The Law School
Bowland North Buildings
Lancaster University
LA1 4YN

e: t.webb@lancaster.ac.uk

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Re: Call for Evidence, Independent Review of the Mental Health Act 1983

Dear Professor Wessely,

1. Introduction

I am a Lecturer in Law at Lancaster University with a research interest in mental health law, in particular the power of discharge available to hospital managers in s.23 of the Mental Health Act 1983 (MHA 1983). In addition, I also sit as a hospital manager – and thus am involved in the exercise of the powers contained in s.23 – for Lancashire Care NHS Foundation Trust. My wider research and teaching interests lie in public and administrative law and the operations of legal systems. A paper I have written examining some aspects of the managers' s.23 discharge is currently under peer review at a leading law journal.

I am writing to you regarding the power of hospital managers to discharge patients from compulsory care contained in s.23 MHA 1983. In particular, I wish to draw your attention to the paucity of available evidence as regards the operation of this power, and so strongly caution against recommending reform of this part of the Act without first establishing an empirical basis for doing so.

2. Terms of Reference and s.23 Reform

In the past, efforts have been made to remove the hospital managers' s.23 power without due regard being paid to the lack of available evidence and understanding about the power. I am conscious that the Terms of Reference for the current Independent Review might legitimately be construed as capturing, among other things, the s.23 discharge power. In particular, the expectation that the Review will give consideration to 'the balance of safeguards available to patients', 'the difficulties in getting discharged' and 'stakeholder concerns that some processes relating to the act are out of step with a modern mental health system', is similar to language that, in the past, has been taken to encompass the managers' s.23 discharge power.

3. The Current Lack of Understanding

To give some sense of the current level of understanding about the operation of the s.23 power, it is worth reflecting on an admission made by the Department of Health during the period of debate leading up to the passage of the Mental Health Act 2007 (MHA 2007). In its evidence to the Joint Committee on the Draft Mental Health Bill (2004-2005 session), the Department of Health conceded that it does not gather statistical information on the number of hearings conducted under the auspices of s.23 (Department of Health, 2004-05, EV491). The Mental Health Act Commission, the regulator at the time, also stated that it did not gather data (a rare example of the opposite is MHAC 2007. fig. 55, 80), and the current regulator, the Care Quality Commission, hardly ever mentions the hospital managers' discharge power in its reports (an unusual example to the contrary is CQC 2015, 59).

Although it might be thought unwise to propose the abolition of a long-standing statutory provision – my research indicates that the discharge power has existed in one form or another since the passage of provisions enabling the establishment of public asylums in the early 19th century – absent this information, this is nonetheless what happened (Department of Health, 2005, 29-30). The desire of the government to push for reform in this particular field with little evidence to justify it was, far from being an aberration, the norm amongst those in favour of abolishing the power. At the same time, the validity of the arguments put forward by those who argued that the power should be retained were similarly weakened by their own lack of evidence to justify their claims.

To my knowledge neither the Department of Health nor any other central organisation (e.g., the Care Quality Commission) has altered their practice regarding the gathering of data about s.23 since the Joint Committee sat. Additionally, informal conversations with individual providers indicate that data gathering practice across organisations varies.

4. Problems with Previous Attempts at Reform

Notwithstanding the lack of available evidence to support reform one way or the other, from at least the early- to mid-1990s concern has been expressed about the s.23 safeguard in Parliament,[1] and also in the literature (Fraser and Winston, 1992; Power-Smith and Evans, 1993). From 1996 until the passage of the MHA 2007 there was a sustained effort on the part of government to remove the power of discharge from hospital managers (DH 1999, paras. 7.8, 10.6; DH and Home

[1] Stephen Dorrell MP, HC Deb 20 February 1996 vol.272. cc.175-187 and Lord Strabolgi, HL Deb 20 February 1996 vol.569 c.1001

Office 2000, para. 7.7; DH 2004, pars. 3.54-3.58, 5.1-5.3, 11.5). Leading commentators on the MHA 1983 have also continued to express their concern regarding s.23 (e.g. Jones 2016, v-vi).

Over the period 1996-2007 the Government's arguments were partly supported by the observations and small amount of data gathered by a Report produced in 1996 by a Working Group established by Stephen Dorrell to investigate the operation of s.23 (MHAC *et al.* 1996, 3), and also by the conclusions drawn by the Report, delivered in 1999, of the Expert Committee, among other sources (e.g. Hardy Review 2005, 7.5.4-7.5.26, 7.6.2-7.6.7). During the same period, some advocated for the retention of the s.23 power (Gregory 2000, IMHAP 2004-05, EV101, EV104; Pacitti 1997). As I have said, the difficulty with both the arguments for and against abolition is the complete absence of an evidential basis upon which to justify the reasons for adopting either position.

5. Wider Problems Facing Future Reform

The criticisms one can make of both sides in the effort to abolish the power as part of wider reform efforts between the 1900s and the passage of the MHA 2007 are part of a wider set of problems regarding our understanding of s.23. These include:

i. We know almost nothing about how the s.23 process works, and can only speculate about the volume of applications received,

ii. Our understanding of who sits as a hospital manager – it is generally believed that the power is usually delegated to specially appointed individuals – is almost non-existent. For example, we know almost nothing about the professional backgrounds of those who sit as managers or how they are appointed.

iii. Our appreciation of the history of the process is sorely lacking.

iv. The hyper-devolved nature of the power means that – although the *Code of Practice* sets up some expectations – implementation of the policy is a matter for individual mental health care providers. Consequently, without being able to estimate the degree of variation this devolution establishes, even quite reasonable amounts of data might not safely be called generalizable.

v. When enacting legislation relating to healthcare, Parliament has, on more than one occasion, forgotten the existence of the power.

vi. The judiciary have had only limited opportunity to comment on, and thus clarify, the requirements of s.23. In view of these observations, our understanding of how s.23 operates might, seen in a sympathetic light, be described as speculative. However, I would suggest it is more accurate to say that there is almost no understanding of how the process operates, and that what little statistical data is available cannot be relied upon to draw general conclusions.

6. Available Evidence

Below I have included a list of the few sources of publicly data available on the operation of s.23 which I have been able to locate. You will appreciate that – notwithstanding particular criticisms which might be made in relation to the data itself – given the time which has elapsed since the data were gathered, they are unlikely to provide a suitable foundation for legislative reform today. Additionally, the data available relates only to relatively functional questions – e.g. how many hearings held nationally in a particular year – and says little about, *inter alia*, variations between providers, the qualifications and training of those exercising the s.23 power, and the views of those who use the process.

* MHAC, National Association of Health Authorities and Trusts, NHS Trust Federation, Royal College of Psychiatrists, *Working Group Report on Managers' Review of Detention Under the Mental Health Act 1983* (July 1996), Annex 2
* Mental Health Act Commission, *Eighth Biennial Report 1997-1999*, para. 4.88
* Joint Committee on the Draft Mental Health Bill, *Volume I: Report*, (Session 2004-05, HL 79-I/HC 95-I), paras. 307 and 301; to be read alongside Department of Health, evidence to the Joint Committee on the Draft Mental Health Bill in *Volume II: Oral and Written Evidence*, (Session 2004-05, HL 79-II/HC 95-II), EV491
* Mental Health Act Commission, *Twelfth Biennial Report 2005-2007: Risk, Rights Recovery* (London: TSO, 2007), fig. 55, p.180
* Singh and Moncrieff, 'Trends in mental health review tribunal and hospital managers' hearings in north-east London 1997-2007' (2009) 33 *Psychiatric Bulletin* 15-17

I have sought to keep my letter to you brief, but I would be happy to discuss any of the points raised in it, or any aspect of the hospital managers' s.23 power more generally in greater detail if that would be useful.

I should close by saying that, although I am a Lecturer in Law at Lancaster University, the views contained in the above letter are my own, and do not represent those of my employer. Additionally, the same disclaimer should be applied to Lancashire Care NHS Foundation Trust, for whom I sit as a Hospital Manager.

Yours sincerely,

Dr Thomas E. Webb

Lecturer in Law, Lancaster University

Institutional web-page: http://www.lancaster.ac.uk/law/people/tom-webb

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