ISSN 1466-2817

Journal of Mental Health Law

NORTHUMBRIA LAW • PRESS

May 2008 pages 1–127

Contents

Page

Continued overleaf

Book Reviews

Foreword

As readers will be only too aware, the 3rd November 2008 will see the coming into effect of most of the amendments made by the *Mental Health Act 2007* to the *Mental Health Act 1983*[1]. It is also the date on which the Mental Health Review Tribunal becomes one of the new First-tier tribunals[2] within the Health, Education and Social Care Chamber consequent to the provisions of the *Tribunals, Courts and Enforcement Act 2007*. With the publication of numerous regulations and lengthy Codes, the implementation of the Deprivation of Liberty (formerly a/k Bournewood) safeguards still scheduled to take effect in April 2009[3], and the *Mental Capacity Act 2005* having not yet been in force for even a year[4], these are very demanding (and interesting) times for all those working in the field covered by mental health law, be it, for example, as practitioners attempting to get to grips with the new legal provisions; lawyers seeking to advise and assist clients, sometimes against a background of some uncertainty; trainers attempting to convey the extent of the changes without alienating their audience by the sheer volume of material; or MHA administrators seeking to devise appropriate procedures. There is so much to be considered and written about[5], but of course potential authors (particularly at this time) have many other pressing demands made of them, in addition to any requests editors of academic journals may make. Fortunately some have found the time to write for this issue of the JMHL. As ever, we are very grateful to them for their generosity.

In the November 2007 issue Kris Gledhill, a barrister now lecturing in the Law School at the University of Auckland, New Zealand, critically analysed 'Community Treatment Orders'[6]. Mat Kinton, Senior Policy Analyst at the Mental Health Act Commission, has helpfully taken matters further, and provided a detailed look at the detailed provisions contained within ss. 17A to 17G of the amended MHA 1983, which should help '**Towards an Understanding of Supervised Community Treatment**'. I do hope that in future issues the JMHL will carry reports indicating the extent to which use is made of CTOs. Will they prove to be as damp a squib as the soon-to-be-abandoned After-care under Supervision has proved to be, or will they be utilised as much as in some other jurisdictions[7]?

Anselm Eldergill, a former Visiting Professor in Mental Health Law at Northumbria University's law school, turns his (and our) attention to the Republic of Ireland. In '**The Best is the Enemy of the Good: the Mental Health Act 2001**', he carefully analyses some of the provisions of the Republic's 2001 Act, a consideration of other provisions being promised in Part 2 of his article, to be published in the next issue. As regular readers will know, the JMHL's Editorial Board is very keen to publish articles about other jurisdictions, and these two articles about Ireland are of course most welcome.

In previous issues of the JMHL, the plight of offenders with mental health problems has perhaps not received the attention it warrants. We make some amends within this issue. In '**Proposed reforms to Partial Defences and their Implications for Mentally Disordered Defendants**', Dr. Andy Bickle, Specialist Registrar in Forensic Psychiatry, provides a detailed consideration of the Law Commission's proposals for new definitions of provocation and diminished responsibility, and includes a discussion of their consequences for the provision of expert psychiatric opinion. In '**The Community Order and the Mental Health Treatment requirement**', Linda Seymour and colleagues from the Sainsbury Centre for Mental Health report on that organisation's ongoing research into the use made of such orders by the criminal courts.

1 *See www.dh.gov.uk .*

2 *The other two tribunals within the Chamber are to be the Care Standards Tribunal and the Special Educational Needs and Disability Tribunal (England). For more information about the proposed changes see www.tribunals.gov.uk .*

3 *See www.dh.gov.uk*

4 *The implementation date of the Act was 1st October 2007*

5 *E.g. the 'Guardianship and deprivation of liberty' debate, encouraged by a subsequently much-discussed article which was published in the November 2007 issue of the JMHL (pp 170 – 173) – 'Deprivations of Liberty: Mental Health Act or Mental Capacity Act?' by Richard Jones.*

6 *'Community Treatment Orders' Gledhill (2007) JMHL November pp 149 - 169*

7 *For some idea of CTO statistics elsewhere, see f/n 103 of Gledhill, op.cit.*

In the past the JMHL has not published many accounts of research. This issue is somewhat of an exception. In addition to the article from the Sainsbury Centre, we have two further reports of investigative work. Dr. Bickle and forensic psychiatrist colleagues from Rampton High Security Hospital summarise an '**Audit of Statutory Urgent Treatment at a High Security Hospital**' (namely Rampton). The audit concentrates on the use made of section 62 MHA 1983. Mat Kinton and a Commissioner colleague, Bob Jones, invite us to consider '**A snap shot of long-term section 17 use in South West England**'. I am delighted that the JMHL has been invited to convey reports on these interesting pieces of innovative work, and I hope other researchers will submit articles to us for consideration for inclusion in future issues.

We are again well-served with case reports. They cover a wide range of issues:

- Peter Bartlett (Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law at Nottingham University) considers '**Capacity, Best Interests and Sex**', when reviewing Munby J's lengthy judgment in *MM v Local Authority X*[8], a case of interest and importance to all concerned with issues of 'capacity' and 'best interests'.
- Roger Pezzani and Stephen Simblet (both Barristers) find that '**Section 75(1) of the Mental Health Act 1983 is compliant with Article 5(4) of the European Convention on Human Rights… just**'. They review the Court of Appeal's decision in *R (Daniel Rayner) v Secretary of State for Justice*[9] about the statutory duty of the Secretary of State for Justice to refer the case of a recalled conditionally discharged patient to a Mental Health Review Tribunal.
- Neil Allen (Barrister and Teaching Fellow at Manchester University) analyses the Court of Appeal's decision in the important case of *Savage v South Essex Partnership NHS Foundation Trust*[10]. In '**Protecting the Suicidal Patient**', Mr. Allen concludes that: "If suicide prevention is to be a national priority, obliging mental health services to take reasonable steps to protect life in limited circumstances would surely be a positive, and not unduly onerous, judicial development." This highly significant case will be considered by the House of Lords later this year.
- In a third contribution to this issue, Dr. Bickle recognises that '**The Secretary of State for Justice has a duty to provide Offending Behaviour Programmes in prison – submissions to the contrary are lacking in realism!**' In the combined cases of *R (Walker) v Secretary of State for Justice* and *R (James) v Secretary of State for Justice*[11] the Court of Appeal considered the consequences of an insufficient number of offending behaviour programmes in prisons for indeterminately detained 'dangerous offenders'. Given the fact that "a significant proportion of those in line to participate in [such] programmes will suffer from a mental disorder" (to quote Dr. Bickle), I have no doubt that a review of this interesting case warrants inclusion in the JMHL.

We conclude with a number of book reviews. We consider '**Risks, Rights, Recovery**', the Twelfth Biennial Report (covering 2005 – 2007) of the Mental Health Act Commission; '**Mental Health Law**' by Professor Phil Fennell; '**Blackstone's Guide to the Mental Health Act 2007**' by Paul Bowen (Barrister); and two books by Professor Jacqueline Atkinson – '**Advance Directives in Mental Health: Theory, Practice and Ethics**' and '**Private and Public Protection: Civil Mental Health Legislation**'.

The last Foreword in the November 2007 issue ended with a statement that every effort would be made to adhere to the publication date of the next (this) issue of May 2008. Regrettably, despite our best efforts, that has not proved possible, and for this I do of course apologise. I hope however that readers will find the contents of this delayed issue to be interesting, informative and helpful. I would be delighted if it also inspired the submission of contributions for future issues.

John Horne

Editor

8 *[2007] EWHC 2003 (Fam)*
9 *[2008] EWCA Civ 176*
10 *[2007] EWCA Civ 1375*
11 *[2008] EWCA Civ 30*

Towards an Understanding of Supervised Community Treatment

Mat Kinton[1]

The reason of a thing is not be enquired after, till you are sure the thing itself be so. We commonly are at *what's the reason of it?* before we are sure of the thing.

John Selden, *Table Talk* (1689)[2]

Writing in the last issue of this journal, Kris Gledhill gave a broad account of the introduction of supervised community treatment (SCT) to the law of England and Wales as a result of the amending provisions of the *Mental Health Act 2007*[3]. Gledhill argued that the new SCT status, in which a patient is technically deemed not to be liable to be detained but *is* liable to recall to hospital, amounts to a less honest re-labelling of existing practice in using long-term s.17 leave of absence from detention in hospital, but left off his account with the observation that "it will come down to how the regime is operated in practice" on its implementation[4]. Some months after Gledhill was writing, we now have Codes of Practice for England and (in draft) Wales[5], a draft reference guide providing the Department of Health's interpretation of its legislation[6], and two very useful and detailed legal commentaries by Phil Fennell[7] and Paul Bowen[8]. Armed with these documents, it is possible to look in some more detail at how the new legal landscape might be negotiated by practitioners upon its full implementation in November 2008.

I intend here to look at two related areas: first, the actual powers that SCT provides to clinicians, especially in relation to the administration of treatment, and, second, the relationship of SCT with the other community powers of the Act, especially the power under s.17 to allow detained patients leave from hospital. Whether (mindful of the epigraph to this paper) such a focus will enable us to be "sure of the thing" that is SCT is perhaps doubtful, and we obviously cannot resolve the question of how (or indeed if) the SCT regime will be operated in practice across England and Wales, but it may help us to think

1 *Senior Policy Analyst, MHAC; Senior Researcher in Mental Health Law, UCLAN.*

2 *This epigraph was borrowed from chapter 5 of Andrew Scull's Decarceration (2nd Edition, 1984, New Jersey: Rutgers University Press).*

3 *Gledhill, K (2007) Community Treatment Orders. JMHL 16: 149-169, Nov 2007, p.169*

4 *Ibid.*

5 *Department of Health (2008) Mental Health Act 1983 Code of Practice, May 2008; Welsh Assembly Government (2007) Mental Health Act 1983 Code of Practice (consultation version), Nov 2007.*

6 *Department of Health (2008) Draft Reference Guide to the Mental Health Act 1983 as amended by the Mental Health Act 2007. Jan 2008.*

7 *Fennell, P (2008) Mental Health: The New Law. Bristol: Jordans. A review of this book is published elsewhere within this issue of the JMHL.*

8 *Bowen, P (2008) Blackstone's Guide to the Mental Health Act 2007, Oxford University Press. A review of this book is also published elsewhere within this issue of the JMHL.*

more clearly about the possibilities and prepare ourselves to untangle some of the knots established in the primary legislation. I will conclude with some comments on the potential numbers of patients involved and whether Scotland's experience of community treatment orders tells us anything about the likely implementation of powers in England and Wales.

The main provisions of supervised community treatment

Supervised community treatment might be thought of as a form of conditional discharge for unrestricted patients. Just as with conditional discharge, the patient ceases to be "liable to be detained" upon leaving hospital, but is subject to a power of recall. The following is a brief outline of the main components of SCT.

Criteria for initiating SCT

Only patients who are detained under s.3 or unrestricted part 3 hospital orders or transfer directions are eligible for SCT. To make a community treatment order (thus initiating SCT), the responsible clinician[9] and approved mental health practitioner (AMHP)[10] must agree that the statutory criteria are met. These criteria are, in summary, that the patient's mental disorder warrants treatment which is available; that it is necessary for the patient's health or safety or the safety of others that such treatment is given, but that it can be given outside hospital; and that it is necessary that the responsible clinician should be able to exercise a power of recall over the patient[11].

Conditions

It is a mandatory condition of SCT that the patient makes him or herself available for examination enabling renewals and second opinion visits[12]. The responsible clinician and AMHP also must agree at the point when SCT is initiated any further conditions to which the patient will be subject whilst the SCT is in force[13]. The Act gives a very broad discretion over the nature of those conditions[14]. Any condition (which may include, for example, attendance at an outpatient clinic or abstention from particular conduct) must meet the statutory criteria of being necessary *or* appropriate, either to ensure that the patient receives treatment, or to prevent harm to the patient's health or safety, or to protect other people[15]. Once the community treatment order has been made, the responsible clinician can amend or suspend the conditions without reference to the AMHP[16], although the revised Code suggests that "it would not be good practice to vary conditions which had recently been agreed with an AMHP, without discussion with that AMHP"[17].

The powers of recall and revocation

If the patient breaches a mandatory condition of SCT, the responsible clinician can (but does not have to) recall him or her to hospital. Otherwise, the responsible clinician can only recall a patient to hospital

9 *This is the revised Act's structural equivalent of a responsible medical officer. The holder will not necessarily be a doctor, but could also be a nurse, social worker, psychologist or occupational therapist.*

10 *This is the revised Act's structural equivalent of a approved social worker. The holder will not necessarily be a social worker, but could also be a nurse, psychologist or occupational therapist (but not a doctor).*

11 *For the exact wording of the criteria see MHA 1983 as amended by the MHA 2007, s.17A(5).*

12 *MHA 1983 as amended by the MHA 2007, s.17B(3).*

13 *Ibid., s.17B(2).*

14 *See Fennell, P (2008) Mental Health: The New Law , p.212.*

15 *MHA 1983 as amended by the MHA 2007, s.17B(2).*

16 *Ibid., s.17B(4),(5).*

17 *Revised Mental Health Act 1983 Code of Practice, para 25.41*

if the patient requires treatment in hospital and there would be a risk to the health or safety of the patient or to other persons if the patient were not recalled for that purpose[18].

Upon recall, the patient can be held for up to 72 hours, by the end of which he or she would have to be released (returning to SCT status in the community) unless during that time SCT status is revoked. Technically patients do not regain the status of being "liable to be detained" (or even of being inpatients) whilst held for up to 72 hours following recall, but to all practical effects it is as if they were so liable: they cannot leave and may have treatment imposed upon them (see under '*Consent to treatment upon recall or revocation*' below). If the SCT is revoked, the patient's dormant liability for detention is revived, and he or she will be treated as still subject to the detention powers that he or she had been discharged from (although for the purposes of renewing that detention power, or for rights of application to the MHRT, the detention power is treated as though it had commenced afresh on the day that the SCT had been revoked)[19].

Consent to treatment in the community

The treatment of SCT patients who are in the community with psychiatric medication (or ECT) will be regulated by the new part 4A of the *Mental Health Act*. This provides a reduced scope for the imposition of treatment than that available under part 4 in respect of patients detained in hospital. Most importantly, professionals cannot override the capable refusal of consent to treatment of a community patient who is over 16 years of age (or the refusal of a *Gillick* competent community patient of less than 16 years of age) under the scheme established at part 4A[20]. As such, the only way to impose medication upon an SCT patient who has capacity and refuses consent whilst in the community is to recall that patient to hospital. It will remain the case that patients who are detained in hospital and subject to part 4 powers can be given medication (but no longer ECT) despite their capable refusal of consent.[21]

In general terms, the revised Act allows treatment to be imposed upon any SCT patient who has not been recalled to hospital and who lacks capacity to give consent, provided that it is unnecessary to use force to administer it.[22] However, such force "as is a proportionate response to the patient's suffering harm, and the seriousness of that harm" may be used on an incapacitated patient where urgent treatment can be justified against criteria equivalent to those set out s.62 of the 1983 Act.[23]

A substantial difference between the two schemes of part 4 and part 4A is the role of advance directives and proxy decision-makers provided for incapacitated patients under the *Mental Capacity Act 2005* (i.e. donees, deputies and the Court of Protection). The scheme applicable under part 4A to SCT patients in the community allows that proxy decision-makers may consent or refuse to consent on behalf of an incapacitated community patient, and that valid advance directives must be respected as if they were a contemporaneous refusal of consent.[24] By contrast, a Second Opinion Appointed Doctor (SOAD) will, as now, be empowered under part 4 of the Act to certify that medication is appropriate and may be given to a patient detained in hospital, even in the face of a refusal of consent by a proxy-decision maker or through a valid advance directive, and proxy decision-makers may not consent on behalf of such a

18 *MHA 1983 as amended by the MHA 2007., s.17E(1).*

19 *MHA 1983 as amended by the MHA 2007, s.17G.*

20 *Ibid., s.64B and 64C (adults) and s.64E (children).*

21 *Ibid., s.58.*

22 *Ibid., s.64D*

23 *Ibid., s.64G. The criteria for treatment to be deemed immediately necessary are if (a) it is immediately necessary to save the patient's life; or (b) if it is immediately necessary to prevent serious deterioration of the patient's condition and is not irreversible; or (c) it is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or (d) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous (s.64G(5)).*

24 *Ibid., s.64C(2), 64D(6)*

patient[25]. The amended Act *does* allow that (1) a valid and applicable advance decision of refusal in respect of electro-convulsive therapy (ECT) must be respected, and (2) proxy decision-makers under the MCA can refuse (but not consent to) ECT on an incapacitated detained patient's behalf[26], *although* such advance decisions and proxy refusals may be overridden in any emergency where the treatment may save life or prevent a serious deterioration of the patient's condition.[27]

Any ECT treatment of SCT patients who have not been recalled to hospital must be certified by a SOAD, whether the patient consents to ECT or is incapable of consent. The treatment of any SCT patient with medication must, after a certain period, be similarly certified (again, whether the patient consents or is incapable of consent). This period is one month from the commencement of SCT in all cases, although, if the patient was placed upon SCT whilst still subject to the three month rule applicable to detained inpatients, and that three month period has longer than a month to run when they become an SCT patient, then no certificate will be required until the three month period has run its course.

Consent to treatment upon recall to hospital and revocation of SCT

Part 4A only applies to SCT patients when they are in the community. If an SCT patient is recalled to hospital, the powers of part 4 apply (albeit with certain modifications discussed below), even during the period prior to any revocation. The most important consequence of this is that a patient's capable refusal of consent can be overridden upon that patient's recall to hospital. Thus recall powers may be used simply as a short-term holding power allowing for the administration of medication without consent, even if the responsible clinician has no intention of revoking the patient's SCT status (although see under *The example of Scotland* below).

The consent to treatment rules regarding recall and revocation appear to be unnecessarily complex, and although the following is an attempt to explain them with some clarity, it is unavoidably hard work to comprehend them.

The revised Act states that a recalled SCT patient is subject to part 4 consent to treatment provisions[28], although s.62A makes certain special provisions that slightly alter the way in which part 4 works in their case. For example, s.62A(2) provides that a patient who is recalled from SCT (or has SCT status revoked) is treated "as if he had remained liable to be detained since the making of the community treatment order" for the purposes of determining the three-month period during which medication need not be certified under part 4[29]. The obvious (and clearly intended) effect of this provision is to ensure that the three-month period does not start afresh when an SCT patient is recalled to hospital. If, however, a patient is subject to his or her original three-month period when recalled to hospital from SCT, or when his or her SCT status is revoked, there is no requirement that treatment with medication be certified until *that* three-month period has expired, and consent of the patient "is not required" for such treatment given by or under the direction of the approved clinician who is in charge of it[30]. The same principle, with rather less justification, applies to any patient who is recalled within the first month of being discharged onto SCT: the one-month period where certification is not required follows the patient back to hospital, so that there is no need for certification of treatment whilst it runs its course[31].

25 *i.e. under MHA 1983 s.58(3)(b).*

26 *MHA 1983 as amended by the MHA 2007, s.58A(5)(c)(ii)*

27 *Ibid., s.62(1A)*

28 *Ibid., s.56(4)*

29 *For this 'three-month period' see MHA 1983 s.58(1)(b)*

30 *MHA 1983 as amended by the MHA 2007, s.63*

31 *ibid, s.62A(3)(b)*

Another consequence of sections 56(4) and 62A(2) appears to be that any certificate that had authorised treatment prior to the patient's discharge onto SCT regains technical validity upon his or her recall to hospital. It is not clear that this consequence was anticipated in the drafting of the Act: the Department of Health appears to have the role of the surprised women in this particular resurrection story[32]. In the only reference to this revival of old certificates that I have found in the official literature, the revised Code of Practice for England advises that

> *it is not good practice to use a certificate issued to a patient when detained and who has since been discharged onto SCT to authorise treatment if the patient is then recalled to hospital, even if the certificate remains technically valid.*[33]

In my view this statement correctly identifies as "not good practice" the fact that an authority for treatment dating back to when a patient was detained regains validity upon their recall from SCT. It might be argued, however, that the "not good" practice was evident in the legislation's drafting, and that it is a bit late now to try to make amends with advice upon its implementation. Nevertheless, it is obvious that any certification of a patient's consent to treatment (i.e. on what is now Form 38) should not be relied upon after the patient has been discharged from hospital onto SCT and then recalled under duress: it is likely that the consent so certified is no longer being given, and at the very least the consent should be reaffirmed by the treating clinician. Neither, in my view, should any certification that treatment in the absence of consent was appropriate before the patient was discharged onto SCT be taken as reliable authority that it is still appropriate after a patient has been so discharged and recalled. Firstly, this is because such a certificate may well be rather old by this time. Secondly, it is because a SOAD system that provides *any* protection for patients should certify only that which is appropriate given the patient's specific circumstances and the prognosis of the case at the time of the SOAD visit. In my view, discharge into the community and recall to hospital are significant events in a patient's treatment that should be taken into account when deciding what imposition of treatment is appropriate.

It may be questionable whether the Code of Practice has the legal authority to tell practitioners to disregard otherwise valid statutory forms authorising treatment, or indeed to require them to do so, on the basis of "good practice"[34]. But if the Code cannot protect patients against the revival of long-dormant certificates authorising treatment without consent, then it may be possible to encourage SOADs to provide such protection themselves by adding, as a condition to any certificate authorising such treatment whilst a patient is detained in hospital, that the certificate expires upon the patient's discharge onto SCT.

The revised Act also allows that a SOAD authorising treatment for an SCT patient in the community may, at the same time, authorise such treatment as he or she feels would be appropriate upon the patient's recall to hospital. Such a certificate (although technically made under part 4A), provides authority for the treatment to be given when the patient is recalled, even trumping any old part 4 authorities revived as a consequence of the recall[35]. The SOAD would have to expressly state on the part 4A certificate that it authorises the particular treatment upon recall to hospital, and will be empowered to also specify any conditions attached to such authority. The revised Code of Practice for England provides the banal-sounding advice that this power to specify future treatment upon recall should only be exercised where

32 *cf. Luke 24:1-4.*

33 *Revised Mental Health Act 1983 Code of Practice, para 24.81*

34 *On the question of "good practice" setting aside of valid legal forms generally, see Jones R (2006) Mental Health Act Manual, (2006) (10th ed) (Sweet & Maxwell), para 1-721 under the note to 'certified', where the current Code of Practice's guidance that Forms 38 should be considered to 'lapse' when there is a change in responsible medical officer, is disputed.*

35 *MHA 1983 as amended by the MHA 2007, s.62A(3) & (5).*

SOADs "believe they have sufficient information on which properly to make such a judgment"[36]. The Code is here treading lightly upon what may turn out to be very thin ice.

The draft revised Code was more explicit in stating how this power to authorise future treatment might be exercised, with its advice that "the SOAD can specify, if appropriate, that an antipsychotic can be given to the patient on recall without the patient's consent"[37]. For some reason this statement has been excised from the version of the Code that was placed before Parliament. It may be that the drafters of the Code realised that it raised difficult questions, such as what would be deemed "appropriate"? The domestic courts have already determined, in response to a challenge that the imposition of treatment to a refusing patient under the current provisions of the Act breached Articles 3 and 8 of the Convention, that to be "in accordance with law" such imposition must not only meet the criteria established within the Act itself, but must also be justifiable as being in the best interests of that patient in accordance with the common law test[38]. There are inherent difficulties in providing such justification in advance of the circumstances in which it might apply. On this basis, Lord Patel of Bradford, the chairman of the Mental Health Act Commission (MHAC), is on record as saying that "the MHAC will be likely to advise SOADs to be extremely cautious when considering whether or not to authorise treatments to be given in an unforeseeable situation at an unidentified point in the future."[39]

If the Code of Practice discourages reliance on old but revived certificates of authority left over from detention, and the MHAC discourages SOADs from advance certification when they see the patients in the community, where will the authority to treat SCT patients who are recalled to hospital come from? It seems most likely that clinicians will rely upon the "urgent treatment" provisions in the Act. Being subject to part 4 of the Act, recalled SCT patients may have treatment imposed upon them that meets the criteria for urgent treatment set out at s.62(1). A provision mirroring s.62(2) is also applicable to SCT patients on recall, allowing the continuance without certification of any treatment underway at the time of recall (but only pending a SOAD visit) if discontinuance is deemed to be likely to cause serious suffering to the patient concerned[40].

These are broad powers, but not without some problems. It is easy to imagine, for example, clinicians being reluctant to use either of these powers in preference to authority that might be claimed from a "technically valid" revived SOAD authority dating back to the patient's detention. Indeed, the lawful basis of doing so might be questioned. Furthermore, the draft Code may provide a disincentive to using s.62, by requiring the recording and monitoring of the justification for its use, with the clear implication that hospital managers should be on guard against excessive usage[41]. Clinicians may also struggle with the expectation that the use of urgent treatment powers should trigger a SOAD visit (or in the case of s.62A(4), that such use is only valid whilst such a visit is being arranged – "pending compliance with s.58"[42]). If the clinician's intention is simply to pull a patient into hospital to administer a depot injection of antipsychotic drugs, it may also be intended that the patient is returned to the community long before any such visit might be arranged. In such cases, it may well be appropriate to arrange for a SOAD to visit the patient in the community, but such a visit would be for the purposes of part 4A rather than part 4. Could a patient challenge the use of s.62A(4) on the grounds that "compliance with section 58" was, in such circumstances, never realistically possible?

36 *Revised Mental Health Act 1983 Code of Practice, para 24.30.*

37 *Department of Health (2007) Draft Mental Health Act 1983 Code of Practice, Oct 2007, para 26.7*

38 *R (on the application of PS) v (1) Dr G and (2) Dr W [2003] EWHC 2335 (Admin)*

39 *Hansard (Lords) 26 Feb 2007, Col 1451*

40 *MHA 1983 as amended by the MHA 2007, s.62A(4)*

41 *Revised Mental Health Act 1983 Code of Practice, para 24.37.*

42 *Ibid., para 24.31*

These thickets of consent to treatment provisions may discourage practitioners from exploring the statutory landscape of SCT, perhaps especially because of the relative simplicity of the law relating to consent to treatment for patients given long-term s.17 leave, where part 4 certificates simply follow the patient out into the community. With this in mind, we now turn to the relationship between SCT and existing community powers.

The relationship of SCT with other community powers

Prior to the 2007 Act amendments, the *Mental Health Act 1983* already contained a number of potentially coercive powers over patients in the community, notably: leave of absence (s.17); supervised discharge (s.25A-J); guardianship (ss.7 or 37); and, in the case of restricted patients, conditional discharge (ss.42,73).

Conditional Discharge

The introduction of SCT has no effect on the provisions of conditional discharge. SCT and conditional discharge provide essentially the same power over patients (i.e. discharge from liability to detention with a fast-track power of recall), and the choice between the two regimes is simply determined by whether or not the patient concerned has a restricted status. Only unrestricted patients are eligible for SCT, and only restricted patients can be conditionally discharged.

Guardianship

There is a less clear-cut division between patients for whom SCT or guardianship might be considered. An important and very real distinction between the two regimes is that a patient must be detained under s.3 or its part 3 equivalents to be eligible for SCT, but there is no comparable threshold for imposing guardianship[43] (although it is the case that a patient who is detained in hospital under the 1983 Act can be transferred to guardianship with minimum formality[44]). Government guidance in the revised Code of Practice for England would seek to make a further distinction: that SCT is intended as a power enabling quick recall to hospital for treatment, whereas guardianship is a community power intended to focus on "patient's general welfare, rather than specifically on medical treatment"[45]. There is clearly a role for guardianship in protecting patients from exploitation and neglect, but the Department's distinction is far from self-evident. Guardianship also can provide a route to detention under s.3 of the Act and subsequent treatment powers should these be required[46], and has been used to encourage if not enforce treatment compliance[47]. Indeed, in previous debates about community treatment powers, the MHAC has suggested that guardianship provisions could address the needs of the majority of the patient groups targeted[48]. The Code further suggests that the choice between SCT and guardianship may rest on whether the primary agency responsible for the patient's care package is characterised as health or social services (with guardianship being the preserve of the latter)[49]. Such a distinction may seem anachronistic to combined services.

43 *The criteria for guardianship, as amended by the 2007 Act, will be that the patient is suffering from mental disorder of a nature or degree which makes it appropriate; and it is necessary in the interests of the welfare of the patient or for the protection of other persons (s.7(2)).*

44 *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 7.*

45 *Revised Mental Health Act 1983 Code of Practice, para 28.6.*

46 *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 8(3).*

47 *See Jones R (2006) op cit, para 1-086.*

48 *Ibid., para 1-280*

49 *Revised Mental Health Act 1983 Code of Practice, para 28.3*

Guardianship is used patchily[50]. It is unfortunate that certain patients with learning disability are still to be excluded from guardianship provisions (as they are excluded from detention and will be excluded from SCT) unless they exhibit abnormally aggressive or seriously irresponsible conduct[51]. Guardianship will therefore probably continue to be used mostly as a framework for arranging the care of people with mental illnesses, predominantly the elderly. It seems likely that those few services who have had cause to discharge patients from detention under the Act into guardianship (an arrangement that probably accounts for only a small proportion of guardianship cases) will find reasons to continue to do so in similar circumstances.

Supervised Discharge

The implementation of SCT powers will coincide with the repeal of supervised discharge ("aftercare under supervision"), which was inserted into the 1983 Act's framework by the previous administration[52]. About 600 patients are made subject to supervised discharge every year, although no statistics are available on the total number of patients so subject at any one time[53]. The transitional mechanism for the introduction of the new powers will allow that patients subject to supervised discharge upon its demise *could* be transferred to SCT status, although there will be no automatic transfer and such patients who meet other criteria (i.e. for guardianship, detention in hospital or absolute discharge) may be dealt with accordingly[54].

Leave of Absence

The relationship between SCT and leave of absence is more complex. Gledhill has described how the courts have gradually allowed s.17 leave to be extended in duration so that it now provides authority for long-term community treatment[55]. The revised Act now includes a definition of such "longer-term leave", which is deemed to be any leave under s.17 that is either authorised without specified limit of time, or is authorised (whether in the initial authorisation of leave or in subsequent extensions of the period initially granted) for a specified limit of time that exceeds seven consecutive days[56]. It will be a requirement of s.17(2A) that longer-term leave of absence under s.17 may not be granted to a patient unless the responsible clinician "first considers" whether the patient should be dealt with under supervised community treatment instead[57]. It seems likely that the policy intention behind this is to ensure that practitioners do not use longer-term leave when SCT might otherwise be applied, and thus anticipates resistance from practitioners to the new SCT powers. Whether the statutory construction achieves that intention is open to question.

---

50 *See Information Centre (2007) Guardianship under the Mental Health Act 1983, England 2007, p.3: 16 (12%) of 133 local authorities accounted for 402 (44%) out of 926 guardianship cases open at March 31 2007. Similar proportions are reported in previous years.*

51 *MHA 1983 as amended by the MHA 2007, s.1(2A) and 1(2B). See Bartlett P & Sandland R (2007) Mental Health Law Policy and Practice, third edition, p. 489-490 on the exclusion of LD patients from guardianship.*

52 *MHA 1983 as amended by the Mental Health (Patients in the Community) Act 1995, s.25A – 25J (repealed under the Mental Health Act 2007 from November 2008)*

53 *Department of Health (2007a) Mental Health Act 2007 Secondary Legislation Consultation, p. 167. See Information Centre (2007) In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, NHS Trusts, Care Trusts, Primary Care Trusts and Independent Hospitals, England; 1995-96 to 2005-06, table 7, p.21 for data.*

54 *See Mental Health Act 2007 (Commencement No.6 and After-care under Supervision: Savings, Modifications and Transitional Provisions) Order 2008 (No. 1210).*

55 *Gledhill, K (2007) op cit.*

56 *MHA 1983 as amended by the MHA 2007, s.17(2B)*

57 *The Revised Mental Health Act 1983 Code of Practice restates this requirement, keeping carefully to the language used in the Act itself, at para 21.9.*

Indeed, there is a whiff of absurdity in this provision of the law, in that it appears at first sight to be very prescriptive and yet, as if by some failure of nerve, its actual requirement remains rather vague. What does it mean, after all, to "consider" something? From one point of view, "consider" is an ordinary word of the English language and nothing may be inferred from it beyond its ordinary use[58]. As such, the legal requirement upon responsible clinicians when they are minded to let a detained patient leave hospital for more than seven days without granting an absolute discharge may be viewed as nothing more than that they contemplate mentally and weigh the merits of using either s.17 leave or SCT[59].

However, it has been argued by Bowen that SCT provides better patient safeguards and raises fewer human rights implications than longer-term s.17 leave[60]. If this is correct, then the mental scales upon which a responsible clinician is required to weigh the merits of either regime should tip strongly in favour of SCT.

Bowen's contention is echoed, at least in part, by the Code of Practice, which describes SCT as "a more structured system than leave of absence" with "more safeguards for patients"[61]. The Code, as a document drafted by officials of the Department of Health, understandably is rather coy in pointing out the lack that is highlighted in s.17 by the requirements and procedures of SCT. Not so Mr Bowen. He suggests the following contrasts between the two regimes:

1. That a responsible clinician and AMHP must be satisfied that the criteria for SCT are met, whereas the decision to grant long-term s.17 leave is taken by the responsible clinician alone, without any applicable criteria at all[62].
2. SCT is subject to provisions for expiry, renewal and discharge, and the patient has the right to apply to the MHRT to be discharged, "whereas s.17 contains no such safeguards beyond those that apply to the underlying application for admission for treatment"[63].
3. The criteria for recall "are more stringent (if not by a significant degree) than those that apply to s.17 leave"[64].
4. SCT patients are, whilst in the community, treated under the new consent to treatment provisions of part 4A, which do not permit the compulsory treatment of a competent patient, whereas patients on s.17 leave are subject to the provisions of part 4, which do permit the overriding of a competent refusal of consent and forcible treatment.[65]

Further to this, Bowen suggests that SCT is "probably less likely" to violate the European Convention on Human Rights (ECHR) than does the long-term use of s.17, for the following reasons:

5. The lack of criteria and procedure noted at (1) above result in s.17 powers that are "arguably" too vague to meet the requirement that any interference with rights protected by Article 8 (private and family life) be "in accordance with the law"[66]; and

58 *A version of this argument was suggested from the floor by Richard Jones at the Cardiff University Law School conference ('the Mental Health Act 2007') of the 15 February 2008.*

59 *See Concise Oxford Dictionary: "Consider v.t.: contemplate mentally; weigh merits of (course of action…etc)…"*

60 *Bowen, P (2008) op cit., paras 5.09-11, 5.89-93*

61 *Revised Mental Health Act 1983 Code of Practice, para 28.5.*

62 *Bowen, P (2008) op cit, para 5.10*

63 *Ibid.*

64 *Ibid. The criteria for recall from s.17 are that this is necessary for the patient's health or safety or for the protection of other persons: see MHA s.17(4).*

65 *Ibid.*

66 *Ibid., para 5.90*

6. The lack of stringent criteria for recall to hospital from s.17 noted at (3) above potentially allows for recall where the *Winterwerp* criteria (justifying detention upon the basis of up to date medical evidence of unsoundness of mind) are not met[67].

Some of these complaints against s.17 leave appear to have a rather speculative basis: and Bowen acknowledges as much in relation to the "human rights implications"[68] listed at points 5 and 6. An implication is not a violation, and even such a skilful and tenacious advocate[69] as Mr Bowen might run into difficulties in arguing, as he appears to do at points 3 and 6, that legal consequences arise from an *insignificant* difference in the degree of stringency between two sets of criteria. It would seem to me self-evident that, if the criteria are essentially the same, they must either stand or fall together. Similarly, it is not clear to me what practical consequences emerge from the fact, set out at point 2, that the expiry, renewal and discharge mechanisms for s.17 patients are those that apply to the underlying application for admission for treatment, whereas such mechanisms for SCT patients are contained within the provisions of the Act that establish SCT and its administration. It may be that there is a significant difference of entitlement between the practical effects of such mechanisms, but if so I have not seen it. It is also unclear how the relatively broad discretion given to a responsible clinician to grant s.17 leave (point 1) fails any specific requirement of law, given that the patient given leave under these circumstances must still meet the criteria to remain liable to be detained, and that renewal of such liability will require the agreement of another professional to the responsible clinician.

This leaves the differences in consent to treatment provisions between the two regimes raised at Bowen's point 4. Some of these differences are undeniably significant: in particular the ability to enforce treatment, at least in principle, on a capably refusing s.17 leave patient whilst that patient remains in the community, which is not replicated in SCT provisions. Faced with this difference, alongside the SCT regime's complex arrangements for additional SOAD visits and the Code of Practice's explicit statement that SCT has more safeguards for patients, a court (or for that matter an MHRT panel) might be easily persuaded that a patient subject to long-term s.17 leave who appears otherwise eligible for SCT is getting a raw deal.

As such, it is quite possible that the contention that SCT has better patient safeguards than s.17 could have some influence over responsible clinicians' choice between the two regimes. But if the gravitational pull of SCT is thus increased, so might be the resistance to it by responsible clinicians who perceive it as bureaucratic or as a curtailment of their power. Such clinicians may find some assistance in the chapter of the Code of Practice dealing with the choice between community powers.

In the Mental Health Bill debates, the Secretary of State for Health (Patricia Hewitt) stated that SCT was

> *"designed particularly for the so-called "revolving door patients"—people who are hospitalised, whether under compulsion or voluntarily, who respond to treatment, who are released, and who then fail to maintain their treatment, producing another crisis and yet another hospitalisation."*[70]

The revised Code of Practice for England, at chapter 28, suggests some "pointers" for clinicians deciding between leave of absence and SCT, including a table essentially similar[71] to that reproduced at Table 1. In this schema, patients for whom community arrangements are likely to break down, and who are likely

67 *Ibid., para 5.91*

68 *Ibid., paras 5.89 – 91.*

69 *Ibid, p.vii: the description is that of Sir James Munby (High Court Judge).*

70 *Hansard (Commons) 16 April 2007, Col 56.*

71 *Although I have slightly condensed the phrases and included two statements (shown in quotation marks) from the text of that chapter.*

to require future hospitalisation without consent, are deemed appropriate for longer-term s.17. Patients for whom the likelihood of community arrangements breaking down is serious but not high, and who are unlikely to require future hospitalisation without consent, are marked out for SCT. As such, the attributes of a "revolving door" patient (or any patient for whom there is deemed to be a risk of relapse) can as easily, if not more easily, be ascribed to the description of patients for whom the Code recommends longer-term s.17 leave than SCT. Whilst the Code is careful not to appear prescriptive in its guidance over which power to use, that guidance could be used as an excuse by clinicians who are reluctant to engage with the new powers.

Section 17 leave	**Supervised Community Treatment**
• Discharge from hospital for specific purpose or fixed period: "may be useful where the clinical team wishes to see how a patient copes outside hospital before making a decision to discharge".	• Confidence that patient is ready for discharge on more than a trial basis: "focus on ensuring patient continues to receive medical treatment without having to be detained again".
• Patient is likely to need further inpatient treatment without compliance or consent.	• Good reason to expect that patient will not need to be detained for the treatment they need.
• Risk of arrangements in the community breaking down or being unsatisfactory is high.	• Risk of arrangements in the community breaking down or patient needing to be recalled to hospital for treatment is sufficiently serious to justify SCT, but not so high that it is very likely to happen.

Table 1 – Pointers to the use of leave of absence or SCT, from the MHA Code of Practice (England), chapter 28

Estimating the likely implementation of SCT

The above discussion has not established any very solid ground upon which to base estimations of the likely impact of SCT. Indeed, such an estimate must range from anticipating almost no effect upon implementation (if practitioners ignore the new SCT powers, as they have largely ignored the powers of supervised discharge, and continue to use leave of absence powers as a community-based power) to expecting a significant shift in the means by which patients released from detention in hospital remain subject to compulsion under the Act (if practitioners largely abandon longer-term s.17 leave in favour of SCT, and/or use SCT as a standard discharge package for s.3 detainees). However, we can identify the pool of patients whose legal status (if not necessarily individual circumstance) makes them eligible for SCT, and we can look to the example of Scotland where community treatment orders, although not identical to SCT, have been in effect from October 2005.

The number of patients eligible for SCT in England and Wales

The *Count Me In* census recorded a population of 8,223 detained patients who were subject to s.3 (or a relevant part 3 order) in England[72], and 1,501 in Wales[73] on the 31 March 2006. As such we might assume a likely 'pool' of roughly 10,000 patients who will be broadly eligible for SCT upon its implementation in England and Wales. Counted over the course of a whole year, that pool may be almost four times larger. Section 3 powers were applied to 37,777 patients in England in the financial year 2006/07, and at least 470 patients were made subject to relevant part 3 sections[74]. Of course, not everyone who is detained under a relevant section of the Act will be a suitable patient to be discharged onto SCT, whether this is because their recovery is more complete than would justify continuing powers; or because they never become compliant with a care package; or for any number of other reasons. The Department of Health has estimated that 2% of such potentially eligible patients will be made subject to SCT in the first year of implementation, rising to 10% within 5 years[75]: this implies a starting population of 200 SCT patients, rising to approximately 4,000 initiations of SCT each year.

The example of Scotland

The number of people made subject to community treatment orders in Scotland has shown a steady rise from their introduction in October 2005[76]. In January 2006 there were 65 patients on community orders (about 4% of all patients subject to compulsory treatment orders overall), rising to 280 patients (18% of all patients on treatment orders) at the end of April 2007[77]. Statistics were not available to show the rate at which people are discharged from community orders, although in the financial year 2006/07, 90 orders *either* lapsed *or* were revoked, whereas 371 new orders were made[78].

There are significant differences between the Scottish legislation and that being introduced to England and Wales, which clearly limit the extent to which the Scottish experience can act as a model to predict the impact of SCT. Most notably, in Scotland the community order is free-standing and not necessarily a power of discharge from detention, although over half (197) of all new Scottish community orders in 2006/07 were effectively discharge from detention in hospital[79] (thus suggesting that community treatment orders upon discharge from hospital account for approximately 9% of all hospital and community orders made in the second year of implementation). This might suggest that the Department of Health has underestimated the rate of use for SCT.

There may be lessons from the Scottish experience in *how* SCT powers will be used. In particular, it may be instructive to look at how or why patients are recalled to hospital from community treatment orders in Scotland. The Scottish Act differs markedly from the SCT regime in that the former provides a specific power in relation to CTO patients who fail their requirement to attend places of treatment, so that such patients can be taken, conveyed and held for up to six hours at such places for the treatment to be

72 *http://www.healthcarecommission.org.uk/_db/_downloads/xtabEngland_mh.xls*

73 *http://www.healthcarecommission.org.uk/_db/_downloads/xtabWales_mh.xls*

74 *Information Centre (2007) op cit (n.52 above), table 4, p.7, table 1, p.15, & table 7, p.21.*

75 *Department of Health (2006) Mental Health Bill: Regulatory Impact Assessment. November 2006, p.55.*

76 *Mental Welfare Commission for Scotland (2007) Community Based Compulsory Treatment Orders under the Mental Health (Care and Treatment) (Scotland) Act 2003. www.mwcscot.org.uk*

77 *Ibid., page 3.*

78 *Mental Welfare Commission for Scotland (2008) Our overview of mental welfare in Scotland 2006-07, p.46.*

79 *Ibid.*

administered[80]. This is in addition to powers of recall which allow that a patient who has failed to comply with the requirements of any order may be retaken to hospital and detained there for up to 72 hours in the first instance[81], extendable to 28 days[82], if the responsible medical officer has tried to contact the patient, given the patient the chance to comply, and believes that it is reasonably likely that further non-compliance would lead to significant deterioration in the patient's mental health.

Table 2 shows the use of these powers as reported in Scotland. By the end of April 2007, only nine people were known to have been made subject to the six-hour holding power for enforced treatment (s.112), although one patient had been so subject four times, whereas 64 patients accounted for a total of 71 recalls to hospital under the initial 72-hour holding power (s.113), with 54 such recalls leading to a further 28-day detention (s.114)[83]. Nineteen further community patients were directly readmitted to hospital under emergency or short-term detention powers during this period[84].

Compulsory measure used	No. of occasions	No. of people	No. of people as % of all on community treatment orders
s.112 (six hour treatment power)	12	9	3
s.113 (recall for up to 72 hours)	71	64	23
s.114 (recall for up to 28 days)	54	50	18
s.36 (emergency detention – up to 72 hours)	3	3	1
s.44 (short-term detention – up to 28 days)	16	16	6

Table 2 – Recall of community patients in Scotland, 5 October 2005 to 26 April 2007

The apparently scarce use of the six-hour treatment power in Scotland (if it is not simply a reflection of failure to report its use to the Mental Welfare Commission) may indicate something quite significant about the use of community powers in general. Although specifically empowered to do so in Scotland, it appears that professionals may be reluctant to pull patients into hospital under compulsion solely for the purpose of administering medication by force. There is no direct equivalent of the six-hour treatment power in the amended Act for England and Wales, but it has been a long-standing assumption that patients who are made subject to the 72-hour recall power might be held only for so long as is required for the safe administration of medication without consent before being released back into the community, and in this sense the recall power encompasses the powers created separately in the Scottish legislation.

80 *Mental Health (Care and Treatment) (Scotland) Act 2003, s.112*

81 *Ibid., s.113*

82 *Ibid., s.114*

83 *Ibid, pages 4 – 5 (see table 2)*

84 *Ibid, page 5, table 2*

In particular, as we have seen, the consent to treatment provisions for recalled SCT patients explicitly provide that treatment powers should be available to clinicians immediately upon the patient's recall[85].

There is, no doubt, much that we have yet to understand about the patterns of CTO use in Scotland, but the rarity of use of the six-hour treatment power may suggest that the powers given over patients are being used with more caution, or just with more humanity, than many may have feared. It may be, for instance, that clinicians who decide to recall community patients to hospital view such action as being such a serious intervention, or as highlighting such a serious level of concern over a patient's ability to manage in the community, that to keep the patient for only so long as it takes to administer an injection does not seem to be an adequate response. In such cases, practitioners may choose to bring a patient in for assessment rather than a single forcible treatment. The power to recall for treatment over a maximum of six hours may also be regarded as too nakedly coercive by clinicians who are concerned to maintain a therapeutic relationship with their patients. Perhaps such relationships are less damaged by the softer coercion of persuasion (albeit persuasion against the option of remaining in hospital under detention following recall from SCT), and as such the powers to impose medication will not, after all, be at the centre of decisions to recall SCT patients to hospital. It is important to remember that, from a practical point of view, the continuation of SCT after a patient has been recalled will often rely on regaining that patient's compliance with treatment. A patient who continues to refuse to consent to or comply with treatment upon recall from SCT, even after that treatment is imposed by force, is unlikely to be considered fit to be discharged back into the community on SCT status.

There would be no small irony if the hard-won and controversial legal power to impose treatment upon a patient recalled from a community placement turns out, in practice, to much less of a great clunking fist than was feared by its detractors, or indeed implied by its supporters[86]. The power to recall, and to impose treatment upon recall, may turn out to be only marginally different in effect to the power under supervised discharge or guardianship to convey community patients to places of treatment and there persuade them (by fair or not so fair means) into compliance.

85 *See, for example, Hansard (Commons) 18 Jun 2007: Col 1199, where the relevant Minister (Rosie Winterton) objected to amendments requiring SOAD authorisation of treatment upon recall because that "would, in practice, prevent a patient from being treated without delay on recall to hospital, and would thus render recall useless".*

86 *See, for example, Boateng P (1998) Mental Health Act Review – Speech to the Midhurst Seminar (First. Meeting of the Richardson Scoping Study Review Team): "Non-compliance can no longer be an option … I have made it clear to the field that this is not negotiable"*

The Best is the Enemy of The Good: The Mental Health Act 2001

Anselm Eldergill[1]

§1 — INTRODUCTION

This article examines the *Mental Health Act 2001*, which is now the main piece of mental health legislation in the Republic of Ireland.[2] The new Mental Health Tribunal system came into force on 1 November 2006, and the Act is now fully in force.

The article is being published in two parts. This part deals with the new admission, detention, leave and transfer provisions. The second part, in the next issue of the Journal, examines the new safeguards: the Commission and the tribunals, and the consent to treatment procedures.

1 *Solicitor; President of the Mental Health Lawyers Association; President of the Institute of Mental Health Act Practitioners.*

2 *Referred to in this article as 'the Republic'. The key textbook is Anne-Marie O'Neill's Irish Mental Health Law (First Law Ltd, Dublin 2005, 873pp). This is an excellent piece of scholarship: well-researched, balanced, detailed, authoritative, readable. It is essential reading for academics and practitioners.*

§2 — TERMINOLOGY

The 2001 Act is concerned only with civil admissions.[3] The structure of the Act is distinctive. It does not contain schedules of the kind found in UK legislation and much is left to the discretion of practitioners and the courts.

Most of the terms in the statute will be familiar to practitioners from other jurisdictions. However, at the outset it is useful to know that an 'approved centre for treatment' is the name given to an institution that is approved to admit persons under the Act.

Section 67 provides that, subject to two exceptions, a person suffering from a mental disorder shall not be detained in any place other than an approved centre.

§3 — STATUTORY PRINCIPLES AND BEST INTERESTS

It has become fashionable for statutes to contain a set of principles and the 2001 Act is no exception. Section 4 states that:

> 4. – In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) –
>
> *(a)* the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.
>
> *(b)* due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

A purposive and paternalistic approach

Mr Justice Neill said in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007) that a purposive approach is appropriate when interpreting this type of legislation. The underlying purpose is paternalistic:[4]

> "It has been said and indeed it is common case that in approaching the construction of the Act, the purposive approach is to be adopted ….
>
> In the case of *In Re Philip Clarke* [1950] I.R. 235 … O'Byrne J, delivering the judgment of the court described the general aim the Act of 1945 as follows:
>
> > *"The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and wellbeing of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt present to the minds of the draftsman when it was proclaimed in Article 40.1 of the Constitution that though, all citizens, as human persons are to be held equal before the law, the State, may, nevertheless, in its enactments have due regard to differences of capacity, physical and moral, and social functions. We do*

3 *The provisions concerning mentally disordered offenders are mainly to be found in the Criminal Law (Insanity) Act 2006.*

4 *Unless a case referred to in this article has been given a formal citation, the case is unreported, in which case the date of the judgment is given; any quotations and observations are based on the transcript of the judgment. Many of the transcripts have been published on the Mental Health Commission's website (www.mhcirl.ie) and the website of the British and Irish Legal Information Institute (www.bailii.org).*

> *not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others. The section is carefully drafted so as to ensure that the person alleged to be of unsound mind, shall be brought before, and examined by, responsible medical officers with the least possible delay. This seems to us to satisfy every reasonable requirement and we have not been satisfied, and do not consider that the Constitution requires, that there should be a judicial enquiry or determination before such a person can be placed and detained in a mental hospital. The section cannot, in our opinion be construed as an attack upon the personal rights of the citizen, on the contrary it seems to us to be designed for the protection of the citizen and for the protection of the common good."*
>
> In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder."

According to Mr Justice O'Neill, section 4 gives statutory expression to the kind of paternalistic approach mandated in the case of *Philip Clarke*.

This proposition is difficult to accept when put in such a bald way. The learned judge himself noted in his judgment, "As is plainly obvious there are provisions included in the Act of 2001 which can be regarded as radical reforms of the *Mental Treatment Act 1945*."

The purpose of these radical reforms is an important part of the purpose of the Act. Such reforms were necessary because the old legislation fell short of internationally accepted standards and failed to protect adequately the interests of citizens, and in particular detained persons.

Why reform was necessary was explained by Mr Justice Clarke in *JH v Vincent Russel, Clinical Director of Cavan General Hospital, Health Service Executive (Respondent) and Mental Health Commission (Notice Parties)* (6 February 2007):

> "Almost twelve years ago Costello P in giving judgment in *RT v. Director of Central Mental Hospital* [1995] 2 I.R. 65 said, at p. 81, the following:—
>
> > *"These defects, not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients. The best is the enemy of the good.*[5] *The 1981 reforms which would have remedied the defects were not brought into force because more thorough reforms were being considered (para. 16.13 of Green Paper) …."*
>
> 1.2 … *The Mental Health Act, 2001* … was the means adopted to address those difficulties. It is worthy of note that it was only in the last months of 2006 that some of the most important provisions of the 2001 Act came into force. Costello P spoke of the consequences of a fourteen year search for excellence …."

Although no judge would likely argue otherwise, it must be emphasised that the main purpose of the 2001 legislation was patently not just to repeat the paternal character of the Act of 1945; nor was it intended simply to ensure the care and custody of people suffering from mental disorder. The 1945 Act promoted and secured those objectives. It did not, however, adequately protect citizens against unjustified

5 *A quotation from Voltaire, meaning here that the search over many years for an 'excellent' scheme to replace the old legislation became the enemy of the 'good', because the delays required practitioners to operate for far too long a system which was manifestly not fit for the purpose.*

infringements of liberty. The purpose of the 2001 Act was to address these deficiencies. It does so by prescribing more rigorous detention criteria, by a system of tribunal reviews, by second-opinion procedures, and through an independent Commission.

This is as it should be. Those we describe as 'patients' are individuals, no more and no less than any other individual; individuals who suffer, who will certain ends for themselves and their loved ones, who wish to develop, and be happy and fulfilled. They are members of the public – citizens – people whose needs and interests the Government exists to serve; brothers, sisters, mothers, fathers.

If this is accepted, the main purpose of the Act may be said to be to seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those members of the public who must necessarily be detained.

Ambiguities in the drafting

The drafting is not ideal. According to section 4, the best interests of the patient shall be the 'principal consideration' when deciding to make an order for their compulsory admission to hospital. However, it is clear that an 'order for admission' may only be made if the patient satisfies the statutory criteria for detention. This therefore is the principal consideration and, insofar as distinct, at best the patient's best interests can only be a secondary consideration.

As an illustration of this principle, it would be unlawful to make an admission order in respect of a person on the sole ground that they are addicted to drugs or intoxicants, however much it might be in their best interests to receive treatment for substance misuse. Practitioners and tribunals must always act lawfully.

When interpreting the precise meaning of section 4, the first principle is therefore that the word 'decision' in section 4 means 'lawful decision' so that it should be read as beginning:

> 4.— In making a decision [that may lawfully be made] under this Act … including a [lawful] decision to make an admission order in relation to a person …

For the avoidance of doubt, a decision to admit or renew detention, or not to discharge, is lawful only if the person satisfies the statutory criteria for detention. As to breaches of procedural requirements, the detention of someone who satisfies the statutory criteria for detention is lawful unless non-compliance with prescribed procedures has affected the substance of the order or has caused an injustice.

Where risk to others is the main issue in a particular case — which quite often it is — then, provided the admission criteria are satisfied, in reality this is the 'principal consideration', not the best interests of the patient. Giving priority to the patient's interests in such a case would require not having 'due regard' to the need to protect other persons from serious harm (One might argue that it is never in a patient's best interests to harm someone but this is straining the language beyond breaking point. It is the legitimate interest of other members of the public in being protected from harm that is the reason why detention is necessary. The patient's interests are secondary.)

When interpreting the precise meaning of section 4, the second principle is therefore that the best interests of the patient are not the principal consideration in cases where there is a serious likelihood of immediate and serious harm to other persons.

Solicitors and section 4

Section 4 has generated quite heated debate about the extent to which it requires solicitors to depart from their instructions or 'to turn a blind eye to' legal irregularities that may entitle their client to be discharged.

The Mental Health Commission, which administers the legal aid scheme, has made clear in its handbook and training materials its view that representatives must act in the 'best interests' of their clients.

Most solicitors have emphasised in training sessions their professional duty to follow their instructions, which includes seeking discharge and raising any issues about the order's legality, regardless of their own personal views as to the wisdom of discharge. A solicitor's professional duties are set out in *A Guide to Professional Conduct of Solicitors in Ireland* (2nd Edition, Law Society of Ireland, Dublin, October 2002):[6]

- Solicitors must serve the interests of justice as well as the rights and liberties of their clients. It is their duty not only to plead their client's cause but also to be their adviser.
- Solicitors should always retain their professional independence and their ability to advise their clients fearlessly and objectively. A solicitor should never permit his independence to be undermined by the wishes of a party who has introduced a client.
- A solicitor should take instructions directly from the client.
- A solicitor should present his client's case to his client's best advantage.
- It is the duty of the advocate to uphold fearlessly the proper interests of his client and to protect his client's liberty.

The answer perhaps lies in the precise wording of section 4. It begins with the words, 'In making a decision under this Act … including a decision to make an admission order in relation to a person …'

Solicitors do not make decisions under the Act and therefore the section does not apply to them.

The legitimate needs and interests of patients, the tribunal and of society in general, are best promoted by ensuring that vulnerable citizens subject to compulsion have available to them a legal advocate, to test the strength of the evidence and to promote *their* case. It would be unethical for a legal representative to do otherwise, not simply in terms of their professional code but more generally.

When interpreting the precise meaning of section 4, the third principle is therefore that solicitors do not make decisions under the 2001 Act. Their duty is different. It is to advance their client's case in a manner consistent with their instructions. In exceptional circumstances, where an incapacitated person cannot give instructions, they must act in accordance with their own perception of their client's best interests. This generally involves testing the medical and other evidence said to support detention.

Effective representation assists the tribunal in reaching the right decision and therefore is consistent with section 4. A best interests approach to representation has to incorporate:

A requirement to always test the evidence.

A requirement to always request the best evidence available.

6 *A Guide to Professional Conduct of Solicitors in Ireland (2nd Edition, Law Society of Ireland, Dublin, October 2002).*

Representing the capable patient in accordance with their instructions as that course best protects the autonomy of the patient.

Representing the incapable patient by adopting clear principles, e.g. promoting the less restrictive alternative and a person's right to be unwise.

The current debate is interesting because it duplicates that in England and Wales following the introduction of legal representation at Mental Health Review Tribunals. As in the early days of the MHRT scheme in England and Wales, the debate is not one of substance, or even ethics in most cases, but an expression of the understandable anxieties of the medical profession about having to justify clinical decisions and being subject to regular judicial scrutiny.

§4 — VOLUNTARY ADMISSION

Section 29 provides that nothing in the Act shall be construed as preventing a person from being 'admitted voluntarily' to an approved centre for treatment or from remaining in such a centre after they have ceased to be liable to be detained.

In most jurisdictions, the term 'voluntary admission' denotes a patient who has capacity to consent, or 'volunteer', to go into hospital. In contrast, 'informal admission' means admission without legal formalities — the underlying idea being that a person may be admitted without the need for a legal order even if they lack capacity to consent to this.

What is the position here? The wording of sections 2 (*Interpretation*) and 29 (*Voluntary admission to approved centres*) suggests that in fact 'voluntary admission' means 'informal admission.'

Anecdotal evidence does suggest that many incapacitated people are being deprived of their liberty in institutions without there being any legal order authorising this. The implications of the *Bournewood* judgment[7] are therefore problematic.

§5 — THE DEFINITION OF MENTAL DISORDER

There are two main ways of defining mental disorder in statutes that deal with compulsory admission.

The first is to begin with a simple definition of mental disorder, and then to set out in separate sections the criteria for compulsory admission.

The alternative approach, seen in the 2001 Act, is to incorporate the criteria for detention within the very definition of mental disorder. Thus, the 2001 Act provides that a person may be involuntarily admitted on the ground that s/he is suffering from mental disorder. Here, the term 'mental disorder' equates to what used to be called 'certifiable mental disorder'; it is the modern version of the term 'lunatic'.

The simple definition approach has the advantage that it can be incorporated into other statutes; for example, legislation that imposes duties on NHS and other public authorities to provide services and after-care to anyone who suffers from mental disorder. Its generality also affords greater legal protection to police officers and other non-mental health professionals who apply the legislation. The alternative approach lacks these advantages but is more constitutionally sensitive. A person only comes with the ambit of the legislation at all if they have a serious mental disorder.

7 *HL v United Kingdom (Application 45508/99 (2004) 40 EHRR 761.*

The difference is perhaps best illustrated if one considers the application of powers of the kind found in sections 135 and 136 of the English and Welsh *Mental Health Act 1983*. A simple definition approach — such as, 'mental disorder means any disorder or disability of mind' — brings many more people within the ambit of these sections than does a definition which states that a person suffers from mental disorder only if they meet the criteria for civil admission to hospital.

§6 — THE CRITERIA FOR DETENTION

As just noted, the 2001 Act provides that a person may be admitted and detained if they are suffering from 'mental disorder'. This term is defined as follows:

> "mental disorder" means mental illness, severe dementia or significant intellectual disability where—
>
> (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
>
> (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
>
> (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Ground (a): Serious likelihood of serious and immediate harm

According to Mr Justice Neill, in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007):

- "The phrase 'serious likelihood' envisages 'a standard of proof of a high level of probability. This is beyond the normal standard of proof in civil actions of "more likely to be true." However, it falls short of the standard of proof required in a criminal prosecution, namely beyond a reasonable doubt: 'What is required is proof to a standard of a high level of likelihood as distinct from simply being more likely to be true.'
- The harm apprehended must in the first instance be "immediate". The critical factor which must be given dominant weight is the propensity or tendency of the person to do harm to themselves or others. If the clinicians are satisfied to the required standard of proof that that propensity or tendency is there then, having regard to the unpredictability of when the harm would be likely to occur, the likelihood of the harm occurring would have to be regarded as "immediate".
- As to what constitutes 'serious' harm, the word 'harm' is a very general expression and its use is intended to encompass the broadest range of injury. Physical and mental injury are included. The term "serious" is more difficult to fully comprehend. It may very well be that a somewhat different standard would apply depending on whether the harm was inflicted on the person themselves or others. Clearly the infliction of any physical injury on another could only be regarded as "serious" harm, whereas the infliction of a minor physical injury on the person themselves could be regarded as not "serious". Thus assaults directed at others, which had the potential to inflict physical injury could be considered to fall within the ambit of the term "serious". Behaviours on the part of a person suffering from mental illness, dementia or disability, where there was a serious likelihood of these

behaviours resulting in serious actual physical injury to the person concerned, should rightly be regarded as "serious" harm. Where the likely end result of these behaviours was merely trivial injury, it would not or should not, normally be regarded as constituting "serious" harm for these purposes."

Objection may be made to the meaning given to the word 'immediate'. Some people who have been diagnosed as having a significant mental disorder certainly do have a propensity or tendency to seriously harm themselves or others. However, it is a long step from there to a finding that there is a serious likelihood of this occurring immediately. That judgment depends not just on the existence of a propensity or tendency to cause serious harm but on a whole range of other factors such as the person's current mental state, the risk factors, their present situation, the level of security and supervision, their compliance with treatment, etc. If they are presently stable, the immediate risk may well be quite low, as in the case of many conditionally discharged restricted patients.

Mental illness, severe dementia, significant intellectual disability

The person must be suffering from mental illness, severe dementia or significant intellectual disability. The Act defines what these terms mean:

(2) In subsection (1)—

"mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

"severe dementia" means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

"significant intellectual disability" means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

It can be seen that:

- A person is only mentally ill if their state of mind seriously impairs their mental function to the extent that they require care or medical treatment;
- The definition of 'severe dementia' requires significant impairment affecting thought, comprehension and memory and severe psychiatric or behavioural symptoms, such as physical aggression; and
- The definition of 'significant intellectual disability' is essentially the same as that of 'mental impairment' in section 1(2) of the *Mental Health Act 1983*.

Exclusions

The 2001 Act provides that a person may not be involuntarily admitted 'by reason only of the fact that s/he is suffering from personality disorder; is socially deviant; or is addicted to drugs or intoxicants.'[8]

These prohibitions are significantly wider than those in section 1(3) of the 1983 Act. They prevent citizens from being detained merely because they have a personality disorder or are socially deviant

8 *Mental Health Act 2001, s.8(2).*

(which presumably includes the more specific English and Welsh exclusions of immorality, sexual deviancy and promiscuity).

The Northern Irish legislation has for some time excluded persons suffering from personality disorder. The research base is poor so that it is impossible to know the precise effect such exclusions have in practice. The author's impression — based on his time as a Commissioner in Northern Ireland and the operation of the *Mental Health Act 1959* in England and Wales — is that this exclusion is generally not determinative where a person poses a significant risk to others. If a similarly loose approach is taken in the Republic, it may be tempting for doctors to argue that such people are 'mentally ill' in a legal sense, because their state of mind affects their emotion or judgment, and this seriously impairs their mental function.

Implications in practice

The compulsory admission criteria provide the citizen with a fair measure of protection.

The admission and renewal procedures are explained later on. However, it is important to appreciate that the 2001 Act does not contain separate 28-day and six month admission orders equivalent to sections 2 and 3 MHA 1983. There are only 'admission orders,' which usually have an initial duration of 21 days and then may be renewed as necessary.

This is significant, as can be seen if one takes the case of someone with a learning disability. The definition of 'significant intellectual disability' in the 2001 Act is essentially the same as that of 'mental impairment' in the *Mental Health Act 1983*. Consequently, a person with a learning disability may only be detained under section 3 or an admission order if their disability is associated with abnormally aggressive or seriously irresponsible conduct. In the Republic the matter ends there because there is only one kind of admission order. Under the *Mental Health Act 1983*, there remains the option of admission for up to 28 days because section 2 does not require that the patient's learning disability is associated with a conduct disorder of the kind described.

The greater protection afforded to citizens under the 2001 Act emerges quite clearly if one considers what must be shown before an admission order may be made in a 'significant intellectual disability' case:

DETENTION OF PERSONS WITH A LEARNING DISABILITY			
REQUIREMENT			*PROTECTION FOR CITIZENS*
1. The person must satisfy the definition of significant intellectual disability			
1		*A state of arrested or incomplete development of mind*	This requires that the person's mind (brain) never developed completely, or its development was arrested. It therefore excludes an adult whose brain is injured after developing fully, for example as a result of a road accident.
2	+	*Significant impairment of intelligence*	Conventionally, this requires an IQ of 70 or below.
3	+	*Significant impairment of social functioning*	Even if a person's intelligence is significantly impaired, an admission order may not be made unless their social functioning is also significantly impaired. Any significant impairment of social functioning present must be an aspect of their arrested or incomplete development of mind, and not caused, for example, by personality disorder.
4	+	*Abnormally aggressive or seriously irresponsible behaviour*	The person's learning disability must be associated with abnormally aggressive or seriously irresponsible conduct. Aggression is only abnormal in this sense where such an association exists.
2. The person must also meet the criteria in condition 2(a) or (b) below			
2a. Detention on the grounds of			
5a	**+**	*Serious likelihood of immediate and serious harm*	It is not enough that harm to the patient or others is possible.
6a	**+**		It is not enough that harm is 'likely'.
7a	**+**		It is not enough that harm is 'seriously likely' if this harm does not amount to 'serious harm'.
8a	**+**		Even if 'serious harm' is 'seriously likely', that harm must be 'seriously likely' to happen 'immediately'.
9a	**+**		If 'serious and immediate harm' is 'seriously likely', this identified risk of harm must arise 'because of' the individual's significant intellectual disability.

2B. Detention on the grounds of			
5b	+	*Likelihood of material benefit or alleviation*	The person's judgement must be impaired.
6b	+		If it is impaired, it must be impaired by reason of their disability.
7b	+		It is not enough that a failure to admit could lead to the condition deteriorating; 'serious deterioration' must be 'likely'.
8b	+		The proposed in-patient treatment must be 'appropriate treatment'.
9b	+		It may be that 'appropriate treatment' could be given as a voluntary patient, or as an out-patient, etc.
10b	+		Any benefit or alleviation of the patient's condition arising from forced 'reception, detention and treatment' must be of a 'material extent'.

§7 — APPLICATIONS AND ADMISSIONS

To anyone used to the *Mental Health Act 1983*, the application and admissions processes in the 2001 Act are distinctive.

As drafted, subject to very limited exceptions, 'any person' may make an application to a registered medical practitioner for a medical recommendation that any other person be involuntarily admitted to an approved centre.

A person may not make an application unless they have observed the person not more than 48 hours before the date of the making of the application.

The medical practitioner to whom such an application is made must not be a member of staff of the approved centre to which admission is sought, and often will be a general practitioner.

Unlike in England and Wales, the applicant is only applying for a medical recommendation to be given, not applying to a hospital for admission on the basis of completed medical recommendations.

Once such an application has been made, the Act provides that the medical practitioner 'shall' carry out an examination of the person within 24 hours. As drafted, there is no discretion; any person may apply to a doctor for any other person to be involuntarily admitted, and it is then mandatory for the doctor to examine the named person within 24 hours.

What if the named person refuses to be examined during the 24 hour period? The doctor is under a duty to examine the individual within 24 hours, but the named individual is under no duty to co-operate or to attend for examination. Nor is there any statutory power, equivalent to section 135 MHA 1983, which authorises a person's removal from private premises for the purposes of examining and assessing them.

A recommendation for admission is mandatory if the examining doctor is satisfied that the named person is suffering from mental disorder. The outcome will therefore be either that the doctor recommends admission or that the application is refused, and no recommendation is made.

If the application is refused, any future applicant must notify the doctor to whom they apply of any known previous applications which were refused. This has the advantage that the doctor knows that a professional colleague was not satisfied previously that the person was mentally disordered. On the other hand, as drafted, an examination within 24 hours is still mandatory for every application made.

Where a recommendation is given, it is given to the clinical director of the specified approved centre and remains in force for seven days.

The next task is how to get the patient to the designated approved centre. The Act provides that a copy of the recommendation shall be given to the applicant, who 'shall arrange' for the 'removal of the person' to the specified approved centre. If the applicant is unable to arrange this, the clinical director (or a consultant psychiatrist acting on their behalf) must arrange for the person's removal by staff of the centre, if the doctor who gave the recommendation requests this.

There is one further option in cases where there exists a serious likelihood of immediate and serious harm: The Garda can be required to assist staff with the person's removal to the centre, for which purpose members of the Garda can enter premises without a warrant and use any necessary detention or restraint.

There is, it seems, a drafting omission here. The criteria for compulsory admission are (a) that there is a serious likelihood of the person causing immediate and serious harm to themselves or others, or (b) that failure to admit the person would be likely to lead to a serious deterioration of their condition, etc. As drafted, it is only if a person requires admission on the first of these grounds that the Garda can be required to assist and may enter premises without a warrant. If the recommendation has been given on the other ground, the Garda have no such powers. The named person may therefore prefer to remain indoors until the medical recommendation has expired.

Assuming the patient is admitted within the statutory seven-day period, s/he must be examined 'as soon as may be' by a consultant psychiatrist on the staff of the approved centre. A consultant psychiatrist, medical practitioner or registered nurse on the staff of the centre may take charge of the person and detain them for up to 24 hours, so that this examination can be carried out.

The examining psychiatrist must make an 'admission order' if s/he is satisfied that the person is suffering from mental disorder. S/he must refuse to make such an order where s/he is not satisfied that this is so.

§8 — DETENTION AND ADMISSION OF VOLUNTARY PATIENTS

The procedures just described are appropriate for admitting a person to an approved centre from the community.

What is the position where an admission order is required in respect of a 'voluntary patient' already at an approved centre?

Sections 23 is concerned with the short-term detention of voluntary patients, and is broadly equivalent to section 5 of the *Mental Health Act 1983*.

Section 23(1) is triggered if an adult who is being treated in an approved centre as a voluntary patient indicates that they wish to leave. It enables a consultant psychiatrist, registered medical practitioner or

registered nurse on the staff of the centre to detain the person for up to 24 hours if of opinion that s/he is suffering from a mental disorder.

Where such a person is detained, section 24 provides that the consultant psychiatrist responsible for the patient must either discharge the patient or arrange for them to be examined by another consultant psychiatrist.

If a second consultant is asked to examine the patient, and is satisfied that they are suffering from a mental disorder, s/he must certify this opinion in writing. Once this is done, the patient's consultant must then make an admission order, authorising the individual's detention and treatment in the approved centre.

Where the second psychiatrist instead certifies that s/he is not satisfied that the patient is suffering from a mental disorder, the effect is that the person is discharged.

Case Law

There have been a number of cases on sections 23 and 24:

In *Q v St Patrick's Hospital (Respondent) and Mental Health Tribunal, Mental Health Commission (Notice Parties)* (21 December 2006), an admission order was made under section 24 in respect of a voluntary patient who had not indicated an intention to leave. Section 23 had therefore not been triggered and Mr Justice Higgins therefore held that the detention was unlawful; section 23 must be invoked before section 24 applies.

The wording of the sections is unambiguous and this is undoubtedly what they say. There is no problem if the ordinary admission procedure used for patients in the community can, where appropriate, also be used in respect of voluntary patients. If not then, without an expressed wish to leave, it would not always be possible to make an admission order where powers of detention and restraint are being used, or are required, in respect of a voluntary patient; where an incapacitated voluntary patient is effectively being detained on a best interests common law basis (the *Bournewood* type scenario); or where it is desirable that a person without capacity receives the protective mechanisms afforded by the Act.

In *T O'D v Central Mental Hospital, HSE (Respondent) and Mental Health Commission (Notice Party)* (25 April 2007), the Central Mental Hospital had made a series of very basic errors in relation to the new detention provisions.[9] On 6 December 2006, a renewal order was not made in time and the patient became a voluntary patient. He expressed an intention to leave and an admission order was made under section 24. For the second time, the hospital failed to renew an order in time, so the patient again became a voluntary patient. He again indicated a wish to leave, on 17 January 2007, and was detained. However, the admission order required by section 24 was not signed for a week, until 24 January. On review, the tribunal affirmed the admission order.

Mr Justice Charleton upheld the patient's detention, stating that a purposive approach to the legislation is required, that section 4 (best interests) infuses the entire legislation, and that the tribunal was entitled to take best interests into account. Indeed, had the tribunal not taken section 4 into account, that would be grounds for judicial review:

> "26. … I would hold that the purpose of s.18(1) [tribunal's jurisdiction and powers] is to enable the Mental Health Tribunal to consider afresh the detention of mental patients and to determine,

9 *The Central Mental Hospital was built in 1850 and is thought to be the oldest forensic mental health facility in Europe. It was originally the Republic's equivalent of Broadmoor Hospital but now provides high, medium and low secure places.*

> notwithstanding that there may have been defects as to their detention, whether the order of admission or renewal before them should now be affirmed. In doing so, the Mental Health Tribunal looks at the substance of the order. This, in my judgment, means that they are concerned with whether the order made is technically valid, in terms of the statutory scheme set up by the Act or, if it is not, whether the substance of the order is sufficiently well justified by the condition of the patient …
>
> I would specifically hold that the purpose of s. 18(1) of the Act is to enable the Tribunal to affirm the lawfulness of a detention which has become flawed due to a failure to comply with relevant time limits."

JH v Jonathan Swift Clinic, St James Hospital, Dublin (Respondents), Mental Health Tribunal (Notice Party) (25 June 2007) also concerned the application of sections 23 and 24. The admission order made in this case was made 20 minutes outside the permitted 24 hour period, and the consultant psychiatrist who made it was not the patient's responsible consultant psychiatrist.

Mr Justice Peart held that a purposive approach should be adopted and that regard should be had to the best interest requirement in section 4(1). One had to balance the interest of a patient against failure to adhere strictly to time limits and procedures. Not every incident of non-compliance would render a detention unlawful. This could be inferred from the fact that tribunals could affirm orders in cases where procedural irregularities did not cause injustice or affect the substance of the order. A slavish adherence to the 24-hour time limit would militate against the very purpose of the legislative protection, which was to care for a vulnerable person. An admission order was mandatory once the second psychiatrist had certified that the patient met the criteria and the patient had therefore not been prejudiced. The moment the locum consultant psychiatrist came on duty, he became the consultant in charge of the patient's care.

§9 —DURATION AND RENEWAL OF ADMISSION ORDERS

The Mental Health Commission must be sent a copy of any admission (or renewal) order within 24 hours. On receiving its copy, the Commission arranges for the patient's case to be reviewed by a Mental Health Tribunal. The tribunal must conduct its review and make its decision within 21 days of the making of the order. It must affirm the order if it is satisfied that the patient is suffering from mental disorder and that any failure to comply with the statutory admission or renewal procedures has not caused injustice or affected the substance of the order.

An admission order lasts for 21 days unless it is extended by a tribunal for a further period.

The tribunal has a limited power to extend the usual duration of an admission order (or renewal order). Section 18(2) requires a tribunal to make its decision no later than 21 days after the making of the admission (or renewal) order. However, by sub-section (4), this period may be extended by a tribunal for a further period of 14 days, either on its own motion or at the patient's request. It may then be further extended by the tribunal for a second period of 14 days, but in this case only on the patient's application and only if the tribunal is satisfied that it is in the interest of the patient. Where an extension is given, the admission order (or renewal order) continues in force during the period of the extension.

The second part of this article contains a more detailed account of tribunal procedures.[10]

10 See the November 2008 issue of the Journal of Mental Health Law.

Renewal orders

The Act provides that an admission order may be extended by the consultant psychiatrist responsible for the patient's care and treatment. During the week before the renewal order is made, the consultant must both examine the patient and certify that they continue to suffer from mental disorder. Unless extended by a tribunal in accordance with the procedures described above, the statutory renewal periods are as follows:

- A first renewal order may be for up to three months;
- The second renewal order may be for up to six months;
- Subsequent renewal orders may be for up to 12 months.

As with the original admission order, the Commission must be sent a copy of each renewal order within 24 hours, at which point it refers the patient's case to the tribunal.

In *AMC v St Luke's Hospital Clonmel* (28 February 2007), a renewal order made on 4 December 2006 was to come into effect on 9 December upon the expiration of the previous order. Mr Justice Peart held that the tribunal had to hold its review within 21 days of the making of the renewal order, not within 21 days of the date the order came into effect. Section 18(2) was plain and unambiguous in this respect.

In *WQ v Mental Health Commission, Central Mental Hospital, Mental Health Tribunal (Respondents)* (15 May 2007), Mr Justice O'Neill said that the statutory scheme is based on short periods of detention each disconnected from each other. Consequently, an invalid previous renewal order does not render invalid a period of detention brought about by a subsequent valid renewal order. (The objection to this is that one cannot renew nothing. Once an admission order has expired for want of renewal, nothing then exists to be renewed subsequently.)

Renewal orders must be made by made by 'the consultant psychiatrist responsible for the care and treatment of the patient concerned.' In *JB(2) v Central Mental Hospital (Respondent) and Mental Health Commission, Mental Health Tribunal (Notice Parties)* (15 June 2007), the renewal order was made by a consultant psychiatrist at the approved centre from which the patient had been transferred to the Central Mental Hospital. Upholding the order, Mr Justice McMenamin said that this consultant had been involved in the patient's care and treatment since 2002; that the consultant who renewed an order must be truly engaged in the patient's care and treatment; and that more than one consultant could be involved in a patient's care and treatment. The court again emphasised the purposive nature of the legislation. (The objection is that, although more than one consultant may be involved in a patient's care and treatment, the use of the word 'the' indicates that only one of them is responsible for it, i.e. in charge of it.)

The case of *MD v St Brendan's Hospital, Mental Health Commission, Mental Health Tribunal (Respondents)* (24 May 2007) concerned the timing of renewal examinations and orders. An admission order for 21 days was made on 26 April 2007, which unless renewed would therefore expire at midnight on 15 May 2007. Renewal required an examination during the final week of this period of detention. This was done and a renewal report was issued, on 10 May 2007. On 15 May 2007, a tribunal reviewed the admission order that was due to expire at the end of that day. The patient's representative argued that a renewal order cannot be made until a tribunal has reviewed the prior admission order. Mr Justice Peart rejected this, stating that a renewal order only takes effect on the expiration of the previous order. If the previous order is revoked, the patient is free to leave. This decision was taken on appeal to the Supreme Court, which rejected the appeal, not surprisingly confirming that each new period of detention commences upon the expiry of the previous period.

§10 — LEAVE, TRANSFERS AND DISCHARGE

There are some interesting provisions concerning leave, transfer and discharge.

Leave of absence

Section 26 provides that a patient's consultant psychiatrist may grant the patient permission in writing to be absent from the approved centre. The period of leave granted must be less than the unexpired period of the relevant admission or renewal order. As in England and Wales, leave may be subject to conditions; and the consultant may later direct the patient in writing to return to the approved centre, if 'of opinion that it is in the interests of the patient to do so.'

The fact that a patient may not be granted leave of absence beyond the expiry date of the current order is sensible. However, it does raise the possibility of psychiatrists renewing the sections of recalled patients on the last day of their existing section and immediately sending them out on another period of extended leave.

There have been a number of cases in England and Wales concerning the creative use of leave in this way and the renewal of patients' sections in such circumstances.[11] The wording of the 2001 Act seems to give consultants in the Republic less leeway. Unless the serious likelihood ground is in play (see §6 above), the admission and renewal criteria refer to a 'failure to admit the person to an approved centre' and to the patient's reception, detention and treatment in such a centre. In other words, admission and renewal require that a person actually needs to be detained in an approved centre, rather than merely treated there periodically.

Absence without leave

Section 27 deals with absence without leave. It provides that the clinical director of an approved centre may arrange for members of staff to return to the centre a patient who is absent without leave, or who has failed to comply with any conditions attached to their leave.

The Garda must assist if requested to do so in cases where there is a serious likelihood of the person concerned causing immediate and serious harm to themselves or to others. A member of the Garda may then enter, if need be by force, any dwelling or other premises where s/he has reasonable cause to believe that the patient may be; and may take all reasonable measures necessary for the return of the patient to the approved centre, including the use of detention or restraint.

The Act does not make any provision at all for extending a patient's liability to detention where s/he is absent without leave at the time when renewal is due. All the Act states is that the patient's consultant must examine them during the week before the renewal order is made and certify that the patient continues to suffer from mental disorder.

On the face of it therefore, if the patient is absent for the whole of the renewal week, so that no examination can take place, the order simply expires at the end of that period.

11 *See e.g., R (on the application of DR) v Mersey Health Care NHS Trust [2002] EWHC Admin 1810; R (on the application of CS) v MHRT and another [2004] EWHC 2958 (Admin).*

Transfers

Section 21 is concerned with transfers, other than transfers to the Central Mental Hospital. By section 21, the clinical director of an approved centre may arrange for a patient's transfer to another approved centre if of the opinion either that this would be for the patient's benefit or that it is necessary for the purpose of obtaining special treatment for such patient. Transfer requires the consent of the clinical director of the receiving centre.

Section 22 then deals with transfers to the Central Mental Hospital. The clinical director of the transferring approved centre must notify the Commission of the proposal, and the Commission must then refer the proposal to a tribunal.

The tribunal must review the proposal within 14 days. It must authorise the transfer 'if it is satisfied that it is in the best interest of the health of the patient' or, if it is not so satisfied, refuse to authorise it.

The tribunal's decision concerning a proposed transfer to the Central Mental Hospital may not be given effect until the time for appealing to the Circuit Court has expired or, where such an appeal is lodged, the appeal is determined or withdrawn.

This is an important protection for patients. The only weakness is that, once a patient is in the Central Mental Hospital, the tribunal has no similar power to review, direct or recommend the patient's transfer from the Central Mental Hospital to a local approved centre.

Discharge

Section 28 requires a patient's consultant psychiatrist to revoke an admission or renewal order if s/he 'becomes of opinion that the patient is no longer suffering from a mental disorder.'

What then happens is rather unusual. The discharging consultant must give the patient, or their legal representative, a notice stating that the patient is entitled to give notice during the following next 14 days that they wish to have the discharged order reviewed by a tribunal, or any tribunal review that is in progress completed.

Apparently, this right was incorporated because, when consulted, some patients in England and Wales indicated that they were dissatisfied about being discharged from section shortly before their tribunal took place. They felt that they had been denied their opportunity to question the doctor and to demonstrate to an independent tribunal the weakness of the case for their detention.

From the author's experience in practice, it is certainly true that some patients hope to obtain what might be called a certificate of sanity. The problem is that a tribunal must look at things as they are at the date of the tribunal hearing, not as they were when the order was made. A tribunal finding that a patient is not mentally disordered at the time of the hearing leaves entirely open the question of their mental state when they were sectioned.

Because the patient already possesses an order stating that they are not now mentally disordered, in the form of the consultant's discharge order, asking a tribunal to affirm this finding does not take matters much further. It does, however, carry a risk that the tribunal will find that, in their opinion, the person is mentally disordered, i.e. that the patient does meet the criteria for being sectioned. Such a decision would put the relevant professionals under pressure to arrange for a new admission order.

Proposed Reforms to Partial Defences and their Implications for Mentally Disordered Defendants

Andy Bickle[1]

Introduction

Partial defences are special defences only available in England & Wales to defendants charged with murder. They include provocation, diminished responsibility, infanticide and killing pursuant to a suicide pact. These are known as the 'voluntary manslaughters' where homicide with intent otherwise sufficient for murder ('malice aforethought') is reduced to manslaughter because of defined mitigating circumstances[2]. Provocation and diminished responsibility have proved most problematic and will be the focus of this article. The mitigating factors arise from abnormal mental states, and psychiatric evidence has been at the centre of disputes regarding these defences. In this journal, Kerrigan set out recent problems that have developed with provocation in case law[3]. The degree to which mental disorder can be considered when deciding the standard of behaviour required of the defendant who pleads 'provocation' has fluctuated markedly in recent years. Diminished responsibility, on the other hand, has aroused concern, *inter alia,* over its expansive use to cover a wide range of mental conditions,[4] and the frequency with which expert psychiatrists comment on the 'ultimate issue' of whether all limbs of the test are met[5]. Both problems might be said to arise from vague terms in the statutory definition that are incompatible with contemporary psychiatric practice.

Following the controversial case of *R v Smith (Morgan James)*[6], which permitted mental disorder a much greater effect on provocation, the United Kingdom Government asked the Law Commission[7] ('the Commission') to consider and report on the law and practice of the partial defences provided for by the

1 *Specialist Registrar in Forensic Psychiatry, East Midlands Centre for Forensic Mental Health, Arnold Lodge, Leicester.*

2 *Ormerod D (2005) Smith & Hogan Criminal Law (11th Ed). Oxford University Press: Oxford: 471.*

3 *Kerrigan K (2006) Provocation: the fall (and rise) of objectivity. Journal of Mental Health Law May: 44.*

4 *Editorial 'Partial Defences to Murder' [2004] Criminal Law Review: 1*

5 *Mitchell B (1997b) Putting diminished responsibility law into practice: a forensic psychiatric perspective. Journal of Forensic Psychiatry. 8(3): 620.*

6 *R v Smith (Morgan James)7 [2001] 1 AC 146*

7 *The Law Commission is an independent statutory body created by the Law Commissions Act 1965 to keep the law under review and assist with reform. The Commission conducts research and consultations in order to make recommendations to Parliament. More than two thirds of the Commission's recommendations for reform have been implemented (www.lawcom.gov.uk).*

Homicide Act 1957. This progressed to investigation into wider homicide law and a process of consultation and review which has now passed to the Ministry of Justice. This paper will outline briefly the review process before considering in greater detail the current proposals for new definitions of provocation and diminished responsibility. The Commission would like these to exist within a radically re-structured law of homicide. The implications for mentally disordered defendants and therefore expert psychiatric opinion will be considered.

Partial Defences to Murder: Consultation Paper (2003)[8] & Final Report (2004)[9]

The Law Commission had long considered the law of murder in need of review[10]. However, a wholesale revision was outside its initial terms of reference and so it first considered partial defences in relative isolation. The Commission recommended new principles to govern a reformed provocation defence which omitted reference to the problematic 'reasonable man' whose mental characteristics had been causing the courts so many problems[11]. It also considered a new defence of 'excessive use of force in self-defence', principally to benefit female domestic violence victims, but ultimately preferred instead to reformulate provocation in such a way as to afford better justice to this type of defendant. In contrast, in this first review the Commission recommended no change to the statute definition of diminished responsibility for as long as the law of murder remained unchanged and conviction resulted in a mandatory sentence. However, it suggested a reformulation for further consultation which replaced the problematic concept of 'mental responsibility' (which many experts felt was outwith the expertise of psychiatrists) with a substantial impairment of capacity to understand, judge and exert self-control.

Notably, the Commission's overarching recommendation to the Government was to review the law of homicide as a whole, including the mandatory sentence for murder. It argued the laws of voluntary manslaughter needed to be reviewed alongside those of murder to ensure coherence between the two[12].

A New Homicide Act for England and Wales? (2005)[13] & Murder, Manslaughter and Infanticide (2006)[14]

Consultation

The Law Commission was granted its first wish and invited to review various elements of murder, including the partial defences. The consultation did not examine euthanasia, suicide or abortion, except as they formed part of murder as the Commission believe the fundamental issues involved require separate debate. It also considered creating a new partial defence of duress, which is uniquely unavailable to the charge of murder in England and Wales[15]. The Commission was asked to involve key stakeholders such as the public, criminal justice practitioners, academics, those who work with victims' families, parliamentarians and faith groups and accordingly a significant contribution was made by the Royal College of Psychiatrists as well as individual psychiatrists.

8 *Law Commission (2003) Partial Defences to Murder: Consultation Paper. Law Com No. 173, TSO, London.*

9 *Law Commission (2004) Partial Defences to Murder: Final Report. Law Com No. 290, TSO, London.*

10 *Ibid, para 1.1.*

11 *Ibid, para 1.13.*

12 *Ibid, para 1.12.*

13 *Law Commission (2005) A New Homicide Act for England and Wales? An Overview. Law Com No. 177, TSO, London.*

14 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London.*

15 *It is available to other charges in this jurisdiction.*

The Law Commission's wishes were not, however, all granted. Pointedly, its terms of reference did not include the mandatory sentence. The Commission neatly sidestep this restriction by proposing a grading of homicide and reserving the mandatory sentence for 'first degree murder', thereby creating space for other (second degree) murderers to be subject to flexible sentencing. This legal dexterity has been described as *"a risky subterfuge"*[16].

Structure of Homicide Law

The Law Commission reported in November 2006. Underpinning all of its other recommendations is a fundamental change to the structure of homicide law. It found widespread support (including from the Royal College of Psychiatrists) for its proposal to introduce a 'ladder' of offences creating degrees of murder and so change the distinction between murder and manslaughter that is almost certainly over 500 years old[17].

The existing two-tier structure of homicide law is depicted below:

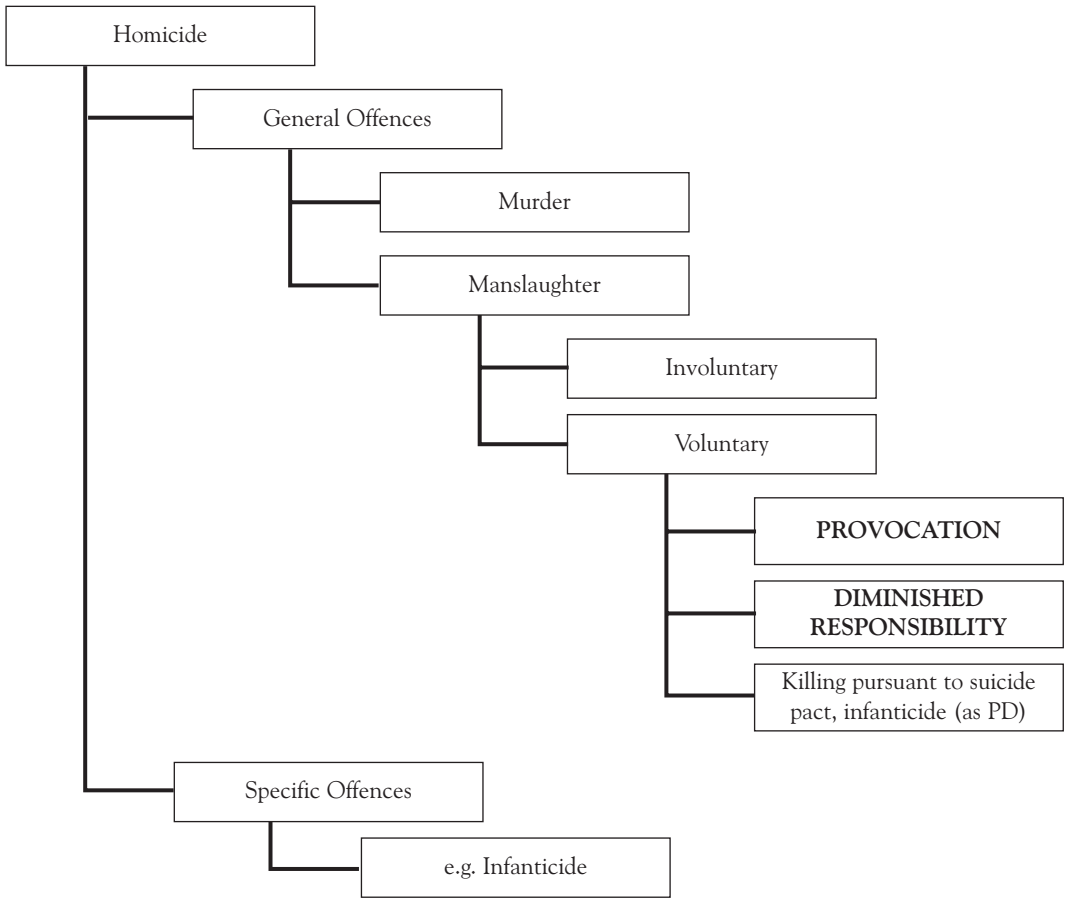


Fig. 1 Current Structure of Homicide

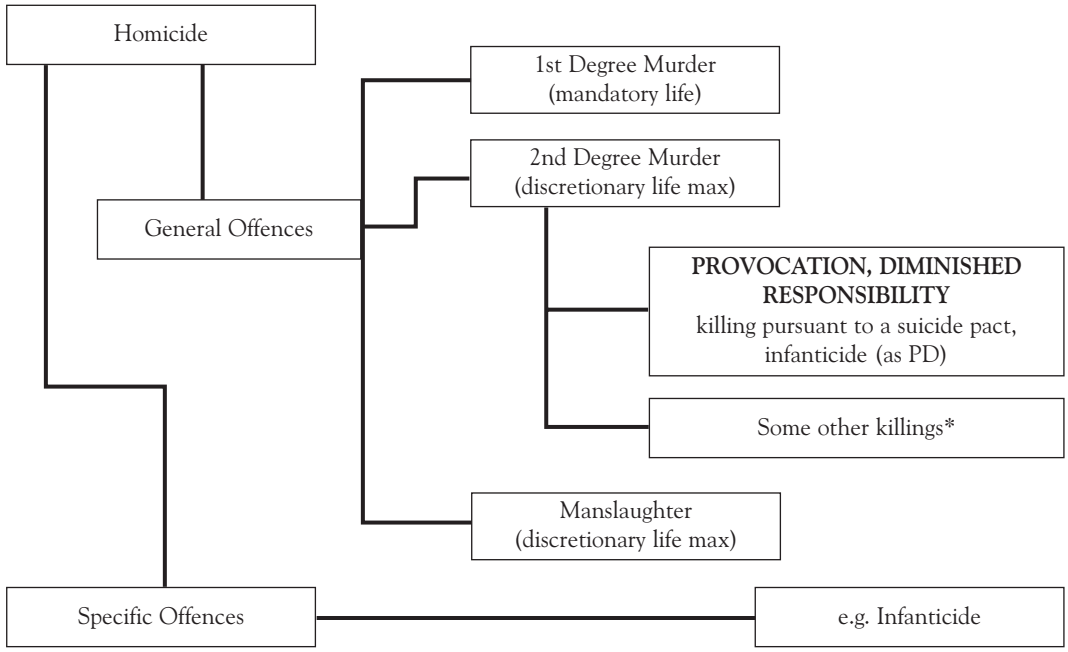
16 *Wilson W. (2006) The Structure of Criminal Homicide. Criminal Law Review: 471.*

17 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 1.32.*

Within this structure there are two tiers of general offences (murder and manslaughter) in addition to specific offences including one based on psychiatric factors (infanticide).

The Commission finds the two-tier structure struggling to accommodate *"changing and deepening understanding of the nature and degree of criminal fault and the emergence of new partial defences"* and feels a more finely graded structure would be better equipped to handle these stresses and strains[18]. It emphasises the 1957 Act represented little more than tinkering with the existing law that elbowed a new defence of diminished responsibility into the existing structure.

The Commission prefers the three-tier structure of homicide it advocated from the beginning of the consultation exercise:



* Killing where offender intended to cause serious injury and killing where offender intended to cause some injury or a fear or risk of injury, and was aware of a serious risk of causing death.

Fig. 2 Structure of Homicide Proposed by Law Commission

Under the new proposals, provocation or diminished responsibility would only reduce first degree murder to second degree murder. Partial defences would not be available to second degree murder or be able to reduce first degree murder all the way to manslaughter. The traditional justification for partial defences has been twofold. Firstly, they have allowed some sentencing flexibility. Secondly, they prevent less

18 *Op Cit.*

culpable offenders from being 'labelled' as murderers. In advocating this new three-tier structure, the Law Commission has made it quite clear that it views the primary and only essential reason for having partial defences is to circumvent the mandatory sentence[19]. The debate around 'fair labelling' is given only brief consideration and described as, *"of secondary importance compared to the sentence mitigation principle"*[20]. The Commission state that when an offender kills with the fault element for first degree murder but successfully pleads a partial defence, he or she still ought to be convicted of an offence of 'murder'. This is a major departure from the current position, of course, and has been criticised by legal academics[21]. Ashworth finds difficulty in the attempt to group five different types of offence together in the category of second degree murder. This would include the three previous types of voluntary manslaughter and some cases which would currently meet a murder charge. Ashworth is willing to accept that current law is too generous to some reckless killings (involuntary manslaughters), but argues that if the culpability in such cases is so high, perhaps provocation and diminished responsibility cases should not receive the same label. This becomes an argument for an even more finely graded homicide law with perhaps four tiers, including a separate one for successful partial defences, which could be given a label such as 'culpable homicide' – a term borrowed from Scots law[22].

The Commission justify witholding partial defences from second degree murder, believing they are not necessary for offences where the sentence will not be fixed by law. The Commission also cites concerns of the Royal College of Psychiatrists regarding the distorting effect of partial defences on expert evidence. The Royal College argued that psychiatric evidence of diminished responsibility is inevitably distorted as it must be made relevant to the verdict rather than the sentence[23]. The Commission believe making partial defences available to second degree murder would increase the number of cases in which psychiatric evidence would be distorted by making it material to the verdict. It might also employ a supplementary argument that expert opinion would be less distorted when the effect on the offence label is only to reclassify to a different grade of murder rather than to remove the label of murder altogether, meaning it has less impact on the verdict.

Another view advanced was that diminished responsibility should have a greater excusatory effect than provocation. In the consultation exercise conducted by the Commission, Mackay, who has completed much research on partial defences for the Commission, expressed his preference for diminished responsibility to reduce first degree murder to manslaughter even if provocation only reduced first degree murder to second degree murder or indeed was abolished[24]. The Commission recognise there may be advantages in this more nuanced approach, but conclude the benefits are outweighed by the drawbacks. Principally, it seems concerned by pragmatic issues. It cannot countenance a situation in which a jury agreed the defendant was not guilty of first degree murder, but nevertheless there needed to be a retrial because it was split between deciding if this should result in second degree murder or manslaughter. This further demonstrates the breadth of the proposed new offence of second degree murder incorporating offences of differing intent and, dare one say, culpability. It might seem counter-intuitive, but it appears that in the proposed new three-tier system, partial defences would find themselves alongside a more heterogenous group of offences than under the overall less differentiated two-tier system.

19 *See Wilson Op. Cit.*

20 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 2.147.*

21 *For example, see Ashworth in [2007] Crim Law Review.: 333.*

22 *Crichton J, Darjee R & Chiswick (2004) Diminished responsibility in Scotland: new case law. Journal of Forensic Psychiatry & Psychology. 15(3): 552-565.*

23 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 2.153.*

24 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 2.134.*

New Provocation

The Commission's preferred definition of provocation remains unchanged from that advanced in *Partial Defences to Murder: Final Report,* save references to duress are removed. The definition is considerably longer than that it is intended to replace, consisting of sections (1) – (5). Section (1):

> *"(1) Unlawful homicide that would otherwise be first degree murder should instead be second degree murder if:*
>
> *(a) the defendant acted in response to:*
>
> *(i) gross provocation (meaning words or conduct or a combination of words and conduct) which caused the defendant to have a justifiable sense of being seriously wronged; or*
>
> *(ii) fear of serious violence towards the defendant or another; or*
>
> *(iii) a combination of both (i) and (ii); and*
>
> *(b) a person of the defendant's age and of ordinary temperament, i.e., ordinary tolerance and self-restraint, in the circumstances of the defendant might have reacted in the same or in a similar way."*[25]

Subsection (1)(a)(i) may not prove too controversial as it largely reflects the existing state of the law. However, the additional requirement that the provocation be 'gross' suggest that graver words or conduct may be expected. Subsection (1)(a)(ii), on the other hand, introduces 'fear of serious violence' as an entirely new basis for provocation. This new defence is intended to meet criticisms that the current law 'goes wrong twice' for women by making no provision for fear of serious violence to reduce murder to manslaughter and by permitting reduction in cases where the provoked murder may have been little more than a reflection of the continuing cultural acceptability of men's use of violence in anger[26]. It has been argued previously that provocation discriminates against women[27]. This group has been regarded less likely to kill following a sudden loss of self-control in response to immediately proximal provocation, but more likely to have done so in fear of continued domestic violence. The Commission accepts that the current law discriminates by elevating anger to the only (partially) excused emotion and rebalances the equation by allowing in fear under (1)(a)(ii) & (iii). To right the second perceived wrong, the Commission has restricted, in its view unambiguously, the scope of provocation in (1)(a)(i)[28]. It should be noted that the removal of the requirement for a sudden loss of self-control to be replaced with a more relaxed approach of not acting in considered desire for revenge also opens up the possibility of other emotions than anger being permissible. Furthermore, the removal of sudden loss of control means that, depending on the circumstances, other acts, such as overreaction in self-defence, could satisfy the gross provocation requirement and result from a justifiable sense of being wronged without the defendant having experienced anger.

25 *Ibid, para 5.11*

26 *Ibid, para 5.63.*

27 *Horder J (2005) Reshaping the Subjective Element in the Provocation Defence. Oxford Journal of Legal Studies. 25(123).*

28 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.64.*

Moving on, subsection (b) begins to set out the standard of conduct expected of the defendant, and this should be read in conjunction with that which immediately follows:

> "*(2) In deciding whether a person of the defendant's age and of ordinary temperament, i.e. ordinary tolerance and self-restraint, in the circumstances of the defendant, might have reacted in the same or in a similar way, the court should take into account the defendant's age and all the circumstances of the defendant other than matters whose only relevance to the defendant's conduct is that they bear simply on his or her general capacity for self-control."*[29]

The difficult figure of the 'reasonable man' is omitted altogether but there remains an objective standard in the form of a person of the defendant's age and of ordinary temperament. However, there exists the potential for many attributes to be given to this person. The provision for all the circumstances of the defendant to be taken into account other than matters whose only relevance is to self-control, is arguably narrower than the current provision in some respects, but wider in others. With regards to the application of mental state factors to the defence, it means that mental disorder could not be adduced if it is only relevant to the defendant's self control. This would bar the defence in cases with similar material facts to those of the difficult case of *Smith (Morgan James)*[30] in which alcoholism was successfully put forward as a factor to be taken into account when considering the required level of self-control[31]. Further, it would appear that a brain-damaged defendant (similar to the defendant in *Luc Thiet Thuan v The Queen*[32] who was unsuccessful in pleading provocation) whose only relevant impairment was in self-control, such as might arise from damage to the frontal lobes of the brain, would not be able to put forward this defence. This may seem harsh upon a defendant who has an impairment arising from a head injury and *prima facie* it is difficult to see why someone with this sort of post-traumatic disorder should be less deserving than someone with a psychological injury such as post-traumatic stress disorder which predisposed them to a fear of serious violence, but it ought to be the case under the new proposals that by stating a specific (in)capacity to control him or herself in the new diminished responsibility definition (see below) any injustices could be avoided. To this extent the proposals seek to move the effect of mental disorder into the partial defence of diminished responsibility.

So how would mental disorder apply to the proposed partial defence of provocation? Firstly, mental disorder would continue to inform the court's decision as to whether the defendant was sufficiently provoked to have behaved in the way they did. The Commission gives the example that low intelligence could be taken into account as part of the circumstances if it meant the defendant misinterpreted a provocative act, thinking it to be graver than a person of higher intelligence might have done[33]. More straightforwardly, mental disorder would apply where it formed the subject of provocative words such as name-calling.

Secondly, in allowing all circumstances of the defendant to be taken into account providing they do not only bear on self-control, the proposed definition opens new areas where mental disorder might apply.

29 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.11.*

30 *R v Smith (Morgan James)32 [2001] 1 AC 146*

31 *A different view on alcoholism and self-control was later taken by the Privy Council in Attorney General for Jersey v Holley [2005] UKPC 23.*

32 *Luc Thiet Thuan v The Queen [1997] AC 131*

33 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London,.para 5.43.*

This can be observed in relation to the new provision for fear of serious violence at (1)(a)(ii). Courts would presumably be asked to decide whether the defendant was indeed in fear of serious violence, paralleling the necessity for them to decide whether defendants relying on (1)(a)(i) were indeed grossly provoked. In other words, juries would likely be asked to decide on the gravity of the fear claimed by the defendant. One can imagine how certain mental disorders would be highly relevant to this requirement. It must be the case that identical acts will induce fear differently depending on the perception of the defendant which may be strongly influenced by mental disorder. For example, a defendant with post-traumatic stress disorder (well conceivable in the oft-quoted context of domestic violence) might be more fearful about the prospect of further enactment of that trauma than another person who did not suffer from intrusive mental re-experiencing of violence. Another example in relation to fear of serious violence might be the psychotic patient whose abnormal paranoid ideation predisposes him to interpreting acts of the victim as threatening. Reading (1)(a)(ii), (1)(b) and (2) together, one might put forward that the defendant's reaction arose from fear to which he was predisposed because of a false belief that the victim wished him harm, developed secondary to auditory hallucinations telling him the same. Furthermore, it can be seen by this second example that mental disorder factors could be applied to other parts of the defence insomuch as such paranoid ideation could also be expected to impact upon the justifiable sense of being wronged in (1)(a)(i). This second example also demonstrates how it appears there would be considerable overlap between provocation and diminished responsibility.

Next, the third section outlines conditions which bar the defence:

> "*(3) The partial defence should not apply where:*
>
> *(a) the provocation was incited by the defendant for the purpose of providing an excuse to use violence; or*
>
> *(b) the defendant acted in considered desire for revenge."*[34]

Subsection (3)(a) clearly excludes cases in which the defendant has induced provocation by the victim to provide excuse for the subsequent act. This is intended to resolve a moderate degree of confusion that has arisen. At common law, 'self-induced' provocation was not regarded as sufficient. However, the *Homicide Act 1957* required the defence to be put to the jury whenever there was evidence of a provoked loss of self-control and may have removed the common law restriction[35]. The Commission believe that the common law position should be reaffirmed[36].

Subsection (b) sounds uncontroversial, but is of particular relevance to the new basis of acting in fear of serious violence. In fact, acting under considered desire for revenge alone is what is being barred here. The Commission prefer that some wish for revenge co-existing with a fear of serious violence would not bar this defence.

Section 4 provides further clarification on the matter of revenge:

> "*(4) A person should not be treated as having acted in considered desire for revenge if he or she acted in fear of serious violence, merely because he or she was also angry towards the deceased for the conduct which engendered that fear."*[37]

34 *Ibid, para 5.11.*

35 *See, for example, R v Johnson [1989] Crim LR 738 in which provocation was not precluded by the fact that the provocative attack by the victim was a predictable result of the defendant's conduct.*

36 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.79..*

37 *Ibid, para 5.11.*

This section qualifies the bar set out in (3)(b), allowing some anger to coexist with fear of serious violence without it being construed as revenge, consistent with the general approach of these proposals which acknowledge the defendant's behaviour may be influenced by several emotions and mental state factors simulaneously[38].

Section 5 addresses a notable omission in the existing law:

> *"(5) A judge should not be required to leave the defence to the jury unless there is evidence on which a reasonable jury, properly directed, could conclude that it might apply."*[39]

Unlike other defences, currently a judge must put the defence of provocation to the jury if there is some evidence of there being provocative acts or words, even if he or she feels the defence unmeritorious. The Commission feels this must raise the probability of defences succeeding (indicating, perhaps, limited faith in the ability of juries to weed out poor claims). It asserts this was probably not the intention of Parliament in passing the 1957 Act, but rather an oversight. Other passages of the report hint at this being more than simply a 'tidying up exercise', as the proposed ability of the judge to withhold defences from the jury is relied upon to prevent miscarriages of justice such as successful claims based on revenge-driven acts.

New Diminished Responsibility

The Law Commission feels that medical science has moved on considerably since diminished responsibility was placed on the statute books half a century ago and consequently the definition is badly out of date[40]. It notes that the existing definition does not make clear that the 'abnormality of mind' must reduce culpability or explain how it does so. Furthermore, the Commission highlight that the use of the term 'abnormality of mind' does not accord well with psychiatric practice[41]. Its primary recommendation is to *"modernise diminished responsibility so it is both clearer and better able to accommodate developments in expert diagnostic practice"*[42]. This appears to place expert witnesses' concerns at the heart of their proposals. Critics have expressed concern that psychiatrists frequently comment on what has been called 'the ultimate issue', in other words that they comment on all factors satisfying the defence including those which arguably should be left to the jury[43]. Importantly, the new definition omits the concept of 'mental responsibility' which many have perceived to be a moral judgement. The new defence would be based on a series of capacity tests that consider specific mental abilities:

> *"(a) a person who would otherwise be guilty of first degree murder is guilty of second degree murder if, at the time he or she played his or her part in the killing, his or her capacity to:*
>
> *(i) understand the nature of his or her conduct; or*
>
> *(ii) form a rational judgement; or*

38 *For example, see the proposals for diminished responsibility which allow a combination of a recognised medical condition and developmental immaturity. Notably this section coheres well with the first section of the provocation proposals where a combination of fear of serious violence and gross provocation (which may often, if not always, be expected to result in anger) may provide a basis.*

39 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para ?..*

40 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 1.49.*

41 *Ibid, para 5.111.*

42 *Ibid, para 5.107.*

43 *Mitchell B (1997b) Putting diminished responsibility law into practice: a forensic psychiatric perspective. Journal of Forensic Psychiatry. 8(3): 620.*

> *(iii) control him or herself,*
>
> *was substantially impaired by an abnormality of mental functioning arising from a recognised medical condition, developmental immaturity in a defendant under the age of eighteen, or a combination of both;"*[44]

Drawing in this way upon capacity to form the basis of legislation appears congruent with recent trends in clinical practice and other legislation culminating, of course, in the *Mental Capacity Act 2005*. Indeed the first two capacities appear familiar, approximating as they both do to elements of the statutory test set out in the MCA 2005,[45] as well as the preceding case law on decision-making capacity. This test may, in fact, have the effect of formalising the approach to 'mental responsibility' frequently taken by experts as evidence suggests psychiatrists tackle the current requirement for (a substantial impairment of) 'mental responsibility' by disaggregating it into putative component mental abilities[46].

One objection to the current test of a 'substantial impairment of mental responsibility' is that the question of the defendant's mental responsibility sounds like one of moral and/or legal philosophy and something in which psychiatric experts do not feel they have special expertise[47]. However, even if it were accepted that mental responsibility could be formulated in terms of cognition or mental abilities (and it should be remembered that notwithstanding their misgivings, most experts do in fact make some comment on mental responsibility), there is the question of whether any impairment was substantial. Even if an opinion on mental responsibility has been offered, arguably it only becomes the 'ultimate issue' if the degree of impairment has also been addressed. Perhaps it is not, therefore, such a problem, but the new formulation would make the respective roles of expert and jury much clearer. It seems that framing impairment(s) in terms of capacities places the issue firmly in the domain of psychiatry. Helpfully, the text of the report explains that it is then for the jury to say whether the relevant capacities are 'substantially impaired'[48]. The expert's role is set out clearly to offer an opinion on:

> *"(1) whether the D [the defendant] was suffering from an abnormality of mental functioning stemming from a recognised medical condition; and*
>
> *(2) whether and in what way the abnormality had an impact on D's capacities, as these are explained in the new provisions."*[49]

It will be noted that only one of the three capacities need be substantially impaired for the defence to succeed. The first capacity bears some similarity to elements of the test for insanity in England and Wales. To "*understand the nature of his or her conduct*" sounds rather like, "*to know the nature and quality of the act he was doing*" as famously set out in *M'Naghten's Case*[50]. Would the interpretation of 'nature of conduct' extend to the moral quality of the act, or in other words, "*that he did not know he was doing what was wrong*"? If not, it could be suggested that this would create a paradox because in this regard the full excusatory effect of insanity would be more available than the partial excusatory defence of diminished responsibility.

44 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.112.*

45 *S. 3 MCA 2005.*

46 *Mitchell B (1997b) Putting diminished responsibility law into practice: a forensic psychiatric perspective. Journal of Forensic Psychiatry. 8(3): 620.*

47 *Op Cit.*

48 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.118.*

49 *Ibid, para 5.117.*

50 *M'Naghten's Case 53 (1843) 10 Cl & Fin 200*

The second limb concerns the defendant's capacity "*to form a rational judgment*" and seems to reflect the conventional requirement in decision-making capacity to weigh up information. Of course, there is generally no requirement in current law for the decision arrived at to be sensible and presumably neither would there be here (only the capacity for a rational decision to be made).

Moving on to consider the final paragraph of section (a), it can be seen that 'abnormality of mental function' has replaced the antiquated, although perhaps not excessively problematic, 'abnormality of mind'. The Commission highlights that 'abnormality of mind' was a legal and not psychiatric term and feels the new definition has been drafted with the needs and practices of medical experts in mind. More important, perhaps, is the change to the aetiology of the mental impairment. In existing law there is a requirement for the abnormality of mind to arise from, "*a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury*"[51]. This would be replaced with a requirement in adults for the impairment to arise from 'a recognised medical condition'. Curiously, the Commission regarded the existing terms too restrictive. Other authorities believe the terms have never been satisfactorily defined[52]. It does seem that a very wide range of mental disorder has been formulated successfully as one of the three underlying conditions, and there is a strong argument that less serious mental conditions have been allowed in order to ensure more a lenient sentence or disposal, for example in cases of so-called 'mercy killings' perpetrated by relatives of terminally ill victims[53]. It is hoped that the new definition would bring clarity to proceedings and allow psychiatrists to limit themselves to recognised diagnoses. It was certainly the belief of the Royal College of Psychiatrists that the proposed restriction would ensure that any such defence was grounded in valid medical diagnosis and would encourage experts to use recognised psychiatric classification systems[54]. This has the potential of being more restrictive towards the perpetrators of mercy killings, although given the likelihood of depressive or trauma-related symptoms in this group it will surely be possible for the courts to show leniency if it is their will until the type of wider investigation into euthanasia recommended by the Commission has taken place. Although, such a development would open up psychiatric classification systems, it would probably not change dramatically the disorders deemed acceptable as the current definition is broad, but it would seem to be more accommodating to personality disorders by allowing them to stand as their familiar clinical classifications rather than having to frame them as arrested development, disease or injury or as an inherent cause.

The other two changes to the basis of the abnormality in mental functioning/mind relate to defendants under the age of eighteen. Firstly, the new formulation allows the substantial impairment of mental functioning to arise from developmental immaturity. This addresses a lacunae in the current law which means that normal developmental immaturity cannot be allowed to form the basis of the defence[55]. This seems important in a jurisdiction where criminal responsibility may be assumed from the age of ten. Secondly, the final provision which allows a defendant under eighteen to be impaired by a combination of a recognised medical condition and developmental immaturity obviates the need to separate artificially these factors in a defendant of that age.

51 *Homicide Act 1957, s2.*

52 *Ormerod D (2005) Smith & Hogan Criminal Law (11th Ed). Oxford University Press: Oxford: 469.*

53 *Mackay R. [1999] The Abnormality of Mind factor in Diminished Responsibilty. Criminal Law Review: 117.*

54 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.114.*

55 *S2 of the Homicide Act 1957 requires an abnormality of mind to cause the substantial impairment in mental responsibilities, which does not accomodate normal developmental immaturity.*

Next, the second section of the new definition contains a requirement for a link between the abnormality of mental functioning and the fatal act or omission:

> *"(b) the abnormality, the developmental immaturity, or the combination of both provides an explanation for the defendant's conduct in carrying out or taking part in the killing."*[56]

The current law does not make explicit that there must be a link between the abnormality of mind and the offending behaviour. The new proposal requires an explanation based on the abnormality before the defence can succeed. The Royal College of Psychiatrists cautioned against a situation where experts might be called upon to 'demonstrate' causation on a scientific basis rather than indicating the likely impact of the abnormality[57]. The Commission feel its terms ensured an appropriate connection between the abnormality of mental function or developmental immaturity and the killing. The phrasing of the requirement being for *an* explanation rather than anything stricter (such as *the* explanation) suggests the test does not require the connection to be demonstrated as an absolute truth at the expense of other explanations, which no doubt would have caused the Royal College concern. This seems based in realism and to reflect the level of evidence involved, which by its nature must be speculative.

Nevertheless, section (b) does call for the link between the abnormality of mental functioning and the act or omission to be made clearer than under the current regime. The current term 'mental responsibility' is vague and open to conjecture about moral connotations as described above. It seems that read together, the specific capacities in subsections (a) (i) - (iii) and the explanation required in section (b) mean that overall there is a requirement for the essential problem or disability at the heart of the defence to be made much more explicit.

Other Potential Defences

Alongside provocation and diminished responsibility, the Commission considered several other potential defences as part of the review: duress, infanticide, mercy killing, killing pursuant to a suicide pact and insanity.

Duress

Duress is a general defence that is uniquely unavailable to murder. The Commission felt at all stages of the exercise that this was not right. Circumstances involving duress arise when the defendant becomes involved in the killing of an innocent person but only because he or she is personally threatened with death or with a life-threatening injury and the only way to avoid the threat is to participate in the killing[58]. Under current law, the defendant would be convicted of murder and given the mandatory life sentence. The Commission point out that sentencing guidelines do not even mention duress as a mitigating factor for murder.

Interestingly, the Commission had initially proposed to make duress another partial defence, which won the support of consultees. However, it reconsiders, thinking this could lead to undue complexity in other areas of homicide citing the difficulty in applying it to second degree murder, attempted murder and manslaughter. Instead, it has gone further and proposes it should be a full defence.

56 *Law Commission (2006) Murder, Manslaughter and Infanticide. Law Com No. 304, TSO, London, para 5.112.*

57 *Ibid, para 5.123.*

58 *Ibid, para 1.54.*

Infanticide

The offence of infanticide will be familiar to many expert witnesses and others. What may be less well understood is that infanticide can also be advanced as a partial defence after a charge of murder has been made. The Commission finds no problem with the current definition, or its position within the structure of homicide, but rather with the procedure for ensuring that evidence of a mother's mental disturbance at the time of the killing is heard at trial[59]. It is concerned that in cases where the defendant denies killing their infant they are unlikely to submit to a psychiatric examination and so are likely to be convicted of murder as they are, for the same reason, unlikely to run with any other defence dependent on mental state. The Commission proposes a new post-trial procedure in these cases:

> *"[I]n circumstances where infanticide is not raised as an issue at trial and the defendant (biological mother of a child aged 12 months or less) is convicted by the jury of murder [first degree or second degree murder], the trial judge should have the power to order a medical examination of the defendant with a view to establishing whether or not there is evidence that at the time of the killing the requisite elements of a charge of infanticide were present. If such evidence is produced and the defendant wishes to appeal, the judge should be able to refer the application to the Court of Appeal and to postpone sentence pending determination of the application."*[60]

The procedure around murder is already unusual in that all defendants should have a psychiatric report. The difference with this suggestion is that the first instance judge would refer the case to the Court of Appeal so an opinion could be obtained.

'Mercy Killing'

The Commission was tasked with considering euthanasia only inasmuch as it formed part of the law of murder and not more widely. It has decided any substantive recommendation on this subject should wait for a more detailed consultation on the issue. It recommends a separate exercise examining whether the law should recognise a separate offence of mercy killing or a partial defence of this type[61].

Killing Pursuant to a Suicide Pact

This is already a partial defence to murder under the 1957 Act. The Commission's starting position was that this provision should be repealed. However, in the light of its decision not to pursue a mercy killing defence without specific consultation, it recommends retaining killing pursuant to a suicide pact as a defence at this stage[62].

Insanity

The complete defence of insanity fell within the terms of reference of the review, but the Commission has decided not to address it, indicating it was not an area of law that seemed to give rise to real difficulty or anomaly[63]. It makes no firm conclusions about how insanity would operate alongside their proposed new provocation and diminished defences. The Commission hypothesises the new defences could be interpreted more or less restrictively than the current law, thus making insanity more or less likely to be

59 *Ibid, para 1.51.*

60 *Ibid, para 8.46.*

61 *Ibid, para 7.49.*

62 *Ibid, para 7.50.*

63 *Ibid, para 1.2-3. However in its report 'Tenth Programme of Law Reform' (11/6/08), the Law Commission list 'Consideration of unfitness to plead and the insanity defence' as one of their 'new projects'.*

advanced instead. Finally, it does not think its recommendations removes the theoretical distinction between insanity as an 'all-or-nothing' defence and diminished responsibility as a partial defence representing a point on a scale of mental responsibility.

What Next? The Government's Response

The Commission has not published draft legislation with its report as it usually does with less controversial legislation. Instead, it recognises that further consultation will be needed before this can be taken forward. The Ministry of Justice finally responded in December 2007 with a brief written ministerial statement which outlined the Government's plans. It has decided to proceed on a 'step by step basis' and look first at:

> "*(1) reformed partial defences to murder of diminished responsibility and provocation (including the use of excessive force in self-defence);*
>
> *(2) reformed offences of complicity in relation to homicide; and*
>
> *(3) improved procedures for dealing with infanticide."*[64]

The statement by the junior minister goes on to express the Government belief that, "*it is right to deal with these crucial elements of the existing law before going on to consider the wider structural proposals from the Law Commission*"[65]. Finally, the minister promises to publish draft clauses for consultation in Summer 2008 prior to introducing any necessary legislation.

Prima facie, the Government's approach does not seem entirely consistent with that of the Law Commission. After all, the wider review of the homicide law followed the Commission's assertion that partial defences could not be examined in isolation, but needed to be considered alongside their position and effect in homicide law as a whole. There must be a suspicion that the Government may revise the definitions of provocation and diminished responsibility but take reform no further. At the very least they have decided upon a process which would allow this to happen and which weakens the argument that reform of the definitions of partial defences and the structure of homicide law are inseparable. In short, the Commission's 'risky subterfuge' regarding mandatory sentencing will not have paid off unless the Government eventually takes this review to a second step and is willing to countenance a discretionary sentence for some types of murder.

On balance, this article finds the definitions advanced by the Commission are somewhat broader than those currently in force. Overall, viewing the whole package of proposals, any increased availability of these defences appears to be balanced by a reduction in the excusatory effect of a successful plea to the (albeit important) one of allowing flexible sentencing. If the Government accepts the Commission's definitions, it may be a desire to revisit the overall balance of reform that drives the review process forward to a second step.

64 *http://www.justice.gov.uk/news/announcement_121207a.htm*

65 *Op Cit.*

Conclusions

Precipitated by problems with partial defences to murder, the UK Government asked the Law Commission to review homicide law as a whole. Its resulting proposals would radically restructure homicide law and make substantial revisions to provocation and diminished responsibility. It would also introduce duress as a full defence to murder and make important changes to infanticide. The Commission recommends the Government hold the debate around euthanasia elsewhere and retains killing pursuant to a suicide pact until such a consultation has been completed.

The Commission's proposals would change the definition of the partial defences and the effect of a successful plea. The scope of provocation would broaden and be available to those who acted in fear of serious violence. It is hoped this would prevent injustice to abused female defendants. The troublesome figure of 'the reasonable man' has been omitted altogether, and with it some of the relevance of mental disorder in homicide to provocation. The Commission has signalled a clear desire to move much of the effect of mental disorder on self-control 'into' diminished responsibility but has opened up new areas where mental disorder could be relevant to provocation as well as retaining its relevance to the gravity of provocation.

The new definition of diminished responsibility is capacity-based. Two of the capacities will be familiar to any doctor who has been concerned with assessing their patient's decision-making ability, but the third (for self-control) is less familiar and arguably has the potential to make this defence more available to defendants with personality disorder and other disorders. The new definition appears to place assessment of the relevant impairment incontrovertibly in the domain of psychiatry. However, experts would not be expected to comment on the ultimate issue of whether the entire defence is satisfied. Crucially, the Commission expects juries to decide on the critical degree of impairment present. Other changes attempt to anchor the relevant abnormality in contemporary psychiatric diagnoses, recognise the role of normal developmental immaturity and make explicit the link between abnormality of mental functioning and the fatal act or omission.

The overall effect of the proposals might be seen as balanced in terms of the sympathy and excuse offered to mentally disordered offenders. The new provocation test would allow a greater number of defendants to plead this defence successfully, especially female defendants with the psychiatric sequelae of trauma. Most mental health concerns excluded from the self-control limb of provocation should be absorbed into diminished responsibility. The diminished responsibility test is more detailed than that it is intended to replace, but as only one of the newly-identified capacities need be substantially impaired, more defendants may 'pass' the test. The increased availability is contrasted by the reduced effect of a successful plea. The defences would only reduce first degree murder to second degree murder. The Commission argues that flexible sentencing is the only allowance this group of offenders absolutely require to meet justice. However, it cannot be entirely unimportant that these offenders will no longer be convicted of manslaughter but rather be labelled as 'murderers', albeit of a lesser degree.

The overall package of reform proposed is a most interesting one with several attractions, but will also present significant challenges to mentally disordered defendants, their legal representatives and those submitting psychiatric evidence. The momentum now lies with the Government which, with regard to partial defences, has decided to first review provocation and diminished responsibility definitions as well as procedural aspects of infanticide, before there is any possibility of advancing a further step to consider the Commission's other proposals. Further consultation with interested parties is promised and it is clear that this process of review which started in 2003 is some way from being completed.

The Community Order and the Mental Health Treatment Requirement

Linda Seymour, Max Rutherford, Husnara Khanom, Chiara Samele[1]

Introduction[2]

Just a few months into 2008, a convergence of unfortunate circumstances has brought the plight of offenders with mental health problems into sharp focus. Figures released by the Ministry of Justice showed there were 92 apparently self-inflicted deaths among prisoners in England and Wales in 2007, compared with 67 in 2006.[3] This 37% increase in suicides in prison has been associated with the overcrowding that has continued inexorably. Indeed towards the end of February the population of offenders in the prison estate rose above the critical 82,000 mark for the first time.[4] The Home Office has predicted that the prison population could rise to 101,900 by 2014. [5]

As can be seen from **Table 1**, reviews have found a high prevalence of mental illnesses among prisoners in England and Wales. [6,7,8,9]

1 *Respectively: Head of Policy; Policy Officer; Research Assistant; Head of Research – all at the Sainsbury Centre for Mental Health.*

2 *Unless otherwise stated, statistics on the use of community orders were obtained from the Ministry of Justice and are unpublished.*

3 *http://www.guardian.co.uk/uk/2008/jan/02/conservatives.politics*

4 *(http://www.guardian.co.uk/society/2008/feb/24/prisonsandprobation)*

5 *Home Office (2007a) Prison Population Projections 2007 – 2014, England and Wales 11/06. London. Home Office*

6 *Fazel S and Danesh J. (2002) 'Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys', Lancet 359:545-550.*

7 *Social Exclusion Unit (2002) Reducing re-offending by ex-offenders, London: SEU*

8 *Singleton N, Meltzer H and Gatward R. (1998) Psychiatric morbidity among prisoners in England and Wales, London: ONS*

9 *Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2000) Psychiatric morbidity among adults living in private households, 2000. London: Office of National Statistics.*

Table 1: Mental health problems in prisons and the general population

	Prevalence among prisoners	Prevalence in general population (adults of working age)
Psychosis	6% – 13%	0.4%
Personality disorder	50% – 78%	3.4% – 5.4%
Neurotic disorder	40% – 76%	17.3%
Drug dependency	34% – 52%	4.2%
Alcohol dependency	19% – 30%	8.1%

The Government has acknowledged that too many people with mental health problems continue to be imprisoned [10] , particularly as the mental health care provided in prisons is often poor.[11] However mental health problems are also common amongst people receiving community sentences. According to the national risk/needs assessment tool for adult offenders in England and Wales, the Offender Assessment System (OASys), the level of emotional needs that may have been directly related to the criminal behaviour of those serving community sentences in 2005/6 was 43 per cent.[12] Supervised women offenders appear to have higher levels of mental health need than men. A national study in 1997 found that a third of women subject to community supervision by the Probation Service described themselves as having a mental disorder. During the same period the figure for men was one in five.[13]

Levels of mental health need for offenders managed in the community appear to be increasing. In 2002 a review of work in Inner London Boroughs found that at least 20 to 30 per cent of individuals in touch with the Probation Service displayed evidence of a mental disorder.[14] By 2006 further research demonstrated that 48 per cent of those in contact with the Probation Service were experiencing mental health concerns and as many as a third of offenders in the community also suffered from problems associated with a personality disorder.[15]

The number of people receiving community sentences has increased in parallel with the rising numbers in the prison population. For example, in the decade between 1995 and 2005 the number of people sentenced to community sentences (repackaged as Community Orders[16] in April 2005 as part of the implementation of the *Criminal Justice Act 2003*), rose by nearly 74,325, to 204,247 during 2005.[17]

In April 2005, the Community Order became the new generic community sentence available to magistrates and judges as an alternative to prison, when a fine or a discharge is deemed inappropriate.

10 *Home Office (2006), A Five Year Plan for Protecting the Public and Reducing Re-offending, London: Home Office, p. 26.*

11 *Duncan G. (2008) From the Inside: Experiences of prison mental health care. London. Sainsbury Centre for Mental Health (www.scmh.org.uk)*

12 *Solomon E and Rutherford M (2007) Community Sentences Digest, London: Centre for Crime and Justice Studies*

13 *Mair G and May C (1997) Offenders on probation. Home Office Research Study 167. London: Home Office*

14 *London Probation (2002) The London Probation Area Strategy for Work with Mentally Disordered Offenders. London Probation, p. 1*

15 *See footnote 8 above.*

16 *The Community Order should not be confused with the Community Treatment Order (a/k Supervised Community Treatment) enshrined in the Mental Health Act 2007. See 'Towards an Understanding of Supervised Community Treatment' by Mt Kinton, earlier within this issue of the JMHL.*

17 *Home Office (2007b) Sentencing Statistics 2005. London: Home Office. p. 12–13.*

The Community Order utilises a choice of twelve different requirements including unpaid work, electronic curfew, supervision, and drug and alcohol treatments. One of the twelve is the Mental Health Treatment Requirement (MHTR) which can be issued to offenders who have an identified mental health problem; where treatment is readily available; and when the offender has given their consent. Despite the high levels of mental health problems among offenders serving sentences in the community, the MHTR has been used in less than one per cent of all requirements issued. Only 725 were issued in England and Wales in 2006, out of a total of 203,323 requirements.

This article gives an overview of the MHTR and its use within the context of community sentencing and the Community Order. Various hypotheses are posited that might explain the low uptake of the MHTR by sentencers. We conclude by describing the Sainsbury Centre's research programme on the MHTR and describe the pilot phase of the research.

Community sentences overview

Since the Probation Service's inception in 1907, community sentences have been renamed and reconfigured many times, most recently in 2005. **Table 2** summarises how the sentences have developed.

Table 2

Name of Order	Date Introduced	Details
The Probation Order	1907	Involving one-to-one sessions with a probation officer, lasting for a minimum of six months and a maximum of three years. Replaced by the Community Rehabilitation Order (CRO) in 2001
The Community Service Order (CSO)	1972	Lasted between 40 hours and a maximum of 240 hours. In 2001 it was replaced by the Community Punishment Order (CPO).
The Combination Order	1991	Combined probation and community service, and was introduced in the 1991 Criminal Justice Act. Probation involvement lasted between 12 months to 3 years, with community service of 40-100 hours. In 2001 it was renamed as the Community Punishment and Rehabilitation Order (CPRO).
The Drug Treatment and Testing Order	2000	Lasted between six months and three years.
The Community Order	2005	Implemented as part of the Criminal Justice Act 2003 **replacing all other community sentences**. Twelve requirements became available to sentencers to form the new Orders.

Over a 10-year period up to 2005, the number of people given community sentences increased by more than 74,000, representing a rise of 57 per cent. The largest proportion of offenders given community sentences committed an offence type of other summary offences, theft, or summary motoring.[18]

The Community Order

In April 2005, as part of the implementation of the *Criminal Justice Act 2003*, the community sentence was re-launched as the Community Order and since that time has been used for all offenders given community sentences.[19]

The new Order offered sentencers more flexibility and choice when assigning a community sentence to an offender. Court disposals could be adapted more closely to the needs of the offender and community while applying the sentencing principles of punishment, rehabilitation, reparation and public protection more effectively. The twelve possible requirements allowed by the Community Order invited a *hybrid* approach to community sentences, with requirements issued in proportion to the seriousness of the offence. The overarching aim of this new approach was to increase public confidence in community sentences.

The twelve requirements

The table below describes the main elements of the twelve requirements available for sentencers when constructing the Community Order.[20, 21]

Table 3: The 12 requirements of the Community Order

Requirement	Serving hours demanded	Details
1. Unpaid work	40-300 hours	An Unpaid Work Requirement must be completed within 12 months. It involves activities, such as cleaning up graffiti, making public areas safer or conservation work. The work is intended to benefit the local community and often residents are able to suggest projects for offenders on Unpaid Work to carry out.
2. Supervision	Up to 36 months	An offender will be required to attend appointments with an Offender Manager or Probation Officer. The focus of the supervision and the frequency of contact will be specified in the sentence plan based on the particular issues the offender needs to work on. The length of a Supervision Requirement must be the overall period for which the Community Order is in force.

18 *See footnote 5 above.*

19 *As prescribed by law however, for offenders whose crimes were committed before April 2005, previous sentence types were applied.*

20 *National Probation Service (2006) The Tailored 12 Requirements Poster, London: Home Office*

21 *Mair G et al (2007) The use and impact of the Community Order and the Suspended Sentence Order. London: CCJS, p. 9*

3. Accredited programme	Length to be expressed as the number of sessions; must be combined with a Supervision requirement	These are aimed at changing offenders' thinking and behaviour. For example, the Enhanced Thinking Skills Programme is designed to enable offenders to understand the consequences of their offence, and to make them less impulsive in their decision-making. This requirement is particularly intended for those convicted of violence, sex offending, drug or alcohol abuse, domestic violence and drink impaired driving
4. Drug rehabilitation	6-36 months; offender's consent is required	If offenders commit crime linked to drug abuse, they may be required to go on a Drug Rehabilitation Programme. Programmes may involve monthly reviews of an offender's progress
5. Alcohol treatment	6-36 months; offender's consent is required	This Requirement is intended for offenders whose crime is linked to alcohol abuse and treatment.
6. Mental health treatment	Up to 36 months; offender's consent is required	After taking professional advice, the court may decide that the offender's sentence should include mental health treatment under the direction of a doctor or psychologist.
7. Residence	Up to 36 months	An offender may be required to live in a specified place, such as in a probation hostel or other approved accommodation.
8. Specified activity	Up to 60 days	Including community drug centre attendance, education and basic skills or reparation to victims.
9. Prohibited activity	Up to 36 months	Offenders may be ordered not to take part in certain activities at specified times, like attending football matches. If offenders do not comply with this Requirement, they can be sent back to the courts for re-sentencing.
10. Exclusion	Up to 24 months	An offender may be prohibited from certain areas and will normally have to wear an electronic tag during that time.
11. Curfew	Up to 6 months and for between 2–12 hours in any one day; if a stand-alone curfew order is made, there is no probation involvement and is privately contracted	An offender may be ordered to stay at a particular location for certain hours of the day or night. Offenders will normally wear an electronic tag during this part of their sentence.
12. Attendance	12-36 hours with a maximum of 3 hours per attendance	For offenders under 25, the court can direct the offender to spend between 12 and 36 hours at an attendance centre over a set period of time. The offender will be required to be present for a maximum of 3 hours per attendance on each occasion. The attendance centre Requirement is designed to offer 'a structured opportunity for offenders to address their offending behaviour in a group environment while imposing a restriction on their leisure time'

The Home Office has mapped the twelve requirements against their intended effects of:-

- **Punishment:** Offenders should be properly punished for their crime and a lengthy, well-planned and properly supervised community sentence is tough on offenders and offers far more constructive possibilities for the future.
- **Reparation:** Offenders may be required to face their victim or give back to their local community, which can facilitate their viewing their crimes in a different way.
- **Rehabilitation:** Offenders need support and opportunities to change to deter them from committing more crimes.
- **Protection:** Protecting the public is the top priority.

Table 4: Requirements and their intended effect (Home Office 2005)

Requirement	Punishment	Reparation	Rehabilitation	Protection
Unpaid work	**P**	**P**	**P**	
Supervision			**P**	
Accredited Programme			**P**	
Drug Rehabilitation			**P**	
Alcohol Treatment			**P**	
Mental Health			**P**	
Residence			**P**	**P**
Specified Activity		**P**	**P**	
Prohibited Activity	**P**			**P**
Exclusion	**P**			**P**
Curfew	**P**			**P**
Attendance Centre	**P**			

The Mental Health Treatment Requirement (MHTR)

The MHTR as part of the Community Order might be deemed a re-launch of the Probation Order with Psychiatric Treatment. This type of order was phased out in 2001, as was subsequently the little-used Community Rehabilitation Order with a requirement for psychiatric treatment (for more on the predecessors to the MHTR, prior to their introduction, see Clark et al 2002[22]).

22 *Clark, T., Kenney-Herbert, J. and Humphreys, M. S. (2002) 'Community rehabilitation orders with additional requirements of psychiatric treatment', in Advances in Psychiatric Treatment, vol. 8, pp. 281–290, http://apt.rcpsych.org/cgi/reprint/8/4/281.pdf*

In summary, before using a MHTR, the court must be satisfied that[23]:

- The offender should submit to treatment by, or under the direction of, a registered medical practitioner or a chartered psychologist, with a view to the improvement of the offender's mental condition;
- The treatment given to the offender should be *either* treatment as a resident patient in an independent hospital or care home, or a hospital (but not in hospital premises where high security psychiatric services are provided) *or* on a non-residential basis;
- On the evidence of a registered medical practitioner, the mental condition of the offender is such as requires and may be susceptible to treatment, but is not such as to warrant a hospital order or guardianship order under the *Mental Health Act 1983*;
- Arrangements have been or can be made for the treatment intended, including arrangements for the reception of the offender where he or she is to be required to submit to treatment as a resident patient; and
- The offender has expressed his or her willingness to comply with a MHTR.

Requirements issued

Relatively few MHTRs have been issued across England and Wales, compared with some other requirements since 2005. For example there were 725 MHTRs issued between January and December 2006 compared with 11,361 Drug Treatment Requirements issued in the same period.

There are a number of possible explanations for this variance e.g.:-

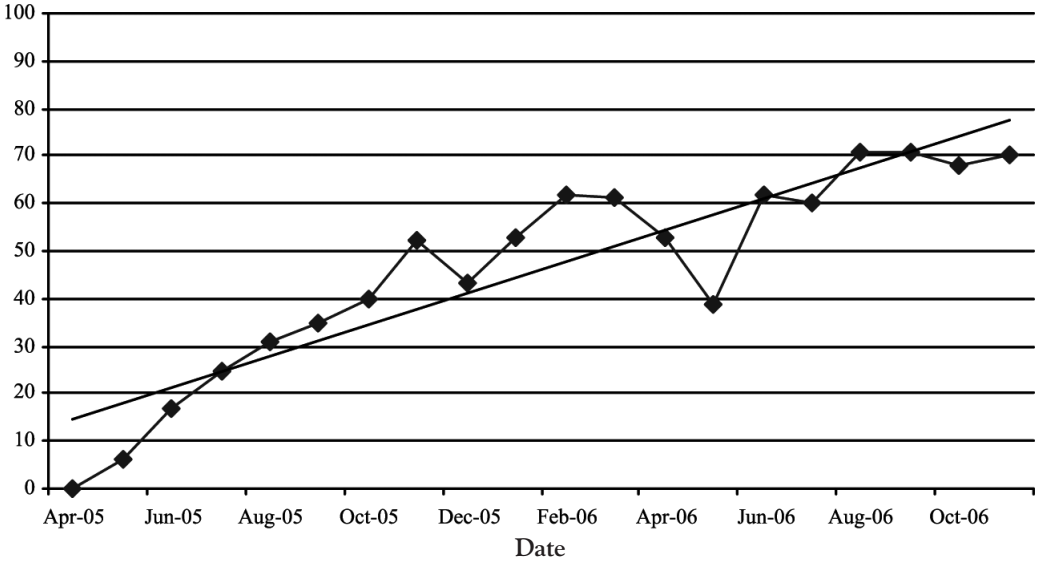
- the relationship between substance misuse and crime, and mental disorder and crime, is different;
- there are national targets for drug treatment requirements that must be met by probation and other partners such as drug action teams and there are no such targets for numbers of MHTRs.

Despite the low overall numbers to date however, the use of MHTRs has been steadily increasing month by month. In the first and second quarters of 2007 the MHTR was issued a further 384 times. After two years of use, the total number of MHTRs issued with Community Orders has exceeded 1,300.[24]

23 *S 207 Criminal Justice Act 2003*

24 *Ministry of Justice (2007) Probation Statistics Quarterly Brief, April-June 2007, England and Wales http://www.justice.gov.uk/docs/q2brief-probation-2007.pdf*

Table 5: Monthly use by the courts of the Mental Health Treatment requirement with Community Orders, April 2005 – November 2006[25]



Stand-alone and combination requirements

In 2006, a total of 60,253 Community Orders with only one requirement were issued. In 19 of these the requirement was a MHTR. In contrast 39,392 single-requirement orders for Unpaid Work were issued over the same period. 72 per cent of all MHTRs used with a Community Order were combined with a Supervision requirement.

From the existing data it is not possible to draw any firm conclusions as to why the courts are rarely issuing other requirements alongside the MHTR, such as Unpaid Work, Drug Rehabilitation or Accredited Programme. It seems that offenders with mental health problems are being denied access to the full range of sentencing options by both criminal justice and health practitioners and there could be an association with mental health stigma and discriminatory attitudes. This hypothesis shall be explored in the course of the Sainsbury Centre's research programme on the MHTR.

Regional variation[26]

During 2006, seven out of the 42 probation areas – London, Kent, West Midlands, Merseyside, Thames Valley, Essex and Greater Manchester – accounted for 55 per cent of all MHTRs issued despite the fact that these areas accounted for 36 per cent of the total number of requirements issued nationally.

The London probation region used the MHTR more, both numerically and proportionately, than any other region. In 2006 they issued 201 MHTRs, 0.8 per cent of the total numbers of requirements issued in London with Community Orders.

25 *There are no figures for December, owing to fewer sentencing days.*

26 *See footnote 1 above.*

In contrast, London's usage of MHTRs was proportionately more than four times higher than the lowest issuing region of Yorkshire and Humberside. The latter issued 39 MHTRs, 0.16 per cent of their regional total.

- Further variations are notable in the 2006 figures for the 42 probation areas:-
- 20 issued fewer than 10 MHTRs;
- 8 areas issued MHTRs less than 5 times each;
- Northamptonshire issued a MHTR only twice – out of 4,851 requirements levied;
- North Yorkshire issued a MHTR only twice – out of 2,861 requirements levied.

Ethnic and gender variation

Only 9 per cent of the general population of England and Wales derives from non-white ethnic groups, but 25 per cent of the prison population is comprised of people with a non-'white British' ethnicity.[14]

There was significant variation by ethnicity in the use of the MHTR in 2006. 28 per cent of all MHTRs issued during this period were given to non-white ethnic groups. 12 per cent were issued to black or black British offenders and this group also received the MHTR proportionately more often than any other. These figures must be considered within the context of the regions where the MHTRs were issued, i.e. the London probation region may contain a higher proportion of people of non-'white British' ethnicity than areas issuing fewer requirements.

An average of only 14 per cent of all requirements issued with Community Orders were for female offenders, with 15 per cent of MHTRs issued to females. Proportionately women were more likely to be given a drug treatment requirement than men and more likely to receive a supervision requirement, but less likely to receive an accredited programme requirement. Comparatively, women are as likely to receive a MHTR as men.

Obstacles to use of the MHTR

The court may face a number of difficulties in issuing the MHTR and these may explain some of the shortfall in its use. The Sainsbury Centre's initial assessment of the available data offers some suggestions, not in any order of importance, as to why the MHTR may be less well used than other requirements of the Community Order.

Legislative obstacles

The law states that the offender must have enough of a mental health problem to warrant the requirement, but not so great as would warrant the making of a hospital order or guardianship order under the *Mental Health Act 1983*. Despite the high prevalence of mental health problems among offenders serving community sentences, the requirement is therefore only suitable in very particular cases.

It is instructive to revisit the actual wording of S. 207 (3) *Criminal Justice Act 2003*:

> *"A court may not by virtue of this section include a mental health treatment requirement in a relevant order unless*
>
> *(a) the court is satisfied, on the evidence of a registered medical practitioner approved for the purposes of section 12 of the Mental Health Act 1983, that the*

mental condition of the offender-

(i) is such as requires and may be susceptible to treatment, but

(ii) is not such as to warrant the making of a hospital order or guardianship order within the meaning of that Act;

(b) *the court is also satisfied that arrangements have been or can be made for the treatment intended to be specified in the order (including arrangements for the reception of the offender where he is to be required to submit to treatment as a resident patient); and*

(c) the offender has expressed his willingness to comply with such a requirement."

The necessity for consent (which also applies for alcohol treatment requirements and drug rehabilitation requirements) may be a stumbling block for the courts even in the cases where the first two potential obstacles (as set out in (a) and (b) above) have been addressed, because of the stigma attached to disclosure.

Research has shown that mental health service users in the general population have repeatedly identified stigma and discrimination as significant obstacles to their quality of life and access to employment and other services.[27] As a consequence, the prevalence of mental illness stigma can be a powerful influence on offenders in open court. The offender may feel that consenting to drug or alcohol treatments is preferable to consenting to mental health treatment, although it is possible that mental health problems could be the underlying issue.

Access to services

There is a lack of access to mental health services for offenders supervised in the community. A report commissioned by the Home Office and the Department of Health published at the end of 2005 looked at community provision for offenders. It concluded:

There is a particular dearth of mental health provision for offenders in the community. Whilst the Offender Mental Health Care Pathway published in January 2005 by the Department of Health provides some examples of good practice, this primarily relates to the provision of mental health services to ex-prisoners discharged into the community.[28]

Mental health assessment

One of the most substantial obstacles that prevents the court from issuing a MHTR is the apparent difficulty in obtaining access to psychiatric assessment, the gateway to this disposal.[29] *Assessment* by a s. 12 approved doctor is an essential pre-requisite to the process, even where the *treatment* of the requirement is going to be carried out by a chartered psychologist.

Many offenders who have mental health problems are not given a MHTR simply because their mental health needs have not been identified. Before a MHTR can be imposed, a psychiatric assessment must be carried out. If this assessment is not arranged and conducted, the MHTR will not be issued, thus

27 *Thornicroft G, Rose D, Kassam A and Sartorius N (2007) 'Stigma: Ignorance, prejudice or discrimination?', British Journal of Psychiatry. 190: 192-193.*

28 *Offender Health Care Strategies (2005) Improving health services for offenders in the community, (http://www.ohcs.co.uk/pdf/guides/000101_hop_report.pdf)*

29 *A DH project piloting Service Level Agreements for securing timely psychiatric court reports is currently in process in London and the South West.*

depriving the offender of the care, treatment and interventions that could make a crucial difference both to their mental health and their offending behaviour.

The problems of obtaining timely psychiatric assessments can be due to local budgeting or time pressures. Yet even where assessment has been arranged, it has been suggested that unless the psychiatric reports are commissioned by psychiatrists with local connections it may not be possible to access local mental health services for the offender.[30]

Complex needs

Research by the voluntary sector service provider *Turning Point* demonstrates that offenders on community sentences, who have both mental health and drug problems, face particular difficulties accessing services and treatment. They found that *"…support is not offered for mental health needs until after drug treatment has ended or may not be offered in cases in which mental health needs are only identified once treatment has started. Some areas don't take people with mental illness because these clients are assessed as not being able to cope with the available treatment'*.[31] In addition, offenders are more likely to receive an alcohol or drug treatment requirement if they have a dual diagnosis, than a MHTR, as part of their community sentence.

Similar problems confront offenders with complex needs. Research amongst *Revolving Doors*' clients, many of whom had spent different periods on community sentences and often also in custody, revealed that:-

- just under half required support to address at least two significant problems, such as housing difficulties, drug issues and alcohol dependency;
- offenders with mental health problems on community sentences have been slipping through the net of services with their needs unidentified;
- a third of clients had some unmet needs.
- of the third, a small proportion were at immediate risk of physical or mental ill health.[32]

The MHTR research project

A key priority for the Sainsbury Centre's criminal justice programme is to redirect people with mental health problems into care and treatment and, where appropriate, away from custodial sentences. The data presented in this article describe both the rising trend in usage of community sentencing, and the infrequent and differential application of the MHTR. This requirement may offer offenders with mental health problems a viable alternative to custodial sentences. In the absence of a clear understanding of its application and effect, however, it is less likely that a recommendation for MHTR will be made.

To remedy this situation, the Sainsbury Centre has commenced a research programme to address the knowledge deficit in this important area of policy and statute. During 2008 the Centre is collecting primary data to explore the MHTR, its usage, delivery and impact across nine boroughs in Greater London.

30 *NACRO (2007) Effective mental healthcare for offenders: the need for a fresh approach, London: NACRO, p. 12*

31 *Turning Point (2004) Contribution on alcohol and drugs to the Big Conversation (http://www.turning-point.co.uk/NR/rdonlyres/A99F485D-EE0B-4029-AB07-39AB5D374D6F/608/TheBigConversation.doc)*

32 *O'Shea N (2003) Snakes and Ladders: Findings from the Revolving Doors Agency Link Worker Scheme*

The research will explore how an offender is issued with a MHTR, and the decision-making processes prior to, and at the point of, sentencing. There will be a particular focus on identifying the factors that facilitate or prevent a MHTR being issued.

Since there is currently very little known about how an offender is managed and co-ordinated post sentence, the research also aims to acquire an understanding of the detail of MHTR treatments, the key professionals or agencies involved in delivering the MHTR, and relevant processes and procedures for implementing the sentence.

To that end, interviews will be conducted with a range of professionals and practitioners from courts, probation and healthcare services, as well as relevant voluntary sector professionals involved in after-care services following sentencing.

The research will be conducted in three phases: at the court level, in probation and in healthcare. The interviews with sentencers and legal professionals have explored awareness and identification of mental health problems, understanding and awareness of the MHTR and the barriers that are preventing a requirement from being issued.

The forthcoming interviews with staff from probation and healthcare will indubitably draw attention to a range of related issues, which it is hoped will inform the development of a framework for addressing the key research questions.

Conclusion

The mental health of offenders continues to be a pressing issue for policy makers, and health and criminal justice practitioners. Appropriate care and treatment for mental health conditions is not often best delivered within the prison estate. As a consequence there has been an increasing focus on diversion to alternative settings that will address both retribution and rehabilitation for this group.

For example, the Corston review[33] recently recommended that:

> *DH at the highest level should reconfirm its commitment to implement not just its own Women's Mental Health Strategy but also to the action it signed up to in respect of the Women's Offending Reduction Programme (WORP). This will require senior leadership within DH.*

The government replied as follows:[34]

> *Part of the work on the Women Offenders Health Pathway will include consideration of whether the mental health needs of women offenders could be best addressed through making more use of the Mental Health Treatment Requirements as part of a community order, or if a different approach would be more effective.*

Similarly, in February 2008 the Justice Minister, Lord Hunt, spoke about tackling offending by improving health. He said:

> *"With the Court Service we will improve liaison with NHS mental health bodies, so that offenders who are suffering from mental illness can have their conditions fully considered by the courts before sentencing.*

33 *Home Office (2007) A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system. (http://www.homeoffice.gov.uk/documents/corstonreport)*

34 *Home Office (2007ii), The Government's Response to the Report by Baroness Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System. (http://www.justice.gov.uk/docs/corston-review.pdf)*

> *The Sainsbury Centre reported recently that not enough use is made of the mental health treatment element of community orders. They concluded that people are currently serving prison sentences who might possibly have been disposed in the community had the courts made fuller use of this sentencing option*[35]*."*

However against this background of heightened interest in the use of the MHTR, the actual numbers issued have fallen. Probation quarterly statistics for the quarter July to September 2007 confirm that there were 173 MHTRs attached to Community Orders. These figures represent a 30% decrease in use from the previous quarter.[36]

The Sainsbury Centre's research programme into the MHTR will provide the opportunity to explore the workings of an extant piece of under utilised policy and statute. At the end of the project the Centre will be in a stronger position to make informed recommendations. Updated information will be made available as the project progresses, on the Sainsbury Centre website (www.scmh.org.uk).

35 *The full speech is at http://www.justice.gov.uk/news/sp080208a.htm*

36 *Ministry of Justice/National Offender Management Service. Probation Statistics. Quarterly Brief. July to September 2007. England and Wales. Table 4. (http://www.justice.gov.uk/docs/q3brief-probation-2007.pdf)*

Audit of Statutory Urgent Treatment at a High Security Hospital

***Andy Bickle*[1], *Tarek Abdelrazek*[2], *Anne Aboaja*[3] *& Kim Page*[4]**

Introduction

Section 62 of the *Mental Health Act 1983* ('the Act') allows urgent treatment for mental disorder to be given without patient consent, and overrides the requirement for the procedural safeguards provided for within sections 57 and 58. *"It is not applicable to any treatment that does not come within the remit of either section 57 or section 58"*[5]. This statutory 'urgent treatment' provision applies only to patients liable to be detained under the long-term sections of the Act[6]. Under s62, treatment may be given:

> *(1)* *(a)* *which is immediately necessary to save the patient's life; or*
>
> *(b)* *which (not being irreversible[7]) is immediately necessary to alleviate serious suffering by the patient; or*
>
> *(c)* *which (not being irreversible or hazardous[8]) is immediately necessary to alleviate serious suffering by the patient; or*
>
> *(d)* *which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.*

Section 62 can also be applied where a responsible medical officer considers that discontinuance of the treatment already in progress would cause serious suffering to the patient[9]. Such a situation might occur, for example, when a patient withdraws their consent but it is deemed necessary for treatment to continue until a second opinion can be obtained.

It can be seen that this section lifts the legal requirement to obtain a patient's consent or the authorisation of a SOAD for treatment with medication after the first three months, or for treatment with

1 *Specialist Registrar in Forensic Psychiatry, East Midlands Centre for Forensic Mental Health, Arnold Lodge, Cordelia Close, Leicester.*

2 *Associate Specialist in Forensic Psychiatry, Rampton Hospital, Retford, Nottinghamshire.*

3 *Specialist Registrar in Forensic Psychiatry, Rampton Hospital, Retford, Nottinghamshire.*

4 *Consultant Forensic Psychiatrist, Rampton Hospital, Retford, Nottinghamshire.*

5 *Jones R. (2006) Mental Health Act Manual (10th Ed.) Sweet & Maxwell: London, page 332.*

6 *It does not apply to patients liable to be detained under ss. 4, 5(2), 5(4), 35, 37(4), 135, 136 or patients who have been conditionally discharged and not recalled. See s. 56 MHA 1983..*

7 *Meaning, at s62(3), "if it has unfavourable irreversible physical or psychological consequences".*

8 *Meaning, at s62(3), "if it entails significant physical hazard".*

9 *S62(2).*

ECT at any time. It can also provide a legal basis, where immediately necessary, to provide the type of treatments described in section 57 which otherwise require both consent and a second opinion (although given the nature of treatments - in practice only psychosurgery - covered by section 57, the circumstances in which such power would be invoked are "difficult to envisage"[10]).

The powers of urgent treatment provided under s.62 will be essentially retained following the amendments made to the Act by the *Mental Health Act 2007*, although their application in the case of ECT will be restricted to situations where treatment is immediately necessary to save life or, not being irreversible, to prevent serious suffering (i.e. the criteria under s.62(1)(a) or (b)). By virtue of a new s.62A, urgent treatment powers under s.62 will be applicable to patients recalled to hospital from supervised community treatment (SCT), and to such patients whose SCT status is revoked. Emergency treatment powers over SCT patients who have not been recalled to hospital will not apply where the patient has given a capable refusal of consent.[11] It appears that existing standards for best practice (outlined below) will remain authoritative as they are all retained in the revised Code of Practice published by the Department of Health in May 2008.

These standards are set out in the current Code of Practice[12]. They concern the proper application of the section, patient consent and proper documentation. The Mental Health Act Commission has given additional guidance regarding second opinions. No statutory forms are provided to document the use of section 62[13]. Instead, the Code recommends that hospital managers devise their own forms[14]. Little audit or research on the proper use of statutory urgent treatment has been reported in the literature. *Johnson & Curtice* found in their general psychiatry service that section 62 was used exclusively to authorise ECT[15]. In contrast, *Haw & Shanmugarutnum* found that in a large hospital including patients detained under Part III of the Act in conditions of low and medium security, this section was used mostly to give medication[16]. Neither of these audits was reported in detail and so compliance with all of the available standards is not known. In Scotland, *Nelson et al*[17] audited notification documentation relating to treatment given under section 98 of the now repealed *Mental Health (Scotland) Act 1984* (which was equivalent to section 58 of the *Mental Health Act 1983*). They found that regular medication was stated in over 90% of cases, but 'as required' medication was less well recorded, suggesting perhaps that psychiatrists are less good at documenting unplanned treatment.

The aim of the audit which is the subject of this article, was to measure the use of statutory urgent treatment at one of England's three high security hospitals (Rampton Hospital) against the standards set out in the Code and by the MHAC. Rampton Hospital is a large hospital which averaged around 400 beds during the audit period and has a catchment area of approximately one third of England. The hospital accommodates patients who suffer from a wide range of mental disorders, having directorates for mental illness, learning disability, personality disorder, women and (from 2004) 'Dangerous and Severe Personality Disorder'. All patients are detained under the *Mental Health Act 1983*. It was submitted that the proper use of statutory urgent treatment is important to Rampton Hospital as an institution which accommodates patients presenting with the highest security needs owing to their risk to others.

10 *Jones R. (2006) Mental Health Act Manual (10th Ed.) Sweet & Maxwell: London, page 333.*

11 *MHA 2007, s.64B(3), 64G(5)-(7), and 64G*

12 *Dept of Health & Welsh Office (1999) Code of Practice. Mental Health Act 1983. London: HMSO, see chapters 1, 15 and 16.*

13 *This is in contrast to forms 38 & 39 which are provided for the documentation of consent and treatment decisions relating to sections 57 & 58 of the Act.*

14 *At para 16.41.*

15 *Johnson I & Curtice M (2000) Use of Section 62 in clinical practice. Psychiatric Bulletin 24: 154.*

16 *Haw C & Shanmugarutnum R (2000) Use of Section 62 in clinical practice. Psychiatric Bulletin 24: 276.*

Method

The study audited all episodes of urgent treatment authorised by section 62 at Rampton Hospital over nearly 5½ years between January 1st 2000 and June 1st 2005. A list of all episodes within the audit period was generated by the Information Governance Department at Rampton Hospital. This was based on their log of section 62 documentation sent to them *as per* hospital procedure. A data collection tool was designed for the task. Data was collected from medical records and Mental Health Act Office files. Records were retrieved from the Rampton Hospital Archive where necessary. Relevant information was found on Section 62 forms, other MHA-related paperwork (forms 38 & 39), the continuous healthcare record and medication cards. It was assumed that any second opinion given within ten days of statutory urgent treatment had been requested as a result of that treatment episode.

Standards

Three audit standards were extracted from the Code of Practice (1999):

1. Section 62 should only be applied to those patients and types of treatments provided for in sections 57 and 58 of the Mental Health Act (1983).[18]
2. The patient's consent should be sought for all proposed treatments which may lawfully be given under the Act. The interview at which such consent was sought should be properly recorded in the medical notes.[19]
3. Every time urgent treatment is given under section 62, the patient's RMO or the doctor for the time being in charge of the patient's treatment should complete a form giving details of:
    1) the proposed treatment;
    2) why it is of urgent necessity to give the treatment;
    3) the length of time for which the treatment was given.[20]

A further standard was provided by the Mental Health Act Commission:

4. Where section 62 is invoked, a request should generally simultaneously be made for a second opinion, so that repeated use does not arise.[21]

It was expected that every urgent treatment episode would be compliant with standards 1–3. With regard to standard 4, it was accepted that a need for a second opinion would not arise from every urgent treatment episode, but reflecting the assertion that a request should generally be made it was expected that this should happen in a majority of episodes.

Results

It was found that urgent treatment was given at Rampton Hospital under section 62, on 107 occasions between January 2000 and June 2005. The results for each audit standard were as follows:

17 *Nelson D, Wright M, Walsh I, Moody K. & Beveridge L. (2003) The Use of Consent-to-Treatment Forms at the State Hospital: An audit in 1996 and 2000. Medicine, Science and the Law, 43(2), 132-135.*

18 *Code of Practice Mental Health Act 1983, para 16.2.*

19 *Ibid, para 16.4.*

20 *Ibid, para 16.41.*

21 *Mental Health Act Commission (1987) Second Biennial Report (1985-1987). London: HMSO, para 7.6.*

Standard 1

The type of treatment authorised by section 62 was mostly medication:

	No. Cases (%)
S57 treatments	0 (0.0)
S58 ECT	1 (0.9)
Medication	105 (98.1)
Missing data	1 (0.9)
Total	107

Tab. 1 Types of treatment given under section 62

Assessing adherence to this standard involved several considerations. The standard insists that section 62 should only be applied to those patients and types of treatments provided for in sections 57 and 58 of the MHA 1983. All patients at this hospital are detained under long sections of the Act and thus potentially liable to this section. However, 6% (6/107) of episodes involved patients for whom no evidence could be found of having yet been treated with medication for mental disorder and so could potentially have been given medication under the authority of section 63[22] . In a further 7% of episodes (7/107), data were missing.

Whether or not the prescribed medication was treatment for a mental disorder, was considered. This assessment was not straightforward as some medications for mental disorders are also indicated for other disorders[23]. However, most of the medications that were used do not have common physical health indications. It was concluded that in only one episode was medication for a physical disorder given under s.62. Elsewhere, in only one case was section 62 used to authorise ECT.

In summary, we found evidence that standard one was met in 92% of episodes for which data was available.

Standard 2

All types of medical record were scrutinised for evidence that the patient's consent had been sought. The findings were as follows[24]:

22 *"The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer"*

23 *Many mood stabilizing medications are also anti-epileptics and some antidepressants are given for neuropathic pain, to name but two examples.*

24 *We required specific reference to an attempt to obtain consent and did not accept it had been made if merely reference to a meeting with the patient proximal to the treatment had been made, even when the patient was described as "unco-operative" or in similar terms.*

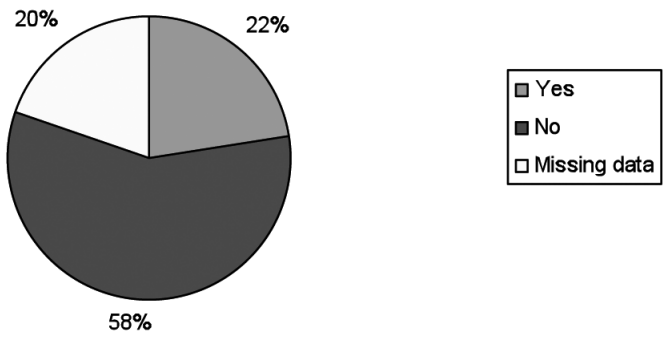


Fig. 1 Was there evidence of an interview at which consent was discussed?

Of the cases for which data was available, there was evidence of an interview at which consent was discussed in only 27% (24/88) of cases.

Standard 3

It was found in the large majority of cases that details of treatment, and a reason why it was of urgent necessity, was recorded. In far fewer cases (little more than a third) the length of the treatment was given:

	Present	**Absent**	**Missing Data**	**Total**
Treatment	105 (98.1%)	1 (0.9%)	1 (0.9%)	107
Reason given	100 (93.5%)	4 (3.8%)	3 (2.8%)	107
Length of time given	38 (35.5%)	65 (60.7%)	4 (3.8%)	107

Tab. 2 Details given on section 62 treatment notification form

In nearly all cases for which data was available (99%), the form had been completed by a doctor. One form had been completed by a member of nursing staff. Most commonly it was completed by the patient's responsible medical officer (53.3%). It was not possible to ascertain whether in the remaining cases, the doctor was definitely the doctor for the time being in charge of the patient's treatment, but in most cases it appeared to be the on-call duty doctor, whom it was felt met that description.

Standard 4

It was found that a second opinion had been requested after a small majority (49/94 = 52.1%) of episodes for which data was available. In a further 13 cases it was not possible to form a view as to whether or not a second opinion had been requested, owing to missing data.

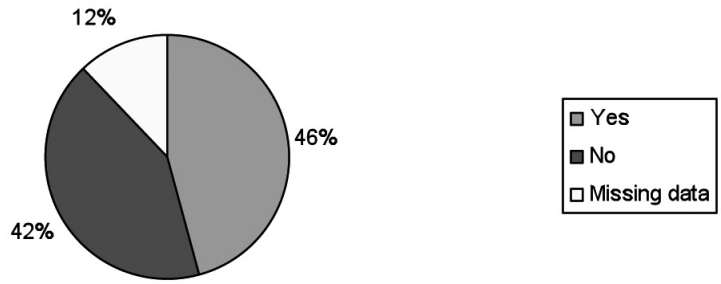


Fig. 2. No. of episodes which were followed by a request for a second opinion

Further Finding

The reasons given for the urgent necessity of treatment *as per* the statutory provisions were reviewed. As might be expected, section 62 was most commonly invoked to prevent the patient behaving violently or being a danger to himself or others:

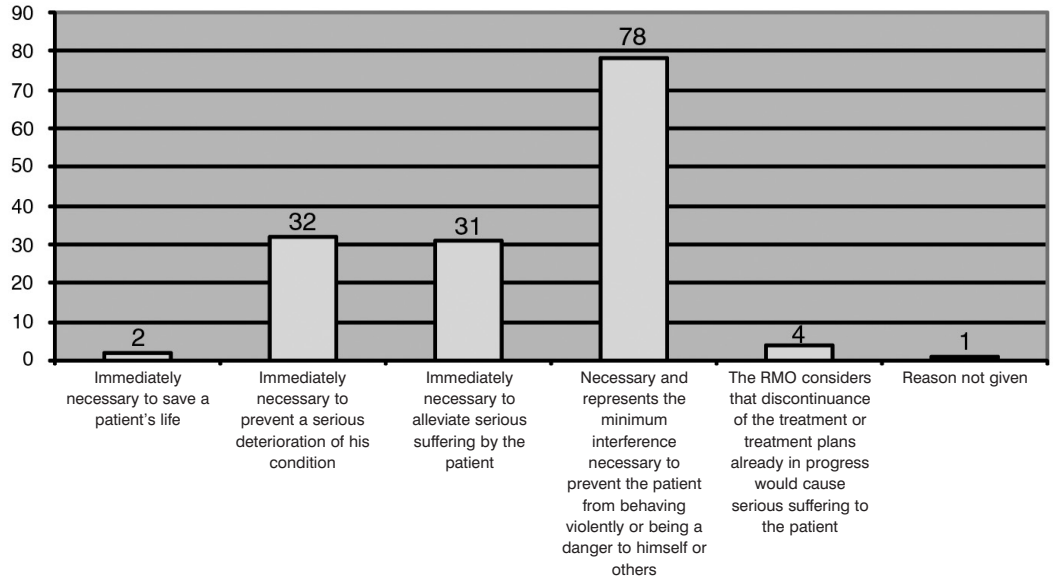


Fig. 3 Reason given for urgent necessity of treatment (more than one reason may be given)

In only a handful of episodes, did RMOs exercise their power to use section 62(2) so as to continue with a treatment plan pending compliance with section 57 or section 58.

Conclusions

We conclude that the provisions for statutory urgent treatment for mental disorder were generally being applied at Rampton Hospital to give appropriate treatments[25] to appropriate patients and the basic details of treatment were being documented. Therefore, it is our view that standards 1 and 3 were largely satisfied. We found that doctors did not routinely demonstrate that consent had been sought, and so practice in this regard fell well short of standard 2. We also note that those detailing urgent treatment did not outline the length of time for which treatment was to be given. We speculate that this may be because this standard as derived from the Code does not accord well with clinical practice inasmuch as it is phrased in the past tense as if to capture the entire treatment episode, when in fact this form is usually completed at the beginning of an episode of urgent treatment. Finally, we found that around half of episodes stimulated a second opinion request, suggesting that standard 4 was close to being met.

Overall, we observe that episode details which were prompted for specifically by the existing notification documentation were well recorded and details which were not prompted for specifically were not well recorded, either on the notification form or elsewhere in the clinical records. For example, the reason for urgent treatment was requested on the documentation form, but confirmation that consent had been sought was not. Similarly, a prompt for the type of treatment given was included on the form, but did not go so far as to ask for the length of treatment. This correlation between well-recorded data and the content of the data collection form is not surprising, but in our view does emphasise the importance of well-structured and fail-safe data collection systems.

Audit Cycle – The Next Step

In keeping with the belief that audit should be an ongoing process or cycle enabling continual improvement, we implemented interventions to improve the quality of section 62 usage. Most importantly, we redesigned the notification documentation so it included specific prompts for every piece of information required to meet the audit standards. For example, to make the recording of consent more user-friendly, we introduced a list of tick box options to document that an attempt had been made to obtain consent and the reason why this had not been successful. In addition, we presented our findings locally at a meeting of Rampton Hospital doctors and at a national meeting of forensic psychiatrists. The new notification documentation has now been in use for over a year and later in 2008 we will repeat the audit to measure its effectiveness.

Discussion

We believe this project was ambitious in scale, auditing as it did the use of section 62 within the entire patient population of a high security hospital for more than five years. There is little in the literature with which our results can be directly compared. Of interest, our finding that section 62 was being used almost entirely to administer medication accorded with that of *Haw & Shanmugarutnum*[26], and not with *Johnson & Curtice*[27] who in contrast found it was only used to authorise ECT. An explanation for this might be that the former audited a population which contained forensic patients and so was more akin to our own. Their sample is likely to have exhibited higher rates of severe and enduring mental disorder and lower

25 *We mean this in a legal sense; this project was not designed to assess clinical judgment in individual treatment episodes.*

26 *Haw C & Shanmugarutnum R (2000) Use of Section 62 in clinical practice. Psychiatric Bulletin 24: 276.*

27 *Johnson I & Curtice M (2000) Use of Section 62 in clinical practice. Psychiatric Bulletin 24: 154.*

rates of depression and acute suicidality than would be found in a general psychiatric setting.

Our main findings demonstrated that psychiatrists showed mixed ability at complying both with secondary legislation and guidance from the Mental Health Act Commission. However, when supported by structured information governance systems, their performance was, in our view, good. We hope that we have helped to improve compliance by introducing better notification documentation. However this finding does, perhaps, suggest there ought to be a statutory data collection vehicle for section 62 treatment as there is for other sections of the Mental Health Act, and that this should not be left to local hospital managers to design. Probably the worst recorded was information as to whether consent had been sought. As practising psychiatrists, we can see that where urgent treatment is being considered, the clinical situation is likely to be one where seeking consent is particularly difficult. One response to criticism on this issue may be that the patient's mental state was so disturbed that any serious attempt would have been futile and may even have delayed treatment without any realistic prospect of benefit. Nevertheless, we feel that it is important to document this as the reason why consent had not been obtained, and our new documentation provides for this.

There were several limitations to this audit. Firstly, we were reliant on a list generated from records returned to a central office for detection of statutory urgent treatment. This may have introduced a sampling bias as there may have been something different about urgent treatment episodes which were not reported in this way (although all should have been reported). For example, episodes not reported to the central office may have been less well documented. From our consultations with stakeholders at both ends of this process (both ward staff and information governance staff) we feel reasonably reassured that the practice of notification was well-established and understood. We feel we have to accept this limitation owing to the practical difficulties of collecting the data for an audit on such a scale in this setting, but we are mindful that the results obtained may be unrepresentative to some degree.

Secondly, there were problems inherent in collecting data respectively from such a long sample period. Some data was missing (the exact percentage varied according to each piece of information as they were available from different sources such as multidisciplinary record, drug card etc). Most of the missing data was accounted for by entire records being missing. It appeared that this usually occurred when the patient had been transferred to another high security hospital. This was less often the case when the patient had been transferred to a less secure hospital or discharged to prison or elsewhere. Therefore, it is possible that the missing data represented patients who were more mentally disturbed and were in need of a high security hospital environment in the longer term. Other problems with collecting data highlighted deficits in recording the requisite information on existing documentation. For example, there was no space or prompt provided to comment on consent. This meant that we had to review all contemporaneous available clinical information to see if it had been recorded elsewhere. This made data collection less robust and increased the possibility of not finding information.

Thirdly, the difficulty in ascertaining when records were missing may have led to us overestimating the number of patients who had not previously received medication for mental disorder, and thus could have been treated without their consent under the three month rule without resorting to section 62. For example, in reviewing the extensive records we may have concluded there was no evidence that they had received medication before, but there may have been missing documentation of which we were unaware which showed that they had. If there were indeed such cases we will have underestimated the number of episodes in which this standard was met. However, as compliance with this standard was already good at over 90% we do not believe any error would significantly alter our conclusions.

Fourthly, with respect to standard four, we inferred that a request for a second opinion had been made if one was given within ten days. We had no means of assessing directly whether a request had in fact been made to the Mental Health Act Commission. We hope that any request would have been met within ten days, but it is possible that some opinions took longer to arrange. Conversely, it is possible that a visit from a second opinion doctor had already been arranged before section 62 treatment took place, and so had not been precipitated by use of the section.

We acknowledge these limitations, but despite these shortcomings we believe that valid observations can be made and drawn upon to improve adherence to legislation. Furthermore, we are confident we have taken important practical steps to enhance our own practice. The available evidence suggests that the audit standards we adopted will continue to form the basis of guidance on statutory urgent treatment after the amendments to the Act by the *Mental Health Act 2007* come into force. Therefore, we believe that the audit cycle started here will be relevant for the foreseeable future. We look forward to repeating this audit and assessing the impact of our interventions. Our next audit should be amended slightly to acknowledge the amendments made to s. 62 in respect of ECT. Similar audits completed in settings receiving patients recalled from the community under community treatment orders should include this type of patient within their sample.

The authors would like to thank Dr Emmet Larkin (Consultant Forensic Psychiatrist & Associate Medical Director, Rampton Hospital), Joanne Gleaden and Julie Smith (Health Effectiveness & Audit Team, Rampton Hospital), Lynn Lamb, Beth McCarthy and Keith Allen (Information Governance, Rampton Hospital) and Linda Fields (Mental Health Act Administration Team, Rampton Hospital) for their kind and frequent assistance with this project.

A snap-shot of 'long-term' section 17 use in South-West England

***Bob Jones*[1] *and Mat Kinton*[2]**

The Mental Health Act Commission (MHAC) does not have a culture of visiting patients in the community, having a primary statutory duty of visiting detained patients in hospital, and no remit over patients placed under Guardianship or Supervised Discharge (s.25A)[3]. The MHAC's statutory remit does, however, encompass patients who remain liable to be detained but are granted leave of absence from hospital, and will extend to patients who are subject to supervised community treatment upon the implementation of SCT powers in October 2008[4], although proposals in the *Health and Social Care Bill*, which was passing through Parliament at the time of writing (March 2008) would merge the MHAC with the Healthcare Commission and Commission for Social Care Inspection, into a broad-based 'Care Quality Commission' effective from April 2009.[5]

Where MHAC visits to hospitals are announced in advance, it may already request that hospital administrators contact patients who are out on leave, letting them know that they could meet with a Commissioner if they attend hospital on the day of the visit. However, many MHAC visits are unannounced, or announced only at very short notice, making this difficult. In any case it is likely that some patients who are on leave would be unwilling, or unable, to attend hospital on the day of an MHAC visit just to speak with a Commissioner. Even patients who are detained in hospital may be initially hesitant in coming forward to speak with Commissioners, although such initial hesitance can often be overcome over the course of the visit, either through the encouragement of Commissioners themselves or through peer-support and example set by fellow patients: such mechanisms clearly do not apply when a patient is isolated from other detainees and away from the site of the visit. There are no general statistics on the numbers of such leave patients seen by the MHAC in the course of its routine activity, but we believe that number to be very small.

In an attempt to get a better understanding of patient and process issues that are likely when visiting community-based patients, the MHAC has been running some exploratory visits to detained patients on long-term section 17 leave. These visits have been carried out under the MHAC's statutory remit. This is a brief account of one such exercise in the South-West of England.

1 *Mental Health Act Commissioner*

2 *Senior Policy Analyst, MHAC; Senior Researcher in Mental Health Law, UCLAN.*

3 *Mental Health Act 1983, s. 120(1)*

4 *Ibid., as amended by the MHA 2007, schedule 3, para 26(2).*

5 *Clause 1 and Schedules 1 and 3 of the Health and Social Care Bill 2007.*

Defining 'long-term section 17 leave'

A patient who is liable to be detained under the Mental Health Act at a hospital can only be lawfully absent from that hospital if his or her responsible medical officer (RMO) grants leave of absence, using the powers vested in the RMO under s.17 of the Act. As discussed by Gledhill in the last issue of this journal[6], over the last five years or so, case-law has interpreted the language of s.17 to allow for the renewal of a patient's liability for detention whilst that patient is on leave of absence from hospital, even where the continuing hospital treatment is only on an outpatient basis, and even where the RMO's "grasp" on the patient is "gossamer thin" during the process of staged discharge[7]. In recent years we have heard anecdotally that increasing numbers of patients are thus subject to 'long-term' s.17 leave of absence from hospital. Establishing a fixed point at which a period of leave becomes 'long-term' is necessarily arbitrary, especially if, as we have done in this exercise, we follow the assumed definition in the revised Act (which requires responsible clinicians to consider SCT as an alternative to any period of leave exceeding seven consecutive days)[8]. It may be possible to avoid such arbitrariness through attending to the intention and circumstances of the leave rather than to its duration, although retaining objectivity in such categorisation could be difficult. In this exercise we started from the crude but objective measure of 'long-term' leave as leave that had exceeded, or was intended to exceed, seven consecutive days.

Making contact with patients on long-term section 17 leave

One of the authors (Bob Jones) contacted two NHS Trusts in the South West of England and requested the details of all patients who were liable to be detained but on section 17 leave from hospital, and who had been granted s.17 leave for in excess of seven consecutive days. The larger of the two Trusts (Trust A) provided details of 18 patients; the smaller (Trust B) with the details of seven patients. We asked Trust A to contact the three patients who had been on leave for the longest period of time, and Trust B to contact four of its seven patients (one patient was excluded because of serious mental incapacity, and two others were due to be taken off leave). Altogether six of the seven patients that we asked to be contacted requested a meeting with the Commissioner (the one who did not had ceased to be detained). Meetings were arranged at a place of the patient's choosing, providing that this was not their home. Four patients chose to meet at the hospital where they remained liable to be detained, one chose the office of her home treatment team, and one chose to meet in a communal area of her supported housing unit. Although the MHAC had been prepared to reimburse travel expenses for patients, in the event the Trusts as, detaining authorities, had already made funding arrangements when the Commissioner met with the patients.

Matters raised in the patient meetings

The six patients raised several issues which provide some general indication of some of the process and patient problems which SCT and extended s.17 leave patients might experience:

- Due to a misunderstanding between professionals, one patient had not received his depot medication for some time (the patient thought three months, but staff informed the Commissioner that it was considerably longer).

6 *Gledhill, K (2007) 'Community Treatment Orders', JMHL 16, Nov 2007, p.149-169 (p.149-153).*

7 *R (on the application of CS) v MHRT [2004] EWHC 2958, para 46; (see Thompson S and Marchant S (2005) "'Hospital treatment' further defined", JMHL 13; 191-198). See also R (on the placation of DR) v Mersey Care NHS Trust [2002] EWHC 1810, and discussion of that case in Hewitt, D (2003) 'There's no magic in a bed – the renewal of detention during a period of leave'. JMHL 9; 87-101 (July 2003).*

8 *Mental Health Act 1983, s.17(2A) and 17(2B), as introduced by the Mental Health Act 2007, s.33.*

- The authority for treating one patient under section 58 was an 18-month old Form 39. This did not fully cover the medication that the patient was actually receiving.
- One patient had been resident in supported housing for some time, although this was not stated as a condition of his leave on the leave form. The manager of the supported housing had, we were told, asked him to vacate by Easter 2008. With nowhere else to go, this was causing some anxiety, not least because of the possible need to return to hospital. It was unclear who was helping him with this.
- The patient who was visited at her supported housing unit had, as part of her leave arrangements, the condition that she was allowed out for only 2 hours a day. Thus for the most part she was detained in the community.
- One patient had no traceable section 17 leave form, whereby staff could determine the agreed leave parameters.
- One patient stated that her RMO had advised her to withdraw her appeal to the Mental Health Review Tribunal (MHRT). This patient saw the Commissioner together with her advocate, who confirmed the RMO's comment. The RMO's comment left the patient feeling that exercising her right of appeal would be held against her in the long run.

Where appropriate, issues raised were dealt with either on the day of the visit or by writing to the Trust for comment.

The scale of long-term section 17 leave

To enable us to draw a profile of patients subject to long-term leave, we asked Trust B to supply us with details of their age, gender, and whether they were resident at home or at another place. The Trust's seven patients on long term S.17 leave had an age range between 35 and 64 years (mean age 50), and four were female. Two patients, aged 54 and 60, were recorded as living in residential care, but the remaining five patients resided at home. Trust A was not asked to supply the information detailed above, but we take the view that this sort of information should be routinely collected in future monitoring of community powers, including whether or not the place of residence is specified as a condition of leave or SCT.

We also asked for the length of time spent on leave. Of all 25 cases of 'long-term' leave notified to us by both Trusts, three had not yet been out of hospital for longer than a week, but had been authorised leave that would extend beyond such a time. Only one patient had been on leave for longer than eleven weeks, having been on leave for four and a half months. The mean length of time outside hospital for all patients was 35 days. The range of time spent on 'long-term' leave for all 25 patients is shown at table 1 below.

time spent on leave	< 1 week	1 – 2 weeks	2 – 3 weeks	3 – 4 weeks	4 – 5 weeks	5 – 6 weeks	6 – 7 weeks	7 – 8 weeks	8 – 9 weeks	9 – 10 weeks	10 – 11 weeks	> 11 weeks
number of patients	3	5	2	2	1	2	4	1	2	1	1	1

Table 1: time spent on leave of 25 patients classed as on 'long-term' leave at time of notification

We have sought to estimate what proportion of all patients who are liable to be detained in each Trust is made up of patients subject to long-term leave. Trust A operates approximately 300 inpatient beds, and Trust B approximately 130 beds[9]. In the South West of England, an average of two-thirds of psychiatric inpatients noted in the 2006 census had informal status[10]: so this implies a detained *inpatient* population of roughly 100 patients in Trust A, and 43 patients in Trust B.

As such, perhaps surprisingly, the numbers of patients who are on long-term section 17 leave *may* account for between 16 and 23 per cent of the population liable to be detained under the *Mental Health Act* in each Trust[11]. However, this figure is perhaps inflated by the definition of 'long-term' leave that we used.

Implications for SCT numbers

The statutory and practical criteria for eligibility for SCT are discussed by Kinton elsewhere in this issue[12]. In summary, the statutory criteria are that the patient's mental disorder warrants treatment which is available; that it is necessary for the patient's health or safety or the safety of others that such treatment is given, but that it can be given outside hospital; and that it is necessary that the responsible clinician should be able to exercise a power of recall over the patient[13]. Emerging guidance[14] and ministerial statements in parliament[15] suggest that patients need at the very least to be co-operative with treatment to be practically eligible for SCT. As SCT patients are not 'liable to be detained' whilst in the community[16], the conditions set as a part of SCT should not amount to a deprivation of liberty, at least until the deprivation of liberty safeguards come into force.[17]

In our view, taking account of these criteria, only two or three of the six patients that met with the MHAC would have been likely to be deemed suitable for SCT.

In one case, which we suspect would have had echoes in the circumstances of some other patients whom we did not meet, SCT would not have provided the legal authority required for the patient's care whilst on leave, as the latter itself amounted (in our view) to a deprivation of liberty. A patient who is effectively deprived of his or her liberty at the place to which he or she had been sent on leave could, at least until the deprivation of liberty safeguards come into force[18], only be subject to such a regime whilst retaining the legal status of 'liable to be detained' and under the broad discretionary powers of s.17 leave. Such

9 *These numbers were supplied to the `Count Me In' census team by the respective Trusts for the 2008 census as estimations of their bed capacity.*

10 *http://www.healthcarecommission.org.uk/_db/_downloads/xtabSHAS10MH.xls*

11 *This is calculated as follows: Trust A has 100 detained inpatients, of which 18 patients (18%) are on long-term leave. Trust B has 43 detained inpatients, 7 of whom (16%) are on long-term leave. In previous census returns, Trust A reported approximately 230 rather than the 300 beds reported this year: at the former level (i.e. assuming a detained inpatient population of about one-third of inpatients, or 77 patients), 18 patients on long-term leave would account for 23% of all patients liable to be detained. It should be emphasised that the detained inpatient figures are arrived at through the application of general statistical averages and not actual head-counts.*

12 *See Kinton M (2008) `Towards an Understanding of Supervised Community Treatment', JMHL 17 pp. 7–20.*

13 *See MHA 1983 as amended by the MHA 2007, s.17A(5) for the exact wording of the criteria.*

14 *See Kinton, op cit. Table 1 in this issue, summarising advice at chapter 28 of the revised Mental Health Act Code of Practice for England.*

15 *See, for example, Hansard (Commons) 18 Jun 2007: Col 1199, cited in this issue at Kinton, op cit, n.85.*

16 *MHA 1983 as amended by the MHA 2007, s.17D(1)&(2)*

17 *The deprivation of liberty safeguards are expected to come into force in April 2009. See revised Mental Health Act Code of Practice for England, para 28.8, which suggests that deprivation of liberty under the MCA can exist alongside SCT or such leave. We remain uncertain that it will be deemed permissible, should the matter be challenged in the courts, for the conditions of SCT to constitute deprivation of liberty, even if concurrently authorised under the MCA.*

18 *See n. 17 supra.*

circumstances are perhaps most likely where s.17 is used for 'trial' transfers from one hospital to another, or for transfers to strict regimes in care homes or other supported accommodation, and where it is perhaps misleading to consider the use of long-term leave as a form of *community* treatment.

In the case of the other two or three patients for whom we doubted SCT would be deemed appropriate, this was largely because of the criteria for SCT and, most importantly, the assumption that SCT patients must be co-operative with the conditions set by their responsible clinician.

There are, of course, many limitations to this exercise as an empirical study (a purpose for which it was not initially designed). Although we started with a reasonably large baseline population across two NHS Trusts of considerable geographic area, a much more widespread survey would be required to capture the details of a suitably large number of long-term leave patients to enable statistical analysis. We have applied local statistical averages and not actual head-counts to provide a baseline population of patients liable to be detained against which to compare the numbers of patients on leave. This exercise (one of a number of exploratory meetings with patients on leave being conducted by the MHAC at the time of writing) took place in an area of England where particularities of geography and infrastructure may limit the potential for generalising our findings. Mindful of these limitations, these findings do, nevertheless, support the general view that long-term leave of absence from detention in hospital already plays a substantial role in the management (and indeed coercion) of people with serious mental disorder. Future monitoring arrangements (including local auditing arrangements by the detaining authorities themselves) could build on or learn from these tentative beginnings.

Following the implementation of the changes to the Act in November this year, professionals responsible for the care of such patients may prefer to engage with the perceived clearer legal boundaries of SCT than the vagaries of discretionary powers under s.17, but in any case will be required by law to consider SCT for them. However, this study has indicated to us that some patients on long-term s.17 leave will be ill-suited or ineligible for transfer across to the new community treatment regime.

Casenotes

Capacity, Best Interests and Sex

Peter Bartlett[1]

In the Matter of MM: Local Authority X v MM and KM.
[2007] EWHC 2003 (Fam).

Facts

MM had paranoid schizophrenia, a moderate learning disability and poor cognitive functioning. For some 15 years, she had been in a relationship with KM. KM led a nomadic life, encouraging MM to accompany him. In this process, he encouraged MM to disengage with psychiatric services. He further had a history of violence toward MM.

In March 2006, MM took up residence in supported accommodation. Thereafter, on the encouragement of KM, she left the accommodation for extended periods at various times, apparently sleeping rough and not receiving medication.

The relevant court proceedings commenced in June 2006, for determination of MM's capacity and best interests. An ex parte interim declaration was made that MM lacked capacity to decide where she would reside and with whom she would associate. It was declared that it was not in her best interests to be removed from the accommodation, and that she was not to have unsupervised contact with KM. Such contact was to occur at least twice weekly, for periods of at least two hours per session.

On 14 July 2006, these orders were continued. MM was missing from the accommodation at that time. KM was ordered to assist the LA and the police in achieving the return of MM to the accommodation, and the local authority (LA) was given the power to terminate contact between KM and MM if KM was under the influence of alcohol, abusive, aggressive, or put the LA's staff at risk of harm. MM was eventually returned to the accommodation by the police on 27 July 2006. She was in a dishevelled and unkempt condition. Deterioration in her mental health was resolved by medication. However she became aggressive and abusive to staff and other residents in the accommodation. The situation deteriorated, and MM was sectioned under section 2 of the *Mental Health Act 1983*, on 10 October 2006.

MM was moved to a family placement on 30 October 2006. At this time, her contact with KM was reduced to once per week. That placement broke down in December 2006. MM eventually moved into an independent supported living placement in March 2007. That placement appeared to have been successful.

The final hearing took place on 5 June 2007 (with judgement being reserved until 21 August 2007). The

1 *Nottinghamshire Healthcare NHS Trust, Professor of Mental Health Law, University of Nottingham*

LA sought declarations that MM lacked capacity to litigate, to make decisions as to where and with whom she would reside, to determine with whom she would have contact, to manage her finances, and to marry. The LA accepted that MM had capacity to consent to sexual relations. It sought an order that MM's best interests were that she reside in supported accommodation provided by the authority, and would not be removed from that accommodation without the authority's consent. Finally, it sought an order that contact with KM would be restricted to once per month for a period of two hours, and be supervised by the local authority.

The Decision

The Court granted these declarations, with the exception that contact with KM was increased to weekly for a minimum of four hours, and would not be supervised. Further, the LA was required to make appropriate facilities available during this contact for MM to continue her sexual relationship with KM.

The decision was made before the relevant provisions of the *Mental Capacity Act 2005* came into effect. It was therefore decided under the Court's so-called 'inherent' jurisdiction. At issue was whether and for what decisions MM lacked capacity, and as concerned those matters, what decisions would be in her best interests. Both KM and MM testified in this case. Further evidence was provided by a psychiatrist, a social work consultant, and representatives of the LA. The Official Solicitor also provided statements.

The determination of capacity was issue-specific: there was nothing inconsistent in MM having capacity for some purposes but not others. The determination of capacity in various contexts had in turn given rise to a variety of different common law tests of capacity. Capacity to litigate, for example, was generally determined with reference to *Masterman-Lister v Brutton & Co (No 1)*;[2] capacity to consent to treatment with reference to *Re MB (Medical Treatment)*;[3] capacity to consent to marry with reference to *Sheffield City Council v E*;[4] and capacity to consent to sexual relations *X City Council v MB, NB and MAB (by his litigation friend the Official Solicitor)*.[5] In the view of the court, these were different iterations of the same fundamental question: can the individual understand the nature and quality of the relevant transaction? That was to be determined based on the specific decision to be made, at the time it was to be made.

That approach also applied to capacity to make decisions as to where one would live, with whom one would associate or have contact, and issues concerning personal care.

Within that framework, and consistent with the expert evidence, the court held that MM lacked capacity to litigate, to make decisions as to where and with whom she would reside, to determine with whom she would have contact, to manage her finances, and to marry. It held that MM did have capacity to consent to sexual relations.

Given those determinations, the Court considered what decisions were in MM's best interests. Of particular concern was that the decisions made should be consistent with MM's rights under Article 8 of the ECHR, and in particular her right to privacy. That right included the right to pursue ones own personal life, develop ones personality as one chooses, and to interact and develop relationships with other human beings and the world at large. For the individual lacking capacity, that right could be restricted in his or her best interests, for example to protect the individual's safety; but the individual's views were also highly relevant to the appropriateness of intervention. As the court asks rhetorically,

2 *[2002] EWCA Civ 1889.*
3 *[1997] 2 FLR 426.*
4 *[2004] EWHC 2808 (Fam).*
5 *[2006] EWHC 168 (Fam).*

"What good is making someone safer if it merely makes them miserable?"[6] Proportionality is the key.

While there was no legal presumption that an incapable individual would be better off with his or her family, it was equally to be acknowledged that institutions, no matter how well-intentioned or enlightened their managers might be, were also problematic. Removals to institutions could only be justified if a better quality of care would be offered by the state than by the individual's family. The Court in such cases as this is exercising a protective jurisdiction, and intervention should occur only if there is a need to protect the vulnerable adult from abuse or the real possibility of abuse.[7]

The evidence in this case supported that MM had been subject to violence in her relationship with KM to the extent that when they were cohabiting together, she was frequently forced to leave the accommodation with him, resulting in periods of homelessness. In these periods, she had suffered from deteriorating mental health resulting in hospitalisation. KM seemed unable to take responsibility for his conduct towards MM. Notwithstanding MM's desire to live in the community with KM, therefore, the Court held that her continued residence away from KM at the independent supported living placement run by the LA was in her best interests.

At the same time, over-control of contact between MM and KM would have the effect of precluding their sexual relationship, a relationship into which MM had capacity to enter and which appeared beneficial to her. The LA had initially proposed contact of once per month, supervised, for up to two hours. The Court held that such limited contact would violate MM's Article 8 rights. By the time of the court hearing, the LA had agreed that weekly contact of up to 4 hours would be appropriate. The Court held that this was the minimum acceptable period. The contact should further be unsupervised.

Finally, the contact would be required to be organised in a fashion that would allow MM and KM to continue their sexual relationship, as for example by provision of a hotel room. The obligation to do so arose from the fact that the state's involvement had resulted in MM being given a residence that KM was not permitted to visit. That involvement carried with it positive steps to avoid a breach of MM's article 8 rights, in this case by taking steps to ensure that MM's sexual relationship with KM could continue in an appropriate and dignified way.[8]

Discussion

Capacity to consent to sex, but not to determine with whom to associate

The case is eye-catching because it decides that while MM had capacity to consent to sexual congress, including sexual congress with KM, she did not have capacity to decide with whom she would associate. The result is that the LA could closely control MM's association with KM, precluding him from visiting MM at her supported housing placement for example, but was required to facilitate unsupervised contact with KM that would allow the sexual relationship to continue.

While these decisions regarding capacity draw attention, they do not really raise new issues of law. As the court notes, capacity determination rests on the individual decision to be made, and people may have capacity for some purposes but not others: this is now trite law. The tests applied by the court may be more controversial. Thus capacity to consent to sexual activity merely requires an ability to understand the nature of the specific act in question. It is not necessary to understand the consequences of such

6 *Paragraph 120.*

7 *Paragraph 118.*

8 *Paragraph 162.*

activity with a particular partner. It is further said by the court to be a "*simple*" determination, not requiring reference to some of the more complex tests of the common law.[9] Commentators who view sexual behaviour as a morally complex area are likely to view understanding those complexities as requisite to capacity, and thus unlikely to share the view that the question of capacity is 'simple'. Similarly, parents of an adolescent girl may take the view that whether the object of her affections is, for example, a nice seventeen-year-old boy or a not nice fifty-two-year-old man may be of pivotal importance to the girl's capacity to consent, even if the proposed activity is the same. Controversial though the court's approach may be, it is not new to this case: see *Sheffield City Council v E*[10] and *X City Council v MB, NB and MAB (by his litigation friend the Official Solicitor)*.[11] Given this approach, it is unsurprising that some people will have capacity to consent to sexual activity, but not to decide with whom they will associate.

The requirement that the LA organise contact between MM and KM to facilitate the continuation of their sexual relationship is new. The court in MM is clearly right that best interests determinations must be made consistently with the incapable individual's Article 8 rights, and the ECHR jurisprudence regarding restriction of rights upon imprisonment expressly protects rights to communicate with close family members,[12] and to attend the funerals of close family members.[13] There is an obligation to provide visiting facilities for prisoners' friends,[14] and particular efforts must be made to give effect to court-ordered rights of access to children.[15] The scope of rights under a best interests determination must be at least this broad, as there is no reason to restrict MM's rights further than those of an individual in a punitive environment. The specific question of conjugal visits does not appear to have been litigated in a non-criminal context. Within prisons, *Aliev v. Ukraine*[16] noted with approval moves in a number of European countries to provide conjugal visits to prisoners, but nonetheless held that the failure to provide such visits was justified under Article 8(2) 'for the prevention of disorder and crime'.[17] It is not obvious that this could be a factor in the context of MM's placement by the LA, however, as the restriction of her rights did not flow from a criminal process. This would appear to provide her with a markedly stronger argument for the provision of such visits.

Identity of Common Law tests of capacity and the Mental Capacity Act 2005

The case was determined under the so-called 'inherent' or 'declaratory' jurisdiction of the court, prior to the introduction into effect of the relevant sections of the *Mental Capacity Act 2005* on 1 October 2007. Nonetheless, much of the interest of the case is in its treatment of how the existing case law regarding mental capacity will integrate with the provisions of that legislation.

This is a complex question. As the court notes, the MCA does not supersede the tests of capacity developed at common law; it instead provides a process allowing decisions to be made for people lacking capacity, as defined by the MCA. This creates the possibility of ragged edges: a person might theoretically have capacity at common law but not under the MCA, or vice versa. It is not even obvious that the common law tests are themselves consistent with each other.

9 *Paragraph 84.*

10 *[2004] EWHC 2808 (Fam).*

11 *[2006] EWHC 168 (Fam).*

12 *McVeigh, O'Neill and Evans v. the United Kingdom, Application Nos. 8022/77, 8025/77 and 8027/77, decision 8 December 1979, 25 DR 15, (1983) 5 EHRR 71 paras. 52-3, confirmed by Committee of Ministers, (1983) 5 EHRR CD305.*

13 *Ploski v. Poland, A application No. 26761/95, judgment 12 November 2002, paras. 32, and 37.*

14 *X. v. the United Kingdom, Application No. 9054/80, judgment 5 November 1981, 30 DR 113, (1981) 4 EHRR 188..*

15 *Ouinas v. France, Application No. 13756/88, decision 12 March 1990, 65 DR 265 at p. 277.*

16 *Application No. 41220/98, judgment 29 April 2003, (2004) 11 I.H.R.R. 170, para. 188.*

17 *Aliev, paragraph 188.*

Further, the declaratory jurisdiction of the courts to make decisions for people lacking capacity developed after the Law Commission's report on Mental Incapacity established the overall framework that went on to become the MCA. The MCA was thus designed to deal with an absence of overall court jurisdiction to make decisions on behalf of people lacking capacity, but in fact has to deal with the jurisdiction that has developed. And it is not necessarily clear even that the capacity determination under the declaratory jurisdiction will match the remainder of the common law. As the Court notes, it is not theoretically impossible or inconsistent that the test for capacity to consent to sexual activity be different under the criminal than under the declaratory jurisdiction.[18]

From these divergent threads, the courts will have to create some sort of coherence, and this case represents an early, tentative step in that direction.

Interestingly, the court in MM seems to take it as a given that the declaratory jurisdiction of the court will continue in its current and ever-expanding form, notwithstanding the introduction of the MCA procedures. A more limited version of this view must be correct. The jurisdiction to make declarations on points of law is established by rule 40.20 of the CPR, and extends well beyond determination of decisions relating to persons lacking capacity. In that form at least, it obviously continues.

Case law in the last decade or so has however considerably expanded the role of the courts regarding persons lacking capacity, well beyond the jurisdiction envisaged by rule 40.20 and on pivotal points, with highly doubtful legal justification.[19] The result is a system that largely mirrors the MCA: both systems allow decisions to be made in the best interests of persons lacking capacity. The desirability of the continuation of this expanded form is much more doubtful. Where a detailed statute governs the MCA processes, the declaratory jurisdiction is the result of organic common law growth: it is as broad as the court says it is. The court acknowledges that efforts should be made to merge the criteria of these systems, acknowledging that it would be unfortunate if the result of applications were determined on the basis of the forum in which they were brought.[20] This is no doubt correct, but it begs the question of whether the declaratory jurisdiction should continue at all in this form. Part of the point of the MCA was to introduce a specialised court to deal with matters of incapacity; if the declaratory jurisdiction continues, this objective at least will be undermined. Further, either its results will precisely mirror those that would be attained under the MCA, in which case it is difficult to see that the declaratory jurisdiction adds anything, or its results will differ from those under the MCA, in which case forum-shopping seems inevitable and undesirable. The introduction of the MCA processes provides an occasion for re-consideration of the role, if any, of the enhanced declaratory jurisdiction of the courts. It would be a shame for that opportunity to be missed.

As for dealing with potentially ragged edges between the manifold tests of incapacity, both at common law and in the MCA, the Court in MM emphasises their overall consistency of object and approach. The test of capacity to consent to medical treatment in *Re MB (Medical Treatment)*[21] and of capacity to litigate in *Masterman-Lister v Brutton & Co (No 1)*[22] become 'essentially the same test … albeit expressed in slightly different words'.[23] These are in the court's view in turn essentially the same as the test of capacity found in s 3(1) of the MCA.[24] The Court further acknowledges that insofar as there are differences between the statutory definition and those at common law, the common law courts where appropriate may move closer to the statutory definition.[25]

18 *Paragraph 88.*

19 *See P Bartlett, Blackstone's Guide to the Mental Capacity Act 2005 2nd ed (Oxford: OUP, 2008), chapter 2.*

20 *Paragraph 78.*

21 *[1997] 2 FLR 426.*

22 *[2002] EWCA 1889.*

23 *Paragraph 71.*

24 *Paragraphs 73-4.*

25 *Paragraph 80.*

Consistency between the statutory and common law tests is unquestionably a good thing, and inconsistency risks undermining the coherence of the statutory scheme. For example, the common law contains tests of capacity to make a will that are phrased somewhat differently from the test of capacity in the MCA, yet it is the test in the MCA definition that determines whether the Court of Protection may draft a will for a person lacking capacity. Inconsistencies in those tests could mean that either the testator *and* the court have authority to draft a will, a result which could create ambiguities, or that neither do, a result that would defeat the intent of the statute. Either way, this would not be a helpful outcome, and the court is right to favour convergence.

The court does make it clear that it is for the common law courts, if they think it appropriate, to move toward the MCA definition; it is not for the Court of Protection or others bound by the MCA to move from the MCA definition.[26] It is therefore somewhat distressing to see the court in the next breath bludgeon the MCA definition into conformity with previous common law jurisprudence. At issue is whether, in order to have capacity, an individual must believe the information presented to them. Following *MB*, the court states:

> *"If one does not 'believe' a particular piece of information then one does not, in truth, 'comprehend' or 'understand' it, nor can it be said that one is able to 'use' or 'weigh' it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information."*[27]

This is not a convincing reading of s 3 of the MCA. Inability to believe had been part of the common law test for many years prior to the passage of that Act,[28] in cases expressly considered by the Law Commission.[29] Its absence from the MCA cannot thus be viewed as accidental.

In cases where an individual does not believe the information provided, the reasons for the non-belief should be pivotal in the capacity determination. Certainly, there will be cases where the reason for lack of belief strongly suggests incapacity. A lack of belief flowing from a psychotic delusion is an obvious example. It is equally easy to imagine cases where a lack of belief does not constitute incapacity. If a patient is herself an experienced consultant, for example, it would be bizarre to say that she lacked capacity simply because she disagreed with her doctor, a less-experienced colleague in her field. Similarly, at least in the mental health field, doctors sometimes change diagnosis. Is a patient really to lack capacity because he prefers the old diagnosis to the new one, perhaps for coherent reasons? Is this not precisely what is meant by an ability to 'weigh' the information provided, as required by s 3(1)(c) of the MCA?

This is a vital point for the credibility of the MCA. The legal literature is replete with case notes suggesting the manipulation of the capacity threshold to achieve specific results. Further, there is a risk that 'lack of belief' can become a euphemism for decay of trust between an individual and his or her carers, but a formulation that focuses attention solely on the vulnerable person. If the issue is really a breakdown in trust, it behoves the court to consider the nature of that breakdown, not to disguise the real problem with a convenient finding of incapacity.

26 *Paragraph 80.*

27 *Paragraph 81.*

28 *See, eg., Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290, at 295.*

29 *Law Commission, Mental Capacity, LawCom 231, (London: HMSO, 1995), para 3.15.*

Best Interests

Although the discussion of the law of capacity in the case is structured around the consistency between the common law and statutory tests, this theme is curiously absent from the discussion of best interests. This is curious, as the declaratory jurisdiction, as it has developed, adopts a much more flexible approach to best interests determination than that of the MCA. The determination under the declaratory jurisdiction is 'akin to a welfare appraisal',[30] with virtually no limits on material to be considered or people to be consulted. The MCA is much more prescriptive. It expressly requires consideration of whether the individual will regain capacity, and requires the maximum involvement of the person lacking capacity (P) in the decision-making process. P's wishes, feelings, beliefs and values, both at the time the decision is to be made and at a time when P had capacity must be considered, and to that end, consultation with specific carers is required.[31] When restraint is necessary, it must be to avert harm to P, and the restraint must be proportional to the risk and severity of that harm.[32]

It is perhaps arguable that these differences are smaller than they at first appear. The best interests criteria under the MCA are not closed: all relevant circumstances must be considered.[33] Further, much of what is in the MCA could arguably be viewed as good practice under the common law approach. Certainly, the court in MM notes that the wishes and feelings of the vulnerable adult are an important factor in determination of best interests.[34] Over-statement of these similarities is ill-advised, however, as they risk reducing the requirements of the MCA to mere tick boxes. These are new requirements, and they are meant to be taken seriously. The MM case offers no guidance as to whether the court will do so.

Instead, discussion in MM focuses most interestingly on the determination of best interests within the context of Article 8 of the ECHR. The court finds that intervention with Article 8 rights is justified when necessary for the welfare of the incapable adult. That said, rather refreshingly, the court further acknowledges the shortcomings of institutional care:

"We have to be conscious of the limited ability of public authorities to improve on nature. We need to be careful not to embark upon 'social engineering'. And we should not lightly interfere with family life. If the State – typically, as here, in the guise of a local authority – is to say that it is the more appropriate person to look after a mentally incapacitated adult than her own partner or family, it assumes, as it seems to me, the burden – not the legal burden but the practical and evidential burden – of establishing that this is indeed so. And common sense surely indicates that the longer a vulnerable adult's partner, family or carer have looked after her without the State having perceived the need for its intervention, the more carerfully must any proposals for intervention be scrutinised and the more cautious the court should be before accepting too readily the assertion that the State can do better than the partner, family or carer."[35]

Intervention would be justified only if the care offered by the public authority was demonstrably better than that offered by the family.[36] The court continues, *"the court should only intervene where there is a need to protect a vulnerable adult from abuse or the real possibility of abuse."*[37] While this seems obvious, it is (notwithstanding the court's protestations to the contrary[38]) a departure from the spirit of the established case law. In *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)*,[39] the court had held that the only

30 *Re A (Male Sterilisation) [2000] 1 FLR 549 at 560.*
31 *MCA, s 4.*
32 *See, eg., MCA s 6.*
33 *MCA s 4(2).*
34 *Paragraph 121.*
35 *Paragraph 116.*
36 *Paragraph 117.*
37 *Paragraph 118.*
38 *Paragraph 115.*
39 *[2002] EWHC 2278 (Fam).*

criterion for intervention in the life of an incapable adult was best interests. There was no applicable threshold comparable to that of 'significant harm', such as needed to be shown under s 31(2) of the *Children Act 1989* for the removal of a child. While it is likely to be unhelpful to debate the differences between 'significant harm' and 'abuse or the real possibility of abuse', there can be little doubt that some substantive threshold of harm prior to intervention is a desirable outcome. In this, the *MM* decision is to be celebrated.

Conclusion

Viewed in this light, *MM* is a case in the calm before the storm. It provides a hint as to how courts may deal with the introduction of the MCA, and its interface with common law. The real engagement with those issues, however, will occur in cases which arise after 1 October 2007, when the MCA came into effect. It is at that time that the problems become real, rather than matters of speculation.

Section 75(1) of the Mental Health Act 1983 is compliant with Article 5(4) of the European Convention on Human Rights…just.

Roger Pezzani and Stephen Simblet[1]

R (Daniel Rayner) v Secretary of State for Justice [2008] EWCA Civ 176

Introduction

This case addresses for the first time the compatibility of section 75(1) of the *Mental Health Act 1983* with Article 5(4) of the European Convention on Human Rights. The decision of the Court of Appeal was that the statutory duty of the Secretary of State to act quickly in referring a recalled patient's case to the Mental Health Review Tribunal, combined with the patient's right to challenge the lawfulness of his detention by way of judicial review, was sufficient to satisfy the requirements of Article 5(4).

The Facts

Daniel Rayner was convicted in 2002 of assault and possession of an offensive weapon. He was diagnosed as suffering from schizophrenia and made the subject of hospital and restriction orders under sections 37 and 41 of the *Mental Health Act 1983* ['MHA']. In 2004 a Mental Health Review Tribunal directed his conditional discharge under section 73 MHA. In 2005 he was readmitted as a voluntary patient, and on 14 June 2005 the Secretary of State for the Home Department issued a warrant under section 42(3) MHA formally recalling him to hospital.

In response to a letter from Mr Rayner's solicitors, the Home Office wrote on 8 August 2005 that, due to an oversight, a referral to the tribunal was not made following the recall to hospital in June. The referral was made that same day.

The tribunal arranged for the hearing of the reference to take place on 27 September 2005, but that date had to be vacated because of problems in providing the necessary reports in time. The hearing eventually took place on 28 October 2005, when the tribunal directed the deferred conditional discharge of Mr Rayner; because one of the conditions was only fulfilled on 12 January 2006, it was only on that date that he was discharged.

The Law

Where a conditionally discharged patient has been recalled, section 75(1) MHA requires the Secretary of State to refer his case to the tribunal within one month of the day on which he returns to hospital. Once the reference has been made, rule 29(cc) of the Mental Health Review Tribunal Rules 1983 requires a hearing to be fixed in the period between five and eight weeks after the date of the reference.

In this case, therefore, the Secretary of State was required to refer Mr Rayner's case to the tribunal before, at the latest, 14 July 2005.

1 *Barristers, Garden Court Chambers, London. The authors are grateful to Paul Bowen (Barrister) for providing the information at notes 2 and 3.*

Article 5(4) of the European Convention on Human Rights provides: "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."

In the Administrative Court, the case came before Holman J. He concluded that the legislative scheme was compatible with the European Convention on Human Rights. He held however that Mr Rayner's case should have been the subject of an "immediate" referral by the Secretary of State and that the Secretary of State's delay in referring the case was unlawful. Both the Secretary of State and Mr Rayner appealed.

At the appeal stage, it was conceded on behalf of Mr Rayner that the timescale for a reference in section 75(1) is not incompatible with a patient's rights under Article 5(4) of the Convention; it does not prevent a prompt reference and a speedy decision by the tribunal, and the stipulation that the Secretary of State must act within a maximum of one month does not prevent him from acting with such promptness within that month as is required by Article 5(4).

However, it was argued that the absence of any statutory means by which a patient can make his own application to the tribunal after he has been recalled is incompatible with his Article 5(4) right to take proceedings by which the lawfulness of his detention shall be decided. Mr Rayner's cross-appeal therefore focused on the legislative requirement for dependence upon the Secretary of State to provide him with access to a court.

The Secretary of State conceded that on the facts of this case, he was in breach of Article 5(4) and of the duty under section 75(1), in that the reference was not made by him until 8 August 2005, which was almost two months after Mr Rayner's return to hospital with the status of a compulsory detainee. That delay meant that a speedy determination of the lawfulness of his detention was not achieved.

However, the Secretary of State challenged the way in which Holman J at first instance described the duty of referral under section 75(1). The judge spoke in terms of Article 5(4) requiring an "immediate reference" to the tribunal and stated that a case should be referred "at once" unless the circumstances of the applicant or his case positively required otherwise. The judge noted the evidence given on behalf of the Secretary of State that his normal practice was to refer within 72 hours of recall, in the light of which he found that in this case "the very last day upon which the Secretary of State could lawfully have referred the case was Monday 20 June".

The Decision

(i) The Secretary of State's duty of referral

The period of one month within which the Secretary of State must refer a recalled patient's case to the tribunal (section 75(1)(a)) runs from the return of the patient to hospital, not the date of the recall. The need to comply with the obligation to refer cannot have come as a surprise to the Secretary of State, because it is he who issues the warrant of recall.

The requirement in Article 5(4) is that a court decision is obtained speedily, rather than that proceedings are started speedily; that is, the obligation relates to the period within which the proceedings are determined, and not the speed with which they are initiated. In theory, laxity at the referral stage could be vitiated by alacrity by the tribunal upon receipt of the reference.

The Secretary of State is not generally entitled to take the statutory maximum of one month before

making a reference: a more energetic approach is required where the liberty of the subject is at stake, and, since a recalled patient has no direct right to apply to the tribunal himself, it is all the more important that the Secretary of State should act with despatch. It was the Secretary of State's practice to make a reference as soon as possible and normally within 72 hours; there would normally be no reason for him to take longer. Moreover, it is his duty to obtain without delay the necessary information as to the patient's return to hospital.

However, Holman J's use of the word 'immediate' to describe the reference required by Article 5(4) was incorrect: that interpretation of the word 'speedily' was not supported by the decisions of the Strasbourg Court, which has dealt with Article 5(4) issues on a case-by-case basis. The domestic courts should adopt the same approach, and should not prescribe quantified periods of time within which determination should be achieved; many factors, including delays by the patient and his representatives, could affect the timing of the hearing.

The test for the Secretary of State's duty to refer under section 75(1) was whether there was a failure to proceed with reasonable despatch, having regard to all the material circumstances. The test was as appropriate to the section 75(1) duty (i.e. to make the referral) as it was in respect of the timescale for determination.

On the facts, Holman J's conclusion that the reference should have been made by 20 June 2005, almost a week after the issue of the warrant, was correct. It was in any event conceded by the Secretary of state that he was in breach of Article 5(4) and section 75(1).

(ii) The right to take proceedings

Keene LJ identified a recent shift of emphasis in the Strasbourg jurisprudence, towards a greater emphasis on the Article 5(4) requirement that a detained person should be able to take the initiative to start proceedings to challenge the lawfulness of the detention. For example, in *Rakevich v Russia* [2004] MHLR 37, despite there being a duty on the detaining hospital to make an application to a court for approval of the patient's detention, Article 5(4) was violated because the patient did not herself have the direct right to apply for her release (that is, to *take* proceedings as opposed to have them initiated on her behalf).

However, because in English domestic law there is a statutory mechanism requiring the state authorities to act quickly in getting the issue of the lawfulness of a detention before the courts (which duty may be enforced by the patient by way of judicial review), and because a detained patient, including a recalled patient, has the right to use judicial review or habeas corpus to mount a direct challenge to the lawfulness of his detention, Article 5(4) was not violated. Keene LJ added that the Administrative Court, on an application for judicial review or habeas corpus by a detained patient, could order the Secretary of State to discharge the patient on a conditional basis if it was appropriate.[2]

Comment

The Secretary of State's position, that he could wait up to a month before making a reference, was unlikely to be accepted by the court. In *R (C) v Mental Health Review Tribunal* [2002] 1 WLR 176, a successful challenge to an administrative practice whereby the Mental Health Review Tribunal would list every case after eight weeks, Lord Phillips MR stated it was not lawful to make no effort to see that the individual application is considered as soon as possible. It was therefore unsurprising that Keene LJ in

2 *A petition to the House of Lords is intended to be made.*

Rayner at paragraph 21 observed that the Secretary of State could not generally be entitled to wait for a month before making the referral and that the where the liberty of the subject is at stake, speediness requires a more rapid and energetic approach. On the other hand, the Court of Appeal did not accept the patient's submission (accepted by Holman J in the court below) that an immediate referral was required, and observed the distinction between "speedily" (in Article 5 (4)) and "promptly" (in Article 5 (3)), the latter importing a more exacting requirement of expedition. However, Holman J's finding that a referral should have been made within a week was upheld.

This case is reminiscent of *R (SC) v (1) MHRT (2) The Secretary of State For Health & Secretary of State For The Home Department* [2005] MHLR 31 - in both cases, flaws in the terms of section 75 MHA were decided nevertheless to be compatible with detained patients' Article 5 rights because the Administrative Court is available as a form of panacea. However, whilst in *SC* the court's role was as a subsequent corrective to an unlawful tribunal decision, *Rayner* goes further.

Keene LJ concluded at paragraph 46 that section 75, if it stood alone, might not now be sufficient to accord with the requirements of Article 5(4). But, taken with the Administrative Court's post *Human Rights Act 1998* ['HRA'] power to step into the role of an Article 6 court and reach substantive decisions on the merits, it was saved.

This is a procedure which the Administrative Court is likely to approach with considerable distaste. Keene LJ relied heavily on *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 , in which the Court of Appeal decided that Article 6 of the Convention required a patient's judicial review of a decision to treat him compulsorily under section 58 MHA to be a full merits hearing with, if necessary, the cross-examination of witnesses. However, in *R (N) v* M [2003] 1 WLR 562, when the Court of Appeal considered the same point, following the first substantive claim of this nature, it said at paragraph 39: "although in some cases the nature of the challenge may be such that the court cannot decide the ultimate question without determining for itself the disputed facts, *it should not be overlooked that the court's role is essentially one of review*" (emphasis added).

As a very strong indication of the continuing difficulty of this question, the judgment of Baroness Hale of Richmond in *R (H) v Secretary of State for Health* [2005] 4 All E.R. 1311 is instructive: at paragraph 31 she describes the post HRA possibility that the Administrative Court will be obliged to conduct a merits review of a patient's detention where a patient is detained under section 2 MHA for longer than is usually allowed, because there are parallel proceedings relating to their nearest relative. She said the Court is not well equipped to conduct such a review, and may take some persuading that it is necessary:

> *"First, it is not used to hearing oral evidence and cross examination. It will therefore take some persuading that this is necessary: cf* R (Wilkinson) v Broadmoor Special Hospital Authority *[2002] 1 WLR 419 and* R (N) v M *[2003] 1 WLR 562. Second, it is not readily accessible to the patient, who is the one person whose participation in the proceedings must be assured. It sits in London, whereas tribunals sit in the hospital. How would the patient's transport to London be arranged? Third, it is not itself an expert tribunal and will therefore need more argument and evidence than a Mental Health Review Tribunal will need to decide exactly the same case. All of this takes time, thus increasing the risk that the determination will not be as speedy as Art 5(4) requires."*

Despite these misgivings, Baroness Hale, who gave the only reasoned speech in *H*, decided in relation to a similar issue as was before the Court of Appeal in *Rayner* that speedy action by the Secretary of State

and the lower courts combined with, if necessary, a full merits hearing in the Administrative Court, was sufficient to render section 29(4) MHA compliant with Article 5(4)[3].

Similarly, as a matter of judicial theory if not of actual practice, the Court of Appeal's decision in *Rayner*, and hence the compatibility of section 75(1) MHA with the Convention, relies squarely on the Administrative Court's availability to act as a kind of ersatz Mental Health Review Tribunal. Keene LJ added a caveat at the close of his judgment, to the effect that a patient would normally find it quicker and more effective to apply for an order enforcing the Secretary of State's statutory duty rather than to embark on a direct challenge in the courts to the lawfulness of the detention.

But how would a direct challenge in the Administrative Court work, particularly in relation to conditional discharge? Would the deferred conditional discharge procedure established by the Court of Appeal in *R (IH) v Secretary of State for the Home Department [2002] 3 WLR 967* (approved by the House of Lords *[2005] 3 WLR 867*) be followed? If not, would there not be a risk of the patient falling into the Article 5(4) violating limbo which the new regime established in *IH* was designed to cure? Would the often drawn out provisional discharge procedure require an Administrative Court judge to order the Secretary of State to direct discharge *if* the proposed conditions can be implemented, requiring the indefinite deferral of a mandatory order? And what if in the meantime the patient has his statutory hearing before the Mental Health Review Tribunal, the decision of which is at odds with that of the judge?

It would perhaps be overly cynical to suggest that these are questions which will never be answered because the Court of Appeal's judgment in this case relied on a theoretically available direct right of access to the courts which, while convenient as an Article 5(4) compliant veneer, is never likely to be of practical use. After all, it is a first principle of the Convention that the protection it affords is practical and effective.

3 *The European Court of Human Rights has recently referred the case of MH v United Kingdom (the appellant in H) to the Government for its observations both on admissibility and merits. A review of R (H) v Secretary of State for Health [2005] 4 All E.R. 1311 was published in the May 2006 issue of the JMHL @ pp66–75 – see 'Executive Action and Convention Compliance? A Risk Unrecognised by the House' by Kris Gledhill.*

Protecting the Suicidal Patient

Neil Allen[1]

Savage v South Essex Partnership NHS Foundation Trust [2007] EWCA Civ 1375

Introduction

Suicide prevention is said to be a key national priority for mental health services in England and Wales.[2] Nonetheless, over 1300 patients already known to those very services commit suicide every year;[3] an average of almost *four a day*. Around 450 take their own lives whilst, or soon after, receiving inpatient treatment.[4] Providing mental health care is an inherently risky business. Indeed, protecting mentally ill patients from themselves is often the very justification for depriving them of their liberty under the *Mental Health Act 1983*. But how far must public authorities go in safeguarding society's interest in preserving the sanctity of human life?

Article 2(1) of the European Convention on Human Rights 1950 provides that 'Everyone's right to life shall be protected by law'.[5] Ranked as one of the Convention's most fundamental provisions, it imposes both negative and positive obligations upon the State. Whilst the negative obligations require public authorities to refrain from the intentional and unlawful taking of life,[6] the positive obligations necessitate the taking of appropriate steps to safeguard the lives of those within its jurisdiction.[7] The latter requires the State to 'establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life.'[8]

This legal framework typically comprises of criminal, civil and disciplinary measures designed to deter those who would otherwise devalue the right to life. For example, suicidal patients may raise issues of individual and corporate criminal liability. Although attempted suicide is no longer unlawful,[9] it is an

1 *Barrister, Young Street Chambers (Manchester), and Clinical Teaching Fellow, University of Manchester.*

2 *The Department of Health aims to reduce the death rate from suicide by at least 20% by 2010 (National Suicide Prevention Strategy for England, Department of Health, 2002). This followed its White Paper, Saving Lives: Our Healthier Nation (1999) (Cm 4386).*

3 *See Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness (University of Manchester, December 2006) at pp14 and 32. This can be contrasted with the 92 suicides in prison custody in 2007 (Ministry of Justice announcement 1st January 2008).*

4 *Meehan J. et al., 'Suicide in mental health in-patients and within 3 months of discharge' (2006) 188 British Journal of Psychiatry 129 at 133. During the study period, an average of 180-190 patients per year died whilst receiving inpatient care and around 275 patients per year died within three months of being discharged from hospital.*

5 *Article 2(2) provides that deprivation of life is not unlawful where it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; or (c) in action lawfully taken for the purpose of quelling a riot or insurrection.*

6 *McCann and Others v United Kingdom (1996) 21 EHRR 97 at para 148.*

7 *LCB v United Kingdom (1999) 27 EHRR 212 at para 36.*

8 *R (on the application of Middleton) v West Somerset Coroner [2004] 2 AC 182 at para 2 per Lord Bingham of Cornhill.*

9 *Suicide Act 1961 s 1.*

offence to assist a patient to kill themselves.[10] Moreover, as I have argued elsewhere,[11] hospital Trusts may be prosecuted for corporate manslaughter where patients die as a result of gross systemic negligence. In terms of civil liability, the law of negligence may compensate a self-harming patient whose actions result from a breach of their clinician's duty of care.[12] A claim may also be brought under either the *Law Reform (Miscellaneous Provisions) Act 1934* or the *Fatal Accidents Act 1976*.[13] Finally, mental health practitioners are regulated by their respective professional bodies which are able to impose disciplinary sanctions.[14]

In addition to requiring such a comprehensive framework, the positive obligations in article 2 include two distinct duties; hereafter referred to as the 'investigatory duty'[15] and the 'protective duty'.[16] The former obliges[17] the State to adequately investigate death or near-death[18] and lies beyond the scope of this paper. The latter arises only in limited circumstances and requires public authorities to take steps to protect endangered life. The case of *Savage v South Essex Partnership N.H.S. Foundation Trust* considers the appropriate test to be used in determining whether this protective duty has been violated. After providing an overview of the case, I shall analyse its implications by drawing comparisons with the position at common law as discussed in *G v Central and North West London Mental Health NHS Trust*.[19]

The Facts and Judgments to Date

With the trial yet to have taken place, and permission to appeal having been given granted by the House of Lords, the reported judgments contain very little detail regarding the facts of the case. The day after voluntarily attending Runwell Hospital, Mrs Carol Savage was detained for treatment of her paranoid schizophrenia under section 3 of the *Mental Health Act 1983* ('MHA'). With a long history of mental illness, she was kept on an open acute psychiatric ward. It is alleged that, despite making a number of attempts to leave, she was left unsupervised on hospital grounds because she was considered to be at low

10 *Suicide Act 1961 s 2 prohibits the inciting, aiding, abetting, counselling or procuring of suicide. Where a person kills another pursuant to a suicide pact, s/he will be guilty of manslaughter under the Homicide Act 1957 s 4(1). Note that article 2 does not incorporate a 'right to death' according to Pretty v United Kingdom (2002) 35 EHRR 1 at para 39.*

11 *See N. Allen, 'Medical or managerial manslaughter?' in C. Erin and S. Ost (eds), The Criminal Justice System and Health Care (2007) Oxford University Press. Offences committed after 6th April 2008 must be charged under the Corporate Manslaughter and Corporate Homicide Act 2007 which endorses a direct liability approach to corporate culpability.*

12 *For a discussion on the extent to which their duty of care requires doctors to prevent suicide, see K. Wheat, 'The Law's Treatment of the Suicidal' (2000) 8 Medical Law Review 182. See also Corr v IBC Vehicles Ltd [2008] 2 WLR 499, HL, where a negligent employer was held to be liable for his ex-employee's suicide which occurred nearly six years after the breach of duty.*

13 *Sections 1 and 1A of the Fatal Accidents Act 1976 provide an exhaustive list of potential claimants. It remains to be seen whether article 2 of the ECHR will require that list to be expanded to include non-qualifying dependents (see Cameron v Network Rail Infrastructure Ltd (formerly Railtrack Plc) [2007] 1 WLR 163; [2007] 3 All ER 241).*

14 *Note the reform proposals in the White Paper, Trust, Assurance and Safety – The Regulation of Health Professions (2007) (Cm 7013). See also M. Brazier and E. Cave, Medicine, Patients and the Law (4th ed.) (Penguin, 2007) Chapter 1.*

15 *Sometimes referred to as the 'procedural' or 'adjectival' obligation.*

16 *Also known as the 'substantive obligation'.*

17 *See, for example, R (on the application of Amin) v Home Secretary [2004] 1 AC 653; R (on the application of Takoushis) v Inner North London Coroner [2006] 1 WLR 461; Emms, Petitioner [2007] CSOH 184; (2008) 99 BMLR 116; Shevchenko v Ukraine (2007) 45 EHRR 27; Dodov v Bulgaria (Application no. 59548/00) (unreported) 17 January 2008.*

18 *R (on the application of D) v Secretary of State for the Home Department [2006] EWCA Civ 143; R (on the application of JL) v Secretary of State for the Home Department [2008] 1 WLR 158; [2007] HRLR 39.*

19 *[2007] EWHC 3086.*

risk of suicide. One day she was able to escape, walking two miles to Wickford railway station before fatally jumping in front of an oncoming train. Substantial issues regarding the nature and adequacy of the hospital's management have been raised, with allegations focusing upon whether there was a failure to take reasonable measures to prevent the risk of suicide and absconsion.

It is not in dispute that the State's investigatory duty has been discharged as a coroner's inquest has been held and the deceased's family are able, if they so wish, to bring civil proceedings against the Trust. Neither has gross negligence been alleged. Instead, Anna Savage contends that the hospital staff have violated her mother's right to life under article 2.[20] As a preliminary issue, the Court of Appeal was asked to determine a matter of principle: what was the correct test to establish a breach of the right to life in these circumstances? The Trust submitted that it was necessary to prove at least gross negligence; whereas the claimant asserted that negligence, or something less, would suffice.

At first instance[21]

For Swift J. it was 'crucial' to consider 'the context in which the detention occurred.'[22] A distinction between custody and hospital deaths had been drawn in *R (on the application of Takoushis) v Inner North London Coroner*[23] when, in relation to the latter, it was further observed that there was 'an important difference between those who are detained by the state and those who are not.'[24] However, those distinctions were made in the context of the *investigatory* duty in article 2. They did not necessarily assist in determining whether different tests should be applied to detained patients and voluntary patients insofar as the *protective* duty was concerned. Often treated side-by-side, both groups may present analogous clinical issues necessitating similar therapeutic judgments. Indeed, Swift J. considered their similarities to be greater than those between a detained patient and a prisoner. To apply different tests might, therefore, result in defensive psychiatric practice.

In *Takoushis*,[25] Sir Anthony Clarke M.R. had endorsed the view[26] that 'simple negligence' resulting in a patient's death 'was not sufficient in itself' to breach the positive obligations in article 2, adding that the position 'is or may be different in a case in which gross negligence or manslaughter is alleged'. Perhaps constrained by precedent, Swift J. declared[27] that the proper test for establishing a violation of article 2 was 'at least gross negligence of a kind sufficient to sustain a charge of manslaughter'. In light of her Ladyship's earlier comments, this test would presumably have been applicable to both detained and voluntary patients. As gross negligence was never alleged, the judge made an order for summary judgment against the claimant.

On appeal[28]

The Court of Appeal seems to have been heavily influenced by the European Court of Human Rights' (ECtHR) decision in *Tarariyeva v Russia*[29] which, according to the Master of the Rolls, 'to some extent

20 *A claim under article 8 (respect for private and family life) was dismissed at first instance, and arguments concerning article 14 (discrimination) were advocated on appeal, although not ruled upon.*

21 *[2006] EWHC 3562 (QB).*

22 *Ibid at para 45.*

23 *[2006] 1 WLR 461.*

24 *Ibid at para 108.*

25 *Ibid at paras 95-96.*

26 *As per Richards J. in R (on the application of Goodson) v Bedfordshire and Luton Coroner [2006] 1 WLR 432 at 454. This view was largely based upon his interpretation of the investigation case of Powell v United Kingdom (2000) 30 EHRR CD362.*

27 *Ibid n 21 at para 48.*

28 *[2007] EWCA Civ 1375; [2008] HRLR 15.*

29 *(Application no. 4353/03) (unreported) 14 December 2006.*

maintained but to some extent blurred'[30] the distinction between custody and hospital cases. The case was 'of considerable interest'[31] as the State was held to be liable for a prisoner's death which resulted from the negligence of *hospital* staff. Although their Lordships understood the analogy drawn by Swift J., they considered the position of detained patients to be more akin to that of prisoners than to that of ordinary patients. The 'critical point' was that both groups were 'particularly vulnerable' and 'under the control of the state in a way in which ordinary patients are not'.[32] This was the case whether or not they were detained on a locked or unlocked ward. There was therefore no reason to afford those detained under the MHA 1983 any less rights under article 2 than those detained in prison or prison hospitals. Voluntary mental patients were vulnerable but in 'a rather different way' and whether or not a different test should apply to them, that was not the position at common law as the same duty of care was owed.

In a somewhat dramatic volte-face, the Court distanced itself from the 'probably obiter' comments it had made in *Takoushis*. Its previous reference to simple and gross negligence was not part of that decision, nor was the distinction drawn between detained and voluntary patients.[33] Thereby released from the shackles of precedent, the Court unanimously held[34] that it was not necessary to establish gross negligence or anything more serious. Instead, the *Osman* test[35] should apply in determining whether the positive obligation in article 2 had been breached. Thus, the claimant had to show that:

> *'… at the material time the Trust knew or ought to have known of the existence of a real and immediate risk to the life of Mrs Savage from self-harm and that it failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.'*

Elaborating upon these elements, the Master of the Rolls endorsed the view[36] that 'a real risk is one that is objectively justified and an immediate risk is one that is present and continuing'. This set a 'high test'. The appeal was therefore allowed and the action would proceed to trial. The judgment, however, concluded with the uncertain remark: 'While we would not prohibit [Ms Savage] from arguing at the trial for a lower test, we see no warrant for such a lower test …'

Comment

These proceedings are the first to identify the appropriate threshold for the protective duty in a medical negligence context. While the Court of Appeal's adoption of the *Osman* test is a welcome development, it is submitted that its reasons for doing so could have been clearer. I shall first contend that Mrs Savage's detention status was not relevant as the *Osman* test is applicable to any patient, detained or otherwise. Secondly, it will be noted that the scope of this test is qualified by its elements so as to severely restrict the circumstances in which public authorities are likely to violate their protective duty. Finally, the potential repercussions of the *Savage* proceedings for the law of medical negligence will be briefly considered.

(a) Unnecessary analogies and frail distinctions

The Court of Appeal's justification for rejecting the gross negligence threshold in favour of the *Osman* test appears to be that patients detained for treatment under section 3 of the MHA 1983 are in an

30 *[2007] EWCA Civ 1375 at para 20.*

31 *Ibid at para 25.*

32 *Ibid at para 32.*

33 *Ibid at para 9.*

34 *Ibid at para 35.*

35 *Osman v United Kingdom (1998) 29 EHRR 245.*

36 *In re Officer L (Respondent) (Northern Ireland) [2007] 1 WLR 2135 at 2143 where the House of Lords adopted the same test as originally suggested by Weatherup J. in Re W's Application [2004] NIQB 67 at para 17.*

analogous position to prisoners. They are 'particularly vulnerable' and 'under the control of the state in a way in which ordinary patients are not'. It follows, presumably, that the *Osman* test would be equally applicable to those detained for assessment,[37] in emergency circumstances,[38] or under the temporary holding powers.[39] The logic might even extend to those informally deprived of their liberty under the forthcoming provisions of the *Mental Capacity Act 2005*.[40] Why should the protective duty in article 2 not extend to those recently discharged from detention for whom the risk of suicide is at its greatest?[41] What is the appropriate test for the vast majority of psychiatric patients who are not in detention?

The risk of defensive psychiatric practice in the face of such an arbitrary legal distinction seems not to have concerned the Court;[42] but referring to detention status is, in my view, unnecessary in the present context and may cause conceptual difficulties. As the Master of the Rolls rightly observed,[43] the European jurisprudence has extended the protective duty to those who are not in detention.[44] Indeed, domestic law has begun to follow suit.[45] Why should the presence of mental disorder make a difference?

Whilst the issue of detention status will be relevant to determining whether the protective duty has been breached,[46] it should not be used to circumscribe the types of patients to whom that duty is owed. This explains why the *Takoushis* distinctions were merely obiter. Consider *G v Central and North West London Mental Health NHS Trust*[47] where the patient had run out in front of a bus and tried to overdose on paracetamol before her voluntary hospital admission. Detention under section 3 of the MHA 1983 was considered to be unnecessary because she had agreed to have her liberty restricted on an informal basis, although there were short periods during which she was temporarily restrained.[48] If detention status was relevant, the *Osman* test might only apply during the hours of temporary detention whilst some other evidential test might apply to the remainder of her informal stay. The applicable legal test would therefore be dependent upon whether she was prepared to consent to the informal arrangements.

37 *MHA 1983 s 2.*

38 *Ibid ss 4, 135 or 136.*

39 *Ibid s 5.*

40 *Section 50 of the Mental Health Act 2007 inserts Schedule A1 into the Mental Capacity Act 2005 which will contain the procedural safeguards precipitated by the ECtHR's decision in HL v United Kingdom (2005) 40 EHRR 32. On the meaning of 'deprivation of liberty' see JE v Surrey County Council, re DE [2006] EWHC 3459 (Fam), [2007] 2 FLR 1150; Sunderland City Council v PS [2007] EWHC 623 (Fam), [2007] 2 FLR 1083. Salford City Council v GJ and others [2008] EWHC 1097 (Fam).*

41 *National Suicide Prevention Strategy for England: Annual report on progress 2006 (CSIP, April 2007) at p4. See also K v Central and North West London Mental Health NHS Trust [2008] EWHC 1217 (QB).*

42 *Ibid n 28 at para 33.*

43 *Ibid at para 26 which refers to Öneryildiz v Turkey (2005) 41 EHRR 20 at paras 69-73 and 107, Abdurrahman Kilnic v Turkey (unreported) 7 February 2005, and Ataman v Turkey (Application no. 46252/99) (unreported) 27 April 2006.*

44 *See also LCB v United Kingdom (1998) 27 EHRR 212; Mahmut Kaya v Turkey (1999) 28 EHRR 1; Mastromatteo v Italy (Application no. 37703/97) (unreported) 24 October 2002; Gongadze v Ukraine (2006) 43 EHRR 44.*

45 *See, for example, R (on the application of Dudley, Whitbread and Others) v East Sussex County Council [2003] EWHC 1093 (Admin) at para 28; R (on the application of Plymouth City Council) v County of Devon Coroner [2005] EWHC 1014 (Admin), [2005] 2 FCR 428; Van Colle and another v Chief Constable of Hertfordshire [2007] 1 WLR 1821; Smith v Chief Constable of Sussex [2008] EWCA Civ 39.*

46 *This conforms with R (on the application of DF) v Chief Constable of Norfolk Police, Secretary of State for the Home Department [2002] EWHC 1738 (Admin) at para 37 where Crane J. held that 'the requirement that the authorities knew or ought to have known of the risk will usually be satisfied much more readily in relation to a prisoner, than in relation to a member of the community in general'.*

47 *[2007] EWHC 3086 (QB).*

48 *Indeed she was detained under s 3 after her suicide attempt.*

(b) The Osman elements

Rather than referring to detention status, a clearer approach might be to rely upon the elements of the *Osman* test to prescribe the necessary trigger for invoking the protective duty. Thus, the duty will be owed to *any* identifiable patient whenever hospital staff are aware, or ought to be aware, of a real and immediate risk to that person's life. This degree of foresight sets a very high threshold which will not be readily satisfied.[49] For no question can be raised under article 2 unless the staff have such actual or constructive knowledge of the risk.[50] The nature of that risk will also be important because the patient must present an objectively justified risk *to life*; a risk of serious injury resulting from self-harm would not suffice, although this distinction may in practice be occasionally difficult to draw.[51] In addition, the real risk must be present and continuing at the time of the alleged violation; if its immediacy subsided before the expectation to take precautions arose, the necessary causal link will not have been established.

Contrast this clear formula with the line of judicial authority[52] which favours a variable threshold of risk, tailored to the particular circumstances of the case. It purports to water down the *Osman* elements for individuals whose lives have been put at risk by the actions of the State; for example, those in a 'special category of vulnerable persons' or those required by the State to perform certain duties on its behalf. Their enhanced status, it is said, entitles them to expect a 'reasonable level of protection' which is achieved by interpreting any risk as a 'real risk' and interpreting 'immediate' to simply mean 'present and continuing'. It is this 'lower test' which the Court of Appeal in *Savage* may have been referring to in its concluding remark, although it rightly saw no warrant for it. Indeed, it is submitted that the approach to be preferred is that endorsed by the House in *In re Officer L*: '… the standard is constant and not variable with the type of act in contemplation, and is not easily reached.'[53] Requiring the real risk to life to be immediate in the sense of being 'present and continuing' avoids frail distinctions, for example between those who may, or may not, be vulnerable, and is non-discriminatory in nature.

Returning to G, in the week before her suicide attempt at Baker Street Tube station, the patient absconded, withdrew money and bought a map of the infamous Beachy Head. She also preoccupied staff with discussions about the unit's suicide rate. Although no claim was brought under the *Human Rights Act 1998*, it is certainly arguable that there was a real and immediate risk to G's life at the time her consultant decided to continue with unescorted leave around hospital grounds. Moreover, the staff knew, or at least ought to have known, of that risk. In those circumstances, it is submitted that her informal detention status should not prevent the protective duty being owed, though not necessarily breached, in these circumstances.

49 *For a detailed analysis of the relevant considerations, see J. McBride, 'Protecting life: a positive obligation to help' (1999) European Law Review 43.*

50 *An example where such knowledge was held to be absent is R (on the application of Plymouth City Council) v County of Devon Coroner [2005] EWHC 1014 (Admin). See also Trubnikov v Russia (Application no. 49790/99) 5 July 2005, ECtHR.*

51 *Cf. The right to life, as preserved by the offence of gross negligence manslaughter, requires nothing short of a risk of death: R v Adomako [1995] 1 AC 171 at 187 and R v Misra and Srivastava [2005] 1 Cr App R 21 at para 52. See M. Brazier and N. Allen, 'Criminalising Medical Malpractice' in C. Erin and S. Ost (eds), The Criminal Justice System and Health Care (2007) Oxford University Press.*

52 *R (on the application of A) v Lord Saville of Newdigate [2002] 1 WLR 1249 at paras 28-31; R (on the application of DF) v Chief Constable of Norfolk [2002] EWHC 1738 (Admin) at para 38; R (on the application of Bloggs 61) v Secretary of State for the Home Department [2003] 1 WLR 2724 at paras 54-55 and 60-61; Van Colle and another v Chief Constable of the Hertfordshire Police [2007] 1 WLR 1821 at paras 75-77; Savage v South Essex Partnership N.H.S. Foundation Trust [2006] EWHC 3562 (QB) at paras 33-37 which were not disapproved of by the Court of Appeal [2007] EWCA Civ 1375 para 16; and Mitchell v Glasgow City Council [2008] CSIH 19 at paras 63-65.*

53 *[2007] 1 WLR 2135 at para 20.*

Satisfying the *Osman* elements serves only to trigger the State's protective duty. To establish its breach, the claimant must go on to prove that the authorities failed to do all that was reasonably to be expected of them to avoid the risk to life. The European jurisprudence embraces the principle of proportionality in this regard:

> *'…[B]earing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.'*[54]

Such a wide margin of appreciation aims to strike a fair balance between individual and community rights. It requires the Court to consider the precautionary options available to hospital staff, their likely effectiveness and the reasonableness of implementing them. This will take into account how difficult it may be to implement the precautions and the resources available. The protective duty, therefore, does not require staff to guard against *every* risk to life; in fact it would be impossible to satisfy such an absolute standard. Indeed, to do so may well threaten their therapeutic relationship with the patient.

Rather than applying a 'but for' test to determine whether the materialised risk could be said to be 'caused' by the State's actions or omissions, the test employed by the Court of Appeal mirrors the causative language used by the ECtHR in *Osman.*[55] Thus, the State will be liable if it fails to take protective measures 'which, judged reasonably, might be expected to avoid' the risk to life. With the *Osman* elements setting a high threshold for triggering the protective duty, this 'reasonable expectation' test for causation seems appropriately generous to claimants and conforms to European jurisprudence. Unlike the stricter test adopted in *Van Colle,*[56] which requires the measures to have had 'a real prospect of altering the outcome', it relinquishes the claimant from having to prove that matters would have turned out differently had the relevant precaution been taken. This ensures that the right to life is afforded real and effective protection in domestic law.

(c) Implications for the law of negligence

Were the House of Lords to adopt the *Osman* test and permit the *Savage* case to proceed to trial, assuming the *Osman* elements are satisfied so as to trigger the protective duty, the *human rights* issue will be whether her consultant failed to take measures within the scope of her powers which, judged reasonably, might have been expected to avoid the risk to life. This can be contrasted with the G case where the *negligence* issue was whether her consultant acted in accordance with a practice accepted as proper by a responsible body of practitioners skilled in the relevant field.[57] The common law duty of care can be seen to be covering much the same ground as the Convention right. Yet an alleged breach of the former will be determined according to the deferential *Bolam*[58] test whilst an alleged violation of the latter will call for

54 *Ibid n 35 at para 116; see also Keenan v United Kingdom (2001) 33 EHRR 38 at para 90; Akdogdu v Turkey (Application No. 46747/99) at para 45; Uçar v Turkey (Application No. 52392/99) at para 84.*

55 *In Dodov v Bulgaria ibid n 17 the ECtHR asked whether the public authorities did 'all that could have been required of them to prevent the life of the individual concerned from being, avoidably, put at risk'.*

56 *Ibid n 45 at paras 81– 83. This was used by the ECtHR in the context of article 3 in E v United Kingdom (2002) 36 EHRR 519 at paras 99-100.*

57 *Ibid n 19 at paras 87-9. G's consultant was held not to have been negligent.*

58 *Bolam v Friern HMC [1957] 1 WLR 582 at 587. The House of Lords in Bolitho v City and Hackney Health Authority [1998] AC 232 largely reaffirmed the Bolam test, stressing that only in rare cases will the courts be able to disallow an accepted medical practice.*

a greater degree of judicial scrutiny under the *Osman* test. Those claimants who do not begin proceedings within one year[59] might therefore lose this enhanced degree of Convention protection.

Adopting the *Osman* test is likely to exacerbate the recent tremors in the law of negligence.[60] The judiciary have begun to evolve the duty of care owed by the police so as to act compatibly with the Convention.[61] Whether the *Bolam* test provides the necessary degree of scrutiny must now be in doubt[62] as the contemporary view seems to be that compartmentalising human rights and negligence actions is not an acceptable way for the law to develop. Although the judiciary is not duty-bound to do more than the Strasbourg Court, it must certainly do no less.[63] Might this therefore be the beginning of the end for *Bolam?*[64]

Conclusion

Assessing the risk of suicide is an inherently unreliable exercise;[65] after all, 'psychiatry is not an exact science'.[66] This may explain why at their final point of contact with mental health services, immediate suicide risk was estimated to be low or absent for 86% of the deceased.[67] The cases of *Savage* and G vividly illustrate the potential for human error.

It has been argued that the protective duty is triggerable for all patients, regardless of their detention status, once the heavily qualified elements of the *Osman* test have been established. The margin of appreciation permitted by European jurisprudence in determining whether that duty has been breached should, it is hoped, discourage clinicians from engaging in defensive practice. In these early stages of articles 2's development into the health care setting, a careful legal balance must be struck between risk and liberty, between paternalism and self-determination. If suicide prevention is to be a national priority, obliging mental health services to take reasonable steps to protect life in limited circumstances would surely be a positive, and not unduly onerous, judicial development.

59 *Human Rights Act 1998 s 7. There is a discretion to allow late applications to proceed under s 33 where the Court considers it 'equitable' to do so.*

60 *The relationship between Convention and common law rights was considered in A v B and C [2002] 2 All ER 545 at para 4; and D v East Berkshire Community Health NHS Trust and others [2005] 2 AC 373.*

61 *See Smith v Chief Constable of Sussex Police [2008] EWCA Civ 39. Although the Court did not hear full argument on the issue, Rimer L.J. at para 45 considered it to be arguable that the positive obligations in article 2 should impact upon the development of the common law principles of negligence 'on the basis that where a common law duty covers the same ground as a Convention right, it should, so far as practicable, develop in harmony with it'.*

62 *Ibid at para 56 per Pill L.J. The ECtHR has held 'The Court must subject allegations of breach of [article 2] to the most careful scrutiny' (see Nachova and Others v Bulgaria (2006) 42 EHRR 43 at para 93; Angelova and Iliev v Bulgaria (Application no. 55523/00) (unreported) 26 July 2007 at para 91).*

63 *R (on the application of Ullah) v Special Adjudicator [2004] 2 AC at para 20.*

64 *See M. Brazier and J. Miola, 'Bye-bye Bolam: A Medical Litigation Revolution?' (2000) 8 Medical Law Review 85 and J. Miola. Medical Ethics and Medical Law: A Symbiotic Relationship (Hart Publishing, 2007).*

65 *The Department of Health has published guides to best practice in risk-assessment: 'Independence, choice and risk: a guide to best practice in supported decision-making' (DH, May 2007 for all N.H.S. services); 'Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services' (DH, June 2007 for mental health services).*

66 *R (on the application of B) v Ashworth Hospital Authority [2005] 2 AC 278 at para 32 per Baroness Hale.*

67 *Avoidable deaths, ibid n 3 at p14.*

The Secretary of State for Justice has a duty to provide Offending Behaviour Programmes in prison – submissions to the contrary are lacking in realism!

Andy Bickle[1]

R (on the application of Walker) v Secretary of State for Justice; R (on the application of James) v Secretary of State for Justice

[2008] EWCA Civ 30

Introduction

The cases which form the subject of this review brought into focus the interface and tension between two major developments in criminal justice over the last two decades: the trend towards longer than normal sentencing for 'dangerous' offenders and the rise of accredited offending behaviour programmes.

Successive governments in the United Kingdom have legislated for more severe punishment for certain categories of offenders. The *Criminal Justice Act 1991* introduced longer than commensurate sentences and revised extended sentences for violent and sexual offenders. The *Crimes Sentences Act 1997* brought in automatic life sentences for a second serious offence. More recently, sentencing legislation was overhauled in the *Criminal Justice Act 2003* (the 'Act'), which represented a further shift towards public protection as the primary rationale in sentencing serious offenders[2]. One consequence of this shift has been the increasing availability of, and requirement for, indeterminate sentences[3]. The general approach of the Act is to introduce a new framework whereby offenders convicted of at least moderately severe violent or sexual offences must be assessed for 'dangerousness' and if found to be a significant risk of causing serious harm must receive heavier sentences for the purpose of public protection. The Act introduced a statutory assessment of dangerousness containing a 'statutory assumption of dangerous', meaning that an adult offender found guilty of a second or subsequent 'specified' violent or sexual offence is assumed to be dangerous unless that assumption can be rebutted under s229(3). Specified offences are listed in Schedule 15 of the Act, but are simply all violent or sexual offences carrying a maximum sentence of two or more years' imprisonment. Violent and sexual offences carrying a maximum sentence of ten or more years' imprisonment are further identified as 'serious offences'. The Act created new sentences for those identified as dangerous, including 'imprisonment for public protection' ('IPP') - an indeterminate sentence for offenders convicted of a serious offence, but not meeting the requirements of

1 *Specialist Registrar in Forensic Psychiatry, East Midlands Centre for Forensic Mental Health, Arnold Lodge, Leicester.*

2 *Ashworth A. (2005) Sentencing in Criminal Justice (Fourth Edition) Cambridge University Press; Cambridge: 218.*

3 *Bickle A. (2008) The Dangerous Offenders Provisions of the Criminal Justice Act 2003 and Their Implications for Psychiatric Evidence in Sentencing Violent and Sexual Offenders. Journal of Forensic Psychiatry and Psychology (in press).*

imprisonment for life[4]. In the first two years after the Act came into force, more than 2,200 IPPs were handed down[5] and the number of 'lifers' detained on the prison estate rose by nearly 10%[6]. Official estimates suggest over 10,000 prisoners will be detained in custody under an IPP by 2014[7] and they have been identified as a cause of prison overcrowding[8].

Historically, indeterminate sentences were largely reserved for offenders in whom a degree of 'mental instability' had been demonstrated *as per R v Hodgson* (1967) 52 Cr App R 113[9]. In *R v Wilkinson* (1983) 5 Cr App R (s) 60, Lord Lane went so far as to state that discretionary life sentences were reserved, broadly speaking, for those who could not be dealt with under mental health legislation, yet were in a mental state which made them dangerous[10].

Therefore, it can be seen that under previous regimes, indeterminate sentences were given to offenders exhibiting some degree of mental abnormality in a broader sense. Presumably, the new indeterminate sentences introduced by the Act, including the IPP, 'capture' a similar group of mentally abnormal offenders, as well as other serious offenders who are likely to have deficits in a range of domains including interpersonal behaviour, social skills, pro-social problem-solving and consequential thinking in addition to having histories of substance misuse.

The notion that one cause of offending is deficits in cognitive skills which can be made good (or least diminished) through cognitive-behavioural therapeutic approaches, and in turn reduce recidivism, forms the theoretical underpinning of cognitive skills programmes that have been introduced to UK prisons. In the 1970s there was considerable pessimism about the effectiveness of rehabilitation interventions aimed at reducing re-offending, encapsulated in the widely-held view that 'nothing works'[11]. From the mid-1980s, a body of research assembled which asserted that offending behaviour groupwork could produce a

4 *The dangerous offender provisions of the Act (set out within ss 225-228) introduced three new sentences for adult offenders: (new) extended sentences, imprisonment for public protection and imprisonment for life. Extended sentences are for dangerous offenders who have committed a specified, but not serious, offence. The extension period should be of such length as the court considers necessary for protection of the public from serious harm from further specified offences.*

Imprisonment for life is reserved for offenders who stand convicted of an offence with a maximum sentence of life imprisonment and, having satisfied the other conditions for identification as a 'dangerous offender', also have their offence considered serious enough by the court to justify the imposition of a life sentence. Imprisonment for public protection must be given to a dangerous offender committing a serious offence for which life is unavailable or where the other condition for life imprisonment is not considered to be met.

It should be noted that (1) the obligation to pass one of these sentences, if the criteria are met, may be overridden if the criteria requisite to the imposition of a hospital order under section 37 Mental Health Act 1983, are satisfied (see paragraph 38 Schedule 32 Criminal Justice Act 2003), and (2) greater judicial discretion is likely to be re-introduced by the Criminal Justice and Immigration Bill 2007, currently before Parliament.

5 *Ministry of Justice (2007a) Penal Policy – A Background Paper. Ministry of Justice: London.*

6 *Epstein R (2007) Prison Crisis: Why The Rising Numbers? Justice of the Peace, 171: 671.*

7 *Ministry of Justice (2007b) Ministry of Justice Statistical Bulletin: Prison Population Projections 2007-2014 England and Wales. Ministry of Justice: London.*

8 *Thomas D.A. (2007) Sentencing: Overcrowding of Prisons. Criminal Law Review, Jun: 501.*

9 *Except, of course, for offences where the sentence was fixed by law. In effect, this meant the mandatory life sentence, and before that the death penalty, for murder.*

10 *It should also be remembered that Hospital Orders (s37 of the Mental Health Act 1983) and Interim Hospital Orders (s38 of the Mental Health Act 1983) require the court to be of the opinion that these orders are the most suitable means of disposing of the case. This is in addition to the requirement for the presence of a mental disorder of a nature or degree to warrant detention in a hospital (and in the cases of mental impairment and psychopathic disorder additional evidence of 'treatability'). Therefore, it must be possible that some offenders who would otherwise meet the criteria for detention in hospital are detained in prison because the court does not regard hospital admission as the most suitable disposal.*

11 *Hollin C.R. (1999) Treatment Programs for Offenders: Meta-Analysis, 'What Works' and Beyond. International Journal of Law and Psychiatry, 22(3-4), 361.*

small but significant reduction in offending and became subsumed under the '*What Works*' banner of interventions[12] [13]. These programmes are not without their critics and several studies have failed to replicate positive findings[14]. Nevertheless, metanalyses seem to support the view that well-designed, structured and targeted cognitive-behavioural approaches can reduce recidivism by around ten percentage points[15] and they were incorporated into a UK government strategy which adopted the '*What Works*' brand in 2000[16].

These interventions are typically focussed, time-limited, structured and are delivered by trained staff in prison and probation with the assistance of a training manual. In the UK, HM Prison Service now offers thirteen fully or partially-accredited programmes covering such areas as enhanced thinking skills, anger management and specific criminogenic attitudes such as those underpinning sexual offending[17], although the problem of access to such courses forms the basis of the current case. The need for such courses is commonly written into sentence plans and reports from course facilitators are reviewed by the Parole Board, as noted in *James* and *Walker*.

The Facts

Mr Walker was convicted of two offences of sexual assault and given an IPP with a minimum term of 18 months, which expired in October 2007. Mr James was convicted of wounding with intent and given an IPP with a minimum term of one year and 295 days which expired in July 2007. Both were detained at HMP Doncaster, a local remand prison. This establishment had very limited resources for offending behaviour work. Furthermore, neither offender was moved on to a 'first stage' lifer establishment or had a sentence plan drawn up[18].

The report for the Parole Board prepared by Mr Walker's Life Manager stated that although his behaviour may have justified transfer to open conditions or release, the facts that he had no sentence plan and had not undertaken work around relapse prevention meant that no recommendation could be made for release or transfer to open conditions. Like Mr Walker, Mr James had received no formal sentence planning. He had undertaken a short (2 week) alcohol-related course, but he had not the opportunity to undertake several other courses that Parole Board reports indicated he probably needed. His Life Manager similarly reported to the Parole Board that as he had not yet been given a sentence plan or

12 *Blud L, Travers R, Nugent F. & Thornton D. (2003) Accreditation of offending behaviour programmes in HM Prison Service: 'What Works' in practice. Legal and Criminological Psychology, 8, 69.*

13 *McGuire J. (1995) What Works: Reducing reoffending. Guidelines from research and practice. Chichester: Wiley.*

14 *See, for example, Falshaw L, Friendship C, Travers R. & Nugent F. (2004) Searching for 'What Works': HM Prison Services accredited cognitive skills programmes. British Journal of Forensic Practice 6(2), 3, which found that two of the oldest and most established offending behaviour programmes (Reasoning & Rehabilitation and Enhanced Thinking Skills) did not reduce the short term recidivism of prisoners released from English and Welsh prisons.*

15 *Hollin C.R. (1999) Treatment Programs for Offenders: Meta-Analysis, 'What Works' and Beyond. International Journal of Law and Psychiatry, 22(3-4), 361.*

16 *Chapman T. (2005) Publication Review: What Works in Probation and Youth Justice: Developing Evidence-Based Practice. British Journal of Criminology, 45(5), 785.*

17 *www.hmprisonservice.gov.uk/adviceandsupport /beforeafterrelease/offenderbehaviourprogrammes/*

18 *At the Court of Appeal, reference was made to the Prison Service's policy on the management of life sentence prisoners (PSO 4700). This explains that a typical male lifer will generally pass through a remand centre/local prison, a first stage establishment (high security or category B), a second stage establishment (high security, category B or category C) and a third stage establishment (category D, open, semi-open or resettlement) before release. The same policy states an intention that lifers will move on from their local prison within approximately six months.*

undertaken any work related to his offence, no recommendation for release or transfer to open conditions could be made.

At Mr Walker's judicial review, Laws LJ stated that it was an underlying premise of the new legislation (the CJA 2003) that courses in the prison would be available to *"maximise the opportunity for lifers to demonstrate that they were no longer a danger to the public by the time their tariff expired (or as soon as possible thereafter)"*[19] and that failure to provide the same was unlawful. He reasoned that an indeterminate sentence comprised of a tariff element for punishment and a post-tariff element for public protection. Only periodic assessment of the need for public protection could justify continued detention. In the absence of effective assessment, detention could not be justified and was unlawful in common law (although the decision in *Cawser* [2004] UKHRR 101 closed off any possibility that detention of a lifer beyond his tariff period was in breach of ECHR article 5(1)).

At Mr James's judicial review, Collins J applied the decision in *Walker* and held detention beyond tariff to be unlawful. In this case the stakes were higher as James, unlike Walker, was already post-tariff. Collins J decided that although it was, "*potentially disastrous*"[20] his immediate release must be ordered. Mindful, not unlikely, of the immense consequences of this decision to the population of post-tariff life prisoners, the judge stayed his decision to give the Secretary of State the opportunity to appeal.

The Decision

The appeal was allowed in part. On the decision to order James's immediate release, the Court of Appeal, presided over by Lord Chief Justice Phillips, ruled that the finding that the detention of life prisoners beyond their tariff in such circumstances was unlawful, was itself erroneous. Primarily, the Court accepted the 2003 Act had made express statutory provision for the circumstances in which IPP prisoners may be released:

> *"Central to this is the requirement that the Parole Board is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined. It is not possible to describe a prisoner who remains in accordance with these provisions as 'unlawfully detained' under common law. The common law must give way to the express requirements of the statute"*[21]

The Secretary of State's success was limited to this (albeit important) aspect of the cases.

The Secretary of State's submission that he was not under any relevant duty to provide treatment or training in prison was found to be *"lacking in realism"*[22]. His counsel asserted that there was no basis for saying it was an underlying premise of the Act that he would provide IPP prisoners with the maximum opportunity to demonstrate to the Parole Board that it was no longer necessary to detain them for the protection of the public[23]. Furthermore, the appellant claimed it was for the independent Parole Board to decide what evidence satisfied it that an IPP prisoner should be released and any fettering of its discretion (such as by making release dependent on the completion of courses) would itself be unlawful[24]. In rejecting this submission, the Court of Appeal decided that the performance of the appropriate courses is likely to be a prerequisite to a prisoner satisfying the Parole Board because experience had shown that

19 *Walker v Secretary of State for the Home Department [2007] All ER (D) 479, para 26.*

20 *James v Secretary of State for the Home Department [2007] EWHC 2027 (Admin), para 10.*

21 *R v (on the application of Walker) v Secretary of State for Justice; R (on the application of James) v Secretary of State for Justice [2008] EWCA Civ 30 para 47.*

22 *Ibid, para 39.*

23 *Ibid, para 36.*

24 *Ibid, para 37.*

such courses are usually necessary if dangerous offenders are to cease to be dangerous, and highlighted the significance of such evidence in current practice. The Court noted the Secretary of State had chosen to bring the Act into force and yet had not provided the resources to give effect to his own policy of offering these courses[25]. It concluded that this conduct breached his public law duty because its direct and natural consequence was the detention of some prisoners beyond the time necessary either for punishment or for the protection of the public, contrary to the intention of Parliament (and the object of Article 5 of which Parliament must have been mindful).

The Court turned lastly to claims made on behalf of the prisoners that their treatment constituted infringement of certain of their rights under article 5(1) and 5(4) of the European Convention of Human Rights[26]. The Court reviewed the Strasbourg and domestic jurisprudence on indefinite detention. In lengthy considerations it agreed that the legality of the post-tariff period of an indeterminate sentence imposed for the public protection is dependent on the prisoner remaining a threat to the public and reasoned:

> *"Article 5(4) requires this legality to be subject to periodic review by a body with the qualities of a court. If, in the period between two such reviews a prisoner ceases to be dangerous, this will not mean that his detention in the remainder of that period infringes Article 5(1). That article must be read in conjunction with Article 5(4) so as to produce a practical result. If, however, a review is unreasonably delayed and it is shown that, by reason of the delay, the prisoner has been detained after the time that he should have been released, that period of detention will constitute an infringement of Article 5(1)."*[27]

Applying these tests to the cases before them, the Court considered whether the Parole Board could review detention as required by Article 5(4) when offenders had not completed treatment courses. They concluded that whilst this state of affairs would not formally prevent a case being heard, the review would be an empty exercise and the outcome a foregone conclusion. For each claimant it found that if the situation continued it would be likely to result in a breach of Art 5(4). However, their Lordships did not apparently feel the delays were yet long enough for that breach to have taken place.

There remained the question as to whether in the absence of periodic review the offenders were no longer being detained for the object for which the IPPs were imposed, which would mean their detention could not be justified under Article 5(1)(a). The Court accepted that if so long a time elapsed without a meaningful review, detention would become disproportionate or arbitrary. However, without further explanatory comments they decided that this stage had not been reached, and emphasised that failure to comply would not in itself result in infringement of Article 5(1)(a). Nevertheless, the decision explicitly left open the possibility that this article could be so infringed in the future.

Comment

The Secretary of State's partial success has avoided the "*potentially disastrous*" prospect (identified by Collins J. at first instance) of indeterminately detained dangerous offenders being released without demonstrating they no longer represented a significant risk of serious harm to the public. However, the conduct of the Secretary of State has been strongly criticised and held to be in breach of his public law

25 *Ibid, para 40.*

26 *Mr Walker, who made his application before his tariff had been reached, claimed that the unavailability of courses had the potential to infringe his human rights. Mr James, as a post-tariff lifer, submitted that in his case Article 5 had actually been breached.*

27 *R v (on the application of Walker) v Secretary of State for Justice; R (on the application of James) v Secretary of State for Justice [2008] EWCA Civ 30 para 61.*

duty. The effect of such a ruling on policy and resource allocation is unclear. Ultimately, the likely future infringement of Article 5(4) and potential future infringement of Article 5(1) may well prove to be more important drivers for change, especially if a breach were to be determined at the ECtHR. The possibility of an individual case progressing to the point at which a breach may be said to have occurred does not seem fanciful. In its deliberations, the Court of Appeal endorsed the observations that flowed from *R (Noorkoiv) v Secretary of State* [2002] EWCA Civ 770, in which the claimant successfully argued that a delay of 2 months before a parole hearing (brought about by a policy of holding hearings quarterly to make best use of resources) infringed his Article 5(4) right. A report published by the National Audit Office soon after *James & Walker* gave timely information about delays currently experienced in the parole system[28]. They found that only 32% of oral hearings for indeterminate sentences were being held on time. One of the two most common reasons for deferrals was the Board not receiving the information required to make a decision. In particular, 97 of 276 indeterminate cases did not contain either an Offender Assessment System report (which would draw heavily on reports from offending behaviour courses) or a life sentence plan. In these circumstances it is not difficult to envisage how a lengthy delay might occur.

In the longer term, the problem of offending behaviour programme provision and other problems arising from having a large population of prisoners detained indeterminately with short tariffs may be ameliorated to some extent by provisions of the *Criminal Justice and Immigration Bill 2007*, which is currently before Parliament. Part of this wide-ranging bill seeks to amend the dangerous offender provisions of the Act. Most significantly, in a notable volte-face by the Government, it intends to remove the statutory assumption of dangerousness and also allow courts discretion in sentencing offenders who meet all the criteria for IPP and extended sentences. There would still remain ample opportunity to impose indeterminate sentences, but such amendments would probably reduce the numbers of those detained indeterminately whose short tariff perhaps hints at the courts' misgivings in handing down this type of sentence in the first place.

In conclusion, this judgement confirms the right of indeterminately detained prisoners to access appropriate offending behaviour programmes in a timely fashion. It affirms the regard in which cognitively-oriented psychological and educational interventions are now held and the importance placed on such work by criminal justice system. In the long view, all this seems far removed from the period less than three decades ago when little in the way of psychological rehabilitation was viewed as of any great proven worth. Debate may continue as to whether the statistically significant effects of these courses equate to a significant reduction in recidivism or to value for money, but it looks as though they will be offered ever more widely.

The relationship between mental disorder and crime is complex, controversial and well beyond the scope of this article. We can say that offending behaviour courses in their current form attempt to bring about changes in cognition (such as comparative thinking and paranoia) and behaviour (such as substance misuse and emotionally dysregulated violence) which in some individuals will form part of a syndrome of mental illness or other mental disorder. Indeed some courses, in particular substance misuse courses, might be said to treat or prevent classifiable mental disorders specifically. We do know that the prison

28 *National Audit Office (2008) Protecting the public: the work of the Parole Board. TSO: London.*

population as whole contains extremely high rates of mental disorder representing considerable unmet need[29]. Thus, a significant proportion of those in line to participate in offending behaviour programmes in prison will suffer from a mental disorder. The gold standard for treatment for severe mental disorder may be transfer to hospital, but the majority of mentally disordered offenders are detained in prison. It is of interest when evaluating the status of prison-based programmes to reflect that psycho-educational interventions offered in secure hospitals bear many similarities to prison courses and in some institutions some of the very same courses are offered. In conclusion, it can be seen that many of the prisoners to whom this judgment applies will have mental disorders, and in confirming the duty to provide cognitive-behavioural interventions in prison, the Court of Appeal ought to have improved the likelihood of certain mental health treatment needs being met.

29 *Several large epidemiological studies have highlighted the high rates of mental disorder in all types of prisoner, as summarised in: Birmingham L. (2003) The mental health of prisoners, Advances in Psychiatric Treatment, 9, 191. Mental disorder (including substance misuse diagnoses) was found in 37% of sentenced male prisoners and 57% of sentenced female prisoners in: Gunn J, Maden A. & Swinton M. (1991) Mentally Disordered Prisoners, London: Home Office. Amongst remand prisoners, mental disorder (also including substance misuse diagnoses) was found in 63% of male prisoners and 76% of female prisoners in: Maden A, Taylor C, Brooke D. et al (1995) Mental Disorder in Remand Prisoners, London: Home Office. Even excluding substance misuse diagnoses, about a quarter of men entering prison on remand were found to have some form of mental disorder in: Birmingham L, Mason D. & Grubin D. (1996) Prevalence of mental disorder in remand prisoners: consecutive case study, British Medical Journal, 313, 1521.*

Book Reviews

Risk, Rights, Recovery
The Twelfth Biennial Report 2005-2007. The Mental Health Act Commission

Published by TSO (The Stationery Office) (2008), £25.00
ISBN 978 0 11 322807 2

To quote the title of the 1969 Country Joe and the Fish album, "*Here We Are Again*". And indeed here we are once more - with the Twelfth Biennial Report of the Mental Health Act Commission, this most recent one covering the period from 2005 to 2007. Not only that but whoever would have expected, or even thought it? On the other hand perhaps one might be forgiven for thinking the near impossible, if only simply on the basis of the quite extraordinary events which have led to the effective demise of what was intended to be wholly new mental health legislation but resulted in something, arguably, but potentially maybe, really quite different.

Be that as it may the Mental Health Act Commission is still going strong, a fact to which their most recent Report attests. They are due to be subsumed, if the Government's plans proceed in that respect at least as announced[1], into the Care Quality Commission in the early to middle part of 2009. In the meantime this Report suggests that they were, during the two years covered, and still are from my own experiences as a working clinician, very much on post and firing on all cylinders. And thank goodness for that one might add – given the content of some of the chapters and sections. I found myself repeatedly wondering, as I read and re-read through the 250 plus pages of this document, how, in the early part of the twenty first century and in one of the wealthier countries in the world, health services involved in the care and treatment of some of the most vulnerable individuals in our society could still be as they are described in places here. Perhaps it is just that fact in itself? Maybe the very things that characterise the needs of those with mental health problems are exactly what makes it so apparently easy to ignore them. Is there any other branch of medicine in the UK where patients would be expected to sleep in the ward day room on a mattress on the floor with no space for their personal effects? Where else in modern health services would it be considered appropriate, even in the most extreme of circumstances, to nurse a terminally ill individual in the unit's dining room where other patients were eating? These may be relatively uncommon occurrences. If so thank goodness. And yet both, with others, were recorded and reported by Commissioners during visits to hospitals where there were detained mentally disordered patients within the last two years.

The Twelfth Biennial Report is a rather slimmer volume than the Tenth and Eleventh editions, marginally so in the case of the tenth edition and by quite a bit when compared to that covering the 2003–2005 period. I would also say that the content leans rather less heavily towards the analysis of the law, in all its

1 *See Health and Social Care Bill, introduced into Parliament on 15/11/07.*

various forms, and across all areas of its place and influence in mental health care, than those two, certainly the former. Despite this it does provide a clear and structured analysis of pertinent issues, and in any event that is almost certainly to do with the fact that there have probably been rather fewer mental health cases coming before and being dealt with by the courts within the last two years than in the preceding four. The main point of reference throughout though is of course the advent of the 2007 Act and it's potential influence on things.

All the same *Risks, Rights, Recovery* does strike at the heart of many important areas that anyone involved in providing for the care of those suffering from mental ill health in the widest possible sense, and not only that but who are where they are against their expressed will or because they cannot object or speak for themselves, should be aware of and know about and be seeking to change. At the very outset in only the second paragraph of the Introductory Chapter, whose title cleverly turns around that of the report itself to *Rights, Risk, Recovery*, perhaps to represent the priorities more clearly, the Commission states its views and purpose:

> *"Much of what we say in this report is critical of services provided to detained patients. We are unapologetic about this: our criticism is more useful than our praise, and we do not wish to lose a focus on what needs to be changed by highlighting that which is changing."*

Some, including myself at times, might take gentle issue with the second half of this paragraph. Telling someone they are doing well, or even just thanking them for what they have done, albeit something that may be part and parcel of their day-to-day work and, therefore, expected of them, goes a long way. That is not in any way to excuse or disagree with the criticisms that are raised, and quite rightly so, by the Commission throughout it's latest report. One is, however, increasingly aware that those working in the Health Service as a whole, let alone in perhaps some of the most beleaguered areas of health care, attract far more criticism, and sometimes outright condemnation, and are certainly subject to far greater public scrutiny, which of course is no bad thing, than they ever do praise and encouragement. Nevertheless it is far more common to be told how poorly one is performing than how well. As someone whose main clinical focus is almost exclusively with detained patients, most in hospital subject to a restricted hospital order or conditionally discharged into the wider community, and with additional major commitments to University work, I once made an approximate calculation of the number of different individuals, agencies and other bodies with some official or formal interest in my work, it's nature, its quality and its quantity. It came to more than twenty, all of whom were concerned with what I should do more of or do better, rather than what I might be doing all right with already. But of course I acknowledge that quite properly the base line for standards of medical care should be at the level of excellence. And that is why potential readers of the Commission's most recent report, particularly those who come from a health care background, should not be put off. What the Commission are saying, I think, is that they recognise, and indeed acknowledge in many places in the text, examples of changes being made for the better and in particular the commitment of most staff in mental health services, even when under terrible pressure and working in difficult and often under-resourced situations, to at least provide something. But they are also concerned to point out that despite what good might already have been done, there is much, much more still to do, and that that work has to be got on with and not ignored further for the sake of offering congratulations on what might already have been achieved, and that anyway just providing "something" is simply not enough. In fact what the Commission are doing, to my mind, is in support of that which the vast majority of mental health care professionals, those I know at least, strive for and seek to attain. That is high quality, humane, holistic, rights-based care of the sort that we would all want for ourselves and those we love in the same circumstances. In my view if one loses sight of that as the goal, it is time to

quit. On the other hand I would make a plea to those coming to *Risk, Rights, Recovery* from any other background or standpoint that they do give some credence to the fact that there are genuinely very large numbers of people working with, and for, those bearing the burden of mental illness and disorder who simply want the right thing for them and labour very hard to achieve it.

As with all the Commission's two yearly reports, this one presents a multitude of facts and figures on various aspects of the operation of the 1983 Act concisely and clearly and in a way that makes what might otherwise seem rather dry or routine, quite fascinating. And their scope and range means there is something of note and importance for everybody, from mental health service commissioners to hospital managers, from Mental Health Review Tribunal (MHRT) members to Second Opinion Appointed Doctors (SOAD) and from lawyers and mental health professionals working in the field to prison governors. Some of the tables and their accompanying text require more concentration to understand than others but that is simply a product of the richness and complexity of the information presented. There are just one or two minor typological errors, almost inevitable in such a sizeable and detailed document, but these are easily resolved by careful reading.

The report is at its strongest when it provides an overview of a particular issue and the numbers and statistics, but perhaps even more so when it describes individual patients and carers and their experiences. So for example at Chapter 3 there is a section entitled *Length of hospital stays* which is quite hard going but well worth the effort. There the issue of *de facto* detention of informal patients in locked or other secure settings is raised. In addition the fact that those detained with learning disability in the private sector are placed on average more than four times further away from home than those admitted to an NHS hospital is identified. There also we see that on the day of the *Count Me In* census there were apparently no fewer than 17 patients detained in terms of section 2 of the *Mental Health Act* each of whom had already been in hospital for in excess of five years. They had not, of course, been detained for that length of time on that order, but had either been in hospital informally or subject to some other form of compulsion during the intervening period seemingly for between six and 41 or more years in each case. This did lead me to wonder just how long clinicians actually need to establish a diagnosis, to formulate an agreed treatment and care plan and to feel that they have an established understanding of the patient's needs, thus enabling them to move to the use of Section 3? I was struck by the data also presented in Chapter 3 showing the small, but by no means insignificant, number of patients detained for the treatment of personality disorder who were deemed incapable of giving consent to treatment. By contrast earlier in the same Chapter there is a brief, but no less thought-provoking for that, and certainly deeply affecting, account of the case of a woman admitted under Section 2 to a private hospital paid for by her father and the potential ramifications of such a desperate situation.

Of course with a publication like the Mental Health Act Commission's report, it is impossible to do justice to the entire content and my opinion remains unchanged from previously, namely that it is of value to those who wish to search, and research, a specific area or issue, to those whose concern is with the welfare of all detained patients, particular aspects of the law as it applies, or will apply in future, to their care, and to those with any sort of personal or professional involvement. It is also such a good starting place for other reference material in the field of mental health law and practice, coming as it does, based on the foundation and tradition of earlier volumes. The part that deals, for instance, with Medical Treatment is, in my judgement, vital reading for all those discharging the duties of a Responsible Medical Officer and also anyone else trying to come to terms with the changes to the SOAD's role in considering consent to treatment for those who are placed on the new Community Treatment Order. There is a Chapter specifically dealing with the Act and it's use in Wales and another on forensic psychiatry. And as well as

what one might consider coverage of such "mainstream" matters there are also brief sections addressing rather more uncommon, but no less important concerns such as the prescription, or administration or taking by detained patients, of herbal remedies and fish oils and their certification under the Act, the matter of mental health service users consenting to having a photograph taken for incorporation into leave care plans and documents, the position of a school governor detained under the Act who is then required immediately to relinquish that position as compared to a Member of Parliament who is only compelled to abandon his or her seat in the House after a period of at least six months detained in hospital or on leave, and the potential minefields of access to mobile phones and the internet, both now so much a part of ordinary everyday life, for involuntary patients.

There are many concerns raised and, as they make plain at the outset, the Commission are not there to offer a pat on the back at the expense of time spent in identifying shortcomings and stating them. They are right in what they do and in the reasons for doing it. Lastly one or two things struck a particular chord with me. Why is the issue of voting and the right to vote for patients detained under the Act not fully sorted out? It still isn't. How can anybody possibly justify patients being denied their entitlement to leave for want of appropriate escorting staff? They can't. Where will detained patients obtain expert legal advice and support at Mental Health Review Tribunals and in other circumstances, most particularly in the most complex cases, with the so-called "rationalisation" of legal aid funding of solicitor's MHRT work? They won't. What is the basis for the cessation of all benefit payments to those transferred to hospital for treatment of mental disorder as sentenced prisoners? That can't be right.

The Mental Health Act Commission's Twelfth Biennial Report, possibly, one might even go so far as to say probably, their last but one, has the same strengths and certainly gravitas as it's predecessors. It's content should, I would argue, be taken as a whole, although there is also a separate summary document of *Key findings about the use of the Mental Health Act*, and seen as a logical progression and extension of the work contained in the earlier volumes. That doesn't mean that it has to be read in its entirety to make sense of some of the most important aspects of the treatment of compulsorily detained patients and the ways in which all of those concerned with their care must remain constantly alert to the need to improve on standards. As Lord Patel in his capacity as Chair of the M.H.A.C wrote to the Secretary of State for Health in his letter of 30th July 2007, (reproduced at Appendix 1 of *Risk, Rights, Recovery*):

> *"We are worried that their" [detained patients'] "protection will not be given sufficient attention in the new regulator, and look to you to assure us that our concerns will be addressed in legislation and in the performance framework you give to Ofcare*[2] *once established."*

Hear! Hear!

Dr Martin Humphreys

Senior Lecturer in Forensic Psychiatry, University of Birmingham and Honorary Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust

2 *The Office of the Health and Adult Social Care Regulator*

Mental Health – The New Law by Phil Fennell

Published by Jordans (2007), £39.00
ISBN 978 1 84661 074 5

There are a number of problems facing the writer of a new book on mental health law. One such is whether in publishing in the middle of a time of considerable statutory change occurring in stages over a period of many months it is best to attempt to outline the law as it will be on various significant dates during that period (say in October 2007, October 2008, April 2009, April 2010 and beyond), or to set out the position as it will be once all the significant changes have come into effect. The former option has the advantage of clarity, ease of reference and certainty; however it is less straightforward than might be supposed because important changes have and will continue to come into effect at regular intervals between such dates. Examples would be the recognition of civil partners for the purpose of determining who is the Nearest Relative (December 2007); the need formally to admit a 16/17 year old who is competently refusing admission to psychiatric hospital (January 2008); and the possibility of moving a person from one place of safety to another under S136 (April 2008). Moreover this approach means that large sections of the work would quickly become out of date. The latter option more easily allows an overview of the overall impact of the changes, while having to face a Code of Practice, Mental Health Act Guide and regulations in draft form only and the need regularly to point out which provisions are not yet in force. The problem is magnified because it is not simply changes to the *Mental Health Act 1983* which need to be considered but also the impact of the *Mental Capacity Act 2005* as already in force and as amended probably in April 2009 with the introduction of the deprivation of liberty "safeguards" procedure.

One of the most difficult issues facing health and social care professionals as the various amendments take effect is the question which route to take in respect of a patient and indeed whether there is a true choice at all. Patient safeguards versus a less restrictive alternative; which alternative is the less restrictive anyway; Guardianship under the *Mental Health Act* versus deprivation of liberty under the *Mental Capacity Act*; statutory principles versus Code of Practice principles; the significance of important but inconclusive case law? Such issues can hardly be dealt with by assuming a detailed knowledge of the provisions of the *Mental Capacity Act 2005* as originally enacted, and the question is the extent to which those provisions need to be covered in a book primarily aimed at expounding the law once the amendments introduced by the *Mental Health Act 2007* have come into effect.

Professor Fennell has unequivocally taken the overview approach, for which this reviewer is profoundly grateful. One can end up questioning one's sanity after any length of time spent exploring the arcane byways of new Part 4A of the *Mental Health Act* or Schedules A1 and 1A to the *Mental Capacity Act*, becoming consumed by the need to rediscover the wood for the trees. Two formerly comprehensible Acts of Parliament have been rendered needlessly complex at a stroke. Are bets being taken on the number of pages of forms that will ultimately be needed to implement the deprivation of liberty "safeguards" procedure alone?

The great strength of Professor Fennell's book is not just that there is an early chapter summarising in sufficient detail to be useful the impact of the *Mental Health Act 2007*, but that frequently throughout the other chapters elaborating the provisions, there are at the beginning and the end overviews and conclusions, which allow one to ground oneself again.

The book is not an annotated version of the amended *Mental Health Act 1983* but a general outline of mental health law including where relevant the *Mental Capacity Act 2005*, the *Children Act 1989*, the *Domestic Violence Crime and Victims Act 2004* and other legislation. It starts with immediate historical background to the amended legislation, seeing a continuity of reform going back to the 1959 Act. The second chapter then summarises the 2007 Act reforms and their impact, highlighting the interface issues between the MHA and the MCA. These two chapters will prove enduringly useful in reminding the reader of the overall scheme of mental health legislation and its areas of controversy. Thereafter the book is topic based: so "Mental Disorder" and the Availability of Appropriate Treatment; Statutory Powers of Staff; Detention of Mentally Disordered Offenders (a particularly lucid summary); Compulsory Powers in the Community; Consent to treatment; Children; etc. As such the book can be read cover to cover as a comprehensive overview, or dipped into topic by topic, although the subheadings within chapters can be a little misleading or confusing to navigate. There is a consolidated version of the MHA 2007 and MHA 1983 provided, which although adding considerably to the length of the book is necessary with the failure to date of the Government itself to provide a consolidation Act; however the attempt to identify at the end of each Section of the consolidated Act which wording has been amended by which provision of the 2007 Act is largely unsuccessful as the "words prospectively substituted" cannot be identified by use of italics, brackets or other means. The provisions of the 2007 Act amending other legislation, in particular the Deprivation of Liberty "safeguards" procedure are reproduced in a separate Appendix. There is a full table of Cases, and Table of Statutes. The Contents description is much more useful than the Index, which apart from being confusingly laid out contains the somewhat alarming reference to "depravation" of liberty! Grammatical and typographical errors do seem to plague the book: IMCA for IMHA, RMO for RC. There is a reference to an outline of the renewal of powers of detention which directs the reader to some non-existent paragraphs; also a statement that the role and function of the Mental Health Act Commission will be explored in Chapter 10 when in fact it is not.

The main provisions of the unamended *Mental Capacity Act 2005* are extremely lucidly and helpfully set out in a few short pages, and in enough detail to make sense of the amendments to come and to serve as a background to the issue of which route to take. Perhaps the summary of sections 5 and 6 is a little dense and the very lengthy paragraph 6.33 might be better subdivided, but the reader probably has all that he needs.

This is not a book which sets out merely to outline the changes to existing mental health law but as mentioned describes the law in its entirety as it will be once those changes have taken effect. Those areas of the law remaining largely unaltered are covered in almost as much detail as those which are subject to radical change. It is likely therefore to be particularly useful as a first point of reference for practitioners and as an introduction to the subject for students. As one would expect from Professor Fennell, there is a particular emphasis on the *Human Rights Act 1998* implications of the amendments and on the issue of consent to treatment for mental disorder. The book is especially stimulating in its discussion of what constitutes a true mental disorder as opposed to behaviour deviating from society's norms, in the context of the removal of the exclusions relating to promiscuity or other immoral conduct and sexual deviancy; equally in dealing with the issue whether the possible lack of involvement of a doctor in the process of renewal of a patient's detention will be held to be Convention compliant. Will the background qualifications, expertise and training of an Approved Clinician who is not a doctor, satisfy the Winterwerp[1] requirement of objective medical evidence of a true mental disorder? In his discussion of the

1 *Winterwerp v Netherlands (1979) 2 EHRR 387*

removal of the treatability requirement and its replacement with the "availability of appropriate treatment" test Professor Fennell seems to come down on the side of those who believe that the overall effect of the changes, along with the removal of the exclusions in relation to sexual deviancy etc is real rather than apparent, and will be to "set the legal scene for increased use of mental health legislation to detain people who have not yet committed a crime but who have a personality disorder and pose a risk to self or to others". While the question of appropriate treatment is fully discussed one would have welcomed a little more space being given to the issue of when treatment might properly be said to be "available". The statement in the Explanatory Notes that it is not enough that appropriate treatment exists in theory for the patient's condition does not really take the matter much further. To what extent will, for example, geographical and financial considerations legitimately play a part?

For the Government, the introduction of Supervised Community Treatment and the consequent abolition of Aftercare under Supervision is one of the cornerstones of the amended legislation. For many practitioners, particularly once the Government decided that prior admission under Section 3 or 37 was a condition precedent to being placed on a CTO, the courts in a series of decisions had already created CTOs in all but name by considerably extending the opportunities for renewing a patient's Section while he was on Section 17 leave, sometimes with minimal hospital contact (certainly as an in-patient.) Professor Fennell covers the case law clearly and succinctly in one of the book's best chapters dealing logically with compulsory powers in the community: CTOs, and Guardianship as well as extended Section 17 leave. In particular a good point is made about the conditions that must or may be attached to a CTO. It was regarded as a concession extracted from the Government that the ability to attach a condition to a CTO whereby a person was "not to engage in specified conduct" was withdrawn; in fact as Professor Fennell points out the scope of the conditions on personal freedom that remain, being left to the discretion of healthcare professionals, is subject only to an extremely lax "necessary or appropriate test" for treatment or to prevent risk to self or others. The draft revised Code of Practice too hardly seems to limit the scope of the discretionary conditions.

On the other hand, although Professor Fennell points out that a Responsible Clinician granting leave for more than seven days must first consider whether the patient should be made subject instead to a CTO, a discussion of just what such consideration might comprise, and in what circumstances the Responsible Clinician might be vulnerable to challenge if he decided to use extended S17 leave, would have been welcome. The same point might be made about the implications of the use of the barring order to prevent discharge of a patient ordered by the NR: the statutory provision is set out but not the practical consequences. Other areas where a more extended discussion would have been beneficial include the somewhat limited nature of the ability (set out at several points in the text) of a patient to displace his nearest relative: no right to choose who should fulfil the role, merely a right to apply to the Court: but even then the mere fact that the patient's preferred candidate might be *more* suitable than the statutory incumbent would be insufficient to displace him. Will this be sufficient to ensure compliance with Article 8? Incidentally does the statement in chapter 2 that *R(E) v Bristol City Council*[2] decided that an ASW does not have a duty to consult the NR if the patient objects overstate the effect of the decision? Elsewhere in chapter 4 the judgement is more cautiously discussed but unfortunately the vital last sentence in paragraph 4.29 is incomplete, depriving us of Professor Fennell's conclusion. Completing this reviewer's wish list for a second edition would be an elaboration of the Part 4A treatment provisions for CTO patients which are set out but without a great deal of accompanying explanation.

2 *R (on the application of E) v Bristol City Council (2005) EWHC 74 (Admin)*

As drafted they are difficult to comprehend, and I am not sure that reading the five pages of text that the description occupies in the relevant chapter will cause the scales to fall from many eyes.

The question of deprivation of liberty looms large over the book. The new safeguards procedure itself is very clearly summarised in chapter 6. In addition, Professor Fennell does not shy away from the question whether Guardianship constitutes a deprivation of liberty. He believes that it can, and implies that the MHA procedure, familiar to health and social care professionals (particularly now that it will include a power to take the patient to his place of residence) should be preferred to the complexity of the new "safeguards" procedure notwithstanding the MCA Code of Practice guidance that "decision-makers must never consider guardianship as a way to avoid applying the MCA". In discussing what constitutes deprivation of liberty Professor Fennell reports the *JE v DE and Surrey County Council*[3] decision of Munby J, which has given rise to so much (? too much) argument, as well as the distillation of current guidance from the Strasbourg case law to be found in the draft addendum to the MCA Code of Practice. It is hard to know how one can go much further to assist professionals on the ground: cases which will always differ on their facts from those in the law reports will have to be approached in the light of general principles and with fingers firmly crossed. The disagreement between Professor Fennell and Richard Jones as to whether giving ECT or strong psychotropic medicine to an incapacitated patient might constitute deprivation of liberty so requiring the *Mental Health Act* to be invoked is very fairly rehearsed. With the advent of S58A covering ECT and the safeguards for incapacitated detained patients and for all child patients this is an issue unlikely to go away.

Professor Fennell states in his preface that the aim of his book is "to explain the new framework of mental health legislation in a way which is accessible not only to professionals but to service users, carers and interested lay readers" (and I would add, students). In this aim he unquestionably succeeds, although health care professionals will need to look elsewhere for more detailed identification of ,and solutions to, those practical problems which will increasingly confront them as the legislative changes are progressively implemented. This reviewer is likely to turn frequently to the book as a first point of reference, and whenever the need arises to fit the pieces of the jigsaw together.

Paul Barber

Consultant to Bevan Brittan, Solicitors (Bristol)

3 *JE v DE, Surrey County Council and EW (2006) EWHC 3459 (Fam), FD*

Blackstone's Guide To The Mental Health Act 2007 by Paul Bowen

Published by Oxford University Press (2007), £34.95
ISBN 978 0 19 921711 3

Having spent (far too) many hours trying to make sense of the *Mental Health Act 2007* (MHA 07), the amendments it introduces to the *Mental Health Act 1983* (MHA 83) and the *Mental Capacity Act 2005* (MCA), this guide was much anticipated and welcomed with considerable relief. Does it (could it) live up to such expectations? In short the answer is a most definite 'yes'.

Despite its title, this guide, as noted at the outset by the author, is (and necessarily so) really a guide to the MHA 83 and MCA, as amended by the MHA 07. It is divided into two parts, the first dealing with the MHA 83, as amended, and the second the MCA and amendments introduced to it.

It is expressly stated that the first part, dealing with the MHA 83 amendments, is *not* intended to provide a detailed consideration of those aspects of the MHA 83 that remain largely unaffected by the MHA 07 amendments, but rather is intended to be complementary to other texts in that regard. What it aims to do – and in the reviewer's opinion, it admirably succeeds - is to provide a guide to the effect of the MHA 07 amendments, as and when these come into force. Consequently, although the MHA 83 provisions are dealt with, as necessary, to set the scene and aid understanding of the MHA 07 amendments, the MHA 83, as a whole, is not dealt with in detail.

The same does not, however, apply to the second part, which is a detailed consideration of the MCA, pre and post MHA 07 amendments, as well as consideration of the common law position prior to the MCA coming fully into effect, in relation to medical treatment.

Although separated into two distinct parts, the interface between the two Acts is comprehensively and very helpfully considered in chapter 15.

It is a testament to the skill of the author, that the detailed explanation of the MHA 07 provisions and their effect on both Acts, appears so clear and comprehensible. An impressive feat, as many who have attempted to interpret some of the more complex aspects, will no doubt testify. The complexities are identified by the author, who notes that the impact of the MHA 07 amendments on the MHA 83 means that the MHA 83 "now has the added vice of being exponentially more difficult to understand". Some reassurance to those (including the reviewer) who have grappled at length with some of the trickier provisions.

This is not to suggest that the guide in any way 'ducks' the difficult issues - which must have been very tempting at times. The guide tackles many of these 'head on', particularly with regard to issues relating to children and young persons, potential Human Rights implications, and the interface between the two revised Acts. This guide does not take the easy way out, by simply stating/summarising the provisions, but provides a detailed consideration of the amendments, helpfully comparing and contrasting, for example with the pre-amendment position, and the positions of different groups of patients, to enable a much clearer understanding of the potential impact in a practical and a legal sense.

Interesting submissions are provided as to the author's view of the HRA compatibility of the amendments, and how they may (or may not) work in practice. There is a strong focus on human rights implications throughout. Although this may appear less relevant to those working with the MHA on a

day to day basis, however, this reviewer would echo the sentiment expressed by Sir James Munby in his foreword, in relation to the readers of this guide, when he writes, "I hope they will read it and not merely dip into it".

For the busy practitioner, however, this may be an unaffordable luxury, where so much statutory change has already been, and is gradually to be, introduced, (in practical implementation terms, at least) in a relatively short period. In the reviewer's opinion, such practitioners are also well served by this guide. It is clearly structured and laid out, and broken down into carefully numbered and referenced parts. Detailed summaries of each chapter's contents are set out at the beginning of the chapter, which generally commence with a summary of the 'key features'. Although this inevitably results in some repetition, it enables the reader, at a glance, to note the key points, identify the relevant part of the chapter where the point is dealt with in greater detail, and easily cross-reference to related areas. It also aids understanding, and puts the provisions in context. This is particularly important where the provisions are like a jigsaw puzzle, the whole picture being necessary at the outset, as a guide to a more detailed understanding of the parts and how they fit together.

Another challenge presented by the MHA 07 to any commentator, is how to deal with the phased implementation, and issues of timing. The guide very helpfully includes copies of both the MHA 83 and MCA, clearly showing the position pre-and-post amendment. This is invaluable, not just pending full implementation of the MHA 07, but also to enable the reader at a glance, and without having to cumbersomely cross refer to other texts, to identify the changes and thus to better appreciate their potential impact. The guide sets out and analyses the position and interface between the MHA 83 and MCA, both pre-and-post amendment. Again, this is essential for those attempting to understand the position pending full implementation, and to carry out the necessary preparations. Once the MHA 07 is fully implemented, this will still be a very useful guide, not just for the academic and the student, but also for the practitioner, to aid understanding and interpretation, pending clarification (in due course) by the courts.

Chapter 1 introduces the guide, its content and structure. The background to the MHA 07 is summarised, setting the scene and context of the MHA 07. A brief, but interesting, consideration of the history and development of mental health legislation follows. The chapter also introduces key relevant human rights concepts - such issues are a particular focus of the guide throughout.

Chapter 2 provides a helpful overview of the MHA 83 and the amendments introduced. Thus, at glance, a busy practitioner can identify the key changes to the Act as a whole and the overall impact, and is cross-referred to relevant chapters where the particular issues are considered in more detail. A particular strength of this guide is the ease with which the reader is able to identify and locate relevant sections and commentary, and consider them in context.

The amendments to the compulsion criteria, for detention and guardianship are covered in more detail in chapter 3. This considers the amendments introduced to the definition of mental disorder and the removal of the 'treatability' test, to be replaced by the new 'appropriate treatment' test. Helpfully the current provisions are reviewed first, with the amendments then being introduced and their impact considered. This provides a very clear picture of the effect of the changes, both for those who are very familiar with the MHA 83 provisions, and those who may be less so. More on the impact in practical terms of the new 'appropriate treatment test' would have been useful. The chapter concludes with a thoughtful consideration of the 'missed opportunity' (in the author's view) to introduce an 'impaired judgment' requirement into the MHA, which would 'bring the provisions for compulsion under the 1983

Act into line with more contemporary attitudes to respect of patient autonomy' (para.3.111). Interestingly, the author raises the possibility that, at some point in the future, Article 5 ECHR may be interpreted to include such a requirement.

Chapter 4 considers the additional safeguards introduced for patients by the MHA 07. This includes consideration of the Code, nearest relative provisions, the Mental Health Review Tribunal, and new IMHAs (Independent Mental Health Advocates). The additional safeguards for children are also considered.

A very useful description and analysis of the new community treatment provisions (Supervised Community Treatment- SCT) is set out in chapter 5. The relevant treatment provisions applicable to SCT, in the community and on recall/ revocation, are clearly and comprehensively dealt with in chapter 6. SCT is compared to 'existing forms of community treatment': s.17 leave; guardianship; and the supervised discharge provisions it replaces. The chapter concludes with a consideration of the human rights implications of SCT, and its interaction with 'long-term' s.17 leave.

In addition to dealing with the new treatment provisions for patients subject to SCT, chapter 6 unpicks the other amendments relevant to the medical treatment provisions set out in Part IV of the MHA 83. Again, to aid understanding of the amendments and their impact, an overview of the existing provisions is provided. Helpful summaries of the impact of the new provisions, together with very effective cross-referencing, are typical of this guide, and particularly effective in chapter 6, when dealing with the complex new treatment provisions for SCT. The chapter closes with a brief consideration of the interface of the amended MHA provisions with the MCA, which is picked up in more detail in the final chapter of the guide.

The final chapter in part 1 deals with the 'other amendments'. This succinct 'sweep up' includes consideration of victim's rights; offences; transfer to/ from Scotland; the amendments to s.136; and impact on criminal provisions, namely the removal of time limited restrictions, and the extension of the hospital direction. It also includes consideration of the new professional roles, the AMHP (Approved Mental Health Professional) and Responsible Clinician (RC). Consideration of the RC role usefully pulls together the relevant sections of the MHA that will continue to require the involvement of a doctor, and those (notably s.20 renewals) that will not. The section on AMHPs is very brief, and one of the rare occasions when the guide leaves you wanting more. A chapter dealing, in more detail, with these new roles and their practical implications, would have been welcome.

Another aspect which could usefully have been considered in some detail is the amendment to s.18, in relation to guardianship, and the power to take the patient to the place where they are required to reside, rather than just to return them there.

Part 2 provides a very helpful and comprehensive consideration of the MCA now, and post-amendment, (including the MCA, showing the pre-and-post MHA 07 position) and supplementary texts (other than the Code) should not be necessary. This is, however, subject to the caveat that the focus on the MCA is on personal welfare decisions, rather than property and affairs.

Part 2 is introduced in chapter 8. This includes a history of the developments leading up to the MCA, the 'Bournewood' case (of which, of course, the author (as junior counsel for L throughout from the High Court through to Strasbourg) has the benefit of first hand knowledge) and the amendments introduced by the MHA 07. In relation to the new provisions to be introduced to the MCA to 'safeguard' the 'Bournewood patient', the author notes (para. 8.22), that these are 'long.., complex, overly bureaucratic

and ironically, may still not comply with the requirements of Articles 5(1) and 5(4).' Indeed the author further comments (para.8.23), that the amendments 'will lead to excruciating difficulties for those charged with responsibility for deciding both which detention regime and which treatment regime is appropriate for a person suffering from mental disorder. This complexity becomes increased exponentially for children.' Fortunately for the reader, the author tackles these difficult issues in the final chapter.

Chapter 9 sets the scene by describing the common law position before the MCA came into force, with a particularly useful section focusing on children. Chapters 10 and 11 go on to focus on care and treatment under the MCA, chapter 10 focusing on such care without detention, and chapter 11, where the person is detained. Chapter 10 is a comprehensive consideration of the relevant MCA provisions, and again, the guide's structure with 'key features' followed by (and cross-referenced with) more detailed consideration, and with frequent summaries, is very effective.

One of the most difficult issues currently facing those charged with care and treatment of those who lack capacity, is that raised by the potential for such care and treatment to constitute a deprivation of liberty, and, where a person is (or may be) so deprived, the lack of an effective legal framework to provide for such a deprivation and extend the necessary safeguards. This is clearly detailed in chapter 11, which outlines the common law position, what is meant by deprivation of liberty, and the position under the MCA, prior to its amendment by the MHA 07. The chapter goes on to consider the amendments introduced by the MHA 07, and the new 'authorisation' process. The detail of the complex process of authorisation is considered, commendably clearly, in chapter 12, with a supporting flowchart at appendix 4. Chapter 13 focuses on the representation of the new 'schedule A1 detainees'.

The Court of Protection, its jurisdiction and the application process is dealt with in chapter 14, which also considers the role of the Public Guardian and Court of Protection Visitors.

In the final chapter, chapter 15, the author does not shirk from considering the most challenging aspects of the MHA 07, namely the interface between the regimes. The position in relation to treatment for mental disorder, both with and without detention, together with treatment for physical problems, and urgent cases, are all considered. The position relating to children is considered, broken down into 16/17 year olds and under 16s. This chapter provides invaluable assistance to those who are - and will be - required to weave their way through this legal labyrinth.

Sir James Munby concludes his foreword by both commending and congratulating the author on "the great service he has done us all". This reviewer for one is very grateful for the hours and anguish already saved by this guide, which in its short life has become an essential point of reference.

Helen Kingston, Senior Lecturer, School of Law, Northumbria University

Advance Directives in Mental Health: Theory, Practice and Ethics by Jacqueline M. Atkinson

Published by Jessica Kingsley (2007), £19.99
ISBN: 978 1 84310 483 4

Jacqueline Atkinson, the Professor of Mental Health Policy at the University of Glasgow, has put together a compendious volume on advance directives in mental health. This relatively slim volume can be highly commended as a relatively up to date authoritative text, and I am sure that it should be on the bookshelves of every department that has an interest in mental health law and not just within the UK. The book provides good coverage of relevant law in the USA (as shown by Table 5.1, which records in summary form the legal provisions relating to all 50 states), as well as some discussion of other jurisdictions, such as Australia, Canada and New Zealand. And, of course, this is not a book solely for lawyers since it contains information and arguments that will be of interest and concern to many others, from clinicians to ethicists to users of mental health services.

The book is divided into three main sections. The first is concerned to set the scene and outline the context, describing how the idea of advance directives emerged in general and in mental health in particular. This includes a look at mental health legislation in various countries, and the connection between it and advance directives. The second section turns to consider a number of important underpinning philosophical themes relevant to advance directives. We find a discussion of the central notion of autonomy, which many might see as the main point of advance directives, as well as consideration of the related issues of personhood, rationality and responsibility. The final section turns to practical matters: research, how to implement advance directives, clinical experience of them, attitudes and other approaches to advance care planning. Each of the fifteen chapters covers its territory in a laudably clear and concise manner.

This is a timely book, certainly in England and Wales where the *Mental Capacity Act 2005* (MCA)[1] recently came into effect, and where the amendments made to the *Mental Health Act 1983* by the *Mental Health Act 2007* will be in force in a few months time. Sadly, the book was obviously written a little too early to capture the details of either the MCA or the 2007 amendments[2], although it helpfully makes reference to the *Adults with Incapacity (Scotland) Act 2000*. That the book is not as current as we might like should not, however, detract from the usefulness of its discussions. Even if it does not capture the details of the latest legislation, Atkinson is up to the mark when it comes to the issues and arguments. It is almost impossible to come up with an issue in connection with advance directives in mental health that is not touched upon. In short, there is much to commend.

If I had a criticism it would be more to do with style. Atkinson writes very clearly, but it is perhaps an unavoidable effect of the way in which she captures the literature that some sections become a little too much like reading a whole lot of journal papers all at once. If concentration slips for a second, it is quite hard to recall the wood from the trees. Chapter 12, for instance, scarcely has a paragraph that does not contain numerous percentages as the results of one study after another are reported in some detail. By the end of the chapter I was really quite bemused and unsure whether the percentages were good or bad. Still, to pull off the right balance, with enough detail and a clear overview, would be a tall order.

1 *In particular sections 24-26 which deal with advance decisions to refuse treatment.*

2 *In particular section 58A(5) which accords recognition to a valid and applicable advance decision in relation to electro-convulsive therapy (other than in an emergency).*

Rather than criticize, however, I shall focus the rest of my comments on three issues and offer some opinions in the hope of enlarging the debates that Atkinson has already captured so well.

First, the whole issue of autonomy needs to be considered further. Atkinson correctly reflects the spirit of the age in placing autonomy as the guiding principle of medical ethics. Advance directives seem indeed to be mainly about trying to respect autonomy. None the less, as Atkinson recognizes,

> '*Even within a society which values autonomy, choices and actions are both constrained and caused by external factors. If we add to this the external forces that shape physical, psychological and moral development then it would seem that no one is truly autonomous*' (p. 83).

But perhaps this line of thought needs to be pushed further. For instance, a closer examination shows not that we lack autonomy, but that the other side of the same coin is dependency.

I can make autonomous choices about where to go for this year's holiday. Now, there is an obvious sense in which my choices are externally constrained by just the sort of factors Atkinson alludes to: I can neither go to the moon, nor to stay on the luxury yacht of Mohamed Al Fayed. Even setting aside, however, the external constraints implied by these extraordinary possibilities, the autonomous choices that I *can* make are also dependent ones. My autonomy is exercised through my dependency. I can choose between Tunisia or Croatia because I can rely upon – and I have to rely upon – the many people and organizations who have set up holidays in these areas. Without them I have little chance of going to Croatia this summer; I might as well hope for a call from Mr Al Fayed. The point is that it is not *either* autonomy *or* dependency. It is inextricably both.

The nuanced position is not that my dependency is an external constraint; it actually contributes to my autonomy. It is the means by which I have the level of autonomy that I do. In which case, given that we have agreed that autonomy is central to advance directives, it follows that central to our consideration of advance directives should be the notion of dependency. Now this might seem counter-intuitive, because our normal way of thinking is to suggest that advance directives are there to guard against just the sort of dependency that comes with ill health. The point is, however, that our autonomous choices – if they are to be truly realistic – must also contain an innate recognition of our dependency. Perhaps this might feed into the 'autonomy of authenticity rather than autonomy as sovereignty (or self-governance)' (p. 88), which Atkinson mentions at the close of Chapter 6.

This leads to one further point about autonomy, which is that its position as the central principle of medical ethics is coming under increasing scrutiny. One way in which this can be seen to be the case is in the re-emergence of interest in virtue ethics as a way to deal with dilemmas. The question then becomes what would the virtuous person do in this situation? Although the answer from the virtuous doctor might often be that the person should be shown respect, the principle of autonomy does not inevitably win the day. Perhaps it is equally valid to suggest that compassion, honesty, integrity, bravery, steadfastness, practical wisdom and so on, should be guides to moral decision-making. In which case, once again, the standing of the advance directive has to be seen in a broader context.

The second, related, issue I shall discuss is that of personhood. Atkinson discusses this in Chapter 7, which focuses on:

> '*…the continuity of persons through time since this is central to the concept of advance directives*' (p. 91).

The chapter makes reference to the views of philosophers such as Locke and Parfit who have emphasized the importance of consciousness as the means by which personal identity is maintained. Atkinson then gives an account to Nozick's theory of the 'closest continuer', according to which 'the properties and

characteristics of the original give rise to the properties and characteristics of the closest continuer' (p. 93). Such characteristics can include personality traits and physical properties. Identity is maintained by the similarities that link the characteristics of the original to the individual that emerges.

The chapter then turns to consider a paper concerning advance directives in mental illness by Savulescu and Dickenson, which appeared in *Philosophy, Psychiatry, & Psychology* in 1998, and the responses to it. All this is well and good, but the discussion of the literature is relatively thin at this point. For instance, one might have expected to read something of Dworkin's distinction (from *Life's Dominion*) between 'critical' interests (those that shape our lives as a whole, perhaps well thought out at the time of completing an advance directive) and 'experiential' interests (those that can be demonstrated in the immediate present, but perhaps unforeseen at the time the advance directive was completed). Another important text would be Jennifer Radden's *Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality* (Cambridge, MA: MIT Press; 1996). In discussing advance directives or 'Ulysses contracts' elsewhere, Radden makes the following point:

> *'Our ability to entertain second thoughts – to reconsider, adapt, and change direction in the light of a new piece of information or a telling experience – is deeply bound up with what makes us autonomous human beings and is as essential to the full and complete exercise of our freedom as is our ability to bind ourselves with a plan'.*[3]

It is also worth highlighting those theories of personhood that entertain the thought that we are more than simply our consciousness or memories. The notion of the person as a situated embodied agent, for instance, acknowledges that the person is, indeed, a physical being, but stresses the situatedness of our lives. We are embedded in a multilayered and complex context. Put simply, this means that, once again, our autonomous wishes are not the only pebbles on the beach. We are also situated in a field of ethical, legal, spiritual, social, historical, cultural, familial, psychological concerns (to name but a few). So our advance directives need to be considered in such a context. They might even need quite sensitive interpretation in the light of the complicated nexus of relationships that help to co-create our narratives.

Such a way of understanding the person lends weight to the idea of a values history. As Atkinson says, a values history,

> *'… does not take the place of a clinician having a good, personal understanding of a patient, nor should such a relationship preclude the need for a written values history. It has a specific purpose in guiding decisions when the person is unable so to do. … explaining important values allows those who have to respond to the advance directive to follow its spirit, even if they cannot always comply with the detail'* (p. 184).

This brings me to the final issue I shall discuss. Atkinson mentions the disappointing uptake of advance directives in mental health (as in physical health) and suggests two barriers: the complexity of the task and the feeling that they will not in the end make a difference, given that mental health legislation will often mean they can be overruled. She continues:

> *'The lack of enthusiasm from different professional groups, but probably especially from psychiatrists, contributes to both the above problems. Clinicians are not actively seeking to promote advance directives, so patients do not know about them and do not get help in making them. This would suggest that at least as much energy must go into educating professionals and motivating them as is needed in promoting advance directives to patients'* (p. 187).

3 *Radden, J. (2004). Personal identity, characterization identity, and mental disorder. In: The Philosophy of Psychiatry: A Companion (ed. J. Radden), Oxford and New York: Oxford University Press; pp. 133-146. Actual quote from pp. 139-140.*

On the face of it this seems fine and dandy. It does, however, seem to presuppose that advance directives are what we need to make the world a better place. They may well contribute. But there is perhaps a caution required. The worry is to do with the simplicity of the thought that something like a form or written statement will sort out the major problems facing people with mental health problems. Some of those in favour of advance directives are also at the forefront of the user movement. It would be wrong to paint the user movement with a single gloss. But some of those who are active in this movement are more likely to have had bad experiences of mental health treatment than those who do not participate. For this group of activists (where this appellation is neither intended to suggest approbation nor disapprobation) advance directives are understandably very important and it is a matter of some concern, as Atkinson's review of research suggests, that there is little evidence of their effectiveness.

But the apparent lack of interest in going to the bother of devising and drawing up an advance directive might reflect a set of much more mundane facts. Perhaps people just do not feel that they need to. Perhaps they have some confidence that they will be looked after appropriately when it comes to it. Perhaps their previous experience is reassuring. Perhaps, alternatively, they recognize the complexity and do not think it is something they wish to commit time to, given the little difference it might make in the end (and perhaps they consider this to be no bad thing). Perhaps they have confidence that ordinary conversations with professionals amount themselves to a negotiation and agreement on how best to proceed. Perhaps the complexity is a suitably valid reason to conclude that future options are best not judged too far ahead or hypothetically.

Putting forward a list of objections to the very idea of advance directives might seem to place me in the 44% of those English psychiatrists whom Atkinson records did not think we needed advance directives (p. 173). The list of putative objections certainly encourages the thought that Atkinson's research should continue, because there is something here to be understood. But, actually, right towards the end of the book she suggests that the early assumptions about supporting autonomy might need to be placed in a wider framework. Atkinson continues, in a vein with which I can wholeheartedly agree,

> *'Autonomy does not have to mean being independent. It could include having improved relationships between patients and clinicians, ensuring that communication is enhanced and that there is more appropriate sharing of ideas and making realistic choices, whether to preferred treatment or to the options and consequences of reduced treatment'* (p. 187).

My rider to this would be that, even if advance directives might help the process of improving this sort of understanding between clinicians and patients, it is not the only way. Improvements in communication skills training might already be helping. More idealistically, a dose of virtue ethics might help clinicians to act wisely, which has always included the idea that compassionate listening, fidelity and honesty might be helpful to all concerned. All of this might be possible, therefore, without a written advance directive. The idea that health services can be improved by using more forms is in the end self-defeating. But the idea that the notion of an advance directive is itself useful as a way to drive up standards does not seem nonsensical. In some circumstances advance directives will seem imperative and this book helps in our understanding of them.

Dr Julian C. Hughes

Consultant and Honorary Clinical Senior Lecturer

Psychiatry of Old Age, Northumbria Healthcare NHS Foundation Trust.

Private and Public Protection: Civil Mental Health Legislation by Jacqueline M Atkinson

Published by Dunedin Academic Press (2006) £12.95
ISBN: 978-1903765616

This book is a timely reminder of the contrasting paths which determined the review and reform of legislation in the United Kingdom, concerning the care and treatment of individuals experiencing mental disorder. The Scottish experience concluded some time ago and we are already learning from this experience[1], whilst the process concerning England and Wales has in comparison only recently been brought to some kind of conclusion. After bitter debate and considerable wrangling, the new *Mental Health Act 2007* received Royal Assent on the 19th July 2007, and most of its amendments to the *Mental Health Act 1983* are due to be implemented on 3rd November 2008, with other provisions (such as those amending the *Mental Capacity Act 2005*) coming into effect in 2009 or (in the case of age appropriate services) 2010. However, after the fierce and repeated attempts to introduce new legislation, this is arguably a fudged outcome, once again amending the existing legislation. The 2002 and 2004 draft bills for England and Wales were arguably ill-conceived and unworkable, but we are yet to discover whether the enacted legislative measure has provided the solution so many sought. Arguably, whilst it is often considered that our Scottish colleagues appear to have got it right first time around, as the author notes in her concluding remarks, only time will tell.

Professor Atkinson is a Chartered Psychologist who has demonstrated a meticulous attention to the field of mental health, particularly concerning advance decision-making[2] and variable aspects of related mental health policy and legislation. Combined with her experience as advisor to the Scottish Parliament Health and Community Care Committee when considering the Mental Health (Scotland) Bill in 2002, she is clearly well positioned to undertake this analysis.

This text is refreshingly accessible, yet detailed and well supported. The interface of research, contextual reference points and detail assists one in assimilating the salient arguments with relative ease. The primary focus of the work is the development and detail of the *Mental Health (Care and Treatment) (Scotland) Act 2003*, and the experience in England and Wales is drawn upon and acts as a contrast. The author acknowledges that the book is limited to only reviewing the civil aspects of the legislation and again only specific elements of this. Given the material which has been presented, a less restrictive vehicle would undoubtedly have facilitated a fascinating read.

In the opening chapter, *Review of Mental Health Legislation: A New Act for a New Century*, the author manages to summarise with accurate brevity contrasting cultures, practices and experiences which present the backdrop to the divergent paths taken each side of the border. The different approaches to managing potentially high profile situations and the reduced presence these have had in the Scottish media cycle as a result are described, along with the political developments which afforded Scotland flexibility and freedom to offer time to their own issues. Against this backdrop, the reform process is summarised, starting with the initial committees set up to review the respective existing legislation in

1 *Lawton-Smith, S. (2006) Community-based Community Treatment Orders in Scotland: The Early Evidence, London, Kings Fund*

2 *A review of her book 'Advance Directives in Mental Health: Theory, Practice and Ethics' (Jessica Kingsley) (2007) appears elsewhere in this issue of the Journal of Mental Health Law.*

each jurisdiction, taking the reader through the suggested principles, and revisions to the definition of mental disorder. The limitations placed upon the Richardson Committee are stark when placed against the context of the approach taken by the then Scottish Minister for Health, Sam Galbraith. Although, in some ways these differences are a testament to the work of the Richardson Committee, given the similarities of the reports presented to the respective governments and the overall positive response they received from stakeholders (p.7).

As the book progresses, we are offered an understanding of the core framework for compulsory treatment under the Act, and of changes to detention criteria and focus, such as the inclusion of capacity criteria and the resultant complex problems inherent in the assessment of impaired decision making. Arguably however, the real focus of this section is the Community-Based Compulsory Treatment Orders (C-B CTO). Again, time is spent putting this issue into context, setting the provisions explored against a body of evidence which the author contributed to the development of. The historical and in some ways moral review of the C-B CTO argument helps us understand the presentation of the measure as included in the Scottish Act, but also acts as a reminder of the intense emotions this particular issue generates and how the history books will represent events in our past.

Whilst international research on C-B CTOs existed at the time of the reforms, as the author cautions, this was (and still is) limited and difficult to compare. The vital need for usable data to inform policy and legislative decisions at that time led to additional research being commissioned by the Department of Health in support of the proposals for England and Wales[3]. What is notable is that this was not published until the 7th March 2007, by which point the Bill had already proceeded through the House of Lords (including Committee and Report stages) and was available only for the later Commons debates[4]. This is despite requests from both houses for the release of the findings of the research in December 2006[5], a failed request under the *Freedom of Information Act 2000* by an opposition minister, and the subsequent repeated requests on the floor of the Commons on the 9th January 2007, including an unchallenged statement by Tim Loughton M.P. that he believed the report had been with the Department of Health since the autumn of 2006[6]. It is somewhat inevitable that when the report was finally published, its results were inconclusive. In essence, the authors stated that it was not possible to state whether C-B CTOs were harmful or beneficial to patients. This echoed extant work which questioned whether the legal measure, or the heightened service activity surrounding the person under the C-B CTO, led to any perceived benefits. However, it is the timing and circumstances surrounding the report's availability which will be something that observers will judge when contrasting how Scotland and England did things so differently.

The introduction of the Mental Health Tribunal system to Scotland is a clear development for Scotland in terms of ensuring greater patient's safeguards and a timely shift away from the sheriff court's role in determining compulsory treatment and hearing appeals. Once again, this is covered in clear detail, as far as the limitations of this volume allow. It would appear that many of the challenges that have faced the Tribunal system in England and Wales are to be faced in Scotland (e.g. insufficient numbers of medical members), and that these will need to be addressed fully to effectively deliver this service. The observed fight for dominance between the medical and legal professions (p.38) is unsurprising given the medico-legal battle which has itself dominated the history of mental health legislation. We have seen the

3 *Churchill, R. et al (2007) International experiences of using Community Treatment Orders, London, Institute of Psychiatry / Kings College London*

4 *Indeed this publication date neatly coincided with the Bill's 1st Reading in the Commons*

5 *HC 5th December 2006 cc377W-378W, HL 13th December 2006 WA210*

6 *HC 9th January 2007 cc131-132*

pendulum swing throughout the course of mental health legislation reform, with the tension between these two approaches often being the deciding factor as to how the current administration would respond to what was normally a public outcry, or some similar external pressure. There have been repeated instances of expressed concern for those who may have been wrongfully incarcerated and various legal measures enacted to balance and rebalance the desire to keep the 'well' and the 'unwell' in their 'rightful' places. Sadly, this has pervaded into the risk-orientated driver which the author identifies has steered the most recent reform process south of the border, although she recognises that the risk agenda has caused concern within Scotland too.

Thankfully however, other patients' rights and safeguards have been a feature of the recent reform process in England and Wales, as this book demonstrates they were in Scotland. The successful introduction of advocacy services under the Scottish Act is considered, although at the time of writing it was still unclear what impact the use of advocacy would have on patients' involvement with services or how it will assist them with regard to the amended legal processes. With specific regard to advance decision making or arrangements for future decision-making, we are offered detailed coverage of both advance statements and the patient's representative. We are introduced to some of the broader historical, international and practical issues surrounding advance decision-making. However, with the mix of terminology referred to and the measures in the *Mental Capacity Act 2005*, one must not confuse *Advance Statements* under the *Mental Health (Care and Treatment) (Scotland) Act 2003*, with those in the capacity legislation south of the border – they have significantly different purposes. In saying that, a crucial issue is shared between the measures intended to facilitate advance refusal in both jurisdictions, that of capacity. The author explores the difficulties which will be faced when considering the validity of an advance decision, and a myriad of other issues which inevitably only time will resolve, on both sides of the border. This uncertainty is however countered by some very useful and indeed practical guidance on the use of advance statements (as per the Scottish Act).

The author's ability to summarise depth into a limited space is demonstrated in the introductory pages to the role and involvement of the patient's relative. Here we are offered a précis of the importance and impact of relatives (even if sometimes abusive), and the role of legislation in attempting to manage both the consequences of mental disorder and the people surrounding the person experiencing this. The development of the role of the relative is reviewed against the backdrop of case law, political and strategic agendas and cultural influences. Some of the glitches in the new *Named Person* role are identified, whilst the material issues are explored, including a potential difficulty for the Mental Health Officer to be sure who the current named person is[7], and the challenge to balance the rights of the patient and the named person.

The last chapter covers a range of issues which have been given space previously, and some which have not, but here from the perspective of the interface between the legislation and mental health service delivery (e.g. age appropriate services for children, reciprocity and resource issues). The chapter is not exhaustive in this regard as not all of the implications are covered, but the introduction openly admits to this, citing the limitations of space as the primary culprit. Indeed, this seems to be a theme throughout this review. Whilst the book is deeply satisfying, it also leaves one wishing that there had been more space. The cogency of argument, the quality of research, the interplay between policy, case law and various stakeholder quotations are excellent, but is also a peek at a vision of what could have been.

7 *Largely because the patient has the right to change their mind without any requirement to complete a form, register their nomination or any revocation.*

However, for a book which barely has 80 pages to convey its actual contents, a surprising breadth of information is levered into such a compact package. Whilst at times the information may not always be in the same place (for example, details of the discussion concerning C-B CTOs is spread between chapter 2 and from a different angle, the final chapter 6), it is generally nonetheless there. Although, because of the size of the work, some material which would have made a useful contribution to the debate is absent (e.g. further discussion regarding some of the problematic issues with the legislation or Codes of Practice[8]). However, as concerns go, this is very much being picky, with regard to a book which is overall extremely well-researched, balanced and presented.

This text will undoubtedly be of interest to those who work within or have an interest in mental health, social care, social policy and of course the law. Equally so, as the focus of the book is set against the new political landscape in Scotland, a political scientist would find this an interesting read, particularly if their work ventured into health or law. It is a well-prepared piece of work which offers an insight into the development of Scottish mental health legislation. It would be interesting to see a follow on, after the passing of time has allowed the legislation to settle. Then perhaps the question of whether it was done right first time around can be answered with greater precision.

James Trueman, Senior Lecturer, Anglia Ruskin University

8 *See for example Patrick, H. Mental Health, Incapacity and the Law in Scotland, Tottel Publishing (2006) (reviewed in the November 2007 issue of the Journal of Mental Health Law @ pp 252-255)*