Reviews

Symposium: The British Government White Paper on the Mental Health Act 1959. From *International Journal of Law and Psychiatry* (1979), Vol II, No 2. Oxford: Pergamon Press. £7.00

These four articles on criticisms of the White Paper—mainly to do with human rights—are extremely detailed and interesting. Larry Gostin, research director of MIND, deals with the basis of the common law of trespass and battery and the ramifications of the mental health law in a detail which is heavy going for a psychiatrist and can probably only be answered by a lawyer. The full references to court decisions, however, add greatly to the article's value. The White Paper proposed the removal of all civil disabilities from informal patients; further it took the view that the right to detain does not imply the right to treat without consent (except in emergencies) and proposed a number of rules about the incompetent detained and those competent to consent, and about when a consultant should, or must, obtain a second opinion from a multidisciplinary committee. But all the contributors consider these insufficient, leaving doctors with more power than they should have or often want themselves. MIND, and the Butler Committee, made several suggestions which the last Government did not accept, but which commend themselves to the authors. Some of Gostin's views in this paper, however, seem excessively litigious and unpractical, requiring much greater legal control at all stages, almost back to the American model. There seem to be ideological difficulties in perceiving what the law can and cannot do. It can require certain objective procedures (a second opinion, a more experienced opinion by some objective criterion) but it cannot usefully require doctors to express qualitative opinions, e.g. in what way a patient is considered dangerous. It is no doubt right that the White Paper misses the opportunity of a great leap forward in concepts of mental health, but any survey of the extreme fragility of the mental health service at present would hardly suggest that it could do any leaping.

Dr Steadman, an American sociologist, is probably America's most distinguished lay research worker in the mental health field. He is Director of Research for the New York Department of Mental Hygiene, and has castigated the errors and inefficiencies of his own department with a freedom which English civil servants might envy. He has compared with some difficulty the White Paper with MIND's comments. Amusingly, he refers to the White Paper's limpid phrases as 'obtuse prose' and 'concentration on specific statutory language to the detriment of explicit assumptions'! Although strongly biassed towards reducing the assumption of power and expertise by doctors, he is always absolutely fair, unlike his collaborators, in supporting his criticisms by facts and figures which demand explanation. He refers to a similar battle in the USA between doctors and excessive legal intervention in compulsory detention, resulting in patients being freed 'to die with their rights on'. He mentions, but does not sufficiently explain, the new trend for Federal and State funds to be supplied only 'under contract'. 'These contracts will state tasks to be performed, re-imbursement schedules for their services *and criteria to determine the effectiveness of the services delivered'!* He disagrees with Gostin's idea that detention should be based only upon explicit dangerousness (which tends to mean danger to others, and which the White Paper rejects as 'stigmatising'). He is a principal authority on the prediction of danger, pointing out that even among manifestly dangerous patients the best prediction results in two being needlessly detained for every one who subsequently proves dangerous. But in New York, armed psychotics are a real danger, unlike our own innocuous-free chronic schizophrenics, and regularly shoot half a dozen policemen every year. As Robertson and I have shown, of our abnormal offenders detained fifteen years ago, only 2-3 per cent committed a major serious crime subsequently.

The two English psychiatrists take a wider view of how a new Act might help to make the system more efficient as well as fairer. Professor Russell Davis' most important point, in my view, is that there is a gross lack of information about how our system works. The White Paper is based upon collected opinions, not collected facts. The biennial Mental Health Enquiry gives statisitics of the sections of the Act under which Part IV patients are detained, but not the reasons or circumstances. Moreover, as any research worker will find out, the information on admissions and discharges is quite unreliable. There is no information about the discharge of detained patients except in the small group for whom the Home Office has a responsibility. The White Paper will not alter this; it is a major task for University psychiatric departments.

Professor Russell Davis points out that for several years 60 per cent of admissions under Part IV have been 'emergencies' under Section 29, mainly by general practitioners, whereas, in the best practice, hospitals arrange for a consultant and social worker to make a domiciliary visit. He gives compelling examples of applications which on investigation have proved quite unnecessary, usually in domestic disputes in which one or other spouse has become alarmed and called the doctor. He does not discuss direct police admissions (Section 136), which, although small in number, are more frequent than all forms of Part V admissions. Since they are (or were) only used in central London and Durham, each must be balanced by three or four Section 29 admissions by police surgeons from police stations, and one can calculate that, if so, they may reach a

quarter or a third of such 'emergencies'. This would not in any way invalidate Professor Russell Davis' point. He also observes that there are wide differences in the frequency between Regions and even Areas—in Area 1 of the S.W. Region 76 per cent, as against 20 per cent in Area 2. No doubt this depends upon geography and consultant availability, but Davis thinks the Section should be more explicit than merely referring to 'undesirable delay'. He also objects to the sudden imposition of a Section 26 merely to overcome the patient's objection to a treatment, and suggests that there is little evidence that withholding drug treatments which are objected to has led noticeably to deterioration in the patient.

Professor Gunn's paper is more comprehensive than the others since it deals with every Section of Part V admissions, and cannot be summarized. It is given greater weight by having the agreement of three experienced forensic psychiatrists, including Dr MacKeith, regional forensic psychiatrist for S.E. Thames. Psychopaths present a particular problem because they are never incompetent to consent to treatment but have diminished competence and responsibility, which is only recognized in the Homicide Act. The White Paper preserved the capacity to detain them, and even removed the age barrier of 21 for non-offenders. Professor Gunn suggests that they should be required to state their willingness to be treated; but in comparing this with the consent required in a psychiatric probation order he overlooks the fact that in the latter case the court retains jurisdiction and can impose imprisonment for a breach; in other cases the judge must commit irrevocably to doctors who he hopes share his view on the public interest. There are still very mixed views about whether restriction orders should be limited or unlimited in duration. MIND would like to see limitation to the sentence usually awarded, the Butler Committee suggested that all should be unlimited, and the White Paper wisely provided for both sorts. We found that limited orders definitely shortened the detention of subnormals, where criteria of improvement are so vague, but less so with the mentally ill. Since nowadays nearly all go to Special Hospitals, MIND has had its way, since hardly any have not committed offences carrying a life sentence.

Perhaps Professor Gunn's last point is the most important. The Mental Health Service is near to breaking down. In the last ten years there have been 15 major Inquiries into conditions bordering on the scandalous, largely due to staff demoralization as a result of inadequate finance and services, which a new Act will do nothing to remedy.

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An Ordinary Life. King Edward's Hospital Fund for London. March 1980. £1.00.

This publication is the result of a series of small workshops held in 1979 to explore how local residential services for the mentally handicapped might be further developed in Britain. Half of the Working Group of twelve are employed by the NHS, i.e. one doctor (a consultant in mental handicap), two nurses, and three psychologists.

The paper is based on three key principles which demand not only equal rights for the retarded but also (like Warnock) a right to additional resources. The duties of society corresponding to these rights are enlarged upon, and also the duty of the handicapped to behave within the limits of the law, but there is no mention of what happens when they do not.

What is envisaged is a separate, comprehensive community-based service with a range of facilities from the person's parental home to group homes for four to six people (clients is the word used) with residential staff. It is realized that occasional help from other services may be required and in this category are included local GPs and hospital (including specialist) services. There is a novel suggestion for dealing with clients when changes in dependency arise, e.g. 'A client who is at first very dependent may, as he or she gains new skills, need less time and attention from staff. A client who is fairly independent may go through a crisis in which he or she needs considerable support for a time'. To cope with situations like this it is recommended that, to avoid disruption, staff rather than clients should move from one home to another.

For the 85 per cent of mental defectives who are already in the community, and for some of the most able patients in hospital, the proposals could provide a great improvement in the services at present available. However, they are as unrealistic as the Jay Report in ignoring the severe nursing and behaviour problems which account for most of the admissions to hospitals nowadays, and which are included in Table 25 (VII, p 28) of the Jay Report.

The paper is deliberately unfinished as it is designed as a basis for discussion. To facilitate the creation of real services along the lines proposed, nine main questions are listed with suggested answers. One of the answers given is that there should be an insistence on distinguishing myth from reality. We hope that those who follow up the work of this study group will make every effort to do so.

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