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Foreword

Since publication of the last issue of the Journal, there has been considerable and increasing speculation about the Government's timetable, and indeed intentions, with regards to progressing the reform of mental health legislation as outlined in the White Paper published in December 2000. As this issue goes to print, the uncertainty persists, as does the debate on what will/should be the detail of the Bill to be presented in due course to Parliament. Consistent with our aim when publishing previous issues, we intend that the contents of this issue of the Journal will contribute to that debate.

Our first article is by Professor Herschel Prins. Professor Prins contributed to the June 2001 issue with some 'comments ' on Part II of the White Paper. In this issue, he takes a broad overview of the concepts of dangerousness and risk. He places them in past and present contexts, and provides examples of how supervision of dangerous offenders might be made to be more effective. He reminds us that "occasional failures are inevitable" once "society has ordained that risks through legislation will be taken".

Paragraph 2.25 of the White Paper states the Government's intention that "the Patient Advocacy Liaison Service [PALS] announced in the NHS Plan [July 2000] will be the gateway to specialist advocacy services". In our second article Sinead Dalton and Peter Carlin take a 'brief look' at Independent Advocacy, and express concern that independent schemes might be threatened by PALS. They urge that independent advocates develop a greater understanding of the law affecting their practice, and that schemes develop more adequate policies and guidelines, particularly in relation to confidentiality.

In our third article, Dr. Alec Buchanan encourages us to return to the 'capacity' debate highlighted by the Report of Professor Richardson's Expert Committee, and subsequently responded to by the Green Paper of November 1999. He returns to basics and asks why we have mental health legislation. He suggests that if one answer is to provide criteria for psychiatric detention and treatment, those criteria should be based on a person's ability to make a proper choice.

As we await legislative developments, courts and tribunals have been fully occupied grappling with difficult issues relating to the care and treatment of those with mental health problems - not least because of the possibilities presented by the Human Rights Act 1998 to imaginative lawyers. Space allows us to examine in detail only a small number of the reported cases potentially of interest to our readership. In this issue: Hilary Patrick reviews the important Privy Council decision on the Scottish Parliament's controversial 'public safety' legislation in *A v The Scottish Ministers;* David Hewitt considers the Court of Appeal's views on the further detention of a recently-discharged psychiatric patient as conveyed in their judgments in *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg;* Paul Bowen recognises the significance for those detained patients who refuse treatment, of the Court of Appeal decision in *R (on the application of Wilkinson) v Broadmoor RMO (1) Mental Health Act Commission (2) Secretary of State for Health (Interested Party);* Anne Stanesby reflects on the European Court's finding of inhuman and degrading treatment and punishment of a mentally ill prisoner, in the case of *Keenan v The United Kingdom;* and finally Elizabeth Griffiths contemplates

the failings of disability discrimination legislation and government guidance to have sufficient recognition for workplace difficulties faced by those with a mental illness, in her consideration of the Employment Appeal Tribunal decision in *Leonard v Southern Derbyshire Chamber of Commerce.*

Richard Jones's Mental Health Act Manual (published by Sweet and Maxwell) is widely regarded by practitioners from many disciplines (and members of the judiciary) as 'the bible' in the field of mental health law. In the autumn of 2001, the 7th edition was published. In our Book Reviews section, Robert Brown and Anthony Harbour contribute a critique of this authoritative and invaluable text. In December 2001, the Mental Health Act Commission published its Ninth Biennial Report, covering the period 1/4/99 to 31/3/01. In our second book review, Professor Anselm Eldergill, whilst acknowledging the Report as "essential reading" and as providing "an excellent summary of where mental health services stand", casts a critical eye over its contents, bearing in mind the Commssions statutory remit.

As always we express our gratitude to those who have so generously contributed to this issue of the Journal.

John Horne
(Acting Editor)

Incapacitating the Dangerous in England and Wales

High Expectations - Harsh Reality

Herschel Prins[1]

'Never predict anything, particularly the future.'
(Attributed to Samuel Goldwyn, Film Producer)

Introduction

This presentation offers some brief comments on the socio-historical concept of 'dangerousness', legal and sentencing issues in contemporary context, problems of definition and, finally, some clinical considerations in the light of the foregoing discussion. A number of these issues are discussed more fully in my book 'Will They Do it Again?'[2]

Historical Context

It has been suggested that the first recorded use of the word 'danger' occurred in about 1523 and that its use in the civil and criminal courts increased in the 19th Century.[3] The word certainly has powerful and pejorative connotations. For example, English law - from Elizabeth I onwards (and earlier) - had always catered for the 'dangerous' classes, holding that the poor were not only 'idle' but likely to be 'dangerous'. Harsh penalties were therefore imposed upon 'sturdy beggars' and 'vagabonds'. Such legacies remained in various revisions of the Poor Law until the late nineteenth century. From then onwards the law attempted to define categories of persons who were considered to be a threat to the social and economic fabric of society. For example, the Prevention of Crime Act of 1908 introduced the notion of Preventive Detention for persistent offenders (not all of them dangerous); this was carried forward into the Criminal Justice Act of 1948. This latter enactment also introduced Corrective Training and a revised form of Borstal Training. These

1 *Professor, Midlands Centre for Criminology and Criminal Justice, Loughborough University, Leicestershire, LE11 3TU.*

2 *Prins, H. (1999) Will They Do It Again? - Risk Assessment in Criminal Justice and Psychiatry, Routledge.*

3 *See Craft, M. (1984) Predicting Dangerousness and Future Convictions Among the Mentally Abnormal, in M. Craft and A. Craft, (eds) Mentally Abnormal Offenders, Baillière Tindall.*

measures were superceded in the Criminal Justice Act of 1961, into which was introduced the provision of the Extended Sentence.[4] It should also be remembered that notions of dangerousness were reflected in early mental health practice. For as Parker states:

> The practice of confining some of the insane stretches back more than 600 years in England. The type of detained patient has varied, always including those considered to be dangerous ... The forms of security employed have changed little over the period; perimeter security, internal locks and bars and individual restraint by both physical and chemical means have been in continuous use to a greater or lesser degree in various guises up to the present day.[5]

A socio-cultural perspective has also been provided by commentators such as the French authority Foucault. He suggested that from the 19th century onwards alienists (early psychiatrists) were employed increasingly to manage and understand patients' often unpredictable and disturbed behaviour.[6] Recent concerns are dealt with in the following sections.

Recent Concerns

Background

A number of legislatures, notably in some of the states on the continent of North America, have made attempts to define dangerousness for the purposes of incarceration of individuals adjudged to be dangerous, be this incarceration in penal or mental health care institutions. Currently in the UK, there are no statutes that attempt to define dangerous individuals specifically, though the law does recognise for example such offences as reckless (dangerous) driving, endangering the lives of passengers, and being in possession of, or distributing, dangerous drugs. However, as I shall show in the next sub-section, in recent times the notion of dangerousness has been an important consideration in criminal justice and mental health legislation.[7] It is also of interest to note that in the last few years there has been an increase in the use of the 'life' (indeterminate) sentence for cases not involving homicide. This has been justified in various appeal court decisions on the grounds that by such means offenders considered to be dangerous (but not necessarily mentally abnormal within the meaning of the current mental health legislation) can be incarcerated until such time as the authorities (for example, the Home Secretary) consider, on the basis of expert advice, that they may be safely released. However, it should also be noted that decisions based solely on concerns about dangerousness appear to have recently become 'contaminated' by considerations based on political expediency. This would appear to have occurred in Myra Hindley's case and some others[8] So far as those formally judged to be mentally disordered are concerned, current mental health legislation recognises the concept of potential dangerousness.

4 *See Norval Morris for a useful account of the genesis of the 'habitual criminal' legislation up to and including the 1948 Act. Morris, N. (1951) The Habitual Criminal, Longmans. The earlier history of notions of 'dangerousness' in criminal justice may be found in Rennie. Rennie, Y. (1978) The Search for Criminal Man, Lexington.*

5 *Parker, E. (1985) The Development of Secure Provision, in L. Gostin (ed), A Review of Special Services For the Mentally Ill and Mentally Handicapped in England and Wales. Tavistock.*

It should also be remembered that it was only after Hadfield's case in 1800 that special secure provision was made available.

6 *Foucault, M. About the concept of the "dangerous individual" in 19th Century Legal Psychiatry. International Journal of Law and Psychiatry, 1, 1-18, 1978.*

7 *See for example, Baker, E. 'Dangerousness' - The Neglected Gaoler: Disorder and Risk Under the Mental Health Act, 1983. Journal of Forensic Psychiatry, 3, 31-52, 1993. See also Baker, E. Dangerousness in English Law. International Bulletin of Law and Mental Health, 5, 40-42, 1994.*

8 *See The Times, Law Report, December 19 1997, p.39 (Q.B. Divisional Court) for the judgment in R. v. Secretary of State For the Home Department, ex parte Hindley.*

Thus, Sections 2 and 3 of the 1983 Mental Health Act (England and Wales), make provision, *inter alia*, for the compulsory detention of an individual with a view to the 'protection of other persons'. And Section 25 of the Act uses the words 'dangerous to other persons'..in dealing with restrictions on discharge by the nearest relative. In addition, Section 41 of the Act makes provision (subject to certain criteria being satisfied) for placing an order restricting discharge upon a person made the subject of a Hospital order to protect the public from 'serious harm'[9] More specifically, the proclivities of some offender-patients are recognised in the setting up and maintenance of the three High Security Hospitals in England and Wales (Broadmoor, Rampton and Ashworth) for those patients who 'exhibit dangerous, violent or criminal propensities'[10] During the past two decades the law and practice relating to both mentally abnormal and dangerous offenders have been examined by five different groups - *The Butler Committee, The Scottish Council on Crime, The 'Floud' Committee, The Reed Committee* and, most recently, in the joint *Home Office and Department of Health* report on *Managing People with Severe Personality Disorder.*[11]

Current Concerns

Put somewhat crudely, the last ten years or so have witnessed an almost morbid governmental pre-occupation with the need for public protection. This concern has been reflected in a number of legislative 'themes'. *First*, certain changes in sentencing policy and practice introduced by the Criminal Justice Act, 1991 (as amended by a further enactment in 1993), the Criminal Justice and Public Order Act, 1994, the Crime (Sentences) Act, 1997, (as amended by the Powers of Criminal Courts (Sentencing Act, 2000)), and the Sex Offenders Act, 1997.[12]

In brief, and taken together, the effect of these pieces of legislation has been to concentrate the minds of sentencers, criminal justice and mental health professionals, not only on just deserts, but on *public protection*; the latter a concern much espoused by past and present Home Secretaries. So rapid and numerous have been the various enactments, and so ill thought out as to their possible overall consequences, that it led one distinguished legal academic (who had best remain anonymous) speaking at a conference on severe personality disorder, to state that (and I paraphrase slightly) it seemed to him that legislation appeared to be written down on the back of a post-card between the Home Office and the House of Commons! Such legislation seems to seek an uneasy and perhaps not very workable compromise between punitive and rehabilitative values, with an emphasis on the former. David Faulkner has cogently described this trend in terms of 'exclusive' and 'inclusive' views of society and human relationships. He states:

> The 'exclusive' view emphasises personal freedom and individual responsibility, but is inclined to disregard the influence of situations and circumstances. It distinguishes between a deserving majority who are self reliant, law abiding and entitled to benefit themselves without

9 *For a discussion of 'serious harm' see Stone, N. A (1995) Companion Guide to Mentally Disordered Offenders. Owen Wells, at pp 71-72.*

10 *Section 4 National Health Service and Community Care Act 1990.*

Soctland has its own 'State Hospital' at Carstairs. Northern Ireland makes occasional use of the English and Scottish facilities. Dangerous offender-patients in the Republic of Ireland are detained in the Central Hospital, Dundrum.

11 *See Prins, H. (1999) Will They do It Again? pp 14-16; also Padfield, N. (1996) Bailing and Sentencing the Dangerous, in Walker, N. Dangerous People, Blackstone Press. See also Home Office and Department of Health, (1999), Managing People With Severe Personality Disorder - Proposals For Policy Development, and Prins, H. Dangerous Severe Personality Disorder - An Independent View, Prison Service Journal, 126, 8-10, 2000.*

12 *For a very helpful discussion of the use of the mandatory life sentence for a second 'serious' offence see Plowden, P. Journal of Mental Health Law, 5, 101-110, 2001.*

> interference from others; and an underserving, feckless, welfare dependent and often *dangerous minority* or underclass from whom they need to be protected [emphasis added] ... The contrasting 'inclusive' view recognises the capacity and will of individuals to change - to improve if they are given guidance, help and encouragement; to be damaged if they are abused or humiliated.[13]

Current legislation and practice seem to reflect this polarisation suggested by Faulkner.

Second, current mental health legislation has tended to focus attention and controversy on issues of dangerousness to self and to others.[14] These latter concerns are the subject of legislation for the supervision of a small group of seriously mentally ill persons in the community, thought to be dangerous to self and others, largely on the basis of their non- or sporadic compliance with medication. (Mental Health (Patients in the Community) Act, 1995).

A *third* area has been an increasing preoccupation with the introduction of adequate supervisory procedures, and in particular, the registration of risk. Guidance has emanated from a variety of sources - from central government (NHS Executive) circulars of guidance, from professional bodies (such as the former Association of Chief Officers of Probation, and voluntary bodies such as the Zito Trust, and NACRO). This third force for changes in, and exhortations to improve, practice has been prompted significantly by the publicity given to various *causes célèbres* over the years, for example, the cases of Sharon Cambell, Christopher Clunis, Jason Mitchell, Beverley Allitt and others. Such cases have been the mainspring for the introduction of independent inquiries into homicides committed by those known to the psychiatric services. The need for such inquiries has been the subject of much scrutiny and criticism; it appears that their future control and format will be under the recently established *National Patient Safety Agency* - to be fully operational in 2002.[15]

Ethical Issues

Before passing on to more clinical matters, it would seem wise to comment briefly upon some important ethical issues. One of the most crucial dilemmas faced by those involved in considering the incapacitation of persons who have exhibited, or are thought likely to continue to exhibit, dangerous behaviour is the requirement for them to balance the need to act in the interests of the community as agents of control and custody on the one hand, and to serve the interests of the individual on the other. Walker has written extensively and informatively on this topic and the brief commentary that follows rests quite heavily upon his work.[16] He alerts us to the fact that, given the current inadequacies of predictive measures (see later), we are likely to detain people in prisons or hospitals on the grounds of their potential dangerousness for far longer than we would on tariff grounds alone. In order to try to limit the need for such detention Walker proposed a set of five 'non-arithmetical rules', as follows:-

13 *Faulkner, D. Building a System on Evidence and Principle: Law Structure and Practice. Vista, 3, 164-180, 1998.*

14 *A theme very much emphasised in the recent Government White Paper Reforming the Mental Health Act, Parts I and II. Cm 5016-I and II. Department of Health and Home Office, 2000. See also Prins, H. 'Offenders, Deviants or Patients' - Comments on Part Two of the White Paper, Journal of Mental Health Law, 5, 21-26, 2001.*

15 *See Prins, H. (1999) Will They do It Again? Chapters 4 and 5 for a description of a number of 'homicide inquiries' - their advantages and disadvantages. The announcement of the new Patient Safety Agency is contained in NHS Confederation - Briefing - Issue No.49, May, 2001.*

16 *Walker, N. (1982) Protecting People in J. Hinton (ed) Dangerousness: Problems of Assessment and Management. Gaskell, pp23-28.*

(1) The exclusion of most property offenders and those cases which he described as causing temporary alarm such as minor threats to decency, for example indecent exposure. (The latter exclusion seems somewhat questionable since the offence of indecent exposure can cause considerable psychological trauma; moreover, a small proportion of indecent exposers go on to commit more serious sexual crimes.)

(2) He suggests that isolated out-of-character acts should not be included. Previous similar conduct would help to establish whether or not a pattern existed as, for example, declared intentions of future vengeance.

(3) This rule would operate in an offender's favour if the incentives for his initial offending ceased to exist or, through incapacity, he or she was considered unlikely to repeat his conduct. However, we should note that the first criterion may be less easy to implement than the latter, since it is not unknown for those who have killed to find surrogate victims.

(4) More frequent use should be made of close supervision and monitoring in the community. In addition, with his customary foresight, Walker suggested barring certain offenders from certain employments (for example with children).

(5) Finally, Walker suggests that for those who need to be incarcerated for long periods, their detention should be as humane and progressive as possible. Concerns about prison overcrowding and the treatment regimes in certain Special Hospitals and prisons indicate that Walker's laudable suggestion may not be being fully implemented at the present time.

The Culture of Risk and Blame

'Risk is ubiquitous and no human society can be considered risk free.' This short statement from a publication by the Royal Society rightly emphasises the ever-present nature of risk and the foolhardiness of trying to prevent it with absolute certainty. However, we know that humankind abhors ambiguity and uncertainty; humans will engage in dubious and sometimes harmful practices to avoid them. Much recent and current concern about so-called 'dangerous' people has its roots in these phenomena; unless they are properly understood, many of our efforts aimed at dealing with such people will fail. Beck puts an eloquent gloss on the matter - as follows:

> Calculating and managing risks which nobody really knows has become one of our main preoccupations. That used to be a specialist job for actuaries, insurers and scientists. Now we all have to engage in it, with whatever rusty tools we can lay our hands on - sometimes the calculator, sometimes the astrology column.[17]

It is crucial to understand the uncertainty of risk prediction (see later). This is particularly important at the present time when blame is so quickly apportioned in a variety of hazardous and tragic circumstances, be they homicides, train or air disasters, flood damage, or BSE. Much concern about risk is media driven; if mental health, criminal justice and legal professionals are forced into making predictions, there may be an assumption on the part of the public that such professionals are capable of getting it right every time. The latter will then assume (perhaps unwittingly), a mantle of infallibility and have to count the cost when they get it wrong, as from time to time they assuredly will. Homicide inquiries are a good example of this problem and one that needs placing

17 *Beck, U. (1998) Politics of Risk Society. In J. Franklin (ed) The Politics of Risk Society, Polity Press.*

in perspective. Although the number of homicides committed by persons with mental disorders (particularly mental illness) is very small (and has, in fact, contrary to public opinion, actually declined over the past decade) the media seem to have vastly influenced the politicians in their somewhat frenetic search for solutions.[18] It is also worth remembering (as a means of gaining historical perspective) that 'fashions' in criminal justice and mental health come and go. Soothill[19] has demonstrated the manner in which this may occur. He cites as examples our almost ten-year cyclical preoccupations with, for example, homosexuality and prostitution, with rape, with physical child abuse and with so-called 'satanic' child sexual abuse etc. Recent preoccupation has been with so-called 'serial killing' - a much ill-used and abused term which often serves to obfuscate rather than illuminate.[20] Very recently it has been pointed out to me that current 'folk devils'[21] appear to be 'stalkers' and 'errant doctors'. (Dr. Edward Petch, Personal communication, 13.6.01).

Reference has recently been made to the hazards of prediction; it is worthwhile commenting on this aspect in a little more detail. The sometime science correspondent of The *Independent* - William Hartston - once expressed our inadequacies very well - as follows:

> Such are the risks we all run every day that, if you are an adult between 35 and 54, there is roughly a one-in-400 chance you will be dead within a year. *Homo sapiens* is a bit of a twit about assessing risks. We buy lottery tickets in the hope of scooping the jackpot, with a one-in-14 million chance of winning, when there's a one-in-400 chance that we won't even survive the year ... the evidence suggests that our behaviour is motivated by panic and innumeracy. (*The Independent*, 19 September, 1997, pp 10-11).

There is a vast and ever growing literature on the prediction of risk.[22] If, by prediction, we mean the capacity to get it right every time, the short answer has to be 'no'. If we have more modest goals, and ask if there are measures that could be taken to attempt a possible reduction in dangerous behaviour, then it is possible to give a qualified 'yes'. Pollock and Webster put the matter very succinctly: 'From a scientific perspective [the question] is impossible to answer since it is based upon an unscientific assumption about dangerousness, namely that it is a stable and consistent quality existing within the individual.'[23] They suggest that a translation into more appropriate terms would produce the following question:

> What are the psychological, social and biological factors bearing on the defendant's ... behaviour and what are the implications for future [behaviour] and the potential for change?

Despite the fact that considerable actuarial and computer facilitated research has been carried out into the prediction of anti-social behaviour generally, this tends to suggest that although actuarial

18 *See for example, Taylor, P. and Gunn, J. Homicides by People With Mental Illness: Myth and Reality, British Journal of Psychiatry, 174, 9-14, 1999.*

19 *Soothill, K. The Serial Killer Industry, Journal of Forensic Psychiatry, 4, 341-354, 1993.*

20 *Prins, H. A Proposed Socio-Legal Classification of Serial Killing - With Special Reference to 'Serial Killing'. The British Journal of Forensic Practice, 2, 9-11, 2000.*

21 *Taken from the title of Stanley Cohen's book Folk Devils and Moral Panics, McGibbon and Key, 1972. (A book that could usefully be read and re-read by all politicians).*

22 *For studies of the more general aspects of risk and risk-taking see Adams, J. (1995) Risk. University College London Press. Also, the Royal Society (1992) Risk Analysis, Perception, Management, London. More specifically, in relation to criminal justice and mental health see: Monahan, J. and Steadman, J.H. (eds) 1994, Violence and Mental Disorder: Developments in Risk Assessment. University of Chicago Press.*

23 *Pollock, N. and Webster, C. (1991) The Clinical Assessment of Dangerousness, in R. Bluglass and P. Bowden (eds.) (1991) Principles and Practice of Forensic Psychiatry. Churchill Livingstone.*

techniques can discriminate between high-risk and low-risk *groups*, there will also be a residual majority in the *middle-risk* groups whose re-offending rates are too near 50-50 to be much use prognostically in *the individual case.*[24]

For some years, workers in the criminal justice and mental health fields have taken comfort from the oft-quoted statement by the American psychologist Kvaraceus that 'nothing predicts behaviour like behaviour'.[25] However, as recent commentators such as Gunn, have pointed out, such statements may rest upon statistical error and reinforce the fallacious view that risk is a static phenomenon and unaffected by changes in social and other circumstances.[26] At the end of the day:

> Predicting and preventing violence is a fundamental part of clinical practice ... forensic psychiatrists, psychologists and clinical criminologists are asked to assess cases to make a prediction of the likelihood of harm to others in the future.[27]

What's in a Name?

The words 'danger', 'dangerousness' and 'risk' have little real meaning on their own. It is only when placed in context that they become useful, but any interpretation must, to some extent, be subjective. Walker makes a useful point when he suggests that 'dangerousness is not an objective quality, but an *ascribed* quality like trustworthiness. We feel justified in talking about a person as dangerous if he has indicated by word or deed that he is more likely than most people to do serious harm'. (Emphasis added).[28] The Butler Committee, in examining the notion of dangerousness *in relation to mentally abnormal offenders*, considered it to be 'a propensity to cause serious physical injury or lasting psychological harm. Physical violence is, we think, what the public are most worried about, but the psychological damage which may be suffered by some victims of other crimes is not to be underrated'.[29] Practising clinicians and others who have day-to-day contact with those deemed to be dangerous, generally agree with the late Doctor Peter Scott's definition that dangerousness is 'an unpredictable and untreatable tendency to inflict or risk irreversible injury or destruction, or to induce others to do so'.[30] Some clinicians, for example, Tidmarsh,[31] have suggested that Scott's inclusion of unpredictability and untreatability can be questioned, since the anticipation and modification of a danger does not necessarily minimise the risk. However, Scott did suggest that a key element in the notion of dangerousness was the risk of repetition in the face of measures to reduce it. He also stressed another very important element, namely that its use as a label might contribute to its own continuance - a point that should be heeded by lawyers,

24 *In an evaluation of two risk and need assessment instruments in use by the probation Service, it was found that although the devices predicted reconviction more successfully than 'chance levels' the devices were not 'appropriate for use as the main method of assessing dangerousness'. Home Office, Findings No.143, 2001, p.2*

25 *Kvaraceus, W. (1966) Dangerous Youth, Columbus, p.6.*

26 *Gunn, J. (1996) The Management and Discharge of Violent Patients. In N. Walker (ed) Dangerous People, Blackstone Press.*

27 *MacCulloch, M., Bailey, J. and Robinson, C. Mentally Disordered Attackers and Killers: Towards a Taxonomy. Journal of Forensic Psychiatry, 6, 41-61, 1995*

28 *See note 16 supra.*

29 *Report of the Committee on Mentally Abnormal Offenders. (Chairman, Lord Butler of Saffron Walden). Cmnd 6244, 1975, p.59. (However, it should be stressed that not all dangerous offenders are mentally disordered and not all mentally disordered offenders are dangerous).*

30 *Scott, P.D. Assessing Dangerousness in Criminals. British Journal of Psychiatry, 131, 127-142, 1977.*

31 *Tidmarsh, D. (1982) Implications From Research Studies, in J. Hamilton and H. Freeman (eds), Dangerousness: Psychiatric Assessment and Management. Gaskell Books.*

sentencers and criminal justice and mental health professionals. For the purposes of this contribution, it is worth noting Floud's statement that 'risk is in principle, a matter of fact, but danger is a matter of judgement or opinion'.[32] Thus, the notion of dangerousness implies a prediction, a concern with future conduct. Most authorities agree that apart from a very small group of individuals who may be intrinsically dangerous because of some inherent physical or other defect (which may make them particularly explosive), the general concern is with the *situation* in which the combination of the *vulnerable* individual with a *provoking incident* may spark off explosive and dangerous behaviour. As noted by the Butler Committee, 'the individual who spontaneously "looks for a fight" or feels a need to inflict pain or who searches for an unknown sexual victim is fortunately rare, although such people undoubtedly exist. Only this last category can be justifiably called: "unconditionally" dangerous'.[33] For our purposes it would seem sensible to now distinguish between *risk* and *danger.*

Risk may be said to be the *likelihood* of an event occurring, and danger may be said to be the *degree of damage (harm)* that may occur should the event take place. Grounds makes the important additional point that both of these also need to be distinguished from worry.

> They are not well correlated and judgements and decisions based on worry may not be well founded. The problem is that feelings of worry are expressed by professionals in the vocabulary of risk. The feeling 'I am very worried about X' is likely to be translated into 'X is a high risk' in written and spoken communications. Worry may, however, be excessive or insufficient in relation to the risk. The test is the same as for risk: how well grounded is it in history?[34]

Dangerousness of course means different things to different people. If I asked readers of this journal to rank the following people in order of their dangerousness, they would probably find themselves in some difficulty. Of the following who, for example, would be considered the more dangerous? The bank robber, the persistent paedophile, the person who peddles dangerous drugs to children, the person who drives when knowingly unfit to do so, the swimmer who has a contagious disease, but continues to use the public baths, the bigoted patriot, national leader or politician who believes they are always right, the computer hacker, the person who is HIV positive or has AIDS who persists in having unprotected sexual intercourse with a variety of partners, the consortium which disposes of toxic waste products without safeguards, the forensic mental health or criminal justice professional who always acts on their own initiative without adequate consultation with colleagues and who believes that their 'personality' will 'get them by' in dangerous situations? All of these persons present hazards of one kind or another depending upon the situation in which they find themselves.

Clinical Considerations

Sentencers (both professional and lay) and mental health and criminal justice professionals have to carry out their work of limiting 'mayhem' within the constraints of the complex legislative and administrative frameworks referred to earlier; so complicated has this legislative framework become, that even experienced sentencers find some of the legal requirements difficult to

32 *Floud, J. Dangerousness and Criminal Justice, British Journal of Criminology, 22, 213-223, 1982.*

33 *See note 29 supra.*

34 *Grounds, A. (1995) Risk Assessment and Management in Clinical Context, in J. Crichton, (ed) Psychiatric Patient Violence: Risk and Response. Duckworth, pp 54-55.*

interpret. It might be worth considering whether a consolidating piece of legislation dealing with serious and high-risk offenders ought to be introduced. Professionals not only have to deal with these legal complications, but also have to carry out their work within the current 'blame culture' and to endeavour to balance offenders' and offender-patients' needs against the need to protect the public. As has already been stated, the current political climate puts a premium on the latter. In the concluding section of this contribution I endeavour to point out some of the pitfalls for professionals and to suggest ways in which practice might be improved. I begin by providing four case examples in order to demonstrate some of the dilemmas involved.

Case I

'Paul' is in the community on conditional discharge from hospital (Sections 37/41 Mental Health Act, 1983). The order had been imposed for killing his wife. He had been detained in hospitals for some ten years before being conditionally discharged by a Mental Health Review Tribunal (MHRT). The facts of his original offence were that, having killed his wife (by manual strangulation) he had secreted her body, and it was some months before it was discovered. At the time of his arrest he had been seeing another woman on a regular basis. A year after being conditionally discharged into the community he informed his supervising probation officer that he had been seeing a woman and hoped to marry her. In this case the probation officer's responsibilities seemed quite clear. In the first instance, the development needs to be reported to the Home Office (Mental Health Unit - who have central government responsibility for mentally disordered offenders). Second, the officer needs to ascertain from 'Paul' more details of this new relationship. In the course of such discussion 'Paul' would need to be advised that he should inform the woman of his past history (given the particular circumstances of his original offence). Should 'Paul' be unwilling to do so, it is likely that his probation officer (having taken advice from his line management, and maybe the Home Office) would need to inform 'Paul' that in the light of his refusal to do so, he would have to inform her himself.

To some, perhaps, this might seem like an intrusion into an offender-patient's personal liberty, but the broader issue of the protection of the public, in this case the woman he is seeing and maybe others, necessitates such action. The issues seem clear cut. In other cases there are grey areas that require careful consideration of who else should be involved - as illustrated in case 2.

Case 2[35]

'Tom' is a 60-year-old offender released on life licence for killing a child during a sexual assault. He had been convicted on a previous occasion of indecent assault and had then been made the subject of a Hospital Order without restrictions (Section 37 Mental Health Act, 1983). He had been living in the community on life licence for about two years, and had so far not given his probation officer any cause for concern. His probation officer has just received a 'phone call stating that 'Tom' has been seen 'loitering' by the bus stop outside a local primary school. What should his probation officer do about this development? There would appear to be several steps that need to be taken. First, further information is required as to the source and reliability of the information received. Did this information come via the school or, for example, from a bystander who knew 'Tom's'

35 *This case situation arose and was dealt with before the current sex offender registration procedures were in force.*

history and was perhaps out to make trouble for him by deliberately misconstruing a quite innocent piece of behaviour? (After all, he *could* have been waiting for a bus quite legitimately). The second step in trying to elucidate the problematic behaviour would be to arrange a very urgent appointment to see 'Tom'. Why, for example, was he at this particular bus stop? His responses would have to be judged in the light of details about his previous offences. It would be very ominous if, for example, the circumstances of the offence for which he received his life sentence were similar to the present behaviour. Third, the probation officer would have to consider the pros and cons of contacting the school and/or the local police to ascertain if any complaints or comments had been received concerning similar conduct by 'Tom'. Whatever steps the probation officer takes, *the offender is entitled to be told of the action proposed and the reasons for it*. Such information will be likely to be received and accepted more easily had 'Tom' been given very clear indications at the start of his life licence (or conditional discharge, if he had been dealt with through the mental health care system) concerning his obligations under their terms. 'Tom' needs to be made aware of his supervisor's responsibilities to report any apparently untoward conduct. Sadly, there have been occasions in the past when mutual expectations and obligations have not been shared openly. In such cases an offender or offender-patient can feel legitimately surprised when speedy and sometimes apparently condign action is taken. Some other aspects of the "need to tell" are illustrated in the next two case examples.

Case 3

A psychiatrist had been seeing regularly a male patient on an informal out-patient basis over a period of several months. In the past, he had had a number of compulsory admissions to hospital for a paranoid psychosis. (Sections 2 and 3 of the Mental Health Act, 1983). During a recent session with his psychiatrist, he reveals a powerful belief that a former girl friend has been unfaithful to him, that he has been following her, and that he feels like killing her. What should the psychiatrist do? In the first instance he needs to check back over past records to see if similar beliefs have been expressed on other occasions and what the outcomes were. Second, he needs to make a careful appraisal of the quality of the patient's intended actions, discussing the case with other professionals and/or his professional bodies. For example, the circumstances of the self-reported 'stalking' require careful and detailed evaluation, as does the quality of his expressed feelings about killing her. *Feeling* like killing someone is not quite the same as expressed threats to kill (which of course in law constitute a criminal offence). If his past history reveals similar threats and his *current* threats have a delusional intensity, then the psychiatrist would be exercising appropriate professional responsibility if he arranged for the patient's former girl friend to be warned about his feelings.

Case 4

My final example concerns a case in which the offender-patient had given clear indication of possible intended harm. This concerned events uncovered during a homicide inquiry which I chaired. The perpetrator of the homicide, who had been known to various health care and other agencies, had given a clear written warning to his supervising social worker of his possible intentions. He wrote a letter from the prison in which he was then being held - as follows:

> I think that jail is the Best place for me at the moment because it sort's my head out. If I was on the street I would put peples life at risk, so that's over with [original spelling].

We commented as follows:

> Although in retrospect, everyone [now] considered that this letter was important and significant, at the time, its content and import were not communicated [by social services] to the Probation Service ... With hindsight, it would appear that the content of this letter might have prompted a referral for further psychiatric assessment.[36]

It is hoped that the above short case examples illustrate some of the dilemmas faced by professionals and will serve as an introduction to the concluding section of this contribution. It is divided into four parts - as follows:

(i) Aspects of Communication.

(ii) Vulnerability.

(iii) Establishing an Effective Baseline.

(iv) Improving Practice.

(i) Aspects of Communication

A non mental health and criminal justice professional has wisely stated that 'All tragedy is the failure of communication'.[37] Such a statement embraces four aspects of communication that are relevant to this discussion.

- The need for good interprofessional communication. For example, case conferences frequently fail to work because of the mistaken belief that multi-agency is synonymous with multidisciplinary when, in terms of role perceptions and territorial boundaries, it clearly is not.[38]

- The need for adequate communication between worker and offender-patient and an understanding of the impediments to this. These include ambivalence, hostility, fear and denial, not only on the part of the offender-patient, but also that of the worker. Denial is by no means the sole prerogative of offenders and offender-patients. Maybe both offenders, offender-patients and their professionals should heed Banquo's advice to his fellows:

> 'And when we have our naked frailties hid,
> That suffer in exposure, let us meet,
> And question this most bloody piece of work
> To know it further.'
>
> *Macbeth*, II:iii

36 *Prins, H., Ashman, M., Steele, G. and Swann, M. (1998) Report of the Independent Panel of Inquiry into the treatment and care of Sanjay Kumar Patel. Leicester Health Authority.*

37 *Wilson, J. (1974) Language and the Pursuit of Truth. Cambridge University Press, p.9.*

38 *For an account of an 'imaginary case conference' see Prins, Will They do It Again? pp 127-129.*

• How well do professionals 'hear' the concerns of the carers of their charges? In the Andrew Robinson enquiry, it became abundantly clear that Andrew's parents had tried to draw attention repeatedly to their fear of his continued psychotically motivated aggression and violence towards them. Their home had become a place of terror and accounts of their fears appear to have gone unheard. Similar accounts of lack of family involvement may be found in a number of other homicide inquiries.[39]

• The need for professionals to be 'in touch' with the warring and less comfortable parts of themselves. This need may show itself in misperceptions of race and gender needs. For example, in our inquiry into the death of Orville Blackwood in Broadmoor, we considered that perceptions of young African-Caribbeans as always being 'Big, Black and Dangerous' might seriously have handicapped some of the staff's handling of this group of offender-patients.[40]

• There may also be unresolved and professionally limiting personal conflicts about certain specific forms of conduct, notable those involving extreme sexual deviance. Perhaps professionals working in this field should heed the statement by Pericles in Shakespeare's play of that name that 'Few love to hear the sins they love to act'. (Act I:i).

ii) Vulnerability

The assessment and management of dangerous behaviour and the risk factors involved are concerned, essentially, with the prevention of vulnerability, namely taking care not to place the offender or offender-patient in a situation in which they may be highly likely to re-enact their previous pattern(s) of dangerous behaviour. The recognition of this reduces the vulnerability of both the public to the commission of 'unfinished business' and the vulnerability of the offender/offender-patient.[41]

We would do well to heed the musing of King John in Shakespeare's Play when he says, in thinking about what he has set in train for the young Prince Arthur, 'How oft the sight of means to do ill deeds makes deeds ill done' (IV:ii).

(iii) Establishing an Effective Base-line

All the research and clinical studies in the area of risk assessment and management in criminal justice and mental health attest to the importance of obtaining the basic facts of the situation. It is this kind of evidence that decision-making bodies, such as Mental Health Review Tribunals, the Parole Board and the Home Office require in order to make the most effective decisions. This necessitates having an accurate and full record of, for example, the index offence, or other incident and, in addition, the person's previous history, especially their previous convictions. A bare legal description tells us nothing about seriousness of intention at the time of the offence, or its prognostic significance. This has become of increasing importance today when 'plea bargaining'

39 *Blom-Cooper, L. Q.C., Hally, H., Murphy E. (1993) The Falling Shadow: One Patient's Mental Health Care, 1978-1993. Duckworth. For other examples see Prins, 38 above - Chapter 5.*

40 *Prins, H., Backer Holst, T., Francis, E. and Keitch, I. (1993) Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients. 'Big, Black and Dangerous?'. Special Hospitals Service Authority.*

41 *Cox, M. (1979) Dynamic Psychotherapy With Sex Offenders, in I. Rosen (ed), Sexual Deviation, (Second ed), Oxford University Press.*

and advocates' attempts to 'down-grade' offences have become more frequent. An incident that may well have had the ingredients to justify an original charge of attempted murder may eventually end up, by agreement, as one of unlawful wounding. Neither do the bare details of an offence give any real indication of motivation. For example, burglary may take the form of a conventional break-in, or it may have more ominous prognostic implications if, say, the only items stolen were the shoes belonging to the female occupant of the premises. In similar fashion, those males who expose themselves to women in an aggressive fashion associated with erection and masturbatory activity need to be distinguished from those who are more passive and who expose from a distance without erection; the former group are those who are sometimes more likely to go on to commit serious sexually assaultive offences. Scott, in his seminal paper on assessing dangerousness in criminals, stressed the need for a most careful scrutiny of the facts,[42] but sixty years earlier, Freud had also wisely stated 'I learned to follow the unforgotten advice of my master Charcot (the neurologist): to look at the same things again and again, until they themselves began to speak'.[43] And the novelist and polymath Umberto Eco states in his book *Foucault's Pendulum* that 'No piece of information is superior to any other. Power lies in having them on file and then finding the connections'.[44]

Some useful guidance on the basic requirements for risk assessment may be found in the Department of Health's Guidance on the *Discharge of Mentally Disordered People and their Continuing Care in the Community.*[45] The advice emphasises the following points, among others, advocated by the Panel of Inquiry into the case of Kim Kirkman:

> past history of the patient; self reporting by the patient at interview; observation of the behaviour and mental state of the patient; *discrepancies between what is reported and what is observed*; statistics derived from studies of related cases and prediction indicators derived from research. (Emphasis added)[46]

Similar points were made by the former Association of Chief Officers of Probation (ACOP) in their *Guidelines on the Management of Risk and Public Protection*. For example, they suggest such questions as:

> Who is likely to get hurt? How seriously and in what way? Is it likely to happen right now, next week or when? How often? In what circumstances will it be more rather than less likely to occur? Is the behaviour that led to the offending continuing? What is he/she telling you, not only by words but also by demeanor/actions? [47]

High hopes have been placed upon various procedures for risk *registration*. However, some of the evidence I once gathered from the fields of child care and probation seems to indicate that risk registration does not *necessarily* ensure good practice.[48]

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42 *Scott, P.D. Op Cit*

43 *Freud, S. (1914) On the History of the Psychoanalytic Movement. Vol IV of the Standard Edition of the Works of Sigmund Freud. (Ed. J. Strachey), Hogarth Press.*

44 *Eco, U. (1989) Foucault's Pendulum. Secker and Warburg.*

45 *Department of Health (NHS Executive) Guidance on the Discharge of Mentally Disordered People and Their Care in the Community. HSG/94/27, 10 May 1994.*

46 *West Midlands Health Authority (1991) Report of the Panel of Inquiry Appointed to Investigate the Case of Kim Kirkman. West Midlands Health Authority.*

47 *Association of Chief Officers of Probation (1994). Guidelines on the Management of Risk and Public Protection.*

48 *See Prins, H. "I've Got a Little List" (Koko:Mikado) But Is It Any Use? Comments on the Forensic Aspects of Supervision Registers For the Mentally Ill. Medicine, Science and the Law, 35, 218-224, 1995.*

(iv) Improving Practice

There is no doubt that many professionals carry out very high-quality work in cases requiring risk management. However, there have been instances when the quality of work has shown deficiencies; some of these deficiencies have been highlighted in recent inquiries, such as those into the cases of Andrew Robinson and Jason Mitchell. I now wish to illustrate why this might be and how such deficiencies might be remedied. Basically, it has to do with asking uncomfortable questions. I have tried to group these questions under seven headings in order to describe them as seven possible sins of omission. But before doing so, one or two preliminary general observations may be helpful. Professionals in this difficult and often highly charged area need two types of supervision and support. The first is the support and supervision that holds them accountable to their organisation for what they do. The second, and equally important, is the supervision from line management that enables them to do more effective and empathic work. It is very important for workers to have the chance to share perspectives with their peers. This may assist in the development of knowledge and confidence. The following seven areas of questioning may go some way to providing more effective engagement.

(1) Have past precipitants and stresses in the offender-patient's background been removed? If still present, are they amenable to further work and, more importantly, has the worker the courage to deal with them? A period of long-term work with an offender or offender-patient may induce in the worker a form of 'familiarity' , which may blind them to subtle changes in the individual's social and emotional worlds. If we have worked very hard to induce change through the establishment of a 'good' relationship, we may not wish to do anything that may challenge that; we may prefer not to know. Genders and Player, in their study of Grendon Prison, state that they were often reminded of the words of the old song 'I wish I didn't know now what I didn't know then'.[49]

(2) What is the person's current capacity for dealing with provocation? It is useful to remember Scott's advice that aggression may be deflected from a highly provoking source to one that may be scarcely provoking at all. He cited the legendary Medea who, wishing to get back at her unfaithful husband Jason, killed her baby, saying 'that will stab thee to thy heart'.[50] Some of our most perplexing cases are those in which serious violence has been caused to the 'innocent stranger' in the street. Careful scanning of the immediate environment may enable us to sense (and perhaps help the individual to avoid) potentially inflammatory situations. For example, to what extent has the over-flirtatious wife or partner of a jealous husband (partner) courted a potentially dangerous situation by sarcasm, making denigrating remarks about sexual prowess, been otherwise contemptuous, or worn provocative clothing? The same is true with the male in the provocative role, as is the case from time to time, in homosexual relationships. Detailed accounts of previous provoking incidents are therefore vital in order to assess future risk and provide effective continuing management.

(3) How does this offender-patient continue to view him or herself? The need for a 'macho' self image in a highly deviant male sex offender is often based upon unresolved past conflicts with women. This may make him likely to continue to take his revenge by way of serious sexual assaults accompanied by extreme violence and degradation of his victims.

49 *Genders, E. and Player, E. (1995) Grendon: A Study of A Therapeutic Prison. Clarendon Press.*

50 *Scott, P.D. Op. Cit.*

(4) To what extent have we been able to assess changes for the better in this person's capacity to feel empathy for others? Does this individual still treat others as objects rather than as persons upon whom to indulge their deviant desires and practices? The true, as distinct from the pejoratively labelled psychopath, tends to see all those around him (or her) as malevolently disposed.

(5) To what extent does the behaviour seem person-specific, or as a means of getting back at society in general, as is the case in some arsonists who, like the monster in Mary Shelley's *Frankenstein*, are 'malicious' because (they are) 'miserable'? The person who says with continuing hatred in their voice, 'I know that one day I'm going to kill somebody', has to be taken very seriously. To what extent are thoughts of killing or injury still present? Is there a pleasurable feel to their talk about violent acts? Is there continuing interest in such material as violent pornography, horror videos, the occult, atrocities, torture, etc.? Sometimes the 'evidence' is less tangible and 'hunches' need to be relied upon - but always carefully followed up and checked out. Thus, Commander Dalgleish in P.D. James' *Original Sin* described his 'instinct' [as something] which he sometimes distrusted, but had learned not to ignore.[51]

(6) How much continuing regard has been paid to what the offender-patient actually did at the time of the offence? Was it so horrendous that they blotted it out of consciousness? For example, did they wander off in a semi-amnesic state or, upon realising what they had done, summon help immediately? Or did they, having mutilated the body, go off happily to a meal and a good night's sleep? How much are they still claiming it was a sudden and spontaneous crime, when the evidence shows planning and premeditation? What was the significant role of substance abuse of one kind or another? Prisons and, to a lesser extent, secure hospitals are not ideal places for testing out future proclivities in such people. However, escorted periods of leave with close supervision may enable alcohol intake and its effects to be assessed. The persistent paedophile on an escorted group outing to the seaside may alert observant nursing staff to continuing abnormal sexual interest by having eyes only for the semi-naked children playing on the beach. In similar fashion, staff may report patients' interest (and arousal) when in the presence of the children of visitors to the ward, or to pictures of children on the television. How much is known about what 'aids' to sexual fantasy they are storing in their rooms or cells? (For example, newspaper clippings, graphic details from court depositions.) The offender-patient who says he is writing his life history in a series of exercise books could well be asked to show them to us; somewhat surprisingly, they are very often willing to do so. We may find detailed descriptions of continuing violent and/or sadistic fantasies, which are being used as rehearsal for future activity. All these indicators, coupled with psychophysiological measures, may help us to obtain a better, if not conclusive, perception of likely future behaviour.

(7) To what extent can we discern that this individual has begun to come to terms with what they did? It is important for all professionals and decision-makers to regard protestations of guilt and remorse with a degree of caution. As Russel and Russel state:

> A person who expresses guilt is to be regarded with vigilance. His next move may be to engineer a situation where he can repeat his activities (about which he expresses guilt), but this time with rationalisation and hence without guilt. He will therefore try to manipulate his victim into giving him a pretext.[52]

51 *James, P.D. (1994) Original Sin. Faber.*

52 *Russel, C. and Russel, W.M.S. (1961) Human Behaviour. Little Brown.*

Sometimes, an offender or offender-patient may be reluctant to acknowledge the truth of what they have done for fear of causing hurt to relatives and others close to them. The late Doctor Patrick McGrath, sometime medical superintendent at Broadmoor, cited the case of a paedophilic sadistic killer who consistently denied his guilt in order to spare his 'gentle devoted parents who could not believe his guilt'. When they died, within a fairly short while of each other, he willingly admitted his guilt, and in due course was released.[53] Neither should we forget that in relation to confession and guilt, offender-patients may, in fact, not be guilty of any crime, as a number of *causes célèbres* have so sadly demonstrated.

7. Concluding Comments

In this contribution I have endeavoured to place notions of dangerousness and risk within past and current contexts. I have tried to provide some helpful examples of ways in which the supervision of dangerous offenders might be made more effective. Although the advent of sophisticated computational techniques has undoubtedly provided a platform for actuarial advances, it is still the worker at the *individual* level who has to make prognostic judgements and undertake the hazards of ongoing supervision. It is comparatively easy and safe to predict what someone will do two weeks or even a month hence; much more hazardous to predict what they might do in a year's time. In recent years, a good deal of time and energy has gone into other advances, such as offender profiling and much has come to be expected of it. However, recent work has tended to show that much more needs to be done in this field. In addition, profiling is not without its critics.

Central to the task of the criminal justice or mental health professional is a commitment to detail and to tracing connections between behaviour patterns. It also involves a great deal of personal soul-searching in order to come to grips with behaviour that is frequently anxiety-making and sometimes horrifying. It also calls for operating with a greater degree of surveillance and close monitoring than is customary in some areas of 'counselling'. It certainly involves a capacity not to attempt to 'go it alone' and in this area of work there is no place for 'prima donna' activities. Despite the difficulties (or maybe because of them), many workers enjoy the challenge presented by those who have shown, or are adjudged likely to show, dangerous behaviour towards others.[54]

Sadly, but perhaps understandably, politicians and the general public have very high expectations that mental health and criminal justice professionals can 'get it right' every time. Professionals can only give of their best on the understanding that they are not infallible; and if society has ordained that risks through legislation will be taken, then occasional failures are inevitable. This is the harsh reality in a field where much is still uncertain and as yet unknown.[55]

Acknowledgement

My thanks, as usual, to Mrs. Janet Kirkwood for bringing order out of the usual chaos of my drafts.

53 *McGrath, P. Book Review. British Journal of Psychiatry, 154, p. 427, 1989.*

54 *Such was the view of a small group of consultant forensic psychiatrists when asked for the reasons why they chose to specialise in forensic psychiatry. See Prins, H. Characteristics of Consultant Forensic Psychiatrists: A Modest Survey. Journal of Forensic Psychiatry, 9, 139-149, 1998.*

55 *After this contribution had been drafted, I came across a very thought-provoking paper by Rumgay and Munro (2001) in which they provide an innovative perspective on why it is that professionals seem to be found wanting in so many homicide inquiries. Their central thesis is to suggest that apparently what appears to be 'insensitive behaviour stems from the deployment of rationalization for denying care to mentally ill individuals, in situations in which professionals experience powelessness to intervene effectively'. See Rumgay. J and Munro, E. The Lion's Den: Professional Defences in the Treatment of Dangerous People. Journal of Forensic Psychiatry, 12, 357-378, 2001*

Independent Advocacy

A brief look at its past and present. Is its future under threat?

Sinead Dalton and Peter Carlin*

Summary: *The need, in mental health care, for advocacy which is independent of the health care provider is clear and acknowledged but the existence of the schemes which provide it might be seriously threatened by PALS. Principles of independent advocacy have been developed over the last twenty five years. Unfortunately many advocates are unfamiliar with the law affecting their practice and its impact upon those principles, especially in respect of confidentiality. The advocate is the client's agent, owing a duty of care but unable to guarantee confidentiality. It is likely that most independent advocacy schemes have wholly inaccurate and inadequate confidentiality policies and guidelines. If these inadequacies are not addressed independent advocacy will not be able to compete with rival systems and it will be in danger of disappearing.*

Those who receive a diagnosis of mental disorder are thereby placed in a uniquely disenfranchised position. It is recognised that they frequently benefit from the assistance of an advocate and that, since their disenfranchisement is imposed by the service provider and the medical profession, there is an essential role for an advocate who is independent of both and who will seek simply to express the views of the service user.

Psychiatric nurses are taught to regard advocacy for their patients as part of their role[1] but there is an obvious likelihood of conflict between what the client wants and what the mental health team thinks is best for them. In such a situation the "nurse advocate" will almost inevitably bow to the weight of medical opinion and say that the patient must do likewise.

Advocacy in the context of mental health is therefore a manichean concept labouring under two very different principles, the one being independent "client led" advocacy which adopts as its final position the principle that "the service user must be heard"; the other being "profession led" advocacy which adopts as its final position the principle that "the medical profession and the service provider know best".

* *Sinead Dalton is the Information Officer for Derby Mind, and formed the Derby Mind Individual Adult Advocacy Service. Peter Carlin is the vice-chair of Derby Mind, and a partner in the firm of Irvings, Solicitors, Derby.*

1 *See eg "Guidelines for mental health and mental disabilities nursing"; 1998, UKCC*

The government has proposed an NHS - wide Patient Advocacy and Liaison Service (PALS)[2] which will provide a "patient advocate team [which] will act as a welcoming point for patients and carers and a clearly identifiable information point" and "build on and support current specialist advocacy services".

The terms in which PALS has been proposed suggest that it will lean very heavily on the model of "profession led advocacy" and in fact will provide a service which is advisory and not advocacy at all. Since PALS will receive government funding there has to be a danger that independent client led advocacy will become a poor relation and gradually disappear. The duality which presently afflicts the concept of advocacy will be resolved when all advocacy, under the auspices of PALS, will be "profession led".

If independent advocacy does survive and prosper alongside PALS it will be because its practitioners understand both the principles governing their practice and the legal context within which they work. That understanding will provide a firm platform from which they will be able to present arguments justifying their position.

This article (which covers a very wide area and, we acknowledge, only scratches the surface of many subjects which each deserve their own much deeper consideration) addresses issues which we believe must be clearly understood by all independent advocates. The article comes in two halves. In the first half we consider, briefly and broadly, the history of advocacy in the context of mental health, the various types of independent advocacy practised at present and the principles which guide them. In the second half we consider, from a practical point of view, the legal relationship between the advocate and the client and difficulties which arise, particularly in respect of the confidentiality with which the patient/client will expect communications with the advocate to be treated. The issue of capacity has to be briefly considered in this context. We believe that many providers of advocacy services have not addressed these difficulties, which arise from tensions between the law and the ethos of advocacy, and which must be confronted.

Unless the context indicates otherwise the word "advocacy" means "independent advocacy" throughout the rest of the article.

What is advocacy?

In this context the word "advocacy"is used idiosyncratically. It does not mean conducting or presenting a case before a court, tribunal or assembly but has a meaning very different from that used in common parlance and it is emphatically very different from the advocacy practised by the legal profession.[3]

Advocacy in a mental health setting means assisting service users to express themselves and take an active part in the making of decisions affecting their lives. The assistance may sometimes take the form of speaking on behalf of the service user, but it will more often comprise the provision of information and moral support, as well as being a good listener.[4]

The purpose of advocacy is to ensure maximum preservation of each service user's personal autonomy and self determination. It follows that the advocate will not offer either opinion or advice and will not judge either the service user or what they want to say.[5]

2 *NHS Plan: A Plan for Investment A Plan for Reform; Chapter 10, Changes for Patients*

3 *Advocacy - A code for practice: 1994: UKAN p.4 refers to "... the need for advocates to follow rather than lead [people]". On p.14 it says "Advocates are there to speak with, rather than for people whenever possible".*

4 *ibid p.10.*

5 *ibid p.11: "the giving of advice and the exertion of influence on peoples' choices are, in effect, breaches of the Advocacy Code of Practice".*

History and development of independent advocacy.

Advocacy has been linked with mental health services as far back as the 17th Century. There is evidence of a campaign for conditions to be improved in Bedlam in 1620[6] and an article written by A.Cruden in 1739 notes that ex-patients were openly complaining about practices in psychiatric hospitals[7]. John Percival has been identified as the first known peer advocate in Britain for the work he did in the mid-nineteenth century[8].

The modern advocacy movement began to emerge in Britain in the 1970's and 1980's. In 1972 the Scottish Union of Mental Patients was formed, closely followed by the establishment of the Mental Patients' Union in London. Membership was restricted to patients and ex-patients who then campaigned to have conditions improved in psychiatric hospitals and raised issues they felt were of concern. Although the Unions were not then called 'advocacy groups' they certainly were examples of collective self-advocacy by those personally using mental health services.

In 1982 the Advocacy Alliance was formed to introduce independent citizen advocacy. At that time in the Netherlands wide scale independent advocacy was being established in psychiatric services and the work undertaken there influenced pioneering work in Britain. The Nottingham Advocacy Group developed 'patients councils', forums within psychiatric hospitals where patients met to discuss common issues and then tried to resolve them with staff. By the end of the decade many such forums had been established.

In 1990 a national user conference was held to look at the possibility of setting up a national body to represent the numerous advocacy services, patients' councils, and user groups that were by then in existence. The United Kingdom Advocacy Network (UKAN) was founded as a result.

Several writers, including Feenon and Campbell (2001), attribute the growth and expansion of the advocacy movement during the 1980's in part to a raised awareness, in health and social care services, that mental health service users are consumers with the right to have their views aired and to be involved in the services they use. Barnes also notes in her research that the acceleration of the developments in advocacy can be linked to an acknowledgement of the possibilities and existence of abuse and low levels of care, and an awareness of the damaging effects of living in institutions.[9]

In the Netherlands in 1996 legislation was passed which provides that every psychiatric institution is obliged to have a patients' council and that council's approval has to be obtained on such issues as appointments to management and changes in complaints procedures. The effect has been to indicate the value which the legislature attaches to the views of mental health service users. In Britain there has been no similar legislative recognition.

'Advocacy - A Code of Practice', developed by UKAN, was published in 1994. It drew together the existing principles and guidelines for good practice. In the same year the Butterworth Report highlighted the conflict of interest for health providers acting as advocates and said that service users should have access to advocates, who can put forward their views "unreservedly".[10] In 1996 Building Bridges, a guide to inter-agency working for the care and protection of severely mentally ill people identified service users involvement as a fundamental principle in mental health care and spoke of advocacy supporting the process.[11] In 1995 the Patients Charter[12] had given patients the

6 *Brandon, D 1991*
7 *Mind, 1992*
8 *Conlon, E in UKAN 1994*
9 *1.10; Barnes, 2001*
10 *Department of Health, 1994*
11 *Department of Health, 1996*
12 *Department of Health 1995*

right to be involved in their own care, and in 1997 the Mental Health Patients Charter[13] stated that service users should be informed of and have access to any local advocacy services. The Mental Health Act Commission referred to advocacy in their biennial reports of 1997 and 1999 and at this time developed the practice of checking on the availability of advocacy services on their visits to psychiatric hospitals.[14] In the Mental Health National Service Framework[15] published in 1999 advocacy is treated as an essential part of mental health services. Now at the turn of the century we have advocacy discussed in the NHS National Plan and in the Mental Health White Paper.

Models of Independent Advocacy

Over the last twenty years various forms or 'models' of independent advocacy have evolved. Whilst this list must not be regarded as a comprehensive description of all advocacy practised in Britain, it is a familiar list frequently used to describe the main models of advocacy on offer.[16]

Self-advocacy, as the name suggests, is individuals acting and speaking for themselves. "Self advocacy is about power - about people regaining power over their own lives".[17] It may be hard for people to speak up in this way; the formation of self-advocacy groups has enabled them to support each other. Survivors Speak Out is perhaps the best known self-advocacy organisation in mental health advocacy.

Group advocacy - Group or collective self-advocacy occurs when a specific group of people unites to raise and put forward shared views. Patients' councils and mental health user groups are examples of group advocacy.

Peer advocacy is support from a person who is or has been a service user for another who is confronting experiences or difficulties similar to their own. It has been said that the uniqueness of the peer advocacy role is in the advocate's empathy with the client's situation; their experience may have equipped them with valuable skills or qualities and the client may feel that they have a particularly equal relationship with the advocate.[18]

Citizen advocacy is an independent, long term, one to one partnership between a volunteer citizen advocate and a person who needs help in representing and defending their interests and rights as a citizen. Citizen advocates are usually part of a scheme (led by a paid co-ordinator) which will recruit, train and support the volunteers. The citizen advocate role is different from other forms of advocacy in that it involves a long-term partnership with one person and involves responding to and representing many concerns or views that their 'partner' may have in different areas of their life.

Paid/ formal advocacy - is where a trained, paid worker offers independent, short term, one to one support to a client who wishes to access the service or is a service user. This type of advocacy has often been developed and managed by voluntary organisations.

'Best interests' (non-instructed) advocacy - We argue below that there is no legal basis for this type of alleged advocacy which consists of an advocate acting on behalf of someone who is unable to express their views and instruct the advocate. The 'advocate' may act without instruction from their client[19] by representing what they feel the person's wishes would be if they could express

13 *Department of Health 1997*

14 *Mental Health Act Commission Biennial report 1997/ 1999.*

15 *p.10, Department of Health, 1999*

16 *See Advocacy - A Code of Practice 1994 and The Mind Guide to Advocacy 2000.*

17 *Survivors Speak Out 1990 cited in MIND p.9, 1992*

18 *Conlon, E in UKAN 1994*

19 *Kelley 2001: see also The Mind Guide to Advocacy 2000 p.5*

them. This type of work has been carried out by people working with dementia sufferers who have been unable to communicate clearly to the advocate.

UKAN, among others, has stressed that the ultimate aim is to have people advocate for themselves, yet frequently this is not possible. 'Formal' advocacy has developed out of the recognition that there are times when people are unable to represent their own views and interests.

Principles have evolved which we think are accepted by all providers of advocacy services as governing the advocate/client relationship. Namely, that it is independent, client led, non-judgmental and confidential.[20] These principles have been developed from guidance issued by organisations such as UKAN and from work carried out by organisations that have provided formal advocacy over a period of time.

Principles of Independent advocacy

Independent

The independence of the advocate is of crucial importance if they are to represent the client's view as faithfully as possible. Advocacy is acknowledged as being within the role of mental health professionals but there are limits as to how far they can advocate for the users of their services.[21] [22] [23] There is the potential for conflict of interest arising from their role of service provider. Ultimately, as mental health professionals, they have power over users of their services and they also have to use their own judgement and assessment of a service user's needs.[24] An advocate must be an independent supporter who is there purely for the 'user' with a loyalty to them alone.

Barnes (2001) and UKAN (1994) note that there are several issues that need to be addressed to ensure that the independence of an advocacy service is not compromised. A clear example is the funding and management of the service. If these are controlled or led by a service provider then there is the danger that the advocate will fail to perform their task to completion because if they were to do so they would be taken to the point at which they would be advocating against the people who pay their wages and supervise their work.

Client led

Independent advocacy aims to be led wholly by the 'client/user'. The advocate will only support a person if they want support and the client will guide the advocate. Kelley offers a clear description of the role; "instructed advocacy – if the person asks for it the advocate does it, if they don't ask for it, the advocate doesn't do it".[25] The purpose of offering advocacy support is to give the control and power to the client and not to take it away by speaking and deciding for them.[26] The advocate should not offer their own opinion nor should they offer advice or tell the client what they should do. The advocate's role is to provide the client with information and the opportunity to discuss concerns and options.

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20 *Gathercole 1986 in Butler, Carr & Sullivan, p.2; 1988. UKAN 1994 p.14-16*

21 *"Guidelines for mental health and learning disabilities nursing"; p.14, 1998, UKCC.*

22 *Brandon, D in Professional Social Work, p13, April 1995*

23 *Hopton, J; p.3, Openmind ed.69, June/July 1994*

24 *Read and Wallcraft; "Guidelines on Advocacy for mental health workers", p.17; 1994; Unison/Mind*

25 *p.11, Openmind Jan/Feb 2001*

26 *Royal College of Psychiatrists 1999, p.6; UKAN 1994, p.14*

Non judgmental

The advocate should not make any judgements.[27] The advocate is acting not as a mental health professional but as a messenger for their client. They will therefore not interpret or assess what the client is saying but will work with the client to ensure that what they advocate is what the client is saying.[28] At this point misunderstandings can occur: other mental health workers sometimes think that an advocate is acting against the client's best interests if they seem to be 'supporting the client's delusions'.[29] It is important to remember that the advocate is supporting the client's right to be heard. It is not the advocate's role to decide if the client is capable of putting forward a view nor to analyse what is being said, but to ensure that the client's view is expressed, irrespective of how others may view it. The tensions between this principle and legal considerations of capacity are addressed below.

Confidential

The confidential nature of the advocacy relationship is of great importance but there is a tension between its theory and practice. The UKAN Advocacy Code of Practice states on page 15 that "Advocates will disclose to service users complete details of all communications concerning them, but they will not disclose information about them to others without their express consent". That statement misrepresents the true legal position because neither privilege nor confidentiality apply to the relationship if it can be demonstrated that a third party has a sufficient interest in acquiring information which has been received by the advocate in the course of the relationship. This issue, which also raises the questions of capacity and undue influence, is addressed below.

The Challenge Now: To match the principles with the law

Currently those who practise independent advocacy have no professional or governing body to provide rules and guidance. In view of the government's proposals contained in the NHS Plan it is essential that they now identify and clarify where they stand on fundamental points of ethics and practice. If they do not they may find that a system of ethics and a code of practice which do not reflect their own understanding of their work is forced upon them.

With that in mind we now consider five inter-related questions, which we think must affect, on a daily basis, the practitioners of peer advocacy, citizen advocacy, "best interests advocacy" and especially paid/formal advocacy.

The questions are:

i)What is the legal relationship between the advocate and the service user?

ii) Does the advocate owe a duty of care to the service user and if so what does it involve?

iii) To what extent are communications between service user and advocate privileged or confidential?

iv) How do the two separate, but often inseparable, issues of capacity and undue influence impact on these questions, and is the advocate ever entitled to raise the issue of capacity?

27 *Mind guide to advocacy; p.3; 2000*

28 *Curran & Grimshaw, Openmind Jan/Feb 2000*

29 *Read and Wallcraft 1994, p.16*

v) In view of the conclusions reached in answering questions iii) and iv) above, how is the client to be protected from the risk of the unpleasant consequences of reporting information to the authorities?

Legal Relationship Between Service User and Advocate

At present the provision of advocacy services by independent schemes has no statutory basis. We are not aware of any schemes which enter into contracts with clients for the provision of advocacy.[30] However, it is clear that a relationship is formed between the service user and the advocate in which the service user relies on the advocate to assist them and speak for them as and when necessary. No payment is made for the service.

Some help is to be found in cases which have been concerned with the provision of a service in a contractual or quasi-contractual situation.

Perhaps agency is the formal legal category which best accommodates the relationship. The advocate is the agent of the service user.

Lord Cranworth discussed the formation of an agency in *Pole v Leask*[31] saying "no one can become the agent of another person except by the will of that other person. His will may be manifested ... simply by placing another in a situation in which ... according to the ordinary usages of mankind, that other is understood to represent and act for the person who has so placed him". That seems to fully cover the situation in which an advocate, having been asked by a service user to assist and speak up for them does so and is accepted by those to whom they speak as having the necessary authority.

In *Chaudhry v Prabhakar and another*[32] the Court of Appeal held that "a gratuitous agent who offered to [make a purchase] on behalf of another owed [that other] a duty of care to exercise the degree of care and skill which could reasonably be expected of him in all the circumstances, that degree of care and skill being measured objectively and not subjectively". It is clear from that case that in a very informal situation in which no money passes between the parties and no formality accompanies the arrangement a person who "speaks up" for another, claiming to have sufficient expertise and knowledge to justify their doing so, acts as the agent of the other person and owes a duty of care to that other which renders them liable to be sued if the duty of care is breached.

When one considers "best interests advocacy" the first sentence of the quotation from Lord Cranworth (above) assumes particular importance.

The position was painstakingly spelt out recently by the Employment Appeal Tribunal in *Gloystone and Co Ltd v Martin*[33]. Lindsay J provided "... a brief look at how ostensible authority arises. Putting the point alphabetically, B does not become A's agent in dealings with C, nor does B acquire authority from A to act on A's behalf in relation to C by way only of what B says to C. If that was the case, principals could have agents completely unknown to them and over which they had no control. Rather the case is that B becomes A's agent in dealings with C by reason, in general of what A says to C on the point or whether A conducts himself to C in such a way that reflects on the possibility of B's agency".

30 *Advocacy - A Code of Practice p.12 states "There will be no charge for advocacy services".*

31 *(1863) 33 LJ Ch 155 at 161-162*

32 *[1988] 3 All ER 718*

33 *[2001] IRLR 15*

It is also noteworthy that although there is a limited class of case in which a person may be bound by the acts of another, performed without authority on the grounds of urgent necessity, it is extremely doubtful whether a person can be bound by the act of a complete stranger *(Jebara v Ottoman Bank)*.[34]

It is difficult to see any lawful justification for the authority which is apparently claimed for an advocate engaging in "best interests" advocacy. In fact, there seems to be a real risk that such an advocate, acting upon limited information, would risk taking steps which would turn out to be inappropriate and leave themselves vulnerable to allegations of negligence. Similarly, any person who incorrectly treated the advocate as having authority which s/he did not have and acted upon incorrect or incomplete communication from the advocate might likewise be vulnerable to such a claim.[35]

Duty of Care

The circumstances in which advocates employed by independent schemes take instructions from service users necessarily have the appearance of informality but, as the case of *Chaudhry v Prabhakar* indicates, despite those appearances the arrangement is under-pinned by a firm legal framework and it is important that that be recognised.

A service user is entitled to expect that an advocate has received training which enables her/him to understand the difficulties in communication which may arise from the service user's illness.[36] The advocate comes to the relationship with the authority of the scheme by which s/he is employed. It is clear in those circumstance that the service user is being invited to trust the advocate to understand instructions and the circumstances in which they are received, and to deploy communication and negotiation skills to assist the service user. That is a relationship which is quite simply and clearly covered by the "neighbour test" prescribed by Lord Atkin in *Donaghue v Stevenson*.[37] The advocate owes a duty of care to persons who are so closely and directly affected by the advocate's act that s/he ought reasonably to have them in contemplation as being so affected when s/he is directing her/his mind to any acts or omissions which might occur during the conduct of the case. It follows that there will have been negligence if the advocate, for want of care or skill, fails properly to understand the instructions given by the service user, or fails properly and accurately to communicate them to others.

The question which then arises is "by what standard is the skill used by the advocate to be tested?" Because advocacy is such a new discipline, and there is at present no body which sets its standards, it is not possible to establish, on the basis of common practice, what is accepted by advocates generally as good practice. Nor is it possible to identify a responsible body of advocates whose opinion on the point might be sought. It is perfectly clear now that in any event the practice and standard which is thought by advocates to be good must stand up to analysis and be reasonable. *(Bolam v Friern Hospital Management Committee* and *Bolitho v City and Hackney HA)*.[38]

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34 [1927] 2 KB 254

35 Those who lack capacity are represented and protected under the present system by litigation friends, guardians ad litem, the Official Solicitor and Public Trustee, and the procedures of the Court of Protection. Advocacy schemes which provide a "best interests advocacy" service are unauthorised trespassers in the province of these well entrenched systems.

36 The Mind Guide to Advocacy; p.3: 2000 and Advocacy - A Code of Practice: chap5.

37 (1932) AC 562

38 [1957] 2 All ER 118 and [1997] 4 All ER 771

It seems that as things stand, if the courts were called upon to decide whether or not an advocate's conduct of a case had fallen below the standard which was to be expected of him/her, and thus amounted to negligence, the advocate's conduct and competence would have to be judged on the particular facts of each case simply against the standard which a reasonable person would expect to be achieved in that case.[39]

Too literal an acceptance of instructions by an advocate may lead to an allegation of negligence. For example, a service user might tell an advocate that s/he intends to perform an act of self harm but insist that that is confidential information which must not be repeated to anyone else. If the advocate were to honour that request for confidentiality and the service user did inflict self injury the service user might subsequently allege that the information given, along with the request for confidentiality, was a "cry for help" influenced by her/his mental state at the time, that the advocate should have appreciated that it was an attention seeking ploy and, despite the words actually used, that the advocate should have understood that a report to the authorities was precisely what was needed, that the failure to report amounted to negligence and that the service user is entitled to damages as compensation for the self inflicted injury.

Confidentiality

It seems fair to say that those who administer many schemes would be well advised to radically redraft their confidentiality policies so that they accurately reflect the law. Quite possibly in the near future they will have policies imposed upon them by the Commission for Mental Health. Those responsible for the drafting will doubtless look to the guidelines which are currently provided for other professions.

Confidentiality and privacy concerning details of our daily lives, which are the business of no one else, are largely governed or protected by the Data Protection Act 1998, and the Human Rights Act 1998, and by the guidelines issued to various professions and referred to below. But advocates will sometimes encounter circumstances in which they are ostensibly asked to keep quiet about situations involving serious personal injury and/or serious crime. Those situations are not granted privilege or confidentiality by statute, common law or guidelines.

First we take the question of privilege: can the service user ever be assured that information will be safe from third parties?

Most of us appreciate that the majority of situations which we deal with in confidence are not privileged, so the confidence would not be protected or respected if we were required to give evidence on the subject. However, it is not widely appreciated just how limited a protection is given to confidential information in general, and in respect of communications concerning medical matters in particular. Blackstone's Criminal Practice 2001,[40] in a passage which covers both civil and criminal law, states the position as follows "at common law no privilege attaches to communications made in confidence except in the case of :-

39 *We are not aware of any litigation which has arisen from an allegation of negligence against an advocate. The well known cases of alleged negligence by counsel are of no help, dealing as they do with issues peculiar to the position of counsel in relation to litigants and the court. (see eg Arthur S J Hall & Co v Simons; Barratt v Ansell and others;Harris v Scholfield Roberts & Hill and another [2000] 3 All ER 673; Saif Ali v Sydney Mitchell & Co [1978] 3 All ER 1033; Rondel v Worsley [1967] 3 All ER 993).*

40 *F9.8*

a) Communications between a client and a legal advisor made for the purpose of the obtaining and giving of legal advice; and

b) Communications between a client or his legal advisor and third parties, the dominant purpose of which was preparation for contemplated or pending litigation".

Blackstone's continues:

"Although the courts have an inherent wish to respect the confidences which arise between doctor and patient, bankers and customers, etc, if the question to be put to a witness is relevant and necessary in order that justice be done, the witness will be directed to answer ... Thus, no privilege exists to protect medical records or communications between doctor and patient ... not withstanding that the rule is regarded as unsatisfactory ... Similarly, there is no privilege for confidential communications between friends".

It follows that an advocate cannot ever give an absolute guarantee to a service user that information will remain private. Of course, the firm assurance can be given that no communication between service user and advocate will be disclosed unless the law or the policy of the scheme requires it.

Turning to the question of confidentiality: will the advocate ever have a duty to report to a third party information given "in confidence"? It is of interest to look at guidelines in this respect provided to other professions.

The GMC Confidentiality: Protecting and Providing Information, September, 2000 advises doctors that they must respect requests by patients that information should not be disclosed to third parties save in exceptional circumstances. It further advises that even in exceptional circumstances consent to disclosure should be requested where practicable, and the patient should generally be informed before disclosure of the information. However, the guidance does provide that disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm. Examples are given of exceptional circumstances and include "where disclosure may assist in the prevention, detection or prosecution of a serious crime. Serious crimes, in this context, will put someone at risk of serious harm and *usually* be crimes against the person, such as abuse to children" (our italics).

The British Association of Social Workers code of ethics states that a social worker "respects the privacy of clients and confidential information ... gained in his relationship with them ... He will divulge such information only with the consent of the informant except where there is clear evidence of serious danger to the client, worker, other person or the community, in other circumstances judged exceptional, on the basis of professional consideration and consultation".

The Guide to the Professional Conduct of Solicitors advises solicitors that they may reveal confidential information to the extent that the solicitor believes it necessary to prevent the client or a third party committing a criminal act that the solicitor believes on reasonable grounds is likely to result in serious bodily harm.

The guidance issued to solicitors representing patients at Mental Health Review Tribunals advises that if a client discloses that they intend to do serious harm to themselves or someone else guidance should be sought from the Law Society's Professional Ethics Division.

These guidelines simply reflect the reasoning of the Court of Appeal in *W v Egdell* which decided that a psychiatrist who is concerned by information acquired in a confidential relationship "is entitled to take such steps as are reasonable ... to communicate the grounds of his concern to the authorities".[41]

If the reasoning behind these guidelines is applied to the advocate/client relationship it is possible to envisage a policy which denies confidentiality to the communication of information indicating that the service user or anyone else is at risk of serious bodily harm. We suggest that those responsible for the administration of any advocacy service would wish to have in place a confidentiality policy which makes such a provision.

It is a matter worthy of note that the guidelines seem to refer almost exclusively to a risk of serious bodily harm whereas service users are also at risk of being victims of serious economic crime. Some service providers have addressed this issue by producing policies which state that confidentiality will not apply to information indicating a risk of serious crime which is identified by reference to the definition in section 116 of the Police and Criminal Evidence Act 1984.[42] That definition does include theft and makes the point that the degree of seriousness is determined by the effect of the crime upon the victim as much as by the economic value of what is stolen. This is a point to be borne in mind when confidentiality policies for advocacy schemes are being drafted.

Many advocates will think that a difficulty arises if the only person at risk is the service user who has provided the information. If the service user demands confidentiality, they will ask how its refusal can be compatible with the client-led ethos of advocacy? As indicated above, there is a considerable risk that the advocate will be failing in their duty of care to the client if they remain silent. Every advocacy service should protect its advocates from this difficulty by providing a confidentiality policy which puts the issue beyond doubt by requiring that in such a situation the information must be reported by the advocate to the authorities. The policy itself should provide that the advocate must inform the client of its provisions at the commencement of the relationship.

Unfortunately the difficulties do not end there. What of a client who is suffering harm which is not so serious as to come within the contemplation indicated in the guidelines? The harm might be self inflicted or it might be caused by another, possibly someone who is in a position to exert undue influence over the client. If the client demands confidentiality for information concerning that harm, should the advocate be allowed to question whether or not the client has sufficient capacity to make that demand? How does the raising of that question comply with the ethos of non-judgmental client-led advocacy?

Capacity and Undue Influence

A discussion of the notoriously slippery concept of capacity is beyond the scope of this article but the following points must be borne in mind by advocates and those who administer the schemes within which they work.

41 *[1990] 1 All ER 835. The Supreme Court of California has gone further and said that such a psychiatrist has a duty to take reasonable steps to protect any identifiable person who is at risk of harm: Tarasoff v Regents of University of California (1976).*

42 *See for example Surrey - wide Operational Partnership Group Confidentiality Policy Document: Mental Health Services, Appendix 5: 2000 and Worthing Mind "Confidentiality and Use of Information" para 9.*

- The validity of any work done by an advocate arises only from the authority of the instructions received from the client. A service user who lacks capacity cannot give instructions which confer that authority and so, strictly speaking is not a client at all. It follows that if the service user lacks capacity there is no advocate/client relationship and the question of whether or not it is client-led and non-judgmental does not arise.
- The question of whether or not a service user has the necessary capacity to instruct the advocate can arise at any stage of the relationship but the tests for capacity will vary from issue to issue as they arise: see *In re:T.(Adult; Refusal of Treatment)*.[43]
- It is not unusual for doubts as to a client's capacity to arise from facts which also indicate the presence of undue influence: see *In re: T. (Adult; Refusal of Treatment)*.
- *R v Collins and Ashworth Hospital ex parte Brady* [44] seems to lend authority to the proposition of the Richardson Committee that a person with a psychiatric disorder lacks capacity where, although intellectually able to understand and apply information, they nonetheless reach a judgment which they would not have reached in the absence of the disorder.

We suggest that if the question of capacity arises the advocate has no choice but to investigate it. A lack of capacity at the beginning of the client/advocate relationship will prevent the formation of the agency which is the legal foundation of that relationship. In law the advocate and client will be strangers and the advocate will have to make decisions about confidentiality and the client's welfare in the same way as any other well intentioned person who has become aware of the client's predicament. A loss of capacity during the relationship will, we suggest, leave the advocate still owing the client a duty of care which would require her/him to act in the client's best (social and medical) interests and make decisions regarding confidentiality accordingly.

Every scheme providing an advocacy service should have in place a protocol and guidelines to assist the advocate when this situation arises. It is beyond the scope of this article to suggest the detail of what should be the contents of those documents.

Protecting the Client in the absence of Confidentiality

A very simple and practical problem arises when confidentiality is denied.

Service users will request confidentiality essentially for two reasons. They will be afraid that the information which they have communicated will bring upon them unwanted attention from the authorities. They will also be afraid that they will suffer at the hands of those who, as a result of the communication of information, will suffer similar attention. This fear will almost always arise because a criminal investigation has been commenced.

Advocate and client both need help and advice as to what practical protection is available for the client.

If the client appears to be a danger to themselves or others then clearly the authorities must act appropriately and there is nothing to be done to prevent that. Safeguards provided by the Mental Health Act 1983 and the inherent jurisdiction of the High Court are in place to ensure that the authorities act lawfully and proportionately.

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43 [1992] 3 WLR 782 *Journal of Mental Health Law December 2000.*

44 [2000] LLRM 355. See also "Treatment for Mental Disorder - another step backwards": Simon Foster

An advocate who is in the unfortunate position of having to "betray" the confidence of a client who is at risk of violence or harassment will need to know what steps might be taken to protect their client and what assurances might be given. The advocate should be provided with this information by the organisation for which s/he works.

In reality very little real protection will be available and the assurances which can be given are slight.

The following points, which can always be made to the authorities when information is reported to them, may provide some assurance to the client.

- There is a long established rule of law that in criminal proceedings informers should not be identified because the Courts appreciate the need to protect their identity, not only for their own safety but to ensure that the supply of information about criminal activities does not dry up.[45]
- If there is to be an investigation the fact that disclosure came from the service user and the advocate should not be mentioned in the course of that investigation unless it is unavoidable.
- There is a public interest in allowing people to withhold material containing information which would not have been provided if the person who did provide it had believed that it would later be made public. This principle, however, frequently conflicts with the other public interest that justice should be public and seen to be done. Where the conflict arises in an individual case the balance has to be weighed by the Court.
- If at the end of an investigation a prosecution has to be considered the prosecuting authority must also weigh in the balance the public interest and that will include the effect of a prosecution on the service user. It does not have to follow that the detection of a crime will lead to a prosecution.

These principles can be invoked to reduce the risk to the client.

In Conclusion

We suggest that it is beyond dispute that there must be available to all users of mental health services the assistance of a completely independent advocate who will, non-judgmentally, assist the service user to communicate with service providers and others. This has been acknowledged by the government in their proposal regarding PALS but the terms in which that introduction has been made indicate that PALS will not be independent and will not provide advocacy of the kind which we have discussed.

If independent advocacy, which has grown out of the history and developed the principles described in the first part of this article, is to have a chance of survival, its practitioners must fully understand the principles which govern their work and the impact which the law has on those principles. They must also be provided with clear guidance in the form of policies and protocols to assist them when confronted by difficult cases.

If the understanding and guidance for which we are pleading are acquired and put in place they could become the guts and sinew which enable independent advocacy to compete against rival systems and overcome hurdles which will inevitably continue to be put in its way. In their absence, sadly, independent advocacy will not stay the course. It will be left behind by those rival systems and lost from sight. If that happens every aspect of mental health care will be the poorer.

45 *Blackstone's Criminal Practice 2001: F9.5*

Psychiatric detention and treatment: a suggested criterion

Alec Buchanan *

Abstract

Calls for a new Mental Health Act for England and Wales, and the government's response to those calls, raise the question of why we have mental health legislation. One answer is that we wish to provide criteria for psychiatric detention and compulsory treatment. It is argued that we are willing to coerce some people with mental disorders in this way when we conclude that their ability to make a proper choice is impaired. Mental health legislation could and should be designed to take this into account.

Key words

Legislation, capacity, choice, detention, coercion, treatment

The 1990s heard repeated calls for a new Mental Health Act for England and Wales.[1] Before we design a new Mental Health Act we ought first to answer the question: "What do we want a Mental Health Act to do?" If, as the government's response[2] to these calls suggests, we want an Act which will provide criteria for detention in psychiatric hospital and compulsory treatment, we are required to answer a further question: "Why do we detain and treat some people with a mental disorder who pose a risk to themselves or others?" After all, we do not detain other people who pose this kind of risk unless they have been convicted of an imprisonable offence.

Some of the calls for reform expressed the view that the existing criteria for detention under mental health legislation in the UK, criteria which require, in general terms, the simultaneous presence of mental disorder and a perceived risk to the patient's own or someone else's health, were incorrect and should be replaced. The authors argued that new criteria should be based on the common law of capacity.[3] The end of the decade saw discussion of this question by a government appointed Expert Committee[4] and a decision, later reversed, by the Court of Appeal

* *The author has worked as a psychiatrist since 1987. He currently works as a senior lecturer in the Department of Forensic Psychiatry at the Institute of Psychiatry. His publications include books on compliance with treatment and the jurisprudence of abnormal mental states.*

1 *See N. Eastman (1994), Mental health law: civil liberties and the principle of reciprocity 308 British Medical Journal 43-45; G. Thornicroft (1996), Review British Medical Journal 312, 786*

2 *Department of Health and Home Office (2000), Reforming the Mental Health Act. The Stationary Office: London.*

3 *G. Szmukler and F. Holloway (1998), Mental health legislation is now a harmful anachronism 22 Psychiatric Bulletin 662-665*

4 *Department of Health (1999), Report of the Expert Committee. Review of the Mental Health Act 1983, Department of Health: London.*

in *Bournewood*[5] which suggested that capacity-based criteria were already required at common law. The government's legislative proposals, published in 2000, revealed that these views had not prevailed.[6] This paper asks whether they should have been allowed to do so.

Even to ask what are the proper criteria for detention and compulsory treatment is to ignore two possibilities, possibilities which will not be discussed further here. These are what might be termed an extreme libertarian position, that no-one should ever be coerced unless convicted, and an extreme paternalist position, that everyone should be liable to coercion if their behaviour deviates from that which is in their own best interests. It will be assumed also that what is required is a dichotomous classification, into those deemed able and unable to manage their own affairs, and that there can be no equivalent, in civil legislation, of the criminal law's "diminished", or partial, responsibility. In addressing these questions, the remit of this paper is limited to civil procedures and does not include the admission and treatment of patients from prison and the courts under Part III of the Mental Health Act 1983.

The approach adopted here parallels one used by Herbert Hart.[7] In *Punishment and Responsibility* Hart is concerned with a different question, namely, why does the criminal law usually require, as a condition of punishment, the presence of mental states such as intention and recklessness? Why do we excuse, partially or completely, those who were provoked, insane or simply mistaken as to what they were doing? He examines a number of possibilities and by answering the question, "Why does the law require certain mental states?", suggests how we might assess the adequacy of the defences available, at law, to those whose mental state is different.

Hart's analysis

The first possibility which Hart discusses is that the requirement for excuses stems from a more fundamental requirement that, in order for criminal responsibility to be present, there must be moral responsibility. By this argument we recognise excuses because we wish to ensure, before a prosecution can be successful, not only that the person intended to act as he did, but that he intended to do wrong. This view, that the law exists to punish, not acts which are simply forbidden, but acts which are morally wrong, has been expressed on both sides of the Atlantic.[8] Hart argues that it is incorrect and points out that the law defines as offences numerous forms of behaviour whose moral wrongness is, at best, in doubt.[9]

The second possible reason, which Hart examines, for our desire to convict only the "mentally responsible" relates to what he calls Jeremy Bentham's "economy of threats". Bentham thought that it was wrong to punish where the threat of punishment could not deter a potential offender from indulging in criminal behaviour in general or the act for which he was being tried in particular.[10]

5 *L. v Bournewood Community and Mental Health Trust ex parte L [1998] 1 All ER 634.*

6 *Department of Health and Home Office (2000), Reforming the Mental Health Act. The Stationary Office: London.*

7 *H. Hart (1968), Punishment and Responsibility. Oxford: Clarendon Press.*

8 *In England Lord Denning said that, "In order for an act to be punishable, it must be morally blameworthy. It must be a sin" (see A. Denning (1953), The Changing Law. Stevens and Sons: London, p.112). In the United States Professor Jerome Hall has argued that the general principle of liability is that, for conviction, there be proved the, "voluntary doing of a morally wrong act" (see J. Hall (1947), General Principles of Criminal Law. Second edition. Bobbs-Merrill Co.: Indianapolis, p.103).*

9 *Hart cites as an example legislation intended to give effect to a state monopoly of road or rail transport.*

10 *Bentham (1823), Introduction to the Principles of Morals and Legislation, Volume Two. Second edition. Pickering: London, pp. 1-13.*

Punishment in such cases was wasteful because suffering was caused to the accused in circumstances where it could do no good. Hart's argument in reply is that it is far from clear that making punishment dependent on responsibility is, in fact, the most efficient way of persuading people to observe the law. Doing away with "accident" as an excuse, for instance, might make everybody more careful. We recognise excuses despite the possibility that suffering would be reduced by our not doing so.

Instead, Hart argues, the criminal law is best seen as a "choosing system"[11] in which individuals are aware of the costs and benefits of various courses of action. He points out the similarities between conditions which excuse under the criminal law and those which invalidate marriages, contracts and wills. In the absence of such invalidating conditions as accident, mistake and insanity, contracts entered into without the individual making a real choice would remain in force and the individual would suffer a corresponding loss of control over his or her future. Similarly, by attaching excusing conditions to criminal responsibility we maximise the chances of an individual successfully predicting whether sanctions will be applied to him and choice becomes one of the factors which determines whether such sanctions will be applied.

An analysis for civil legislation

Hart's arguments concerned the criminal law. This paper addresses civil provision. Why do we have a law that permits the detention of some people when they present a risk to themselves or others? In particular, why does this risk justify the detention of mentally disordered people but not others? One possibility is that we have utilitarian motives. Left to their own devices, perhaps, an unacceptable number of those we detain would harm themselves or others. In support of this being our motivation is the stress laid on harm done to others in press criticism of some decisions to release detained psychiatric patients. But even those who consider the mentally disordered, as a group, no more dangerous than the population at large are content for compulsory detention to continue. And we do not detain in hospital those non-disordered people who are, sometimes by their own descriptions, dangerous. Our behaviour cannot be wholly explained in terms of utilitarian motives.

A second possibility is that we regard it as a moral necessity that sick people receive medical attention. Certainly the Mental Health Act requires that someone be placed, not simply out of the way or under supervision, but in hospital. Again, however, this explanation of our current practice seems, on its own, inadequate. First, even when treatment has begun, things are sometimes done which are not in the best interests of health. Where the diagnosis or prognosis is uncertain, patients are routinely subjected to two operations, the first exploratory, so that informed consent can be obtained for the second.

11 *H. Hart (1968), Punishment and Responsibility. Oxford: Clarendon Press, p.31.*

Second, many people fail to seek help or refuse it without our seeking to compel them. Those, such as Jehovah's Witnesses, who refuse blood transfusions on religious grounds are dramatic examples. But it is easy to think of more mundane instances of people failing to act in their own best interests where we see no reason to intervene. The value of medical treatment for diabetes and high blood pressure is seldom questioned, yet research into how best to improve the uptake of such treatment does not conclude that compliance should be compulsory.[12] And even when a disease is infectious and an effective treatment is available, proposals for improving compliance make no mention of coercion.[13]

It seems more reasonable to suggest that we detain those we believe incapable of making proper choices. This incapacity applies to choices regarding the way they treat others, their care of themselves and their willingness to seek medical treatment. Hart thought it no coincidence that the range of conditions which reduce criminal responsibility, duress, accident and so on, are the same conditions which invalidate contracts and wills. I think it is no coincidence that the mental conditions used to justify detention in hospital, mental disorder, mental illness and so on, are the same mental conditions which invalidate contracts and which permit the management of one's financial affairs by the Court of Protection.[14] To the extent that we can control our futures, we do so by making choices. When we can no longer make choices properly we allow, and perhaps even expect, others to attempt to control the future for us.

The language employed by the common law and, in particular, the law's repeated use of the word "choice", offers some support for this explanation of why we remove autonomy from some people but not from others. Where no mental disorder has been held to be present, the courts have wished to respect the patient's "rational choice"[15] and "absolute right to choose".[16] When allowing treatment against the express wishes of the mentally disordered they have been, if anything, even more explicit in their use of choice as a criterion. Hoffman L.J. doubted that,

> "someone who acknowledges that in refusing food at the critical time she did not appreciate the extent to which she was hazarding her life ... could be said to be capable of making a true choice."[17]

The right of a man with schizophrenia to refuse surgery hinged on his, "comprehending and retaining treatment information, ... believing it ... and ... weighing it in the balance to arrive at choice."[18] One authority concludes that a "true choice criterion" for the right to refuse treatment

12 *See D. Sackett, R. Haynes, E. Gibson, B. Hackett, D. Taylor, R. Roberts and A. Johnson (1975), Randomized clinical trial of strategies for improving medication compliance in primary hypertension i Lancet 1205-7; R. Haynes, D. Taylor and D. Sackett eds. (1979), Compliance in Health Care, Johns Hopkins University Press: Baltimore.*

13 *See, for example, J. Volmink and P. Garner (1997), Systematic review of randomised controlled trials of strategies to promote adherence to tuberculosis treatment 315 British Medical Journal 1403-1406*

14 *See the frequent references to mental disorder in A. Guest (ed.) (1994), Chitty on Contracts. 27th edition. Sweet and Maxwell: London, 8-064 - 8-073. Of particular relevance to the present argument, however, is that the presence of mental disorder alone is insufficient to render most contracts invalid. There must be a consequent inability to manage one's affairs (at 8-071). Similarly, the Matrimonial Causes Act 1973, while identifying mental disorder (as defined by the Mental health Act) as one of the grounds for voiding a marriage, also requires that the disorder be "of such a kind or to such an extent as to be unfitted for marriage".*

15 *Sidaway v. Governors of Bethlem Royal Hospital [1985] 2 W.L.R. 480 at 505.*

16 *Re T [1992] 3 Med. L. R. 306 at 307.*

17 *B v. Croydon Health Authority [1995] 2 W.L.R. 294 at 300.*

18 *Re C [1994] 1 All E.R. 819 at 824.*

has become entrenched in common law.[19] The Law Commission included the phrase "true choice" in their proposals to change the law relating to mental incapacity.[20]

If choice is the criterion which determines whether someone's stated wishes should be respected then choice is the criterion which should appear in the legislation which governs the circumstances in which those wishes can be ignored. This is not to argue that difficult cases would cease to be difficult. It is to argue that difficult cases would be decided according to the appropriate criteria. Several other issues would arise, however, if a "choice test" were included in any new Mental Health Act.

The first concerns the term "mental disorder". Should this, or similar, wording be retained such that detention and treatment would be dependent on, for instance, "the inability, by reason of mental disorder, to make a proper choice as to one's need for treatment"? It could be argued that "mental disorder" should be omitted. If someone is, for whatever reason, unable to choose, why should their access to medical services be dependent on something as difficult to define as mental disorder?[21] There are, however, many non-psychiatric causes of an inability to make a proper choice: physical threats, for instance. Retention of the term "mental disorder" would achieve the uncontroversial objective of restricting the use of the Mental Health Act to cases where the inability to choose stemmed from mental ill-health.

A second is whether any of the other elements should be changed. The Mental Health Act 1983 contains a number of criteria in addition to the requirement that mental disorder be present. Among these are that there be a risk of harm to the patient himself or to others, that treatment is necessary and that it be impossible to provide treatment by other means. These criteria, which seek to ensure only that compulsory measures will be invoked where they will be of some benefit and where there is no other way of achieving this benefit, seem unexceptionable.

Third, it has not been suggested here that any future legislation should expand on the term "proper" or, perhaps, "true" choice". In *Re C*[22] the court seems to be describing the royal road to choice in its reference, previously described, to, "comprehending and retaining treatment information, ... believing it ... and ... weighing it in the balance". Whether this route is the only one seems an open question.

19 *Fennell (1995), Treatment Without Consent. Routledge: London, p.267.*

20 *See Law Commission (1993), Consultation Paper No. 128. Mentally Incapacitated Adults and Decision Making. H.M.S.O.: London, p.32. The proposal was dropped from the final report, which made reference instead to the ability to "make a decision". See Law Commission (1995) Mental Incapacity. Law Commission No. 231 H.M.S.O.: London, p.39.*

21 *See the reviews by Hoggett (1990), Mental Health Law. Third edition. Sweet and Maxwell: London, and Jones (1994), Mental Health Act Manual. Fourth edition. Sweet and Maxwell: London. Hoggett considers the definition of mental illness, one of the forms of mental disorder named in the Act, so vague as to do no more than describe instances where a layman would say, "the man must be mad" (p.48).*

22 *Re C (1994) 1 All E.R. 819.*

It is suggested that it may be more appropriate to describe, in each case, the reasons why someone's choosing might be defective than to attempt to provide a definition of proper choice which will be universally applicable. The situation is analogous to that which obtains in respect of s.2 of the Homicide Act 1957. No definition of responsibility is available to assist the court. Instead, it is open to the defence to introduce evidence to the effect that, in this case, responsibility was diminished. The procedure is able to operate because the initial presumption, that the defendant is responsible, holds until the contrary is shown to be the case. Given that the same presumption made by the common law in respect of capacity is widely seen as satisfactory,[23] further definition may not be required.

Finally, legislation would have to take account of the fact that a person's ability to make a proper choice will vary over the course of their illness. People who are made subject to coercion need to be able to make plans for the future and those plans need to be made in the knowledge of whether or not they will continue to be coerced. The plans made by professionals and services need to take this into account also. In cases where someone's condition fluctuates rapidly, ensuring that every clinical decision is made after an assessment of that person's ability to choose is unlikely to be practicable. A compromise would have to be reached between the requirements of consistency and predictability for patients and staff and the need for a patient's legal status to reflect their ability to choose.

Conclusion

Fennell[24] has argued that the primary purpose of legislation is to regulate what the common law permits, and in some cases expects, doctors to do anyway. Eastman[25] has suggested that the law should be there, in part, to insist that where autonomy is removed, something is given in return. If part of the task of mental health legislation is also to define the criteria for detention and compulsory treatment, however, it has been suggested here that those criteria should be based on a person's ability to make a proper choice. It is this ability, or capacity, on which the courts have based their decisions as to who should, and who should not, be permitted to act autonomously in other respects and there seem to be good reasons why the same principles should be applied in respect of those with mental disorders.

The report of the government's Expert Committee[26] suggested that the presence or absence of capacity was an appropriate criterion by which to identify a group of people who could properly be made subject to compulsory measures and psychiatrists have argued that capacity would represent a sound basis for a reformed Mental Health Act.[27] The government's most recent legislative proposals[28] would permit the detention and compulsory treatment of patients with capacity who

23 *See Lord Chancellor's Department (1997), Who Decides. Making Decisions on Behalf of Mentally Incapacitated Adults. Cm 3803. Stationery Office: London., p.11; Law Commission (1995) Mental Incapacity. Law Commission No. 231 H.M.S.O.: London.*

24 *Fennell (1995), Treatment Without Consent. Routledge: London.*

25 *N. Eastman (1994), Mental health law: civil liberties and the principle of reciprocity 308 British Medical Journal 43-45.*

26 *Department of Health (1999), Report of the Expert Committee. Review of the Mental Health Act 1983, Department of Health: London.*

27 *For a psychiatric advocacy of this position, see G. Szmukler and F. Holloway (1998), Mental health legislation is now a harmful anachronism 22 Psychiatric Bulletin 662-665; G. Szmukler and F. Holloway (2000), Reform of the Mental Health Act: health or safety 177 British Journal of Psychiatry 196-200.*

28 *Department of Health and Home Office (2000), Reforming the Mental Health Act. The Stationery Office: London.*

present a risk to others. If the argument presented here is accepted, the justification for measures to detain such patients will be couched in terms different from those employed to justify the coercion of people whose mental disorders render them incapable of making a proper choice.

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Casenotes

Scottish 'public safety' test for discharge of restricted patients held ECHR compatible

*Hilary Patrick**

A v The Scottish Ministers [2001] SLT 133I

The Privy Council (15th October 2001) Lords Slynn, Hope, Clyde, Hutton and Scott

Introduction

While 'preventative detention' of people with serious personality disorders has not found favour in Scotland, new legislation recently imposed a public safety test for patients already detained in hospital. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 was the first Act of the new Scottish Parliament. It altered the Mental Health (Scotland) Act 1984 by providing that, if there were public safety concerns, patients with severe anti-social personality disorders could continue to be detained in hospital even though their condition was not treatable and even if they were not, in fact receiving treatment. The new legislation has recently survived an ECHR challenge to the Judicial Committee of the Privy Council.

Three restricted patients held in the State hospital at Carstairs challenged the new legislation on the grounds that it was outside (or in Scotland, 'outwith') the competence of the Scottish Parliament, being contrary to the European Convention on Human Rights. The court upheld the decision of the Inner House of the Court of Session and dismissed the appeals, saying that there was no requirement in the ECHR that detention in hospital had to be linked to treatment. The new legislation was a proportionate response to the risk.

Background and facts

In July 1999 Sheriff Douglas Allen granted Noel Ruddle, described as a person with a severe personality disorder and a danger to the public, an absolute discharge from detention in the State hospital at Carstairs.[1]

The sheriff's decision followed the ruling of the House of Lords in *Reid v Secretary of State for Scotland*.[2] In that case it was held that a proper reading of s64 of the Mental Health (Scotland) Act (the 1984 Act) had to 'read into' the discharge provisions the conditions which applied at a patient's initial detention, currently in s17(1) of the 1984 Act. Section 17(1) provides that a patient with anti-social personality disorder (the Scottish Act does not use the term 'psychopathy') can be admitted to hospital only if treatment will alleviate his or her condition or at least prevent it getting worse.

* *Solicitor, member of the Millan Committee, Honorary Fellow in the Faculty of Law, University of Edinburgh.*

1 *Ruddle v Secretary of State for Scotland, 1999 GWD 29-1395.*

2 *[1999] 1 All ER 481.*

In Ruddle's case the sheriff found that he was receiving very little treatment, other than containment, and that there was no evidence that medical treatment would improve his condition. He was, therefore, given an absolute discharge.

When the new Scottish Executive came to power it was advised that this apparent 'loophole' in the 1984 Act could lead to the discharge of around a further twelve patients currently detained in the State hospital. Two such patients, R and A, did, in fact, put in appeals in July 1999. There was considerable public dismay following Ruddle's discharge and the Scottish Executive was under pressure to allay public concerns.

The first Act of the new Scottish Parliament, was, therefore, an attempt to plug the Ruddle gap. The 1999 Act was passed in 13 September 1999, just twelve days after the Parliament first met for business. It inserted a new sub-clause into the appeal provisions. Where a sheriff found that there were compelling public safety concerns, a patient could not be discharged, even though his or her mental disorder was untreatable and even though no further treatment was proposed.

The Act was regarded as a temporary measure, pending the reports of the MacLean Committee into serious, violent and sexual offenders, including people with personality disorders, and the Millan Committee, which was reviewing the Mental Health (Scotland) Act.

All three appellants were long term patients in the State hospital. A and R had been sent to hospital under hospital orders with restrictions, while D had been transferred to hospital from prison in Northern Ireland via a restriction direction and later transferred to the State hospital from that hospital. (Northern Ireland has no high security hospital provision and all patients needing such provision come to the State hospital.)

All three patients had been diagnosed as suffering from anti-social personality disorders. The medical evidence was that such patients would not be sent to the State hospital today, as their conditions were regarded as untreatable.

A and D applied to the local sheriff for discharge in July 1999. D, being subject to a transfer direction, applied for discharge from hospital and to complete the remainder of his sentence in prison. The 1999 Act legislation was retrospective and thus covered D and A, even though they had put in appeals before it was passed. R, having failed to obtain his discharge from the House of Lords,[3] made a further application to the sheriff for discharge in March 2000.

The sheriff referred the cases to the Inner House of the Court of Session, which determined that the legislation was within the Parliament's powers. The patients appealed to the Judicial Committee of the Privy Council.

Legal provisions

Section 64 of the 1984 Act contains provisions relating to the discharge of restricted patients very similar to those contained in s73 Mental Health Act 1983.

Where an appeal to the sheriff is made by a restricted patient who is subject to a restriction order, the sheriff must direct the absolute discharge of the patient if s/ he is satisfied that the patient is not suffering from mental disorder of a nature or degree which makes it appropriate for him/her to be liable to be detained in a hospital for medical treatment; or that it is not necessary for the

3 *See [2] above. The Lords had held that it was not appropriate for him to be discharged, as R was receiving treatment at the State hospital, in the form of anger management training, which was preventing his condition from getting worse.*

health or safety of the patient or for the protection of other persons that s/he should receive such treatment; and (in either case) that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

Section 1 of the 1999 Act inserts a new subclause into s64. If an appeal to the sheriff is made by a restricted patient subject to a restriction order, the sheriff must refuse the appeal if s/he is satisfied that the patient is, at the time of the hearing of the appeal, suffering from a mental disorder the effect of which is such that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital, whether for medical treatment or not. The burden of proof of the matters as to which the sheriff is to be satisfied for the purposes of this provision is on the Scottish Ministers.

The 1999 Act was challenged on the basis that s1 was contrary to Articles 5.1(e) and 5.4 of the ECHR and thus outwith the legislative competence of the Scottish Parliament.

Article 5.1(e)'s terms are as follows:

> 'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:…*(e)* the lawful detention of ……persons of unsound mind …….'

Article 5.4 states:

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

Section 29(2) of the Scotland Act 1998 provides that a provision of an Act of the Scottish Parliament is outwith its legislative competence if, among other things, 'it is incompatible with any of the Convention rights …'. Convention rights are the rights detailed in section 1 of the Human Rights Act 19984 and include Article 5 of the ECHR. Section 29(1) of the Scotland Act states that 'An Act of the Scottish Parliament is not law so far as any provision of the Act is outside the legislative competence of the Parliament'. The court is given power to strike such provisions out of offending legislation.

Questions for the court

Three major questions were considered.

Firstly, and crucially, was the public safety test in s1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 in breach of the ECHR and therefore beyond the competence of the Scottish Parliament under s29(2)(d) of the Scotland Act 1998?

Secondly, should the case of D be distinguished from those of A and R? D applied to be returned to prison to serve the remainder of his sentence of imprisonment and did not seek to be discharged into the community. The public at large would not be affected by D's discharge from the State hospital. Could the 'public safety' provisions in the 1999 Act be relevant to D?

Thirdly, was the retrospective application of section 1 to pending proceedings incompatible with Article 5(4) of the EHCR?

4 *Scotland Act 1998, s126(1).*

Judgement

Was the public safety test in breach of the ECHR?

The judges did not agree that the public safety provisions were in breach of Article 5(1)(e). There was no reference in that Article to detention being for the purposes of treatment and the court could find no reference in the case law to suggestions that it should be.

The case law did not make treatment a requirement of detention. The court quoted the conditions as set out in *Winterwerp v The Netherlands*.[5] These were objective proof of 'unsound mind', mental disorder of a kind or degree warranting compulsory confinement and the validity of continued confinement depending upon the persistence of such a disorder. All such requirements were met in the case of the appellants. *Winterwerp* did not impose a requirement that treatment be offered or likely to improve the patient's condition.

Counsel for the appellants argued that in terms of the second *Winterwerp* test, confinement could be 'appropriate' only if treatment were to be offered. However the court dismissed this argument. Public safety concerns could justify confinement whether or not the patient's condition could be improved by treatment. In *Luberti*[6] the European Court held that confinement was appropriate and did not suggest that the second requirement involved consideration of treatment. It was sufficient that the patient posed a 'real danger' at the time of the confinement.

In *Ashingdane*[7] the court stated that article 5(1)(e) was not in principle concerned with whether the treatment offered to a patient or the conditions under which s/he was detained were suitable.

In *Guzzardi v Italy*[8] the court said that article 5(1)(e):

> 'refers to persons of unsound mind, alcoholics and drug addicts. The reason why the Convention allows the latter individuals …… to be deprived of their liberty is not only that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention.'

In *Litwa v Poland*[9] the court said that all the categories of people noted in article 5(1)(e) could be deprived of their liberty 'either in order to be given medical treatment or ……on both medical and social grounds'.

In *Johnson v United Kingdom*,[10] the court recognised that that the release of a person previously found to present a danger to society 'is a matter that concerns, as well as that individual, the community in which he will live if released'. Such discharge should not take place immediately but the authorities should be able to give consideration to 'whether the interests of the patient and the community into which he is to be released would in fact be best served by [the patient's] discharge.'

The appellants claimed that there must be a relationship between the purpose of the confinement and the place of confinement. Confinement in hospital must be to serve the purpose of treatment and if the condition is not susceptible to treatment then the person should not be confined in a hospital. In *Aerts v Belgium*[11] the court stated that:

5 *(1979) 2 EHRR 387, 403.*
6 *6 EHRR 440, 449, para 28.*
7 *7 EHRR 528, 543, para 44.*
8 *(1980) 3 EHRR 333, 366, para 98.*
9 *App No 26629/95, 4 April 2000, at paragraph 60.*
10 *27 EHRR 296, 322, para 62.*
11 *(1998) 29 EHRR 30, 85, para 46.*

> 'there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the 'detention' of a person as a mental health patient will only be 'lawful' for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution.'

However the Judicial Committee said that the final four words showed that what mattered was that the place of detention was appropriate. This could be a hospital or some other institution. It did not follow that detention in the State hospital was inappropriate for the appellants, even although the purpose was for public safety rather than treatment.

The court also cited with approval *R (on the application of H) v Mental Health Review Tribunal, North and East London Region*.[12] In that case Lord Phillips MR expressed the view that once it was established that a person was of unsound mind the Convention did not link detention in hospital to treatability.

The court concluded that it was a matter for domestic law to determine whether deprivation of liberty in circumstances meeting the *Winterwerp* criteria should be possible only if the patient was treatable. Domestic law could also decide the place of detention, so long as this was a place which was suitable for the detention of persons of unsound mind. The fact that a patient's mental disorder was not susceptible to treatment did not mean, in Convention terms, that his or her continued detention in hospital was arbitrary or disproportionate.

Was the new legislation flawed because of its retrospective nature?

The appellants argued that the new legislation was flawed because it was applied to cases which were part of the existing legal process. However the court held that, although the Convention did 'not readily admit' retrospective legislation, there was no absolute prohibition. Such legislation must be treated 'with the greatest possible degree of circumspection'[13] and could be justified only if there were 'compelling grounds of general interest'.[14]

The court held that in this case there were such compelling grounds. The risk the Scottish Parliament faced, of the possibility of successful appeals by up to twelve patients with similar diagnoses, was real and imminent. The response was proportionate. The test imposed by the new legislation was a strict one. The sheriff had to be 'satisfied' that the conditions of public risk were met. There must be a risk to the public of 'serious' harm. The burden of proof was put on the Scottish Ministers.

The court said that, while there was a delicate balance to be drawn between the rights and liberties of people with mental disorders and the rights of the public to be free from the fear of assault or injury, it could not be right that public peace and safety should be subordinated to the rights of people whose disorders rendered them a threat to society. There was nothing in the Convention to suggest otherwise.

12 *[2001] EWCA Civ 415 (Court of Appeal) 28 March 2001. See commentary in Journal of Mental Health Law June 2001, p75.*

13 *See The National & Provincial Building Society v United Kingdom (1997) 25 EHRR 127, 181, at para 112.*

14 *Zielinski v France (2001) 31 EHRR 19, at para 57.*

Was the case of D different, in that if his appeal were successful he would be returned to prison?

D argued that it was inadequate drafting of the 1999 legislation which had applied s1 to patients subject to restriction directions as well as to those subject to restriction orders. He argued that the second *Winterwerp* test did not apply in his case, and thus the legislation breached his Convention rights. If he was right, the section should fall, as it would be outwith the legislative competence of the Parliament.

However the court held that the safety of the 'public' could apply either to the public at large or to a section of the public. If D were discharged to prison, he might put the safety of prison officers or other inmates at risk. The sheriff was, therefore, entitled to find that he posed a risk to the public. However it followed that if D's mental condition was not treatable and the Scottish Ministers were not satisfied it was necessary for him to be detained in hospital to protect a section of the public from serious harm, D should be transferred back to prison.

Commentary

The court was influenced in its decision by the decision of the European Court in *Koniarska v United Kingdom*.[15] The facts were similar. K suffered from a psychopathic disorder which could not be treated. The court said that her detention was needed, as there was a danger of her injuring herself or other persons. It held that there could be said to be both medical and social reasons for her detention and that this was not in breach of Article 5(1)(e).

While the House of Lords in *Reid* made it clear that patients with severe personality disorders could be subject to continued detention in hospital only if there was some possibility of treatment alleviating their disorder or at least preventing its deterioration, this is now no longer a requirement in Scotland. Long term containment is now possible and has been held not to be in breach of ECHR. This may have unfortunate repercussions for the management of such patients' cases.

Effect on conditional discharge

In *Reid* Lord Clyde pointed out that conditional discharge, a very useful rehabilitation tool, could not be available for a patient for whom 'treatment' (as defined in the 1984 Act) was unlikely to provide benefits. Conditional discharge is a possibility only if the sheriff is satisfied that it may be appropriate to recall the patient to hospital 'for further treatment'.[16] If no treatment is proposed, other than containment, an attempt at rehabilitation which failed would not allow doctors to recall the patient to hospital. There is thus a perverse disincentive to attempt such rehabilitation.

It was pointed out in *Reid* that a wide definition of 'medical treatment' is necessary to give the best possible likelihood of the conditional discharge option being available. Medical treatment is defined in s125(1) of the 1984 Act as including nursing, and care and training under medical supervision. While the term clearly covers medication or other psychiatric treatment designed to alleviate or to prevent a deterioration of the mental disorder, it can also cover other things which are done for either of those two purposes under medical supervision. This can include treatment, such as anger management, which does not treat the disorder itself but alleviates or prevents a deterioration of the symptoms of the disorder.

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15 App No 33670/96), 12 October 2000, (currently unreported).

16 Mental Health (Scotland) Act 1984, s64(1)(c).

Conditional discharge is regarded by forensic psychiatrists as a very useful rehabilitation tool. With the imposition of the 'public safety' test in Scotland, coupled with the implications of the *Reid* judgement, it may be less possible to use this for patients in Scotland with untreatable anti-social personality disorders. We will have to wait to see how this works out in practice.

Burden of proof

It is interesting to note that the 1999 Act specifically states that the burden of proof that a patient constitutes a serious danger to the public should rest with the Scottish Ministers. This pre-empted a possible ECHR challenge to the legislation, on the grounds that the patient was being required to prove his/her safety.[17]

However the remaining provisions of the section, which require the patient to satisfy the sheriff that s/he no longer requires treatment, could now be subject to challenge.

Legislative reform and the future of the provision

The 1999 Act was expressed to be a temporary measure, pending the reports of the Millan Committee's review of the Mental Health (Scotland) Act 1984 and the MacLean Committee's review of the sentencing and treatment of sexual and violent offenders, including offenders with personality disorder. Those Committees have now reported.

The Millan Committee, which had criticised the new legislation, recommended its repeal, in favour of new safeguards at the time of sentencing and the greater use of hospital directions,[18] which would ensure that convicted persons whose conditions later proved untreatable could be returned to prison to complete their sentences.

However neither Millan nor MacLean could make any recommendation to cover those patients who were subject to the existing legislation. They could not be transferred to prison (unless, like D, they were subject to a restriction direction), as they had not received a prison sentence at their trial.

MacLean recommended that crucial to the proper management of their case was a high standard of risk assessment to consider their suitability for transfer to less secure facilities. Millan, while recommending that the legislation be repealed for the future, accepted that there might be a need for some transitional provisions to retain the provisions of the 1999 Act for this very limited group of high-risk patients.

The Scottish Executive is thought unlikely to repeal the 1999 Act as part of its new Mental Health Bill, expected in the spring. In its policy statement *Renewing Mental Health Law* (October 2001), the Executive said that it could not make firm recommendations until the outcome of the Privy Council case was known.[19] However its inclination was to retain the public safety test if a patient continued to suffer from a mental disorder and to pose a serious risk to the public.

17 *See R (on the application of H) v Mental Health Review Tribunal, North and East London Region [2001] EWCA Civ 415 and commentary in Journal of Mental Health Law, June 2001, p75.*

18 *Under s.59 of the Criminal Procedure (Scotland) Act 1995, where a person is convicted on indictment in the High Court or the Sheriff Court of an offence punishable by imprisonment, the court may make a direction authorising his or her detention in hospital in addition to any sentence of imprisonment which it may impose. Equivalent provisions are found in s.45A of the Mental Health Act 1983. Millan conceded that hospital directions have not been widely used in Scotland, referring at paragraph 35 of chapter 26 of their report to a "handful". Hospital directions are considered by some to be particularly appropriate for offenders with personality disorders who may benefit from treatment in hospital. If treatment is found to be ineffective, the person can be returned to prison.*

19 *At para 64.*

Detention of a recently-discharged psychiatric patient

*David Hewitt**

R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg

Court of Appeal, 21 February 2001, The Master of the Rolls, Buxton LJ and Sedley LJ [2001] 3 WLR 588

Although it was unnecessary to show a change in circumstances following discharge by a MHRT, it would be difficult for an ASW to be satisfied that a fresh application for detention, made within days of detention, ought to be made

Introduction

This case was heard on the same day, and by the same judges, as *R v Camden & Islington Health Authority, ex parte K*.[1] It was an appeal against a decision of Burton J refusing judicial review of an application by the Second Respondent, an Approved Social Worker ('ASW'), for the Appellant to be detained in hospital under section 3 of the Mental Health Act 1983 ('MHA 1983'), and of a decision by the First Respondent, 'the managers' for the purposes of MHA 1983 section 145 of the hospital in which the Appellant consequently came to be detained, to accept that application.

In *Ex parte K*, the Master of the Rolls explained why the Court had decided to hear the two cases consecutively. He said:

> "In each case the Applicant was a patient compulsorily detained under the Mental Health Act 1983. In each case a Mental Health Review Tribunal … had ordered the discharge of the Applicant. In each case the Applicant sought judicial review on the same basis that the Tribunal's order had unlawfully been prevented from being implemented by, in the first case, omissions and, in the second case, acts of the relevant professionals. Each appeal turns on a different narrow, though important, point of statutory construction. Each appeal raises wider issues of general importance. Each appeal involves areas of law and practice in relation to mental health of some complexity."[2]

* *Solicitor, Hempsons; Mental Health Act Commissioner; Associate Lecturer, Faculty of Health, University of Central Lancashire. The views expressed in this paper are entirely the author's own*

1 *[2001] 3 WLR 553; see Dr Kristina Stern, Clinical Disagreement with a Deferred Conditional Discharge, Journal of Mental Health Law, June 2001, edition no 5, pp 86-92*

2 *Ibid, para 1*

Facts

On 15 March 2000, the Appellant was admitted to hospital under section 4 of the Mental Health Act 1983 ('MHA 1983'), and later that day detained under MHA 1983, section 2. On 31 March 2000, a Mental Health Review Tribunal ('MHRT') granted his application for discharge, which it deferred under MHA 1983, section 72(3) until 7 April 2000. It said as follows:

> "The Tribunal are satisfied that [there] may be evidence of mental illness, but do not believe that it is of a degree which justifies detention. Moreover, having heard [the patient's] own account of the episodes of alleged aggression, we do not consider that his own health or safety requires detention, nor do others need to be protected from him. In the light of our concern, however, that [the patient] may continue to suffer from a mental illness, it is appropriate for accommodation in the community to be found for him and a care plan be made including possible medication. The discharge has therefore been delayed to enable this to happen."

However, on 6 April 2000, the day before the deferred discharge would be realised, the Appellant was detained again, under MHA 1983, section 3. The application for detention was made by an ASW who had appeared before the MHRT on 31 March and opposed the Appellant's discharge; and one of the medical recommendations was provided by his Responsible Medical Officer, who had done the same. Neither of the medical recommendations referred to the MHRT decision or indicated that there had been any change in circumstances since it was made.

The Law

In *R v Secretary of State for the Home Department, ex parte K*,[3] McCullough J considered the circumstances in which the Home Secretary might recall to hospital a restricted patient to whom a MHRT had recently granted a conditional discharge. He concluded that such would not be lawful,

> " … unless meanwhile something has happened which justified the belief that a different view might now be taken about one of the factors on which his release had depended."

Although McCullough J's decision was upheld on appeal, the Court of Appeal did not comment upon this particular passage of his judgment.[4]

However, a contrary view was expressed in *R v Managers of South Western Hospital, ex parte M*.[5] On the day that a patient's deferred discharge was due to take effect, she was detained again, under MHA 1983, section 3. In upholding this subsequent detention, Laws J held that it was not necessary that there had been a change of circumstances since the MHRT heard her case, and he accepted as correct the following submission:

> "[MHA 1983,] section 13 imposes a duty on an approved social worker to make a section 3 application in the circumstances which that section specified; the duty is not abrogated, or qualified, in a case where there has been a recent tribunal decision directing discharge; if it were to be abrogated or qualified, section 13 would say so. That being the case, the hospital managers must be obliged to consider on its merits an application made by the approved social worker in pursuance of his or her duty, and the existence of a recent tribunal decision can no more fetter this obligation than it can the social worker's own express duty under section 13."[6]

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3 *[1990] 1 All ER 703*
4 *[1990] 3 All ER 562*
5 *[1993] QB 683*
6 *Ibid., p 694*

The learned judge found against the requirement for a 'change of circumstances'. He said:

> "Honest and responsible doctors and other experts will differ upon such questions as the significance of any apparent change in a patient's condition – even when there has been a change; to make the legality of a detention dependent upon issues of that sort would be to abandon any claim in this area to a reasonable degree of legal certainty and would, likely as not, put the experts involved in individual cases in an invidious if not impossible position."[7]

Finally, Laws J distinguished the decision of McCullough J in *Ex parte K*. He spoke of a "plain nexus" between the MHRT's power under MHA 1983, section 73(2) conditionally to discharge a restricted patient, and the Secretary of State's MHA 1983, section 42(3) power to recall such a patient to hospital, and he suggested that the legality of such recall may depend "upon the Secretary of State's having had regard to the basis of the earlier tribunal decision so as to avoid any frank inconsistency with it."[8] However, Laws J could find no such connection between the MHA 1983, section 3 regime and the functions of the MHRT under MHA 1983, sections 66 and 72(1). He therefore concluded:

> "I can see no basis for construing [MHA 1983] so as to produce the result that the duty and discretion of the approved social worker to make the section 3 application, and the function of the managers in considering it, are to any extent impliedly limited or abrogated by the existence of an earlier tribunal decision to discharge under section 72."[9]

Argument – the Appellant

The Appellant's principal contention was that, once a MHRT has ordered that a patient be discharged from detention, the MHA 1983 makes it unlawful for an ASW to apply to re-detain him, or for the 'managers' to accede to such an application, unless they can show that there has been a relevant change of circumstances. It was argued that this interpretation was necessary both to give effect to the scheme of the MHA 1983 and to fulfil the obligation to interpret it compatibly with the European Convention on Human Rights ('ECHR').[10] The Appellant argued that if the relevant professionals could procure the readmission of a discharged patient without a change in circumstances, this would rob the MHRT of its status as a 'court' and reduce it to a mere advisory body – a status, it was clear, that would offend against ECHR, Article 5(4).[11] Thus, the Appellant argued, the analysis by Laws J in *R v Managers of South Western Hospital, ex parte M* was incorrect: a 'change of circumstances' test would not introduce criteria that were either subjective or elastic, and in any case, such a test had been already approved, both in mental health[12] and in other fields of law.[13]

However, the Appellant conceded that it would not be necessary for those re-detaining a recently discharged patient to demonstrate a relevant change in circumstances where such would be impracticable or would involve excessive delay.

7 *Ibid., pp 694-695*

8 *Ibid., p 696*

9 *Ibid.*

10 *Human Rights Act 1998, s 3(1)*

11 *X v United Kingdom (1981) 4 EHRR 188*

12 *R v Home Secretary, ex parte Harry [1998] 1 WLR 1737, per Lightman J at p 1745*

13 *R v Secretary of State for the Home Department, ex parte Danaie [1988] 1 All ER 84 at p 92*

Argument – the Respondents

The Respondents contended that there had, in fact, been a relevant change in the Appellant's circumstances following his discharge by the MHRT. However, they also argued that the power to detain him again was not, in fact, contingent upon such a change.

The First Respondent, the detaining 'managers', accepted that there might be circumstances in which a patient's detention in hospital would be unlawful where a MHRT had already ordered his discharge. However, it contended that the existence of such an order was merely one factor that would have to be taken into account, and that the MHA 1983 required the professionals involved to consider the criteria contained in section 3(2)(a) and (c) in the light of the circumstances that then obtained. In support of this contention, the First Respondent cited the case of *St George's Healthcare NHS Trust v S*,[14] in which Judge LJ held that the provisions in MHA 1983, section 13:

> " … make clear that the [approved] social worker must exercise her own independent judgment on the basis of all the available material, including her interview and assessment of the 'patient', and personally make the appropriate decision."[15]

For the Second Respondent, the ASW, it was argued that the right to apply for the patient's further detention had not been abrogated by the MHRT discharge. In fact, it was suggested that MHA 1983, section 13 compelled such an application if the ASW was satisfied that it "ought to be made" and that it was "necessary and proper" in the circumstances then existing. Furthermore, when an ASW was contemplating making an application for a patient's further detention, it was unrealistic to require him to obtain and scrutinise all the material available to any MHRT that had recently discharged him. However, the Second Respondent conceded that, because an ASW was obliged to act rationally and in good faith, he would be obliged to have regard to an earlier MHRT decision of which he was aware. Where a patient had recently been discharged by a MHRT, a further detention application would only be valid if the ASW considered that the facts relevant to the admission criteria had changed. In the absence of such a change, it was likely that a decision to apply for detention would be irrational, although it might be justified by matters other than a change of circumstances, such as the discovery of information that had not been available to the MHRT.

Decision

The lead judgment was delivered by the Master of the Rolls, Lord Phillips. He accepted the contention on behalf of the Appellant that Laws J had erred, and that there was, in fact, a "cross-reference" between the MHA 1983, section 3 regime and the functions of the MHRT under MHA 1983, sections 66 and 72(1).[16] He noted the decision in *Reid v Secretary of State for Scotland*,[17] whose import, he stated, was that:

> "A finding by a Tribunal pursuant to section 72 that a patient must be discharged amounts, in terms, to a finding that one or more of the criteria necessary to found admission under section 2 or section 3 are not present".[18]

14 *[1998] 3 All ER 673*

15 *Ibid., at p 694*

16 *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg [2001] 3 WLR 588, para 17*

17 *[1999] 2 WLR 28*

18 *Para 18*

The Master of the Rolls held that in most cases, a "sensible period" would elapse between the patient's discharge by a MHRT and an application for his re-admission under the MHA 1983, and that the statutory requirement for a 'change of circumstances', for which the Appellant contended, would therefore be "neither necessary nor sensible".[19] Any new application would probably be prompted by behaviour that was a reaction to the patient's return to the community, which might constitute a relevant change of circumstances. In those circumstances:

> "To require the professionals involved to investigate and attempt a comparison between the two sets of circumstances in order to decide whether or not there has been a relevant change of circumstances would not be helpful or even meaningful."[20]

However, the position was very different "where an application for re-admission is made within days of a Tribunal's decision to discharge". Such a decision would imply a finding by the MHRT that the statutory criteria for the patient's detention were no longer met. In such circumstances, it would be the view of the MHRT that must prevail, particularly if the patient had not subsequently left hospital and been exposed to different environmental influences.[21] In such circumstances, the Master of the Rolls indicated:

> " … I do not see how an Approved Social Worker can properly be satisfied, as required by [MHA, 1983,] section 13, that 'an application ought to be made' unless aware of circumstances not known to the Tribunal which invalidate the decision of the Tribunal."[22]

The Master of the Rolls held that, in the absence of such circumstances, an application by an ASW for the patient's further detention would probably be "irrational", and be struck down upon judicial review. Whether such a result was appropriate in this case would depend upon factual evidence, which had not been rehearsed at first instance and upon which, therefore, it would not be appropriate for the Court of Appeal to express a view.[23] However, the Appellant had failed to establish that, as a matter of statutory interpretation, the MHA 1983 requires a change of circumstances before a patient who has been discharged by a MHRT may be re-detained under section 2 or section 3.[24] Therefore, his appeal would have to be dismissed.

Buxton LJ agreed with this conclusion, and with the analysis that had prompted it.

For Sedley LJ, the significance of this case was that, although the Appellant had succeeded in his challenge to the decision of Laws J in *Ex parte M*,[25] and had established as false the proposition that "there is no sense in which those concerned in a section 3 application are at any stage bound by an earlier tribunal decision", he had failed to re-introduce the 'change of circumstances' test in its place. The void was now to be filled with the test set out by the Master of the Rolls,[26] and an ASW would be bound to have regard to "a recent – and often a not so recent – order of a tribunal for discharge".[27] Such an order,

> " … if the circumstances have not appreciably changed, must be accorded very great weight if the second decision is not to be perceived as an illicit over-ruling of the first".[28]

19 *Para 30*

20 *Ibid.*

21 *Ibid., para 31*

22 *Ibid., para 32*

23 *Ibid., para 34*

24 *Ibid., para 33*

25 *see note 6, above*

26 *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg [2001] 3 WLR 588, para 38*

27 *Ibid., para 41*

28 *Ibid.*

Thus, although those involved in a subsequent application for detention would not be bound by a recent MHRT discharge, they may not lawfully ignore it, and

> " … must have due regard to such a decision for what it is: the ruling of a body with duties and powers analogous to those of a court, taken at an ascertainable date on ascertainable evidence. The second decision must be approached with an open mind, but it is not necessarily going to be written on a clean slate."[29]

All of which, Sedley LJ concluded, represented "a significant movement in the law as it has thus far been understood".[30]

Commentary

It is, perhaps, regrettable that the Master of the Rolls, and Sedley and Buxton LJJ did not address the central issue of this case in more detail and, in the case of the first two of them, that they did not agree a common definition of their terms.

It is clear that the considerable latitude afforded to practitioners by the judgment of Laws J in *R v Managers of South Western Hospital, ex parte M*[31] has been reduced, but it is doubtful whether the 'change of circumstances' test set out by McCullough J in *R v Secretary of State for the Home Department, ex parte K*[32] has been rejected quite so thoroughly as the Court seems to have supposed.

Certainly, it is unnecessary to demonstrate a change in circumstances where "a sensible period [has elapsed] between discharge and readmission",[33] but few difficulties were ever encountered in that regard. In any case, this judgment offers no guidance as to the course that is to be adopted where a patient has remained in hospital for such a "sensible period" following his discharge by a MHRT, and has not therefore been exposed to the sort of stressors that might be expected to bring about a change in his circumstances.

Difficulties have, of course, been encountered, in the words of the Master of the Rolls, "where an application for readmission is made within days of a Tribunal's decision to discharge".[34] However, it is unlikely that this judgment will do very much to alleviate them. As we have seen, Laws J believed that the 'change of circumstances' test would import "criteria which were subjective and elastic".[35] However, the test that the Master of the Rolls has sought to put in its place is no more objective and no more firm. He seeks to clarify the position "where an application is made *within days* of a Tribunal's decision to discharge",[36] but for precisely how many days after discharge will his stipulations apply? Sedley LJ simply compounds this uncertainty, because he speaks of the inhibiting effect of "a recent – and often a *not so recent* – order of a tribunal for discharge".[37] How much time will have to elapse before a "not so recent" discharge is no longer "recent" at all?

Even if these temporal confusions were to be resolved, there would still be doubt as to the factors that will permit an ASW to act, and those that will prohibit him from acting. The Master of the

29 *Ibid., para 42*
30 *Ibid, para 43*
31 *see note 6, above*
32 *see note 4, above*
33 *Lord Phillips, MR, at para 30*
34 *at para 31*
35 *Lord Phillips, MR, at para 15*
36 *at para 31; emphasis added*
37 *at para 41; emphasis added*

Rolls has stated that an application for further detention will not be irrational where the ASW who makes it is "aware of circumstances not known to the Tribunal which invalidate the decision of the Tribunal".[38] This is not so, he makes clear, because the law is to be interpreted as requiring a change of circumstances. Such was the conclusion of McCullough J in *R v Secretary of State for the Home Department, ex parte K*,[39] and it was erroneous. The requirement for knowledge of additional circumstances before a subsequent detention application may be made is to be inferred from MHA 1983, section 13. Without it, that application would have to be over-ruled because the ASW's belief that it "ought to be made" would be improper. Of course, by so finding, the Master of the Rolls explicitly joins issue with – and over-rules – Laws J in *R v Managers of South Western Hospital, ex parte* M.[40] However, he also alters the context in which the ASW's conduct is to be viewed. It will now fall to be judged, not according to principles of strict legal construction, but, because the new benchmark is the ASW's MHA 1983, section 13 duty, according to its more general 'necessity' or 'propriety'. As we shall see, this may make it more difficult for an ASW to secure the detention of a patient under MHA 1983, section 3 in the face of objections from the nearest relative.

It is also necessary to attempt to identify the sorts of circumstances knowledge of which will justify re-detention. The formulation put forward by the Master of the Rolls – "circumstances not known to the Tribunal which invalidate the decision of the Tribunal" – suggests that they are confined to matters of which the MHRT was unaware, even though they were in existence at the time of the initial hearing. However, logic dictates that the power to re-detain cannot be contingent only upon those circumstances, and that it will also be justified by *post*-hearing changes that are genuine and empirically-observed. If so, it is surely inaccurate to state, as Sedley LJ states, that the "change of circumstances criterion for readmission" has not been re-introduced.[41] The truth, surely, is that the 'change of circumstances' test has been re-asserted, albeit – because of the judgment of the Master of the Rolls – in a slightly enlarged form.

It is, perhaps, curious that Sedley LJ never seems to acknowledge this re-formulation; never seems to concede that after-acquired knowledge of pre-existing facts might in itself justify re-detention. His words are imprecise, and the concepts they convey vague. He speaks of the need to respect an existing MHRT discharge "if the circumstances have not appreciably changed",[42] and confirms this analysis by suggesting that "where readmission comes hard on the heels of discharge by the tribunal, there may … be little practical difference between what [the Appellant] has sought and what he has achieved".[43] These words do not seem significantly different to those of McCullough J, who, it will be remembered, in a judgment that has come to be seen as the highwater-mark of the 'change of circumstances' test, argued that it would be unlawful for the Home Secretary to recall a conditionally discharged restricted patient to hospital:

> " … unless meanwhile something has happened which justified the belief that a different view might now be taken about one of the factors on which his release had depended."[44]

38 *at para 32*

39 *see note 4, above*

40 *see note 6, above. The importance of this judgment is being gradually eroded – see, for example: Re S-C (Mental Patient: Habeas Corpus) [1996] 1 All ER 532, CA*

41 *at para 38*

42 *at para 41*

43 *at para 39*

44 *see note 4, above*

Thus, Sedley LJ's suggestion that the *Von Brandenburg* decision represents "a significant movement in the law as it has thus far been understood" may be sustainable only if one ignores his own contribution to it. It seems clear that in his view the current understanding of that law had been based upon the judgment of McCullough J.

The admittedly brief intervention of Buxton LJ is both curious and ambiguous. He states that he agrees with the Master of the Rolls "for the reason [sic] that he gives",[45] and must therefore be taken to concur in the purported rejection of the 'change of circumstances' test. It is surprising, then, to discover that he had recently concurred in a decision in which that test was specifically affirmed.

In *Smirek v Williams*,[46] a patient had been granted a delayed discharge by a MHRT upon his assurance that he would comply with his medication regime. When he failed so to comply, consideration was given to detaining him in hospital once again. Although his statutory 'nearest relative' objected to such a course, he was held to have done so unreasonably, and was therefore displaced by a county court judge.[47] The Court of Appeal upheld this displacement, notwithstanding the recent deferred discharge. However, Hale LJ held that:

> " … it cannot possibly be outside that band of reasonable decisions for the [nearest relative] to agree with, and rely upon, a recent decision of a Mental Health Review tribunal unless there has *since* been a change in the circumstances leading to that decision".[48]

Buxton LJ agreed with this view, stating:

> "The Tribunals' decision is to be respected unless there has been … some change in the circumstances of a significant kind which would enable the Tribunal to take a different view if the matter was referred to them again".[49]

If the test adumbrated by Buxton LJ (and Hale LJ) in *Smirek* is different to that of Phillips MR (and Sedley LJ) in *Von Brandenburg* – with which test, of course, Buxton LJ concurred – he has contradicted himself. If it is the same test, then Sedley LJ is wrong, Von Brandenburg does not represent a "significant movement in the law as it has thus far been understood", and the much-maligned 'change of circumstances' test still obtains.

Of course, following *Smirek v Williams*, if the circumstances obtaining at the time of the MHRT hearing had not changed subsequently, Hale LJ's test would permit the nearest relative's objection to be 'reasonable' – and would therefore render the nearest relative incapable of being displaced and a subsequent detention unsustainable – even where information had come to light suggesting that the circumstances upon which the discharge decision was based had been misunderstood. Yet, according to the judgment of Lord Phillips MR in *Von Brandenburg*, such after-acquired information may now be capable of justifying the patient's re-detention. Thus, where the proposed detention is under MHA 1983, section 3 – and therefore relies upon the absence of objection from the nearest relative – an ASW might find himself unable to secure the nearest relative's displacement where, following *Von Brandenburg*, an application for the patient's detention would be perfectly proper. This is the undesirable result of shifting the basis of analysis from strict principles of legal construction to the more general questions implied by MHA 1983, section 13: although an ASW may support an application for detention under MHA 1983, section 3 according

45 *at para 37*

46 *Unreported, Court of Appeal, 7 April 2000*

47 *Following an application under MHA 1983, s 29(1)*

48 *Ibid., at para 17; emphasis added*

49 *Ibid., at para 21*

to circumstances obtaining at the time of, but not mentioned at, a MHRT hearing, the reasonableness of a nearest relative's objection to such an application is only to be judged against subsequent events.

Conclusion

The decision of the Court of Appeal in *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg* will do little to assist practitioners faced with a MHRT decision that they find disappointing, and the more recently that decision was made, the greater will be their difficulty. If, despite the protestations of the Master of the Rolls, the 'change of circumstances' test still obtains, it is likely that it will be capable of being satisfied, not only by subsequent events, but also by those which, although they occurred before the hearing, were unknown to the MHRT and would have affected its decision to discharge. In that sense, this decision represents a development of the existing law. However, those requiring firm guidance as to precisely when, or in precisely what circumstances, a new application might be made to detain a patient recently discharged by a MHRT will search for it in vain. By impliedly creating different standards by which to judge the propriety of an ASW's application for a patient's detention and the 'reasonableness' of his nearest relative's refusal to consent to it, this judgment simply serves to compound the considerable confusion that is already experienced by many practitioners.

Detained patients and the right to refuse treatment

*Paul Bowen**

R (Wilkinson) v. Broadmoor RMO (1) Mental Health Act Commission (2) Secretary of State for Health (Interested party) [2001] EWCA Civ 1545

Court of Appeal (22nd October 2001) Simon Brown LJ, Brooke LJ and Hale LJ

A detained patient's right to refuse treatment to which he or she objects has been greatly strengthened by a recent decision of the Court of Appeal, applying the provisions of the Human Rights Act 1998, although in reaching its decision the Court of Appeal has posed as many questions for the future of the law in this area as it has answered.

Facts

Mr. W is a restricted patient who has been detained at Broadmoor hospital for the last 34 years under sections 37 and 41 Mental Health Act 1983. He has consistently been diagnosed as suffering from a paranoid personality disorder, classified as psychopathic disorder for the purposes of the MHA. In July 1999 he was placed under the care of a new responsible medical officer (RMO), Dr. H, who decided that Mr. W might benefit from a trial of anti-psychotic medication, either because he was suffering from a previously undiagnosed psychotic mental illness or because such medication would ease the more paranoid aspects of his personality disorder. Mr. W made his objection to such medication very clear. Because Mr. W had been subjected to a brief trial of medication in the past, to impose the medication compulsorily Dr. H was obliged by sections 63 and 58 MHA to obtain a supporting second opinion from a psychiatrist appointed by the Mental Health Act Commission (SOAD). A SOAD was appointed, examined Mr. W and agreed with Dr. H that a trial of anti-psychotic medication was 'within the bounds of acceptable medical practice'. On the same day Dr. H, aided by several nurses, forcibly injected Mr. W with anti-psychotic drugs. The procedure was repeated a fortnight later. On each occasion Mr. W struggled as he said he would. Before the procedure could be repeated a third time, Mr. W consulted Scott-Moncrieff, Harbour & Sinclair, solicitors, who obtained an emergency injunction in High Court proceedings for judicial review preventing Dr. H from imposing further such treatment by force.

Dr. H's decision to treat Mr. W was highly controversial. A number of psychiatrists who had examined Mr. W on previous occasions – including a previously appointed SOAD – had been of the opinion that anti-psychotic medication was not clinically justified. Most recently he had been examined by Dr. G, another consultant forensic psychiatrist, who disagreed with the diagnosis of mental illness and considered compulsory medication for Mr. W's personality disorder was not clinically justifiable; that, in any event, Mr. W had capacity to refuse such treatment; and, most seriously, Mr. W suffered from a heart condition that could prove fatal if further medication was imposed upon him by force.

Armed with this evidence, Mr. W's lawyers argued that further treatment would constitute a violation of Mr. W's rights under the European Convention on Human Rights, guaranteed by the

* *Barrister, Doughty Street Chambers, London. Counsel for the appellant/patient in the case under review*

Human Rights Act 1998 since its coming into force on 2 October 2000. The risk of a fatal heart attack meant that further treatment could violate his right to life, contrary to Article 2 of the Convention. Moreover, the imposition of medication against a detained patient's will was a violation of his right not to be subjected to inhuman and degrading treatment, contrary to Article 3; alternatively, if the level of suffering caused did not reach the necessary threshold for the purposes of an Article 3 violation, the treatment was certainly an unjustified interference with Mr. W's right to respect for his private life, safeguarded by Article 8 of the Convention. That was particularly so, it was argued, because Mr. W had capacity to refuse the treatment, and had refused, so to impose it upon him by force was to override his fundamental right to autonomy or self-determination. Last, Article 14 was also breached because no sufficient reason existed for distinguishing between those capacitated patients who are detained, who can be compulsorily treated, and those who are not, who cannot be treated against their will; even a detained prisoner, provided he is of sound mind, is permitted to refuse treatment, notwithstanding that refusal will lead to his death.

In order to establish this case, Mr. W's lawyers further argued that it would be necessary for the High Court to hear evidence from the relevant experts (Dr. H, Dr. G and the SOAD), a highly unusual procedure in judicial review proceedings. The High Court ruled that the case could be determined upon written evidence alone, since in judicial review proceedings the High Court's role is limited to reviewing the lawfulness of the decision in question, in particular whether it was *Wednesbury* 'reasonable'; it would not (nor could not) decide for itself on the merits of the case whether the treatment should be imposed or not. It was this ruling that Mr. W appealed to the Court of Appeal.

The Court of Appeal's ruling

The Court of Appeal overturned the decision of the High Court and ordered that the relevant experts should attend for cross-examination. In doing so it affirmed that the imposition of compulsory treatment can amount to inhuman and degrading treatment contrary to Article 3 of the Convention, particularly where a patient has capacity to refuse treatment. The Court cited with approval a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment published in August 2000, which states that '… every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention', other than in 'clearly and strictly defined exceptional circumstances'. In addition, the decision as to whether such treatment may amount to a violation of Articles 2, 3 or 8 was to be taken by the High Court on the merits of the case; the Court was not limited to its usual role in judicial review of deciding whether the decision under review was a reasonable one to reach. The Court could not exercise that function without hearing evidence from the relevant expert witnesses. Indeed, to adopt any other approach would violate Mr.W's right to a fair trial under Article 6 of the Convention.

In reaching its decision the Court of Appeal also considered the current guidance issued by the Mental Health Act Commission to SOADs to be wrong (and, therefore, unlawful, although the Court did not explicitly say so). Under section 58(3)(b) MHA a SOAD should only authorise compulsory treatment if he decides that 'having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition, the treatment should be given'. That, said the Court of Appeal, requires the SOAD to reach his own independent view of the desirability and

propriety of the treatment. However, the most recent MHAC guidance from April 1999 advises SOADs that they should authorise treatment if it is 'reasonable', even if it would not accord with the SOAD's own personal practice. That approach, said the Court of Appeal, was unduly deferential and was incorrect.

Comment

The Court of Appeal's decision is significant in a number of respects, as regards both the rights of detained mental patients and the procedure for bringing challenges under the Human Rights Act 1998.

The role of the SOAD

The most immediate, and possibly most far-reaching, aspect of the Court of Appeal's ruling is in relation to the proper function of the SOAD. The point was made during submissions that over 90% of all SOADs approve the treatment plan proposed by the RMO. The MHAC Biennial Report for 1997-99 discloses that for medication, in 85.3% of cases the SOAD makes no change to the RMO's proposed treatment plan; in 12.8% of cases there is a slight change; in only 1.9% of cases there is significant change. With ECT the figures are more stark: 92.9% no change, 6.4 % slight change, 0.7 % significant change. Reference was made to the passage in Brenda Hoggett's book, 'Mental Health Law', 4th ed., 1996, page 145 in which she had observed:

> 'This [that over 90% of all SOADs approve the treatment plan proposed by the RMO] is scarcely surprising as both the Commission and the Code of Practice advise that the SOAD's role is to decide whether the proposed treatment is 'reasonable in the light of the general consensus of appropriate treatment for such a condition' and not whether it is what he himself would have done in the circumstances' (ibid, p. 145).'

It was perhaps not surprising that Brenda Hoggett – now Hale LJ, and sitting on this appeal – agreed with the rest of the Court that the MHAC guidance to SOADs did not comply with section 58, which requires the SOAD to exercise his or her own independent professional judgment in deciding whether 'the treatment should be given'. It will be interesting to see if the rate of SOAD approvals will be correspondingly lower in future.

The significance of capacity

The decision of the Court of Appeal goes some way to affording competent detained mental patients the same rights of autonomy and self-determination as other competent members of society enjoy. As will be seen, however, there remains room for further development of this fundamental right.

At common law the right of a capacitated individual to integrity of the person and to self-determination are fundamental human rights (*Airedale NHS Trust v Bland* [1993] A.C. 1, per Lord Goff at 864). Medical treatment is *always* an interference with the first of these rights, the right to integrity of the person, constituting a criminal and tortious assault and battery in the absence of some lawful justification for it (*Re. F* [1990] 2 AC 1, 73-74). The right of autonomy dictates that a capable person's consent to treatment provides lawful justification; by the same token, it also dictates that a capable person's *refusal* to consent must be respected, however drastic the

consequences for the individual concerned. In *Robb v Home Secretary* [1995] Fam. 127, Thorpe J. granted declarations on the application of the Home Office that it was lawful for prison staff and physicians to respect a prisoner's refusal of all nutrition and medical treatment. The prisoner was on hunger-strike. He had been assessed by five psychiatrists and a psychologist, all of whom had agreed he had capacity to consent, and therefore to refuse consent. The judge agreed the following statement of principle (130C-D):

> '… the principle of self-determination requires that respect must be given to the wishes of the patient. So that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so.'

By contrast, for patients detained under the Mental Health Act 1983 the right of autonomy has been modified, so that a capacitated person's refusal to accept treatment may be overridden. Indeed, under this statutory scheme a capacitated refusal has no greater significance than the refusal of a patient who lacks capacity.

Section 63 authorises compulsory treatment provided it is 'treatment for the mental disorder from which [the patient] is suffering' and is 'given by or under the direction of the responsible medical officer'. Where section 58 applies (namely for ECT and medication given for a period of more than 3 months), a capacitated refusal may be overridden by the RMO provided a SOAD has certified that 'having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given' (section 58(3)(b)). Neither provision requires either the RMO or SOAD to take into account, or give particular weight to, the fact the patient has capacity.

It was Mr. W's contention that this statutory scheme failed to protect his Convention rights, notably under Articles 3 and 8. Compulsory treatment that was not a therapeutic necessity was both degrading and an invasion of privacy, whether a patient had capacity or not (considering *Herczegfalvy v Austria* (1992) 15 EHRR 437). Moreover, even if medically justified, compulsory treatment of a capacitated patient was degrading and an invasion of privacy. The capacitated patient's right of autonomy should prevail over the doctor, other than where treatment was necessary for the protection of others. Mr. W's lawyers could not cite any directly relevant Convention authority in support of the latter proposition, but relied upon a growing national and international consensus to that effect, including the 2000 report by the European Committee for the Prevention of Torture and Inhuman or degrading treatment, referred to above, which provided, at §41:

> 'Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorizing treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.'

The Court of Appeal all agreed that treatment that was not a medical necessity would amount to a breach of Articles 3 and 8. They were not, however, unanimous as to the significance of a patient having capacity to refuse consent. Simon Brown LJ considered the fact the patient had capacity to be highly significant, if not determinative. He said that 'the precise equivalence between

incompetent patients and competent but non-consenting patients seems to me increasingly hard to justify' (§29), and went on 'If in truth this appellant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subject to it'. Hale LJ adopted a more cautious approach, saying this (§80):

> 'I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non- consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify. Whether the criteria for non-consensual treatment of the capacitated should be limited to treatment which is for their own safety (as opposed to their health) is a difficult and complex question. Mr Bowen tried to persuade us that there was a developing consensus to that effect. There are indeed indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment. But we have not yet reached the point where it is an accepted norm that detained patients who fulfil the Re MB criteria for capacity can only be treated against their will for the protection of others or for their own safety.'

Brooke LJ did not deal with the issue in his judgment and, accordingly, both Simon Brown LJ and Hale LJ's views are, strictly, *obiter*, and the question whether the Convention prohibits compulsory treatment of capacitated patients except in exceptional circumstances remains for determination on another day. The Court of Appeal's decision goes a long way towards establishing the proposition that a competent patient's right to autonomy is protected by Articles 3 and 8. In this writer's view it is strongly arguable that sections 63 and 58 Mental Health Act 1983 are incompatible with detained patients' Article 3 and 8 rights in that they permit the compulsory treatment of a non-consenting capacitated patient without qualification, rather than limiting such treatment to 'clearly and strictly defined exceptional circumstances'. This would have great significance for the Government's current proposals for reform of the Mental Health Act 1983. A suitable case engaging the point directly will have to find its way before the Courts before such a principle can be established, although it is unlikely to be this case (see postscript, below).

The proper approach in judicial review: merits review, proportionality or 'Super-Wednesbury'?

One key aspect of the Court of Appeal's ruling has an application that goes far beyond the field of mental health law. Having accepted that compulsory treatment that was not a therapeutic necessity would violate Mr. W's Convention rights under Articles 3 and 8 (and, in the light of Mr. W's heart condition, also raised issues under Article 2), the Court had to decide what approach it should take on judicial review in deciding whether the proposed treatment would, in fact, breach Mr. W's Convention rights: was the proper approach the traditional public law *Wednesbury*-type review of the RMO and SOAD's decision, the private law *Bolam/ Bolitho* test of negligence, or did the Human Rights Act 1998 demand a more intense scrutiny than either test allowed? It was argued on Mr. W's behalf that the Court had to reach its own conclusion on the merits as to whether the proposed treatment would violate Mr. W's Convention rights, while the Respondents argued that a 'super-Wednesbury' approach was sufficient, relying upon the decision of Maurice Kay J to that effect in *R v Collins & Ashworth Hospital ex p Brady* [2000] Lloyds LR Med 355.[1]

1 *See case comentry in Journal of Mental Health Law December 2000 page 180*

The question whether the Human Rights Act 1998 requires the Administrative Court to adopt a more obviously primary decision-making role, at odds with its more traditional review function, has proved to be one of the most intractable thrown up by the Human Rights Act 1998. Successive rulings over the last two years have oscillated between adopting a more intensive 'proportionality' test and the more traditional, deferential *Wednesbury* approach. The House of Lords in *R (Daly) v Home Secretary* [2001] 2 W.L.R. 1622, had recently endorsed the former approach, disapproving the earlier Court of Appeal decision of *R (Mahmood) v Home Secretary* [2001] 1 W.L.R. 840 in which the more deferential test had been preferred. By insisting that the proper approach was to decide the relevant issues on the merits, the Court of Appeal in *Wilkinson* not only disapproved the approach taken in *Brady* but took *Daly* a step further: even in *Daly* Lord Steyn had emphasised that the Human Rights Act did not entail a shift to 'merits' review. However, Lord Steyn had also made clear that 'in law, context is everything', and given the importance of the rights at stake in *Wilkinson* and the fact the Mental Health Act provides no independent judicial scrutiny of treatment decisions, the only way the Court could ensure that Mr. W's Convention rights were protected was by reaching its own conclusions on the merits. It was also relevant that the Courts were already familiar with making their own assessment of the merits of medical treatment both in clinical negligence cases and, more importantly, on applications for 'best interests' declarations in the Family Division.

Simon Brown LJ also considered that a merits-type review was required by virtue of Article 6, distinguishing the recent decision of the House of Lords in *Alconbury* [2001] 2 All ER 929. He noted that the 'Super-Wednesbury' test had been rejected as insufficient for the purposes of Article 13 by the European Court of Human Rights in *Smith & Grady v United Kingdom* (1999) 29 EHRR 493 and commented 'it is difficult to see how it could meet the requirements of article 6 in the present case'.

Wilkinson therefore represents the high water-mark of the Courts' willingness in public law cases, where necessary, to substitute their own decisions for those of the public authority charged with the primary decision-making role by Parliament when they believe them to be incompatible with Convention rights. Again, it remains to be seen whether *Wilkinson* will in future be confined to its own particular facts, or whether it represents a further shift towards 'merits' review of public law decisions engaging human rights issues.

The need for cross-examination

Cross-examination is unusual in traditional judicial review proceedings. The general principle is that cross-examination will be permitted 'where the justice of the case so requires' (*O'Reilly v Mackman* [1983] 2 AC 237, 282D-283A), but such orders are rare, primarily because the traditional role of the Administrative Court is to review the lawfulness of decisions rather than make decisions on the merits, so it does not make primary findings of fact itself. Once the Court of Appeal had decided that the Human Rights Act 1998 compelled it to reach its own conclusions on the merits it followed that it would have to hear all the relevant evidence live, and to allow cross-examination of the experts. Plainly cross-examination will become more commonplace where Convention rights are in issue.

Appropriate forum for challenging treatment decisions

In their respective judgments the members of the Court of Appeal spent some time considering whether judicial review was the appropriate remedy in respect of disputed treatment decisions. On this issue the Court was not as one.

Both Simon Brown and Hale LJJ considered that Mr. W could have challenged the proposed treatment plan by an ordinary private law action in tort for assault (as opposed to negligence) against Broadmoor Hospital. Although section 139(1) of the Mental Health Act 1983 would protect individual doctors against a claim for assault (but not negligence), by section 139(4) the hospital itself would be vicariously liable for any assault by its employees. In any event, Mr. W could bring a claim in the High Court under section 7 Human Rights Act 1998 claiming that the Hospital proposed to act in a manner incompatible with his Convention rights. There would be no requirement for permission to proceed with such a claim.

Brooke LJ disagreed. In his opinion the hospital could not be vicariously liable on a claim for assault because of the statutory protection conferred by section 139(1) MHA. Unless a patient could establish bad faith or negligence (in which case section 139 did not apply), the only remedy to a decision to treat was by an application for judicial review. Moreover, although a claim under section 7 Human Rights Act 1998 could be brought in a private law action in the High Court, Family Division, for a 'best interests' declaration (considering *R (P & Q) v. Home Secretary* [2001] EWCA 1151, §120), such a claim would be caught by section 139(2) MHA and would require the leave of the High Court.

Little argument was addressed to the Court on the question as to whether alternative proceedings would be more suitable than judicial review. In future it is advisable that any such claim be brought by way of judicial review *and* a best interests declaration *and* a private law action in tort for assault. The latter remedies can all be sought in judicial review proceedings, so only one set of proceedings needs to be issued.

Such proceedings are not to be issued other than in the most exceptional circumstances, however. Simon Brown LJ struck the following cautionary note:

> 'I would, however, express the confident hope that challenges of this nature, so far from becoming commonplace, will be rare indeed and will arise only in the most exceptional circumstances. Dr G and others like him will surely hesitate long before being prepared to join issue both with those who have the express statutory responsibility for treating the patient (RMOs) and also, in s.58 cases like the present, those specifically appointed to safeguard the patient's interests (SOADs). SOADs, I should note, are experienced and entirely independent specialists drawn from a panel appointed by the Mental Health Act Commission (MHAC) which was directed by the Secretary of State to discharge on his behalf that function under Part IV of the Act. Courts, after all, are likely to pay very particular regard to the views held by those specifically charged with the patient's care and well-being. I do not go so far as to say that a *Bolam-Bolitho* approach will be taken to their evidence – i.e. that the treatment which they propose will be sanctioned by the court provided only that a respected body of medical opinion would approve it. Certainly, however, courts will not be astute to overrule a treatment plan decided upon by the RMO and certified by a SOAD following consultation with two other persons.'

Post-script

The case is unlikely to go any further as Broadmoor Hospital, the Mental Health Act Commission and the Secretary of State for Health (who applied to be joined to the proceedings as an interested party) have decided not to appeal the decision to the House of Lords. Moreover, the original SOAD authorisation has lapsed, so if Dr. H wishes to impose further such treatment he will need to obtain the agreement of another SOAD – this time applying the less 'deferential' approach demanded by the Court of Appeal. Nevertheless, the decision provides a solid platform to build upon for future challenges in this developing area of law.

Inhuman and degrading treatment and punishment of mentally ill prisoner

*Anne Stanesby**

Keenan v The United Kingdom. TLR 3/4/0I
European Court of Human Rights. Application no. 27229/95
(Judgement 3 April 2001).

The Facts

The applicant, Susan Keenan, is the mother of Mark Keenan who, on 15 May 1993, at the age of 28, hung himself whilst serving a sentence of 4 months imprisonment at HM Prison Exeter.

From the age of 21, Mark Keenan had received intermittent treatment in the form of anti-psychotic medication. Diagnoses of borderline personality disorder and paranoid schizophrenia were made and it was noted in his medical records that he had a history of frequent episodes of deliberate self-harm. He was committed to prison on 1st April 1993, following a 4 month sentence for an offence of assault on his girlfriend, and he was placed in the health care centre of the prison. The senior prison medical officer, Dr. Keith, consulted a Dr. Roberts, the consultant who had been treating Mark Keenan prior to his admission, and the latter concurred with the medication which Dr. Keith had prescribed. Attempts to transfer Mark Keenan to the ordinary prison were unsuccessful due to a consequent deterioration in his condition and the exhibition of behaviour suggesting suicidal tendencies.

On 29 April Mark Keenan was assessed by the prison's visiting psychiatrist, a Dr. Rowe who had treated him previously. He prescribed a change in medication. On 30 April Mark Keenan's mental state deteriorated and a Dr Seale, who had no psychiatric training, prescribed a return to the previous medication. At 6 p.m. that day Mark Keenan assaulted two hospital officers, one seriously. He was then placed in an unfurnished cell within the health care centre and put on a 15 minute watch.

On 1 May a Dr Bickerton, who had six months training in psychiatry as a senior house officer, certified him fit for adjudication in respect of the assault and fit for placement in the segregation unit within the prison's punishment block. The same day the prison's deputy governor ordered Mark Keenan to be placed in segregation in the punishment block under Prison Rule 43. (This provides the power to segregate where it appears desirable for the maintenance of good order or discipline or in the prisoner's own interests). Following a temporary return to the health care centre on a 15 minute watch, Mark Keenan was transferred back to the punishment block on 3 May . The last medical note before his suicide on 15 May was made on 4 May commenting only in respect of medication given. A Dr. Bradley who had no psychiatric training visited him over this time and later did not recall that there had been any cause for concern. However the occurrence

* *Solicitor; Locum Legal Network Co-ordinator MIND (London)*

book for the segregation unit did in fact indicate that some problems had occurred , the last entry being made on 10 May.

On 14 May Dr Bradley, (like Dr. Bickerton on 1 May), assessed Mark Keenan to be fit for adjudication in respect of the assault on the two prison officers on 30 April and for cellular confinement. On the same day Mark Keenan was found guilty of assault and sentenced by the deputy governor to 28 additional days in prison together with 7 days' loss of association and exclusion from work in segregation in the punishment block. At that point Mark Keenan had had only nine days left to serve before his expected release date. At 6.35p.m. on 15 May, Mark Keenan was found by two prison officers hanging from the bars of his cell and he was later pronounced dead.

On 25 August 1993 an Inquest jury recorded a verdict of death by misadventure (and found that the cause of the death was asphyxiation by hanging).

Mark Keenan's mother obtained limited legal aid on 17 November 1993 for a potential action against the Home Office in respect of the treatment of her son and the conditions of his detention. On 14 October 1994 counsel advised that an action in negligence under the Law Reform (Miscellaneous Provisions) Act 1934 would not succeed because as at the time of his death Mark Keenan could not have shown that his mental condition had worsened as a result of his confinement. The mother could not claim bereavement damages under the Fatal Accidents Act 1976 because Mark Keenan was over the age of 18 and he left no dependants who could make a claim under that Act. Legal aid was therefore withdrawn and the applicant could not proceed further in England.

Relevant Domestic Law and Practice

A. Prison Regulations.

The Prison Act 1952 and the Prison Rules 1964 provide for the appointment of prison medical officers and detail the latter's duties. Rule 18 provides inter alia that the medical officer shall inform the governor if he suspects any prisoner of having suicidal intentions, and the prisoner shall be placed under special observation. Pursuant to sections 47 and 48 of the Mental Health Act 1983, any prisoner suffering from a serious mental illness may be transferred to a hospital for detention and treatment.

Rule 43 under which Mark Keenan was segregated provides that the prisoner must be removed from segregation, if so advised, on medical grounds and Rule 53(2) provides that no punishment in cellular confinement is to be imposed unless a medical officer has certified that the prisoner was in a sufficiently fit state of health. Rule 17 provides that medical staff have a discretion to request a psychiatric opinion but there is no legal requirement for the prison to be staffed by a medical officer with psychiatric qualifications.

Remedies available to prisoners at that time consisted of a prison complaint (which would have taken an estimated 6 weeks), an application for Judicial Review (which would not have been available quickly enough to assist in this case) or an action for negligence, assault and misfeasance in public office for damages if the conditions of confinement had caused injury.

B. Inquest proceedings.

Under the Coroners Act 1988 following the death of a prisoner an inquest must be held with a jury. However the primary function of the inquest is to ascertain who the deceased was, and where, when and how he came by his death, not to frame a verdict so as to appear to determine any question of the criminal or civil liability of a named person.

C. Proceedings for injury and death caused by negligence

See above.

The Hearing Before the ECtHR

Article 2 of the Convention.

The applicant complained that the prison authorities through their treatment of her son prior to his suicide failed to protect his right to life contrary to Article 2. Article 2(1) states:

> "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

The Court said in its judgement that the State should take

> "appropriate steps to safeguard the lives of those within its jurisdiction…but the scope of this positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities."

It was common ground that Mark Keenan was mentally ill. There was a dispute as to whether he was schizophrenic. If he was schizophrenic, the risk of him committing suicide was well known. The Court observed that there was no formal diagnosis of schizophrenia provided by a psychiatric doctor who treated Mark Keenan in the material before it. But the Court was satisfied that the prison authorities knew that Mark Keenan's mental state was such that he posed a potential risk to his own life. The immediacy of the risk varied. Therefore it could not be concluded that he was at immediate risk throughout his period of detention. The variability of his condition, however, required that he be monitored carefully in case of sudden deterioration. The question arose - did the prison authorities do all that was reasonably expected of them?

The Court found that on the whole the authorities made a reasonable response to Mark Keenan's conduct, placing him in hospital care and under watch when he evinced suicidal tendencies. He was subject to daily medical supervision by the prison doctors, who on two occasions had consulted external psychiatrists with knowledge of him. The prison doctors, who could have required his removal from segregation at any time, found him fit for segregation. There was no reason to alert the authorities on 15 May that he was in a disturbed state of mind rendering an attempt at suicide likely. In these circumstances it was not apparent that the authorities omitted any step which should have reasonably been taken, such as, for example a 15 minute watch. The Court concluded that there had been no violation of Article 2 of the Convention in this case.

Article 3.

The applicant complained that her son was subjected to inhuman and/or degrading treatment by the prison authorities in May 1993, contrary to Article 3 of the Convention which provides as follows:

" No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

The Court said that ill-treatment must attain a minimum level of severity if it is to fall with the scope of Article 3. The assessment of this minimum is relative and depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.[1] In considering whether a punishment is " degrading " the Court will consider whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3.[2] This has also been described as involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance.[3] It was relevant in this case to recall that the authorities are under an obligation to protect the health of persons deprived of liberty.[4]

The lack of appropriate medical treatment may also amount to treatment contrary to Article 3.[5] The Court pointed out that:

> "In particular, the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment."[6]

Although it was not possible to distinguish with any certainty to what extent Mark Keenan's symptoms during this time, or indeed his death, resulted from the conditions of his detention imposed by the authorities, the Court considered this difficulty was not determinative of the issue as to whether Article 3 had been breached. The Court observed that:

> "Treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects."

The Court was struck by the lack of medical notes (there being no entries from 5 May to 15 May). There was also no subsequent referral to a psychiatrist after the visit on 29th April by the visiting psychiatrist Dr. Rowe. When Mark Keenan's condition deteriorated, a prison doctor, unqualified in psychiatry, reverted to previous medication without reference to the psychiatrist who had recommended the change and the assault on two prison officers followed. Though Mark Keenan asked the prison doctor to point out to the governor at the adjudication that the assault occurred

1 *See, for example, the Tekin v. Turkey judgment of 9 June 1998, Reports 1998-1V, 52.*

2 *See e.g. the Ranine v. Finland judgment of 16 December 1997, Reports 1997-V111, p. 2821-22, 55*

3 *Ireland v. the United Kingdom judgment of 18 January 1978, Series A no. 25, p. 66, 167.*

4 *Hurtado v. Switzerland,Comm. Report 8 July 1993, Series A no. 280, p !6 79.*

5 *See Ilhan v. Turkey (GC) no. 22277/93, ECHR 2000-V11 87*

6 *See e.g. the Herczegfalvy v. Austria judgment of 24 September 1992, Series A no. 244 82; the Aerts v. Belguim judgment of 30 July 1998, Reports 1998-V, p. 1966, 66*

after a change in his medication, there was no reference to a psychiatrist for advice either as to his future treatment or his fitness for adjudication and punishment. Paragraph 115 of the judgement states:

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

Accordingly the Court found a violation of Article 3.

Article 13.

The applicant claimed that there had been no effective remedies in respect of her complaints, invoking Article 13 which reads:

> " Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity. "

The Court said that the remedy must be " effective" - in practice as well as in law. If it were the case, as had been suggested, that Mark Keenan was not in a fit mental state to make use of any available remedy, this would point, not to the absence of any need for recourse but, on the contrary, to the need for the automatic review of an adjudication such as the present one. Mark Keenan had been punished in circumstances disclosing a breach of Article 3, and he had the right under Article 13 to a remedy which would have quashed that punishment before it had either been executed or come to an end. There had therefore been a breach of Article 13 in this respect.

It was common ground that the inquest did not provide a remedy for determining the liability of the authorities for any alleged mistreatment or for providing compensation. The Court considered that, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of possible remedies. The Court concluded that the applicant should have been able to apply for compensation both for her non-pecuniary damage and for that suffered by her son before his death.

No effective remedy was available to the applicant in the circumstances of the present case which would have established where responsibility lay for the death of Mark Keenan. In the Court's view this was an essential element of a remedy under Article 13 for a bereaved parent. Accordingly there had been a breach of Article 13 of the Convention.

Article 41.

Article 41 states as follows:

> " If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

The Court found that Mark Keenan must be regarded as having suffered significant stress, anxiety and feelings of insecurity resulting from the disciplinary punishment prior to his death. The applicant, his mother, must also be regarded as having suffered anguish and distress from the circumstances of his detention and her inability to pursue an effective avenue of redress. Making an assessment on an equitable basis and bearing in mind that this was a case of suicide and not deliberate torture, the Court awarded for non-pecuniary damages the sum of £7,000 in respect of Mark Keenan to be held by the applicant for his estate, and £3,000 to the applicant in her personal capacity. £ 21,000 was awarded for costs and expenses.

Comment.

The Article 2 decision.

The Court concluded that although the prison authorities did know that there was a risk of suicide, this risk did not exist at all times, that on the whole the Authorities made a reasonable response and that therefore Article 2 had not been violated.

However was the risk of suicide really as " variable " as the Court has found? There appears to have been some doubt as to whether Mark Keenan did or did not suffer from schizophrenia. But there are references in the judgment to clear diagnoses of schizophrenia being made on occasions prior to Mark Keenan's admission to prison. Dr. Maden, a consultant psychiatrist instructed by the applicant, noted in his report of 17 August 1994, that Mark Keenan was also given a diagnosis of personality disorder and substance abuse at various times, however, "none of the psychiatrists who saw him appear to have doubted the additional diagnosis of schizophrenia and all continued his treatment with anti-psychotic medication". He continued: " Self harm, suicide and violence are recognised complications of schizophrenia". He was of the opinion that Mark Keenan did indeed suffer from paranoid schizophrenia.

Dr. Reveley, a second consultant psychiatrist instructed by the applicant, supported this view and added: " In my opinion he was recognisably in one of the very highest risk groups".

It appears to the writer that in fact there was strong evidence that Mark Keenan did suffer from schizophrenia and that the risk of serious self-harm was surely constantly present, especially after the adjudication. That being so, surely his treatment or the lack of it must be held responsible for the eventual tragic outcome? Was the punishment block the right environment for someone in his condition? As Dr. Reveley pointed out: "An acceptable level of care in the management of Mark Keenan's condition during this period would have included a close monitoring of the medication as regards dose and side effects; a close monitoring of his mental state as regards symptomatology, and as regards any increased risk of self-harm or suicide. There is no evidence that adequate monitoring of this type was performed during the last thirteen days of his life."

Did the prison authorities do all that could have been reasonably expected of them to prevent the risk of a suicide occurring? Surely the answer to this question must be 'no', since they could have monitored Mark Keenan's condition more closely, they could have transferred him back to the hospital block and they could have considered a transfer to a hospital pursuant to the relevant provisions in the Mental Health Act 1983.

The Article 3 decision.

This is most welcome and highlights a fact that has been known for some time, i.e. that the treatment of mentally ill prisoners in our country is seriously inadequate.[7] Surely there should be a legal requirement that someone on the prison medical staff should have a reasonable length of experience in psychiatry or, if this is not possible, then it should be mandatory that frequent referrals to outside experts should take place. The criticisms regarding poor record keeping and the question marks that must hang over the assessments that Mark Keenan was fit for adjudication and placement in the segregation unit, serve further to illustrate this point.

The imposition of additional punishment is also rightly criticised. Was it fair to punish someone who might only have struck out because his medication was wrong? Did anyone represent him at the adjudication hearing? There is no mention in the judgement to suggest that anyone did. Did anyone think about the issue of Mark Keenan's mental state and vulnerability and of his undoubted need for assistance by someone at the hearing? What about litigation friends or advocates for prisoners?

Articles 13 and 41

The limitations in our inquest procedure are well known. A fundamental review into the inquest system is currently being conducted.[8] The writer hopes that the lessons of this case will not be lost on those conducting that review. In some cases it is now possible to obtain publicly funded representation at inquests more easily than it was,[9] and the rules regarding disclosure of documents have been improved to some extent.[10] However these reforms do not really go far enough and the basic problem with such hearings remains. The bereaved do need to know not just how a person died but if possible who, if anyone, can be held legally responsible for causing that death.

As well as it not being possible for an inquest to award compensation in our country, if a person over the age of 18 dies prematurely, even in clear circumstances indicating negligence, that person's parents have little redress under our current legislation, the Fatal Accidents Act 1976. In this case only funeral expenses could have been claimed by the applicant-mother, and as this

7 *See (1) Care or Custody? Mentally Disordered Offenders in the Criminal Justice System, Judith M. Laing , Oxford University Press 1999; (2) Mentally Disordered Offenders, edited by David Webb and Robert Harris, Routledge 1999; (3) HM Prison healthcare needs assessment, Harty et al, Journal of Forensic Psychiatry, Vol. 12, December 2001, pp 639–645.*

8 *See Annual Report 2001 of the organisation Inquest, and details of the terms of reference reported in LAG Bulletin May 2001, p 5.*

9 *See Law Society Gazette 9th November 2001, report on page 63.*

10 *See article by Danny Friedman "The Human Rights Act and the inquest process - Part 2". Page 16 LAG Bulletin December 2001*

deceased left no dependants there was no one who could pursue a claim for loss of dependency. To dismiss the pain of a bereaved parent in such a way leaves our laws open to criticism. The award of damages to Mark Keenan's mother is to be welcomed as is the award made in respect of the mental suffering which Mark Keenan himself underwent.

Discrimination in Employment on Account of Mental Illness

*Elisabeth Griffiths**

Leonard v Southern Derbyshire Chamber of Commerce [2001] IRLR 19

Employment Appeal Tribunal (10 October 2000). Nelson J, Mrs R A Vickers, Mr G H Wright MBE

Headnote

When considering whether or not the applicant's mental impairment[1] falls within the definition of disability in section 1 of the Disability Discrimination Act 1995 the tribunal have to consider whether that impairment has a substantial adverse effect on the applicant's ability to carry out normal day-to-day activities. In using the Guidance issued by the Secretary of State to assist in deciding such questions the employment tribunal should not balance out the effect of the impairment on those normal day-to-day activities strictly in terms of what the applicant can do against what she cannot do. This the Employment Appeal Tribunal held was inappropriate as an ability to catch a ball did not diminish an inability to negotiate pavement edges safely or diminish the fatiguing effect of carrying out most normal day-to-day activities. Instead, the tribunal should concentrate on what the applicant cannot do or can only do with difficulty.

The Employment Appeal Tribunal allowed an appeal by Jill Leonard from the decision of the Nottingham Employment Tribunal that held that she was not disabled within the meaning of the Act because her clinical depression did not, in their opinion, have a substantial adverse effect on her ability to carry out the normal day-to-day activities specified in the Act. Ms Leonard's discrimination claim against Southern Derbyshire Chamber of Commerce was remitted back to a differently constituted employment tribunal to hear the substantive merits of the case.

The Facts

Jill Leonard was employed by Southern Derbyshire Chamber of Commerce as a claims management advisor from January 1993 until her dismissal in October 1998. She was dismissed on the grounds of capability having been off work since March 1998 with clinical depression. She presented a complaint to the Nottingham Employment Tribunal claiming she had been unlawfully discriminated on the grounds of her disability contrary to the Disability Discrimination Act 1995.

The Tribunal heard evidence from Ms Leonard and considered an agreed medical report from Ms Leonard's own GP. The Tribunal concluded that she was suffering from clinical depression. She had been on anti-depressants since 1995 and started to suffer from panic attacks after being raped in November 1997. She told the Tribunal that she coped with the panic attacks by focusing on her work, although she felt that she had to put in extra hours to deal with the levels of work involved and even then she made mistakes. Unfortunately she felt that she was no longer able to continue

* *Solicitor; Senior Lecturer, School of Law, University of Northumbria.*

1 *It should be noted that the term 'Mental impairment' as used in the Disability Discrimination Act 1995 does not bear the same meaning as the Mental Health Act 1983 section 1(2) definition.*

with her work and she stopped working on 4 March 1998. She had not worked since. Her medication was increased during the months that followed but started to be reduced in February/March 1999. Ms Leonard had also received counselling.

The Tribunal accepted that she had a mental impairment within the meaning of section 1 of the Disability Discrimination Act and that the impairment was long term in its effect. However the Tribunal concluded that her mental impairment did not have a substantial effect on her ability to carry out normal day-to-day activities and therefore she was not disabled within the meaning of the Act.

Jill Leonard appealed to the Employment Appeal Tribunal arguing that the Tribunal had failed to evaluate the evidence properly. She argued that the Tribunal had misapplied the Guidance issued by the Secretary of State for Education and Employment in July 1996 when considering what matters ought to be taken into account when considering questions relating to the definition of disability.

The Law

The meaning of "disability" and "disabled person" are central to the protection afforded to disabled people under the Act. Only those people who fall squarely within the defined terms are protected under the Act. Part I (sections 1-3) of the Act and Schedules 1 and 2 set out the basic definitions of "disability" and "disabled person" for the purposes of the Act. The definition in section 1 is further supplemented by regulations[2] and Guidance issued by the Secretary of State under section 3 of the Act.[3] An employment tribunal or court is required to take account of the Guidance when considering issues relating to Part I of the Act, however the Guidance itself does not impose any legal obligations.

Section 1 (1) of the Act defines a person with a "disability" as someone who has "a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry our normal day-to-day activities."

Therefore not only must the tribunal recognise the impairment, but the tribunal must also determine whether or not the impairment substantially and adversely effects the person's ability to carry out '*normal day-to-day activities*'. The impairment in question must have an adverse effect on one or more of the following (as listed in Schedule 1, paragraph 4 of the Act):

- mobility
- ability to lift, carry or move ordinary objects
- manual dexterity
- physical co-ordination
- continence
- speech, hearing or eye-sight
- memory or ability to concentrate, learn or understand
- perception of the risk of physical danger

2 *Disability Discrimination (Meaning of Disability) Regulations 1996, SI 1996/1455, came into force 30 July 1996.*

3 *'Guidance on matters to be taken into account in determining questions relating to the definition of disability' DfEE (1996, London : HMSO), came into force 31 July 1996.*

This is an exhaustive list. In deciding whether or not the impairment has a disabling effect on these normal day-to-day activities the Guidance suggests that tribunals should consider the time taken to carry out an activity, the way in which an activity is carried out and the cumulative effects of the impairment.

The leading case on the use of the Guidance and the tribunal's approach to the question of whether or not a person has a disability within the meaning of the Act came in *Goodwin v Patent Office [1999] IRLR 4, EAT*. This case was reviewed by Simon Foster of MIND in the February 1999 edition of this journal. The Employment Appeal Tribunal in *Goodwin* held that the Tribunal should focus their attention on things that the applicant either cannot do or can only do with difficulty, rather than on the things the person can do.

The Decision

The decision of the Employment Appeal Tribunal in *Leonard* confirmed this approach and took the arguments in *Goodwin* further. The main focus of the Employment Tribunal hearing had been the effect of Ms Leonard's clinical depression on her ability to carry out normal day-to-day activities. This they did by reference to the Guidance taking each of the headings in Schedule 1 Para 4 (1) of the Act in turn. Mr Justice Nelson, giving the judgement of the Employment Appeal Tribunal, held that the Tribunal came to the wrong conclusion on the facts before them. They had misdirected themselves in the way in which to apply the Guidance. The Tribunal had wrongly decided that Ms Leonard was not disabled within the meaning of the Act as they found that her clinical depression did not have a substantial adverse effect on her ability to carry out normal day-to-day activities.

Mr Justice Nelson confirmed that the focus of attention for the Tribunal should have been on what the applicant could not do or could only do with difficulty, rather than on what she could do. The approach they took led them to wrongly evaluate the evidence before them. The EAT found that in taking this approach the Tribunal seemed to be assessing Ms Leonard's overall physical co-ordination by balancing out examples of what she could not do against what she said she could do.

The Tribunal took each of the headings in Schedule 1 paragraph 4(1) of the Act in turn, whether relevant to a mental impairment or not, and referred to the examples given in the Guidance. For example, under the heading *physical co-ordination* the tribunal noted that 'whilst she might trip over payment edges, she could eat and drink and catch a ball'. The EAT questioned whether or not Ms Leonard's ability to catch a ball was relevant to her condition. They felt this highlighted the over emphasis placed on the examples given in the Guidance by the Tribunal which were meant only to be illustrative rather than exhaustive.

It was not disputed by Mr Justice Nelson in his judgement that it was appropriate in this particular case for the Tribunal to use the Guidance to determine the question of disability before them. However, the Tribunal should not have used the Guidance as a checklist going though each of the examples given and balancing what Ms Leonard could do against what she could not. It was held by the EAT that the Tribunal relied too heavily on the Guidance and therefore took the wrong approach when dealing with the evidence before them. They failed to evaluate her evidence properly as they failed to focus on what Ms Leonard could not do or could only do with difficulty. For example, 'her ability to catch a ball did not diminish her inability to negotiate pavement edges safely. Her ability to write a cheque or remember her children's or work colleagues' names did not diminish her loss of concentration and day-to-day memory retention…'.

The EAT confirmed that it was important that a tribunal should make an overall assessment of whether the adverse effect of the impairment on a normal day-to-day activity, was substantial. However the focus must be on what the applicant cannot do or can only do with difficulty. It was wrong to conclude that because there were many things the applicant could do then the adverse effect of her mental impairment could not be substantial. It could be suggested that this is particularly important in cases of mental impairment.

The EAT also held that when considering a case of mental impairment the tribunal should always consider paragraphs C6 and C7 of the Guidance. The EAT stressed that a Tribunal should take into account the indirect effect of the impairment on the activities listed in Schedule 1 paragraph 4(1) of the Act not just the direct effect. So although a person with a mental impairment may be able to perform a given task, the time it takes them to do it or the fatiguing effect of carrying out the activity may mean that they could not repeat the task over a sustained period of time.[4] Paragraph C7 of the Guidance specifically states that 'where a person has a mental illness such as depression account should be taken of whether, although that person has the physical ability to perform a task, he or she is, in practice, unable to sustain an activity over a reasonable period'.

In Jill Leonard's case the effect of fatigue and tiredness were noted by the Tribunal under various headings from Schedule 1 Paragraph 4(1) of the Act. It was found by the Tribunal that Ms Leonard tired easily, slept for long periods and was shattered after two or three days of normal living. This the EAT held was clearly evidence of her inability to sustain an activity over a reasonable period. The EAT concluded that the Tribunal did not properly take into account the 'overarching effects of tiredness' on Ms Leonard's capacities to carry out normal day-to-day activities. If they had focused on this and on her inability to carry out certain activities, concluded the EAT, then they would have found that her walking was restricted, as was her ability to drive only short distances. Her co-ordination was affected so she might have tripped easily, her ability to lift or carry was affected as was her eyesight because objects blurred easily. With the effect the impairment had on her ability to concentrate and on her memory it was difficult to see how the tribunal could have concluded on the evidence before them that her mental impairment did not have a substantial adverse effect on her ability to carry out normal day-to-day activities.

The EAT were conclusive therefore in finding that the Tribunal had reached the wrong decision on the facts before them and they had misdirected themselves in the manner in which to use and apply the Guidance.

The Employment Tribunal had also considered the fact that Ms Leonard had performed well in front of them during the hearing. They found her to be alert and clear in the presentation of her evidence before them. The EAT held that a person's performance at a hearing should not be regarded as a reliable guide as to whether or not the applicant can perform normal day-to-day activities. The EAT felt that the Tribunal did not recognise this and should not have taken this into account in making their assessment of the effect of the applicant's mental impairment.

The EAT also held that the Employment Tribunal were wrong to conclude on the evidence before them that Ms Leonard, 'notwithstanding the problems she was facing, was still managing to cope'. The EAT felt that she was clearly no longer coping as she had not been able to work since March 1998. So whatever coping strategies she had developed had broken down. Paragraph A8 of the Guidance recognises the situation when coping strategies may break down so that the effects may well continue to occur. This possibility the EAT held, must always be taken into account by a

4 *See paragraph C6 of the Guidance.*

Tribunal considering the effects of an impairment and a person's ability to manage the effects of that impairment.

The EAT concluded that Ms Leonard was disabled within the meaning of the Act and remitted the case back to the Employment Tribunal to decide whether or not she had been discriminated against.

Comment

It is evident from this case that when a Tribunal is considering the question of disability they must focus on what a person with an impairment cannot do or can only do with difficulty. It would be wrong to use the Guidance as a checklist of normal day-to-day activities that create a number of tests which a person with a physical or mental impairment must pass. It is also wrong to undertake some sort of balancing act between what the person with an impairment can do against what he or she cannot. The issue in Ms Leonard's case was whether or not her clinical depression had a substantial adverse effect on her ability to carry out normal day-to-day activities. Just because there were still many things that she could do it did not diminish the substantial adverse effect her mental impairment was having in other significant areas of her life. It was also highly relevant to consider the overwhelming tiredness Ms Leonard felt when she carried out some of the activities set out in Schedule 1 paragraph 4(1) of the Act.

This case also highlights once again that the Act is mainly concerned with physical impairments. The list of activities set out in Schedule 1 paragraph 4(1) of the Act are very much centred on physical impairments. As some commentators have already noted,[5] this case also emphasises the fact that the examples given in the Guidance which are directly relevant to mental impairment – 'memory or ability to concentrate, learn or understand' and 'perception of the risk of physical danger' – demand a fairly high level of mental impairment or even learning difficulty.

The problem for Ms Leonard was that the Tribunal considered all the 'physical' day-to-day activities when assessing the disabling effects of her clinical depression. Many of these activities she coped with well even though they made her very tired and many of which were irrelevant to her case. When the Tribunal evaluated her evidence and mental impairment in relation to those activities in Schedule 1 relevant to someone with a mental impairment, the disabling effects of her impairment on those activities did not outweigh what she had already demonstrated she could do. Therefore it is important for advisers when considering the disabling effects of a mental impairment to consider firstly whether or not they have a case where the Guidance should be referred to at all. Secondly, their approach should be to concentrate on what the person cannot do or can only do with difficulty not on what they can do. Specific reference should also always be made to paragraphs C6 and C7 of the Guidance where the effort required by someone with a mental illness to carry out a specific task and sustain that activity over a reasonable period of time should always be considered.

Once again this case highlights the difficulty faced by the person with a mental illness proving that they are disabled within in the meaning of the Act. Many people with clinically well recognised mental illnesses are able to perform every day tasks with the assistance of medication or because

5 *eg. "The DDA after four years: Part I – the meaning of disability" Equal Opportunities Review No. 94 pp. 12–19 (November – December 2000)*

they have developed coping strategies for dealing with their every day lives. However when it comes to performing work activities over a reasonably sustained period of time they may be faced with difficulties. Whilst *Leonard* takes the arguments in *Goodwin* further, those with a mental impairment claiming to be disabled within the meaning of the Act, cannot escape the narrow definition of disability in the Act. The definition is concerned with the disabling effects of the impairment on normal day-to-day activities not work activities. Therefore a person coping with a mental illness, although able to function on a day-to-day basis, may not be protected against discrimination in the workplace because of an inability to perform or cope with the tasks required of them by their employer. Once the protection Act is lost, employers of course do not have to consider making any reasonable adjustments to accommodate the employee with the mental illness. In short, the mentally ill person may continue to face a struggle in establishing that he or she is 'disabled' within the meaning of the Act.

Book Reviews

Mental Health Act Manual by Richard Jones (7th edition)

Published by Sweet and Maxwell (2001) £49.00

*Anthony Harbour & Robert Brown**

Introduction

Those of us who regularly teach Approved Social Workers will be familiar with the critical rejoinder to a disputed point "well, Richard Jones says...". The tenor of this remark is that if the teacher were to then disagree with the ASW trainee, the teacher must be wrong. Owning the Manual is a compulsory requirement for those that practise in the mental health law field. There are many copies in circulation, some unread and in pristine condition, but many so obsessively colour coded they resemble an on-line encyclopaedia. The value of the Manual is well established and the new edition will be much sought after. This review will nonetheless offer a critique.

The Manual has grown. The first edition (published in 1985) was 2 centimetres thick while the current seventh edition is over 4 centimetres thick. The new edition contains an update on recent litigation in the mental health law field and in particular includes a section on the Human Rights Act. The Manual will continue to grow, with a new Mental Health Act a dark cloud on the practitioner's horizon and threatening a major downpour of new law to be dealt with.

It is worth going back to the origins of the Manual, which are to be found in a slim purple book published in 1983 in the "Current Law Statutes Annotated Reprints" series. This was an annotated version of the Mental Health Act together with its schedules. The seventh edition remains at heart an annotated statute with all the strengths and weaknesses that go with that format. For those who understand the shape and purpose of the legislation then the analysis of the minutiae of statutory wording and accompanying commentaries will be clear and helpful. To the beginner the format may be more problematic.

Indexing is far from clear and the non-lawyer user may have difficulties with legal terms. This is significant, as many social workers, doctors and other mental health professionals will use the Manual. By way of example, "De facto" is undefined. The reader searches through the index for a definition and although there is one reference to the term (Paragraph 1-048) that paragraph in fact contains no reference whatsoever to de facto detention. "De facto" detention is covered in Paragraph 1-1048 but there is no specific definition within the discussion. Perhaps a glossary of terms would be helpful together with a simpler and more accurate indexing system based on page numbers. Unlike the encyclopaedia[1] on which it is based, the Manual is not in loose-leaf format where a paragraph-based indexing system makes more sense.

Similarly a non-lawyer wanting to understand the *Bournewood* case will not be helped at all by the

* *Robert Brown qualified as an ASW and is now self-employed. Anthony Harbour is a solicitor. They both regularly train ASWs and other health and social service professionals on mental health law.*

index. If they know to refer to the Table of Cases they will be referred to eleven disparate references in the case index, and only then if they understand that the case is referred to as *R. v Bournewood Community and Mental Health NHS Trust ex parte L; sub nom: L, Re.* Lawyers may understand this form of referencing, but as so many of the readers of the Manual are non-lawyers more thought and care should be given to signposting the reader.

There is a dearth of up to date texts in the area. Hoggett's incisive book[2] is still required reading. This is so particularly for lawyers given the fact that the author is now a senior judge frequently making decisions in the mental health law field. The latest edition was however published in 1996 and is now showing its age. Eldergill's[3] extraordinary, and sometimes brilliant, book appears from its title to concentrate on Mental Health Review Tribunals. In fact the book covers many areas of mental health law and is therefore probably the most effective companion to the Manual. The once reliable Gostin and Fennell[4] on Mental Health Review Tribunals was published in 1992. The most up to date book which is available is Mental Health Law Policy and Practice by Peter Bartlett and Ralph Sandland.[5] This book bravely integrates areas that have been avoided in the past, such as capacity and service provision. It is however less a practitioner's manual and more an academic text.

So the Manual fills the field. Does the seventh edition fulfil its objectives, which are to provide material and analysis to assist practitioners? To attempt to answer that question some key areas in the text have been analysed.

Children and mental health law.

The Manual includes a new section entitled "The medical treatment of children." The analysis of common law principles is much as one would expect - fair, balanced and comprehensive. Our criticism is the absence of analysis of the difficult interface between common law and statute and in particular the impact of the Convention on this area of law. A person or body with parental responsibility can override the refusal of a capacitous child of whatever age to accept treatment.[6] How does this principle translate into psychiatric practice? Can, or should, children refusing psychiatric treatment be detained outside a statutory framework? Surely this type of detention will violate the child's Convention Rights under Articles 5 and 8, notwithstanding Nielsen?[7] In this case the European Court held that no deprivation of liberty had occurred when the mother of a 12 year old boy consented to his admission to a psychiatric hospital against his wishes.[8] How do those assessing the competent child for Mental Health Act detention reconcile the common law principles identified by Jones with the requirement contained in section 3 that that detention will only be justified if the treatment cannot be provided unless the child is detained?[9]

Although Jones has come up with a thoroughly workmanlike section on the Human Rights Act his

1 *The Encyclopedia of Social Services and Child Care Law edited by Richard Jones and published by Sweet and Maxwell since 1993.*

2 *Hoggett B. (1996) Mental Health Law 4th edition (London Sweet & Maxwell)*

3 *Eldergill E. (1997) Mental Health Review Tribunals – Law and Practice (London Sweet & Maxwell)*

4 *Gostin L. and Fennell P. (1992) Mental health: Tribunal Procedure 2nd edition (London: Longman)*

5 *Bartlett P. and Sandland R. (2000) Mental Health Law Policy and Practice (London:Blackstone Press)*

6 *Mental Health Act Manual page 274*

7 *Nielsen v Denmark (1989) 11 E.H.R.R. 175*

8 *Mental Health Act Manual page 429*

9 *Mental Health Act 1983 section 3(2)(c)*

analysis of the way the Convention impacts on mental health law has not always been effectively interwoven in the text. This is evidenced by his treatment of the common law principles relating to children where Jones does not deal with the conflict between these principles and the children's Convention rights in as comprehensive a way as the subject requires.

There is an ongoing debate amongst those who work in Child and Adolescent Mental Health Service as to whether the Mental Health Act should be used to compel the child patient on the grounds that the child's human rights are best protected by the use of the Act. Because the text is not integrated – moving from Part IV to section 131 to Chapter 31 of the Code of Practice (also included in the Manual) – is not a route that the uninitiated would necessarily know to follow, Jones's contribution to this discussion is hidden.

Mental Health Review Tribunals.

The Manual just missed the Remedial Order and so this heavily annotated edition will have to be even more obsessively overwritten. The commentary on the application of the statutory tests in section 72(1) and 73(1) is now out of date.[10]

The MHRT Rules are included in the Manual. Jones's analysis of the detail in the Rules is sometimes disappointing, if only because his views would be interesting. For instance what are the tribunal responsibilities when an automatically referred patient does not want to participate in the tribunal process? (Rule 22(4) requires the tribunal "to hear and take evidence from the applicant [and] the patient (where he is not the applicant)…") He does however helpfully analyse other problem areas. He identifies the Article 5 rights of the patient as on occasion competing against the Article 8 rights of the relative, and identifies this potential for conflict as a factor that the tribunal should take into account in deciding on disclosure under Rule 12(2).[11] ASWs and other specialist social workers are increasingly being propelled into the tribunal arena and up-to-date guidance in these areas is essential.

Section 2 or 3?

Jones provides a carefully argued analysis justifying the routine use of section 2 which departs from current Code of Practice guidance that section 3 should be used for the patient well-known to mental health services.

The decision to use a section 2 rather than a section 3 is unlikely to be subject to judicial review and so authoritative sounding guidance is important. There are however alternative views which need to be taken into consideration. In reality the use of a section 2 to assess a patient well-known to services may slow down the creation of a treatment plan and inhibit the process of after care planning. This may be for no other reason, as Jones tartly comments in his text, on the "widely held, but totally erroneous view expressed by some practitioners that treatment under Part IV cannot be given to patients detained under section 2"[12]

10 *Mental Health Act Manual commencing page 317*

11 *Mental Health Act Manual page 578 in the footnote to Rule 12(2)*

12 *Mental Health Act Manual page 22*

So Jones departs from Code guidance and offers an alternative route. The difficulty with this approach is that the readers of the Manual do not always distinguish between "the law" and Jones's opinion. Another example is where Jones comments that "using section 2 as the initial detaining power will enable the approved social worker to avoid the difficult situation that can occur when an application under section 3 is met by an unexpected objection by the patient's nearest relative."[13] This contrasts with the Code which states, in its analysis of the merits of section 2 against section 3, "decisions should not be influenced by the possibility that...(d) a patient's nearest relative objects to admission under section 3."[14]

Jones is being used as a judge, a parliamentary draftsperson and an arbiter for good practice. This is unfortunate, as his views should be developed in the context of debate and discussion rather than being cast in tablets of stone. This may reflect the fact that Jones is too modest and does not recognise that his guidance in key areas (consulting the nearest relative would be another good example) is being adopted as the gospel by practitioners.

The appointment of approved social workers

Although the Manual still includes the Code of Practice and various rules and regulations, it no longer contains any government circulars. This is understandable in terms of the pressure on space. Clearly people need to be able to carry the Manual rather than having to use a trolley. However, the absence of the short circular LAC (86) 15 which covers the appointment of ASWs is unfortunate. Jones[15] draws on the circular when forming the view that ASWs must have a contract of employment with the relevant local authority (thereby casting doubt on the legality of the use of locum ASWs employed by agencies). Circulars are not always easily accessible to practitioners and their inclusion in earlier editions of the Manual was helpful.

Conclusions

The Manual is an invaluable text for many mental health professionals. However, we have identified two major problems with this latest edition. Firstly the layout coupled with imperfect indexing mean that the Manual's format does not always allow for a coherent analysis of key problem areas. Improvements in indexing and a glossary of terms might help. Secondly the structure of annotated statute and supporting documents is now being used for purposes for which it was never originally intended.

Jones has an encyclopaedic knowledge of mental health law. His notes on both the statute and its related text reflect that knowledge. He is a "safe pair of hands" and provides a mass of material and analysis to assist practitioners. There is however a danger of his text being used for purposes that were not always intended. Perhaps an introduction on how to use the Manual together with cautionary caveats around some of his views would make the Manual an even more indispensable text to the practitioner.

13 *Mental Health Act Manual page 23*

14 *Mental Health Act Manual page 620 containing paragraph 5(4) of the Code*

15 *Mental Health Act Manual page 463*

The Mental Health Act Commission, Ninth Biennial Report, 1999–2001

Published by The Stationery Office (2001) £16.50

*Anselm Eldergill**

The Mental Health Act Commission's Ninth Biennial Report was laid before Parliament on 3 December 2001.

The report covers the Commission's activities during the two-year period from 1 April 1999 to 31 March 2001.

The Commission was established in 1983, as a Special Health Authority, following publication of the Boynton Report.[1] The report recommended the creation of such a Commission, the functions of which 'might include ... the independent investigation of more serious complaints (from whatever source).'

The Commission's statutory functions are much more limited than those exercisable by the Commissions in Scotland and Northern Ireland. Its main functions are to keep under review the way in which the powers and duties set out in the Mental Health Act 1983 are exercised in relation to people who are liable to detention; to arrange for persons to visit and interview detained patients; to investigate complaints within its jurisdiction; to perform the Secretary of State's consent to treatment functions under Part IV of the Act; and to review any high security hospital decisions to withhold post.

Positives

The biennial report is well presented and well written, and much of the credit here must go to Mat Kinton, one of the Commission's stars. It is a compassionate document, and gives an excellent summary of where mental health services stand. These features reflect the kindness, commitment and skill of its members, and of those who helped them to prepare the report. There is an excellent passage on the effects of the safety and security directions on patient care in the high security hospitals, and useful information about the Commission's survey of all ECT facilities in England and Wales. The output data published in the report provides incontrovertible evidence of the tremendous workload of under-paid but dedicated Commissioners.

* *Solicitor; Visiting Professor, School of Law, University of Northumbria; Former Mental Health Act Commissioner; Author 'Mental Health Review Tribunals - Law and Practice' (Sweet and Maxwell 1997).*

1 *Report of the Rampton Hospital Management Review Team, Chair Sir John Boynton, October 1980.*

MHAC ACTIVITY (1999/00–2000/01)

Patient visiting

Private meetings with document checks	13,042
Individual patients met informally	8,656
Individual patients met in group situations	895
Documents checked but patient not seen	11,285

Second-opinion (SOAD) activity

Medication only second opinions	11,794
ECT only second opinions	4,274
Medication and ECT second opinions	189
Neurosurgery (section 57) consent procedure (all granted)	9

Complaints activity

New complaints received 'and followed up'	747
Formal complaints 'raised or reviewed' during visits (none of which led to a full investigation by the Commissioner)	244

Patient deaths

Deaths of detained patients notified to the Commission	881
Number of inquests attended 127 Patient correspondence (section 134) Number of MHAC reviews/appeals (five appeals granted, and one in part)	15

Source: Mental Health Act Commission, Ninth Biennial Report, 1999–2001. Data represents two years' activity.

Reservations

Some of the main reservations, which necessarily are personal to some extent, concern the format of the report (specifically, the failure to concentrate on the statutory remit and the making of 75 recommendations); the failure to set out a clear position on the White Paper which defends legal standards and the need for effective safeguards; the continued failure to monitor the way in which Mental Health Review Tribunals use their powers; the amount of complaints activity; and a lack of outcome data.

Format of the report

According to the introduction, the Commission 'believes that its focus must be on the implementation of the Act and the patients whose lives are affected by it.'

The main chapters are a distillation of the reports made after each Commission visit during the two years, and also take account of the work of Second Opinion Appointed Doctors. The object 'is to provide an overview that shows how the implementation of the Act is affecting the people it aims to protect; helps the facilities visited to improve their own practice; draws attention to general areas of poor practice; and advises on possible remedies for some of the issues raised.'

According to the report, the way in which the main themes are addressed has enabled the Commission,

> 'to make specific recommendations on the actions that we believe are needed to ensure that the Act is properly implemented. The Commission is not an inspectoral body, but our very wide knowledge of individual patient experiences under the various provisions of the Act puts us in a unique position to comment on implementation. Most of the comments and recommendations relate to the way in which any legislation needs to be implemented and will therefore be as relevant to new legislation as they are to the 1983 Act. We therefore make no apology for using this report to take the logical step from review to recommendation….
>
> Chapter 9 sets out the recommendations from Chapters 2–7, commenting on the wider mental health environment in which they are set. By ordering the recommendations in relation to those with the primary responsibility for implementing them, it is intended to help everyone concerned to work together to achieve higher levels of compliance with the Act and with any new legislation. We hope that the way in which we have been reviewing and changing our own practices during the past two years will make a significant contribution to better implementation of the Act.
>
> In the present transitional period between the 1983 Act and the new legislation … , the Mental Health Act Commission believes that it can best serve the interests of detained patients by highlighting in this report those aspects of the 1983 Act which our work suggests most need attention, both now and in future legislation. This is why, although previous Biennial Reports are valuable reference documents because they range widely over issues of interpretation of the Act, (e.g. summarising changes in legislation, significant law cases and differences of view between academics, lawyers and practitioners) we decided that this report should be a more narrowly focused, action-orientated document. We hope that the Secretary of State … will find it a useful contribution to ongoing consideration of how best to meet the interests of patients subject to compulsion under mental health law.'

The report contains 75 recommendations in all. Contrary to what is said in the introduction, the majority (almost 60%) do not concern the MHAC's statutory functions or the Mental Health Act. Most of them cannot therefore be said to be 'intended to help everyone concerned to work together to achieve higher levels of compliance with the Act and with any new legislation.' The Commission has always spent a lot of its time performing functions that Parliament did not establish it to perform, and this statement reads as a rationalization of its activity, possibly brought about by an increasing awareness of departmental anxiety about this fact.

Although the Commission 'makes no apology' for using the report 'to take the logical step from review to recommendation,' and claims that it is a 'more narrowly focused, action-orientated document,' there is a difference between recommendation and action. A good homicide inquiry

report may set out a manageable number of agreed actions specific to the service that has been reviewed, and an agreed timetable. In general, a few targeted recommendations contribute most of the service improvements there are to be had in the short to medium term, and the rest are either ignored or simply generate a lot of bureaucracy to little effect. Here, the Commission has generated 75 recommendations that require services to devise at least 98 staff-intensive, often bureaucratic, steps, many of which have nothing to do with the 1983 Act:

Undertake full review, keep under constant review, review practice, review systems, review policies, etc.	19
Develop protocols, standards and protocols, etc.	14
Audit, audit and analyse, adequate audit tools and flagging systems, monitoring and flagging systems, audit and review	13
Routine monitoring, regular monitoring, monitoring meetings, etc.	10
Exhortations to action	8
Devise standard forms	5
Collect data sets	4
Devise systems and policies	4
Make arrangements	4
Issue guidelines/ guidance	3
Consider, give consideration to, etc	2
Devise plan, action plan	2
Assess patient response	2
Commission research	1
Make new regulations	1
Undertake consultations	1
Develop programme	1
Develop service agreement	1
Develop new strategy	1
Have discussions	1
Provide explanations	1
Total	98

Assuming for a moment that this is a proper function for a Mental Health Act Commission, does this help professionals to provide better mental health services? The disadvantages are obvious: too many quality-assurance commissions, too much top-down guidance, too many codes of practice, confusion on the ground about what to prioritise, a feeling amongst staff that they are drowning in policies and procedures, the impossibility of meeting all targets, demoralisation, and so on. There is a general weariness about the endless raft of guidance and recommendations, and professionals opening their post may be seen 'binning' what they regard as the NHS equivalent of the innovations catalogue inserted in daily newspapers. This cannot be desirable, and it is perhaps illustrative that not a single person booked to attend a national one-day event arranged to publicise and discuss the recommendations made in the biennial report.

Some objection may also be taken to the content or quality of the recommendations. A number of them are frankly banal, some will be thought condescending by front-line staff, and others offer no help at all. For example,

> 'All those involved with the care and treatment of detained patients should encourage multi-disciplinary liaison to develop protocols which balance the need for confidentiality against the need to share essential information.

The making of so many recommendations in a biennial report seems to be a bad mistake, the more so because so many concern matters outside the Commission's remit.

White Paper on the Mental Health Act

For reasons that are not entirely clear, although they may be political, the White Paper on the Mental Health Act is not discussed in the report.[2] The Chairman does, however, express two opinions about the government's proposals in her foreword.

Firstly, that the Commission 'warmly welcomes the Government's proposals to reform mental health legislation and to strengthen the safeguards available to those who are compelled to accept care and treatment for mental disorder.'

This is rather unnerving coming as it does from the head of that public body dedicated to upholding legal standards for people who are detained under mental health legislation. Why should the Commission welcome those proposals in a White Paper that erode many important safeguards against the poor or inappropriate use of compulsion:

- The absence of any definition of mental disorder means that who is dealt with as a mentally disordered person will no longer be subject to any legal restrictions.
- People may be detained in psychiatric units or subjected to compulsion in the community even if they have no conduct disorder, even if their condition is untreatable, and even if the only reason for intervening is dependency on alcohol or drugs, provided that professionals think this is in their 'best interests'.
- Those detained under the 28-day order will not have an effective appeal, because if they ask for a hearing its purpose will be to determine whether a six-month order is required.

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

- The police may enter private homes without a warrant if advised by a mental health professional that a person within is in need of immediate care or control.
- There will no longer be a statutory duty to provide after-care to former involuntary patients, and they will, it seems, have no right to free after-care.
- Patients will no longer be visited by an independent Mental Health Commission, with power to investigate complaints of abuse or non-compliance with the law.
- Independent hospital managers, Community Health Councils, and independent inquiries will be abolished.
- Hospitals and homes will regulate and investigate themselves, subject only to a quality assurance visit from the Commission for Health Improvement every four years.
- An involuntary patient will no longer have a right to a binding, independent, second opinion on ECT or long-term medication.
- Non-medical involvement in compulsory procedures will no longer be mandatory, and decisions to detain a citizen may be made by three colleagues working for the detaining body.
- Nearest relatives, hospital managers, Health Authorities, NHS trusts, and local authorities will lose their power to discharge individuals from compulsion, and only the patient's clinical supervisor will have this power.
- It will no longer be possible for a patient to be discharged home by their spouse or partner, even if no one is in danger.

Secondly, the foreword states that 'although the Commission accepts that national regulatory bodies and local advocacy services may provide an adequate substitute for our current visiting functions, it is essential that Mental Health Act Commissioners continue to visit detained patients until satisfactory alternative arrangements are in place …'

In truth, there is little to suggest that any of the newly established public bodies will provide an adequate substitute for specialist visiting, and this ought to be pointed out:

- The Commission for Health Improvement (CHI) is not independent of the Secretary of State, who may regulate how it performs its functions. This may be legitimate in the quality arena, but it is undesirable in the arena of individual legal rights.
- CHI's core functions focus on clinical governance and reviewing 'the arrangements made' by trusts for monitoring and improving the quality of health care (c.f. legal standards). It may investigate the provision or quality of 'healthcare' (c.f. legal standards).
- Because CHI is concerned with quality assurance mechanisms, rather than legal standards and protecting vulnerable individuals, it will only inspect NHS bodies every four years.
- Furthermore, because the CHI is concerned with quality assurance mechanisms, rather than legal standards and protecting vulnerable individuals, the regulations may only authorise the disclosure to it of information in in-patient medical notes and health records in very limited circumstances. Namely, if the information is disclosed in an anonymised form; or the individual consents to the information being disclosed; or the individual cannot be traced despite the taking of all reasonable steps.

- The new system for investigating adverse events that cause a member of the public to suffer is tightly controlled by the Secretary of State. Adverse events or incidents may only be independently inquired into with his consent. The motivation here can only be political, for no public interest is served.
- There is no indication that Patient Advocacy and Liaison Services (PALS) representatives will have access to patients' notes or statutory documents, or be legally qualified or otherwise competent to give a legal opinion, and any opinions would carry little weight and not be binding. It may be impractical to have a 'welcoming point' at every mental health unit or centre, and many services are provided outside hospital. It is not clear how the services will operate in high and medium secure facilities.
- Patients' Forums will replace Community Health Councils, and the Secretary of State may (but need not) require health service bodies to allow authorised forum members to inspect premises owned or controlled by them. Again, it is not clear how this will help to maintain legal standards, and the provisions seem designed with acute hospitals in mind. Which members (if any) will be authorised to inspect premises, and who will be excluded? How will members of high or medium secure hospital forums be appointed? Will patients in Broadmoor, or former patients, be entitled to inspect the premises? What does seem clear is that forum members will not have access to patients' notes or statutory documents, or be legally qualified, or have any statutory powers to police or enforce mental health legislation.

Fennell and Eldergill have summarised, and analysed, the proposals set out in the White Paper.[3]

Mental Health Review Tribunals

The 1983 Act provides that the statutory powers and duties which must be kept under review do not include any exercisable by the Court of Protection under Part VII. No such exception applies to the powers and duties exercised by Mental Health Review Tribunals under Part V.[4] Furthermore, the Secretary of State is bound by statute to direct the Commission to perform on his behalf this function of keeping under review the way in which these statutory powers and duties are discharged.[5] Consequently, the Commission has no discretion and must review the workings of tribunals, insofar as they relate to detained patients. However, yet again, it has not.

Outcome data

Although the report includes data on the Commission's activity (outputs) during the two-year period, it contains little information about outcome, and this is a weakness. For example, what percentage of SOAD second-opinions led to the treatment plan being modified in accordance with the patient's reservations? How many complaints investigations undertaken by the Commission were upheld? How many of the scrutinised documents were invalid, and what action was taken? Without this information it is impossible to know whether or not the Commission is performing its functions effectively.

3 *Fennell P., 'Reforming the Mental Health Act 1983: 'Joined up Compulsion'' (2001) Journal of Mental Health Law, 5–20; Eldergill, A., 'Reforming the Mental Health Act' (2001) The Journal of Forensic Psychiatry, 12-2, 379–397.*

4 *Mental Health Act 1983, s.120(7).*

5 *Ibid., s.121(2)(b).*

Complaints investigations

The statutory framework envisages that the Commission will fulfil its duty to keep the operation of the Act under review in two main ways. Firstly, by visiting detained patients and, secondly, by investigating complaints made by them or about the use of the Act. According to the report, 747 new complaints were received 'and followed up' during the two years, and 244 formal complaints were 'raised or reviewed' during visits (none of which led to a full investigation by the Commissioner). It seems that the Commission may not be fulfilling one of its two main statutory functions. However, we are not given the detailed statistics about its complaints activity found in previous reports, and so cannot know the precise situation.

NHS jargon

Although mostly well written, the report does resort to health service clichés and jargon ('pro-active', 'robust', 'rolling out', 'inform practice'). A 'holistic' approach is recommended for many problems.

Summary

The Biennial Report is, of course, essential reading, and it provides an excellent summary of where mental health services stand. That though is not the Mental Health Act Commission's function. It is to keep the operation of the powers and duties in that Act under review. It is not a National Health Service Act Commission or a Mental Health Services Commission. In this respect, the report has little new to say about matters within its statutory remit. Nor does it inform us in any detail about how these powers and duties are being exercised in practice, and what problems have been encountered.

Copies of the Biennial Report can be obtained from The Stationery Office.
Tel: 0870 600 5522. Fax: 0870 600 5533. www.clicktso.com.