survey of varying professional groups, suggests that levels of knowledge vary, sometimes greatly, by group, and that higher knowledge scores are associated within and across groups with more frequent use of the MHA. Mean scores for all groups also demonstrate much better knowledge levels for doctors than the earlier studies. Whilst the relatively low levels of knowledge shown in this study amongst GPs is of concern, since any GP can be called upon to perform their statutorily required function under the MHA, the higher levels of knowledge amongst ASWs and of s.12(2) psychiatrists may serve to 'protect' GPs against their own relatively inadequate knowledge. However, such an inter-professional relationship runs counter to the intention of the MHA to maximise civil rights and clinical outcome via independent assessments. The results have significance for clinical governance, for training and for deciding about future medical roles in the planned new Mental Health Act.[19] Whether GPs should retain a statutory function in the admission process, rather than an advisory one, is, on the basis of this study, more than a moot point.

Acknowledgements

We are grateful to all those (anonymous) respondents to the questionnaire and, in particular to Professor George Gaskell and Dr Patten Smith of the LSE for advice on statistical design and analysis of the questionnaire. We are also grateful to Dr Martin Humphreys for his helpful comments on an earlier version of this article. The research was funded by the Department of Health[20] and conducted as part of a programme of research into the MHA co-ordinated by the College Research Unit of the Royal College of Psychiatrists. Roberts was supported for a further two months during the preparation of this article by a STICERD (Suntory and Toyota International Centres for Economics and Related Disciplines) grant from the LSE.

Declaration of interest: Peay was a member of the Richardson Committee.

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19 *Richardson, G. (1999) Review of the Mental Health Act 1983. Report of the Expert Committee. Department of Health; DoH/Home Office, op.cit., n.14*

20 *Department of Health (2000)* Shaping the New Mental Health Act: Key Messages from the Department of Health Research Programme. *London: Department of Health*

Outpatient Commitment. Some Reflections on Ideology, Practice and Implications for Research

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Introduction

Over the recent years, increased attention has been paid to non-compliance by mentally disordered patients living in the community with outpatient treatment.1 To deal with this problem many countries are now revising relevant legislation, to introduce a broader base for involuntary treatment in the community.2 This paper focuses both on the problems concerning the ideology and implementation of involuntary outpatient treatment, and on some of the research problems related to the evaluation of both the efficacy and effectiveness of outpatient commitment.

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1 *Dennis, D. L., & Monahan, J., (Eds.) (1996) Coercion and aggressive community treatment - A new frontier in mental health law. New York: Plenum Press; Dennis, D. L., (1999) Tracing the development of outpatient commitment. An annotated bibliography. In Coercion in mental health services - international perspectives. Research in community and mental health (eds J. P. Morrissey & J. Monahan), pp. 209-229. Stamford, Jai Press Inc; Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. American Journal of Psychiatry, 156, 1968-1975.*

2 *Department of Health (UK) (1999 . Reform of the Mental Health Act 1983- Proposals for consultation Green Paper: Department of Health. London; Department of Health, Norway, (1999) Lov om etablering og gjennomføring av psykisk helsevem (psykisk helsevernloven) 2. juli 1999, nr 62 (Mental Health Act 1999. In Norwegian)*

One of the most striking features to be found when reviewing the literature on involuntary outpatient treatment is the many and often complex criteria put down in the legislation concerning outpatient commitment.3 This applies both to the criteria authorising the use of outpatient commitment orders and to the circumstances in which coercive powers may be used. Another feature is the proliferation of names used to describe different variants of outpatient commitment. Names such as involuntary outpatient commitment, aggressive community treatment, assisted community treatment, involuntary community treatment, community treatment order, conditional discharge, preventive commitment and more can be found in the literature. Whilst such variations in both nomenclature and content is not surprising, given the diversity of legal approaches to compulsory assessment and treatment as a whole, we use the term outpatient commitment (OC) in this paper to cover *all* forms of involuntary outpatient orders, regardless of such orders' potential to sanction involuntarily treatment of patients in the community.

Different models and solutions

The statutes authorising OC are usually found in the mental health legislation, but in some jurisdictions outpatient commitment is dealt with through guardianship or competency-based statutes.[4] In principle there are two OC models, one being OC as *a condition of leave or discharge*, the other being OC invoked as an *alternative to hospitalisation*. In practice the first model is by far the most common, while OC without any preceding inpatient period is mostly found in more recent legislation.[5] However, within these two main models, a variety of legal approaches have been utilised in practice. Important issues (among others) in this respect concern the responsibility for overseeing OC and whether the criteria for OC should be different from those authorising inpatient civil commitment or not. Regarding the criteria for OC, more lax criteria (compared to the civil commitment criteria applying to in-patients) have been introduced in certain jurisdictions.[6] In some places there is a requirement that the patient must at some time have received inpatient treatment before an OC order can be issued, while no such requirements exist in other jurisdictions. Criteria such as previous non-compliance, dangerousness, a previous

3 *Appelbaum, P. (1988) Assessing the NCSC guidelines for involuntary civil commitment from the clinician's perspective. Hospital and Community Psychiatry, 39, 406-410; Geller, J. L. (1995) A biopsychosocial rationale for coerced community treatment in the management of schizophrenia. Psychiatric Quarterly, 66, 219-35; Hiday, V. A. (1996) see note 3 above; Smith, C. A. (1994) Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill patient. Issues in Mental Health Nursing, 16, 275-84.*

4 *GelIer, J. L., McDermeit, M., Grudzinskas, Jr., et al (1997) . A competency-based approach to court-ordered outpatient treatment. New Directions for Mental Health Services, 15, 81-95; Slobogin, C. (1994) Involuntary community treatment of people who are violent and mentally III: A legal analysis. Hospital and Community Psychiatry, 45, 685-9.*

5 *Department of Health (UK) (1999) . Reform of the Mental Health Act 1983- Proposals for consultation Green paper: Department of Health. London; Department of Health, Norway, (1999) Lov om etablering og gjennomføring av psykisk helsevem (psykisk helsevernloven) 2. juli 1999, nr 62 (Mental Health Act 1999. In Norwegian) ; New York State Assembly. (1999) New York State Bill A08477. New York May 21, 1999; Power, P. (1999) Community treatment orders: The Australian experience. The Journal of Forensic Psychiatry, 10, 9-15; Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. American Journal of Psychiatry, 156, 1968-1975.*

6 *Torrey, E. F., Kaplan, R. I. (1995) A national survey of the use of outpatient commitment. Psychiatric Services, 46, 778-784; Swanson, J. W., Swartz, M. S., George, L. K., et al (1997) Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. Journal of the American Academy of Psychiatry and Law, 25, 5-16.*

positive treatment outcome etc. can also be found in some legislation. In addition all of the above mentioned criteria can be combined in various ways.

It seems that there are different forms of theoretical justification underpinning the two models described above. While the justification for OC following a hospital admission usually focuses on preventing relapse, the justification for OC as an alternative to hospitalisation is based more on a desire to comply with the "least-restrictive-measurement" ideology as reflected in ethical codes and international law.[7] It is important to be aware of these differences because of the impact they may have on the level of coercion employed in the delivery of mental health services. While a focus on relapse prevention will tend to add further coercion to the existing inpatient coercion, outpatient commitment as an alternative to hospitalisation may have the potential to reduce the total amount of coercion in psychiatric care.[8] What will happen in practice remains to be seen, and will among other things depend on the impact of empirical evidence, not as yet available, on the effectiveness of OC.

Procedures and outpatient commitment

To add to the complexity, it should also be remembered that procedural rules are of importance when different versions of outpatient commitment orders are evaluated. Relevant in this context are questions such as who decides to impose outpatient commitment and how is the OC decision made? Moreover, who is in charge of outpatient care? Who is entitled to enforce the law? What measures can be applied? A helpful enlightening example can be found by considering the newly passed Norwegian mental health act (still not in force). The new law authorises OC without any prior hospital admission. At the same time, the decision as to whether patients can be made the subject of an OC order or not, rests with the mental hospital located in the catchment area where the patient lives, and the responsibility for treatment rests with the same hospital. The statutes further states that "knowledge about the course of the disorder based on the patient's symptoms and experiences from earlier episodes is required to the point where it is no doubt about the treatment needed by the patient".[9] It is therefore extremely unlikely that the OC order can be imposed on patients who are not familiar to the hospital staff, i.e. patients who have never previously been admitted. Thus it can be seen that even if an order with the power to commit a patient without a prior hospitalization episode exists, it is in practice virtually impossible to use such an order because of the procedural rules.

Another factor contributing to the confusion about OC is the variation in coercive powers provided by different OC orders. The most important question in this context is whether or not the law authorises forced treatment in the community. Again it may be helpful to give an example. It is repeatedly claimed that the English Mental Health Act 1983 (as currently applied in England

7 *Council of Europe. (1950) The European Convention for the Protection of Human Rights and Fundamental Freedoms; Council of Europe (1983) Recommendation R(83)2. Legal Protection of Persons Suffering from Mental Disorders Placed as Involuntary Patients; Council of Europe. (1996) For the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention of Human Rights and Biomedicine; United Nations. (1948) Universal Declaration of Human Rights; United Nations. (1991) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care; United Nations. (1996) International Covenant on Civil and Political Rights; World Psychiatric Association. (1996) Declaration of Madrid.*

8 *Peay, J., (2000) Reform of the Mental Health Act 1983: Squandering an opportunity. Journal of Mental Health Law, (3), 5-15.*

9 *Section 3 in the provisions on OC in the new Norwegian Mental Health Act.*

and Wales) lacks OC orders, in spite of the fact that the 1983 Act sanctions conditional discharge of certain offender patients. Also, the Mental Health (Patients in the Community) Act 1995 (which amended the 1983 Act) authorises civil patients to be involuntarily taken from their homes to see their therapists or case managers.[10] But because this legislation does not entail any powers to treat patients against their will, and because it is unclear how the power to convey patients can be enforced, scholars assert that outpatient commitment orders do not exist in England. A similar confusion about the existence of OC orders is reported from the US.[11]

Competency, patients' autonomy and mandatory community treatment.

In our opinion the greatest ethical dilemma connected with OC concerns the question of what to do when patients function well enough so as to not to require inpatient care, but at the same time are believed to be likely to be non-compliant with treatment in the community? The answer to this question depends on answers to a number of other questions, such as: What are the reasons for non-compliance? Is it lack of insight as a product of mental disorder, or is it the poor quality of the treatment and services offered to the patient? Another issue is whether patients who function well enough to live in the community can at the same time can be incompetent as regards their ability to consent to treatment? We have not been able to find any study assessing the competency to consent to treatment for patients receiving outpatient commitment orders. Except for patients admitted purely for evaluation purposes, it would be expected that the mental state of most patients would show substantial improvement between admission and the time of readiness for discharge. Patients receiving an OC order, without any inpatient period, are likewise expected to function better than those committed as inpatients. There is some empirical evidence to support this. In the study by Swartz et al.[12], patients subjected to outpatient commitment had a Global Assessment of Functioning (GAF) score close to 50, while civilly committed inpatient populations usually score around 30 at intake.[13] In these circumstances how can (continuing) compulsion be justified?

Some jurisdictions have tried to solve this problem by introducing wider criteria for OC compared to criteria for inpatient civil commitment. Though this would establish a legal base for forced treatment of relatively well functioning (but expectedly non-compliant) patients in the community, it would be violating the principles laid down in international law as well as all international recommendations and guidelines applying to the treatment of mental patients.[14] It would also represent a reversal of the trend towards increased autonomy for mental patients evident over the last few decades (with the possible exception of the 1990s).

10 *Eastman, N. (1997) The mental health (patients in the community) Act 1995: A clinical analysis. British Journal of Psychiatry, 170, 492-496.*

11 *Miller, R. D. (1985) Commitment to outpatient treatment: A national survey. Hospital and Community Psychiatry, 36, 265-7.*

12 *Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. American Journal of Psychiatry, 156, 1968-1975.*

13 *Poulsen, H. D. (1999) Perceived coercion among committed, detained and voluntary patients. International Journal of law and Psychiatry, 22, 167-175; Nicholsen, R. A., Ekenstam, C., Norwood, S. (1996) Coercion and the outcome of psychiatric hospitalization. International Journal of law and Psychiatry, 19, 201-217.*

14 *Slobogin, C. (1994) Involuntary community treatment of people who are violent and mentally III: A legal analysis. Hospital and Community Psychiatry, 45, 685-9. See above note ;. Ferris, R. J., (in press) . Community treatment programs in Europe and the United Kingdom that have proven effective in preventing violence by the mentally ill in the community: Administrative, organizational and clinical aspects.*

Other jurisdictions apply wide criteria for both inpatient and outpatient commitment (e.g. mental disorder, mental illness etc. without any requirements for the disorder to be of a particular nature or degree of severity). If additional power to treat patients involuntarily in the community is incorporated in such legislation the same objections as those mentioned above will apply. But even countries where apparently strict commitment criteria apply may manage to establish a legal basis for OC by introducing a wide interpretation of the basic legal requirements. That is the case in Norway, which has had OC orders since 1961. The legal criteria are such that OC can only be imposed on patients suffering from a "Serious mental disorder", usually understood as synonymous with a psychotic condition. In a Supreme Court verdict of 1993, however, the court ruled that patients who were taking antipsychotics would have manifested psychotic symptoms if they were not taking medication. Thus they were legally to be regarded as still suffering from a serious mental disorder so long as they were taking antipsychotic medication(s), and could accordingly be placed under an OC order, in spite of a lack - for the time being- of any sign of psychotic symptoms. Thus the patient is being coerced to receive continuing treatment with medication in the absence of overt psychotic symptoms, because of a presumption that serious mental disorder persists, and despite the fact that most patients will have retained competency to accept or refuse treatment.[15] This problem is not unique to Norway, but represents a fundamental problem regarding OC legislation and its implementation.

The underlying question is how far is it ethically (and legally) justifiable to deprive patients of their right to make treatment decisions (or to reject treatment)? Even if experience shows that the decisions patients make are poor and probably not in their best interests, should we not respect their right to make bad decisions as we usually do in physical medicine? Irrationality and incompetency are not the same. The former may be evidence of the latter, but it is illogical to permit those with physical illnesses to make irrational decisions, but not to permit those with mental illnesses to make rational decisions. Where the treatment of mental illness is concerned, the competency of the individual patient will be crucial. But by introducing excessively strict competency standards before mental patients are allowed to make treatment decisions, we will certainly run the risk of violating their autonomy. The problem has been pointed to by others[16], but the solution seems to rest partly on balancing empirical evidence not yet available against value-based attitudes towards patients' right to self-determination.

Mandatory community treatment and allocation of resources

Another matter concerning OC is whether or not legislation authorising OC should include quality of care requirements or not. Though the argument that benefits including high quality care, free services etc. should be offered to those subjected to involuntary treatment seems sound, it

15 *Hoyer, G. (1995) Tilbakeslag for psykiatriske pasienters autonomi og rettssikkerhet (A set-back in autonomy and legal rights of mental patients. In Norwegian) . Lov og Rett, 21, 151-167.*

16 *Smith, C. A. (1994) Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill patient. Issues in Mental Health Nursing, 16, 275-84; GeIler, J. L., McDermeit, M., Grudzinskas, Jr., et al (1997) . A competency-based approach to court-ordered outpatient treatment. New Directions for Mental Health Services, 15, 81-95; Tavolaro, K. B. (1992) Preventive outpatient civil commitment and the right to refuse treatment: Can pragmatic realities and constitutional requirements be reconciled? Medicine and Law, 11, 249-67; GeIler, J. L. (1986) The quandaries of enforced community treatment and unenforceable outpatient commitment statutes. Journal of Psychiatry and Law, 14, 149-158.*

often leads to the paradox that services sought on a voluntary basis are compromised.[17] An extreme and paradoxical scenario might see insightful patients lining up eagerly hoping to be committed in order to get access to affordable and acceptable services, because the rest of the services offered on a voluntary basis are too expensive or suffer from a lack of resources. Thus the voluntary treatment alternative will remain less attractive. Involuntary commitment figures will rise artificially, and the positive effect of coercion will most likely be overestimated in outcome studies, as long as a sufficient number of patients formally receiving services under a coercive order are in reality highly motivated to accept the services offered. This potential for skewed quality of care by the introduction of OC orders (or coercive orders in general), should at least call for a close monitoring of the services for such effects.

Outpatient commitment in practice

Even though OC orders have existed for many years in some countries, little is known about how such orders work and to what extent they are used. Generally the utilisation rate of such orders is described as low.[18] Even if this is an accurate generalisation, the variation in the use of coercive orders between countries and jurisdictions is reported to be substantial.[19] More than 40 states in the United States probably have some kind of outpatient commitment statutes[20], though there seems to be some difficulty in determining whether such statutes exist or not in a given jurisdiction. This is reflected in the figures reported in the literature: for example Torrey and Kaplan[21] reported that 35 states had OC orders, while Miller[22] found that 42 states had such orders.

In Europe, OC orders exist in the majority of the European states. Exceptionally Denmark and Italy have no form of OC, but there may be other countries where this is the situation. The reason for this uncertainty is a complete lack of reviews on OC in Europe. The information on European conditions referred to in this paper is based on an unsystematically performed survey including a selected sample of European countries compiled by Ferris[23] supplemented by information from Finland and The Netherlands. This survey did also reveal that the coercive power of the OC order varied considerably between countries. Of those countries in Europe reporting they had some kind of OC order, approximately half also had the power to treat patients forcibly in the community.

17 *Burns, T. (1996) Community supervision orders for the mentally ill: Mental health professionals' attitudes. Journal of Mental Health UK, 4, 301-308.*

18 *Hiday, V. A. (1996) see note 3 above; Swanson, J. W., Swartz, M. S., George, L. K., et al (1997) Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. Journal of the American Academy of Psychiatry and Law, 25, 5-16; Mohan, D., Thompson, C., Mullee, M. A. (1996) Preliminary evaluation of supervised discharge order in the south and west region. Psychiatric Bulletin, 22, 421-423; Miller, R. D., Fiddleman, P. (1984) Outpatient commitment: Treatment in the least restrictive environment? Hospital and Community Psychiatry, 35, 147-151*

19 *Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. American Journal of Psychiatry, 156, 1968-1975; Hiday, V. A. (1996)see note 3 above; Miller, R. D. (1992) An update on involuntary civil commitment to outpatient treatment. Hospital and Community Psychiatry, 43, 79-81.*

20 *Miller, R. D. (1992) note 19 above.*

21 *Torrey, E. F., Kaplan, R. I. (1995) A national survey of the use of outpatient commitment. Psychiatric Services, 46, 778-784.*

22 *Miller, R. D. (1985) note 11 above.*

23 *Ferris, R. J., (in press) . Community treatment programs in Europe and the United Kingdom that have proven effective in preventing violence by the mentally ill in the community: Administrative, organizational and clinical aspects.*

Most jurisdictions in both Australia and New Zealand have put in place OC orders including the power to treat patients on an involuntary basis in the community.[24]

In a recent overview of papers on outpatient commitment in the United States published between 1982 and 1998, 67 papers were identified.[25] However, only 22 of these papers were based on original empirical data, and of those, nine were based on data from one state (North Carolina). The most commonly used end-points of the included empirical studies were frequency of re-hospitalisation and the consumption of hospital days during the follow-up period. Though many studies found a reduction in hospital use by those on OC orders[26], similar reductions in re-hospitalisation have been found in studies exploring the effect of community treatment programs where patients were not subjected to outpatient commitment orders.[27] It is thus impossible to conclude that this outcome can be attributed to the coercive order per se. Nonetheless, some policy-makers refer to the scientific literature as if the efficacy of coerced community orders already had been proven. The preamble to the newly passed so called "Kendra's Law" on outpatient commitment in the state of New York, reads as follows: '"Thirty-nine states have laws providing for court-ordered treatment for mentally ill outpatients with histories of failing to comply with prescribed care, and studies show that outpatients subjected to such laws have fewer psychiatric admissions, spend fewer days in hospitals and fewer incidents of violence than similar outpatients not subjected to Court-ordered treatment".[28] What makes this statement most remarkable is that prior to the passing of Kendra's Law, the New York Legislature in 1994 passed a bill to establish both a three years pilot project of involuntary outpatient treatment, *and* a research study to determine the effectiveness of the program was ordered as a part of that bill. In contrast to what was noted in the preamble to Kendra's Law, the actual research report concluded that the outpatient commitment

24 *Power, P. (1999) Community treatment orders: The Australian experience. The Journal of Forensic Psychiatry, 10, 9-15; Mclvor, R. (1998) The community treatment order: Clinical and ethical issues. Australian and New Zealand Journal of Psychiatry, 32, 223-228.*

25 *Dennis, D. L., (1999) Tracing the development of outpatient commitment. An annotated bibliography. In Coercion in mental health services - international perspectives. Research in community and mental health (eds J. P. Morrissey & J. Monahan), pp. 209-229. Stamford, Jai Press Inc.*

26 *Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. American Journal of Psychiatry, 156, 1968-1975; Fernandez, G.A., Nygard, S. (1990) Impact of involuntary commitment on the revolving door syndrome in North Carolina. Hospital and Community Psychiatry, 41, 1001-1004; Geller, J. L., Grudzinskas, A. L., McDermeit, M., et al (1998) The efficacy of involuntary outpatient treatment in Massachusetts administration. Policy in Mental Health, 25, 271-285; Hiday, V. A., & Scheid-Cook, T. L. (1989) A follow-up of chronic patients committed in outpatient treatment. Hospital and Community Psychiatry, 40, 52-59; Hiday, V. A., & Scheid-Cook, T. L. (1987) The North Carolina experience with outpatient commitment: A critical appraisal. International Journal of Law Psychiatry, 10, 215-23; Van Putten, R. A., Santiago, J. M., Berren, M. R. (1988) Involuntary outpatient commitment in Arizona: A retrospective study. Hospital and Community Psychiatry, 39, 953-958; Zanni & DeVeau, (1986) Inpatient stays before and after outpatient commitment. Hospital and Community Psychiatry 37: 941-2; Sensky, T., Hughes, I., Hirch, S. (1991) Compulsory psychiatric treatment in the community I. A controlled study of compulsory community treatment with extended leave under the mental health act: Special characteristics of patients treated and impact of treatment. British Journal of Psychiatry, 158, 792-799; Munetz, M. R., Grande, T., Kleist, J.,et al (1996) The effectiveness of outpatient civil commitment. Psychiatric Services, 47, 1251-1253; Munetz, M. R., Grande, T., Kleist, J., et al (1997) What happens when effective outpatient civil commitment is terminated? New Directions for Mental Health Services, 15, 49-59.*

27 *Marshall, M., Lockwood, A. (1998) Assertive Community Treatment for People with Severe Mental Disorders. 1998; Cohrane Library. Issue 3. Oxford: Update software*

28 *New York State Assembly. (1999) New York State Bill A08477. New York May 21, 1999*

order had no added value related to treatment outcome.[29] Thus it seems that the introduction of broad outpatient commitment statutes primarily is driven by public concern about mental patients living in the community, and to a lesser degree on empirically based evidence about how OC works.

If we turn to the *content* of outpatient commitment, very few papers describe the kinds of measures and treatment that patients on OC orders are subjected to. We have been able to identify only one paper based on data from Victoria (Australia) where this kind of data has been recorded. In this study it was found that 98% of the patients on an OC order were receiving forced medication, and for more than 50%, this was the only treatment they received. About 44% of the total sample received counseling or psychotherapy in addition to drugs.[30]

Implications for research

A number of interesting research questions remain to be answered. First, we need more descriptive studies on how OC orders work.[31] In particular, we need studies exploring how the orders are enforced (who enforces the law and what do they exactly do? Do they use physical force? Do they inject medication by force in patients' homes? And so forth). Other areas where research is needed include competency evaluations of those placed under OC orders, as well as clinical assessments in relation to the legal requirements underlying OC orders. It would also add important knowledge if prospective studies exploring clinical predictions of need for OC orders could be performed.

The impact of OC orders on the patient-therapist relationship is also a critical aspect to take into account when the benefits and costs of imposing OC are being analysed. Finally the great variations in the use of OC both within and across jurisdictions is another area where research efforts could produce a better understanding of matters influencing the use of such orders.[32]

Research problems

As in most studies trying to explore the effectiveness of a particular intervention, studies on OC should carefully consider the kind of end-points that would be appropriate to use. One Australian paper is relatively critical of all American studies in this respect, claiming that "Overseas research, and in particular United States' scholarship, has tended to concentrate on treatment compliance and readmission rates as primary indicators of the "success" of OPC... .Such simple success measures can be criticised for their lack of consideration of patients' needs, and for relying solely on indicators which emerge from a restricted and fiscally derived model of public policy evaluation".[33] In our opinion this critique is not entirely fair, neither is it constructive. The question is whether the kind of outcome measures mentioned are valid measures of success or failure? Based on research on civil commitment, there are reasons to reconsider in particular the use of re-hospitalisation as a

29 *Policy Research Associates Inc. (1998), Research study of the New York City involuntary outpatient commitment pilot program; Final report. Delmare, NY*

30 *McDonnel, E., Bartolomew, T. (1997) Community treatment orders in Victoria: Emergent issues and anomalies. Psychiatry, Psychology and Law, 4, 25-3624.*

31 *Mclvor, R. (1998) The community treatment order: Clinical and ethical issues. Australian and New Zealand Journal of Psychiatry, 32, 223-228.*

32 *Hiday, V. A. (1996) See note 3 above; Miller, R. D. (1992) An update on involuntary civil commitment to outpatient treatment. Hospital and Community Psychiatry, 43, 79-81; Power, P. (1999) Community treatment orders: The Australian experience. The Journal of Forensic Psychiatry, 10, 9-15.*

33 *See above note 30.*

measure of failure.[34] It could as well be taken as an indication of success provided the re-admission is voluntary and the result of a process where the final decision rests with the patient. Furthermore, there seems no reason to believe that patient-therapist relationship variables like "voice", "procedural justice", "fairness" etc. are of less importance in outpatient settings compared with those that apply to patients being civilly committed as inpatients.[35] The lesson from inpatient civil commitment studies, namely that legal status is an extremely poor measure of coercion, seems to be overlooked in many studies on OC which rely on comparisons made between those legally on an out-patient commitment order to those who are not.

Another problem to be addressed concerns comparisons between OC and alternatives. If you compare patients on OC orders to those civilly committed as inpatients in randomised trials, the conclusions that can be drawn from such studies are limited. You can compare the course of the mental illness between inpatient and outpatient treatment programs, but the question on the effect of adding coercion to outpatient treatment programs cannot be answered. The justification for OC is based on the underlying assumption that it is the coercive power per se that will make the difference compared to outpatient programs offered on a voluntary basis. To answer this question OC programs can only be evaluated in comparison with other non-coercive programs. In the last case careful attention should be paid to the kind of outpatient treatment chosen as comparison. There is for instance some evidence that high quality assertive community treatment (ACT) programs (i.e. well staffed, low caseload per staff, 24 hours outreach service etc.) actually improve outcome[36] compared to other voluntary outpatient treatment programs. But should OC programs always be compared to "state of the art" programs, (or theoretically even better programs), or is it methodologically sound only to ensure that the OC group and controls receive the same treatment in the community (even if this treatment is lacking in quality and quantity)? If patients on OC orders are doing better than voluntary outpatients when both groups are offered a standard treatment program, it is not certain that the same result could be demonstrated if the outpatient treatment program offered was the best conceivable program ever. So even in randomised studies where both groups get the same treatment (except for the involuntary/voluntary dimension), one must be aware of the potential impact of the quality of the actual treatment program. Unfortunately, the possibility of carrying out randomised controlled trials in this field seems remote. Most studies must take place in naturalistic settings with the inherent problems of selection bias. Ethical oversight of studies often adds to the problem by imposing requirements (which may vary between different ethical review boards) for informed consent, and thus excludes the more disturbed patient from studies. Security and safety concerns may also limit the possibility of including potentially dangerous or suicidal patients in randomised studies, both groups who are at great risk of being subjected to civil commitment.

34 *Draine, J. (1997) Conceptualizing services research on outpatient commitment. Journal of Mental Health Administration, 24, 306-315.*

35 *Lidz, C.W., Hoge, S. K., Gardner, W., et al (1995) Perceived coercion in mental hospital admission. Archives of General Psychiatry, 52, 1034-103;. Hiday, V. A., Swartz, M. S., Swanson, J. et al (1997) Patient Perceptions of Coercion in Mental Hospital Admission. International Journal of Law and Psychiatry, 20, 237-241.*

Other important issues regarding research on OC

This paper has not discussed matters such as the introduction of mental health advanced directives (MHAD) in relation to OC orders, though MHAD may have the potential to resolve some of the problems related to treatment refusal.[37] Another topic, also not discussed, is the variation in existing competency tests. As competency is one of the major theoretical and practical issues relating to the implementation of OC programs, it would be appropriate to scrutinise such tests and establish their reliability and validity through research. Nor has the time scale of OC orders been scrutinised. When is the appropriate time to cancel OC orders (presuming that such orders have been effective)[38], and what criteria should be employed? Equally, how long is the appropriate follow-up time in studies looking at the effect of OC programs, just to mention some questions related to time.

Conclusion

Even if some studies suggest that OC orders reduce re-hospitalisation rates, it has not been established that this effect can be attributed to the use of coercive orders *per se*. The increased emphasis on involuntary outpatient treatment raises a series of value based questions about fundamental issues such as patients' autonomy and its potential erosion by the introduction of broader coercive measures in a community setting. As most of the arguments both for and against OC orders are not empirically based, and as mandatory community treatment is likely to increase in the years to come, priority should be given to research on the effectiveness and efficacy of mandatory community treatment. Whilst the design and implementation of such studies are likely to be problematic in respect of both the ethical and logistic issues raised above, they are certainly needed in order to help us understand the consequences of our choices regarding mandatory community treatment.

Acknowledgements

We want to thank Dr Jill Peay, J.D., London School of Economics and Professor Aslak Syse, J.D., University of Oslo for useful comments during the preparation of this paper.

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36 *Marshall, M., Lockwood, A. (1998) see note 27 above.*

37 *Srebnik, D. S., & LaFond, J. O. (1999) Advanced directives for mental health treatment. Psychiatric Services, 50, 919-925; Backlar, P. (1997) Ethics in community mental health care. Anticipatory planning for psychiatric treatment is not quite the same as planning for end-of-life care. Community Mental Health Journal, 33, 261-268.*

38 *Munetz, M. R., Grande, T., Kleist, J., et al (1997) What happens when effective outpatient civil commitment is terminated? New Directions for Mental Health Services, 15, 49-59.*

The Legal Implications of the Administration of Placebo to Psychiatric Patients

*David Hewitt**

Introduction

This paper concerns a practice that is sometimes encountered in the treatment of patients with mental illness: the use of placebo for purportedly therapeutic purposes. It will consider the lawfulness of that practice under domestic law, and suggest that previous attempts to perform such an analysis may be flawed. It will argue that existing statutory restrictions may apply to – and prohibit – therapeutic placebo administration, and will conclude with a brief analysis of the possible impact upon such administration of the Human Rights Act 1998.

The word 'placebo' is here used in the sense of "a pill, medicine, procedure etc., prescribed more for the psychological benefit to the patient of being given a prescription than for any physiological effect".[1] It does not describe the use of any similar substance in the testing of new drugs (nor, to acknowledge every facet of the formal definition, does it connote either vespers for the dead or an eighteenth century sycophant).

Furthermore, it is assumed that the use of placebo is founded upon a clinical assessment that such is the preferable course, for to deny a patient substantive medication that might carry a therapeutic benefit would be to invite litigation, primarily, though by no means exclusively, under the domestic tort of negligence.

Consent

The use of placebo for purportedly therapeutic purposes raises the question of patient consent, which is more fully considered in the Code of Practice to the Mental Health Act 1983.[2] There, 'consent' is defined as:

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1 *New Shorter Oxford Dictionary (1993)*

2 *Chapter 15*

> " … the voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it".[3]

Except where the common law or statute law otherwise allows, such consent is required from every patient who is to undergo medical treatment.[4] It may, however, be dispensed with in the case of a patient who lacks capacity to make a decision about his or her medical treatment. Capacity is to be presumed, although this presumption may be rebutted in certain circumstances,[5] and a person will not be incapable of giving or refusing consent merely because s/he has a mental disorder.

When considering the lawfulness of placebo use, it is necessary to distinguish between informal patients and those detained under the Mental Health Act 1983.

Placebo and informal patients

It is necessary to distinguish between those informal patients who possess, and those who lack, capacity to make a decision about their medical treatment.

Capable, informal patients

It is an established principle of English law that a patient who possesses capacity and is admitted to hospital otherwise than under compulsion may only be given medication to which s/he consents, and may decline to accept any and all forms of medical treatment without penalty.[6] The process that is to be followed when seeking consent from a capable patient is set out in the Code of Practice.[7]

By definition, any consent of a capable patient is to medication other than the placebo that s/he is in fact receiving. S/he has consented to a course of treatment that s/he is not receiving and is receiving a course of medication to which s/he has not consented. Such treatment is not merely different from that consented to, it is in many ways its antithesis. It is therefore difficult to see any lawful basis for the administration of placebo to a capable, informal patient, whether or not s/he is suffering from mental disorder.

Incapable, informal patients

Patients who lack capacity to make a decision about medical treatment, and who are not detained under the Mental Health Act 1983, may be treated in their "best interests" under the common law doctrine of 'necessity'.[8] However, if it is to be lawful, any such treatment must be:[9]

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3 *Code of Practice, paragraph 15.13*

4 Ibid., *paragraph 15.8. See also:* Re T (Adult: Refusal of Medical Treatment) *[1992] 4 All ER 649, CA*; Re MB (Medical Treatment) *[1997] 2 FLR 426, CA [below]*

5 Re C (Adult: Refusal of Medical Treatment) *[1994] 1 All ER 819*; Re MB (Medical Treatment) *[1997] 2 FLR 426, CA. See also:* B v Croydon District Health Authority *(1994) 22 BMLR 13. Code of Practice, paragraph 15.10* et seq

6 Re T (Adult: Refusal of Medical Treatment) *[1992] 4 All ER 649, CA per Lord Donaldson, MR*; Re MB (Medical Treatment) *[1997] 2 FLR 426, CA per Butler-Sloss LJ*

7 *Paragraphs 15.14-15.17*

8 F v West Berkshire Health Authority and another (Mental Health Act Commission Intervening) *[1989] 2 All ER 545, HL*; Re MB (Medical Treatment) *[1997] [see note 6, above]. See also:* R v Bournewood Community & Mental Health NHS Trust, ex parte L *[1998] 3 WLR 107*

9 *Code of Practice, paragraph 15.21*

- necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health; and
- in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area.[10]

It is perhaps only in a minority of cases that the administration of a placebo to an incapable, informal mental patient will fulfil both of these criteria. In any case, the purpose of using placebo is surely to deceive a patient who has knowledge of the benefits of a particular form of medication – or who at least knows that it *has* benefits – into believing that s/he is receiving that medication. Such use therefore depends upon the existence of at least a basic measure of intellect, so that, to put it delicately, there will always be a proportion of incapable, informal mental patients to whom the administration of placebo would be futile.

Placebo and detained patients

It is necessary to distinguish between those patients who have been receiving psychiatric medication for less than three months since being detained under the Mental Health Act 1983 and those receiving it for a longer period.

Medication in the first three months

If it is given "by or under the direction of the responsible medical officer",[11] the consent of "a patient liable to be detained" under the Mental Health Act 1983[12] will not be required for "any medical treatment given to him for the mental disorder from which he is suffering",[13] provided less than three months have elapsed "since the first occasion in that period when medicine was administered to him by any means for this mental disorder".[14] Nevertheless, the Code of Practice states that:

> "Even though the Act allows treatment to be given without consent during the first three months the RMO should ensure that the patient's valid consent is sought before any medication is administered … If such consent is not forthcoming or is withdrawn during this period, the RMO must consider whether to proceed in the absence of consent, to give alternative treatment or no further treatment".[15]

Although it is difficult to see how the RMO might obtain the patient's "valid consent" to a form of medication that may only be effectively administered to him by deceit, for a period of three months such consent is not necessary in law.

It is assumed that approval, if not the motivation, for the use of placebo will come from the RMO, and therefore that such might be said to be given by or under his/her direction. Therefore, the most relevant question in respect of a patient who is not yet subject to the 'consent to treatment' provisions will be whether the placebo is "medical treatment given to him [/her]for the mental

10 Bolam v Friern Hospital Management Committee *[1957] 1 WLR 582, at 587-8 [cf*: Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority *[1997] 4 All ER 771, HL]*

11 *MHA 1983, section 64(1)*

12 *Ibid., section 56(1)*

13 *Ibid., section 63*

14 *Ibid., section 58(1)(b)*

15 *Paragraph 16.11*

disorder from which he [/she] is suffering". Given the wide definition that has been applied to the phrase "medical treatment",[16] (which definition is discussed below,) and given also that the object of such treatment is clearly the patient's mental disorder, it seems likely that placebo *would* be deemed to fall within section 63 and, therefore, to be capable of administration to a patient without his/her consent for up to three months after his/her detention under the Mental Health Act.

Medication beyond three months

The 'consent to treatment' provisions that are contained in section 58 of the Mental Health Act 1983[17] apply to the administration to a detained patient of "medical treatment for mental disorder" and state that, once three months have elapsed since first administration, such a patient may only be given "medicine" – clearly, medicine for mental disorder – if, being capable, s/he consents to receive it.[18] If, though capable, s/he declines such consent, or if s/he is incapable, "medicine" may only be administered to him/her if an independent registered medical practitioner has certified in writing that, "having regard to the likelihood of its alleviating or preventing a deterioration of his [/her] condition, the treatment should be given".[19]

The reasons for prescribing a placebo are likely to vary from patient to patient, but in most cases it is likely that its use will be intended to alleviate or to prevent a deterioration of his/her psychiatric condition. However, this will only become a relevant consideration, and the consent to treatment provisions will only apply, if placebo is "medicine" and/or "medical treatment for mental disorder".

Placebo as 'medicine'

The most commonly expressed view upon the point is that placebo is not "medicine". The Mental Health Act Commission has suggested that:

> " … as an inert substance, a placebo does not fall within the definition of 'medicine' and, therefore, falls outside the provisions of section 58".[20]

If this were indeed so, the administration of placebo would be capable of being controlled only by the requirements of section 63, which, as has been demonstrated, it is likely to fulfil. However, this view may not reflect a complete understanding of the word "medicine".

The word has been authoritatively defined as, *inter alia*, "a substance or preparation used in the treatment of illness".[21] Placebo is almost certainly "a substance or preparation"; but may it truly be said to be "used in the *treatment* of illness"?

This question is of more than lexicological significance for, as has been noted, the consent to treatment provisions will apply only where the psychiatric medication in question is being given to the patient as "medical treatment for mental disorder".[22] Such use is not axiomatic: there are some medicines that are capable of being used in the treatment both of psychiatric and of non-psychiatric maladies.

16 B v Croydon Health Authority *[1995] 1 All ER 683*

17 *MHA 1983, section 58(1)*

18 *Ibid., section 58(3)(a)*

19 *MHA 1983, section 58(3)(b)*

20 Eighth Biennial Report, 1997-1999, *The Stationery Office (1999)*

21 *New Shorter Oxford English Dictionary (1993)*

22 *MHA 1983, section 58(1)*

The Mental Health Act defines "medical treatment" so as to include "nursing … habilitation and rehabilitation under medical supervision",[23] and the latest edition of the Code of Practice expands this definition, applying it to "the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder".[24] It is clear that the latter of these formulations derives from the judgment of the House of Lords in *F v West Berkshire Health Authority and another (Mental Health Act Commission Intervening)*.[25] Furthermore, in *B v Croydon Health Authority*,[26] Hoffman LJ held that "medical treatment" would include "a range of acts ancillary to the core treatment that the patient is receiving", and that treatment would be ancillary to the core treatment if it was "concurrent with the core treatment or as a necessary prerequisite to such treatment".[27]

To elide these formulations and apply them to the circumstances envisaged in this paper: what is placebo if not "a substance or preparation which is ancillary – in other words, concurrent with or a necessary prerequisite of – a patient's treatment"? Whilst placebo may not, perhaps, be a 'prerequisite' of a patient's treatment, given that such treatment might simply consist of "nursing … habilitation and rehabilitation under medical supervision", its use is almost certainly 'concurrent' therewith.

It is therefore at least arguable that placebo used in the manner and for the purposes described above *would* fall within the definition of "medicine", so as to bring it within the 'consent to treatment' provisions of MHA 1983, section 58(3).

Placebo and consent to treatment

If placebo is indeed "medicine", so that its administration will fall within the consent to treatment provisions, several seemingly insuperable problems arise.

First, if treatment beyond three months is to proceed on the basis of the patient's alleged consent, the RMO will have to certify on statutory Form 38 that the patient "is capable of understanding the nature, purpose and likely effects of" the specified treatment and that s/he "has consented to that treatment".[28]

Placebo depends for its effect upon a patient's belief that it is another substance entirely – a drug that will help to alleviate his/her mental illness, or at least the symptoms that it produces. Therefore, unless it has been explained to the patient that his/her treatment will consist of a simple, inert placebo – a most unlikely, not to say self-defeating, course – the RMO will surely find it impossible to make the requisite certification on Form 38. Any more deceitful course – such as entering on the Form 38 the BNF classification of the drug that the placebo purports to be – might extract the patient's acquiescence, but would end with the administration, not of *that* drug, but of "medicine" for which there was in fact no consent. Such administration would clearly fall foul of section 58(3)(a), and the Form 38 itself, being the certificate of a consent obtained by deception and therefore arguably vitiated, might well be susceptible to legal challenge. Without the legal authority of a valid Form 38, the continued administration of placebo/medicine to the patient might well amount to a trespass which would sound in damages.

23 *Ibid., section 145(1)*

24 *paragraph 15.4*

25 *(1989) [see note 8, above]*

26 *[1995] 1 All ER 683; followed in Tameside & Glossop Acute Services NHS Trust v CH [1996] 1 FLR 762*

27 *Ibid., at p 687*

28 *MHA 1983, section 58(3)(a); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations) 1983, regulation 16(2)(b)*

The position is no more propitious where a certificate is required in Form 39. In such circumstances, how might any SOAD certify, as section 58(3)(b) would require him/her to certify, either that the patient "has not consented" to a treatment the nature, purpose and likely effects of which have not, in fact, by definition been explained to him/her, or that "having regard to the likelihood of that treatment alleviating or preventing a deterioration of the patient's condition it should be given"?[29]

The Mental Health Act Commission's revised *Advice to Second Opinion Appointed Doctors*[30] states:

> "If asked, in error, to certify on Form 38 or Form 39 treatments that are not within the remit of section 58 (eg, behaviour therapy, Naso-Gastric Feeding, *placebos*, seclusion or restraint), the SOAD should decline. If, however, such treatments are relevant to the total plan when certifying *bona fide* section 58 treatments, they may be considered in the wider treatment plan and appropriate comments made in the case notes".[31]

This advice is, of course, consistent with the Commission's general stance on placebo use. However, it may be incorrect. As has been argued above, placebo may be capable of being regarded as a "medicine ... given for mental disorder" and, therefore, as falling within the 'remit' of section 58.

Placebo under MHA, section 63

As has been demonstrated, placebo use will only fall within the consent to treatment provisions if it constitutes "medicine" and "medical treatment for mental disorder".[32] If, contrary to the view expressed above, it is not medicine, the only lawful authority for the continued administration of placebo to a detained patient might be sought in section 63, on the basis that, having been given to him/her "by or under the direction of the responsible medical officer", such also constituted "medical treatment given to him [/her] for the mental disorder from which [s/]he is suffering". As indicated above, it is likely that these conditions will be fulfilled.

However, such a course is not itself free from ethical difficulty, not least because the Code of Practice suggests that patient consent should even be sought for medication administered under section 63.[33] Nevertheless, such ethical difficulties are not within the scope of this paper.[34]

Placebo use outside the Mental Health Act

Of course, if a placebo is not 'medicine', so as to bring it within section 58 of the Act, and if it is not "medical treatment given … for mental disorder", there is no statutory authority for – and there can be no statutory control upon – its use. In such circumstances, placebo might only lawfully be administered on the common law basis set out in Introduction to this paper.

29 *Ibid.*

30 *Mental Health Act Commission, 21 April 1999*

31 *Ibid., paragraph 42 [emphasis added]*

32 *Mental Health Act 1983, section 58(1) and (a)*

33 *paragraph 16.38*

34 *See also: Mental Health Act Commission,* Eighth Biennial Report, 1997-1999, *The Stationery Office (1999), paragraph 6.17*

ECHR implications

The Human Rights Act 1998 ['HRA'] came fully into effect on 2 October 2000. Its purpose was to introduce into domestic law the European Convention on Human Rights ['ECHR'], and it requires, inter alia, that 'public authorities' such as NHS trusts and health authorities act compatibly with the ECHR. If the ECHR were to contain anything that might prohibit the use of placebo, it would be extremely hard to sustain such a practice.

Article 2 of the ECHR contains the "right to life", which the European Court has said "ranks as one of the most fundamental provisions in the Convention" and "enshrines one of the basic values of the democratic societies making up the Council of Europe".[35] It may be engaged even where death hasn't in fact occurred, provided it was a potential consequence of the act complained of.[36] Thus, a living mental patient to whom placebo has been administered might bring proceedings under the ECHR for damages in this regard.[37] However, if the placebo represented the only, or at least the best, treatment available for him/her, its administration would probably be considered more likely than any alternative to secure the right to life. Difficulties under Article 2 are only likely to be encountered by those administering placebo to mental patients where they have deliberately chosen to eschew a substantive treatment of proven efficacy. Those are not the circumstances upon which this paper is predicated.

Article 3 of the ECHR contains the "prohibition upon torture and upon inhuman or degrading treatment". Strasbourg has traditionally taken a very restrictive line in interpreting Article 3 in a medical context. So, for example, psychiatric treatment was held not to constitute a breach of Article 3 merely because it caused side effects that the patient found unpleasant.[38] Furthermore, the use of force-feeding, handcuffs, straps, a net and a belt were held not to amount to torture or to inhuman or degrading treatment because they were deemed "therapeutically necessary".[39] This last, of course, suggests that when considering Article 3 in medical cases, the European Court will apply something very similar to the existing domestic test for clinical negligence – the *Bolam* test – which was referred to above and, with neat circularity, concerned a claim for damages for injuries sustained during a course of ECT.[40]

However, the ECHR is a "living instrument",[41] and this has been particularly evident with Article 3, whose requirements are clearly in the process of changing. For example, the hurdle for 'torture' is being lowered, so that some things may now be inhuman or degrading that were not previously considered to be so.[42] In any case, the European Court has already held that treatment may breach Article 3 where it is experimental and administered without the patient's consent.[43] In this context, treatment will be experimental where it has not yet become fully established, and there will be a lack of consent where the patient was not informed of that fact. In the instant situation, the patient will not be aware of – and, as I have already suggested, cannot therefore be said to have consented to – the use of placebo. If it can be shown not to be an 'established' treatment, therefore, such use may constitute a breach of Article 3.

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35 McCann v United Kingdom *(1995) 21 EHRR 97*

36 X v United Kingdom *(1978) 14 DR 31*

37 *HRA 1998, section 7(1)(a)*

38 Grare v France *(1993) 15 EHRR CD100*

39 *Herczegfalvy v Austria (1993) 15 EHRR 437*

40 Bolam v Friern Hospital Management Committee *[1957] 1 WLR 582 (see note 10, above)*

41 Tyrer v United Kingdom *(1993) 15 EHRR 437*

42 Selmouni v France, *The Times, August 24, 1999*

43 X v Denmark, *32 DR 282*

Article 5 of the ECHR contains the "right to liberty and security", which those detained against their will have customarily used to challenge the *fact* of their detention. However, it has also been successfully invoked by a mentally ill offender to challenge the failure to transfer him from prison to a psychiatric hospital.[44] Generally, it is now felt that if the *conditions* in which a patient is kept are having an "anti-therapeutic" effect upon him/her, they may constitute a breach of Article 5. There will have to be some relationship between the justification for detaining a person – that s/he is suffering from an "unsound mind" – and the place in which that detention is effected. If this doctrine is capable of being expanded to cover the regime – and in particular, the *treatment* regime – to which a patient is subject, it may render the use of placebo unlawful under the ECHR, at least where such has proved *counter*-therapeutic. It is also possible that placebo use that has not yet proved counter-therapeutic but which has merely been neutral in its effect, neither ameliorating nor exacerbating the patient's illness, will bring about a breach of Article 5, at least where the patient is detained under MHA 1983. In *Bouamar v Belgium*, the European Court held that detention – in this case, the detention of a child for educational purposes, which is ordinarily permitted under Article 5(1)(d) – would breach the ECHR where it had come to amount to the "fruitless repetition" of placements in institutions with inadequate educational facilities.[45] This would offend against the implicit prohibition in Article 5 upon 'arbitrary detention'. The continued detention of a mental patient solely so that s/he might receive 'treatment' which may not in fact be such, and which is in any case proving ineffective, may also be said to infringe the *Bouamar* reading of Article 5.

Any prediction about the impact of the ECHR upon domestic law – including those contained in this paper – should be viewed with caution. Few of those made in the months before the coming of the HRA have proved correct. In fact, any prudent prediction must have several caveats: first, and as has been explained, the ECHR is intended to change with the times and is clearly doing so; in any case, the HRA adopts an arm's length approach to the ECHR, and only requires domestic courts to "take into account" its jurisprudence;[46] and finally, and as perhaps too few commentators acknowledged prior to 2 October 2000, the existing Strasbourg jurisprudence will have to be passed through the filter of the English courts, which are hardly renowned for their radicalism.

It is certainly true that the Court of Appeal has declared the burden of proof in MHRT proceedings – which at the moment falls squarely upon the patient – to be incompatible with Article 5.[47] However, such a finding had long been predicted.[48] Generally, the domestic judiciary has adopted a restrictive approach to the ECHR and to its application to mental health law.[49]

44 Aerts v Belgium, *Judgment of European Court 30 July 1998*

45 Bouamar v Belgium *(1988) 11 EHRR 1*

46 *HRA 1998, section 2(1)*

47 R v Mental Health Review Tribunal, North & East London Region and Secretary of State for Health, ex parte H, *Court of Appeal, 28 March 2001*

48 *See, for example, Hewitt, D in* Community Care, *2-8 December 1999, p21*

49 R v Secretary of State for Health, ex parte Lally, *The Times, October 26, 2000;* R v Mental Health Review Tribunal, ex parte Secretary of State for the Home Department (M, W and FO Intervening), *The Times, February 20, 2001*

Conclusion

There are few authoritative data about the administration of purportedly therapeutic placebo to mental patients in British hospitals. Nevertheless, anecdotal evidence suggests that, although uncommon, such a practice is by no means unknown. It is therefore desirable that its implications are set out clearly and unequivocally.

There can be no lawful basis for the use of placebo upon a capable patient who is not compulsorily detained in hospital. Such a course in respect of an incapable, 'informal' patient may be justifiable under the common law doctrine of 'necessity', but is unlikely in practice to have very much appeal.

With patients who are subject to the Mental Health Act 1983, the use of therapeutic placebo may be lawful in strict terms for three months after detention. Thereafter, however, the position may be more complex – and the lawful administration of placebo more difficult – than has been previously supposed.

It is at least strongly arguable that placebo use falls within the 'consent to treatment' provisions of the Mental Health Act 1983. Though previous analyses have suggested otherwise, they have been founded upon an incomplete understanding of the word 'medicine'. The nature of placebo is such that the statutory provisions, with their requirement that patient consent at least be sought, simply cannot be fulfilled. Thus, there may be no authority under domestic law for the purportedly therapeutic administration of placebo to many detained mental patients.

The ECHR contains several provisions that may in some circumstances be interpreted so as to prohibit therapeutic placebo use. However, although it would be imprudent to discount the Convention as a force for change, the experience of the months since its introduction into domestic law suggests that it will not be permitted to have such an effect.

Casenotes

The Incompatible Burden of Proof at Mental Health Review Tribunals

*Anselm Eldergill**

R v Mental Health Review Tribunal, on the application of H [2001] EWCA Civ 415
Court of Appeal (28th March 2001). Lord Phillips MR, Kennedy and Dyson LJJ

Introduction

H was detained in a high security hospital in pursuance of hospital and restriction orders made under sections 37 and 41 of the Mental Health Act 1983.

On 29 March 2000, a mental health review tribunal reviewed his detention and decided not to discharge him. The written reasons for the decision stated that H was still experiencing auditory hallucinations and that, if discharged, he would not continue to take his medication. The tribunal were 'clear that this patient needs to be detained in hospital for treatment for his own health and safety.'

On 15 September 2000, Crane J dismissed H's application for judicial review. In doing so, he refused to declare that the statutory test in section 73(1) of the 1983 Act was incompatible with Article 5 of the European Convention on Human Rights. This refusal to make such a declaration was the only issue pursued before the Court of Appeal.

Legal Provisions

The essence of a restriction order is that the usual powers by which a detained person may be discharged or granted greater freedom are restricted.

Section 73(1) of the Mental Health Act 1983, which incorporates section 72(1)(b)(i) and (ii), requires a tribunal to conditionally discharge a detained patient who is subject to a restriction order if they are satisfied as to one or both of the following matters:

1. that he is not then suffering from a form of mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
2. that it is not necessary for his health or safety or for the protection of others that he should receive such treatment.

Absolute discharge is mandatory if, in addition to being satisfied on one or both of these matters, the tribunal are also satisfied that it is not appropriate for the patient to be liable to recall to hospital for further treatment. Its effect is to bring the hospital and restriction orders to an end.

* *Solicitor, Author of 'Mental Health Review Tribunals – Law and Practice.' (Sweet and Maxwell; 1997).*

European Convention on Human Rights

Article 5 of the European Convention on Human Rights provides that:

> '1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ...(e) the lawful detention of... persons of unsound mind...
>
> 4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.'

The case law on Article 5 establishes that a person's detention on the ground of unsoundness of mind is only lawful if it can 'reliably be shown' that he or she suffers from a mental disorder sufficiently serious to warrant detention (*Winterwerp v The Netherlands* 2 EHRR 387, para. 39-40).

Counsels' Submissions

H's counsel submitted that a tribunal's function in such cases is to enable the patient to challenge the legality of his detention; that it is 'a court' for the purposes of Article 5(4); that the statutory criteria which it has to consider are the same as those that govern admission under section 3; and that the wording of section 73 means that a tribunal is not required to discharge unless *satisfied* that at least one of the statutory grounds for detention do not exist. The effect is to place the burden of proof on the patient, and this reversal of the burden of proof is incompatible with Article 5(1) and (4). It is the patient who has to prove that the admission criteria are not satisfied, whereas s/he should be entitled to be discharged if it cannot be demonstrated that they are satisfied.

Counsel for the Secretary of State accepted that a provision which requires the patient to prove the absence of grounds for her or his detention is incompatible with Article 5(1). However, it is possible to read the words in a way which avoids this. The section is silent on the question of the burden of proof, and the negative formulation used in section 72(1)(b) ('not then suffering...') can be read as simply reflecting the fact that the grounds for admission in section 3 are no longer present. Furthermore, the phrase 'burden of proof' suggests an adversarial process, whereas tribunal proceedings are inquisitorial in nature.

Lord Phillips MR

His Lordship referred to the case of *Reid v. Secretary of State for Scotland* [1999] 2 A.C. 513, HL, where Lord Clyde had observed, at p.533, that

> '...the decision is not one which is left to the discretion of the sheriff once he is satisfied on the particular criteria. If he is satisfied, he is obliged to grant a discharge. Secondly, the burden of establishing the particular propositions to the satisfaction of the sheriff will lie on the patient, although in practice it may well be that questions of the burden of proof will not often arise.'

Similarly, in *Perkins v. Bath District Health Authority* [1989] 4 BMLR 145, Lord Donaldson MR had observed that, 'If a tribunal is to make an order under s72(1)(a)(i), clearly they have to be satisfied, and should state that they are satisfied, that he is not then suffering from mental disorder. That is not the same thing as saying the tribunal is not satisfied that he is so suffering.'

The existence of a 'reversed burden of proof' had also been referred to in other cases, including a

recent decision of Latham J in *R v. London and South Western Mental Health Review Tribunal ex p. M* [2000] Lloyd's LR Med 143 at p. 150.

The essential question was whether a patient was only entitled to be released if the tribunal were satisfied that one or both of the statutory grounds for detention were not made out. If this was the position then it was not inappropriate, in cases where a patient applied under section 73, to say that the burden of proof was on the patient.

The courts had to strive to interpret statutes in a manner compatible with the Convention, and in some instances this had involved straining the meaning of statutory language. However, such an approach did not extend to interpreting a requirement that a tribunal must act if satisfied that a state of affairs does not exist as meaning that it must act if not satisfied that a state of affairs exists. The two were patently not the same. A test which allowed a patient's continued detention simply because it could not be shown that his mental condition did not warrant detention violated Article 5(1) and (4). This followed from the following statement of principle in the seminal case of *Winterwerp v. Netherlands* [1979] 2 E.H.R.R. 387 at paragraph 39:

> 'In the Court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.'

Further observations

The court wished to make a number of further observations regarding matters which had not been addressed in detailed argument.

Firstly, it did not follow from the court's decision that Article 5 requires that a patient must be discharged whenever any one of the three criteria in section 3 cannot be demonstrated on the balance of probability. Although detention cannot be justified under Article 5(1)(e) unless it is established that the patient is 'of unsound mind', once this is established, the Convention does not restrict the right to detain to circumstances where treatment is likely to alleviate or prevent a deterioration of the condition (as section 3 does). Nor is it necessary under the Convention to demonstrate that such treatment cannot be provided unless the patient is detained in hospital (see section 3(2)(c)).

Secondly, H's circumstances, which were similar to those considered by Latham J. in *ex p. M*, were not uncommon, and Article 5 did not require that a patient must always be discharged in such circumstances:

> 'A patient is detained who is unquestionably suffering from schizophrenia. While in the controlled environment of the hospital he is taking medication, and as a result of the medication is in remission. So long as he continues to take the medication he will pose no danger to himself or to others. The nature of the illness is such, however, that if he ceases to take the medication he will relapse and pose a danger to himself or to others. The professionals may be uncertain whether, if he is discharged into the community, he will continue to take the medication. We do not believe that Article 5 requires that the patient must always be discharged in such circumstances. The appropriate response should depend upon the result of

weighing the interests of the patient against those of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge.'

Having regard to these considerations, it would be rare that the provisions of sections 72 and 73 constrained a tribunal to refuse an order of discharge in circumstances where continued detention infringed Article 5. Indeed, when a tribunal refused an application for a discharge, it usually gave reasons for doing so that involved a positive finding that the patient was suffering from a mental disorder that warranted his or her continued detention.

Declaration of incompatibility made. Counsel to be heard on the precise form of the declaration. On 4 April 2001, the following declaration was made:

'A declaration under section 4 Human Rights Act 1998 that sections 72(1) & 73(1) Mental Health Act 1983 are incompatible with Articles 5(1) and 5(4) of the European Convention on Human Rights in that, for the Mental Health Review Tribunal to be obliged to order a patient's discharge, the burden is placed upon the patient to prove that the criteria justifying his detention in hospital for treatment no longer exist; and that articles 5(1) and 5(4) require the tribunal to be positively satisfied that all the criteria justifying the patient's detention in hospital for treatment continue to exist before refusing a patient's discharge.'

Commentary

As drafted, sections 72 and 73 require a tribunal to decide whether it is 'satisfied' that the conditions there set out for detention, guardianship or supervision no longer exist. This requirement has given rise to comment about the burden and standard of proof in tribunal proceedings.[1]

It is possible to argue, and was argued in *H*, that the concept of a burden of proof is not relevant to tribunal proceedings, which are inquisitorial in nature. According to this view, it is for the tribunal to satisfy itself that there are no grounds for detention, and the idea of a burden of proof lying on a particular party or person is not germane. There is not always an applicant, the patient may occasionally not attend, and the detaining authority may support a restricted patient's application to be discharged.

Notwithstanding these observations, the reality usually is that it is the applicant who is seeking discharge, and it is that person who must satisfy the tribunal that there are no statutory grounds for compulsion. The risk of non-persuasion - the burden of proof - lies with her or him.

Indeed, because sections 72 and 73 are unambiguous in this respect, attempts to argue that a different construction should be inferred from the statutory framework have failed. Thus, in *ex p. Hayes*,[2] Ackner LJ said that counsel had 'rightly' not pursued his submission that the onus of satisfying the tribunal was not upon the patient. And, in *ex p. A.*,[3] Kennedy LJ observed that the first thing to be noted about the duty to discharge in section 72(1)(b)(i) was that the tribunal is only required to direct discharge if it is satisfied of a negative: if the patient may be suffering from a form of mental disorder of the requisite nature or degree then the obligation to discharge under that paragraph does not arise.

1 *See e.g. Eldergill, A*, Mental Health Review Tribunals - Law & Practice *(Sweet & Maxwell, 1997), p.46 & pp.567-571.*

2 R v The Mental Health Review Tribunal, ex p. Hayes, *9 May 1985, CA (unreported).*

3 R v Canons Park Mental Health Review Tribunal, ex p. A *[1994] 3 WLR 630.*

According to Part V of the Act, therefore, the burden of proof lies on the applicant in all proceedings except those involving conditionally discharged patients, where no burden can exist either way because there is no statutory issue to be determined.

Following these cases, the question which remained open was whether it is lawful under the Convention to require a detainee to prove the absence of grounds for detention before s/he is entitled to be released. Put differently, if the detaining authority cannot satisfy a tribunal that there are lawful grounds for the detention, is it nonetheless lawful to continue to detain the individual because s/he cannot demonstrate their absence?

Here, it may be noted that the *Green Paper*[4] indicated that the burden of proof would be reversed in any new Mental Health Act, but the more recently published *White Paper*[5] was silent on the point.

The declaration in H

In *H*, the transcript of the Court of Appeal's decision states that imposing the burden of proof on the patient (or applicant) is, in one respect, contrary to Article 5. For the detention to be lawful, it must reliably be shown that the individual is of unsound mind. Accordingly, the Convention requires that the patient is released unless the tribunal is satisfied by objective medical evidence that s/he is of unsound mind. However, provided that the tribunal is satisfied on this point, it is lawful to continue the detention even though it is not satisfied as to the existence of one or both of the other conditions forming the section 3 admission criteria: that the patient's condition is treatable in the statutory sense and that treatment cannot be provided unless he or she is detained in hospital.

The terms of the declaration of 4 April go wider than this. It states that 'articles 5(1) and 5(4) require the tribunal to be positively satisfied that all the criteria justifying the patient's detention in hospital for treatment continue to exist before refusing a patient's discharge.'

Nature of the mental disorder

The Master of the Rolls made the further observation that Article 5 does not require a tribunal to discharge a patient where the nature of the illness is such that if s/he ceases to take medication s/he will relapse and pose a danger, and there is uncertainty as to whether s/he will continue to take it if discharged. Continued detention can be justified if it is a proportionate response having regard to the risks involved in discharge.

This observation links with the decisions of the House of Lords in *Reid v. Secretary of State for Scotland* [1999] 2 A.C. 513; of the Divisional Court in *R v. London and South Western Mental Health Review Tribunal ex p. M* [2000] Lloyd's LR Med 143, to which the Court of Appeal referred; and of the Administrative Court in H itself (Administrative Court, 15 November 2000).

In *Reid*, the House of Lords held that the same criteria have to be applied in relation to admission and discharge, but the burden of proof is reversed when a tribunal considers discharge. Notwithstanding this, the application of the discharge test in cases where the medical practitioner

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

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

would not recommend a fresh admission given present circumstances is a practical question which must be resolved in each case on the evidence.

In *ex p M*, the issue was whether a patient who suffers or has suffered from mental illness must be discharged if the admission criteria are no longer met. According to Latham J, provided a tribunal acts rationally, it may disagree with the views of any psychiatrists whose evidence is put before them. Furthermore, *ex hypothesi*, a detained patient is in a different situation from a person in the community. S/he is receiving care and medication in the controlled environment of a hospital and so is not free to exercise her or his own wishes. Consequently, the assessment of risk must involve a judgment as to the extent to which release will give rise to the likelihood of non-compliance with medication, with the consequences described by the psychiatrists. Whether the nature of the illness makes liability to detention appropriate depends on an assessment of the probability that s/he will relapse in the near future if not subject to compulsion. That value judgment must be made in the context of the reversed burden of proof. This is part of the key to understanding how the admission and discharge criteria can be given equivalence, as required by *Reid*.

In *H* itself, Crane J stated in the Administrative Court that it is not fatal if a tribunal decision does not consider, or include in its reasons, a specific answer to the admission criteria question. Provided that it considers the discharge criteria, and in the process effectively considers all of the criteria that would be relevant to admission, its decision is not flawed simply because it does not ask itself separately the question of whether the admission criteria would be fulfilled.

Standard of proof

An important issue not addressed in *H* is that of the standard of proof. What standard of proof is imposed by the word 'satisfied'? Given that the onus is on the patient, to what degree must a tribunal be persuaded by the evidence before it can be satisfied and so under an obligation to discharge? Does 'satisfied,' it is sometimes said, mean satisfied beyond all reasonable doubt or satisfied on the balance of probabilities?

The issue was touched upon in *ex p. Hayes*,[6] where Ackner LJ observed that the patient's counsel had 'sought to raise questions as to the standard of proof required.' In that case, His Lordship could find nothing in the decision which indicated that the tribunal had imposed any undue standard of proof upon the patient, nor therefore any arguable point of law. In *ex p. Ryan*,[7] Nolan J. referred to the 'double-negative' aspect of the discharge test, saying:

> 'The negative form of the requirement required them to be satisfied - a fairly strong word - that the patient was not suffering from psychopathic disorder. So far as the clinical and medical evidence was concerned, it seems to me that they were entitled to say they were not satisfied and in so far as they went on to conclude that his conduct towards young females has been seriously irresponsible resulting from the psychopathic disorder ... Once again there was material upon which the tribunal could properly link the two.'

Although a tribunal which is satisfied that a patient is entitled to be discharged has no discretion about whether or not to discharge her or him, in deciding whether or not it is satisfied that s/he is entitled to be discharged, it has a very broad discretion. Hence, in reality, the effect of the double-negative test is that almost all decisions to discharge are discretionary.

6 R v The Mental Health Review Tribunal, ex p. Hayes, *9 May 1985, unreported (see Eldergill, supra, p.66).*

7 R v Trent Mental Health Review Tribunal, ex p. Ryan *[1992] COD 157, DC.*

It has been variously held in relation to legislation not concerned with mental health that 'satisfied' means to be persuaded[8]; to make up one's mind, coming to a conclusion on the evidence which, together with its other conclusions, leads to the judicial decision[9]; to be satisfied beyond reasonable doubt[10]; that there must be solid grounds upon which the court can found a reliable opinion[11]; that the term is indicative of judicial discretion[12]; and that the word simply says on whom the burden of proof rests, leaving the court itself to decide what standard of proof is required in order to be satisfied.[13]

It should be noted that the criteria for discharge include other qualifying words, which vary according to the particular authority being reviewed. For example, a tribunal must discharge a patient detained under section 3 if it is satisfied that it is not 'necessary' for his health or safety, or for the protection of others, that he receives treatment in hospital. In relation to section 2 patients, the duty to discharge arises if the tribunal is satisfied that the patient's detention is not 'justified' in the interests of his health or safety or for the protection of others. Many things which are not necessary may nevertheless be justified. Similarly, while a tribunal must discharge a section 3 patient if it is satisfied that continued liability to detention is not 'appropriate', it must discharge a section 2 patient if satisfied that his detention is not 'warranted' for assessment or treatment following assessment. Whether the use of a power is appropriate is again rather more subjective than whether or not it is warranted. The use in the criteria of words such as 'appropriate' and 'justified' means that it is not particularly meaningful to approach the criteria for discharge in terms of being satisfied beyond reasonable doubt or on the balance of probabilities. One cannot easily talk of a course of action being appropriate beyond all reasonable doubt and whether something is or is not justified may have little to do with probability.

The tribunal must therefore act judicially and give proper consideration to all of the evidence, ensuring that it has sufficient evidence concerning the statutory matters before reaching its decision. For example, adequate evidence about whether the patient is or may still be mentally disordered and whether his health or safety or other persons would be at risk if set at liberty. The finding reached must be based on some material that tends logically to show the existence of facts supportive of the finding and the reasoning behind the finding must be internally consistent. Beyond that, the tribunal must simply be persuaded, content in their own minds on the evidence before them, that there are no longer any grounds for detention, guardianship or supervision. If the patient's detention followed the commission of very serious offences, it will clearly be more difficult for them to be satisfied that his detention is no longer necessary to protect others or that it is not appropriate for him to remain liable to be detained. However, the fact that it will be more difficult to persuade the tribunal that there are no longer any grounds for his detention does not involve any elevation of the standard of proof. The basic need to be persuaded remains the same. The fact that a particularly persuasive argument is necessary in order to rebut a particularly persuasive argument for continued detention does not involve any alteration in the meaning of the word "satisfied," nor therefore increasing the standard of proof in such cases.

8 *See* Briginshaw v. Briginshaw *(1938) 60 C.L.R. 336,* per *Dixon J.*

9 *See* Blyth v. Blyth *[1966] 1 All E.R. 524 at 541, H.L.,* per *Lord Pearson.*

10 *See* Preston-Jones v. Preston-Jones *[1951] A.C. 391. In general, however, the legislature is quite capable of inserting the words 'beyond all reasonable doubt' if it means that.*

11 *See* R. v. Liverpool City Justices, ex p. Grogan, *The Times, 8 October 1990.*

12 Birch v. County Motor & Engineering Co. *[1958] 1 W.L.R. 980,* C.A.

13 *See* Blyth v. Blyth *[1966] 1 All E.R. 524 at 536, H.L.,* per *Lord Denning.*

Section 73 and restriction order patients

Having regard to the above decisions, it is useful to try to summarise the current state of the law with regard to tribunals applications and references concerning detained restriction order patients.

The criteria governing the imposition of hospital orders and, where restrictions are attached, their discharge are found in sections 37 and 73. Section 73(1) and (2) deal with a mental health review tribunal's power to absolutely or conditionally discharge restricted patients. These subsections, which incorporate section 72(1)(b), are set out below, together with the guidance concerning their proper application given in *Reid* and subsequent cases.

73.–(1) Where an application to a Mental Health Review Tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to such a tribunal, the tribunal shall direct the absolute discharge of the patient if satisfied-

that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment [s72(b)(i)]; or

Although a reverse burden of proof is incompatible with Article 5 of the European Convention, section 73 must be applied as drafted until such time as this incompatibility is removed by Parliament. It remains the case that it is for the patient to satisfy the tribunal that one or both of the conditions justifying detention no longer exist (see Human Rights Act 1998, s.4(6)).

The tribunal should approach the decision-making process in the following manner:

1 Presence of mental disorder

The tribunal must first decide whether the appellant has a mental disorder. If satisfied that s/he does not, then the tribunal must order discharge.

2 The disorder's nature and degree

If the patient has a mental disorder the tribunal must identify the nature and degree of it.

3 The nature and effectiveness of treatment in hospital

The tribunal should turn to the matter of medical treatment in hospital. They will have to consider the nature and effectiveness of any possible treatment.

If the patient is classified as suffering only from psychopathic disorder or mental impairment, the tribunal must consider whether such treatment is likely to alleviate or prevent a deterioration of the condition. If they are satisfied that such treatment is not likely to do

so, then they are bound to grant a discharge.

Put simply, it is never 'appropriate' for a patient to be liable to be detained in a hospital for medical treatment' for one of these conditions if s/he is not at that point in time treatable. The policy of the Act, in relation to patients with psychopathic disorders, is treatment not containment.

4 The appropriateness of detention in hospital for medical treatment

If the tribunal are not satisfied that the psychopathic disorder or mental impairment is untreatable, or if dealing with either of the other form of mental disorder, they must consider 'the propriety' of the patient receiving the medical treatment under detention in hospital. In doing so, they must look to the nature and degree of the mental disorder. If they are satisfied in the light of all the evidence before them, and in the whole circumstances, that the patient is not suffering from mental disorder of a nature or degree which makes it appropriate for her or him to be detained in a hospital for medical treatment, then they must discharge.

The circumstances which they may consider can include the matter of the health and safety of the patient and the safety of other persons, including members of the public; that is to say the propriety, as distinct from the necessity, of his continued detention in hospital.

If the tribunal are satisfied that the patient is entitled to be discharged under paragraph (a), the issue then is whether this discharge should be absolute or conditional.

that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment [s72(b)(ii)] and

5 Whether medical treatment in hospital is necessary for the patient's health or safety or to protect others

The single question under paragraph (b) is whether the tribunal are satisfied that it is not necessary for the health or safety of the patient

or for the protection of other persons that the patient should receive medical treatment in hospital. The standard here is one of necessity, not desirability. If the tribunal are so satisfied then they must discharge the patient, either conditionally or absolutely.

(b) that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

6 Whether liability to recall to hospital for further treatment is appropriate

Finally, if the tribunal are obliged to discharge, paragraph (c) requires them to consider whether it is or is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. The decision on this point determines whether the patient's discharge is conditional or absolute.

It is hard to reconcile an opinion that the medical treatment of mental impairment or a psychopathic disorder in a hospital is not, and never will be, likely to alleviate the condition or to prevent it from deteriorating with the view the tribunal should be invited to order a conditional discharge. The only purpose of a conditional discharge is to enable the patient to be recalled to hospital for 'further treatment', which means treatment which satisfies the treatability test. In other words, a conditional discharge is not an option in these cases. If the treatability test cannot be satisfied, the only option is an absolute discharge.

'Medical treatment' [s145(1)]

The expression "medical treatment" is given a wide meaning by section 145(1) of the Act. The width of the expression is not diminished where it requires to be examined in the context of the "treatability" test. Its scope is wide enough to include treatment which alleviates or prevents a deterioration of the symptoms of the mental disorder, not the disorder itself which gives rise to them. So, if the patient's anger management improves when s/he is in the structured setting of a supervised environment, it will be open to the tribunal to find that the treatability test is satisfied. This will also allow the tribunal to grant a conditional discharge if

> detention for medical treatment in a hospital is no longer appropriate or necessary. The aim of such a carefully designed rehabilitation programme will be to reduce the level of control to a point where a conditional discharge will enable the patient to demonstrate her or his ability to cope with symptoms after release under supervision into the community.
>
> In mental illness cases, where the nature of the illness is such that if s/he ceases to take prescribed medication s/he will relapse and pose a danger to her/himself or others, and there is uncertainty as to whether s/he will continue to take it if discharged, continued detention can be justified if it is a proportionate response having regard to the risks that would be involved in discharge.

Section 72 and unrestricted cases

Arguably, the fact that tribunals have a discretionary power of discharge in unrestricted cases means that they need not, and therefore ought not to, rely on section 4(6) of the Human Rights Act 1998. In other words, it is always within their power to comply with the Convention and, more particularly, the citizen's right to be released unless the detaining authority can establish all of the statutory grounds for the detention. Consequently, they act unlawfully if they refuse to discharge in circumstances where they are not satisfied that such grounds exist. Such a refusal would certainly be held unlawful by the European Court of Human Rights, which may award compensation to the victim; and arguably it also contravenes the 1998 Act, because the tribunal is not bound by legislation to act in this way.

Clinical Disagreement with a Deferred Conditional Discharge

Dr Kristina Stern[1]

R v. Camden and Islington Health Authority ex parte K [2001] EWCA Civ 240
Court of Appeal (21st February 2001). The Master of the Rolls, Buxton LJ and Sedley LJ.

Introduction

In *R v. Camden and Islington Health Authority ex parte K*, the Court of Appeal had to grapple with a problem which has repeatedly been brought before English Courts, i.e. that which arises where a Mental Health Review Tribunal (a "Tribunal") directs the conditional discharge of a restricted patient under section 73(2) of the Mental Health Act 1983 ("the Act"), but imposes conditions on that discharge and defers the direction for discharge until such time as those conditions are satisfied under section 73(7) of the Act. Difficulties arise, as they did in *ex parte K*, where it becomes practically impossible to fulfil the conditions prescribed by the Tribunal, with the result that the patient remains in detention under the Act, with no prospect of being discharged in accordance with the Tribunal's deferred direction.

Background

The starting point for any consideration of this difficulty is the decision of the House of Lords in *R v. Oxford Regional Mental Health Review Tribunal ex parte Secretary of State for the Home Department* [1988] AC 120 (hereafter "*Campbell*"). The case concerned the question whether or not Mental Health Review Tribunals who have directed a deferred conditional discharge have any power to reconsider their decisions in the period between the original direction and the actual discharge of the patient. The House of Lords, in a speech delivered by Lord Bridge, held that they did not and that a direction for a deferred conditional discharge was a final direction which could not subsequently be varied or revoked. Lord Bridge, in his speech, recognised that a Tribunal's decision about discharge will "inevitably be coloured by the conditions they have in mind to impose" and that:

> "..if the tribunal are only able to be so satisfied [about discharge] by the imposition of conditions to which the patient will be subject on release, it is obvious that in many, perhaps most, cases some time must elapse between the decision that conditional discharge is appropriate and the effective order directing discharge of the patient, for the purpose of making the necessary practical arrangements to enable the patient to comply with the conditions, eg. securing a suitable hostel placement for him and finding a suitable psychiatrist who is prepared to undertake his treatment as an out-patient" (at p.127).

It necessarily followed from the decision of the House of Lords that, where a Tribunal directs a conditional discharge, it has no power to reconsider the nature of the conditions, or the nature of the order, in the event that it proves difficult or impossible to comply with the conditions. The unfortunate result for the patient is that he or she remains detained without any redress during

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this period other than the possibility of challenging either the Tribunal decision or the failure to implement the decision by judicial review, or after the requisite period has expired, re-applying to the Tribunal for a further hearing.

In *R v. Ealing District Health Authority ex parte Fox* [1993] 1 WLR 373, the patient successfully applied for judicial review of the Health Authority's failure to implement the conditions set by the Tribunal which led to the indefinite deferral of his order for a deferred conditional discharge. The Tribunal in *Fox* had directed that the applicant, a restricted patient, should be conditionally discharged but that his discharge should be deferred until the Tribunal was satisfied that conditions relating to residence and after care, including supervision by a responsible medical officer, had been met. Otton J. held that the duty to provide aftercare services under section 117 of the Act was mandatory, and was both a general duty and a specific duty owed to the applicant to provide him with aftercare services until such time as the district health authority and local social services authority (together the aftercare authorities) were satisfied that he was no longer in need of such services. He held that the duty was a continuing duty owed to patients who "may be discharged" although the actual duty to provide services was only triggered at the moment of discharge (at p.385). However, Otton J. also dealt with the difficulty where the Health Authority's doctors were disinclined to make the necessary arrangements. He said:

> "..if the district health authority's doctors do not agree with the conditions imposed by the mental health review tribunal and are disinclined to make the necessary arrangements to supervise the applicant on his release, the district health authority cannot let the matter rest there. The district health authority is under a continuing obligation to make further endeavours to provide arrangements within its own resources or to obtain them from other health authorities who provide such services so as to put in place practical arrangements for enabling the applicant to comply with the conditions imposed by the mental health review tribunal or, at the very least, to make inquiry of other providers of such services. If the arrangements still cannot be made then the district health authority should not permit an impasse to continue but refer the matter to the Secretary of State to enable him to consider exercising his power to refer the case back to the mental health review tribunal under s.71(1)." (at p.386).

These difficulties were subsequently considered in the case of *Johnson v. UK* (1997) 27 EHRR 296 in the European Court of Human Rights. On 15th June 1989 a Tribunal had ordered a deferred conditional discharge of Johnson on the ground that whilst it accepted that he was no longer suffering from mental illness, he required rehabilitation under medical supervision which rehabilitation could only be provided in a hostel environment. Following this decision efforts were made to find hostel accommodation for Johnson but to no avail. Johnson applied again to the Tribunal, hoping for an absolute discharge in the light of these difficulties. However, on 9th May 1990 the Tribunal again directed a deferred conditional discharge subject to the same conditions. From late 1990 Johnson began to reject the rehabilitation plans which had been foreseen for him. In April 1991 his case was again considered by a Tribunal which again directed deferred conditional discharge subject to satisfaction of the same conditions. On each occasion the Tribunal accepted that Johnson no longer suffered from mental illness. However, it was not until 12th January 1993 that an absolute discharge was directed and Johnson subsequently released from Rampton Hospital.

In these circumstances, the European Court found that it was legitimate for the 1989 Tribunal to impose conditions on Johnson's discharge notwithstanding their finding that he was no longer suffering from mental illness. This was because a responsible authority is entitled to exercise a

"measure of discretion in deciding whether, in the light of all the relevant circumstances and the interests at stake it would in fact be appropriate to order the immediate and absolute discharge of a person who is no longer suffering from the mental disorder which led to his confinement." (at para 63). It was, however, "of paramount importance that appropriate safeguards are in place so as to ensure that any deferral of discharge is consonant with the purpose of Article 5(1) and with the aim of the restriction in sub-paragraph (e) and, in particular, that discharge is not unreasonably delayed" (at para 63). The Tribunal concluded in the case of *Johnson* that the imposition of the hostel condition had led to the indefinite deferral of Johnson's release from Rampton Hospital. The real problem in the UK system which led to it not complying with Article 5 was that "neither the Tribunal nor the authorities possessed the necessary powers to ensure that the condition could be implemented within a reasonable time" (at para 66). One cannot help feeling, at least in part, that the inflexibility of the approach of the later Tribunals in *Johnson* was a significant factor in the decision of the European Court that there had been a breach of Article 5 in his case.

Another relevant decision is that of the Court of Appeal in *R v. Mental Health Review Tribunal ex parte Hall* [2000] 1 WLR 1323 (CA). At first instance in *Hall* ([1999] 3 All ER 132), Scott Baker J considered the case against the various potential aftercare authorities. He held that "the whole purpose of section 117 is that there should be a working together to ensure that when a patient is released he is given the kind of support that gives him the best prospect of settling in the community" (at 144g-h). He held that this duty imposed on the aftercare authorities a duty to make a full multi-disciplinary assessment prior to the Tribunal hearing and to plan arrangements prior to the Tribunal hearing. Scott Baker J found that the aftercare authorities had acted unlawfully on the facts of that case in failing to take sufficient steps to secure that aftercare planning took place for Mr Hall. This was in part due to their failure to appreciate that as Mr Hall had been resident within the area covered by those authorities prior to his detention, they were the relevant aftercare authorities for the purposes of section 117 of the Act (at p.143f-g). Scott Baker J also held that the Tribunal had acted unlawfully in failing properly to take account of all relevant circumstances when, on the second occasion that they considered Mr Hall's case they had continued to impose the type of conditions (in fact more stringent conditions) which had proved difficulty to comply with in the past, and had failed to ensure that they had before them an up to date care plan for Mr Hall's aftercare.

On appeal by the Tribunal, the Court of Appeal reversed Scott Baker J's finding that the Tribunal had acted unlawfully. The Court of Appeal held that a tribunal which simply discharged its obligations and left other agencies to discharge theirs, as this Tribunal did, was not judicially reviewable because it did not do more. In this case, notwithstanding the history, the decision of the Tribunal was not irrational or otherwise open to judicial review. The flaw in Scott Baker J.'s reasoning was that it blamed the tribunal for failing to exercise a power which it did not have. Whilst it could shame others into action, it could not otherwise ensure that reasonable conditions were met within a reasonable time. Whilst the Tribunal clearly had the power to be more interventionist, for example by adjourning and calling for a care plan which might have "achieved a good deal", and to do everything in its powers to encourage other agencies to fulfil their statutory duties, "that is a long way from saying that a tribunal which simply discharges its obligations and leaves other agencies to discharge theirs is to be regarded as judicially reviewable because it did not do more" (at 1353).

In *Hall* the CA expressly noted that the decision in *Johnson* did "call into question the efficacy of the measures available to ensure that when a Tribunal imposes conditions which are themselves reasonable those conditions are complied with within a reasonable time". Given that statement it is difficult to see

quite how the Court of Appeal in *Hall* then concluded that "the procedure [of the Tribunal] would have satisfied all of the requirements of Article 5.1 as interpreted by the European Court". It manifestly lacked the one requirement criticised in *Johnson* that of putting its decision effectively into practice.

Facts

The Court of Appeal in *R v. Camden and Islington Health Authority ex parte K* grappled with a slightly different problem. In this case the appellant was a restricted patient detained under sections 37/41 of the Act. On 4th November 1997 she had committed, and was on 2nd February 1998 convicted of, the offence of causing grievous bodily harm with intent. Since June 1998 she had been detained in a Medium Secure Unit. She applied to the Tribunal which, on 24th May 1999, adjourned for a care plan to be formulated in accordance with the authority of *Hall*, and for a psychiatric report to be prepared by the North London Forensic Service on her suitability for conditional discharge. This report recommended that she be moved to a Regional Secure Unit in London, nearer to her family. Her RMO gave evidence at the adjourned Tribunal hearing on 16th August 1999 and his view was that she could then be moved to appropriately supported hostel type accommodation but that there should be no conditional discharge.

Notwithstanding this evidence, the Tribunal ordered a deferred conditional discharge on condition that K should reside at her parents' home and should co-operate with social supervision by a social worker to be allocated to her case and with supervision by a forensic Consultant Psychiatrist, and should comply with such treatment as might be prescribed for her. The Tribunal was satisfied that K was suffering from mental illness, namely schizophrenia, the symptoms of which were being fully controlled by medication and that she needed ongoing treatment and medication in order to control her illness. The Tribunal's conclusion was, however, that K was well enough to be discharged to live with her parents and sister at home under psychiatric and social supervision.

The discharge was, however, not effected because those psychiatrists who could have been responsible for supervising her in the community disagreed that conditional discharge was appropriate and, in the exercise of their clinical judgment declined to supervise her in the community. They would only supervise her if she were to live in supported accommodation. Consulting forensic psychiatrists from outside the Health Authority's area were also consulted but no willing forensic psychiatrist was found. The Health Authority was not, therefore, able to satisfy the conditions imposed by the Tribunal and thereby to enable K's discharge. Ultimately, on 3rd March 2000 Dr Kennedy of the North London Forensic Service (by then K's RMO due to her having been transferred to Avesbury House), wrote to the Home Office advising his opinion that the Tribunal's conditions were impossible to meet and asking if the Home Secretary would consider exercising his powers to refer K to a Tribunal for a further hearing[2]. On 17th March 2000 the Home Secretary referred K's case to a further Tribunal.

The Judgments

K argued her case as a matter of domestic law arguing that under section 117 of the Act there was an absolute duty upon the health authority to provide necessary aftercare services, and under the ECHR on the basis that her continuing detention was unlawful under Article 5. Burton J. found

2 *Section 72 (1) of the Act empowers the Secretary of State to refer the case of a restricted patient to a Tribunal 'at any time'.*

that there was no breach by the Health Authority of its obligations and dismissed the application for judicial review. He found that in the circumstances of K's case, it was perfectly proper for the Secretary of State to refer to matter to a further Tribunal.

The Court of Appeal had no difficulty in finding that, as a matter of domestic law, the obligation on the aftercare authorities was, following *R v. Ealing District Health Authority ex parte Fox* [1993] 3 All ER 170 (Otton J), "to attempt with all reasonable expedition and diligence to make arrangements so as to enable the Applicant to comply with the conditions imposed by the Mental Health Tribunal" and to "make practical arrangements for after care prior to that patient's discharge from hospital". More particularly, the Master of the Rolls in *ex parte K* at paragraph 29 held that:

> "…Section 117 imposes on Health Authorities a duty to provide after care facilities for the benefit of patients who are discharged from mental hospitals. The nature and extent of those facilities must, to a degree, fall within the discretion of the Health Authority which must have regard to other demands on its budget. In relation to the duty to satisfy conditions imposed by a Tribunal, I would endorse the concession made by the Respondent Authority as to the extent of its duty [i.e. normally to give way to a Tribunal decision and to use reasonable endeavours to fulfil the conditions imposed by such a decision insofar as they relate to medical care and that failure to use such endeavours, in the absence of strong reasons, would be likely to be an unlawful exercise of discretion]".

As to the question of whether or not Article 5 of the ECHR dictated a different interpretation of section 117 the Court of Appeal unanimously held that it did not. However, the Court of Appeal did consider the wider question of whether or not K's detention some 15 months after the Tribunal ordered a deferred conditional discharge was unlawful. The Master of the Rolls drew a distinction (not accepted by Buxton and Sedley LLJ) between the case where the Tribunal concludes that the patient is not suffering from a mental illness (as in the case of *Johnson*) on the one hand, and cases such as K where the Tribunal concludes that the patient is mentally ill and requires treatment but that under appropriate conditions that treatment could be provided in the community. In the latter case, the Master of the Rolls held that if it proves impossible or impracticable to arrange for the patient to receive the necessary treatment in the community then the *Winterwerp* criteria[3] were made out and the detention was lawful under Article 5. This was because "whether or not it is necessary to detain a patient in hospital for treatment may well depend upon the level of facilities available for treatment within the community" (at para 34) - this echoes the speech of Lord Bridge in *Campbell* that the nature of the conditions imposed necessarily inform a Tribunal's decision to order a deferred conditional discharge.

Of interest, however, is the Master of the Rolls' conclusion in relation to cases where a Tribunal concludes that the patient is no longer suffering from mental illness. In such cases, he held, it is clearly legitimate to order a deferred conditional discharge but "the deferral must be proportionate to its object and cannot become indefinite." (at para 35). His view was therefore that the statutory scheme as interpreted by *Campbell* (i.e. where the decision to order a deferred conditional discharge is a final decision) may not be consistent with Article 5 because "if the Tribunal imposes a condition which proves impossible of performance, too lengthy a period may elapse before the position is reconsidered as a result of a subsequent referral." (para 35). He observed that the

3 *Winterwerp v The Netherlands (1979) 4 EHRR 387. The criteria can be summarised as follows: (1) Except in emergency cases, the individual concerned must be shown by prior objective medical expertise to be suffering from a true mental disorder; (2) the disorder must be of a kind or degree warranting compulsory confinement; (3) the validity of continued confinement requires the persistence of such a disorder.*

solution to this problem may be to reinterpret section 73(7) so as to enable a Tribunal to revisit an order for a deferred conditional discharge.

Buxton LJ disagreed with the distinction suggested by the Master of the Rolls. In his view, the ECHR jurisprudence provided that "once the Tribunal made a decision as to Miss K's release that was contingent on the provision of forensic psychiatric supervision, it became the responsibility of the state to provide that supervision" (at para 44). In his view the lawfulness of a patient's continued confinement during a period of deferral would depend upon whether or not the patient could during that period be said to be suffering from a mental disorder of a kind or degree warranting compulsory confinement (the *Winterwerp* criteria). He did not decide how this applied to K. He was quite clear that if a patient did not meet those criteria then the order of the Tribunal would be frustrated and the patient would be deprived of her Article 5(4) protection. What is not clear, however, is whether or not Buxton LJ considers that there is such a breach in all cases where a Tribunal decision is effectively frustrated, or only in those cases where the *Winterwerp* criteria would not be satisfied. It would appear from the tenor of his judgment that the latter interpretation is correct.

As for the position of K, Buxton LJ held that it did not follow from his conclusion that she may have been deprived of her Article 5 rights that she was entitled to relief as against the Health Authority. In his opinion if she had a complaint about detention, that complaint would have to be directed against the authority responsible for the hospital where she was detained. Such liability depended not upon fault, but upon the fact of K being detained in breach of Article 5(4).

The solution proposed by Buxton LJ was the same as that proposed by the Master of the Rolls, i.e. to reconsider the decision in *Campbell*.

Sedley LJ also considered the human rights dimensions of the case. He differed from both the Master of the Rolls and Buxton LJ in his view that the statutory scheme was in principle Convention-compliant (see para 56). His reasoning appears to be as follows:

- The decision of the Tribunal depended, for its efficacy, upon the professional judgments of those responsible for implementing it.
- If there is an honest difference of professional judgment between the Tribunal and those who would be responsible for implementing its decision, then the condition of practicability, i.e. whether it is practicable for the patient to be treated in the community, is not met and discharge is for the time being not lawfully possible.
- That there is no distinction in principle between the *Winterwerp* class of case and the *Johnson* class of case, they illustrate the differential effect of the same principle on different fact situations.
- That the role of the judge in this is to ensure that the professional judgment is made honestly, rationally and with due regard only to what is relevant. Within this boundary more than one legitimate judgment - that of the community psychiatrist as well as of the MHRT - may have to be accommodated for the purposes of Article 5(4) at least to the extent that the decision of the MHRT is explicitly dependent on the collaboration of the psychiatrist.

Commentary

Ex parte K, in particular the judgments of the Master of the Rolls and Buxton LJ (but not Sedley LJ), has certainly opened the door to challenges to continuing detention for a protracted period of

time following a Tribunal order of deferred conditional discharge where the Tribunal has concluded that the patient no longer suffers from mental illness. Beyond that, however, there is little consensus to be found in the judgments of the Court of Appeal. The broadest judgment, that of Buxton LJ, was that there could be an ECHR problem in any case where an order of the Tribunal is not effected. But according to the Master of the Rolls, the difficulty lies in particular hard cases, i.e. where a Tribunal concludes that a patient is no longer suffering from mental illness at all but discharge is not effected. However, Sedley LJ disapproved of this distinction (as did Buxton LJ) and found that even in cases where the Tribunal concludes that there is no mental illness but nonetheless orders that discharge should be deferred until certain conditions are met, the statutory scheme allowing the impasse was ECHR compliant.

It is, however, clear that following *ex parte K* English courts will not be receptive to challenges against the Health Authority relying upon section 117 of the Act where the impasse is the result of a genuine clinical disagreement. The Court of Appeal reiterated its respect for clinical judgment even in the face of ECHR challenges. Indeed Sedley LJ's view was that the statutory scheme was explicitly dependent upon the collaboration of the psychiatrist. This is a little surprising in the circumstances of *ex parte K* given that there is in fact no reference to such collaboration in section 73 of the Act which governs the discharge powers of the Tribunal in relation to restricted patients. Perhaps Sedley LJ was referring to the general scheme of the Act which is, in many significant respects, one which relies upon collaboration between doctors, social workers, and detaining authorities for its efficacy.

Lest it be suggested that this is a situation which applies only to restricted patients, it must be remembered that similar arguments could (albeit with less force) apply to unrestricted patients in relation to the prospect of a supervised discharge under the Act. A Tribunal may well recommend that an RMO consider making an application for a supervised discharge[4] and a failure by the RMO to do so, or actually to make such an application, may well be challenged where the basis of the Tribunal's recommendation was a finding that it would be appropriate for further treatment of the patient to be provided in the community but under supervision.

The real problem is that the UK has still not addressed the problem identified in *Johnson* of patients being unlawfully detained pending satisfaction of the conditions of a deferred conditional discharge. The possible solution, as suggested by two members of the Court of Appeal in *ex parte K*, is to enable the Tribunal to reconsider its orders for deferred conditional discharge. The difficulty with this is that, as *Johnson*, *Hall*, and *K* show, in such cases Tribunals often reach substantially the same conclusion on their reconsideration of the case. If, in any particular case, the evidence suggests that a patient requires supervision then the likely order even of the fresh Tribunal is likely to be a deferred conditional discharge. The only flexibility lies in the terms of the conditions, and in a case where the requirement is for supervision in the community such flexibility is minimal. If a past impasse suggests that such conditions are unlikely to be met, the only real alternatives are for the Tribunal to try to shame a health authority into activity (which in a case of a longstanding impasse may well not succeed) or to decline to order discharge at all. Few patients are likely, in these circumstances, to be encouraged at the prospect of a further Tribunal hearing.

An alternative solution is for the Tribunal to have more far reaching powers against the aftercare authorities so as effectively to enforce its orders against them. This, however, involves the unpalatable prospect of clinicians being ordered to treat patients contrary to their clinical judgment. That, however, may simply be the cost of being ECHR compliant.

4 *In accordance with its power under section 72 (3A) of the Act*

MHRT Target Hearing Times and the ECHR

Rebecca Trowler[1]

The Queen (on the application of C) v London South and South West Region Mental Health Review Tribunal (Judgment given 21st December 2000 - unreported)

High Court (Queen's Bench Division). Scott Baker J.

Introduction

C challenged the current practice of the Mental Health Review Tribunal ('MHRT') to list applications for discharge in s. 3 cases to be heard within 8 weeks after the making of the application. It was submitted on his behalf that a period of 8 weeks in such cases did not meet the requirement in Article 5 (4) of the European Convention on Human Rights for a speedy review of detention. Scott Baker J dismissed C's application for judicial review holding that neither the current practice nor the facts of C's case gave rise to a breach of Article 5 (4).

Facts

C was diagnosed as suffering from schizophrenia. Over a number of years he had been admitted and detained in hospital on several occasions. On 15th October 2000, having first been taken into custody by the police following a disturbance caused by him at the offices of Lambeth Council and interviewed by a doctor and social worker, C was admitted to South Western Hospital under s. 4 Mental Health Act 1983 ('MHA'). His wife and nearest relative objected to his admission under s. 3. On 16th October a district judge sitting in the County Court displaced C's wife as nearest relative by way of an interim order. The same day C was admitted for treatment pursuant to s.3 MHA. He applied immediately to the MHRT for his discharge from hospital. On 17th October C's wife learned of the order displacing her and sought leave to apply for judicial review of the order on the grounds that it should not have been granted by a district judge. Upon the County Court arranging for an inter partes hearing, leave was refused on 20th October. The interim displacement order was confirmed by a circuit judge at a hearing on 23rd October. On 26th October the solicitors representing C requested without success a hearing of C's application for discharge to the MHRT to be heard in advance of the expiry of the 8 weeks within which the hearing would be listed according to the current practice. Thereafter C was transferred from South Western Hospital to Cane Hill Hospital on 10th November. The tribunal application was listed to be heard on 1st December 2000 to accommodate C's new RMO. On 21st November the interim order displacing C's wife as the nearest relative was discontinued by a circuit judge. On 24th November C's wife successfully applied to the hospital managers for his discharge.

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Law

Domestic Position: Pre-Admission

There is a stringent procedure which must be adhered to before a person can lawfully be admitted to hospital for treatment pursuant to s. 3 MHA. Where a patient is detained pursuant to s. 3 following a failure to comply with the procedure then the admission may be challenged by way of judicial review and/or habeas corpus.[2]

First, an application for admission must be made to the hospital managers by either the nearest relative or by an approved social worker[3]. Where the application is made by an approved social worker that social worker is obliged to interview the patient and satisfy himself that detention in hospital is in all the circumstances the most appropriate way of providing the care and medical treatment of which the patient stands in need[4]. The application may not be made unless the social worker making the application has personally seen the patient within the period of 14 days ending with the date of the application[5] The application must be supported by written recommendations of two registered medical practitioners[6]. One of the two medical practitioners must be approved by the Secretary of State as having special experience in the diagnosis and treatment of mental disorder and one of the two, if practicable, must have previous acquaintance with the patient[7]. Both medical practitioners must personally examine the patient and, if they do so separately, not more that five days must elapse between the days upon which the separate examinations take place[8]. The medical recommendations must include in each case a statement that in the opinion of the practitioner the conditions precedent for admission contained in s. 3 (2) are satisfied[9].

Secondly, if the application for admission is made by an approved social worker, that social worker is required to first consult with the nearest relative (unless it appears to the social worker that such consultation is not reasonably practicable or would involve unreasonable delay) and, if the nearest relative objects to the admission, the application may not be made[10] unless an order is obtained from the county court displacing the nearest relative and appointing either the local social services authority or another person to act in the role[11].

2 *[see Lord Woolf in* R v Barking Havering and Brentwood Community Health Care NHS Trusts *[1999] 1 FLR 106 at 114 to 117 re. the appropriate procedure and remedy in cases of continuing unlawful detention].*

3 *s. 11 (1) and (2) MHA*

4 *s. 13 (2) MHA*

5 *s. 11 (5) MHA*

6 *s. 3 (3) MHA*

7 *s. 12 (2) MHA*

8 *s. 12 (1) MHA*

9 *s. 3 (3) [The conditions precedent for admission set out in s. 3 (2) are that the patient (a) is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital and that (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition and that (c) it is necessary for the health or safety of the patient or for the protection of others that he should receive such treatment and it cannot be provided unless he is detained under s. 3. The statement required by s. 3 (3) must contain particulars of the grounds for the opinion that the conditions in s. 3 (2) (a) and (b) are satisfied and reasons for the opinion that the condition in s. 3 (2) (c) is also satisfied, stating why other methods of dealing with the patient are inappropriate].*

10 *s. 11 (4) MHA*

11 *The County Court has power to make an Order displacing the nearest relative under s. 29 MHA. [Before doing so s. 29 (3) provides that the Court must be satisfied that (a) the patient has no nearest relative or it is not practicable to find him or (b) the nearest relative of the patient is incapable of acting as such by reason of a mental disorder or other illness or (c) the nearest relative unreasonably objects to the application for admission or (d) the nearest relative has, in the past, discharged the patient from hospital without due regard for his welfare or the interests of the public].*

Domestic Position: Post-Admission

Once admitted, a patient may be detained against his will in hospital for treatment pursuant to s. 3 MHA for a period not exceeding 6 months[12] unless it is renewed. However, there are statutory safeguards (aside from the right to apply to the MHRT seeking discharge) which are intended to ensure that his continued detention during that period is not unjustified. In particular the RMO remains under a continuing duty to consider whether the conditions remain satisfied and may discharge him if he is not so satisfied, as may the hospital managers and the nearest relative.[13].

The patient (or the nearest relative whose direction to discharge has been 'barred' by the RMO) may at any time during that six month period apply to the MHRT for his discharge[14]. Following consultation with the Council on Tribunals the MHRT Secretariat has set time limits for listing the hearings of applications for discharge from detention authorised under different sections of the MHA. In s. 3 cases the hearing of the application should take place within 8 weeks from the making of the application[15]. The relevant MHRT Rules are as follows. The responsible authority must provide a statement to the MHRT containing prescribed information as soon as possible and in any event within three weeks upon receipt of the Notice of application. This includes an up to date medical report containing a medical history and a full report on the patient's mental condition and, so long as it is reasonably practicable to provide it, an up to date social circumstances report[16]. At any time before the hearing of the application the medical member must examine the patient and may examine his medical records[17]. The MHRT must give at least fourteen days notice of the time, date and place fixed for the hearing[18] and it has power to give directions as it thinks fit to ensure the speedy and just determination of the application[19]. There is a power to adjourn the hearing of the application and, before doing so, to give such directions as it thinks fit for ensuring the prompt consideration of the application at the adjourned hearing[20].

Article 5 (4) ECHR

Article 5 ECHR enshrines the right to liberty and security of the person but permits detention in limited circumstances including the 'lawful detention … of persons of unsound mind' (Article 5 (1) (e)) where it is justified either in the interests of the person detained and/or in the public interest[21]. Whether a person is lawfully detained under Article 5 (1) (e) must be determined on the basis of reliable evidence from an objective medical expert, the mental disorder must be of a kind or degree warranting compulsory detention and, importantly, must persist during the period of detention.[22] Further, the procedural requirements in domestic law must be adhered to and the law itself must be accessible, clear and not arbitrary[23].

12 *s. 20 (1) MHA*

13 *s. 23 (2) (a) MHA [the power of the nearest relative to discharge is of no effect where, once the nearest relative has given Notice of the intention to discharge, the RMO furnishes the hospital managers with a report stating his opinion that if discharged the patient would be likely to act in a manner dangerous to himself or others (s. 25(1) MHA)].*

14 *s. 66 (1) (b) and (2) (c) MHA*

15 *The same time limit applies to s. 37 cases. In restricted cases (s. 41) the hearing should be listed within 20 weeks of the making of the application. The hearing of applications in s. 2 cases is required by the MHRT rules (Rule 31) to take place in 7 days.*

16 *Rrule 6 (1) MHRT Rules and Schedule 1 Part B*

17 *Rrule 11 MHRT Rules*

18 *Rrule 20 MHRT Rules*

19 *Rrule 13 MHRT Rules*

20 *Rrule 16 (1) and (2) MHRT Rules*

21 *Guzzardi v Italy (1980) 3 EHRR 333 at para 98 ECtHR*

22 *Winterwerp v Netherlands (1979) 2 EHRR 387 at para 39 ECtHR*

23 *Winterwerp v Netherlands at para 45; Van de Leer v Netherlands (1990) 12 EHRR 567 at para 22 ECtHR*

Where detention is justified under Article 5 (1) (e) a periodic review of detention is required by Article 5 (4) which states

> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

The purpose of the Article 5 (4) requirement is to provide those who are detained with judicial supervision of the lawfulness of their detention[24]. In *Megyeri v Germany*[25] the EctHR made it clear that in mental health cases the review must be periodic because his detention will be lawful only for as long as his condition persists.

The review required by Article 5 (4) must be a speedy one. This is particularly so in the case of initial reviews. However, whether a review is sufficiently speedy is determined in the context of the whole of the relevant scheme as apparent shortcomings in one procedure may be remedied in safeguards available in other procedures[26]. Further, an examination of the judgments and decisions of the Strasbourg Court and the Commission demonstrates that whether there has been a breach of the speedy review requirement in Article 5 (4) will depend upon not only the whole of the relevant scheme but also, as is always the case, upon the facts of each case. For example, in *Wassink v Netherlands*[27] the applicant was made the subject of an emergency confinement on 15th November 1985. On 19th November a request was made by the relevant authorities to the court to extend the period of emergency confinement. That request was accompanied by the medical file relating to the applicant. On 20th November the President of the District Court interviewed the applicant, his wife and two doctors over the telephone. On 25th November the President ordered the continuation of the emergency confinement. Under domestic law that Order was valid for a further three weeks. The Court held that a period of three weeks detention without review did not breach Article 5 (4) since, taking the whole of the relevant procedure into account, the review of the position by the President before granting the extension of the confinement amounted to a sufficient review of the lawfulness of the detention in respect of the subsequent three weeks. However, in other circumstances the Court has held that the speedy review requirement has not been met, particularly where there has been no good reason for a delay. This is likely to be the case where there has been administrative delay. For example, in *Koendjbiharie v Netherlands*[28] the Court held that there was a breach of 5 (4) in a case in which 4 months had elapsed between the making of an application to the Court of Appeal for release from extended confinement in a psychiatric clinic and the giving of judgement. The Court found the four month period to be unreasonable as it included a month long adjournment without good reason. Similarly in *E v Norway*[29] 8 weeks was too long when the delay was due, in part, to the judge's absence on vacation. The Court took account of the lack of rules pointing to a speedy conclusion of proceedings, delays in arranging hearings and in giving judgement.

Equally, where the delay is due to requests for an adjournment, there will be no breach of Article 5 (4). For example, in *Cottenham v UK*[30] the MHRT could not be criticised for a delay of 10 months where the patient's solicitor requested an adjournment to obtain independent reports. However, in *Musial v Poland*[31] the EctHR held that a lapse of eighteen months in proceedings to determine the

24 *De Wilde, Ooms and Versyp v Belgium (1971) 1 EHRR 373 at para 76 ECtHR*

25 *(1992) 15 EHRR 584 ECtHR*

26 *X v UK, 05/11/85, App No. 7215/75 EctHR at para 60; Winterwerp v Netherlands at para 62.*

27 *(1990) A/185-A EctHR*

28 *(1990) 13 EHRR 820 ECtHR*

29 *(1990) 17 EHRR 30 at para 66 ECtHR*

30 *[1999] EHRLR 530 ECtHR*

31 *Unreported, 25th March 1999 ECtHR*

lawfulness of the applicant's detention in a psychiatric hospital did breach Article 5 (4). A request by the applicant that he be examined by doctors from outside the hospital where he was detained did not amount to a waiver of his Article 5 (4) rights and the responsibility for the delays in securing the provision of expert opinion rested ultimately with the state which could have, for example, imposed fines on the experts failing to provide reports in time. The Court also stated that the complexity of the patient's medical dossier could not absolve the authorities from its obligations under 5 (4).

Judgment

There was a preliminary issue as to jurisdiction for the Court to decide since C had been discharged from hospital. Both parties urged the Court to decide the application because (i) the point was one of importance affecting many cases, it being routine practice for the MHRT to list the hearing of applications for discharge in s. 3 cases eight weeks after the application and (ii) C was likely to be detained again in the future and, to that extent, he had an interest in the decision. The Court decided to hear the application, its' attention having been drawn to the decision in *R v Secretary of State for the Home Department ex parte Salem*[32].

On the substantive issue in the case the Court held that the current practice of listing s. 3 cases to be heard 8 weeks after the making of the application did not breach Article 5 (4). Nor was there a breach on the facts of the case. In giving judgment Scott Baker J recognised that Article 5 (4) gives the patient a positive right to have the lawfulness of his detention decided speedily and that one of the purposes of the review of detention required by 5 (4) is to remove arbitrariness. He further stated that it is obviously desirable that the MHRT should review the detention sooner rather than later both in order to comply with Article 5 (4) and as a matter of commonsense and that there was a greater need for the detention to be susceptible to review speedily when a detained person is first challenging the propriety of his detention than at a second or subsequent challenge some time into his detention. He accepted the submission made on C's behalf that the question of administrative convenience was irrelevant to the question before the court and that administrative failings on the part of the state may result in a breach of 5 (4).

However, Scott Baker J rejected the primary submission made on behalf of C that s. 3 cases should be dealt with as are s. 2 cases i.e. the hearing of an application for discharge should be required to take place within 7 days[33]. In doing so he distinguished admission under s. 2 in that it permits short term detention for the purpose of assessment only in order to diagnose and/or determine what, if any, longer term treatment is appropriate (relying on the judgment of Tucker J in *R v Wilson ex parte Williamson*[34]). Accordingly s. 2 cases can proceed on a shorter time scale because (i) the permitted detention period is short (28 days) (ii) the nearest relative has no right to prevent admission under s. 2 (iii) the patient is unlikely to be known to other mental health services or to have undergone a

32 *[1999] 1 A.C. 450 [On an appeal on an issue of public law involving a public authority the House of Lords had a discretion to hear the appeal even if by the time it was due to begin there was no longer an issue to be determined directly affecting the parties' rights and obligations inter se: but the discretion is to be used with caution, and academic appeals should not be heard unless there was good reason in the public interest for doing so. See also* R v Secretary of State for the Home Department ex parte Abdi *[1996] 1 W.L.R. 298 at 301 and referred to in the speech of Lord Slynn in* Ex parte Salem *at 456G].*

33 *Rrule 31 MHRT rules.*

34 *[1996] C.O.D. 42*

recent assessment and (iv) the doctors do not have to go through the process of having to consider whether the conditions precedent to admission required by s. 3 are satisfied. For any right of appeal in a s. 2 case to be effective it has to be heard quickly because otherwise the 28 day period will have expired and the appeal will be pointless - hence the need for hearings to be listed within 7 days. The position is different in s. 3 cases. Treatment under s. 3 involves the ongoing management of the patient. Time may be needed to assess whether treatment has been effective. The patient is likely to be well known to the mental health services and to have had a recent assessment and/or be the subject of an informal assessment before being admitted or to have been previously detained under s. 2 and moved to detention under s. 3.

Scott Baker J also rejected the applicant's submission in the alternative that a s. 3 patient should be in no different a position to that of a restricted patient conditionally discharged but recalled. The reference to the MHRT which must be made by the Secretary of State within one month of the patient's return to hospital following recall[35], must be listed for hearing within 5 to 8 weeks of the reference being received at the tribunal offices.[36]

Having rejected the analogy with the position of those detained under s. 2 or conditionally discharged patients recalled to hospital, Scott Baker J considered the scheme for the preparation for and listing of hearings in s. 3 cases which he stated 'gives the impression of importing some urgency into the whole process.' He accepted that it would be wrong to first consider the rules and from the time limits within them conclude that 8 weeks is necessary and appropriate to fit in with them and that accordingly 5 (4) is satisfied. However the Rules demonstrate what is involved in getting all the relevant material before the MHRT. He observed that the provision of evidence as required by rule 6 can often be a substantial task. Further, representatives have to be booked, reports circulated and absorbed and, if necessary, responded to, and disclosure may be necessary. Crucially, a speedy hearing must also be a just one. Article 5 (4) does not require undue haste and it is critical that the MHRT has the relevant information and people before it so that it can give a considered judgement. The point was illustrated by the present case in that the patient may not remain in the same hospital and there may be a change of the RMO making it more difficult to prepare a case for the Tribunal. The MHRT is normally concerned with the substantive justification for a continuing detention rather than its procedural validity. This involves consideration of the medical issues and detailed investigation of sometimes conflicting evidence. Without the result of such investigations the MHRT might well make a decision on a wrong basis possibly with unjust and disastrous results. Balance therefore had to be achieved between putting the best information before the MHRT and having the hearing take place speedily.

Scott Baker J did not explore in detail the various judgments to which the Court was referred stating that to do so was not necessary as all were concerned with different situations from that of the present case. However he set out three points of principle that can be gleaned from the case law: (1) The Strasbourg Court recognises the need for detailed investigations and time for preparation of reports; (2) the word 'speedily' in 5 (4) must be construed against a background of the type of case under consideration; (3) mental health detention presents its own special difficulties. He also observed that in no case has a "not more than eight weeks" time limit for hearing appeals of mental health detentions for the purpose of providing treatment been held to breach 5 (4). He distinguished *E v Norway*[37] noting that in that case the patient was not psychotic at

35 s. 75(1)(a) MHA

36 Rule 29(cc)(i) MHRT Rules

37 [1994] 17 EHRR 30

the relevant time, he was not being detained in hospital for treatment as a mental patient but in prison under preventative measures, and his detention was imposed in response to a criminal offence and not for his own protection or safety under the mental health legislation.

Leave to appeal was requested on the grounds that this was an issue of law which requires clarification in the public interest. Leave was refused because a clear judgement had been given.

Commentary

Little justified criticism can be made of the general approach taken by Scott Baker J to determining the issue before the Court. Taking account of the Strasbourg jurisprudence, as he was bound to do[38], he was right to consider whether the current practice in s.3 cases is in breach of Article 5 (4) in the context of the whole of the relevant scheme including the extent to which a person admitted under s. 3 is known to the psychiatric services and whether he has recently been assessed, the ability of the nearest relative to object to the admission, the purpose of detention under s. 3 and the time that is required to allow for the proper preparation of the hearing. In this regard the distinctions drawn by Scott Baker J between admissions under s. 3 and s. 2 are realistic and indeed reflect the guidance given in chapter 5 of the Mental Health Act Code of Practice. Importantly, it must be right that the patient detained under s. 3, having not only the benefit of a recent assessment (or of being known to the mental health services) and of the right of the nearest relative to object, but also the continuing duty of the RMO to consider whether the conditions for detention persist, does not require a review as speedily as a person detained under s. 2 without the equivalent safeguards.

Although it would have been useful, if, in giving judgment, Scott Baker J had referred to (and distinguished) the decisions of the European Court and Commission of Human Rights to which he had been referred by counsel for the applicant, he cannot otherwise be criticised for failing to do so. It is undoubtedly correct that in every case coming before the Court/Commission which has been concerned with detention under Article 5 (1) (e) and the speediness of review under Article 5 (4) the outcome has been determined according to the particular facts of the case and the relevant domestic scheme regulating the making of applications and which may or may not have provided other safeguards ensuring the continued lawfulness of the detention. None are on all fours with the instant case and, for the reasons given in the judgment, *E v Norway* is readily distinguished notwithstanding that the time period under consideration was also, as it happened it that case, 8 weeks. The most significant factor distinguishing *E v Norway* from the instant case is of course the fact that that *E* was not detained in a psychiatric institution for the purpose of treatment. The implications that follow from detention for the purpose for treatment did not arise.

In reaching the decision that he came to, Scott Baker J placed significant emphasis on the need to achieve balance between the right to a speedy review of detention and the importance of ensuring that the MHRT has the personnel, including representation, and all of the information it needs, including, if appropriate, independent reports, before it in order to make a just determination of the application. Although it might be, in certain cases, that the exercise of achieving a properly prepared Tribunal hearing is or could be completed in fewer than 8 weeks, it is difficult to criticise the decision and, taking all relevant factors in the round, in the opinion of this reviewer it is probably right. The emphasis on balance and the need to ensure that the MHRT does not make ill informed decisions on the wrong basis with potentially 'disastrous results' is in keeping with the

38 s. 2 Human Rights Act 1998

need to find a fair balance between the protection of individual rights and the interests of the community at large which is inherent in Convention jurisprudence. It is difficult to see how it could be argued that the current practice in s. 3 cases, in seeking to strike the right balance, produces such a delay as to destroy the essence of the Article 5 (4) right to a speedy review.

Of course it is not the case that those detained pursuant to s. 3 may never challenge the speediness of the review of their detention under Article 5 (4). In any such case in which there is a failure to list the hearing within 8 weeks and the delay is not insignificant it will be open to the detained patient to bring such a challenge and, in cases where the patient is subsequently discharged from detention by the MHRT at the delayed hearing, to claim damages[39]. The merits of any such challenge will be improved in cases where the delay is due to administrative failings. As Scott Baker J made clear, administrative failings may lead to a breach of the patient's Article 5 (4) rights. To this extent the judgment in the instant case is likely to be helpful to those bringing cases in the future in such circumstances.

Similarly, the Courts have yet to consider the position of the restricted patient whose application should (on the basis of the target hearing times set by the MHRT Secretariat) be heard within not 8 but 20 weeks of its making. There is of course a significant difference between 2 and 5 months and, although different considerations apply, it is arguable that 20 weeks does destroy the essence of the right to a speedy review and is not necessary to achieve the requisite balance between the individual's Article 5 (4) rights and the interests of the community. In the opinion of the reviewer it is unlikely that the State would successfully meet such a challenge simply on the basis of either the shortage of suitably qualified presidents[40] or the time needed by the Home Office to prepare its statement[41]. Scott Baker J has made it absolutely clear, if it was not already, that administrative convenience in this context is an irrelevance.

Postscript

Since this review went to print, the Applicant has successfully appealed to the Court of Appeal ([2001] EWCA Civ 1110). On the appeal it was submitted that the practice of listing all hearings 8 weeks from the date of the application was unlawful (rather than that a delay of eight weeks could not satisfy Article 5 (4)). The Court of Appeal accepted that there is a policy of listing hearings within eight weeks but that in practice hearings are listed 8 weeks from the date of the application and not before. The Court held that the current practice is bred of administrative convenience and, there being no effort to see that the individual case is heard as soon as reasonably practicable, is thereby unlawful. In giving judgment Lord Phillips MR said that he well understood why Scott Baker J rejected the submission made in the court below that the 'lead time' in s. 3 cases should be no longer than in a s.2 case.

39 *For example, an action for breach of the detained patient's Article 5 (4) rights post 2nd October 2000 may be brought under s. 7 HRA '98.*

40 *Rule 8 (3) MHRT Rules states that 'the persons qualified to serve as president of the tribunal for the consideration of an application or reference relating to a restricted patient shall be restricted to those legal members who have been approved for that purpose by the Lord Chancellor'.*

41 *Rule 6 (2) MHRT Rules provides that the Secretary of State 'shall send to the tribunal, as soon as practicable, and in any case within 3 weeks of receipt by him of the authority's statement, a statement of such further information relevant to the application as may be available to him'.*

Proper Protection and Automatic Sentences: the mandatory life sentence reconsidered

Philip Plowden[1]

R v Offen, McGilliard, McKeown, Okwuegbunam, S [2000] 1 W.L.R. 253

Court of Appeal (9th November 2000). Lord Chief Justice (Lord Woolf), Steel LJ and Richards J.

Judgment of the Court given by the Lord Chief Justice.

Introduction

Section 2 Crime (Sentences) Act 1997 [now consolidated as s. 109 Powers of Criminal Courts (Sentencing) Act 2000] requires that a sentencing court must impose a sentence of life imprisonment upon a person convicted of a second "serious" offence unless exceptional circumstances apply. While the second "trigger" offence must have arisen since the coming into force of the provision, the first "serious" offence can have taken place at any time.

In previous cases, the Court of Appeal has taken a restrictive approach to the meaning of "exceptional circumstances". *Offen* - and the four other linked appeals - represents a successful attempt to persuade the court that this earlier restrictive reading of the section can no longer be sustained in the light of the implementation of the Human Rights Act 1998. It is a decision with clear implications for the sentencing of mentally disordered offenders who fall foul of this provision.

The Facts

The facts of the five cases on appeal are instructive, indicating the range of different circumstances capable of falling within the mandatory life sentence provision. It will be noted that two of the five cases involve forms of mental disorder.

Offen

In 1999 Offen pleaded guilty to a charge of robbery using an imitation of firearm. He had previously been sentenced to 30 months imprisonment in 1990 for a virtually identical offence of robbery. In both cases Offen had entered a building society with a toy gun and demanded money. As he left the building society following the 1999 robbery, Offen was followed by a female customer who grabbed the holdall containing the money from him. Offen continued walking away in his slippers. He later told friends what he had done, and the friends rang the police. In interview

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Offen explained that he had not been taking his medication and that he had heard voices that had made him do it. The sentencing judge accepted the medical reports indicating a diagnosis of schizophrenia, but confirming that the defendant was not a danger to society. The judge took the view that there were no exceptional circumstances so that he was bound to impose a life sentence under s.2. Later that year the sentence was upheld by the Court of Appeal[2]. The matter was subsequently referred back to the Court by the Criminal Cases Review Commission[3].

McKeown

McKeown was convicted of causing grievous bodily harm with intent (contrary to s.18 Offences Against the Person Act 1861) in May 2000. In May 1990 he had been sentenced to two years detention in a Young Offenders Institution for an offence of wounding with intent (contrary to the same provision). The facts of the first offence were largely obscure save that it arose during the 1989/1990 New Year period. There had been no offending since 1991 until the 2000 offence. This offence arose from an earlier disagreement between McKeown and another man. McKeown later approached the man and demanded an apology, which was not forthcoming. McKeown then punched the man to the ground and kicked him once. The victim sustained fractures of the nose, cheekbone and head. The judge imposed a life sentence, with a determinate sentence of three years.

McGilliard

In December 1998 McGilliard was drunk and abusive in a pub and swore at a Mr Taylor who remonstrated with him. Mr Taylor then assaulted McGilliard. The next day McGilliard returned and stabbed Taylor in the stomach with a kitchen knife with an 8 inch blade. McGilliard pleaded guilty to wounding with intent (contrary to s.18 Offences Against the Person Act 1861). He had previously been convicted of culpable homicide in 1984, and had been sentenced to six years imprisonment, although the facts of that case were not known to the court.

McGilliard was described in a psychiatric report as suffering from a Serious Alcoholic Dependency Syndrome and had taken heroin on the day in question. The report indicated that no medical disposal was appropriate. The pre sentence report and antecedents indicated a large number of repeat offences of violence, dishonesty and drugs related crime. McGilliard was assessed as being at a high risk of offending. The judge imposed the mandatory life sentence, with a determinate element of seven years.

Okwuegbunam

Okwuegbunam pleaded guilty to a charge of manslaughter. He admitted assaulting the mother of his children (with whom he did not live), allegedly in response to her having chastised their son. None of the blows were hard, but they caused a subdural haemorrhage which killed the deceased when Okwuegbunam forced her to take a cold bath the next day.

Okwuegbunam had a conviction for rape dating from 1990. The facts were in dispute, with the prosecution alleging that the rape had involved the abduction of a 13 year old girl and threats with a piece of broken glass. The defence alleged that the girl knew the defendant and that no kind of weapon was used. Since then the defendant had been convicted of three offences, involving

2 *[2000] 1 Cr. App. R. (S.) 565*

3 *Under s.9(1)(b) Criminal Appeal Act 1995*

criminal damage and dishonesty - for which he received a conditional discharge and fine respectively. There were no reports before the sentencing judge since the defendant had declined to co-operate, and the judge made no finding as to future risk since he took the view that no exceptional circumstances arose. A notional determinate sentence of six years was indicated, and a life sentence imposed under s.2.

S

In March 2000 S was convicted of 15 offences of indecent assault, attempted rape, rape and buggery - and one offence of actual bodily harm - all in respect of his two daughters. He had a large number of previous convictions, including various assault matters. In November 1993 he had been convicted of a s.18 offence (causing grievous bodily harm with intent), following an unprovoked assault on the victim with a pool cue at a pub. The trial judge took the view that exceptional circumstances existed, since the 2000 offences were of a wholly different character to the earlier offence of violence, and instead imposed a custodial sentence totalling 12 years. The Attorney General referred the matter to the Court of Appeal as an unduly lenient sentence[4], arguing that a mandatory life sentence should have been imposed.

The Law

s.2 Crime (Sentencing) Act 1997 provides:

(1) This section applies where–

(a) a person is convicted of a serious offence committed after the commencement of this section; and

(b) at the time when that offence was committed, he was 18 or over and had been convicted in any part of the United Kingdom of another serious offence.

(2) The court shall impose a life sentence, that is to say–

(a) where the person is 21 or over, a sentence of imprisonment for life;

(b) where he is under 21, a sentence of custody for life under section 8(2) of the Criminal Justice Act 1982 ('the 1982 Act'),

unless the court is of the opinion that there are exceptional circumstances relating to either of the offences or to the offender which justify its not doing so.

Sub-section 2(5) sets out which offences are "serious offences" for the purpose of s.2. These include: attempted murder; conspiracy to murder or incitement to murder; soliciting murder; manslaughter; wounding or causing grievous bodily harm with intent; rape or attempted rape; sexual intercourse with a girl under 13; an offence under s.16, 17 or 18 of the Firearms Act 1968; and robbery where, at some time during the commission of the offence the offender had in his possession a firearm or imitation firearm within the meaning of the 1968 Act.

4 *Under s.36 Criminal Justice Act 1988.*

The Judgment

The leading authority on s.2 is *Kelly*[5], which provides that "exceptional" is to be given its dictionary meaning. It therefore applies to " a circumstance which is such as to form an exception, which is out of the ordinary course, or unusual, or special, or uncommon. To be exceptional a circumstance need not be unique, or unprecedented, or very rare; but it cannot be one that is regularly, or routinely, or normally encountered." This definition of "exceptional" is not criticised in any of the linked appeals before the court and is therefore adopted.

In *Kelly* and in *Buckland*[6] the court considered Parliament's intention in passing s.2 - namely, that "the public should receive proper protection from persistent violent or sex offenders. That means requiring the courts to impose an automatic indeterminate sentence, and releasing the offender if and only if it is safe to do so."[7] However, in *Kelly*, Lord Bingham had applied this rationale not to the question of whether there were exceptional circumstances, but to the issue of whether, once exceptional circumstances were established, those circumstances justified the imposition of a sentence other than the life sentence. This has in some cases "accentuated the difficulties" caused by s.2.

Buckland was a case which on its facts was very similar to *Offen*. In that case exceptional circumstances had been found, and the court had concluded that it was not necessary to impose a life sentence. It was seen as a presenting a slightly more flexible approach than *Kelly*.

Quite apart from Human Rights Act arguments, the rationale of s.2 was "highly relevant" in deciding whether exceptional circumstances existed.

> "The question of whether circumstances are appropriately regarded as exceptional must surely be influenced by the context in which the question is being asked. The policy and intention of Parliament was to protect the public against a person who had committed two serious offences. It therefore can be assumed the section was not intended to apply to someone in relation to whom it was established there would be no need for protection in the future. In other words, if the facts showed the statutory assumption was misplaced, then this, in the statutory context was not the normal situation and in consequence, for the purposes of the section, the position was exceptional."[8]

The effect of the Human Rights Act:

Arguments were raised that the s.2 provision was incompatible with Articles 3, 5, 7 and 8 of the European Convention on Human Rights (the Convention).

In relation to Article 7, it was argued that s.2 amounted to a form of retrospective punishment in that it imposed a heavier penalty than the one that was applicable at the time that the offence was committed. Section 2, it was argued, offended against this provision both because it made the punishment for first offence (prior to the implementation of s.2) more serious since it could now lead to a life sentence following a second offence, and also because the life sentence should be seen as being imposed in respect of both serious offences, so that the actual penalty for the first offence was retrospectively increased. However, both elements of this argument relied upon treating the

5 *[2000] QB 198*

6 *[2000] 1 WLR 1262*

7 *White Paper: Protecting the Public, the Government's Strategy on Crime in England and Wales (1996), Cm 3190, paragraph 10.11.*

8 *Offen, paragraph 88.*

life sentence as imposed for both offences. In the light of cases such as *Taylor v United Kingdom*[9] this argument could not be sustained. It is the second, "trigger" offence which is changed by s.2; there is no retrospectivity.

The argument under Articles 3 and 5 is based on the premise that an automatic life sentence would operate in an arbitrary manner (offending against Article 5) and thus would amount to an inhuman or degrading punishment, contrary to Article 3. As s.2 has so far been interpreted, it can clearly operate in a disproportionate manner.

> "It is easy to find examples of situations where two offences could be committed which were categorised as serious by the section but where it would be wholly disproportionate to impose a life sentence to protect the public. …. A life sentence in such circumstances may well be arbitrary and disproportionate and contravene Article 5. It could also be a punishment which contravenes Article 3."[10]

However, if the court interprets the exceptional circumstances proviso "in a manner which accords with the policy of Parliament … the problem disappears."

Section 2 should be read as establishing a norm.

> "The norm is that those who commit two serious offences are a danger or risk to the public. If, in fact, taking into account all the circumstances relating to a particular offender, he does not create an unacceptable risk to the public; he is an exception to the norm."[11]

Whether there is a significant risk will depend on the evidence before the court. Factors such as the offences being of a different kind, or a long period between offending may be a "very relevant" indicator as to the degree of risk.

Section 2 will not offend against the Convention if it is read in this way, as is required by s.3 Human Rights Act and by taking into account the rationale of the provision.

Applying the revised test to the cases on appeal:

Offen: the evidence suggests that the appellant presents no significant risk to the public. Exceptional circumstances therefore exist, and a determinate sentence of three years imprisonment is substituted for the life sentence.

McKeown: there is no material to suggest that the appellant presents a significant risk to the public. Exceptional circumstances exist, and a determinate sentence of three years is substituted for the life sentence.

McGilliard: there is evidence that the appellant presents a serious and continuing danger to the public. His record, the circumstances of the instant offence, the pre-sentence and medical reports all indicate that there are no exceptional circumstances. A life sentence falls to be imposed under s.2.

Okwuegbunam: no finding as to dangerousness was made by the judge. The Court of Appeal has considered the appellant's antecedents and the circumstances of the second offence, in the absence of any reports. The appellant is given the benefit of the doubt as to his account of the circumstances of the first offence (rape) since it is not clear whether his account was accepted at the time. This is a borderline case, but the appellant constitutes a significant risk to the public, and no exceptional circumstances therefore exist.

9 *[1998] EHRLR 90: confiscation orders under the Drug Trafficking Offences Act 1986 - Article 7 argument manifestly ill-founded.*

10 *Offen, paragraph 107.*

11 *Ibid, paragraph 109.*

S: again, there was no finding by the judge as to dangerousness. However, the defendant's long history of offending, and the circumstances of the second offence, indicate that he poses a significant risk to the public. The Attorney General's reference succeeds and a life sentence is substituted, with a notional determinate sentence of 12 years.

Commentary

Mere statutory interpretation?

Although the point is curiously blurred in the judgment itself, *Offen* represents a substantial re-writing of s.2 in the light of Human Rights Act arguments.

Lord Woolf takes the line that the *Offen* interpretation of s.2 is required not merely by virtue of s.3 Human Rights Act (which requires courts to read legislation in a Convention compliant way if such a reading is "possible") but also since such a reading is required in order to give effect to the original intention of Parliament. Indeed, the re-reading is, in Lord Woolf's words, "quite apart from the impact of the Human Rights Act."[12] This approach echoes the approach taken by the Court of Appeal in other significant cases[13], where the court has promoted the line that it is business as usual following the Human Rights Act and that all that is required is to interpret the law as it would in any event have been interpreted under traditional domestic law principles[14]. Indeed one commentator has stated:

> "It appears that the Court would have adopted this interpretation quite independently of the Human Rights Act 1998, by the application of the traditional "mischief" rule of statutory interpretation. It did not need the Human Rights Act 1998 to reach this conclusion."[15]

But while it may not have "needed" the Human Rights Act to arrive at the conclusion, it is noticeable that the approach to s.2 taken by the Court of Appeal prior to the Human Rights Act, (including the decision of that court in Matthew Offen's first appellate hearing) suggests that it has taken the implementation of the Human Rights Act before the court was prepared to interpret the provision in a manner that took proper account of the circumstances of the offences - and indeed the offender.

Indeed, there is a strong argument that as a matter of pure statutory interpretation - without regard to the Convention issues - the approach taken by earlier courts in cases such as *Kelly* more accurately reflects the intention of the statute. It will be recalled that the White Paper speaks of "requiring the courts to impose an automatic indeterminate sentence, and releasing the offender if and only if it is safe to do so."[16] This needs to be compared with the central contention made in *Offen* - namely that "the section was not intended to apply to someone in relation to whom it was established there would be no need for protection in the future."[17] With respect to Lord Woolf, the

12 *Ibid, paragraph* 88.

13 *See for example,* R v Togher, *[2001] Crim.L.R. 124, paragraph 33.*

14 *For another example of this approach see* R v Central Criminal Court ex parte Guardian, Observer and Bright, *The Times, July 26, 2000where Judge LJ conducts a wide ranging review of domestic law with the apparent intention of showing that Strasbourg jurisprudence has little to add to existing domestic safeguards for civil liberties.*

15 *David Thomas, [2001] Criminal Law Review 63, 67.*

16 *Op cit.*

17 Offen, *paragraph* 88

18 *"[A] monstrous carbuncle on the face of English criminal jurisprudence.": David Thomas, Criminal Law Review, op cit.*

White Paper does not at first glance seem to create a mere presumption that a second time serious offender will be dangerous to the public - a presumption which can be rebutted if it can be shown to the court's satisfaction that no serious risk exists. Rather it seems to be a provision which "requires" the court to impose a life sentence, with the intention that public safety will then become an issue at the release point - rather than itself being the gateway issue that may or may not permit the life sentence. Indeed, given that many of the serious offences in s.2(5) carry potential life sentences in their own right, the purpose behind the provision was presumably the perceived disquiet at the failure of the courts to use their sentencing powers in a manner that protected the public, with the result that the provision was intended to remove judicial discretion except in specific exceptional circumstances.

Most commentators would take the view that the s.2 provision represents populist law making, by the then Government, which had both eyes firmly on the headlines in the popular press and a forthcoming election. Judicial and academic disquiet over the injustice to which the provision gave rise[18] certainly suggests that the decision in Offen is to be welcomed. However, Lord Woolf's statement that the new interpretation of the provision simply gives effect to the original Parliamentary intention may need to be treated with some scepticism.

The effect of Offen:

Offen applies the "serious risk of harm" test to the issue of whether exceptional circumstances exist which permit the court not to impose the life sentence. In the light of *Offen*, it is clear that where a court concludes that there is no serious risk to the public, that of itself will constitute exceptional circumstances, thereby enabling the court to impose a determinate sentence.[19] What then are the relevant factors for the court to take into account in arriving at its decision on risk?

In *Kelly* Lord Bingham rejected arguments that either youth at the time of the first offence or the differing nature of the offences were exceptional circumstances.[20] *Offen* indicates that the latter at least may be among the factors to which the court can legitimately have regard, not as exceptional circumstances in their own right, but in deciding whether there is a significant future risk - itself the primary exceptional circumstance. In looking for risk factors, it must be borne in mind that the fact that the defendant has been convicted of two serious offences gives rise to a presumption of future risk - or in Lord Woolf's words: "The norm is that those who commit two serious offences are a danger or risk to the public." It may be relevant that the two offences are of different kinds, but the court's decision in S's appeal shows that this is far from being determinative. Of far greater significance are any reports that are before the court, taken in conjunction with the defendant's general antecedents, including the lack of convictions between the two serious offences. Here it should be noted that Offen had only two theft matters dating from 1990 in addition to the two

19 *Interestingly, the courts have now had to address the obverse of this situation. In* R v Frost, *Times, January 5th, 2001, the court was faced with an offender who was felt to represent a high risk to the public. The trigger offence had been a serious assault using a hot iron. However, the first serious offence had taken place when Frost was 15 in 1991. He had received a supervision order, which the court concluded did amount to a conviction. However, it was pointed out on appeal that had Frost been 17, he would have received a probation order instead, and that (at that time) would not have been a conviction and hence would not have triggered s.2 ten years later. The court accepted the argument that this anomaly could not be justified "by any apparent or sensible … sentencing policy", and took the view that the anomaly therefore constituted exceptional circumstances, notwithstanding the serious risk, so that a life sentence could not properly be imposed.*

20 *Kelly, op cit.*

robberies in issue, and McKeown had not offended since 1991. In both cases there were reports indicating that risk to the public was low. In contrast, however, while Okwuegbunam had only minor convictions in between the first offence of rape and the later manslaughter, there were no reports before either court (Okwuegbunam having declined to co-operate with a pre sentence report). What effect this had on the court is not clear, since apart from indicating that the case was "close to the borderline" the court gives no indication of why they concluded that Okwuegbunam constituted a significant risk to the public. It will be recalled that the court accepted Okwuegbunam's assertion that the rape was not rape of a stranger, and that the manslaughter was of a family member; however, it is not clear whether these factors were of relevance in the risk assessment process. In the cases of S and of McGilliard, where both defendants had very substantial records for a variety of offences, including offences of violence, the court had no difficulty in concluding that the there was a significant risk, and no ground for finding any exceptional circumstances to merit the passing of a sentence other than the mandatory life sentence.

Obviously, the decisions in *Offen* make clear the importance of thorough risk assessment in the pre-sentence reports, and in any medical reports. However the court was faced with the difficulty that there was often no information as to the circumstances of the first offence. In McGilliard's case there was no information about the circumstances of the earlier culpable homicide. In Okwuegbunam's the court was again faced with a lack of information about the basis for sentencing on the rape. In McKeown the court knew nothing of the first assault offence. Where the court is taking upon itself the risk assessment in respect of future offending, it is hard to see how the court is going to be equipped to decide whether the statutory "norm" (two serious offences indicates a likelihood of future serious risk) is justified where it only has the circumstances of one of the relevant offences before it. Nor is it clear whether any administrative steps are now to be taken to ensure that information is kept on all "first" serious offences so that this can then be made available to any subsequent court in dealing with a second such offence.

Offen and mentally disordered offenders

Prior to *Offen*, the position of mentally disordered offenders and s.2 had been confirmed by the Court of Appeal in *Newman*.[21] In 1999 Newman pleaded guilty to manslaughter on the basis of diminished responsibility, having killed his grandmother and violated her body while suffering from a paranoid psychotic illness. Newman had a criminal record dating back to 1987, and had been made subject to a hospital order in 1991 for shoplifting, and again in 1992 for a number of offences of violence, arising from a serious knife attack on a stranger on a train. The 1992 convictions included a charge of causing grievous bodily harm with intent, so that at the sentencing hearing for the 1999 manslaughter offence, the issue of s.2 arose.

Reports before the judge indicated that Newman's condition was treatable, and recommended a hospital order and a restriction order under sections 37 and 41 of the Mental Health Act 1983. Indeed certificates authorising Newman's admission to Rampton High Security Hospital were before the judge. The judge indicated that he accepted that Newman was "plainly" mentally ill. However, the judge took the view that mental illness could not be an exceptional circumstance for the purposes of s.2.

21 *[2000] 2 Cr. App. R. (S.) 227.*

The Court of Appeal agreed. Section 37(1) Mental Health Act 1983 had been amended to take account of the 1997 Act to permit the making of a hospital order but not where:

> *an offence the sentence for which is fixed by law or falls to be imposed under section 2(2) of the Crime (Sentences) Act 1997 ….*

Additionally, while section 37(1)(A) of the 1983 Act permits the making of a hospital order rather than the mandatory sentences imposed under sections 3 or 4 of the 1997 Act (in respect of repeat burglars and drug dealers), s.2 is conspicuously omitted. Finally, s.45A(1) of the 1983 Act provides that it will not apply where the offence "*is one the sentence for which falls under section 2*" of the 1997 Act. The court in *Newman* went on to state:

> "It is not suggested that there is here any exceptional circumstance other than mental illness. That alone will not avail the appellant. We must dismiss the appeal. It is a matter for concern that a defendant so obviously and acutely suffering from mental illness should be ordered to prison and not to hospital. Even though, in practical terms, the difference between the two orders may lie less in the mode of treatment after sentence than in the procedure governing release and recall, we regret our inability to make what seems on the medical evidence the more appropriate order."

There is nothing in *Offen* that changes the propositions put forward in *Newman*. Of itself, mental disorder will not therefore constitute an exceptional circumstance. However, the re-reading of the "exceptional circumstances" test so that lack of risk will constitute an exceptional circumstance has clear implications for those mentally disordered offenders, such as Matthew Offen himself, who are able to show that they pose no future risk to the public. But offenders who do present a future risk - such as Dean Newman - remain excluded from the Mental Health Act sentencing regime, and will be subject to life sentences under s.2[22]. Given that the rationale of s.2, both as stated by the White Paper and as re-interpreted by the court in *Offen*, remains the imprisonment of offenders only for so long as public safety requires that course, such offenders will need to be kept under assessment. Moreover, in the case of those offenders who would otherwise be subject to hospital orders, it is likely that any failure to provide a similar standard of support and treatment would amount to a breach of Article 3 of the Convention. In this regard, practitioners will note the recent decision of the Strasbourg court in *Keenan v United Kingdom*[23], where a breach of Article 3 was held to have occurred in respect of Mark Keenan, a mentally ill prison inmate who committed suicide having been punished for an assault on prison hospital staff which he alleged arose from a change in his medication:

> "The lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him in those circumstances of a serious disciplinary punishment – seven days' segregation in the punishment block and an additional 28 days to his sentence imposed two weeks after the event and only nine days before his expected date of release – which may well have threatened his physical and moral resistance, is not compatible with the standard of treatment required in respect of a mentally ill person. It must be regarded as constituting inhuman and degrading treatment and punishment within the meaning of Article 3 of the Convention."[24]

22 *Although subsequently of course such offenders may be transferred from prison to hospital in accordance with the provisions of sections 47 and 49 of the Mental Health Act 1983.*

23 *The Times 18th April 2001, Application no. 27229/95, Judgment 3rd April 2001*

24 *Ibid, paragraph 115.*

Conclusion

The decision in *Offen* is clearly to be welcomed. Mandatory sentences - as politicians are aware - play well with the press and the public, but inevitably give rise to injustice unless they can be applied according to the circumstances of the offence and offender. By re-reading s.2 Crime (Sentences) Act 1997 (now s.109 Powers of Criminal Courts (Sentencing) Act 2000) in such a way as to create a rebuttable presumption as to sentence, the court has created a greater scope for imposing sentences appropriate to the offence and the offender. Such a re-reading does, however, give rise to the question of whether the s.2 provision can be referred to as an automatic life sentence when in reality that sentence will only be imposed where the court considers that the defendant has failed to rebut the presumption that he will constitute a future risk[25]. Indeed, it may be queried whether the *Offen* test now brings the s.2 sentence into line with the considerations that will apply in any case where a life sentence falls to be considered. The impact of the provision on dangerous but mentally disordered offenders remains hard to justify, however, and it is to be hoped that the court will be asked to reconsider the decision in *Newman* in the light of the Human Rights Act in the near future.

25 *See for example* Close *(unreported, CA, 25th April 2001, Lawtel), where psychiatric evidence indicated that the defendant's behaviour had improved following an anger management course and that there was no personality order. The court concluded that there was no evidence of serious risk and quashed the life sentence under s.2 under the principles in Offen. Had a personality disorder been disclosed, it would presumably have been harder for Close to satisfy the court that no risk arose, and consequently harder to displace the s.2 "norm".*