ALBA LECTURE

"LIBERTY"

THURSDAY 29TH NOVEMBER 2001

When I was called to the Bar in 1962 I wore a wig that I had inherited from my grandfather. He was called to the Bar by Gray's Inn. He did not practice at the Bar but achieved an office that was then rather brutally described as Master in Lunacy. In his latter years he went a little mad himself but in a way that would have been considered no more than mild eccentricity had he been the Duke of Grafton whom he came to believe that he was. At the instigation of his wife, my grandmother, he was "certified" and detained in a institution known as Holloway Sanatorium. I well remember going to visit him there with my father and taking him home to Sunday lunch rather like taking a schoolboy out from boarding school. He was full of talk of the comings and goings in the sanatorium, where he seemed to be relatively content to reside. It was a large red brick Victorian building, somewhat in the style of the Law Courts although with even more striking architecture. It had spacious grounds and seemed a benevolent institution. While we sat with him in the gardens, my grandfather would describe in an embarrassingly loud voice the nature of the mental disabilities of his fellow residents. I have never researched the predecessor to the Mental Health Act 1959 in order

to see the basis upon which my grandfather and his fellow residents were detained. Few if any of them would have qualified for compulsory detention under the Mental Health Act 1983. No doubt as a result of the changes made by that Act Holloway Sanatorium opened its doors to release its residents and metamorphosed into luxury flats. Other similar institutions suffered the same fate. It must be open to doubt whether the revenues realised by the sale of these properties to the private sector have been devoted, as one would have hoped they would be, to funding adequate facilities for care in the community. If the statutory scheme at present in force is to function as it should such facilities are essential. Since I started to sit as Master of the Rolls just over a year ago, I have heard no less then four appeals dealing with detention under the Mental Health Act. This is an area where submissions made in relation to the effect of the Human Rights Act have been particularly pertinent and this evening I propose to explore the deprivation of liberty in relation to persons of unsound mind that the Human Rights Convention permits. I apologise to those of you who have come here this evening in anticipation of a critical analysis of the Home Secretary's proposals for the detention of aliens suspected of terrorism.

Article 5(1)(e) of the Convention provides:

"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:

> The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;"

The genus in which persons of unsound mind is placed does not appear very promising. Nor does this provision give any indication of the circumstances in which the detention of persons of unsound mind is consistent with the right to liberty. For that we have to look to the Strasbourg Jurisprudence. Before doing so it is important to note that Article 5(4) provides that everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of this detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

The Mental Health Act 1983 has complex and lengthy provisions that govern the circumstances in which it is lawful to detain in a hospital persons of unsound mind. These provisions are intended to satisfy the requirement of the Human Rights Convention, and before looking at them I propose to consider the Strasbourg Jurisprudence. Before doing that, however, I would like to draw attention to the startling fact that for every

patient compulsory detained under statute in a mental hospital there are many persons of unsound mind who are effectively detained without any statutory safeguards under the common law doctrine of necessity. To demonstrate this I must refer you to the decision of the House of Lords in *R v Bournwood Community and Mental Health NHS Trust* ex parte L [1999] AC 458. This case was my first introduction after joining the Court of Appeal to the law relating to mental health – a baptism by fire because I was party to getting the answer wrong. The application for judicial review was initiated by the devoted carers of a 48 year old man who was autistic and profoundly mentally retarded. He had gone to live with the carers after being resident for some 30 years in a mental hospital and for 3 years had lived with them and attended a day centre. They had got very fond of him. One day he became agitated at the day centre, his carers could not be contacted and so he was taken back to the hospital. The hospital decided that he needed treatment as an in-patient. He was sedated and kept in a room which, thereafter, he made no attempt to leave. Had he sought to leave he would not have been permitted to do so. His carers, who wanted to take him back to live with them, were told that this could not be permitted. The hospital did not section their patient. They considered that they were acting lawfully in treating him as an in-patient by virtue of Section 131 of the 1983 Act which provides:

"Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act."

On behalf of this patient it was argued first of all that he was being detained by the hospital because, although he had not tried to leave, the hospital was determined to ensure that he did not leave should he try to do so and would physically prevent him from doing so, if necessary. The Court of Appeal held unanimously that this state of affairs constituted detention. The next issue was whether the detention was lawful. The hospital argued that they could justify detaining the patient under the common law doctrine of necessity, preserved by S.131. The Court of Appeal held that the right of a hospital to detain a patient for treatment for mental disorder was to be found exclusively in the provisions of the 1983 Act and that Section 131 of that Act dealt solely with the position of patients who were admitted and treated with their consent. The House of Lords reversed the Court of Appeal on both grounds. In the leading speech Lord Goff first referred to the widespread consternation that the Court of Appeal's decision had caused to those involved in the care and treatment of mentally disordered persons. The average number of detained patients resident on any one day in England and Wales was

approximately 13,000. On any one day there were a further 22,000 patients who were compliant but mentally incapable of giving consent to their treatment in hospital. These were kept in hospital without being sectioned. If the Court of Appeal was right all of these were being unlawfully detained.

Lord Goff held that the common law doctrine of necessity entitled a hospital to treat and to care for patients who had been admitted as informal patients but who lacked the capacity to consent to such treatment or care. He referred to a line of authority of which he had been unaware which showed that the common law permitted the detention of those who were a danger, or potential danger, to themselves or others, insofar as this was shown to be necessary. He held, however, that inasmuch as *L* had not been physically restrained from leaving, for he had not tried to leave, he was not deprived of his liberty. Lord Lloyd and Lord Hope concurred in the judgment of Lord Goff without adding reasons of their own. Lord Nolan and Lord Steyn each expressed a powerful dissent to the proposition that, on the facts, *L* was not detained. They each, however concurred in holding that his detention was justified under the common law doctrine of necessity. In the context of mental health, that doctrine had been preserved.

Lord Steyn ended his speech with the following observation:

> "The common law principle of necessity is a useful concept, but it contains none of the safeguards of the Act of 1983. It places effective and unqualified control in the hands of the hospital psychiatrist and other healthcare professionals. It is of course true that such professionals owe a duty of care to patients and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients. Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protection of the Act of 1983 from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less. The only comfort is the counsel for the Secretary of State has assured the House that reform of the law is under active consideration."

I would echo Lord Steyn's concern. But my concern goes further. As we live longer more of us are faced with the prospect that our minds may wear out before our bodies. Very large numbers of elderly persons whose minds have sadly degenerated as a result of Alzheimers or similar

diseases are accommodated in homes of one kind or another around the country. In many cases it will be necessary for them to be detained for their own safety. But it cannot be satisfactory that the detention of such persons should not be attended by any statutory safeguards.

With these introductory thoughts I turn to consider what the court at Strasbourg has had to say about the detention of persons of unsound mind by public authorities. It is no surprise to find that Strasbourg has stringently circumscribed the circumstances in which deprivation of liberty of a person of unsound mind can be justified.

The starting point is of course the decision of the European Court in *Winterwerp v The Netherlands* (1979) 2 HER R387. The applicant in that case was a Dutchman who had been detained in a mental hospital for over 10 years. The power to detain him was annually renewed by court order, but he was not notified of the court proceedings or allowed to appear or be represented. The Strasbourg court identified three important requirements that had to be satisfied before the deprivation of liberty of a person of unsound mind could be justified.

(1) While it was not possible to give a precise definition of "persons of unsound mind" no one could be confined as "a person of unsound mind"

in the absence of medical evidence establishing that he was suffering from a true mental disorder.

(2) Objective medical expertise showing that the mental disorder was of a kind or degree warranting compulsory confinement was called for.

(3) Continued confinement could only be justified so long as the disorder persisted. These requirements were satisfied in the case of Mr Winterwerp. The court hearings that had taken place in Mr Winterwerp's absence had, however, not satisfied the requirement of article 5(4). The court observed (at p409):

> "It is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, when necessary, through some form of representation, failing which he will not have been afforded "the fundamental guarantees of procedure applied in matters of deprivation of liberty."

Mental illness might entail restricting or modifying the manner of the exercise of such a right, but it could not justify impairing the very essence of the right.

The provisions of the Mental Health Act 1983 were intended to satisfy the requirements of Article 5(1)(e) as identified in *Winterwerp*. Sections 2 and 3 address the first two requirements. Section 2 provides for compulsory admission and detention for a period not exceeding 28

days for the purpose of assessment. Before a patient can be detained for this purpose it must be shown that the detention is warranted because he is suffering from a mental disorder of such a nature that he ought to be detained in the interests of his own health and safety or with a view to the protection of other persons.

A patient admitted for assessment under Section 2 can be detained beyond the 28 day period if admitted for treatment under Section 3. The requirements for admission for treatment are exacting. First the patient must be suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder must be of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital. Secondly, in the case of psychopathic disorder or mental impairment such treatment must be likely to alleviate or prevent a deterioration of his condition and thirdly it must be necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it must be the case that the treatment cannot be provided unless he is detained in the hospital. The so call treatability test laid down by this section is a gloss on the requirement in *Winterwerp* that the mental disorder must be of a kind or degree that warrants compulsory confinement. In the Scottish case of *Reid v Secretary of State for Scotland,* ~~to which I shall revert in another context,~~

the House of Lords gave a very generous construction to the kinds of medical treatment that would satisfy the treatability test. Nonetheless that case raised the spectre that psychopathic patients who would be a serious danger to others if not detained in a mental hospital would be discharged because they no longer derived any benefit from medical treatment. I should add that the relevant provisions of the Scottish Mental Health Act which were in play in *Reid* mirrored those of the English statute.

Alive to the danger, the Scottish Parliament amended the Scottish Act so as to render it lawful to detain a patient in hospital if he is "suffering from a mental disorder the effect of which is such that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital whether for medical treatment or not." This amendment was effected by the first statute to be enacted by the new Scottish Parliament. It was immediately challenged by three mental health patients on the ground that it fell outside the Scottish Parliament's legislative competence, in that its provisions were incompatible with the patient's Convention rights. The issue in a nutshell was whether it was compatible with Article 5(1)(e) to detain a patient in hospital in circumstances where there was neither a genuine intention to provide medical treatment nor the possibility of benefit from such treatment. The Judicial Committee of the Privy Council gave their

decision on the 15th October last. They held that, provided the three *Winterwerp* conditions were satisfied, there was no additional requirement that the mental disorder that had resulted in the detention of the patient should be susceptible to treatment. It was neither arbitrary nor disproportionate to detain in hospital a patient who would otherwise pose a risk of serious harm to members of the public.

It follows that the requirement of treatability in the English Act goes beyond the criteria that must exist if the detention of a mental patient is to be justified under Article 5(1)(e). This was a conclusion that the Court of Appeal had reached in the case of *H* in the previous year. In that case the Court made a declaration that the provisions of the Mental Health Act 1983 in relation to discharge were incompatible with the Convention. I have already pointed out that compulsory admission for treatment requires demonstration of mental disorder, treatability and necessity for the health or safety of the patient or for the protection of others that he should receive treatment that cannot be provided unless he is detained. The provisions entitling a patient to discharge under Section 72 of the Act included the following:

> "The Tribunal shall direct the discharge of a patient... if they are satisfied (1) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental

impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (2) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment..."

The appellant had applied to the Mental Health Review Tribunal to be discharged and his application had been refused. His challenge was to the test applied by the provisions that I have just read. They provided that he was entitled to release only if the Tribunal was satisfied that at least one of the pre-conditions to his compulsory admission no longer pertained. Thus, on the natural meaning of the language of the section the burden of proof was on the applicant to show that he was entitled to be released whereas it should have been for the Tribunal to be satisfied that his deprivation of liberty remained justifiable.

Counsel for the Secretary of State accepted that if, on their true construction, the provisions required the appellant to prove that he was entitled to release they infringed the Convention. He urged the court, however, to give a purposive interpretation to the language so as, in effect, to reverse the burden of proof that, on its natural meaning, it imposed. There was previous precedent, pre-dating the Human Rights

Act, directly in point which ran counter to this suggestion. In the case of *Perkins v Bath District Health Authority* Lord Donaldson MR had said:

> "If a tribunal is to make an order under Section 72[(1)(a)(i)] clearly they have to be satisfied, and should state that they are satisfied, that he is not then suffering from mental disorder. That is not the same thing as saying the tribunal is not satisfied that he is so suffering".

The court did not accede to the invitation of counsel to the Secretary of State to adopt a purposive construction that differed from the views of Lord Donaldson. It observed:

> "It is of course the duty of the court to strive to interpret statutes in a manner compatible with the Convention and we are aware of instances where this has involved straining the meaning of statutory language. We do not consider however that such an approach enables us to interpret a requirement that a tribunal must act is satisfied that a state of affairs does not exist as meaning that it must act if not satisfied that a state of affairs does exist".

This result has been criticised as unduly timorous. Certainly it contrasts with the approach of the House of Lords in *R v A*. It had, however, a potential advantage. Reversing the burden of proof would have meant that the tribunal was bound to discharge a patient if not satisfied as to any

single one of the criteria for admission in Section 3. The court pointed out that the Convention did not require so drastic a result.

> "Detention cannot be justified under Article 5(1)(e) unless the patient is "of unsound mind", but once that is established we do not consider that the Convention restricts the right to detain a patient in hospital, as does Section 3, to circumstances where medical treatment is likely to alleviate or prevent a deterioration of the condition. Nor is it necessary under the Convention to demonstrate that such treatment cannot be provided unless the patient is detained in hospital".

Thus the court left it open to the government to take a more radical step to amend the law in the manner subsequently adopted by the Scottish Parliament. In the event the Secretary of State has simply amended the Act so as to reverse the burden of proof. He has done that by a remedial order pursuant to Section 10 of the Human Rights Act, which came into effect three days ago.

One provision of the 1983 Act has given rise to particular difficulty in the context of Human Rights. That is the power conferred by Section 73 to direct the conditional discharge of a patient who is under a restriction order. A conditional discharge is one that requires the patient

to comply with specified conditions, such as a condition of residence and psychiatric supervision after discharge. Where it has decided to impose such conditions, the Tribunal has the power to defer the direction for the conditional discharge until appropriate arrangements have been made to enable the conditions to be complied with. In *R v Oxford Regional Mental Health Review Tribunal* a case better known as *Campbell*, Woolf J as he then was held that a Tribunal which had determined to make a conditional discharge but had deferred doing so retained jurisdiction to reconsider the appropriate order if exceptional circumstances made this necessary. The Court of Appeal reversed this decision and was upheld by the House of Lords. They held that once a Tribunal has decided to order a patient to be discharged, albeit only after appropriate arrangements have been put in place, the Tribunal has no further jurisdiction. This gives rise to great difficulty if it proves impossible to put in place the arrangements necessary to satisfy the conditions that the Tribunal had decided to impose. Such a case was *Johnson v United Kingdom* which went to the Strasbourg Court in 1997 – 27 EHRR 296. That case concerned a restricted patient. The Tribunal found that he was no longer suffering from mental illness. It decided however to impose a condition that the patient reside in a hostel. The patient did not co-operate in attempts to arrange a placement and the condition proved impossible to satisfy. In the event, the patient remained detained in hospital for a further five

years. The Strasbourg court held that it could be justifiable to defer the discharge of a person no longer suffering from mental disorder in order to make arrangements for a conditional release. The authorities were, however, bound to make such arrangements within a reasonable time. The indefinite detention that had taken place constituted a violation of Article 5(1) of the convention.

The facts of *R v Camden and Islington Health Authority,* which was decided by the Court of Appeal in February of this year, were similar but not identical. In that case the applicant was a restricted patient who had been found by the Mental Health Review Tribunal still to be suffering from a mental disorder requiring ongoing treatment and medication, but of such a nature that this could be provided in the community. The Tribunal decided to direct a conditional discharge under which the patient would be required to live at her parents' home and co-operate with supervision provided by a consultant forensic psychiatrist. Discharge was deferred to enable the arrangements to be made. They proved impossible because the health authority into whose area the patient was to be discharged could not find a forensic psychiatrist willing to supervise her otherwise than in a nursing home. To put in bluntly, the psychiatrists did not agree with the order that had been made and were not prepared to co-operate in giving effect to it. The applicant contended

that the local health authority had been under an absolute statutory duty to ensure that the condition was complied with. The Court of Appeal unanimously rejected this contention holding that all that the local authority had been required to do was to use reasonable endeavours to fulfill the conditions imposed by the Tribunal which it had done.

In a case such as this where an impasse is reached in enabling a conditional discharge to take effect, it seems to me plainly desirable that the Tribunal should retain jurisdiction to consider an alternative more practicable condition or, indeed, whether the patient should be discharged without condition. In such circumstances the Secretary of State has power to remit the matter to the Tribunal if he so chooses, but this course may involve a longer delay than is compatible with Article 5. In the course of my judgment in that case I suggested that it might prove necessary to review the decision in *Campbell*. The Human Rights Act renders it possible for the Court of Appeal to enjoy the heady experience of reversing the House of Lords.

R was tried at the same time as another case where the professionals appeared to differ from the view of the Tribunal. This was the case of *Count Franz Karl Wilhelm von Bandenberg* also known as Nicholas Hanley. The Mental Health Review Tribunal ordered the

applicant's discharge overriding medical advice against this. Discharge was deferred for two weeks to enable appropriate accommodation in the community to be obtained and a care plan made. Before the patient could be discharged he was readmitted under Section 3. On the face of it the professionals responsible for his readmission seemed to be flouting the decision of the Tribunal. He challenged his readmission contending that it was illegal unless there had been a change of circumstances. This contention was based upon an asserted implication of statutory construction. This the court rejected. It indicated, however, that there might have been scope for a challenge of the rationality of the decision to readmit. The statutory scheme gives the Mental Health Review Tribunal the last word and those considering sectioning a patient cannot properly disregard a recent decision of such a Tribunal.

Article 5(4) of the Convention confers the right on those detained to have the lawfulness of their detention decided speedily by a court. In an attempt to comply with this requirement a target was introduced under which all applications to Mental Health Review Tribunals should be heard within 8 weeks. What then happened was that it became the norm for the date of a hearing to be fixed 8 weeks from the date of application. This had the advantage of facilitating the preparation of an orderly timetable that would, in most cases, enable those involved to prepare

adequately for the hearings. In *R (C) v the Mental Health Review Tribunal for London South and South West Region* the applicant challenged this practice on the ground that a delay of 8 weeks did not satisfy the Convention requirement for a speedy determination. 8 weeks may not seem a long period to those at liberty but it can seem very long indeed for a person detained by compulsion. The Court of Appeal held that there would be cases where an 8 week delay was justified and within the Convention. What was not justified, however, was a regular practice of delaying the hearing for 8 weeks, regardless of whether on the particular facts this was necessary or not.

My experience of these cases has led me to conclude that the 1983 Act has a number of shortcomings. First it is an extremely complex piece of statutory legislation. It is not easy to interpret the effect of some of its important provisions. Secondly it does not make adequate provision for those patients for whom ongoing treatment is essential, if those who could provide the necessary facilities and treatment in the community refuse to do so, perhaps because they consider that the treatment should be administered in a hospital. There is no obvious way of compelling them to do so. Nor is there any power to compel the patient to submit to treatment in the community, although the threat of being recalled to hospital will in some cases be an effective sanction. If an impasse

develops so that discharge of a patient is indefinitely deferred, the patient may not have sufficiently speedy access to the Tribunal to satisfy the requirements of Article 5(4). Finally, the requirement that those suffering from psychopathic disorder or mental impairment can only be detained in hospital if they are susceptible to treatment means that some patients have to be discharged albeit that they pose a danger to the public.

Most of these shortcomings are recognised by a White Paper that the Secretary of State for Health and the Home Secretary presented to Parliament at the end of last year. The fundamentally new mental health regime that this White Paper describes is likely to have considerable resource implications which may explain why it is not intended to give effect to the proposals until 2003. I propose to spend the last part of this talk outlining what those proposals are.

Compulsory measures will be taken in relation to mental health patients in the form of "care and treatment orders". The following novel features of these are particularly striking: first compulsory treatment will be imposed not only in hospitals but also in the community. Secondly, those who can be subjected to care and treatment orders will be not merely those who are susceptible to treatment but also those who are not susceptible to treatment but who pose a serious risk to others. The care

and treatment plan imposed pursuant to such an order may be directed to treating the underlying mental disorder but it may simply be designed, and I quote, 'to manage behaviours arising from the disorder' – a rather bland phrase which I suspect is going in some cases to embrace a very significant deprivation of liberty.

Compulsory treatment will begin with the decision that a patient should be assessed. This decision will normally be taken by two doctors and a social worker or a mental health professional, all of whom must agree that the conditions for the application of compulsory powers are met. What are those conditions? The first is that the patient is suffering from a mental disorder that is sufficiently serious to warrant further assessment; the second is that, without such intervention, the patient is likely to be at risk of serious harm or to pose a significant risk of serious harm to other people. If these conditions are satisfied a full assessment will be ordered. If the patient does not co-operate in this he can be compulsory detained in hospital for the purpose.

At this point a particularly important persons enters the picture. This is the clinical supervisor – the consultant who is to have lead responsibility for the care of the patient. He will normally be a consultant psychiatrist and will lead a multi-discipline team responsible for the

assessment, care, treatment and supervision of the patient. He replaces the current "Responsible Medical Office".

The clinical team has 3 days to prepare a preliminary written care plan. The remainder of the 28 day period is then spent in preparing a full plan of care and treatment. If during this period the clinical supervisor decides that compulsory detention is not justified he will be bound to discharge the patient. During this period the patient can apply to the Mental Health Tribunal for review of the use of compulsion. He must be given a hearing within 7 days.

The Mental Health Tribunal will be entirely independent of the clinical team. It will be the body with responsibility for deciding whether compulsory powers shall continue to be used after the 28 day assessment period has elapsed. This new tribunal will have a legally qualified chair and two other members with experience of mental health services. In reaching its decision the Tribunal will be assisted by the evidence of an independent doctor drawn from a specialist panel who will have examined the patient. If the Tribunal is satisfied that the use of compulsory powers remains justified, it will make a care and treatment order which will normally be that proposed by the clinical supervisor. A novel and important feature of this order is that it may provide for

compulsory care and treatment either in hospital or in the community. Furthermore, and I quote:

> "When a patient is subject to a care and treatment order outside hospital, those responsible will be required to ensure that services are provided in a way that enables the patient to comply."

If this proposal is implemented problems that arose in *R v Camden* should, in theory, be avoided. I do not find it easy to see, however, how health professionals can be forced to take responsibility for treating a mentally disordered patient in the community if they remain adamant that satisfactory treatment can only be administered in hospital.

Where the object of the care and treatment is therapeutic, the plan of care and treatment must be such as is considered necessary directly to treat the underlying mental disorder. Where the object of compulsion is primarily to address the risk that the patient poses to others the plan will aim at the management of behaviours arising from the mental disorder.

Before the Tribunal makes a care and treatment order it will have to hold an oral hearing at which the patient will be entitled to be legally represented. The advisory assistance provided to patients will not, however, end there. A person, selected with assistance from the patients relatives, will be nominated to be consulted by the clinical team in all

cases where a patient is subject to care and treatment under compulsory powers. The clinical team will consult the nominated person during the period of assessment and initial treatment, at any time when a substantial variation in treatment is proposed and before discharge. The nominated person will also be entitled to attend any tribunal hearing. In addition to this the patient will have access to a new independent specialist advocacy service. Advocates in this service will help the patient to present his views in discussion with the clinical team about his care and treatment and will also give advice to the nominated person. It is not clear what, if any, qualifications these advocates will have, for the White Paper draws a distinction between them and legal representatives.

On the first two occasions the tribunal will be able to make a care and treatment order that will last for a maximum of six months. Thereafter it will be able to make orders for up to twelve months at a time. The patient will be entitled to request one review during the period of any order, and will be entitled to legal representation at the hearing at that review.

These are only some of the safeguards that will be inserted into the new Act to protect mental patients. Consideration will always be given, insofar as possible, to the wishes of the patients. A patient will, where

appropriate, be encouraged, with the assistance of the clinical team, to enter into an advance agreement as to the type of treatment to be administered should his or her condition deteriorate. Just as in the case of the 1983 Act there will be special safeguards in relation to particularly invasive treatment and psycho-surgery. Carers will be consulted in relation to the decision whether to embark on assessment and initial treatment under compulsory powers and whenever a change in treatment is proposed. This will be an improvement on the position the helpless carers found themselves in ex parte *L.* In the case of patients detained for therapeutic treatment, the Tribunal will normally give authority to the clinical supervisor to discharge the patient where the supervisor concludes that detention can no longer be justified. Such authority will not be given however in the case of patients detained because of the risk they pose to others.

The most controversial feature of the new legislation is that it will empower the indefinite detention of persons, who have committed no offence, simply because of the potential danger that they pose to others. The White Paper is divided into two parts and the second concentrates exclusively on so called high risk patients. These will include persons who are DSPD –dangerous as a result of a severe personality disorder. "Personality disorder" is defined as :

"A disorder of the development of personality. It includes a range of mood, feeling and behavioral disorders including anti-social behavior.

The dangers of a law which permit the locking up of persons on the round of anti-social behavior are obvious and the safeguards that I have outlined will be particularly important. The White Paper at present defines DPSD as a phrase designed to cover individuals who

- Show significant disorder of personality;
- Present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover, e.g. homicide, rape, arson; and in whom
- The risk presented appears to functionally linked to the personality disorders.

The White paper comments:

"We intend to refine this definition during the pilot period as we develop a clearer picture of the nature and characteristics of this group".

The statutory definition that is adopted will clearly be of critical importance.

Statistical analysis suggests that there are at present between 2,100 and 2,400 men who are DSPD. These estimates are now being refined to include women. The majority of these patients are likely to be criminal

offenders. A criminal court will have powers to remand a defendant for assessment on the basis of a single medical recommendation although a second medical opinion will be required before compulsory treatment can be given. The remand will be renewable by the court for 28 day intervals for up to a maximum period of 12 months on the recommendation of the clinical supervisor. The sentencing powers of the court will include a care and treatment order on the basis of a full assessment for a period of up to six months, a restriction order, which will have the same consequences as it does under the present legislation and a hospital and limitation direction which will combine a prison sentence with an order for care and treatment. Under this order, when detention for treatment is no longer necessary, the patient will be transferred to prison to complete the sentence.

How will persons whose behaviour poses a severe risk to others but who have committed no offence be identified? There have recently been set up under the stimulus of the requirements of the Sex Offenders Act 1997, multi agency risk panels comprising of the criminal justice agencies working with health, social services and housing agencies. There will be an obligation on the authority providing specialist medical health services in the area to undertake a preliminary examination of a person on request from the police, the probation services, the court, the

prison service or a patient's GP or carer where there is ground for apprehension that a person is DPSD. If it is decided that assessment for care and treatment is required, this will be carried out by a specialist National Health Service DSPD assessment facility where those responsible for the assessment will have appropriate professional expertise. The White Paper gives a useful case study:

> "A is currently living in bed and breakfast accommodation and is supervised by the probation service. She has a history of setting fires and convictions for theft and arson; during previous periods in detention she has assaulted staff. She has no family contact. Her most recent offence resulted in the death of her victim. She was held on remand and then assessed for treatment of her personality disorder under the Mental Health Act 1983, but considered 'untreatable' given currently available services. The Courts imposed a detention prison sentence and she is now on licence in the community having served the custodial part of the sentence without parole. She is a compulsive self harmer and emotionally unstable. She presents a risk to herself and others, having made suicide attempts in the past and is unwilling to engage in meaningful dialogue with the agencies to get to the roots of her present situation and behaviour.

The probation service would be able to refer A for assessment under the new mental health legislation. A DSPD screening assessment could be carried out in the community, but A's unsettled lifestyle may indicate that she should be detained in a suitable NHS facility for an initial examination. If further intensive assessment was indicated, she would be transferred to a specialist NHS DSPD assessment facility and at 28 days the Mental Health Tribunal would be asked to authorise a further period of specialist assessment. A care and treatment plan would then be drawn up which would be delivered in an appropriate therapeutic environment within the NHS".

Only tribunals, or the Home Secretary in the case of restricted patients, will be empowered to discharge high risk patients. Most of these are likely to then require compulsory care and treatment in the community. The clinical supervisor will be empowered to recall such a patient to hospital.

That concludes my attempt of a brief summary of the detailed and lengthy White Paper. Care has been taken in an attempt to make it Human Rights compliant and many more safeguards are built in to protect the carer that exist under current legislation. The new Act which will permit a wide variety of compulsory care and treatment in the

community will provide, so it seems to me, a statutory regime that can embrace the many cases where elderly people of unsound mind currently have their liberty restricted, avowedly for their own protection, under the common law doctrine of necessity. Whether that doctrine will survive in the context of mental health, or be displaced by the statute will remain to be seen. If and when I come to believe that I am the Duke of Grafton I think I should be grateful for some statutory protection.

The Right Hon. Sir Nicholas Phillips
Master of the Rolls