

**IN THE PUBLIC INTEREST?**

**THE ROLE OF EXECUTIVE DISCRETION IN THE RELEASE OF  
RESTRICTED PATIENTS**

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**A thesis submitted to the Department of Sociology of the London  
School of Economics for the degree of Doctor of Philosophy  
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## ABSTRACT

This thesis is a sociological analysis of the role of executive discretion in decisions about the release of restricted patients. Located in England and Wales, the thesis is an empirical study of the decision-making process, based on fieldwork conducted from 2005-2006 at the Mental Health Unit of the Home Office, and with non-government actors in the system including legal and clinical practitioners, and mental health and victim organisations.

Studying the intersection of mental health and criminal justice at the site of the restricted patient system, the mechanisms for preventive detention within mental health policy have implications for the increasing effort to control dangerousness within criminal justice. Using key areas of literature from criminology, sociology and socio-legal studies, the conceptual tools of analysis include contemporary analyses of penal policy, particularly concerns to control risk; legal decision-making; and constructions of public opinion and their effects on criminal justice policy.

The thesis argues that, while the role of executive discretion was originally intended to meet the public protection agenda, much of the protection offered is symbolic, based largely on reassurance of public fears. The notion of 'the public' is constructed in opposition to the interests of patients, and through particular groups constitutive of the public, including victims of patients. The dominant conception in how the executive understands the public is as people fearful and at risk. This is a reflection of contemporary criminal justice policy which is increasingly looking for frameworks to control dangerousness in ways that the criminal law, because of its traditional reliance upon conviction and consequent sentencing, cannot offer; and whose objects are not only offenders, but other so-called risky individuals whose perceived threat to the public justifies an increasing range of mechanisms for containment.

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### Declaration

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## INTRODUCTION

Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section, either without limit of time or during such period as may be specified in the order; and an order under this section shall be known as "a restriction order" (*Mental Health Act 1983*:section 41).

This thesis examines the role and effect of executive decisions to release patients who have been subject to a restriction order in England and Wales. Restricted patients have been convicted of offences in a Crown Court. They have then been given a hospital order, requiring that they be detained for compulsory treatment of their mental disorder in a hospital, instead of a prison sentence for punishment of their offence. After making a hospital order, the court restricts that order on the grounds that the person poses a particular risk to public safety. The nature of the restriction is that any change in the location of the patient's detention must be made under executive authority. Such changes include transfer to a less or more secure facility, leave privileges and discharge from hospital, either conditionally or absolutely. The executive's authority is exercised under the powers of the Home Secretary. The Mental Health Review Tribunal also has the power to order conditional or absolute discharge of restricted patients, but has no power over the preliminary steps leading towards release.

At the time of my research a restriction order could be time limited by the Court in which the criminal matter was heard, for instance for five years. During this time the Home Secretary and Tribunal had the powers set out above, but once the time expired the restriction order was automatically lifted. However, most restriction orders were indefinite. Time limited restriction orders were subsequently abolished by the *Mental Health Act 2007*.

Once the Court makes a restriction order, the responsibility for the patient's care and treatment rests with the detaining hospital. However decisions

relating to the nature and place of detention in which that care and treatment are provided are made under executive authority. Each step in the progress leading towards release, including leave and transfer to less secure hospitals, is determined by the Home Secretary; and only the Home Secretary or the Mental Health Review Tribunal may authorise a patient's discharge to the community. While the severity of the offence or a history of dangerous behaviour by the patient might be elements that lead to a restriction order being imposed, these are only some of the factors taken into account by the Court (Jones 2004). The purpose of a restriction order is to provide for public protection, and that purpose is the focus of my thesis.

### **Research Questions**

At the time of my research, executive discretion over decisions about the release of offenders had declined significantly from its once-central role in criminal law. While executive discretion was re-emerging as a policy for dealing with politically sensitive and criminalised groups (such as immigration and asylum seekers and terrorism suspects), the restricted patient system was noteworthy because it had maintained executive discretion throughout the era in which government authority over most offenders had been handed to courts, tribunals and quasi-judicial bodies like parole boards. I was interested in exploring why executive discretion remained over the release of these people. The immediate answer, contained in statute, was that executive discretion was retained in the interests of public protection. This answer merely begged further inquiry. Restricted patients were a population of offenders who sat at the intersection of criminal justice and mental health policy. Legally they were patients not offenders. I wanted to investigate why these offender-patients were conceived of as posing such a particular risk to the public that it required the rare exercise of executive discretion over their treatment and release.

I undertook to examine the role and effect of executive discretion on the system, and how the executive met its agenda of public protection. My key research questions were as follows:

- i. How did other actors view the role and effect of the executive in the restricted patient system?
- ii. How was the concept of 'the public' constructed and to what extent did it have an impact upon decision-making in this system?
- iii. How did the executive meet its self-stated aim of protecting the public?

These questions were important because they struck at the central purpose of executive discretion. Here was a department of government traditionally responsible for criminal justice, exercising executive authority over a population of patients detained in hospital. That discretion was exercised in a context where criminal justice policy intersected with mental health, requiring the interaction of very different institutions, principles and personnel. The executive's authority was retained for the purpose of public protection, yet there was no legal clarity as to what that meant. Thus exploring the 'who' and 'how' of public protection was central to understanding the function and effect of executive discretion.

### **Outline of Chapters**

Chapter One sets out the conceptual tools of analysis in this thesis through a review of several bodies of relevant literature. These are:

- i. criminological literature on detention, prevention and protection;
- ii. literature on victim involvement in the criminal justice system;
- iii. the laws and existing research of the restricted patient system in England and Wales; and
- iv. theories of risk in the management of mentally disordered offenders.

The project covered a range of perspectives across criminological and socio-legal theories and there was an extensive range of literature to consider. A complete review of all of it was well beyond the scope or analytical requirements of a doctorate. Therefore my literature review is selectively strategic, focussing on the theories and theorists most relevant to my sociological analysis of executive discretion in the restricted patient system. Chapter One does not constitute the only discussion of theory in this thesis.

A number of areas of relevant literature are considered in subsequent chapters, including decision-making and conceptions of public opinion.

Chapter Two discusses my methodological approach. I explain the origins and design of the project and detail the methods undertaken to obtain the original empirical data introduced in subsequent chapters. The chapter sets out the conduct and progress of fieldwork and then provides a reflexive account of challenges encountered and how these were resolved during my research and analysis.

Chapter Three is the first substantive chapter of the thesis and introduces the Mental Health Unit of the Home Office which was the bureaucratic agency responsible for the supervision of and decision-making about restricted patients at the time of my research. The chapter begins with a discussion of the decision-making literature which was a key tool of analysis throughout this thesis and was not reviewed in the earlier discussion of relevant literature. Focussing on my central interest in the role of the executive in the restricted patient system, the chapter then examines the work of Home Office officials in monitoring and making decisions about restricted patients. In particular, it considers the processes and factors that influenced decisions to approve applications for leave and discharge and to revoke discharge by recalling patients to hospital. The chapter introduces a key element of my thesis that the protection of the public operated in part through a symbolic politics of protection.

Chapter Four examines the relationships between government and non-government actors in the restricted patient system, specifically in relation to the role and exercise of executive discretion. Although practitioners generally accepted the role of the executive in the system, they were concerned at how the Home Office balanced the interests of patients with the public protection agenda. The chapter includes an analysis of multi-agency approaches to restricted patients as a framework for exploring some of the challenges that were raised by the intersection of criminal justice and mental health in this system.

Chapter Five explores how executive decision-makers constructed 'the public'. I argue that the public was constructed in particular ways through specific manifestations of people or groups with whom decision-makers came into contact. Notably, this included the victims of restricted patients. I suggest that the public was conceptualised as the object of executive decision-making in opposition to the patients who were the subjects of those decisions.

Chapter Six analyses one aspect of law reform that took place from 2005-2006 during the period of my fieldwork, focusing on how the government's objectives in that reform reflected its agenda for controlling dangerousness. I argue that the government's focus on risk rather than treatment was largely attributed to the role of the Home Office in the reform process. As restricted patients were the key group of patients with whom the Home Office had contact, the executive's views could have been informed by this group. Yet, mentally disordered offenders received very little attention in the debates that surrounded the process. Consequently, restricted patients constituted a group who defined much of the agenda yet were marginalised in the approaches to law reform of both government and non-government participants.

Chapter Seven is framed around the effect of international human rights instruments on the restricted patient system. Human rights were an important element of case law and legislation in the restricted patient system. I suggest that, by focusing on the implications of human rights for formal procedure, executive decision-makers relegated the protection of restricted patient rights to other actors in the system. My data showed that executive decision-makers perceived their responsibility for patient rights to have been replaced when the authority to discharge was extended to the Mental Health Review Tribunal. At the same time, the Tribunal's powers were relatively limited as a safeguard for the rights of restricted patients.

The brief of the Home Office changed just after the completion of fieldwork for this thesis. In its new structure the Home Office lost its traditional jurisdiction over institutions like courts and prisons; maintained the portfolio of

policing; and acquired a new focus on counter-terrorism. At this time, responsibility for offender management shifted to the Department of Justice and with it went the Mental Health Unit. Nevertheless, the relevance of my research remains as a study of executive decision-making in the interests of public protection.

In conclusion, I argue that while protecting the public was the legislative objective of executive discretion, the way in which that agenda was constructed and achieved was determined by the politics of law and order that marked criminal justice policy at the turn of the last century. The public protection agenda was met in a number of ways, including by containing risks through preventive detention. However the protection offered to the public also operated through symbolic politics, based upon attempts by executive decision-makers to assuage fears and reassure members of the public that their decisions were in the public interest. In order to provide this protection, 'the public' was necessarily conceptualised in opposition to restricted patients. While this construction attempted to provide clarity over responsibilities in decision-making, in practice it produced a dichotomy between the interests of patients and the interests of the public. In that dichotomy, patient interests were continually subsumed within the executive's broad mandate for public protection. Not only did this attract criticism for preventing the progress of patients, but it also established an insurmountable barrier between the objectives of the executive and other actors throughout the restricted patient system.

## CHAPTER 1

### LITERATURE REVIEW

#### Introduction

There is a vast terrain of sociological, health, and legal analysis relevant to this project. There is also an established literature on the intersection of mental health with the criminal justice system, including how laws and courts should respond to mental disorder amongst offender populations, and the increasing challenge of mental illness within escalating prison populations. However there are certain populations within mental health law who have received very little attention in the literature. These are the offenders with mental disorder who are isolated and managed separately from both the general offender and the civil mental health populations. In particular there has been very little analysis of the decision-making processes and outcomes regarding this population. My research contributes a criminological perspective on the role of executive decision-making over restricted patients in England and Wales.

#### *Purpose of this chapter*

This chapter lays the theoretical foundation for the issues I have researched and my analysis of key research questions in the thesis. These questions are:

- i. What is the role and effect of the executive in the restricted patient system?
- ii. How do other actors view the role and effect of the executive in the restricted patient system?
- iii. How is the critical concept of 'the public', which plays a significant part in that system, constructed and to what extent does it have an impact upon decision-making in the system?
- iv. How does the executive meet its mandate of public protection?

In this chapter I cover four bodies of literature which frame how I shall answer these research questions in the ensuing chapters. They are:

- i. criminological literature on detention, prevention and protection;
- ii. criminological literature on victims;
- iii. the laws and existing research of the restricted patient system in England and Wales; and
- iv. theories of risk in the management of mentally disordered offenders.

The theoretical analysis in this chapter will frame discussions throughout my thesis. In the first area I use penal theory to consider the purposes of detention and the uses of indefinite, preventive and protective detention regimes. My thesis is situated broadly within theories of a contemporary practical penalty in criminal justice. From the late 1960s to 1980s, penal policy was focussed on the aim of reducing the prison population (Ashworth 1983). However a new penalty has emerged in recent times, where declining general rates of crime, increasing rates of serious crime, and increased punitiveness are reshaping penal policy towards longer and harsher prison regimes. Contemporary penalty is marked by contradictions at every level, including 'conflicts, interest groups, structural constraints' and 'cultural sensibilities' (Garland 2003:47). Most notably for my purpose, the punitive sentiments of this type of penalty override alternative notions such as rehabilitation, therapeutic intervention and decarceration. The shift towards a more punitive penalty has attracted numerous explanations. For example, in Garland's thesis of penal modernism he suggests that,

what seems to have come into question now, after the acknowledged failure of the most developed form of correctionalism, and in a period when Enlightenment social engineering has become deeply unfashionable, is a basic principle of modern punishment - namely the presumption that crime and deviance are social problems for which there can be a technical institutional solution (Garland 1990:7; see also Garland 2001; 2003).

For Reiner, part of the inherent contradiction of contemporary penalty lies in its discord with other aspects of public policy and debate.

The idea that there is a zero-sum contest between victims and offenders, causal explanation and moral responsibility, understanding

and condemnation, is a key feature of the currently dominant politics of law and order... Punitive obsessions are the undeclared projection, not the obverse, of the evils they condemn (Reiner 2007:19).

Reiner attributes the characteristics of contemporary penality to neo-liberalism which, he says, 'is associated both with higher levels of serious crime than social democracies, and with more punitive and inhumane crime control' (Reiner 2007:13).

I do not seek to conduct a detailed analysis of the identification of, and debates about, the changing nature of penal policy and inquiry. Rather, I am interested in how we can understand some of the shifts in mental health law through the changing agenda of penality. My discussion of penal theory in this chapter lays the groundwork for my substantive analysis later about how the preventive elements of mental health law were used to control dangerousness. Compulsory treatment under mental health law enables detention for preventive or protective purposes justified on the grounds of risk posed by particular individuals categorised as unpredictable and dangerous. As this broadens the scope of detention usually permitted within traditional criminal law, I conclude that there is a lesson for criminology in the scope of preventive and protective detention regimes that lie outside the formal reaches of the criminal justice system; particularly in the existence of regimes which increase the reach and effect of detention on the basis of future behaviour or risk.

I am also interested in criminological accounts of the rise (or return) of a victim focus in criminal justice. Garland and Reiner have talked about the shifting focus towards victims as evidence of the changing landscape of penal policy (Garland 2001; Reiner 2007). Examining the restricted patient system through a criminological lens enabled me to consider what effect these shifts towards a victim focus within criminal justice policy have had on alternative systems like mental health. From my analysis, I suggest that victims are increasingly understood as representatives of the general public, not just as members of it.

The 'public' is a contested term and major questions for this thesis are who was meant by 'the public' and what effect that construction had on decision-making. My discussion considers whether public protection was constructed in response to the challenges of caring for and managing restricted patients, or whether the care and management of restricted patients took place in response to concerns about public protection. For example, how did policy declarations feed into policy- and decision-making and its material expression in terms of outcomes for individual cases? I examine executive decision-makers and both legal and clinical practitioners to analyse these questions further.

I am also interested in the extent to which victims constituted a particular grouping within notions of 'the public'. Exploring the interaction of victim interests and public policy enables an analysis of public perceptions of the restricted patient system, constructions of dangerousness, perceptions of risk, and the notion of protection. While the role of the public in policy development has a long-established tradition, criminal justice policy has taken a particular interest in victim issues in recent decades. I shall explore how this refocusing of criminal justice policy towards victim-related issues has had an impact upon the restricted patient system and particularly on the exercise of executive discretion therein.

This chapter also includes an explanation of the restricted patient system in England and Wales, which was the empirical site for my fieldwork. I begin by setting out the legal structure of this system, showing how restriction orders emerged from existing provisions for compulsory detention under mental health law, as a way of managing people regarded as posing a particular risk of dangerousness to the public. I then review existing research, focussing particularly on decision-making. I draw on some areas that are analogous to my subject to provide a context for my analysis in the absence of an established body of work on restricted patients themselves.

I conclude the chapter with a discussion of the various literatures on risk, specifically from sociological and psychiatric perspectives. Approaches to risk were integral to almost every operation in the restricted patient system. Risk

theory has also been the subject of sustained sociological analysis. My discussion explores the challenges of attempting to weave sociological explanations of risk with the ways it is practiced in forensic psychiatry.

Although imposing a structure for the purpose of discussion brings these areas of literature into sharp relief, my intention is not to present them as distinct, finite bodies of work. The boundaries between them are actually quite fluid. In some cases they run into each other; in others they intersect; and frequently the analysis is relevant at both a theoretical and practical level. For example, the influence of penal policy on criminal law is not unidirectional but interactive, and both areas influence and are influenced by, public opinion. In part, my literature review attempts to elucidate the interaction of theory and practice *per se*, before examining it empirically in the context of the restricted patient system.

The range of theoretical and empirical literature relevant to my study is enormous and reviewing it all would take more than the word limit of a whole thesis. Consequently I have had to be strategically selective in the literature I have explored in terms of volume and how far I could engage with the material. The present chapter is intended to map out the landscape of the laws and system that underpin decisions about the discharge of restricted patients in England and Wales, and of the analytical tools I shall use to analyse them in the substantive chapters of my thesis. Several areas of relevant literature not covered in this chapter, including mental health and human rights, and legal decision-making, are reserved for discussion in subsequent substantive chapters.

### **Section I: Detention, Prevention and Protection**

My research focused on people detained under mental health law. The purpose of their detention was therapeutic, for compulsory treatment of mental disorder; it was *not* punitive. However, I was interested in how public policy and the exercise of executive discretion dealt with the intersection of the therapeutic objectives of mental health law, on the one hand, and the policy imperative of controlling dangerousness on the other. I discuss the origins of the agenda to control dangerousness in the mental health system

in a substantive chapter. However there were other ways to understand the origins of that imperative, not least from the terrain of law and order politics within criminal justice. In this chapter I shall set out some of the dynamics of that 'law and order' context.

In the following section I discuss criminological theories on penal policy. I begin with an analysis of the principles that have traditionally underpinned detention for the purpose of punishment. From here, I examine the growing landscape of preventive and protective detention regimes that have emerged over the last ten years. The purpose of this discussion is to inform consideration in later chapters of the uses of preventive detention in the restricted patient system.

Penality is one of the concepts I shall return to throughout my thesis. I use it in the sense that Garland has set out.

Punishment is taken here to be the legal process whereby violators of the criminal law are condemned and sanctioned in accordance with specified legal categories and procedures. This process is itself complex and differentiated, being composed of the interlinked processes of law-making, conviction, sentencing, and the administration of penalties. It involves discursive frameworks of authority and condemnation, ritual procedures of imposing punishment, a repertoire of penal sanctions, institutions and agencies for the enforcement of sanctions and a rhetoric of symbols, figures, and images by means of which the penal process is represented to its various audiences. ... I have tried to capture this sense of internal complexity by proposing the generic term 'penality' to refer to the network of laws, processes, discourses, representations and institutions which make up the penal realm, and I will use this term as a more precise synonym for 'punishment' in its wider sense (Garland 1990:17).

### ***The purpose of punishment***

The even-handedness of justice is that of universal conscription against a common enemy ... of the abstract definition of rights which places the ban upon anyone who falls outside of its rigid terms. Thus we see society almost helpless in the [grip] of the hostile attitude it has taken towards those who break its laws and contravene its institutions. Hostility towards the lawbreaker inevitably brings with it the attitudes of retribution, repression, and exclusion. These provide no principles for the eradication of crime, for returning the delinquent to normal social relations, nor for stating the transgressed rights and institutions in terms of these positive social functions (Mead 1918).

In traditional criminal law, detention has been utilised as, and sometimes for, punishment. Mead's classic work posited that 'retribution' (deterrence to the offender) and 'prevention' (deterrence to others) were instinctive social responses that shaped public perceptions of criminal justice (*ibid*). The utility of Mead's work today reminds us that many of the contemporary debates about penal policy are not new; and indeed, that penal policy has continuously shifted between expressions of harshness and other sentiments. Alternative approaches have also emerged, such as the growth of restorative justice initiatives. Yet, within the shifting terrain of penal policies, punitiveness has remained on the agenda in one form or another.

In my analysis I use the term 'punitiveness' to connote the use of detention not just as a form of punishment but for punishment. To explain this by way of example, a convicted offender might be sent to prison as punishment. Here, punishment is in the form of the deprivation of liberty that comes from being confined in prison. However, an offender who is sent to prison for punishment might expect a set of harsh conditions while in prison that are intended to make the prisoner experience fear or suffer in other ways.

In the case of mental health law, detention has traditionally been intended for the purpose of compulsory treatment of mental disorder. One of the questions I was interested in considering at the outset of my doctorate was whether the increasing punitiveness observed in criminal justice was being replicated in other systems, such as that of detention under mental health law.

The idea of punishment over and above the fact of detention has gained increasing popularity. In the 1980s, even when the dominant theme of penal policy was a reduction of the prison population (Ashworth 1983), punishment remained on the policy agenda. For instance, Hawkins showed how parole boards utilised their decision-making powers to inflict punishment on inmates who misbehaved (Hawkins 1986). Suggesting that decisions were based on the form of an offender's conduct, rather than its content, Hawkins argued that 'parole board decisions often have little to do with judgments about "rehabilitation", or "risk", or other aspects of a prisoner's future conduct' (Hawkins 1986). Decisions about release were influenced by the behaviour of the offender whilst enduring their punishment through loss of liberty in prison, not simply because of it.

Penal theory has always posited punishment as a means to an end (Garland 1990). Where Mead accounted for that in terms of controlling crime (Mead 1918), other explanations suggested that punishment served more of a social role. For example, Durkheim believed that principles of punishment explained much about social order, and that penal sanctioning was a process that 'both expressed and regenerated society's values' (Garland 1990:23).<sup>1</sup> By contrast, Foucault was interested in the 'internal workings' of punishments: the actual technologies of penal power and their mode of operation (Garland 1990:131). Yet, as Garland argues, institutions are

never fully explicable purely in terms of their 'purposes' ... if we are to understand such artefacts we have to think of them as social and cultural entities whose meanings can only be unravelled by careful analysis and detailed examination (Garland 1990).

While theories of punishment are fascinating in themselves, they are not the subject of my research. However it is important to understand the social context in which punishment takes place and the purposes of it for my subsequent analysis of detention as a mechanism for controlling dangerousness.

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<sup>1</sup> Of course, Durkheim was also motivated by the search for 'the sources of social solidarity which were, for him, the fundamental conditions of collective life and social cohesion', as Garland goes on to point out in his critique (Garland 1990:23).

Additional principles or frameworks which have an impact upon the utility of punishment can also provide some direction on the deeper meanings of punishment. One of the most important of these is the principle of proportionality. A key principle of penal theory is that the amount of time a person is deprived of their liberty should be proportionate to the offence committed. Building on a well-established tradition of scholarship in this area Lukes and Scull argued that the very nature of proportionality pointed to another purpose of punishment - that of prevention (1983). They argued that gradations in punishment were necessary to meet its preventive objectives. Proportionality is nonetheless a contentious issue in penal theory, not least for its applicability to criminal justice processes. Duff and Garland have outlined an argument made by many that, while proportionality may be an idealised principle in theory, it is almost impossible to achieve in practice.

First ... we cannot in practice hope to achieve a proper proportionality between crime and punishment; second, that there are other principles such as that of parsimony in punishment which may conflict with the demands of proportionality; and third that an undue emphasis on strict proportionality stands in the way of making effective use of the wide range of 'intermediate sanctions' which are finding favour amongst penal policy-makers (Duff and Garland 1994:19).

Their critique hints at the irreconcilability of theories of proportionality on the one hand and the practical ways that punishment and detention play out on the other. This tension is also present in systems of control of mentally disordered offenders. For example, an issue that frequently arises is the question of how to respond to evidence of drug use by patients. An example from the jurisdiction of New South Wales (Australia) is a case in point. Wheeler looked at forensic patients who were on conditional discharge in the community, who subsequently tested positive for drug use (2003). Under the recall powers in that jurisdiction, the patients were returned to detention for breaching their conditions of release. Wheeler found that the fact of being subject to executive discretion could result in a patient being detained for months or years as a result of one positive drug test. Yet, had the person been charged, tried and convicted for that drug use in a criminal procedure, they would have been unlikely to receive a period of detention at all. Whilst the example is Australian, the implications have universal application for systems of executive discretion. Charged with protecting the public,

executive decision-makers are unlikely to be deterred from returning someone to detention, simply because it might be a disproportionately harsh response. As Rose argues,

a whole variety of paralegal forms of confinement are being devised ... not so much in the name of law and order, but in the name of the community that they threaten, the name of the actual or potential victims they violate. It appears that the convention of 'rule of law' must be waived for the protection of the community against a growing number of 'predators', who do not conform to either legalistic or psychiatric models of subjectivity (2000).

The potential exists for restricted patients to suffer disproportionately greater penalties than people in the community or other offenders, by virtue of the unfettered discretion the executive has to respond to incidents that take place while a person is on a restriction order. Thus the principle of proportionality raises particular challenges in the context of these mentally disordered offenders.

Bean has argued that 'special restrictions ought not to last longer than a period proportionate to the gravity of the offence for which they were imposed' (1986). Indefinite detention, therefore, raises particular concerns in relation to proportionality. For Wood, because offenders with a hospital order do not have a set date of discharge, 'the lottery of uncertain diagnosis and lack of clarity about appropriate places of detention leads to many clear examples of injustice' (1993). This suggests that not only should the purpose of detention be clear, but the length of that detention should have regard to questions of proportionality, as well as clinical and other considerations.

Essentially, the principle of proportionality turns on the notion that prison sentences (or other measures involving the deprivation of liberty) should be limited with respect to the behaviour they are punishing. A logical extension of the principle of proportionality is that detention ought not to be indefinite. However there have been arguments adduced in favour of indefinite detention, primarily as a solution to the problem of dangerous or high rate offenders (Greenwood 1983). Indeterminate sentences and indefinite detention have been canvassed in relation to selective incapacitation, described by Wilson as a policy that 'reserves the most [prison] spaces and

longest terms for those offenders who commit the most crime while free on the street' (Wilson 1983:279).

These arguments for indefinite detention are useful in considering the way incapacitation as punishment for offending has taken shape in various aspects of criminal justice policy. They are particularly important to bear in mind with respect to the restricted patient system, because of its position at the intersection of criminal justice and mental health policy. The purpose of indefinite detention in the mental health system contrasts strikingly with that in criminal justice policy. Under mental health law, indefinite detention is the basis for compulsory treatment of a mental disorder, for as long as it takes to treat that disorder such that it is no longer of a nature or severity to require compulsory treatment. As such, indefinite detention in mental health law has a therapeutic utility.

This leads to a question which underpins my thesis: what is the role of proportionality in a system where people are detained indefinitely for the purpose of treatment, but as a result of committing an illegal action? Tariffs provide one example of an attempt at proportionality. They are utilised in the UK through the provisions of discretionary life sentences for serious and violent offenders who pose a risk to society. However Mackay has argued that in Canada the contradictory objectives of sentencing policy rendered tariffs ineffective (1995). These provisions were intended to curb the use of compulsory detention under mental health law to detain mentally disordered offenders for disproportionately long periods of time. He found that capping periods of detention for people found unfit to plead or insane were undermined by simultaneously requiring minimum sentences for murder and other serious offences. Whilst capping periods of detention was intended to bring proportionality into the realm of detention of mentally disordered offenders, the objectives of punishment and therapy were simply irreconcilable in practice.

### ***Protective sentencing and preventive detention***

The principle of proportionality is challenged by the ever-increasing range of detention regimes designed to prevent future offending through the logic of

containment (Reiner 2007). Concern about preventive detention is not a recent development in English criminal law. For example, reporting in 1963 the Advisory Council on the Treatment of Offenders argued that the preventive detention regime of the *Criminal Justice Act 1948* was ineffective and contradicted the attempts at a more rehabilitative penal policy of the time (Advisory Council on the Treatment of Offenders 1963). It is a particular mark of modern penality that many of the issues at its core, and the strategies employed to address them, are not new. At the same time, sentencing legislation is an area of policy that changes constantly. These shifts make it an incredibly difficult area to review comprehensively. Yet, it is vital to consider sentencing in the context of notions of public protection and their effect on individual offenders. To that end, the following discussion focuses upon some of the characteristics of preventive detention in contemporary criminal justice policy.

In recent years protective sentencing regimes have emerged sometimes as an extension of existing preventive detention regimes and sometimes as an alternative framework altogether. These regimes are frequently justified on the grounds that 'the harm predicted by any future criminal behaviour on the offender's part is judged greater than the harm inflicted on the offender through the imposition of an additional period of incapacitation' (Henham 2003:58). As Henham argues, protective sentencing legislation has replaced the approach to sanctioning offenders for past offending behaviour with

policies aimed at public protection from predicted future harm. .... The focus of dangerousness assessment and its classification ... became a measure of the extent to which the public needed to be protected from such offenders (2003:59).

Henham argues that protective sentencing is 'a social defence strategy whose political agenda is predicated on the social control of individuals whom the state declares have forfeited their right to be presumed harmless' (2003:65). This echoes Mead's concept of 'instinctive punitiveness'. Yet protective sentencing also raises questions of legitimacy. To what extent should public policy be reactive to public attitudes such as punitiveness or the desire to be protected? Can we assume a clear, coherent structure to the

development and implementation of policy in response to public sentiments? O'Malley has argued that contemporary penal policy is marked by 'volatile and contradictory punishments' in which the policy objectives and evidence-based outcomes are not only inconsistent but may even be diametrically opposed (1999). In other cases there may be a lack of clarity over whether such sentencing policy is punitive or preventive (Henham 2003). Indeed, the question of whether a penal policy is punitive or preventive assumes that sentencing should perform one task only, which is not necessarily the case.

Nevertheless, as the debates about protective sentencing illustrate, critics have been concerned to make a distinction between the punitive and protective elements of penal policy. In another example, Padfield studied discretionary lifer legislation which enables prolonged detention of offenders who are likely to re-offend on the grounds of public protection.<sup>2</sup> She found,

no evidence that deterrence is likely to have an effect on those who commit the most serious crimes for which a life sentence is likely to be imposed. Nor can deterrence itself justify disproportionate penalties. As soon as one accepts that not all lifers are 'dangerous' one has admitted that the sentence is sometimes disproportionate. Nor can life imprisonment be easily justified as an incapacitation or as social protection: many people will be falsely included in the net of the incapacitated. 'Risk', as we have seen, is notoriously difficult to predict (Padfield 2002:152).

The implications are clear and manifold. Whilst the intention of protective sentencing is to protect the public through extended incapacitation, there is no guarantee that it is always successful. Moreover, incapacitation comes at the cost of an additionally punitive effect on the offender. Therefore, increasing degrees of punitiveness are justified on the basis of public protection.

In his analysis of contemporary mental health policy, Monahan observed a difference between the USA, which used mental health law to prolong control of convicted persons nearing the end of their sentence, and the UK, which sought to control those assessed as presenting high risk who had not

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2 The likelihood of recidivism must be to a degree as severe as the index offence for which they were convicted. The sentence involves a tariff setting out the minimum term to be served for the purpose of punishment.

necessarily been convicted (2004). In both cases, the protection of the public was used to justify a protective agenda which prolonged the detention of the mentally disordered offender. Indeed, as Fennell & Yeats argue, discretionary life sentences in England and Wales have resorted to protective sentencing in response to potential risks posed by mentally disordered offenders (2002). The relevance of this discussion to my thesis lies in the increasing conflation of punitiveness towards offenders and protection of the public, through extended periods of detention designed to prevent harm. The implication is that public protection is a justification used to mask punitiveness in longer periods of detention for particular populations. As I shall discuss in later chapters, the very low reconviction rates of restricted patients compared with offender populations were used by some in the system to suggest that these patients were being detained for far longer periods than was warranted either for their treatment or for public protection.

My research revealed that protection of the public was the key consideration of government decision-makers in the restricted patient system. Yet there had been little inquiry in to whether or how the protective trends in alternative systems had affected the restricted system. For example, what was the effect of the protection agenda in a system where the purpose of detention was not punishment but was therapeutic intervention? I consider this question in subsequent chapters of my thesis.

A final consideration regarding punitiveness rests on the priority given to the prevention of risk in penal policy. Undoubtedly, imprisonment itself is still a relatively infrequent penalty considered as a proportion of all convictions. However, my discussion has focused on aspects of prison punishment to enable subsequent analysis of some of the comparisons and contrasts between the purposes of detention in mental health law and criminal justice. In the latter context, one of the ways the purposes of detention have been blurred is through the increasingly punitive effect of attempts to control risk by preventing future acts (Brown and Pratt 2000). Hope & Sparks argue that this preoccupation with risk is not entirely new (2000). Rather, it is the result of 'a series of curious hybrids, whose common context is an intense attention to the process of punishment and to politician's increasingly extravagant claims

to be able to buttress social order through the incarceration of offenders' (Hope and Sparks 2000:7). I am interested in whether this hybrid model is reflected in the restricted patient system. Peay argues that the ability to provide effective intervention to offenders with mental disorder is limited (1993). At an individual level this can serve to undermine the interests of the mentally disordered person in question, such as via compulsory treatment. At a more structural level the preoccupation with risk that underpins contemporary sentencing practices has the potential to leave mentally disordered offenders 'being dealt with more harshly' (Peay 2002:747). Perhaps the elements of punitiveness that pervade penal policy are simply unavoidable in the restricted patient system.

The quotation above from Hope and Sparks points to the politicisation of penal policy towards greater punitiveness. A detailed analysis of the relationship between public perceptions of criminal justice and the shaping of penal policy is beyond the scope of this thesis. However these are important elements of the decision frames operating in the restricted patient system. This means they have an influence on the environment in which these decisions are made. In the thesis I explore the interaction between punitiveness and public opinion as it effects government decisions about restricted patients. Questions considered to this end include whether punitiveness is a factor in this system and if so, how? As Peay notes, for the systems responding to criminal offending by people with mental illness, the competing demands of crime control (protection of the community on the one hand, punishment or treatment of the offender on the other) mean that these systems are 'subject to conflicting pressures deriving from societal and individual interests' (Peay 1993:44).<sup>3</sup> If punitiveness is present in this system, does it determine public opinion? Is it a response to public opinion? Or is there a more complicated process of interaction? I will return to these issues in my analysis in later chapters.

This discussion has introduced the elements of punitiveness, protection and proportionality in contemporary penal policy to provide some terms of

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<sup>3</sup> These conflicting pressures are the subject of further analysis in subsequent chapters.

reference for the various uses of detention in contemporary policy. As I discuss below, the purpose of detention in mental health law contrasts strikingly with that in criminal justice. Far from punishment, it is intended to ensure the therapeutic application of mental health care to people who may not choose it of their own volition. And yet, as my thesis unfolds what will become clear is the potential for these very different purposes of detention to be increasingly blurred by a policy priority on public protection at the exclusion of individual rights and liberties.

## **Section II: Victims**

One of the original research questions for this project was how the increasing focus on victims in criminal justice policy was affecting executive decision-making about the release of restricted patients. Through my empirical work it became clear that the role of the executive was firmly embedded in the agenda of public protection. Within this framework, victims became subsumed within a broader research question of what 'public protection' meant. Who was protected and how? This led to a theoretical re-conceptualisation of victims not just as a unique group in isolation but also as constituent of the public. These considerations form the substance of subsequent chapters. I introduce them here with a discussion of the rise (or re-emergence) of the victim in recent decades firstly in criminological research, and then in criminal justice policy.

### ***Attention to Victims in Research***

Victims have burst onto the stage of criminological research and public policy over the past two decades. This is reflected in a notable (indeed monotonous) trend in most victimological literature to tell the story of this phenomenon. Most discussions of victims begin with a *précis* of the origins of interest in victims and the sudden analytical and political currency of victims. These narratives are generally repetitive and far more detailed than I present here. Rather than cover this ground again I am interested in why these explanations should be felt necessary in so much of the literature. I suggest that it is in part an acknowledgement of just how recent and pervasive the shift towards victims has been. Importantly for my research, the recent

timeframe accounts for the disparity between the evidence of the considerable body of victim-related research, and how the orientation of policy towards victims manifests itself in public policy.

The notion that victims were 'the forgotten man' in criminal justice was central to the early stages of criminological inquiry into victims (Shapland *et al* 1985:176). Historically, victims had a much more central role in criminal justice processes and even shouldered the financial and evidentiary responsibilities for prosecution (Shapland *et al* 1985; Bianchi 1994). Contemporary liberal criminal law emerged out of the political control of the population by Norman kings, which developed the notion of crime as an offence against the state, rather than as conflict between citizens (Bianchi 1994).<sup>4</sup> Over time, this shift resulted in the bureaucratisation of a system for responding to crime, with the victim 'no longer playing a role of importance and no longer able to stop a criminal procedure by settlement without the consent of the state's prosecutors' (Bianchi 1994:17; Rock 2004b). Since then and until very recently, victims were only incorporated in criminal justice as witnesses, if at all. 'Victim's interests were subsumed within the public interest, [believing] that, in the long run, the state's correctionalist policies would work to the interest of both the public and the offender' (Garland 2001:121).

It is no longer the case that victims are forgotten by criminal justice policy (Zedner 2002). In a very short time a veritable canon has developed on the subject of victims in the fields of criminology, sociology, social policy, law, health, psychology and geography (see for example Shapland *et al* 1985; see for example Christie 1986; Fattah 1986; Rock 1986; Mawby and Walklate 1994; Newburn and Stanko 1994; Davies *et al* 1996; Stanko 2000; Zedner 2002; Rock 2004; Walklate 2007). Moreover, as Walklate notes, 'a concern with and for the victim of crime has become not just a symbolic reference point in government policy but the dominant one' (Walklate 2007:7). Reviewing this entire literature is neither necessary nor relevant

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<sup>4</sup> Interestingly, Bianchi suggests this as one explanation for the origins of punitiveness, as 'crime was no longer viewed as a regulable conflict but as a social heresy, the state's business' (Bianchi 1994:17).

here. Instead, I wish to focus on several themes in the literature which I will draw on throughout my thesis.

Firstly, the 'ideal victim', conceptualised in Christie's classic work, has been a key theme in much of the literature (1986). Christie defined the ideal victim as constituted by his or her (relative) powerlessness. Using the example of women as victims of crime, Christie argued that as women gained greater economic power, they would have greater power to demand recognition as victims. However as their power increased their *status* as ideal victim would diminish.

In being an ideal victim, she (or sometimes he) must be strong enough to be listened to, or dare to talk. But she (he) must at the very same time be *weak enough not to become a threat to other important interests*. A minimum of strength is a precondition to being listened to, but sufficient strength to threaten others would not be a good base for creating the type of general and public sympathy that is associated with the status of being a victim (Christie 1986:21, emphasis in original).

As important as Christie's work has been in scholarship about victims, the notion of an idealised victim type has been challenged by other work pointing to the utilitarian and sometimes competitive aspects of victim status. In their analysis of the introduction of hate crime laws in the USA in the 1980s, Jacobs and Potter pointed to the structured hierarchies of violent offending, and by extension of victims, that were created through these laws.

It might be tempting to conclude that jealousies and resentments over exclusions from the hate crime laws can be avoided by drafting these laws to include all salient prejudices. While that would solve the problem of disparaging some groups' victimisations in comparison to others', it would also negate the primary purpose of the hate crime laws: to specially condemn offenders with certain prejudices and specially recognize their victims. Hate crime laws only make sense if certain bigoted offenders are condemned more forcefully and punished more severely than offenders who commit the same crimes but for nonprejudiced reasons. It is the *exclusion* that gives these laws their symbolic power and meaning (Jacobs and Potter 1998:133, emphasis in quotation).

In other words, attaining victim status is a mark of power in a competitive landscape of identity politics.

Writing more recently, Rock notes that 'victim' is not necessarily an 'appealing term', connoting contradictory images of pariah and saint. These contradictions are also evident in the multiple meanings ascribed to victim status:

it tends preponderantly to convey stigmatised meanings of weakness, loss and pain. .... On the other hand, becoming a victim can have its rewards: sympathy; attention; being treated as blameless; the ability to bestow meaning and control on an untoward and disturbing experience; the receiving of exoneration, absolution, validation and credit, exemption from prosecution, mitigation of punishment and financial compensation (Rock 2002:14).

Secondly, and despite the idealisation of victim types, empirical research has found very high correlations between victim and offender demographics, particularly in the shared experience of victimisation by many offenders. What it means to be a 'victim' is complicated even further, for instance, by the secondary stigma associated with the families of offenders, which can lead to both direct and indirect victimisation (see for example Condry 2007). Moreover, there are particular characteristics shared by those most likely to offend and those who have suffered the severest victimisation, as Rock has noted.

They tend to be those at the margins of groups and the feet of hierarchies: the young, male, members of minority-ethnic groups, offenders, squatters, single adults, the geographically mobile, the homeless and the residents of inner city and satellite estates (Rock 2002:21).

Thirdly, and by contrast, as victimised populations have been increasingly scrutinised, research has simultaneously examined the success of victim claims, particularly the way in which certain voices have been privileged over others within the terrain of victim's interests. Zedner argues that,

criminological understanding of victims' needs is largely reliant on views expressed by victims themselves - a source that is necessarily problematic. Vocal, determined, or well-connected victims may express their needs forcibly, ironically at the expense of those whose needs are greatest but whose very vulnerability or inability to ask for help ensures their silence (Zedner 2002:431).

One important consequence of this has been that the success of particular political claims of victims may not reflect the range and diverse objectives of

all victims. Zedner attributes the political currency of victims to successful lobbying, but argues that it is disproportionately greater than their actual needs within criminal justice processes (2002). In other words the loudest voice is not always the most representative.

Media and political messages play a role here producing 'opposing distortions ... where innocent victims tend to be depicted as the very antithesis of wicked criminals' (Rock 2002:14). Rock posits one account for this inability to reconcile the connections between victims and offenders as the failure to consider victimisation as 'interaction' (Rock 2002:18). But it is the policy and process outcome that I shall focus on in chapters to come; that is, the hegemonic positioning of victim interests over other groups in criminal justice policy and process.

The point of this discussion is not to excuse offences committed by people who have also been victimised. Rather, it is to acknowledge that the notion of victims and offenders as two distinct, opposing categories does not reflect the reality of lived experience for many people. To what extent this reality is reflected in policy is another matter. At the point where research and policy intersect, there has been an acknowledgement that policy responses do not always meet the aims and objectives of victims themselves. Rock suggests that, in the priority placed on victims at the Home Office, 'victims and witnesses came ineluctably to take some part of their character from their relation to the twin imperatives of crime reduction and public confidence' (Rock 2004:38). However victims themselves recognised that the politics of the system meant that their own concerns would have an impact only in so far as they suited government objectives of the day (Rock 2004). In other words, the success of victim advocacy may depend upon broader political objectives, which may also mean that the responses to that advocacy are not necessarily what was sought. The extent to which these complexities are engaged with by government responses to both victims and offenders in the restricted patient system is something I consider at length in subsequent chapters.

### **Attention to Victims in Policy**

Earlier I suggested that the standard *précis* of the rise (or re-emergence) of the victim is an acknowledgment of the phenomenal developments around crime victims in a very short space of time. However it can also be seen as an account of the disjunction between the evidence that has emerged from victimological research and how systems respond to victims in practice. Most research on victims does not claim to be definitive about the origins, intentions or effects of victim engagement with criminal justice. However, there is a clear mismatch between what has been well-established within the literature and the directions taken in how policies respond to victims.

The best example of this disjunction is the persistent idea that victims and offenders are distinct, opposing categories. As Christie argued, 'the more ideal a victim is, the more ideal becomes the offender' (Christie 1986:25). Thus offenders are often defined against, or understood in relation to their victims. This attitude has become entrenched in public policy in particular ways, one of which is the use of victim surveys. Stanko suggests that 'the crime survey provides an opportunity to gain a wider picture of crime by allowing the public to give their own account of criminal harm and express anxiety about its potential' (2000:15). Crime has been increasingly understood in relation to the identification of victims; and its severity increasingly measured (in part) by its correlative impact upon victims. 'If a problem of crime is to be taken "seriously", it seems that a crime survey is one of the major devices used to demonstrate the pervasiveness of an issue and to advocate for sympathetic treatment of newly identified "victims" (*ibid*). This is despite questions raised about both their validity and application. As Hough and Roberts note, some survey responses are a direct product of the methodologies employed and therefore 'the correct political response is to disregard what is essentially unreliable evidence' (Hough and Roberts 1998:13). Meanwhile, Rock has suggested that surveys influence perceptions and behaviour no matter how unrepresentative they are:

although public attitudes can assume many shapes, surveys do have a most important effect on political and social conduct. ... Ironically, what may initially appear to be sociologically naive is actually a fairly literal and exhaustive definition of one manifestation of the phenomenon of society's attitudes (1986:34).

Defining social attitudes in this way serves an instrumental purpose in providing a tangible basis for public policy. The representativeness of these attitudes is not called into question. Nevertheless, surveys have been a factor in shaping public perceptions of crime. This framework allows for little nuance in perceptions of victims and offenders. If the fact and severity of crime is understood by its effect on victims, then victims and offenders can only be understood as opposing forces.

This runs counter to the evidence, outlined above, of the correlation between experiences of victimisation and offending. However, it also runs counter to the objectives of many victims in terms of the outcomes of their offender's cases. For example, in characterising victims and offenders as having dichotomously opposed interests, victim interests are easily conflated with punitiveness. As I shall discuss in subsequent chapters, this is as much reflected in relation to restricted patients as to other offenders, where media coverage is frequently accompanied by distraught or enraged messages of vengeance from victims. Yet there is significant evidence to suggest that victim concerns are often far from this. Some of the earliest work on victim involvement in criminal justice found that victims were not 'particularly punitive in the sentences they wanted their offenders to receive', focussing instead on things the victim wanted directly from the offender such as compensation (Shapland *et al* 1985:177). In restricted patient cases Rock found similarly that victim involvement was motivated by a desire to see systemic reform rather than individuals punished (1996). These findings bore out those of Hough and Roberts about public opinion more generally (1998). Examining public opinion on sentencing trends, they found that most public opinion was in response to specific, targeted polling, expressed in the absence of detailed knowledge about the issue in question.<sup>5</sup> When informed about sentencing policy and trends, public opinion had a much closer 'convergence with actual sentencing decisions' (Hough and Roberts 1998:23). Perhaps, then, the notion of a definitive victim standpoint is as

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5 Once again, the distinction between public opinion and public knowledge was not a new one. Writing in the 1970s, Gardiner had noted that, 'unless some unusual event publicizes the policies followed by enforcement agencies and makes them particularly salient to the mass public, the attitudes of the average citizen may not be particularly relevant to the process of law-enforcement policy-making' (Gardiner 1970:33).

much a product of the questions asked of victims and the way they are reported, than of the content and detail of what victims actually want.

A good example of the divergence between the *characterisation* of victim interests and the interests themselves comes from the restricted patient system. As I discuss in this thesis, the victim organisation most involved in the restricted patient system was The Zito Trust. A key element of its advocacy platform has been systemic reform to ensure mentally disordered offenders receive adequate care and treatment to reduce their likelihood of offending. This is not to suggest that victims and offenders are actually seeking the same outcomes. The Zito Trust's approach to care and treatment includes ensuring that offender-patients are compliant with prescribed medication, which some argue is punitive from an offender's perspective. My point is simply to acknowledge how complex and multifaceted victim perspectives are in the area of criminal justice and mental health.

By the time of my research, criminal justice policy was characterised by slogans that talked of 'placing victims at the heart of criminal justice processes' (Home Office 2006). Attention to victim interests was increasingly at the fore of reforms and policy initiatives, and victims were attaining formal recognition as stakeholders in criminal justice processes and outcomes. As my data will show, the strength of the political currency of victims in executive decision-making about restricted patients was undeniable. Yet there has been little research on the extent and effect of victim involvement on executive decision-making models, and in relation to mentally disordered offenders. Throughout my thesis I shall consider a number of questions in this regard, including the extent to which policies introduced as a response to victim lobbying reflected what victims themselves wanted; and the extent to which victims became integral to constructions of the public interest more generally.

### **Section III: The Laws and Existing Research of the Restricted Patient System**

The discussion so far has examined criminological literature about trends in contemporary penal policy and the return of the victim to having a central focus within criminal justice. This analysis sets a theoretical context for examining the effects of criminal justice on mental health policy and on the management of restricted patients throughout my thesis. In the following discussion I introduce the mental health system which was the object of my study.

I begin by setting out how the restricted patient system operated in terms of law. I then explore the research in the field up to the time of my fieldwork and sociological debates about the construction of mental illness and mentally disordered offenders. These discussions set out the terrain which I analyse in the rest of the thesis.

#### ***Restriction Orders***

Restriction orders are a category of hospital order contained in the law of England and Wales, as set out in the *Mental Health Act 1983* (Part III). A hospital order is the process by which a court, after convicting a person of a criminal offence, orders the offender to be treated in hospital for his or her mental disorder. A standard hospital order allows a hospital to release an offender when it is clinically appropriate to do so (Dell and Grounds 1995). Sometimes a convicted person might be discharged from hospital and then taken to prison to serve their sentence. By contrast, a restriction order is made when a court entertains concerns about risks to public safety posed by the offender (Potts 1995). While the offender never serves a prison sentence, his or her discharge can only be determined by the Home Secretary or the Mental Health Review Tribunal. A court may impose a time limited restriction order, meaning that the patient must be discharged once the time has expired, if not before.<sup>6</sup> When this occurs, the limited period is five years on

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<sup>6</sup> This provision was removed with the introduction of the *Mental Health Act 2007*, following the completion of my fieldwork.

average (Street 1998). However it is rare for courts to impose a time-limited restriction order (Peay 2003). Most restriction orders result in an offender being detained indefinitely and, until 1983, his or her release could only be determined by the Home Secretary. Case law from the European Court of Human Rights required the establishment of a process of independent review for all hospital orders (Verdun-Jones 1989), and led to amendments to the *Mental Health Act 1983* empowering the Tribunal to release restricted patients. However, in restricted cases the Tribunal does not have any power over the processes leading to the point of discharge, including transfer to less secure facilities and leave. Nor does the Tribunal have a role in monitoring patients in the community on conditional discharge. The Tribunal's power over restricted patients is limited to conditional or absolute discharge. (The European and UK human rights frameworks have been extremely important in shaping this legal regime and are considered in detail in Chapter Seven.)

### ***Mentally Disordered Offenders as Social Construction***

My sociological approach to this field is informed by some of the classic literature dating from the 1960s and 1970s as well as by contemporary analysis. Central to this literature has been the development of the idea that mental illness was socially constructed. Thomas Szasz, himself a psychiatrist, posited that mental illness was 'a metaphorical disease' (Szasz 1974:x) and that 'psychiatry is not a medical, but a moral and political, enterprise' (Szasz 1974:xiii). Szasz's viewpoint is included here not to argue whether or not it is true but to point to the myriad perspectives of analysis and criticism to which psychiatry has been subject over the years. For my own purpose, the strength of Szasz's critique lies in the attribution of social values to medical processes.

The temptation to embrace all medical interventions as forms of therapy, or to reject them all as forms of social control, must be firmly resisted. It behoves us, instead, to discriminate intelligently and to describe honestly the things doctors do to cure the sick and things they do to control the deviant (Szasz 1974:69).

My own structuralist approach is informed by this framework. I do not seek to discount the function or utility of psychiatry, an exercise which would lead to a different thesis altogether and would undermine the very site of my

empirical fieldwork.<sup>7</sup> The point of departure for this study is that a legal process, involving psychiatric diagnosis, has resulted in a restriction order. Thus I am interested in examining restricted patients through the intersection of medical as well as legal models of practice. However, I am also interested in how social perceptions such as fear influence decision-making in this arena. The challenge of reconciling medical and sociological approaches in the literature in this chapter is analogous to the empirical challenge of examining the intersection of health and legal frameworks in the restricted patient system.

Goffman's work was also important in shaping my approach to fieldwork and analysing the attitudes of actors within that site. Goffman argued that 'mental patients distinctively suffer not from mental illness, but from contingencies' (Goffman 1961:126). Whilst the detention of people in psychiatric hospitals can be justified by those outside ('in society'), in reality the distinction between who is inside and outside may be relatively arbitrary. The legacy of this argument resonates in critiques of the randomness of the classification of people as mentally disordered offenders, discussed below. Goffman did not take a nihilist view that mental illness does not exist. Rather, he was interested in people who were detained because of their mental illness. Understanding detention as a result of contingencies complicated the notion of madness as an objective, diagnosable, physiological condition and situated it within broader social processes of inclusion and exclusion.

Goffman was also interested in the question of protection of the public. As he saw it, 'part of the official mandate of the public mental hospital is to protect the community from the danger and nuisance of certain kinds of misconduct' (Goffman 1961:307). For Goffman, the elements of danger and nuisance posed by people with mental disorder were key in justifying detention for the purpose of social exclusion. Goffman's work is also relevant to this study methodologically. His essays on psychiatric asylums integrated theoretical discussion of the purpose of incarceration with the analysis of the processes and people engaged in those institutions. He examined the relationships

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<sup>7</sup> Of course medical and scientific processes are themselves socialised, the discussion of which would take me away from the aims of my thesis.

between staff and inmates in asylums, showing how those processes produced meaning themselves, as well as being shaped by the impact of institutional imperatives and expectations upon them. Goffman found that relationships between psychiatrists and inmates were,

doomed by the institutional context to a false and difficult relationship and are constantly funnelled into the contact that will express it: the psychiatrist must extend service civility from the stance of a server but can no more continue in that stance than the patient can accept it (1961:320).

Goffman's interest in what he termed the 'governed' and the 'governors' was instrumental in turning sociological inquiry towards the interaction between all the players in institutions of incarceration, not simply the inmates. My interest in decision-making is underpinned by this philosophy that values inquiry into the origins and practices of power, not simply its objects.

### ***Mentally Disordered Offenders: the Legal Context***

According to Peay, the notion of 'mentally disordered offender' as a meaningful category ignores the 'plurality' of mentally disordered offenders as neither a homogenous nor exclusive population, who challenge accepted notions of illness and offending behaviour (Peay 2002:746; see also Peay 2004). James *et al* also note that the singular nature of a classification of 'mentally disordered offender' obscures the many differences amongst the people included within it, such as between people who have been convicted of an offence and diverted to hospital prior to serving a sentence; people who have been transferred out of prison into hospital for compulsory treatment; people who have been found unfit to stand trial because of their mental disorder; people who have been acquitted on the grounds of insanity; and people who have been convicted of an offence but diverted to hospital for compulsory treatment of their mental disorder instead of serving a prison sentence (2002).

Most restricted patients fall into the last group and have often committed very serious offences which may involve violence or harm to others, including manslaughter. However, restricted patients are not necessarily serious or violent offenders. The specific criteria for a restriction order are based upon

the court having concerns about the protection of the public. While this concern should be in relation to the nature of the offence and the risk of further offences, it does not necessarily follow that the offences involved will be violent in nature. The important point here is that the category of 'mentally disordered offenders' masks a wide range of mental conditions, criminal offences and histories of contact with the institutions of mental health and criminal justice. Whilst it is important to acknowledge the wide application of the term, and consequently the problem of deriving clear meaning from it, nonetheless it is a construction that is dominant in the language of the system on which my thesis is based, and does not have a feasible alternative. Accordingly, I use it in my work with all the caveats that the discussion above necessitates.

Prins notes that, historically, the criminal law imposed punishment regardless of the mental state of the accused (1995). However the criminal law currently has multiple procedures to classify someone as a mentally disordered offender, enabling their criminal matter to be disposed of in a way that takes account of their mental state. A hospital order is one such mechanism, facilitating compulsory treatment in hospital if an offender is mentally disordered. Other mechanisms include voluntary treatment in prison and transferring a sentenced offender to hospital from prison. There are also legal frameworks allowing mental disorder to be considered in trial proceedings. For example, the principle of fitness to stand trial embodies the requirement that the accused be of sound mind adequate to understand their charge. When a person is not of sound mind they may be found unfit to stand trial. Until recently, fitness proceedings were rarely used in England and Wales, partly because a finding of unfitness automatically resulted in the accused being hospitalised indefinitely, and partly because the finding did not allow a determination on the facts of the case itself (Kearns and McKay 2000; Peay 2003). However the *Criminal Procedure (Insanity and Unfitness to Plead) Act 1991* introduced greater flexibility in disposal options for people found unfit to plead. That Act also introduced a new procedure to enable a 'trial of the facts', 'which applies to all cases where the jury has decided that the accused is unfit to plead and requires the prosecution to prove that the accused "did the act or made the omission charged"' (Kearns and McKay 2000:532). As a

result, a steady and significant increase in fitness proceedings in recent years has been reported (McKay *et al* 2007).

Mental illness defences are another avenue by which criminal responsibility may be mitigated in the light of mental disorder. In this discussion I touch on two defences that are particularly relevant to restricted patients. The first is the partial defence of diminished responsibility in relation to charges of murder. If successful, a defence of diminished responsibility reduces a conviction of murder to manslaughter. 50% of restricted patients are charged with acts of violence, approximately 40% of which relate to murder or another form of homicide (Ly and Howard 2004). Although diminished responsibility is rarely used, one study found that almost 50% of verdicts of diminished responsibility resulted in a restriction order (McKay 2004:155). This finding of diminished responsibility in a large number of restricted patient cases is important to bear in mind given that, as I shall discuss later in my thesis, restricted patients are often considered in terms of their offending behaviour.

The second defence that is relevant to my analysis is insanity, based upon the 1843 M'Naghten Rules in which a person must know the nature of the act committed, or that the act was wrong, to warrant a conviction. Although important in principle, the insanity defence has never been widely used (Loughnan 2007). Explanations for the low rate of use of the insanity defence include the severity of the test applied according to the M'Naghten criteria (Prins 1990). Another explanation is the introduction of diminished responsibility in 1957 which replaced many insanity pleas (Verdun-Jones 1989; Taylor and Gunn 1999). Moreover, it has long been argued that insanity no longer corresponds to psychiatric conceptions of moral functioning (see for example Smith 1980). Whilst research suggests that courts interpret the insanity defence more broadly than the M'Naghten Rules intended, Peay points out that the original Rules became anomalous both with clinical practice and with legal frameworks shaped by the European Convention on Human Rights (Peay 2003). Where once the insanity defence was an avenue for disposing of some serious cases more leniently, the abolition of capital punishment has also contributed to the waning attractiveness of the M'Naghten Rules.

The other key reason the insanity defence was often avoided was because it resulted in indefinite detention at Her Majesty's pleasure. Depending on the nature of the possible conviction and consequent sentencing policy, an accused who pleaded insanity could spend more time being detained following an acquittal on the grounds of insanity than if they had been convicted (Prins 1990; Mitchell 2003). As I discuss in subsequent chapters, this has significant implications in the restricted patient system. Restriction orders have been widely perceived as being preferable to the indefinite detention of a successful M'Naghten's plea. Yet, I argue that there is very little difference between the two, as a result of how the executive exercises its discretion to release restricted patients.

The insanity defence has now been the subject of a range of legislative reforms. Firstly, the *Mental Health Act 1983* shifted the status of those acquitted on the grounds of mental illness to equate with that of restricted patients (Verdun-Jones 1989). This ensured that people detained following a finding of not guilty by reason of insanity had recourse to independent review via the Mental Health Review Tribunal in the same way as restricted patients. Secondly, the *Criminal Procedure (Insanity and Unfitness to Plead) Act 1991* expanded the options available to courts following a successful insanity defence, so that they included a hospital order without restrictions, a guardianship, supervision and treatment order, and absolute discharge (Mackay and Brooksbank 2005). This significantly widened the options available to courts in these matters, and theoretically increased the attractiveness of the insanity defence.

However, with the introduction of the *Domestic Violence, Crime and Victims Act 2004* the options available shifted once again. Firstly, defendants found unfit to plead or not guilty by reason of insanity could only be given a hospital order if they met the criteria for compulsory detention under the *Mental Health Act 1983* (a safeguard which had been missing from the original provisions). Secondly, the possibility of a guardianship order, which enabled an accused to receive care and protection rather than medical treatment, was removed from the disposal options available. Thirdly, supervision and

treatment orders, modelled on probation orders but including psychiatric treatment as a condition, were replaced by, 'a single supervision order which allows supervision by the most appropriate professional and now applies conditions of treatment to include not only psychiatric treatment for mental disorders but also medical treatment for physical disorders' (Morris *et al* 2006:608). Finally, the provision that raised considerable anxiety in much of the literature was the removal of the requirement that a court heard evidence from the receiving hospital, coupled with the court gaining the power to order an offender to a specific hospital.<sup>8</sup> These changes were criticised by both practitioners and scholars who were concerned that hospitals may have to admit patients without any prior knowledge of the patient's history or mental state and without necessarily agreeing with the medical evidence that was heard by the court (Morris *et al* 2006).

Despite the disposal options for mentally disordered offenders in criminal justice policy, Verdun-Jones has argued that the 'issue of mental disorder has been effectively removed from the arena of criminal responsibility and transferred to the process of sentencing' (Verdun-Jones 1989:20). He notes that the hospital order replaced a sentence in many cases and that it 'does provide a more humane method of dealing with mentally ill offenders than the alternative of sending them to prison' (*ibid*). However, Bean has argued that traditional theories of punishment were not capable of responding appropriately to mentally disordered offenders.

Retribution, based on deserts, cannot apply; mentally disordered people cannot be said to deserve punishment if they lack the necessary responsibility to be aware of their crime. Similarly, individual deterrence cannot apply; mentally disordered people are not responsible for their actions whilst they remain disordered. Rehabilitation will not apply either, for the prison medical services (as currently constituted) cannot provide the necessary treatment (Bean 1986:92).

From this argument, the law has not been able to establish a consistent, coherent system for a category of offenders who challenge the principle of criminal responsibility and the purpose of outcomes like sentencing. At the

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<sup>8</sup> The DVCVA 2004 also removed the requirement that patients be subject to an order issued by the Secretary of State before a hospital could admit them. Consequently, the court's hospital order is sufficient to require a patient be admitted by a hospital.

same time, the critique of criminal responsibility presupposes a complete loss of capacity on the part of the accused, which is not the case for many mentally disordered offenders.

One of the greatest problems of the inadequacies of the laws' response to mentally disordered offenders is its randomness, including whether a defendant is given a psychiatric or penal dispositional outcome. For example, studies of case law have shown that the same legal arguments have produced different outcomes for defendants (Peay 1993; Prins 1993). This creates serious challenges for managing offenders post trial. As Rock has argued, mental disorder lies on the boundary between psychiatric practice and models of punishment and the mentally disordered offender is one with whom the prison system cannot cope (Rock 1996). Yet the extremely high rates of mental illness amongst offender populations are consistent irrespective of where they are detained (in prison or in hospital), and regardless of whether they are formally categorised as mentally disordered (Rock 1996). As Padfield notes,

once a person is labelled a restricted patient, he or she has different procedural rights than does the 'dangerous' person detained in prison. Yet people with similar characteristics may find themselves in one, rather than another, category. And, conversely, the people within the different categories do not necessarily share the same characteristics (Padfield 2002:124).

Over forty years ago Goffman made the same arguments about psychiatric patients in hospital.

Society's official view is that inmates of mental hospitals are there primarily because they are suffering from mental illness. However, in the degree that the 'mentally ill' outside hospitals numerically approach or surpass those inside hospitals, one could say that mental patients distinctively suffer not from mental illness, but from contingencies (Goffman 1961:126).

Importantly, then, the category of mental disordered offender is characterised - at least in part - by an element of arbitrariness. It may not be random; it is a classification which is produced by the application of particular systems and beliefs, not least about the law, mental health and moral responsibility. It is

also a classification that is affected by particular attitudes, or what some describe as stigma or discrimination. Part of the clamour for reform of mental health law in recent years has been in order to move away from the notion that patients of mental disorder should be subject to deprivation of liberty for treatment, when patients of physical disorder are not (this is an issue I shall address in greater detail in Chapters Six and Seven, and see for example Thornicroft 2006; Richardson 2007). Recognising the arbitrariness of the notion of mentally disordered offender challenges the meaningfulness of clear distinctions in the criminal law between sentenced offenders, those under a hospital order, and those under a restriction order. Yet the ability of offenders to access appropriate treatment for their mental disorder is determined by whether they fall within one of these categories. In other words, notwithstanding the fact that the classification of someone as a mentally disordered offender may be arbitrary, there are a range of systems in place in response to that classification, one of which is the subject of study for the present doctorate.

One of the protections against the random application of these categories has emerged through the human rights framework established by the European Convention on Human Rights (Peay 2002; Richardson 2005; Robinson and Scott-Moncrieff 2005). The Convention has been significant in (re)shaping legislation and processes to ensure they adequately protect the human rights of their subjects, such as in the reform of the *Mental Health Act* 1983. The human rights framework has enabled procedural improvements such as the granting of determinative powers to the Tribunal. Yet, as I argue in Chapter Seven, the mere presence of such a safeguard does not necessarily resolve the problems posed by indefinite detention within this system. In any event, the increasing prevalence of indefinite detention warrants interrogation *per se*. As discussed earlier in relation to sentencing policy, the purposes of detention as a form of punishment have been increasingly undermined by 'volatile and contradictory' penal policies that are constantly in flux (O'Malley 1999). The utility of indefinite detention for managing mentally disordered offenders might indicate another system of control for general offender populations.

This discussion has introduced two important features of the restricted patient system that will be discussed in later chapters. Firstly, restricted patients are a group for whom the objectives of care and treatment operate in tandem with the imperative of control. Secondly, categories such as offender or patient symbolise straightforward philosophies of punishment and universes of social action, implying a distinction between criminal offending and treatment for mental illness that is far more complicated in reality.

The question of whether and to what extent legal status is determinative of individual outcome is central to my thesis. Restricted patients provide a case through which to consider the intersection of criminal law and mental health models of intervention. The discussion of mental health law in this chapter has shown the discrepancies and arbitrariness of the allocation of offenders to the mental health system. In subsequent chapters my analysis of decision-making by the Home Office about decisions leave and discharge will show how different are the criteria for those decisions.

#### **Section IV: Theories of risk and the management of mentally disordered offenders**

My discussion of the classification of 'mentally disordered offender' introduced the arbitrariness with which it is applied. This idea is important for understanding the effect of social processes like classificatory systems on legal outcomes, and underpins the following discussion which focuses on the development of forensic psychiatry and the criterion of risk. So far I have outlined the major areas of penal policy and the legal framework that bring people into the restricted patient system. My research is actually focused on the point of exit from this system and the role and effect of executive decision-making in this regard. Executive decision-making is grounded in a public protection agenda that turns upon the notion of risk. In the final section of my literature review, I set out the sociological and clinical approaches to mentally disordered offenders and risk that inform my analysis of decision-making in subsequent chapters.

## ***Forensic Psychiatry***

There is an established literature on forensic psychiatric practice, much of which underpins the policies and processes of the restricted patient system. Importantly, there is also a body of work which critically appraises forensic psychiatry as a discipline. I seek to draw out elements of both bodies of work in this section.

The best estimate is that two out of three predictions of long-term future violence made by psychiatrists are wrong (Monahan quoted in Gigerenzer 2003).

Throughout my thesis, I use the term 'forensic psychiatry' to refer to the practice of psychiatry in relation to some form of criminal justice process. The patients of forensic psychiatry are convicted offenders, including restricted patients; people found not guilty by reason of insanity; and remandees. Forensic psychiatry is practiced in hospitals and prisons and in the ongoing mental health monitoring of offenders in the community. There are varying interpretations of the scope and meaning of forensic psychiatry. Some psychiatrists identify the practice through its patients and the importance of having skill and experience in assessing risk of dangerousness and violence amongst offenders (Maden 2007). Others argue that there is no discipline of 'forensic psychiatry', particularly in those jurisdictions where there is no formal training or qualification for such a specialty, such as Australia (Shea 2003). Those critiques ignore the reality of the particular demands and expectations upon psychiatry within the criminal justice system. The preoccupation with risk and dangerousness may not be isolated to forensic psychiatry. But psychiatric care for mentally disordered offenders is unique for a number of reasons including the need to understand criminal as well as mental health law; an ability to work within secure settings; the nature of the clinical and behavioural histories of the patients; and the constraints upon options for rehabilitation that are consequent on the conditions often attached to the release of offenders into the community.

Nevertheless some of the criticisms of forensic psychiatry are useful for understanding its role in contemporary criminal justice policy. In a scathing critique, its origins have been described as:

examining the psychological and social meaning of whatever constituted 'criminal behaviour' (in a legal sense) rather than the intrinsic nature of the behaviour itself, increasingly focussing on issues about 'dangerousness' of individuals to 'society', irrespective of the nature of the society. In other words, psychiatry (and forensic psychiatry) did not take an ethical position on what constituted criminality - it merely accepted the definition proposed by the state (Fernando 2000:53).

Of course, violence against members of society is not simply an ideological construct. Nonetheless, Fernando's critique is useful for a consideration of the role forensic psychiatry has played within broader debates about crime and criminality. It is the state that defines the criminal law, and practitioners who work within it must accept those definitions. However law is also open to interpretation and the interpretations of psychiatrists are as important as those of lawyers when dealing with mentally disordered offenders. As empirical evidence in later chapters will show, this has raised concern among some psychiatrists and underpinned important criticisms of the approach to risk assessment within the restricted patient system. These concerns contrast strongly with Fernando's critique, in which he blames psychiatry for the construction of mental disorder through notions of dangerousness.

Others have argued that psychiatry's 'claims to scientific neutrality, objectivity and rationality' have lent an authority to the construction of mentally disordered offenders as inherently dangerous (Kendall 2005:46). These claims include expertise in the assessment and management of mentally disordered offenders and, perhaps most importantly, in the protection of the public from any risks these offenders might pose (*ibid*). The implication is that the emerging specialisation of forensic psychiatry has, by definition, forged the conflation of mental disorder with dangerousness and criminality.

Not surprisingly, many of these criticisms have been firmly rejected not least by psychiatrists themselves. Monahan and Steadman, whose work has contributed key scholarship on risk and the treatment of mental disorder,

have attributed the conflation of mental disorder and dangerousness to the law's misunderstanding of what psychiatry can offer (1994). The legal concept of 'dangerousness' confounds the variables on which a prediction is based, the type of event being predicted, and the likelihood of the event occurring. For research purposes 'dangerousness' should first be disaggregated into three component parts: 'risk factors', the variables that are used to predict violence; 'harm', the amount and type of violence being predicted; and 'risk level', the probability that harm will occur. Secondly, the 'harm' that is being predicted should be scaled in terms of seriousness, rather than being treated as a dichotomous variable. Thirdly, 'risk level' (or simply, 'risk') should be seen as a continuous probability statement, rather than a dichotomous variable as in risk or no risk. Fourthly, since risk levels are often not stable but fluctuate over time and context, estimates of risk should be in the form of ongoing 'assessments' rather than one-time 'predictions'. Finally, given that the goal of public health intervention is the prevention, rather than the treatment, of harm, 'risk management' as well as 'risk assessment' should be a goal of research (Monahan and Steadman 1994:2)..

For Monahan and Steadman, the process of risk assessment is a complex, lengthy process based on probabilities, not absolute numbers. Moreover, it is a process which acknowledges the social factors of an individual's situation. Perhaps, then, it is unfair to attribute the conflation of mental disorder and dangerousness to psychiatry alone. Often it is the political imperatives, including protecting ministers and maintaining public confidence in a system, that lead to over-reliance on, or use of, information in unintended ways. In the restricted patient system the political agenda includes public confidence in the system as well as public protection. Representing risk assessment as a straight-forward, comprehensive and accurate process serves the purpose of reassuring the public on both those grounds. It implies risk assessment is a formalised, clearly documented process. But the practical reality is that it is a fluid process with constantly shifting variables dependent upon the familiarity and experience of those making the assessment. Moreover, the process of assessing risk and proposing how to manage it is different from deciding what levels of risk are acceptable. Many psychiatrists argue that their skill lies

in the former, but it is those elected or appointed to represent the public who should determine the latter (Maden 2007).

The question this raises is who makes the claims about the promise of forensic psychiatry? As Rose argues, psychiatry is not a definitive science, but a site of practice where 'research is under way, conflicting theories and hypotheses abound, competing programmes are suggested and occasionally implemented and failure rather than success is the norm' (Rose 2002:5). Psychiatrists themselves are well aware of how little is known about effective risk management. The quotation from Monahan at the beginning of this section reflects a much-used legal folklore. It is a self-criticism, but also an acknowledgment of reality. Reviewing his own and other psychiatric practice, Monahan found a 33-50% range of accuracy for clinical (that is, non-actuarial) risk assessment (2004:254). Yet there is little latitude within legal and political discourse for the limitations of psychiatry. This is evident in the tension between the dictates of law and public policy - that risk be assessed accurately and be managed to provide public protection - and the opinions of psychiatrists as to whether they are capable of undertaking this.

Beyond the question of whether psychiatrists actually can assess and manage risk in this way, there is the equally important question of whether they should. As Mullen argues:

surely it is obvious that the chances of a mentally disordered person acting violently should be carefully evaluated and every step taken to prevent such a consequence. It is, perhaps, not quite as obvious that a central, if not the primary, responsibility of a mental health professional is to the wider community rather than their patient. It is not entirely obvious how a responsibility to predict risk is to be discharged. It is certainly not obvious how a clinician should act if they do suspect their patient is more probable to act violently. And finally, it is far from obvious that we should allow concerns about the risk which some of our patients may present to others to become a major determinant of our approach to all our patients (Mullen 2002:xv).

The implications for the restricted patient system are clear. As Szmuckler asks, 'the worry is that if predictions are limited (often, extremely limited) in accuracy, how do we justify the ongoing preventive detention of people who

are deemed to be unacceptably risky as a result of a risk assessment' (2005:776)?

What emerges is the demand for forensic mental health professionals to discharge both a clinical responsibility for the care and management of their patients and the political responsibility for controlling this population for the protection of society. Hence Rose terms these professionals 'control workers' who,

whether they be police or psychiatrists, ... have a new administrative function - the administration of the marginalia, ensuring community protection through the identification of the riskiness of individuals, actions, forms of life and territories (Rose 2000:333).

Similarly, Seddon has charted the move from understanding offenders as dangerous to perceiving them in terms of risk, a framework which dissolves dangerous individuals into a combination of risk factors (2007). Drawing parallels with Simon and Feeley's work on actuarial justice (1995), Seddon perceives this as a policy shift towards managing groups not individuals (2007). This is a useful critique as it reminds us of the institutional forces at play even in the level of individual case decisions, such as those made by the Home Office about restricted patients. Yet, like the penal policy discussed above, this was another area rife with contradiction. The manifestations of the public protection agenda sit uncomfortably with the realities of skill and resource that shape not just what mental health services can offer, but also how effective they are (Maden 2007). Whilst actuarialism has not taken over psychiatric practice, it does influence the approach to offender populations at a systemic level which, at the time of this research, was managed by the Home Office. In a sign of the pervasiveness of preoccupations with risk, the Home Office had started to term as 'risk workers' police, probation and parole staff and mental health care workers by virtue of the client groups with which they worked.

### ***Risk and Dangerousness***

While the protective element of restriction orders suggests a danger posed by restricted patients, in fact risk and dangerousness are separate issues.

Under section 41 of the *Mental Health Act 1983*, a restriction order can only be made if there is a risk of serious harm. However, the court must already have accepted that the person meets the criteria for compulsory treatment under section 37 of the *1983 Act*; and that a hospital order is the best way of dealing with them. In other words, restriction orders are not *in themselves* an indication of dangerousness posed by the offender. While this may be a legal technicality, it is an important one particularly with regard to attempts to use mental health law to control dangerousness.

Accepting that a preoccupation with risk shapes the policy framework for dealing with all mentally disordered offenders (Solomon 2005), the important point to note is that risk is definitive in a restriction order. It is the risk of a patient's mental disorder, if untreated, leading to similar behaviour in the future that justifies the hospital order; and the potential for serious harm to the public (as evidenced by conviction for a serious or violent offence) that restricts their release to the discretion of the Home Secretary or Tribunal. Risk is codified within legislation and policy in relation to serious harm to the public, as though it were a clear, unambiguous concept (*Mental Health Act 1983:section 41*). However it is a concept that may be defined in numerous ways, and has attracted an entire body of theory in its own right. Moreover, the element of serious harm to the public as the defining requirement for a restriction order ignores some important questions such as the actual nature of the risk posed by mentally disordered offenders and the subjective processes involved in assessing that risk. The following discussion introduces some of the theory relevant to a critical understanding of these concepts, in order to inform subsequent analysis of the function of risk and dangerousness in decision-making about restricted patients.

Giddens argues that the preoccupation with risk is an inherently modern phenomenon.

Modernity is a risk culture. I do not mean by this that social life is inherently more risky than it used to be; for most people in the developed societies that is not the case. Rather, the concept of risk becomes fundamental to the way both law actors and technical specialists organise the social world (Giddens 1991:3).

It is important to heed the modernist argument that the concept of risk is not itself new; only the particular centrality we give it in contemporary research, policy and practice. Indeed, Goffman saw risk as integral to the management practices of asylums:

moving up and down the ward systems means, then, not only a shift in self-constructive equipment, a shift in reflected status, but also a change in the calculus of risks. [...] appreciation that a given risk level is itself merely a social arrangement is a rarer kind of experience, and one that seems to help to disenchant the person who undergoes it (1961:153).

Even earlier, the risk of contamination was an important factor in the segregation policies of late eighteenth century penal institutions (Strange and Bashford 2003). Moreover, the notion that the assessment of risk is a process steeped in social values goes back half a century at least. Nevertheless Giddens' point is that the pervasiveness of risk as the defining characteristic by which whole systems operate is a uniquely modern feature. By recognising that the risk agenda has come to shape not only assessments of individuals, but the practices of whole institutions, we begin to see how mental health care in general, and the restricted patient system specifically, have become systems which rest solely upon the criterion of risk (Giddens 1991; Ericson and Haggerty 1997; Rose 2000).

Meanwhile Douglas has been interested in the language of risk. She argues that it asserts a certainty that the only possibilities are negative.

Risk is unequivocally used to mean danger from future damage, caused by the opponents. How much risk is a matter for the experts, but on both sides of the debate it has to be taken for granted that the matter is ascertainable. Anyone who insists that there is a high degree of uncertainty is taken to be opting out of accountability (Douglas 1992:30).

Thus if public policy and perception are shaped by the risk agenda, its connotations are necessarily negative. For Douglas, this leads to a politicisation of the concept of dangerousness. However for others, risk is itself a politicised term, utilised in relation to certain populations only, and not others. For Rose, risk is applied to 'the usual suspects':

the poor, the welfare recipients, the petty criminals, discharged psychiatric patients, street people. The logics of risk inescapably locate the careers and identities of such tainted citizens within a regime of surveillance in which they are constituted as actually or potentially 'risky' individuals (Rose 2000:333; see also South *et al* 2005).

Any individual subject considered a risk is irrevocably tarred with the brush of dangerousness.

Risk is a self-fulfilling concept: there can never be zero risk. Forensic risk assessment seeks to establish the factors that lead to a person's instability from their mental disorder, including possible offending behaviour. Risk management is how these factors can be controlled to reduce the chance of the behaviour being repeated. Thus clinical risk assessment depends upon an understanding of the individual's behaviour within the social factors that shape their life and the control of those factors constitutes risk management. It is, therefore, ironic that the criminal law is unable to take cognizance of these factors.

Yet, if we consider the risks associated with mentally disordered offenders, the most striking factor is the risk they pose to themselves. A Department of Health inquiry found that 22% of suicides by people under mental health care in England and Wales were believed to have been preventable by care teams, with the figure even higher for those who were in-patients at the time of their suicide (Department of Health 2001). Moreover, in their key English study of homicides by people with mental illness, Taylor & Gunn found that the number of people with a mental disorder who committed homicide has remained constant since the 1970s, and the proportion of homicide offenders they represent has actually decreased (1999). This finding was repeated in a follow up New Zealand study by Simpson *et al* (2003).

The dominance of the risk agenda necessarily casts mental health patients within a negative light. The conflation of mental disorder and criminal offending further relegates these patients to perceptions of dangerousness, both in the public imagination and via legal classification. Thus, it is

prevention of harm to the public that defines restricted patients categorically, despite the fact that the greatest danger they pose is to themselves.<sup>9</sup>

## Conclusion

This chapter has reviewed literature on penal policy, victim involvement in criminal justice, the restricted patient system, and the social and medical constructions of mentally disordered offenders. The purpose of this review was to introduce the key themes and debates about treatment versus control, and individual rights versus public protection, which are the principles that underpin the restricted patient system. What should be evident are the complexity of the terrain and the diversity of opinion on these issues, despite the clarity with which they are often expressed politically, publicly or in the media. Indeed this disparity between the complexity of practice and its oversimplification in public discourse is a major theme running throughout my thesis, as I inquire into the central question of who constructs the public interest, and how that interest is protected in the face of decisions about the release of restricted patients. In the next chapter, I discuss how I set about answering those questions.

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<sup>9</sup> This understanding informs my critique of the risk agenda in relation to mental health law reform and Home Office decision-making in later chapters.

## CHAPTER 2

### METHODOLOGY:

### ACCESS, FIELDWORK AND DILEMMAS IN THE 'RESTRICTED' ZONE

#### Introduction

The present chapter outlines the methodology for my empirical research in this thesis. Whilst the chapter is not a review of methodological theory, I discuss studies and approaches that have informed my work methodologically. Through this discussion I situate my own position in relation to my research and consider how that position affected the data I collected and my analysis of them. I also set out the specific methods used to obtain empirical data for this project and how I negotiated access. I conclude with the ethical dilemmas that were presented by my relative ease of access, including my attempt to strike a balance between protecting my participants and being 'true' to my data.

#### Doctoral Research Project

##### *Origins of the Research*

My doctoral research examines the role of executive decision-making in the release of restricted patients in England and Wales. I arrived at this project from my professional background managing the forensic jurisdiction of the Mental Health Review Tribunal of New South Wales (NSW), Australia. Although they carried a different legal status, forensic patients in Australia were essentially the equivalent of restricted patients in England and Wales. I was responsible for the conduct of Tribunal hearings on the leave, transfer and discharge applications of forensic patients. I was also responsible for liaison with criminal justice agencies, legislative reform and working with individual victims and their representative organisations. Through that work I became interested in why the jurisdiction retained a role for government decision-making about offenders, when executive discretion had been eradicated from most other areas of the NSW criminal justice system. There

was concern amongst practitioners, supported by much of the literature and jurisprudence, that overly cautious decision-making by government was constraining the therapeutic progress of patients. Yet some of those involved in the system, including victim support groups, emphasised public protection over the interests of individual patients. I wanted to investigate whether the interests of patients and of the public were inevitably in conflict; and how these interests manifested themselves in the practice of executive decision-making. I did not want to conduct my research in NSW. I was too close to the system personally and there had been so little criminological enquiry into this area in Australia that there was a dearth of literature within which to position my analysis. Instead, I chose to study the process in England and Wales. As the jurisdiction from which the NSW legislation was derived, it was relatively similar and there was an established body of research and literature with which I could ground my own analysis.

My professional background in the field affected the progress of the research in a number of ways. Firstly, I commenced my research with a significant degree of background knowledge and a clear conception of the project I was undertaking. This proved to be an efficient approach to the often-trying process of doctoral research. Secondly, I quickly identified the various actors in the system and had some insight into the dynamics of their relationships with each other. Thirdly, and perhaps most importantly, my professional experience was a considerable advantage to negotiating access. I did not anticipate the bounty of data I would obtain as a result. I presented myself and was perceived by many working in the system as a colleague. Consequently, those who agreed to participate in my research were open and candid with me. Their openness created some challenges for me because I felt that they told me things they might not have told an anonymous researcher. Ironically, as I analysed my data I became involved in precisely the sort of process I was studying: a balancing exercise between protecting the interests of individual decision-makers whose candour might get them into trouble and the public interest which was best served by a frank and fearless account of my research.

Through reflection on my role as a researcher and unpicking expectations which derived from my experience in an analogous but different system, I came to a more balanced view on the process and findings of my research. I realised how strongly my approach was influenced by my experiences in NSW. There, the system had operated extremely defensively, with poor relationships between government and practitioners, and low confidence in the system by those working in it as well as by the public. Decisions by the executive had been under the authority of the Minister for Health and had been shielded by a wall of secrecy surrounding the evidence upon which decisions those were based and the reasons for them (for a full account of this system see Boyd-Caine and Chappell 2005). Even as a staff member of the Department of Health I had been unable to penetrate these walls. I was expecting a similar culture of mistrust and caution from my doctoral field site and initially attributed the candour of my participants to incautious behaviour on their part. It was only once I acknowledged my prejudicial expectations and put them aside that I came to see how the responsiveness of my participants reflected a different approach to accountability in the system in England and Wales. Indeed, that openness became an important aspect of my data and is the subject of further discussion in later chapters. I move now to outline how I arrived at a methodology for my research.

### ***Research Questions***

Although the executive was formally indivisible from the parliamentary cabinet, in practice the authority of the executive was vested in the Secretary of State for the Home Department. That authority was supported bureaucratically by the operations of the Home Office. The initial premise of my thesis was to explain the role of executive decision-making in community leave and discharge of restricted patients. I had arrived at the short explanation very quickly: the system-wide objectives of the Home Office were to protect the public and to maintain public confidence in the system. However this begged a series of much more detailed questions.

As explained in Chapter One, my research questions were:

- i. How was the concept of 'the public' constructed and to what extent did it impact upon decision-making in this system?
- ii. How did the executive meet its mandate of public protection?
- iii. How did other actors view the role and effect of the executive in the restricted patient system?

Firstly, I was interested in who was understood as 'the public'? How were the public considered in decision-making, and what effect did that consideration have on individual decisions? Was the public an all-encompassing term for anyone and everyone who might ever come in to contact with a restricted patient? Or were there particular groups who constituted the public? For example, from my own professional experience I knew that victims could experience the criminal justice system in a range of ways, from feeling marginalised and voiceless, to being a powerful and persuasive lobby group. In some parts of Australia, victims constituted an important group of people in forensic mental health, not quite direct participants in the way doctors and patients were, but nonetheless involved because of their specific relationship with a patient. I wanted to investigate the involvement of victims in the restricted patient system in England and Wales and how that influenced conceptions of the public? In order to answer these questions I would need to see whether and how this responsibility was set out in policy documents and job manuals. However I would also need to speak to decision-makers directly and to observe (if possible) their practices in this regard.

Secondly, how did the Home Office maintain public confidence in the restricted patient system? Did public confidence interact with the public protection agenda or were they two separate aspects of the system? Did maintaining public confidence require preventing or managing media attention, or attention from other quarters? Did it extend to protecting the reputations of the Home Secretary and other ministers? Did maintaining public confidence in the system entail responsibility for the organisations and agents that were independent of the Home Office, such as the Mental Health Review Tribunal of England and Wales, or clinical practitioners? What effect did the Home Office perceive mistakes or embarrassments to have on public

confidence and did such concerns influence decision-making about individual restricted patients?

Here again there might be initial answers to these questions in the written documents of the system, particularly in the Home Office. But equally, these were complex questions that might have unpredictable consequences in practice. How they were resolved would require consideration and judgment and would be likely to depend on the circumstances of each matter. I needed to speak to people to probe them on these issues and listen to their explanations and examples in order to understand the processes involved.

Finally, I wanted to hear the opinions of other actors in the system; people who had regular, professional contact with executive decision-makers and who were affected by their decisions. Even if I had good access to the Home Office, that would only give me a partial picture (albeit an essential part). The responses of those acting on behalf of the executive would reflect their own roles and responsibilities, and instincts of self-preservation would be likely to imbue their responses with particular accounts and justifications. I wanted to hear what others thought of the process, the actors, and the effects of the decisions made. I needed to go outside the Home Office to develop a perspective on what I observed within it.

### ***Policy Relevant and Critically Engaged***

At the time I was preparing my research, criminology was awash with criticisms that it was obsessed with evaluative research at the cost of theoretical and empirical analysis; and that over-reliance on quantitative methods had led to a renaissance of positivism, abandoning the more effective processes of social inquiry (see for example Hayward and Young 2004; Young 2007). Some theorists had called for criminological research to be 'counter-hegemonic' (Hillyard 2004) and to resist the lure of evaluative research as merely administrative criminology that was inherently atheoretical (Hope 2005; Walters 2005). Underpinning these criticisms was the important concern that rigorous criminological research was being ignored by policy-makers, or was being manipulated by governments to suit their own political ends (Hillyard *et al* 2004b; Hope 2005; Loader 2006).

I was attracted by these calls to a progressive, critically engaged discipline. The call to counter administrative or political hegemony reminds us that independent and rigorous research is a worthy pursuit, even (and perhaps particularly) if it does not meet the public policy objectives of the government of the day. However these critiques were predicated on an assumption that I found questionable: that policy-relevant research was inherently conservative or uncritical. I disagree, and suggest instead that the value of policy-relevant research depends upon the theoretical and empirical approach of the analysis. The important - if small - body of research into the ongoing use of executive discretion in the criminal justice system is a good example here (see for example Hawkins 1992; Padfield 2002). Examining the exercise of these powers could be analogous to interrogating state power, a pursuit often represented as the pinnacle of radical intellectual inquiry (Cohen 2001; see also O'Malley 2001; Green and Grewcock 2002). Moreover, as Downes and Rock pointed out decades ago, the alternative to research that scrutinises government policy and practice is a kind of utopianism which reifies 'the system' and allows flaws to continue unattended (Downes and Rock 1979).

My own commitment to research that is theoretically and academically rigorous parallels my commitment to research that is informative and relevant for public purpose. Consequently this thesis is unapologetically policy-relevant. But I aim for it to be critically engaged also. By contributing to a 'critical narrative' of criminological inquiry I did not seek to criticise everything I have observed in the conduct of my research (Walters 2005:7). Such an approach would assume one knew the answers in advance of the research. States, governments and bureaucracies have problems to resolve which are obdurate and complex. Some policies are well-constructed while others are far from perfect. It was not my intention to reject what I observed on this basis. Rather, by engaging critically with the field, I meant to question and probe the issues that I had observed; to interrogate the *status quo*; and to consider alternative possibilities and explanations for how executive decision-making functioned.

## Methodology

Under part three of the *Mental Health Act 1983* the executive authority in the restricted patient system was held by the Home Secretary. A quick search of the Home Office website revealed an entire section of the Home Office called the Mental Health Unit which was working within the Home Secretary's remit under the *1983 Act*. This presented the first step. I needed to establish how the decision-making process was constructed between the formally ascribed powers of the Home Secretary, and the bureaucracy that worked under him.<sup>10</sup>

My methodology was largely informed by Hawkins' extensive work on legal decision-making, particularly his notions of the 'decision frame' (1986) or surround (2003). These concepts provided useful ways of describing the environment in which decision-making took place: the 'structure of knowledge, experience, values, and meanings that the decision-maker shares with others and brings to a choice' (Hawkins 1986). According to Hawkins,

one of the major tasks for those interested in legal decision-making is to understand why and in what circumstances decision-makers accord changing priority to competing decision frames. This is a massive task, however, because it requires close and careful investigation of the fundamental decision model employed by legal decision-makers. It means, to begin with, lengthy and detailed exploration of the jungle (1986:1242).

The idea of 'changing priority' reflects the constant state of flux of criminal justice policy described in Chapter One. Hawkins' framework enabled this phenomenon to be brought front and centre in my analysis of decision-making.

Equally, Hawkins' description of 'the jungle' was an apt analogy for my field site. Analysing the decision frame of the executive in the restricted patient system necessitated establishing which agencies and personnel were involved in the decision-making process, including those beyond the

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<sup>10</sup> At the time of conducting my research, the portfolio of Home Secretary was occupied by two men: initially Charles Clarke, and subsequently John Reid. By the time of writing, the portfolio had moved to the first female Home Secretary, Jacqui Smith.

machinations of the government in parallel decision-making bodies like the Mental Health Review Tribunal and hospitals. Each of these institutions was engaged in processes that operated in tandem, in support of or in opposition to those of government. I was interested in how these processes reflected back upon government decision-making.

I identified the following people and organisations involved in the restricted patient system:

- i. the Home Secretary;
- ii. the Home Office;
- iii. the Tribunal;
- iv. clinical practitioners, including doctors, nurses, social workers and other health professionals;
- v. legal practitioners who represented restricted patients;
- vi. patients;
- vii. non-government organisations active in this system; and
- viii. 'the public'.

This list ranged across government departments, non-government organisations, practitioners, patients and other individuals, so I adopted the term 'actors' as a collective way of referring to participants in the system. I wanted to examine how the various actors engaged with the system and interacted with each other. Were particular interests served by specific aspects of process? How did the principles of natural justice and procedural fairness, outlined in Chapter One, feature in executive decision-making about restricted patients? How did the intersection of health and legal frameworks operate in practice? Was there a balance to be struck between procedural fairness and natural justice on the one hand, and access to patient information by victims or 'in the public interest' on the other? Were there hierarchies in the importance attached to the views of some actors over others? My methods needed to capture both the detail of information contained in documentation, and the human nuances of practice and perspective represented by these actors. My methods also needed to be responsive to the unpredictability and changing nature of the people and processes I was studying.

## Methods

Hawkins advocates qualitative research methods for understanding legal decision-making. He argues that quantitative methods fail to capture the nature of decision-making as largely bureaucratic, affected by social realities such as resource constraints, the involvement of administrative staff and the impact of community values (Hawkins 1986). Of course, quantitative methods can give a useful idea of the number, distribution and trends of outcomes or outputs; but very little about how they are constructed and what they condense. Hawkins also argues that quantitative methods are unhelpful when analysing legal decision-making because of their function to 'predict decision outcomes rather than to explain decision-making processes' (*ibid*:1186). My study was a sociological inquiry of the decision-making process of actors and agencies engaged in a complex, interactive process. My analysis included but was not limited to outcomes. Indeed, outcomes were an important aid to understanding process, as well as being of interest themselves. But analysing outcomes and processes were complementary aspects of the study. To that end, quantitative data were helpful for illustrating some trends. Beyond this I followed Hawkins' model and adopted a qualitative methodology, using the following methods:

- i. document analysis;
- ii. observation; and
- iii. interview.

Each method was intended to obtain a particular type of data for my thesis. Documentary analysis enabled me to trace the case histories and correspondence determining patients' progress through the system. There were also written instruments such as legislation, policy and job manuals documenting the roles and operations of each agency involved in the system. I could have described the decision frame solely by analysing this documentation. However, written guidelines do not necessarily capture the nuances of how processes operate in practice; the contexts of knowledge, shared understanding, and rules that operate in working environments; the deviations from policy that are necessary to make a process work smoothly; nor the informal relationships established to facilitate information-sharing.

I supplemented documentary analysis with observation of processes and with the participation of the individuals administering them. Here, I relied upon formal interviews or discussion during my observations. Observation provided an opportunity to cross-reference written procedure with staff practice and to elicit further information from staff as inconsistencies and differences emerged. Interviews also assisted my analysis of the different priorities in the system; where they overlapped or diverged; and how they were resolved.

Each of these methods was designed to yield a proportion of the empirical data I needed. In their discussion of methodology Genders and Player note,

it would be a mistake to conceive of each element of the methodology as constituting a discrete area of research ... Rather, they were overlapping and complementary components which needed to be pursued and understood in relation to each other, in order to produce a coherent picture of the life of the institution. Collectively they enabled the cross-checking of information and made it possible to identify the internal consistency of particular findings which, it is hoped, will act to strengthen the validity of the final conclusions (1995:20).

In much the same way, combining research methods enabled me to attain a broader array of data to understand the complexities of the decision frame and strengthen my analysis overall. It also enabled a flexible approach in data collection, so that I could determine the most efficient and relevant method to obtain data at each field site. At some field sites I used all three methods to ensure the most comprehensive analysis.

As stated above, the role of the Home Secretary was delegated to the Mental Health Unit of the Home Office. The Unit had approximately 60 staff at the time of my research. Their total caseload covered a population of up to 6000 restricted patients. Not all of these cases were 'live', which meant a case where an application had been received (for example for leave), or where particular behaviour by a patient had called into question the appropriateness of his or her current arrangements, such as concerns by a family member about someone discharged to the community (see also Dell and Grounds 1995). As the institution responsible for making decisions on the part of the

executive, the Mental Health Unit was the single most important aspect of my field site. Consequently I employed all three of my methods there.

Because of the Unit's focus on applications, a particular methodological danger in this research was over-reliance on the individual case as the primary unit of analysis. Hawkins contends that,

one implication of a claim that a case is decided 'on its merits' is that a case exists as a discrete entity, and decisions are made about its fate quite independently of wider forces and constraints. ... In fact, while an individual may readily be seen as responsible for making a particular decision, a very great deal of legal decision-making is a collective enterprise in which several people, either formally or informally, take part in deciding. ... the idea of the 'case' needs to recognise that a criminal justice decision is often the product of different officials acting at different times making decisions serially in the context of other decisions (2003:194).

To avoid over-emphasising individual cases, I explored the work of the Unit beyond patient applications. As I discuss in substantive chapters, staff were engaged in a range of monitoring activities throughout the system. They also prepared statements by the Home Secretary for Mental Health Review Tribunal hearings; and briefs in response to and in anticipation of issues that might arise about specific restricted patients.

The extent to which the Mental Health Review Tribunal would feature in my study was unresolved at the commencement of my fieldwork. As already acknowledged, my interest in this project originated from my professional experience at the equivalent tribunal in NSW. Professionally I was curious about the similarities and differences between the two organisations. However from the outset it was unclear to me what relevance the Tribunal would have to my thesis. There was already an extensive body of work on the Tribunal in England and Wales (see for example Peay 1989; Richardson 1993 and 2005; Perkins 2003). While my research was situated within the broad field of decision-making in forensic mental health, my empirical focus and original contribution were on the role and processes at the Mental Health Unit. At the same time, ignoring the Tribunal would leave important gaps, not least in analysing the Home Office's decision frame. Thus I included the Tribunal's administrative Secretariat and panels amongst my field sites. My

interviews, observation and documentary analysis of the Tribunal provided essential background information for me, drawing a picture of the interaction across the system from perspectives other than those of the Home Office, and enhanced my comprehension when the Tribunal was mentioned by other participants. I also observed Tribunal hearings and lawyers preparing for these hearings with their clients, which further developed my understanding of the dynamics affecting individual actors within the system. This fieldwork yielded specific data, for example on the role of principles like natural justice, and enriched my analysis of the Home Office. Throughout my thesis I use the Tribunal data where they help to illustrate a point but do not draw on them extensively, in order to maintain my central focus on Home Office decision-making.

I was interested in the individual experiences of patients and victims, and their perspectives on decision-making in the system. However, interviewing patients or victims would have required navigating a daunting tier of health bureaucracy as each National Health Service maintained its own process of ethical research clearance. Although I was not opposed to this *per se*, my focus on government decision-making already required exploring an unknown bureaucratic terrain to establish access for my research. I was also concerned not to expose patients to more stigmatisation than they might have already encountered from their involvement in the restricted system. In the end I obtained these perspectives through advocacy and representative organisations. By interviewing representatives who were already known in the public domain, and who were experienced and confident in their positions, I was able to hear from people with direct experience of being patients or victims, but whose representativeness meant that they were not required to speak from personal experience unless they chose to.

Analysing the ways in which 'the public' was constructed within this decision-making was one of the major theoretical challenges of my thesis. It was equally challenging for the research design to come up with a starting point from which to explore this 'actor' in the system. Conceivably, the concept would be clarified during my fieldwork. Correspondence in patient files might indicate specific attributes of 'the public', or from certain actors' perspectives;

and these examples might show how the public could affect or be affected by the decisions being made. However, it was equally possible that there would be no common conception at all: that views of Home Office staff would differ from or contradict each other; or that 'the public' would be as nebulous a concept to my participants as it appeared to me. I needed a working definition of 'the public'; a category broad enough to capture various manifestations of the public that emerged while simultaneously allowing me to classify the public for the purpose of my analysis.

The working definition I established was based on exclusion. The public included anyone who was not formally associated with or in the restricted patient system. In other words, it became a residual category of 'others' comprised of people lying outside the boundaries of the system. This excluded the Home Office, the Tribunal, health care professionals, lawyers and patients. It included families and friends of patients; victims and their families or friends; non-government organisations that were involved in issues relevant to but not solely focussed on the restricted system; and anyone else that might appear in files or other documentation. Defining the category of public in this way enabled me to build a picture of how the public was constituted as a factor within decision-making processes and to see what influence the public might have on determinations. At the point of research design, this was my own resolution of the problem of defining 'the public'. In subsequent chapters I explore how the decision-makers themselves understood the public in their work.

## **Negotiating Access**

### ***The Mental Health Unit, Home Office***

I had identified the actors and sites relevant to my field of study. The next challenge was obtaining their participation in my research. From the outset of the project the likelihood of gaining access to the Home Office was a concern. My original conception of the project depended upon it, but there was no guarantee that the Home Office would be receptive to my requests for access. I commenced seeking access three months into my doctorate in December 2004. Using a contact of my co-supervisor who was a senior

official in the Mental Health Unit I sent a letter to introduce myself, outlining the project and requesting a meeting to discuss the research. I received a prompt reply inviting me to contact the Unit directly to set up a meeting. The meeting took place in January 2005. The official was interested in my project and positive about the likelihood of my gaining access to the Unit. He advised me to follow up our meeting with a detailed outline of the research and the specific access I was seeking. Serendipitously, the meeting was scheduled on a day when the Unit was hosting an 'away day': a regular workshop to facilitate good working relationships where members of hospital and community treating teams visited the Home Office to meet Mental Health Unit staff and discuss processes and procedures. I spent the day meeting Unit managers and observing their interaction with care teams. I was also given staff work manuals and policy folders to read. It was a positive start.

In the follow-up correspondence I set out my proposed research and access, and foreshadowed possible concerns about confidentiality and use of the data obtained. From the defensiveness I had observed in Australia, I anticipated that the Home Office would be concerned about being exposed to scrutiny. While other researchers told of positive experiences gaining access to the Home Office for their research, I was still anxious about my project. I expected strict terms of access which might include the right to vet and veto any output from my research. I stated that I would anonymise any patient-specific information and that I was willing to discuss any further concerns that might be raised. I did not want to be too specific at this stage to maximise my options for negotiation should the Home Office seek to impose restrictions on my access.

I followed up this second correspondence on several occasions. I spent weeks dialling unanswered numbers, only to be told eventually that the Unit had moved. Several more weeks passed with me leaving messages at the Unit's new numbers and trying to speak to staff to establish the status of my research request. After some time it emerged that my correspondence had been mislaid. It was months after my first meeting at the Home Office that I received an email from the Mental Health Unit which included the following statement:

In principle, we are happy to allow access to MHU documents and staff for interviews for your doctoral research on mentally disordered offenders. However, there are some issues which we would like to discuss further with you - in particular how we would protect the confidentiality of our patient files, and how we would provide that your research does not (whether intentionally or not) undermine public confidence in the system for dealing with dangerous mentally disordered offenders.

Following this correspondence a second meeting was arranged, this time with the administrative head of the Unit. In my concern about strict limitations on access, I had prepared a detailed set of options to negotiate. Again, reception to the project was positive, and the discussion turned to questions of confidentiality at the end of the meeting. I reaffirmed my offer not to use identifying details of patients in my work, something I neither needed nor wanted to do anyway, and to anonymise any cases that I did discuss. The anonymity of other individuals such as family members or victims was not discussed. I would anonymise any personal information about family members and victims for their own protection and because revealing their details would be unlikely to serve any purpose in my thesis. But it was interesting that this was not mentioned by the Mental Health Unit.

At that meeting it was agreed that I could interview staff about their work, and read documentation including job manuals, policies, reports and patient files. The Mental Health Unit also suggested that I shadow staff to observe how they conducted their work. There was no discussion about my use of the data obtained directly from Home Office staff. Officials explained that they were 'not opposed to scrutiny' but were concerned to ensure that there were 'adequate safeguards in place'. However what they meant by 'adequate safeguards' was never qualified: there was no consideration of whether I could name or quote staff; there was no suggestion that Unit staff should be anonymous in the study; and anonymising patient data was the sum total of discussion about what form such safeguards would take. At my suggestion the Unit was willing to read drafts, but this was not stipulated as a requirement on any output from my research. Moreover, officials qualified that they would only read drafts for the purpose of fact-checking, not to vet my analysis.

I was surprised and relieved at the absence of any constraining conditions on my access, and excited to have succeeded in gaining access to my primary field site. It did not occur to me that lack of specified conditions could prove to be a dilemma at a later stage. I regarded unfettered access as the best possible outcome. Accordingly I did not seek to clarify the Home Office's expectations or assumptions about what data I would obtain and how I would use them. This caused me some consternation subsequently.

The Mental Health Unit had advised me that they would seek the Home Secretary's approval for my research and would inform me of the outcome. I spent weeks following up that advice, trying to establish whether it had been sought and what the decision was. My calls and emails were rarely answered, and no-one seemed to know the status of the matter. It had been seven months since my first contact, but despite an initially positive response there appeared no concrete progress on access. Trying a different approach, I emailed the head of the Unit and proposed dates to visit the office and commence my fieldwork. This was a bluff: I thought it might prompt the Unit to follow up the formal approval of access, which I doubted had seen any progress at all. To my surprise I received a response the next day proposing an itinerary for me to come in immediately and begin my research. The itinerary included 'shadowing' at least two members of staff from each tier of the Unit's hierarchy, and an appointment with the Victim and Confidence Unit to discuss the development of policy on victim involvement in the restricted patient system. Subsequently the Unit also arranged for me to interview the Probation and Parole Service, whose responsibility it was to support victims associated with restricted patient cases.

There was no further discussion about confidentiality of the information to which I would have access during the course of my project. There was no suggestion of formalising an agreement about the conditions of my access. Moreover, and as I will discuss further below, the question of how to ensure that my research did not damage public confidence in the system was never discussed, despite having been mentioned in the email cited above. The only documentation I had about the entire process of negotiating access was contained in my own notes of the two meetings that took place. The ease

with which I gained access to the Home Office for my research indicated a refreshingly open attitude towards independent research and a transparency about its processes and operations. Indeed, as I shall discuss in Chapter Five, elements of that transparency were also evident in the Mental Health Unit's relationships with care teams involved in the management of restricted patients also.

### ***Other Actors***

Compared to the length of time it took to confirm the Home Office's participation in my research, gaining access to other actors was quite quick. Whilst my negotiations with the Home Office were in train, I embarked on recruiting participants from my other field sites. At the time of my fieldwork, the draft Mental Health Bill 2004 was the subject of scrutiny by a joint committee of both Houses of Parliament. Submissions to the scrutiny process had been received from government and non-government organisations, practitioners and services, and patients. I analysed these submissions to identify organisations specifically addressing the criminal justice sections of the draft Bill, and contacted their authors to determine the extent to which they worked on issues relating to restricted patients. Many were interested in my research and its outcomes, and so agreed to participate on the basis that the findings would be useful for their organisations. Frequently organisations that were not relevant to my study referred me to others that were. Through this process of exclusion and referral, I developed a list of non-government organisations and practitioners to follow up for interview. At that stage the parliamentary scrutiny process proved to be the major vehicle of recruitment for participants outside the Home Office. It was only months later that its significance as a source of data would also emerge.

### **In the Field**

My primary strategy for approaching research participants was as an 'insider'. This was particularly useful at the Mental Health Unit and Tribunal, whose work most closely accorded to my own professional experience. I had a working knowledge of the tasks their staff had to undertake and the

challenges they faced on a daily basis. My previous work with practitioners also meant that I had a good understanding of their roles and responsibilities, despite being neither a lawyer nor a clinician. Genders and Player consider this process of building rapport between researchers and their participants in the following terms.

At its most basic level the reality is that researchers involve themselves in a human situation, in which demands are made upon their personal resources, to such an extent that it is their own social skills which are in large part central to the success of the whole venture (Genders and Player 1995:18).

Genders and Player argue that the ability to gain the confidence of one's research participants and to establish a balance between participants' demands for reciprocity and the researcher's own professional need for rapport are instrumental in the research process. Undoubtedly, I relied upon my experience to establish my competence within the field; but the wealth of data I obtained was as much in response to my interest in hearing about participants' experiences and perspectives as it was to any sense of shared history.

My collegiate approach was largely successful in building rapport with participants and in reducing the amount of time necessary to cover background information during interviews and observation sessions. It also established certain expectations among research participants, which did not necessarily accord with my own perspective on my role and responsibilities as a researcher. For example, in discussing a difficult issue during an observation or interview, Mental Health Unit staff would frequently ask for my advice or how I might have dealt with similar issues in Australia. I was concerned that this exchange might conflict with my role as a non-participant observer, and initially I found myself uncertain how to respond. My hesitation highlighted my own assumptions about objectivity in research, and my belief in a notion of impartiality on the part of the researcher; ideals which had subtly imbued my approach to fieldwork.

As I became more engaged with the research, and better-acquainted with my research participants, these ideals became less important. Reciprocity was a

matter of courtesy. Resisting it would obstruct my ability to gain the trust of my research participants. More importantly, these interactions with participants were data in themselves. To avoid them would be counter-productive to my research. From their research at Grendon Prison, Genders and Player describe how 'the staff and inmates ... made it impossible for us passively to observe what was going on. Within a short period of our arrival staff and inmates directly sought out our opinions or advice' (1995:39). In much the same way I had to accept the reality that participants might seek my input about issues they faced in their work because of my background in the field.

The clearest example of this was when I questioned participants about a victim-participation policy introduced by the Tribunal during my fieldwork. As I discuss in Chapter Five, posing those questions had a direct effect on participants, many of whom had given little consideration to the policy before I interviewed them. I did not regard these exchanges as problematic. They were common to research, particularly in the social sciences where research and practice are often closely aligned. Genders and Player reflect that:

the effects which we, as researchers, had upon the fieldwork must ... be understood as part of an interactive process, in which we were both shaping and being shaped by the social environment of the study (1995:45).

Accepting that my presence might influence processes or outcomes in unintended ways, I came to see this as an inherent and positive possibility of any research.

## **Taking Stock of Data**

### ***Data Collection***

I conducted my fieldwork from January 2005 to September 2006. At its completion I had collected documentary material in the form of discussion papers, policies, procedures, minutes of meetings, transcripts of evidence, patient reports and correspondence. These documents established a picture of how the system operated at the time, and its origins and development since the *Mental Health Act 1983*. These documents also demonstrated how

the various actors engaged with each other and performed their roles in the system.

I had observed casework staff determining applications at the Mental Health Unit; lawyers preparing for Tribunal hearings and hearings themselves; and the Joint Scrutiny Committee hearings of oral evidence relating to the draft Mental Health Bill 2004. I had interviewed staff in the Home Office; lawyers who represented restricted patients; psychiatrists and nurses doing clinical, policy and research work in forensic mental health; and representatives of mental health and victim organisations.

### ***Response Rate***

It was difficult to measure a response rate for my research because of the nature of my recruitment strategy. As I shall discuss in Chapter Six, the Joint Scrutiny Committee's review of the draft Mental Health Bill 2004 presented itself as an opportunity to recruit participants to my research. The Committee held public hearings from October 2004 to March 2005. These were attended by a large number of organisations and individuals that I was interested in speaking with for my research. I approached them all at the Committee hearings, where I either secured interviews on the spot, or obtained contact details to follow up with colleagues from their organisations or others who would be better placed to participate in my research.

It was unfortunate and disappointing that The Zito Trust never participated directly in my research. As the sole organisation specifically representing victims of mentally disordered offenders, the Trust was integral to analysing the effect of victim involvement in the restricted patient system. Despite my numerous approaches over the course of the fieldwork, in person and via written and telephone contact, and their declared interest and willingness to participate in the project, neither the Patron nor Executive Director were ever able to meet with me. However I have drawn substantially from The Zito Trust's submissions to the Joint Scrutiny Committee and from other sources including their website. In the meantime I was able to meet with representatives of other victim organisations, some of whom had been

involved in high profile incidents of homicide leading to restriction orders for the offenders involved, as well as policy development in the area.

In sum I conducted formal interviews with six Home Office staff, including three officials from the Mental Health Unit; and observed the work and decision-making processes of nine staff. I interviewed five psychiatrists and two allied health professionals; four lawyers who represented restricted patients at Tribunal hearings or with the Home Office; two representatives of mental health organisations and two victim representatives. I also observed a Mental Health Review Tribunal hearing and the lawyer-client meetings that took place before and after the hearing; and interviewed a judicial (presiding) member of the Tribunal. I also observed some staff in the Tribunal Secretariat who processed applications for the Tribunal's restricted patient hearings, and interviewed two senior officials there.

As explained above, the only organisation I approached but was unable to interview or observe was The Zito Trust. There was one lawyer I observed in a Mental Health Review Tribunal hearing who I wanted to interview, but who never responded to my invitations to participate in the research. Beyond these two negative responses, everyone I approached to participate did so either by way of interview, provision of documentation, or willingness to be observed. A table of all participants in my research is included at Appendix 1.

### ***Recording the Data***

Thirteen interviews were recorded electronically and transcribed in full. Although all interviewees were offered a transcript of their interview, only one participant took this up, from a non-government organisation. All other participants were satisfied to review the relevant sections of the thesis once written. I took notes at the remaining interviews and at all observation sessions and additional meetings. I would subsequently review my notes and supplement them with a diary or record of unspoken aspects of the interaction such as mood, location or the nature of rapport between myself and the participant. I was able to photocopy many of the documents I analysed, including those at the Home Office Mental Health Unit. Most additional documents were policy statements available online or from

photocopies, such as reports or correspondence. In total I collected three large ring-binder folders of documents over the course of my fieldwork.

### ***Confidentiality***

As already discussed, ensuring that individual patients, family members or victims were not identifiable was my major concern in terms of confidentiality in my study. Extensive patient-specific information was provided to me by the Mental Health Unit and only one staff member removed identifying information from documents before providing them. By contrast clinicians were extremely careful not to provide any identifying details about patients or families in the examples they discussed. Equally legal practitioners did not divulge personal details unless they were referring to case law.<sup>11</sup> On one occasion I observed a restricted patient's Tribunal hearing and his consultation with his lawyer before and after the hearing. The lawyer had taken instructions from his client who consented to my attendance and observation. I devised an elaborate numerical codified system during my fieldwork to use case studies in my analysis. However when it came to writing, this simply was not necessary. I have referred to examples discussed by participants in unidentifiable terms and patients are cited only in relation to media or official reports which were already in the public domain.

### ***Access Denied***

Only two of my requests for information from the Mental Health Unit were denied. The first was for the formal correspondence setting out the delegation of authority from the Home Secretary to the Unit, which I had requested to see its form and the level of detail it set out. It was denied on the grounds that it was private ministerial correspondence and not available to the public. However its contents and the processes surrounding the delegation were explained to me comprehensively and consistently on a number of occasions. Thus, whilst there might be aspects to the

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<sup>11</sup> Despite these precautions, as I became more familiar with the system and patients in it I began to detect key stories; the same examples that different people across the system drew on to demonstrate a point. While these were actual cases, they took on a folkloric dimension. They were illustrative of a particular problem or development in the system, but they were not necessarily representative of frequency; indeed it was more likely the opposite, given the small number of anecdotes that were relied upon widely.

correspondence that would be interesting to note, I do not believe this denial significantly diminished the validity of my findings.

The second request related to legal advice the Unit had sought in the 1990s on the interaction of victims with the decision-making process. That advice led to policy and then legislation on what information may be divulged to victims about specific restricted patients. As such it went to the heart of the balance between natural justice and patient confidentiality in the restricted patient system. I sought this advice on several occasions from different senior members of the Unit, to no avail. In both cases the denial of access to these materials was justified on the basis of principles of freedom of information or because of legal privilege over information, yet it was noteworthy given the open access I had at the Home Office for the rest of my research.

### **Ethical Considerations**

There was no formal ethical approval process required for my research project. This stood in stark contrast to the position I was familiar with in Australia where formal ethics approval was obligatory in any research involving human participation.<sup>12</sup> As already discussed, the ethical concerns of the Home Office focussed upon ensuring anonymity of patient data, and there is no identifying information about either patients or victims contained in my thesis. All other participants were involved in a representative or a professional capacity. Nevertheless none are identified beyond their professional position, and all quotations are included anonymously. Prior to submitting my thesis for examination, I sent a summary of findings to all those who participated and offered to send more detailed excerpts or the thesis as a whole, or to meet and discuss the research in person, should they so desire.

Only the Home Office asked to see all quotations from its staff. Upon review, officials drew attention to six quotations which they requested be expressed

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12 In fact, by the time I had completed my PhD there was a more rigorous ethical process in place for research than at the outset of my doctorate. My project still satisfied the new requirements.

as reported speech instead of verbatim. They left the decision up to me and noted 'absolutely no desire to shade' my meaning. Several of the quotations they selected had been rare insights into the thought processes of officials and I was hesitant to lose the force of the verbatim statements. At the same time, I was conscious of a tacit agreement with the Home Office through the support it had provided for my research, and I did not want the primary participants in my study to feel mistreated. Consequently I converted the quotations to reported speech as requested.

Despite the absence of any formal requirements, I faced some ethical dilemmas at the completion of my fieldwork and in the early stages of my analysis. I had been given open access to the personnel, policies and procedures of the Mental Health Unit and other relevant areas of the Home Office. When I first began to analyse my data from the Home Office, I was concerned that officials had been too candid with me because they perceived me as a colleague. There were some issues I observed and positions put to me by participants that could have been legally challengeable. This did not mean they were illegal. But as my thesis will show, there were many aspects of the restricted patient system that were open to interpretation, and interpretation varied depending on the standpoint of the actor in the system. I wanted to conduct a detailed investigation of executive decision-making; I did not want to render vulnerable to criticism any of the people who participated in my research.

It was in considering these issues that I returned to the Home Office's concern that my research should not undermine public confidence in the system. I was unsure what this actually required of me. What expectations did the Home Office have about my use of data, largely obtained from their staff? Did they expect me to be as mindful of public confidence in the system as they were required to be?

On closer analysis of my data a picture emerged of actors throughout the system who were sympathetic and willing to acknowledge the competing priorities of the system, and by extension the tensions between the various actors. Executive decision-making about restricted patients in England and

Wales was more transparent than the system to which I had become accustomed in Australia. The decisions made every day in the restricted patient system were not easy. Many of them were complex, and involved arbitration of conflicting interests. But the actors engaged in these processes were the first to acknowledge these tensions. They readily admitted that they were not always right; that mistakes had been made and would be made again in the future; that the system had a high profile and its actors were fallible; and that everyone did the best they could within the resource and other constraints of the system. It was also a system that had rendered itself open to scrutiny by academics and other researchers long before I conducted my research, and I hoped would continue to do so. While I was initially concerned that my research might lay individual participants open to unanticipated scrutiny, I came to see that review of decision-making processes was an integral aspect of the system as a whole. The access the Home Office had provided me was no different in form to the sorts of access it provided to care teams and hospital staff who worked in the restricted patient system.

From the reflections I have outlined in this chapter, my anxieties about the potential harm or other unintended consequences of my own research diminished. In drawing on examples from fieldwork throughout my thesis and complementing these with alternative perspectives wherever possible, I have undertaken to present a fair and frank analysis of executive decision-making in the restricted patient system.

## CHAPTER 3

### THE HOME OFFICE MENTAL HEALTH UNIT

#### Introduction

The broad aim of my research was to examine the role of the executive in the restricted patient system. In law the executive's powers were held by the Home Secretary, but in practice they were delegated to the Home Office, and were carried out by the Mental Health Unit (the Unit). Conducting fieldwork presented an opportunity to get 'inside' the Home Office and consider the actual practice of executive decision-making about restricted patients. The operations of the Unit had been the subject of empirical research a decade earlier when Dell and Grounds examined the discharge and supervision of restricted patients (1995). However, theirs was a study of the supervision of conditionally discharged restricted patients in the community. Whilst the study examined some of the issues around the process of Home Office decisions to release, it was interested primarily in the attitudes of care teams and patients towards those decisions, rather than how the Home Office arrived at them (Dell and Grounds 1995:xi). My research sought to contribute a glimpse into the little-explored aspect of the decision-making process itself, examining the complex and negotiated character of how the executive's mandate was implemented.

This chapter begins that task through a descriptive analysis of the work of the Home Office in the restricted patient system. I seek to establish how the framework for decision-making by the Home Office was constructed in judgements about release, specifically through applications for leave or discharge of restricted patients into the community, and how this in turn formed an implied theory of risk at the Home Office. I shall start with a review of some of the literature on decision-making, leading to a discussion of the exercise of executive discretion within the restricted patient system. I then move to a detailed analysis of the Mental Health Unit as the bureaucratic department to which the Minister's authority was delegated.

Home Office staff clearly understood their mandate to be protecting the public. I was interested in what officials meant when they asserted that all their operations were informed by the public protection agenda; and how they met that agenda. How did protecting the public shape the decisions made by Mental Health Unit staff about individual patients? Was the path to public protection clearly marked at all times, or was this complicated and difficult terrain? In particular, how was risk 'managed' by the Home Office, in order to provide public protection? In the present chapter I begin to engage with these questions, which are central to my analysis throughout the thesis.

### **Decision-Making in the Literature**

A key objective of my thesis was analysing the challenges and processes involved in decision-making which took place at the intersection of mental health and criminal justice. In Chapter One, I reviewed the literature on the 'lottery' by which offenders are determined as mentally disordered or not; and how the specific status accorded as a result of this determination has an impact upon how, where and for how long mentally disordered offenders are detained (see for example Peay 1989 and 2002; Grounds 1995; Prins 1995; James *et al* 2002; Padfield 2002; Grounds *et al* 2003). There is also an important body of work examining the operation of mental health tribunals (Peay 1989 and 2005b; Mohan *et al* 1998; Wood 1999; Perkins 2003) and analyses of the effect of judicial review, including upon bureaucratic decision-making (see for example Machin and Richardson 2000). Tribunal decision-making was a central aspect of the restricted patient system, but was so significantly different from the focus of my own research into the executive that a thorough analysis would detract from the objective of my thesis.<sup>13</sup> Of more direct relevance to my work was the literature about legal decision-making processes, particularly at the point of exit from the system. I introduce this literature now, to set the context for my analysis of the operations of the Mental Health Unit.

Legal decision-making processes can be both formal, such as the recognised processes of a court; and informal or unacknowledged, for example the work

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13 I shall return to the question of Tribunal decision-making in Chapter Seven.

of court staff who support judicial decision-making in the preparation and presentation of information (Hawkins 2003). Hawkins has also contrasted case-specific decision-making with policy decision-making. In policy-based work legal rules are implemented by what he describes as street-level bureaucrats. These are members of formal organisations for whom,

very often the environment of a legal decision, so far as the official is concerned, is partly made up of existing decisions which comprise a policy purporting to inform the handling of particular kinds of cases in particular ways (Hawkins 1986:1171).

Hawkins' analysis requires us to take a broad approach to defining the terrain of decision-making, so that we look beyond the formal institutions that are readily identifiable to the structures that support those institutions. He suggests that decision-making research needs to:

get away from approaches which focus on 'criteria' or 'factors' said to have been taken into account in making a particular choice. The argument, instead, is that decisions can only be understood by reference to their broad environment, particular context, and interpretive practices: their surrounds, fields and frames (Hawkins 2003:189).

Hawkins' analysis informed my own approach to the operation of executive discretion in the restricted patient system. I was not just interested in the final decisions but in the policies, personnel and other factors which lead to those decisions being made. To recapitulate from Chapter Two, these were the factors of the 'decision frame', a 'structure of knowledge, experience, values, and meanings that the decision-maker shares with others and brings to a choice' (Hawkins 1986:1191).

Executive decision-making might not be readily obvious as a form of legal decision-making. The very nature of a decision being made by an elected representative contrasts with what is traditionally considered as legal decision-making such as by the judiciary or *via* tribunals.<sup>14</sup> Nonetheless executive discretion in the restricted patient system was bound by legislative frameworks, such as in the exercise of compulsory powers under the *Mental Health Act 1983*, that clearly constituted a legal decision-making

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14 That excludes those jurisdictions where criminal justice officials are elected, for example some states in the United States of America.

environment. In the restricted patient system, describing Home Office staff as 'street-level bureaucrats' would imply that they were merely lay people without relevant knowledge or experience beyond the machinations of government. Of course, there is an established role for lay people in mental health law. Loughnan suggests that "recognising the role of lay understandings of mental illness is important because it reminds us that the 'battle' about the way criminal law deals with mentally incapacitated defendants is fought on three fronts" (Loughnan 2005:37). Loughnan posits that the jury in the trial process contributes a third level of lay knowledge to those of the legal and medical (psychiatric) forms of knowledge already embedded in criminal procedure. But even accepting this structure, staff of the Mental Health Unit formed something of a fourth layer of decision-maker. They were not employed for their expertise in forensic mental health. There was no requirement that staff had a background or training in the areas of law, criminal justice or mental health, and only one staff member participating in my research acknowledged their training in psychology as a reason for wanting to work in the Unit. On the contrary, some staff members described themselves as members of the public representing the interests of the non-expert in the restricted patient system. Indeed, Unit staff had a breadth of experience and carried responsibility for individuals including patients and their families that extended well beyond those of lay actors like jurors.

The decisions of the Mental Health Unit were what Hawkins would call 'negotiated decisions ... made in private with a low degree of visibility of process and result' (Hawkins 1986:1170). Such decision-making has raised concerns that it can lead to 'arbitrary, inconsistent or unfair decision-making' (Holloway and Grounds 2003). However these criticisms are not unique to executive decision-making. In their study of Mental Health Review Tribunal decisions in a regional secure unit, Mohan *et al* questioned 'whether MHRTs act with sufficient independence to balance the rights of both the public and the detained patient, or whether they are unduly receptive to the [Responsible Medical Officer's] views' (1998:63). That critique points to the important assertion that decision-making takes place within social contexts, political values, resourcing and demands upon prioritisation that may

compete with the interests of those making or effected by the decisions themselves.

While informative and analytically helpful, the existing literature did not wholly account for the nature of executive discretion as it operated in the restricted patient system. The executive occupied a nebulous space between (or outside of) the legal decision-making structures commonly considered by the literature such as courts and tribunals. Executive decision-making shared some but not all of their characteristics; and it contributed new elements to the picture. For example, the idea of flexibility in executive decision-making was repeatedly mentioned by people interviewed in this research. As I will examine in Chapter Six, the government relied heavily upon the element of flexibility in its agenda for law reform. Developing a greater understanding of how notions like 'flexibility' translated into practice was one contribution of this empirical research. Above all, I sought to contribute to the significant gap in the literature on the operation of executive decision-making.

## **Executive Decision-Making in Practice**

### ***The role of the Mental Health Unit***

Whilst the exercise of discretion is the focus of this chapter, it is important to commence by clarifying the meaning of executive. The *Mental Health Act* 1983 provided statutory authority to the Secretary of State to permit restricted patients to take leave from a secure hospital facility, to transfer to a different facility, to be conditionally or absolutely discharged to the community, and to be recalled to hospital (sections 41 and 42).<sup>15</sup> It was the Home Secretary who exercised the legislated power of the executive in this system. In practice the power was delegated to the bureaucracy of the Home Office, specifically the Mental Health Unit (the Unit). This delegation was effected not by way of statute but by agreement between the minister and his or her department. As explained to me by senior Unit officials, a memorandum of understanding was sent to each newly appointed Secretary of State (Home Department), outlining the scope of decisions previously taken by the Unit,

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<sup>15</sup> This was reaffirmed in the amendments to the *Mental Health Act* that were introduced in July 2007, after the completion of fieldwork for this thesis.

and seeking confirmation that the new minister wished this process to continue. Through this process the Unit was given authority to make decisions using the Home Secretary's authority under the *Mental Health Act 1983*. I was not permitted access to the documentation surrounding this process of delegation during my fieldwork on the grounds that it contained 'confidential recommendations' and that the Unit 'don't publish the advice that we give to ministers'.<sup>16</sup>

Importantly, the delegation of power comprised direct authority to the staff of the Unit. With a population of almost 5000 patients, no single person could determine each case individually, least of all a cabinet minister with a portfolio as broad as the Home Secretary's. The decisions taken by the Mental Health Unit were signed by the individual staff member, not 'for or on behalf of' the Home Secretary. As one official from the Unit stated:

Not so long back, five years ago, the great majority of significant decisions like discharge and transfer to low security were taken personally by ministers. Now they're not. Ministers have delegated most decision-making to [the Unit].

There was very little scrutiny from the ministerial level towards the operation of the Mental Health Unit. On the contrary, the Minister only became involved in a matter if it was handed up from the Unit. Indeed, some Unit staff I interviewed said that they found the decision-making process 'isolating', as a consequence of the lack of review of the decisions they made. Nevertheless the Home Secretary was ultimately accountable for these decisions, by legislative mandate under the *Mental Health Act 1983*. How the Home Secretary ensured oversight of the decisions being made under his or her authority seemed to rest with the confidence with which the bureaucracy of the Home Office met its mandate.

There was a clear hierarchy, strongly adhered to, which provided bureaucratic support in the form of avenues available for advice when staff doubted their decisions. It was an example of what DiMaggio and Powell would have termed a structural simulacrum of rational decision-making, that

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16 This was also in accordance with standard provisions under the *Freedom of Information Act 2000* (part ii, section 35).

is internal processes that monitored the decision-making process at every level (1983). There was a strong presumption towards caution in all areas of decision-making, but particularly in decisions about discharge. In many ways staff acted as gatekeepers by exercising caution in decision-making, ensuring that neither the minister nor the system fell into disrepute.

Executive discretion in the restricted patient system essentially involved a form of bureaucratic decision-making. At the government level the Home Secretary remained the challengeable authority in this domain. Should a patient wish to mount a legal challenge against a decision in their case the responding party would be the Home Secretary. But it was civil servants who made the decisions in all but exceptional cases. Their role raised a number of questions including the dual responsibility of both advising and taking direction from ministers and the *realpolitik* of criminal justice policy at the time. These issues pointed to a set of dual mandates operating in the system, and made it even more pertinent to have a detailed analysis of the operations of the Unit. I turn to this task now.

### ***The work of the Mental Health Unit***

The main role of the Home Office in the management of restricted patients is to protect the public from serious harm. ... Our task is to scrutinise proposals relating to restricted patients ... looking for evidence of thorough risk assessment and effective risk management. We need to satisfy ourselves that any risk to the public has been properly identified and evaluated, and that sound measures have been taken to guard against any risk (Mental Health Unit Casework Guide, March 1998, 1A.1, 2).

I conducted fieldwork at the Mental Health Unit of the Home Office from January 2005 to March 2006. The data in this section are taken entirely from that fieldwork. At the time of my research the Unit had approximately 60 staff. Unit staff were predominantly case workers, which meant their work revolved around the cases of specific restricted patients. Staff had two primary roles: dealing with routine applications such as leave requests; and responding to unusual or complex matters, for example a proposed leave plan to the community where a patient had lived and committed their index offence (the offence for which the patient had been convicted). As I will show, although many offenders had histories of dangerous or offending behaviour prior to

their status as restricted patients, the index offence was regarded as a significant indicator of risk and potential harm posed by the patient. Individual staff members each had about two-hundred 'live' files in which patients were awaiting a decision on an application. Around one-quarter of those were likely to be patients on conditional discharge in the community.

There was a widely held perception amongst Unit staff I spoke to that the total time spent on a restriction order was approximately four years, from detention after conviction to absolute discharge. This figure was a notable underestimate of Street's findings that the average stay of restricted patients in hospital was nine years, not counting time spent on a conditional discharge in the community (1998). Discharge was rarely achieved straight from hospital. It usually involved a lengthy process of testing a patient's compliance with treatment and therapy as the patient moved from maximum through to minimum levels of security in hospital. Patient progress was also measured through periods of leave from hospital, where a patient's ability to remain safe in the community was tested over initially short, and then increasingly long periods of time while they continued to be formally detained in a hospital.

The progress of patients through the restricted system was tracked through files maintained at the Unit which contained all paperwork on a case including correspondence, reports, minutes of the Unit's actions and any other material associated with the patient. The Unit might receive correspondence from a solicitor, but the application for discharge (or anything else) came from the patient's medical officer. Staff described a strong sense of responsibility for their caseload, acknowledging that the sheer volume of cases they monitored might lead them to miss something that later proved important. Indeed it was a large population spread well across the country, as the following figures show.

#### *The restricted patient population in England and Wales*

A number of datasets were provided by the Unit during my fieldwork to give a snapshot of the population at the time. They are unpublished figures derived from internal Unit records. At this time the Unit was in the process of

transferring its records from a paper-based to an electronic system. Thus these figures were indicative rather than definitive of the population at the time.<sup>17</sup>

**Table 1: Patient population monitored by the Mental Health Unit (as at 11 August 2005)**

| Detention Status of Restricted Patient              | Number of Patients |
|---|--------------------|
| <b>Detained patients</b>                            |                    |
| Restricted hospital order (section 37/41)           | 2347               |
| Other*  | 1118               |
| <b>Sub-total of detained patients</b>               | <b>3465</b>        |
| <b>Conditionally discharged restricted patients</b> | <b>1306</b>        |
| <b>TOTAL</b>  | <b>4771</b>        |

\* The category of 'other' included the rarely used provisions of the *Mental Health Act* 1983: section 45a where a sentenced prisoner with psychopathic disorder could be directed to hospital admission for compulsory treatment before being sent to prison; sentenced prisoners transferred to hospital for treatment (section 47); and other prisoners such as those on remand or detained in immigration centre who were transferred to hospital for treatment (section 48).

Notwithstanding their limitations, these figures provided some general information about the population being supervised by the Unit. Most notably, almost one-third (27%) of all restricted patients were on conditional release in the community. That meant a significant amount of the Unit's work was focussed on supervision in the community. Yet a number of Unit staff believed that the Home Office had the wrong balance in its workload. During my observation of their work they commented that, whilst they spent most of their time determining applications for leave and monitoring patients in detention, they believed they ought to be concentrating on patients conditionally discharged to the community. Even though conditionally discharged patients only represented one-third of the Unit's caseload, staff believed that those patients warranted the most attention in terms of the risks they posed to public safety. It was interesting that staff felt that the monitoring of patients who were already in the community was more important than the decision to discharge a patient from hospital in the first place; a decision

17 There are some obvious gaps in these data, for example in the inconsistencies in the totals between Table 1 and Table 2; and they reflect the usual problems of census-style data, including the effect on population of movement through the system at the time. The flow data presented elsewhere in Chapter 3 provide a more reliable picture of the system.

which staff might conceivably have felt was a greater burden in terms of their responsibility for public safety. But as I shall discuss shortly, the Unit actually made very few discharge decisions compared with the Tribunal. Thus the area about which staff had the greatest concern in their own work was the monitoring of patients in the community, and decisions that might arise in relation to patient behaviour while there.

**Table 2: Dispersal of restricted patients (as at 11 August 2005)**

| Location                            | Number of Patients |
|-------------------------------------|--------------------|
| High security hospitals             | 713                |
| Other hospitals (medium, low, open) | 2652               |
| Community                           | 1306               |
| <b>TOTAL</b>                        | <b>4671</b>        |

The Unit's workload covered a total of 1159 hospitals in England and Wales in which restricted patients could be detained. In practice the actual spread of patients at any one time was likely to be far less. The three special hospitals of Broadmoor, Rampton and Ashworth maintained the highest level of security and they accounted for 713 restricted patients (20% of the total restricted patient population) at the time of this research. The remaining hospitals were medium- and low-security and open hospitals (facilities with no capacity to secure patients on the site). Very few restricted patients were detained in open hospitals, because it was argued that if they no longer required such security, then they could be conditionally released. Consequently there was a concentration of patients in the three high-security facilities and a large spread of patients throughout the medium- and low-security hospitals of England and Wales.

**Table 3: Discharge to the community by decision-making authority (year to date, as at 11 August 2005)**

| Discharging Authority         | Number of Discharges |
|-------------------------------|----------------------|
| Home Office                   | 250                  |
| Mental Health Review Tribunal | 1056                 |
| <b>TOTAL discharges</b>       | <b>1306</b>          |

The breakdown of conditional discharges by decision-making authority was an important source of data. These data pertained to all patients living in the community on conditional discharge at the time of the research (August 2005). The population ranged from people who had been released since the Tribunal received the power to discharge under the 1983 Act, to people who were discharged up to June 2005, just before the commencement of my fieldwork. From these data, Home Office decisions to discharge represented only 19% of all conditionally discharged patients, indicating that the Tribunal was the primary decision-maker for conditionally discharging patients. These data went a long way to explaining the perception by Unit staff that problems with risky patients in the community arose from Tribunal decisions, an issue I shall discuss below.

Beyond these demographics the majority of the data available from the Unit were outcome-specific, recording the actions of the Unit's staff in response to applications received. 'Output measures and performance indicators' were aspects of the Unit's work that were quantifiable and were measured on a monthly basis for each team within the Unit. Key indicators included applications for every different form of leave, for example escorted and unescorted leave, discharge proposals, Tribunal statements and responding to letters from patients or members of the public. Initial performance was measured by recording things like the number of applications for leave received against the number where a decision had been made. However performance was also measured by timeliness, such as whether a case was completed within ten days, two weeks, three weeks and so on up to one year. Some of these performance indicators also had targets. For instance, leave applications had a completion target of three weeks while discharge applications had a target of two months from the date of receipt of the request (excluding any time taken to request further information). 95% of letters from the public were supposed to be answered within three weeks, a target that was met at the time of my research. Some targets were set externally, such as replies to parliamentary questions which were determined by the Private Office.

Performance indicators and targets had become commonplace throughout the civil service (see for example Home Office 2006b). Importantly, these indicators were a quantitative measure of performance, which necessarily delineated the sorts of processes that they could cover. At the Mental Health Unit, performance indicators measured discrete, case-specific decisions about restricted patients. However Hawkins cautions that 'this individualistic view is partial ... and fails to describe the real character of criminal justice decision-making which has instead to be seen in an holistic or systemic perspective' (Hawkins 2003:194).

According to Hawkins, analysing decisions without examining the environment in which they are made tells us very little about the decision-making process. Nevertheless performance indicators did shed light on the administrative priorities of the Unit. These related to measures of efficiency and to how matters progressed through the Home Office system. They were an important tool for justification and were something of which senior Unit staff were proud. The Unit consistently scored well against its performance indicators, which enabled managers to demonstrate that the Unit was doing its job efficiently.

Although the Mental Health Unit's performance indicators were a reflection of a particular aspect of the Unit's work, they could not be viewed as an overall summary of its entire workload. Notably, performance indicators did not cover the supervision of patients in the community. Monitoring conditionally discharged restricted patients was an area of work that Unit staff found particularly stressful because it involved the greatest likelihood of interaction between patients and the public. The nature of monitoring and supervision of the restricted patient system was central to the Unit's work and the hardest aspect of that work to quantify through discrete numerical values. At the same time, the process of setting performance indicators and targets had effected the structure of the work of the Unit and these 'organisational decisions' came to take on a specific significance because they could be measured as indications of performance (Hawkins 2003). I shall return to the nature of measurable processes and decisions later in this chapter. Before

that, I turn to examine the unquantifiable aspect of the Unit's work: monitoring in the restricted patient system.

### ***Monitoring in the restricted patient system***

Monitoring occurred at every stage of the process, beginning with patients in hospital right through to progress on conditional discharge in the community. In a new case, staff would examine the index offence and the medical reports (including the clinical assessment of the index offence), and would assess these measures against the Unit's checklist that was provided as a reference point for Responsible Medical Officers to make applications and for caseworkers to assess them (the checklist is reproduced at Appendix 2). Some factors were considered routinely, including the extent to which risk factors were being addressed in the care plan; whether and how risk was being reduced; and whether there was a consistent and complete picture about the patient's care plan and progress being conveyed by the treating team. If the treating team's recommendations had changed, Unit staff would seek an explanation. They also monitored staff changes within care teams to ensure an ongoing familiarity with a patient's history. Unit caseworkers interacted regularly with care teams and even sometimes with patients' families in their monitoring and supervision work.

Whilst there was no set template, conditions of discharge generally required a patient to accept psychiatric supervision, prescribed medication and supervision from a social worker or nurse; and to reside at a stipulated hostel, residence or other address as approved by the care team. Conditions might also include an exclusion zone or restrictions on drug and alcohol consumption. Conditions of discharge were an important component of the strategies for public protection undertaken by the Unit even though, as I discuss below, conditions were not necessarily enforceable.

The Unit monitored patients to see whether their restrictions were still necessary; whether their current conditions were appropriate; and if not, whether recall was necessary. The actual nature of these assessments varied across the Unit. One official interviewed explained how she would first check the patient's previous convictions. She would then check the patient's

medical history, to establish whether there was evidence of his or her mental illness prior to the offence. From this she would make a judgment about whether the patient's mental condition was likely to have contributed to the offending behaviour, or whether it was more likely to have been sparked later such as when he or she was arrested. This official believed that the documents in a patient's file were adequate for gleaning these facts. As Hawkins points out, decision-makers 'are rarely, if ever, totally passive participants in the decision-making process' (Hawkins 2003:201). I was beginning to see how the process of the decisions being made might vary, depending on the individual staff member making them.

There were certain markers of behaviour that came to assume importance in decision-making. For example the *pro forma* applications for leave and discharge included information on the person's mental state, behaviour, treatment plan and offending history (specifically, whether or not they were a sex offender). The form also asked for information on any victim or public involvement in the case; the patient's attitude to the victims; and whether the patient posed any risks of absconding. Thus, while it was not the role of Unit staff to contribute expert knowledge to the process, they did structure the information they received along collectively identified avenues, and a common work culture structured around the priorities of the Home Office.

It could be difficult for Unit staff to explain the processes they followed to other actors in the system. An official described a recent interaction with a doctor who had been frustrated when the Unit rejected a transfer application on the basis of the risks to other patients if the patient was transferred. The doctor asked for a copy of the Unit's 'risk assessment document'. In response, the staff member sent him a copy of her file notes. As she explained to me, risk assessment was not an actuarial process: it did not involve a routine approach in each case. Rather, it was 'a matter of personal consideration', taking into account the sorts of issues outlined above. Yet another staff member describing Home Office risk assessments said that they were 'fairly actuarial'. The use of 'actuarial' here could have referred to the systematic process of assessing risk discussed in Chapter One, for example by scoring behaviour with numbers that eventually enabled the

calculation of a probability of risk. However it seemed to me that staff were using the term instead to describe the routine nature of the processes involved. These processes were embedded within an organisational context whose institutional priorities and policies influenced but did not determine the outcomes of decisions. As such, they defied simple description, particularly to anyone working outside the Unit.

Another area of monitoring by the Mental Health Unit was in relation to Mental Health Review Tribunal decisions about restricted patients. The Home Office monitored Tribunal decisions to make sure they did not step outside the Tribunal's mandate, and the Unit could seek judicial review if it believed a Tribunal had acted beyond its purpose or powers. As one senior Unit official commented, the Home Office found it hard to keep the Tribunal's powers closely defined, but judicial review of Tribunal decisions provided one avenue for this.<sup>18</sup> Additionally, Tribunal hearings were monitored for reasons of public protection. One official told me of a case involving a homicide offender whose mental disorder had cleared up fairly quickly after admission to hospital. The care team were preparing an application for release, either conditionally or unconditionally, because the patient no longer met the criteria for detention under the 1983 Act; but the Home Office was concerned that the patient might reoffend. Given the severity of the offence, officials believed the patient exhibited a clear risk to the public and so opposed his discharge, regardless of whether he continued to meet the criteria for compulsory treatment under the Act. The Home Secretary was represented by counsel at the hearing, and the Tribunal granted a deferred conditional discharge. As this official explained, the Home Office had never expected the patient's detention to continue; the most the Home Office could hope for was the conditional discharge that eventuated. But officials had 'pulled out all the stops' to show they had done everything the Home Office could to protect the public.

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18 See for example *R (on the application of the Secretary of State for the Home Department) v Mental Health Review Tribunal* [2001] A.C.D. 62 (High Court), wherein the Home Office sought review of a Tribunal decision to adjourn a hearing to seek further information about an assessment for transfer. The review was based on the fact that transfer was out of the Tribunal's power, and therefore not a legitimate reason for an adjournment.

This focus on the Tribunal by the Unit indicated an *unofficial mandate* that lay outside the executive's official role in relation to restricted patients. These were aspects of the ongoing work of the Unit, yet they were not part of the clear and coherent description of the Unit's role and responsibilities that had been laid down formally in policy. There was no statutory duty of oversight by the Home Secretary in relation to the Tribunal. On the contrary, the Tribunal's powers derived from its independence as a quasi-judicial body working in parallel to the executive. Yet the Mental Health Unit perceived its role of maintaining public confidence as well as public protection to necessitate the review of any decisions made about restricted patients, even under the authority of the Tribunal. The informal status of that monitoring was further reinforced by the absence of performance indicators in relation to it; and by the absence of policy or documentation about it. Yet, the internal review of a Tribunal decision could result in a formal process such as a judicial review. Thus it was an important and sensitive aspect of the work of the Unit.

Monitoring Tribunal decisions was separate from the statutory responsibility of the Home Secretary to provide statements in response to medical reports submitted in support of applications for discharge. These were also undertaken by the Unit which furnished an explanation as to why the Home Secretary was opposed to the patient's discharge (and therefore had not released the patient already). In practice, Unit staff told me that the Home Secretary 'was expected' to comment not only on psychiatric reports but on all reports received by the Tribunal for a hearing (including, for example, nursing or social worker reports). This was a huge task administratively: there were 4000 Home Secretary statements each year. Yet completing these statements was a matter of routine administration.<sup>19</sup> The distinction between providing statements to the Tribunal and monitoring its decisions provided some indication of the broad scope allowed for in the Home Secretary's mandate. The provision of Home Secretary statements on discharge applications to the Tribunal was required by law. The informal monitoring of Tribunal decisions was not. Yet both these aspects of the Unit's work were

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19 Dell and Grounds found that they were generally discounted by Tribunals because they were little more than a summary of information already available to the Tribunal (1995).

considered central to the mandate for public protection that underpinned the work of the Home Office.

The monitoring of Tribunals indicated how much attention the Home Office paid not just to the risks taken in terms of patients coming in to contact with the public, but also about being seen to be acting in the interests of public protection. Padfield *et al* have talked about the extent to which Parole Board Discretionary Lifer Panels were similarly concerned about the public appearance of their decisions, such that it became a standard part of their decision frame (2003). Indeed, Hawkins argues that decisions to lift the criminal sanction are particularly vulnerable to criticism on these grounds.

A successful decision outcome (the released person who readjusts to life in the community, or who successfully completes his or her period of supervision) is invisible; only failure has the potential to come to public attention. To the extent this setting makes decision-makers more cautious, its effects are unlikely to show in conventional corelational research. In analysing decision-making about the risk of offenders, one aspect to take into account is that conceptions of risk have to be understood also as about risk to the decision-makers themselves (Hawkins 2003:211)

This process reflected the sorts of assessments staff engaged in on a daily basis. It could be argued that these were decisions requiring clinical or legal expertise. Indeed, Unit staff based their decisions about patients upon clinical information in the form of medical reports, and legal documents in the form of court transcripts and submissions from lawyers. These views then informed the approach staff took when assessing applications. There were also elements of the decision-making process wherein the idiosyncrasies of individual staff might produce a different method or approach to how caseworkers did their jobs. As another staff member commented to me, it was the care team's responsibility to interpret the patient's behaviour, but the Mental Health Unit's responsibility to monitor that behaviour at all times.

As Hawkins has argued, understanding the environment and context of decision-making is central to analysing its process.

To understand the nature of criminal justice decision-making better, a connection needs to be forged between forces in the decision-making environment, and the interpretive processes that individuals engage in when deciding a particular case (Hawkins 2003:189).

In the restricted patient system, the exercise of executive discretion took place within the bureaucratic environment of the Home Office. However, that environment - or what Hawkins terms the 'surround' - was only one part of the picture. Some of the processes that caseworkers followed could have been interpreted as simply reading the information in a patient's file to familiarise themselves with a case. Yet the process instilled in them a sense of familiarity that enabled them to judge for themselves the quality of the information they were receiving and - by extension - the effectiveness of the steps being proposed by the care team.

One Mental Health Unit member explained that while caseworkers didn't necessarily operate identically at every point, they did so at a broader, institutional level. Essentially, their approach relied upon the fact that Unit staff were neither lawyers nor clinicians, but were intelligent and educated members of the public who were looking at the information coming in from care teams and lawyers. In that sense, he said, the brief of the Unit differed significantly from that of the Mental Health Review Tribunal. Rather than substitute their own judgment for that of the clinicians making an application, Unit officials would assess the information received, including what might be missing from it, and would ask questions of its authors. Consequently, while there might be variance in the individual approaches of caseworkers, decision-making at the Unit was consistent in the emphasis it placed on the interests of public protection.

As I suggested earlier, the work and responsibilities of Unit staff situated them somewhere in between lay and professional actors in the forensic mental health system. Based upon their experience, staff were trying to ensure a consistency of process in a genuinely bureaucratic approach. However it was also important to some staff that they identified with and as members of the public. When I asked whether staff had any training in mental health or illness, one official replied that it was better to have less knowledge

about mental illness when you were working in the Unit, because it enabled staff to examine cases 'like a normal person'. This meant the ability to assess risk issues for the public, as members of the public. Staff would pick up an understanding from doctors reports 'as we go along', but they didn't need a detailed understanding of mental illness in order to make determinations about risk.

A growing body of literature has talked about the deprofessionalisation of approaches to criminal justice. In Garland's critique, he attributes this process to the greater emphasis placed upon public and victim-focussed perspectives.

The dominant voice of crime policy is no longer the expert or even the practitioner but that of the long-suffering, ill-served people - especially of 'the victim' and the fearful, anxious members of the public. A few decades ago public opinion functioned as an occasional brake on policy initiatives: now it operates as a privileged source. The importance of research and criminological knowledge is downgraded and in its place is a new deference to the voice of 'experience,' of 'common sense,' of 'what everyone knows' (Garland 2001:13).

Professional assessments were still a central element of Home Office decision-making, as evidenced by the reliance upon care team's reports when considering applications. Yet the Home Office's role was to assess those reports in the interests of public protection. In pursuing that mandate, the public perspective was given equal weight (at least) to that of the professional.

Sociology has long been interested in ideas of common-sense. As Douglas argues, classical sociologists believed that, in order to mark it as a 'science', sociology had to be 'independent of and in opposition to common sense ideas about man and society' (1971:ix). That assumption shifted with the recognition that, unlike rocks and planets, the forces that moved human beings were the 'meaningful stuff' of 'ideas, feelings, motives' (*ibid*). Meanwhile Edelman had been interested in the utility of common sense within political realms, positing that common sense served 'as a reassuring symbol evocative of an acquiescent mass public response' (Edelman 1964:55). For my own analysis, these theoretical approaches to the role of

common sense in public (and particularly criminal justice) policy provided a useful framework for understanding what was happening at the Unit. It was their own experience as members of the public that Mental Health Unit staff related to and claimed was most important for their decision-making in terms of public protection. In a sense, they occupied a hybrid position as experts of the public interest, combining their professional experience of reading and assessing information by experts, with their personal experience as members of the public. This perception of staff directly representing the public interest is something I return to later in the chapter.

From the discussion so far, it was clear that the distinction between monitoring and decision-making was actually quite blurred in practice. In some of the examples I have given, it was the unofficial monitoring of a patient that created the need for a formal decision, such as whether to recall a patient or seek judicial review of a Tribunal decision. However, I maintain this distinction as an analytical tool to focus on the application-driven part of the Unit's work, which required specific decisions in response to applications or to other situations that arose on an *ad hoc* basis. I turn now to consider in greater detail the decisions made by the Unit.

### ***Determinations***

The purpose of executive discretion in decisions about the release of serious and violent offenders essentially came down to a question of rights *versus* control: the rights of the patient to be released as balanced against the interests of the public to be protected. In the contemporary political and policy terrain, this meant that every decision made by the Unit was reduced to the question of risk. The challenge for decision-makers was that, even accepting this rights-versus-control dichotomy, there were a range of risks that emerged within that dichotomy, and it was rare for one course of action to alleviate them all. In the world of mentally disordered offenders, risk had a set of clinical connotations, based in science and research, which were integral to how a patient's progress was assessed. In the context of public and criminal justice policy, risk of dangerousness to the public was one major element; but equally important were risks to the reputation of the decision-maker, the system and ultimately to the Home Secretary. These risks were

real, as was evidenced by the fall of at least one Home Secretary during the period of my research. In the following discussion I examine how risks were assessed and permitted in decisions that brought restricted patients into contact with the community. I focus on decisions for leave and conditional release.

### *Leave applications*

Applications received at the Unit generally related to requests for leave, transfer or conditional or unconditional discharge. In each of these cases the concern with risk and public protection was paramount to the decision-making process. Beyond this, the extent to which Unit decision-making was informed by therapeutic concerns varied. The consideration of leave applications was a good example. The 'Guidance for Responsible Medical Officers' set out the framework within which doctors applied for leave and the Unit considered their applications. The Guidance stated:

Leave programmes should be designed and conducted in such a way as to preserve public safety, sustain public confidence in the arrangements as a whole, and respect the feelings and possible fears of victims and others who may have been affected by the offences (Mental Health Unit, March 2005:page 2 at 4).

Interestingly, the specified criteria against which applications were assessed had changed little in ten years.<sup>20</sup> Four separate documents outlining the leave provisions for restricted patients made the same points with similar emphasis.<sup>21</sup> A cover letter accompanying the revised 'Guidance to RMOs' that was issued by the Unit in April 2005 noted, 'it does not introduce any major changes ... generally the guidance has been improved to reflect not only the views of RMOs and other users, but also by making the language clearer and the layout more helpful' (SI 4/05, 'Revised Guidance for RMOs: Section 17 Leave', para 2). As I shall explore in Chapter Seven, the operations of the Unit came increasingly to focus on risk after the introduction of the *Mental Health Act 1983*, and particularly throughout the 1990s. Yet,

20 A lot of the documents I analysed were undated. This reflected my own professional experience of working in the public service, where documents rarely recorded their author or date. Any assessment of change over time on the basis of documentary analysis needs to keep this proviso in mind.

21 These were Potts (1995) at Annex B; 'Chapter 7, Mental Health Unit Casework Manual', March 1998 at Checklist in Annex A; 'Guidance to RMOs (leave)', 2001 (provided by the Mental Health Unit); and 'Guidance to RMOs (leave)', 2005 (also provided by the Unit).

even with this renewed focus, it was noteworthy that the processes themselves remained unchanged.

These data confirmed that public protection was the single most important factor taken into account in determining leave applications by Unit staff. Yet, from observing those staff, it was equally clear that how the public protection agenda featured in these decisions was a complicated and variable issue. One staff member stated that there needed to be a justification for a leave arrangement, 'even if the purpose is made up'. She conceded that doctors might be frustrated by this, but insisted that the Home Office could not simply grant patients 'a nice time' (*ibid*). The need for a justification indicated a set of internal criteria for decision-making, based upon the perception of those decisions and the ability to justify them. There is a well-established sociological literature that explores how such processes of justification are integral to the maintenance of social order. For example, Scott and Lyman argued that accounts of decisions or behaviour were 'a crucial element in the social order since they prevent conflicts from arising by verbally bridging the gap between action and expectation' (Scott and Lyman 1968:46). In particular, they noted that 'the rules of bureaucracy, for instance, make available accounts for actions taken towards clients - actions which, from the viewpoint of the client are untowards' (*ibid*:54). In the case above, the justification given took heed of a number of different factors. On the one hand, detention under the *Mental Health Act 1983* was intended to serve the social order through a therapeutic, rather than a punitive, function. Nevertheless, any decision to discharge a patient from that detention needed to fit demonstrably within a model that was both therapeutically appropriate and accountable to the public.

Systemic tensions arising from the different objectives of administrators and professionals are not new, but recent criminological analysis has been interested in these tensions as one of the factors influencing the shifts in contemporary penal policy. For Garland, new management styles and working practices have produced an ongoing tension between 'sections of the practitioner community and political decision-makers' (2001). Decisions about leave for restricted patients provided a case in point. Administrators

were concerned to make sure they could account for their decisions in the face of potential public scrutiny as well as clinical advice, even though the wishes of the public might not coincide with the therapeutic aims of treating teams. This tension reflected a disjuncture between clinical responsibilities to patients and the objective of maintaining public confidence in the system. The Mental Health Unit occupied the space in the middle, balancing the competing demands that were made of it from all sides.

Beyond the existence of the checklist for leave applications discussed above, Unit staff were keen to explain that they did not use a single, specified risk assessment tool. While clinicians and care teams might have relied upon such tools in their own assessment of patients' risks, the process of assessing applications at the Home Office was not standardised via a prescribed formula or tool. Yet there were factors identified in other forms which were regarded as essential to risk assessment. For example, in one patient file there was a document marked 'To Be Kept on Top of Current Sub[mission]'. The document contained a half page of text, commencing with the patient's name and medical record number, and then a heading of 'Key risk factors'. Under this heading were three brief bullet points. The first noted the date and detail of the patient's conviction, and that there were no prior convictions. The second specified the patient's diagnosis. The third noted a history of admissions to hospital under psychiatric care prior to the index offence, and also a history of aggressive behaviour. The next section of the document listed four 'early relapse indicators'. These related to loss of insight into the patient's illness, non-compliance, delusional beliefs and religious mania. At the end of the document, in bold, was the following caution: 'Risk can be considerable if [patient] starts to relapse. Refer to Grade 7 [manager] immediately'.

This document was essentially an efficient summary of the facts of the case. In the Home Office's own words, it was not looking to undertake its own risk assessment. Rather, it was assessing the quality of care team's risk assessments against what was known about a patient's history. As a former Unit staff member writing about risk assessment has put it,

naturally it is not possible literally to 'predict' whether someone is going to do harm in a given situation ... In assessing the proposals made to us by hospitals for the transfer or discharge of restricted patients, we look for evidence both of accurate assessment and of effective risk management (Potts 1995:37).

In the example of the documented risk factors discussed above, all reports received about the patient were checked against this summary document.

The emphasis on particular information as important implied a clear theory of risk and risk factors. To a large extent that theory was based on the commonly-held wisdom that past behaviour was predictive of future risk. Such wisdoms were important because they provided tangible, identifiable factors that could be relied upon during assessment, such as repeated patterns of behaviour. Dell and Grounds found a similar process in the routine refusal of applications for discharge by patients who required medication, even though clinicians felt that two-thirds of their patients would comply with medication without a restricted order (1995). The rejections of discharge applications were based upon the association of medication with a tangible *fact* about a person, even though that fact did not in itself demonstrate a higher likelihood of risk than was present in other patients. Equally, the reliance on the nature of the index offence as predictive of risk provided a fact against which current behaviour could be measured, even if the index offence had occurred many years earlier. Rose has cautioned that, 'once it seems that today's decisions can be informed by calculations about tomorrow, we can demand that calculations about tomorrow should and must inform all decisions made today' (Rose 2002b:214). It was as though the presence of a fact, such as a patient continuing to take medication, was itself determinative of the process to follow.

This might seem unnecessarily *ad hoc* or uncoordinated. However it could also have reflected the fact that precise methods of risk assessment remain hotly contested in clinical practice and in research. There is considerable debate around types of risk assessment and the sorts of variables they involve, for example whether to use static variables (which remain fairly constant) or dynamic variables (which are likely to change over time). Even leading experts in the field of risk assessment have acknowledged that there

are very few effective tools or clear methods to guide risk assessment in practice, and such tools should be used alongside other methods of practice (Monahan 2004).

While many risk assessment tools have emerged out of empirical research, the professionalisation of these tools has added controversy to their use. For example, many psychiatrists and psychologists developing them have increasingly pinned their own expertise on the use of particular tools from which they benefit financially (see for example Hare 1991; Ogloff 2002; Rice *et al* 2002). Within this tricky clinical terrain, the choice by the Home Office not to adopt any particular measure of risk assessment reflected the fact that its priority was not on the nature of the risk assessment conducted but on its quality in terms of the public.

### ***Recall***

My analysis so far has sought to distinguish between the monitoring and decision-making roles of the Mental Health Unit. Like many other areas in my thesis, these categories were not distinct in practice. More often they were an interactive process, where monitoring led to actions taken and vice versa. The clearest example of this was in the process of recall. This was one of the most controversial aspects of the Home Secretary's powers, and its scope, effect and implications warrant detailed analysis.

#### ***Conditions for Recall***

The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged ... by warrant recall the patient to such hospital as may be specified in the warrant (*Mental Health Act 1983:section 42*).

Recall was the process by which a restricted patient, discharged on conditions to the community, was compulsorily returned to hospital. For patients on leave of absence but still formally detained in hospital, both the Home Secretary and the responsible medical officer had the power to recall them to hospital, and either one could recall a patient without the involvement of the other [*Mental Health Act 1983:section 41(3)(c)(iii)*]. The more common

use of recall related to patients who had been conditionally discharged and were residing in the community. Here the power to recall to hospital was vested solely in the Home Secretary. Recall was a particularly sensitive provision because it was the only aspect of the Home Secretary's authority over restricted patients that resulted in the deprivation of a person's liberty. For most restricted patients, the fact of their detention had been determined by an order of the crown court. However when recalling restricted patients from conditional discharge in the community, the deprivation of a person's liberty took place under the Home Secretary's authority alone.

As with all other powers of the executive, the discretion to recall patients hinged on the protection of the public. To that end, the statutory provisions for recall did not place any constraint on how the executive could exercise them. However certain conditions had been established through case law emerging since the 1970s. The so-called Winterwerp criteria, arrived at following a case before the European Court of Human Rights, required that the nature and degree of mental disorder had to meet the criteria for detention under mental health law in order to avoid arbitrary detention (*Winterwerp v The Netherlands* 1979). This criteria applied to recall and to all other forms of detention under the 1983 Act. A number of other conditions operated alongside the Winterwerp criteria. For instance, decisions to recall a patient had to be reviewed and confirmed by the Home Secretary within five days of the patient being returned to hospital; and following that, the matter had to be referred to the Tribunal to confirm the appropriateness of the detention under the 1983 Act. Although a patient could be recalled on the grounds of protection of the public, the patient's current mental state had to meet the criteria for detention under mental health law. Importantly, it was not necessary for a patient's mental state to have deteriorated since their discharge in order to justify recall (*K v UK* 1998). Additionally, the requirement for up to date medical evidence confirming the nature and degree of a patient's mental disorder did not mean that the patient's treating team had to support the decision for recall (*B v MHRT and SSHD* 2002). Case law had also established that when a conditionally released patient was voluntarily readmitted to hospital, the Home Secretary could choose to recall

them, thereby changing their status of treatment from voluntary to compulsory under the 1983 Act (*Dlodlo v MHRT* 1996).

A number of these cases had confirmed existing Unit policy. Nevertheless the exercise of recall provisions had attracted some criticism in the literature. For example, Dell and Grounds had expressed concern that some of the principles on which recall operated conflicted with key tenets of mental health law, such as that of care and treatment in the least restrictive circumstances. They found that 'people were recalled against psychiatric advice, in order to prevent the possibility of their committing further offences' (Dell and Grounds 1995:xiii). Whilst this amounted to preventive detention, practitioners and patients had to accept the executive's authority. Subsequently, the finding in the case of *B* provided an important judicial affirmation of the Unit's policy in this regard (*B v MHRT and SSHD* 2002).

Not all practices at the Mental Health Unit had been supported by case law. For example, the Unit had not always obtained up to date medical evidence of current mental disorder prior to initiating a recall. That position changed with the case of *K v UK* (1998), which found that 'in the absence of an emergency, a patient's leave of absence should not be revoked without up to date medical evidence to demonstrate that he or she remains mentally disordered' (Jones 2004:1-179). From then on, up to date medical evidence was required in order to confirm that a patient met the criteria for detention under the 1983 Act, in order to justify a recall.<sup>22</sup>

The case of *K* was also important because it provided legitimacy for the detention of patients *via* recall on the grounds of dangerousness without requiring any causal relationship between the dangerousness and mental

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22 After I completed my fieldwork a case in the Court of Appeal (England and Wales) provided further clarification on the requirement of medical evidence. In *The Queen on the application of MM v the Secretary of State for the Home Department*, a restricted patient challenged the legality of two decisions by the Home Secretary to recall him in 2006 (MM v SSHD 2007). On the basis of slightly different accounts of the communication between the Home Office and the treating psychiatrist prior to the order for recall, the challenge turned on the question of whether the criteria for current medical evidence set out in Winterwerp had been met. The appeal against the decisions was lost with the court favouring a less stringent test of current medical evidence than that being claimed by the appellant. The finding supported the argument made by a psychiatrist I interviewed, that the framework of European human rights law provided little protection for restricted patients.

disorder. As long as there was evidence of current mental disorder of a nature or degree to meet the criteria for compulsory treatment, a person could be detained under the *Mental Health Act 1983* on the grounds of public safety.

A number of Home Office officials I spoke with said that there had been a growing emphasis on public protection through the exercise of recall provisions. They referred to the increased frequency of recalls to demonstrate this point. The following table provides a snapshot of recall actions by the Unit, based on Home Office data provided to me during my research.

**Table 4: Patient recalls over a three-year period**

| Patient status                | 2001-02 | 2002-03 | 2003-04 |
|-------------------------------|---------|---------|---------|
| Detained                      | 3107    | 3132    | 3212    |
| Conditionally Discharged (CD) | 1152    | 1156    | 1169    |
| Recalls                       | 54      | 86      | 130     |
| Recalls as a % of CD patients | 4.68    | 7.44    | 11.12   |

Whilst three years was a relatively small timeframe from which to establish any broad trend, it was certainly true that the rate of recall had increased annually in the short term from 2001 to the start of my research.

Unit staff believed that increased recalls reflected a harsher stance being taken by the Home Office in relation to behaviour in the community. One official told me that the Mental Health Unit had become more willing to challenge care teams who were themselves unwilling to recall conditionally discharged patients. He gave the example of a recent case he had dealt with, where a conditionally discharged patient had become unsettled after consuming alcohol. Previously, the Unit would have checked the most recent medical reports about the patient and would not have taken any action if there was no evidence of current mental disorder. Now, however, the official had gone back through the patient's file to examine the index offence. He saw that it had occurred under similar circumstances. The official wrote to the patient's care team reminding them of the circumstances of the index offence and advising them to monitor the patient more closely in the community. His

action stopped short of recall but constituted an intervention in the care team's approach. That response was determined by the increased emphasis on public protection and the sentiment expressed frequently by Home Office officials that patients in the community presented the greatest risks to public safety. The official described his role as 'acting as a trigger' for the care team, who might not pay as much attention to matters of public risk as the Home Office did.

The recall process demonstrated the hierarchy of authority and accountability of executive decision-makers in the restricted patient system. From observation of recalls that took place during my fieldwork, it was clear that these decisions required close liaison between the care team working with the patient in the community and the hospital to which the patient was to be recalled. However it was equally clear that the actual decision to recall someone was made entirely by the Unit, regardless of whether that decision accorded with the wishes of clinicians or the submissions of legal advocates. This was an indication of the authority of the Home Secretary and the extent to which public protection was the dominant measure of accountability for the executive. It was also an indication that processes like recall were based upon an implied theory of risk. In the next section I shall consider this further.

#### *The utility of recall in protecting the public*

In their study of the supervision of restricted patients, Dell and Grounds found that the Home Office relied upon the threat of recall to obtain compliance from patients coercively, and that clinical practitioners were extremely concerned that the way the Home Office exercised its recall powers 'was to impose restraints on [patients'] liberties and obstacles to their discharge which were unjustifiable' (Dell and Grounds 1995:xii). Their finding resonated with risk theorists who have argued that risk is immeasurable and that, by extension, it is difficult to know what is or is not justified (see for example Giddens 1991). Recalling a patient did not mean that he or she presented a clear danger to themselves or to others. Indeed, Dell and Grounds found that the high proportion of cases where recall was not justified on the basis of dangerousness meant that 'recall cannot ...be equated with failure on

conditional discharge' (Dell and Grounds 1995:xii). The use of recall indicated an assessment of unreasonable risk to the protection of the public.

For example, one official reported that he would recall a patient 'where there was evidence of risk to the public. Not because of a need for treatment in hospital'. Another Unit staff member pointed out that a patient could be recalled if the patient stopped attending supervision sessions, because he or she could no longer be monitored. These decisions to recall did not necessarily require the patient's mental state to have deteriorated since discharge. They were based on a concern about what risk the public *might* be exposed to in the event of a *potential* deterioration. In that regard, the recall provisions were a good example of how preventive detention operated through the restricted patient system based on the implied theory that past behaviour determined future risk.

However risk could also be associated with more common problems of case management. One official told me of a patient with 'challenging behaviour' attributed to a combination of mental impairment and autistic character traits. According to the official, the patient also had a very difficult mother who was a 'destructive influence' on her son's progress and rehabilitation. This meant that the patient could not be conditionally discharged to his family home and that he needed to be escorted at all times while on conditional discharge. The patient had lived in supported accommodation for a short time, but the arrangement had not lasted. In the absence of existing services to provide adequate support, and no appropriate alternatives, the patient was recalled. He was not exhibiting an increased risk since his conditional discharge, nor had his mental state deteriorated. But the political imperative of public protection determined that, if the patient remained in the community unsupervised, he might pose an unacceptable level of risk.

Above all, the utility of recall lay in the ability to detain people who posed a risk of harm to others. Yet its effectiveness was also based on the deterrent effect of the threat of loss of liberty. Breaching conditions of discharge did not necessarily constitute grounds for a recall. For example, one official explained that a patient who ceased to take their medication would not

necessarily be recalled; it depended on the patient's mental state as a result. In practice, a breach of conditions often led to increased monitoring of the patient, rather than recall in the first instance. During my observations, an official was closely monitoring a conditionally discharged patient who had returned a positive drug screen for marijuana some weeks earlier. Drug screening was part of the ongoing monitoring of patients in the community, and was sometimes relied upon as a form of current medical evidence in considering a patient recall. In this case drug use was known to trigger a deterioration of the patient's mental condition. The patient was believed to be becoming paranoid and his girlfriend had expressed fear to the community care team. The official decided to recall the patient because of the risk of his mental deterioration due to his use of drugs.

Repeatedly in the examples of recall I came across, the political mandate for public protection dominated the executive's decision frame over the opinions of medical or legal practitioners. In the criminal justice system, a person charged with using marijuana would be most unlikely to receive an indefinite sentence. Similarly, a patient receiving psychiatric care who returned a positive result after a drug screen could not be detained compulsorily under the *Mental Health Act 1983*. But as I discussed in Chapter One, restricted patients were particularly vulnerable to sanctions for actions like drug-taking which could just as easily be considered part of everyday life (Padfield *et al* 2003). The potential risk of harm to others produced by such behaviour enabled the executive to literally contain those risks through preventive detention.

The discretion to enforce preventive detention on the grounds of public protection contrasted starkly with the powers that were available to alternative legal decision-makers such as courts and tribunals. A significant literature on penal modernism has examined the increasing curtailment of judicial discretion through guideline and minimum sentencing policies and the imposition of statutory tariffs (see for example Simon and Feeley 1995; Fennell and Yeates 2002; Hawkins 2003; Thomas 2003; Richardson and Freiberg 2004; Rose 2004). For the Home Office as decision-maker, its function was to protect the public and it had unfettered discretion in that

regard. Yet the public were simultaneously the objects of executive discretion and the mechanism for its accountability. There was little scope for the appeal or review of decisions by the Secretary of State. The accountability of the system came in the extent to which ministers were answerable to Parliament and subject to public criticism and electoral favour. As such, the effectiveness of executive discretion was measured by the *absence* of incidents in which the public was put at risk. Coming full circle, the democratic accountability of ministers provided a further impetus for preventive detention in the containment of risks to the public.

The issue of democratic accountability raised the spectre of appearance as a constitutive element of public confidence in the restricted patient system. In the final section of this chapter, I consider to what extent public confidence was based upon the apparent effectiveness of executive discretion, in the symbolic value of the executive's mandate for public protection.

### **The Symbolic Politics of Public Protection**

Criminology has long been interested in attempts to reduce *fear* of crime through criminal justice policy, as a distinct objective from reducing crime itself. Recently, Simon has remarked how policies that increase police presence on the street seek to reduce fear based on the assumption that visibility of police will reassure the general public of their safety as much as it will effectively counter street crime (Simon 2007). The Home Secretary has also acknowledged that reducing people's fears of crime was equal to addressing offending behaviour in the objectives of criminal justice policy ('Today' program 2007).

One way to understand the underlying rationales of these policies is through the notion of symbolic politics. Writing about the symbolic uses of politics in the 1960s, Edelman pointed to a shift in American political acts at the time, away from a critical probing of the limits of the state's authority, towards 'a predilection for staying so comfortably inside the limits that the main impression conveyed is one of craftsmanship in conforming to the prevailing political climate' (1964:105). The potential of politicians to challenge people and to develop ideas as leaders was increasingly being marginalised by

attempts to be seen to be doing things that would maintain political popularity amongst the electorate. As Edelman propounded,

not only does systematic research suggest that the most cherished forms of popular participation in government are largely symbolic, but also that many of the public programs universally taught and believed to benefit a mass public in fact benefit relatively small groups (Edelman 1964:4).

The symbolism of the act was itself an assurance of political popularity, whether or not it resulted in direct or effective action.

Mead's account of social behaviour, discussed in Chapter One, has also provided some foundation to the idea that assurance or predictability are important aspects of political action. Mead wrote,

the general pattern of social or group behaviour which is reflected in the respective organized attitudes - the respective integrated structures of the selves - of the individuals involved, always has a wider reference, for those individuals, than that of its direct relation to them, namely a reference beyond itself to a wider social environment or context of social relationships which includes it, and of which it is only a more or less limited part (1934:272).

At the time, Mead was interested in globalisation as a process whereby understanding individual actions as part of society would enable social understanding at a broader, even international level. But his development of the idea of individual identity as contingent upon group or social dynamics was a significant precursor to later analyses of the importance of symbolic politics. Both his and Edelman's theses contributed to a developing body of sociological inquiry into the interaction between individual, social and political behaviour.

Building on these approaches, later work examined how knowledge compared with individual associations of morality and values in the opinions people formed about their social environment. Gardiner's empirical research found that, 'whenever symbols of law enforcement and official morality were brought into survey questions, most respondents opted for public norms of morality' (Gardiner 1970:55). His study suggested only a tangential relationship between policy and operational objectives, for example between

government anti-corruption strategies and attempts by police to reduce corruption.

Writing far more recently, Newburn and Jones have argued that symbolic politics 'downplays the complexities and long-term character of effective crime control in favour of immediate gratifications of a more expressive alternative' (2005:73). As crime policy has become more politicised and populist, so such 'acting out' has become a more central feature; the coupling between symbolic politics and operational outcomes in criminal justice has become ever looser (Newburn and Jones 2005:73).

As I set out in Chapter One, by the time of my research Mead's notion of a 'social environment' was increasingly viewed through a lens of risk. Through that lens, actions and consequences were understood in terms of the chance of their occurring and the variable consequences depending on whether that chance or risk could be prevented and how it might be responded to. In the context of these social perceptions of risk, individuals expected their governments to provide a social environment in which they were protected as much as possible. Being seen to respond to those expectations had become as much a challenge for political viability as effectively responding to them.

Perhaps the best example of the centrality of managing public fear within the mandate of the executive in the restricted patient system arose in the operation of conditions of leave and discharge. The main purpose of conditions was to provide compulsory supervision of patients in the community. While this purpose operated primarily in relation to discharged patients, it was also a function of conditions on leave. Yet the extent to which conditions operated as a mechanism of control was questionable. A number of Mental Health Unit staff members told of cases where concerns expressed by victims had resulted in an exclusion zone being included in a patient's conditions of discharge. Exclusion zones were supposed to prevent patients from attending particular areas such as a town or suburb where their victims lived. Restricting a patient's travel gave the impression that victims were being protected from coming in to contact with their offender. However exclusion zones were not enforceable. They provided no guarantee of

avoiding such a confrontation, nor would a breach of an exclusion zone necessarily have negative consequences for a patient. One official commented that recall conditions were pretty meaningless, as evidenced by the ease with which patients could breach them. In that official's view, exclusion zones provided a measure of deterrence for patients, and were an important source of reassurance that the Home Office could offer victims. But they provided no guarantee that victims and offenders would not come across each other in the community.

Another staff member told of a patient whose leave provisions prohibited the patient from visiting his home town where he had committed the index offence. There was significant ill-feeling from the local community towards the patient and the victims still lived there. The exclusion zone was intended as much to protect the patient from the ire of the public as to prevent the victims and the patient from confronting each other. However the patient's parents were ill and infirm and still lived in the town. As a result, the patient kept breaching the exclusion zone to visit them. When it became clear that the patient was not going to comply with the exclusion zone, the Unit removed it as a condition of his discharge. Instead, a new provision was introduced which forbade the patient from contacting the victims. The example illustrated the symbolic importance of conditions both as a deterrent to certain activity by patients and as a mechanism for reassuring people like victims that their concerns were being taken in to account in the decision-making process. However it also demonstrated the latitude with which breaches of conditions could be viewed. While the threat of recall was always present, it was clearly not invoked as an automatic response when conditions were breached. The primary utility of conditions remained the ability to supervise patients in the community.

In these examples, conditions of discharge were explained in terms of public protection. Yet the protection they offered was as much through the appearance or assurance of public safety as it was a substantive measure to prevent harm. The effect of the executive's mandate was not just on individual patients but was also on the perceptions of families of patients, victims, and the broader communities with which patients were engaging.

Media attention was also a factor in decision-making. Any such attention to a case was likely to have an impact upon the entire system and consequently the level of confidence with which the public viewed it. In that sense, controlling risk in the restricted patient system was both a matter of individual patient management and of controlling damage to the public's confidence in the system as a whole. As Garland notes,

*for political actors, acting in the context of electoral competition, policy choices are heavily determined by the need to find popular and effective measures that will not be viewed as signs of weakness or an abandonment of the state's responsibility to the public* (2001:111, emphasis in quotation).

Symbolic politics were an important component of the executive's mandate for public protection. In reality, Home Office staff were aware that some of the conditions they put in place for public protection had no binding power. Yet symbolically, they were an extremely important expression of 'terminology and rhetoric' (Newburn and Jones 2005:74). Similarly, the exercise of recall provisions emerged as both a mechanism for preventive detention and a powerfully symbolic tool of deterrence.

Mead argued that the principles of deterrence through the standards of retribution and prevention underpinned public perceptions of criminal justice (Mead 1918). While there had undoubtedly been a shift in the balance of these standards over time, their symbolic importance remained as an example of what Edelman described as 'emotional commitment' to a symbol that was 'associated with contentment and quiescence regarding problems that would otherwise arouse concern' (Edelman 1964:32).

The executive's authority was operating within a law that enabled preventive detention on the basis of public protection. As the examples and statistics presented in this chapter indicated, a reasonable number of patients were recalled, and this figure had been increasing over time. So the power to recall was no empty threat: it constituted a mechanism for control through containment and the Home Office's willingness to use this mechanism was well-established. Yet at the same time the executive was not immune to the role of instincts in constructing social interaction. The threat of recall had a

strongly deterrent effect which was relied upon as much as the use of detention itself. Recall was both a coercive legislative provision and an important symbol of the powers that lay in the hands of executive discretion for the protection of the public.

Edelman suggested that symbolic politics were useful and effective ways to meet both individual and collective expectations of social behaviour.

On the whole ... the diverse symbolic responses to political acts and events fall into place to build a remarkably viable and functional political system. It is a system that provides for both change and stability. It involves mass audiences emotionally in politics while rendering them acquiescent to policy shifts through that very involvement (Edelman 1964:15).

For the decision-makers in the Mental Health Unit, familiarity with patients' index offences and therapeutic progress, and with other people involved such as family members or victims, gave officials confidence that they could anticipate the concerns from - as well as the risks to - the public, and that they could reassure them appropriately. The ability to detect and prevent risks of harm to the public was supplemented by the ability to reassure members of the public accordingly. While the actual risks posed by patients could be managed by provisions like recall, the fears of the public could also be managed through the symbolic politics of protection. Controlling fear of crime through the symbolic power of social interaction operated alongside the very real powers to contain and control people through preventive detention.

## CHAPTER 4

### RELATIONSHIPS IN THE RESTRICTED PATIENT SYSTEM

#### Introduction

The previous chapter analysed the role and work of the Home Office regarding restricted patients, specifically the dual functions of monitoring or supervising patient progress and making decisions in response to issues that arose from supervision or applications. In many ways this work was part of the formal mandate of the executive's function in the system. In the present chapter I shall explore further what I have described as the informal mandate of the Home Office: the responsibility it took for other people working in the system, including practitioners, clinicians and the Tribunal. I will examine how this work differed from the supervision of patients and how other actors in the system responded to these aspects of the executive's informal mandate.

As I set out in Chapter Two, I refer to the various participants in my research as 'actors'. This is not intended to dehumanise the people who participated in my research nor to suggest that participants were playing a role in the system in any pejorative sense of the term. Certainly, people who represent institutions often adhere to a policy or practice that they might not necessarily subscribe to personally, because of their responsibility to that organisation. But these professional responsibilities are common and are not in themselves a subject of inquiry for my thesis. Rather, I use the term actors as a collective noun to encompass both the range and nature of the participants in my research. Some of the people I observed and interviewed were engaged in the restricted patient system in their own right, for example as advocates or practitioners. However others were involved as representatives of their organisations or departments; and both the Home Office and the Mental Health Review Tribunal had a strong presence as institutions in my research, not just by virtue of the staff that represented them. The term 'actors' is simply an attempt to capture the breadth and range of the participants in my research, from individuals to institutions.

There is an established body of literature criticising executive discretion in mental health law. Executive decision-making has been perceived as overly cautious (Mohan *et al* 1998); as arbitrary (Prins 1993); and as unwilling to recognise the rights of patients until forced to do so by the *European Convention on Human Rights* and subsequently the *Human Rights Act 1998* (Richardson 2005). The limited ability of the criminal justice system to provide effective intervention to offenders with mental disorder and the preoccupation with risk that underpins contemporary sentencing policy has also been held responsible for creating the potential to leave mentally disordered offenders 'being dealt with more harshly' (Peay 2002:747). Within this critique of structural disadvantage, there is a propensity for double jeopardy by containing risk through the use of preventive detention rather than managing the people who pose those risks in the community (Hawkins 1986; Peay 1993). Finally, the failure to grant decision-making power to the Mental Health Review Tribunal in the transfer and movement of patients through the system at points other than discharge has been criticised for undermining the right to liberty (Richardson 1999).

Notably, the small body of literature in support of executive discretion over restricted patients comes primarily from government sources. One of the main expressions for this support was in the form of the government's agenda for reform of the *Mental Health Act 1983* (see Chapter Six). Another example is a study into restriction orders which was conducted under the auspices of the Home Office Research and Statistics Directorate. While that study pointed to some problems in communication between various actors in the system including the Home Office Mental Health Unit, the Mental Health Review Tribunal and clinicians, its overall finding was that the imposition and supervision of restricted hospital orders was effective in protecting the public from risk (Street 1998). There is little other literature in support of executive discretion *per se*, although some writers have been supportive of the executive's mandate for public protection (see for example Maden 2007).

The nature of scholarly debates about executive discretion provided an interesting insight into the links between advocacy and scholarship within the

academic discipline of mental health law. It was an area rich in empirical research and analysis, as my literature review in Chapter One revealed. There was also a high degree of engagement by academics at the level of public policy and debate about law reform. Indeed, the distinction between scholarship and advocacy was not always as clear as those terms might suggest and a number of the authors of well-respected academic work in the field were also keen advocates for particular policies or approaches (see for example Thornicroft 2006; Richardson 2007; Peay 2007b).

The critiques of executive discretion informed one of the underlying questions of my research, namely how harshness in contemporary penal policy influenced executive decisions about offenders whose substantive legal status was 'patients'. There was a gap in the literature on this point and also on the views of practitioners about the systemic challenges to treating forensic patients. The present chapter seeks to fill this gap by exploring the relationship between the Home Office and other actors in the system, specifically the Tribunal, clinicians and lawyers. I begin by discussing the attitude of Home Office staff to the Tribunal. I then explore the opinions of other people about the function and value of the Home Office in the restricted patient system. What emerges is a complex picture of different opinions and critical insights (although not necessarily criticisms) across a wide range of people engaged in the system.

Part of the layering of relationships between various people in the system was structured around the formalised interaction of agencies on questions of risk. This took place under the policy of Multi Agency Public Protection Agreements (or MAPPA): an inter-governmental strategy designed to offer greater protection to the public. MAPPA provided an ideal site through which to consider the tensions between patient therapy and public protection at a systemic level. MAPPA also provided a context in which to consider how the public was constructed by policy-makers and practitioners engaged in the management of restricted patients.

## **Rights vs Control? The Relationship between the Home Office and the Tribunal**

The relationship between the Mental Health Unit and the Mental Health Review Tribunal in the restricted patient system was important in a number of ways. At a theoretical level, it demonstrated the central sociological problem explored in my research of the tension between rights and control in the management of mentally disordered offenders. That tension will be discussed in greater detail in Chapter Seven. In the present chapter, I examine the practical differences in decision-making between the two bodies and how these differences emerged as an important element of the decision frame of the Mental Health Unit. Specifically, the perception of the Tribunal as being less cautious regarding public protection and consequently as discharging patients whom the Unit claimed were too risky, meant that Unit staff kept a close eye on the decisions of the Tribunal in restricted cases. Monitoring the Tribunal was not formally set out in statute or departmental policy. Yet from my observations and interviews with staff it clearly formed an important aspect of the Unit's work. Whilst related to the official mandate of the Home Office to provide public protection, this formed an unofficial dimension of the Unit's work.

At the outset, I considered there would be a degree of similarity in the decision-making environments of the Mental Health Unit and the Tribunal. The propensity for their decisions to receive public attention was high and both could be expected to be concerned about the public perception of their work (Hawkins 2003; Padfield *et al* 2003). However from my fieldwork there was no sense of mutual sympathy at the extent to which the two organisations were exposed to public scrutiny. On the contrary, there was a degree of disregard in the attitudes of each towards the other. At best, this could be described as 'institutional inertia'; a general malaise towards the efficiency and appropriateness of the actions of the one as perceived by the other (Padfield 2002:137, see also Street 1998). Home Office staff spoke of how the Tribunal administration was chaotic and expressed frustration at the fact that the Tribunal frequently lost Home Secretary statements, or asked for comments on a report only days before the hearing.

However other people in the system attributed that same problem to the Home Office. One lawyer who represented restricted patients told me that the Home Office tended to send reports late or refused to comment on care team reports which led to cancelled or adjourned hearings. Tribunal staff and practitioners cited the unavailability of Home Secretary reports at the time of Tribunal hearings as a major cause of adjournments and other delays. These participants interpreted the Home Office's actions in such situations as obstructionist. There was no acknowledgement or sympathy for the idea that the Home Office might have had insufficient time to pay due regard to the case in question. Not surprisingly, these tensions led to some bad feeling between the Tribunal Secretariat and the Mental Health Unit and cynicism about the efficiency of the system on the part of practitioners.

The Home Office was tightly bound by its formal mandate of public protection. This mandate informed the basic criteria for executive decision-making about restricted patients. By contrast, the Tribunal's decision-making hinged on safeguarding patient rights according to the criteria for detention under the *Mental Health Act 1983*. While this division of labour was forged by legislation, it meant that there was a difference in the criteria upon which the two organisations made decisions about discharge (Peay 1989). The perception at the Home Office was that this difference was particularly marked. Not only did the Home Office recognise its own mandate specifically in terms of public protection; it also regarded the Tribunal's mandate as defined solely in terms of patient rights. These perceptions contributed substantially to the reduced legitimacy which Home Office officials accorded decisions made by the Tribunal.

For example, some Unit staff expressed distrust of Tribunal decisions. They claimed that the Tribunal released patients even when the risk they posed to the public was too great. As evidence of this, several people told me that when something went wrong in the community it was usually the Tribunal that had conditionally discharged the patient against the wishes of the Home Office or care team. In many ways this perception reflected the way in which the division of labour played itself out ideologically and culturally in the

workings of the bureaucracy. It created a logic of accountability for decisions, but it also created a mechanism for attributing blame for perceived mistakes in decision-making.

An illustration of this logic of accountability was in the descriptions by Home Office staff of the 'problem' of patients discharged by the Tribunal who subsequently suffered mental deterioration; or who exhibited dangerous behaviour in the community prompting recall or other intervention by the Unit. The construction of these episodes as problematic was telling in itself. Staff instinctively viewed any patient behaviour that warranted intervention by the Unit as problematic, and this construction then reflected poorly on the decision-maker, which was often the Tribunal. Yet, as Dell and Grounds' study of Home Office supervision of restricted patients showed, recall was not itself evidence of a failed discharge and 40% of cases did not cite dangerousness as the reason for recall (1995). Moreover, there was a statistical likelihood that the decision-maker in these cases would be the Tribunal as it was responsible for 90% of all discharges of restricted patients.

None of the Unit staff I spoke to considered fluctuations in mental disorder or difficulty adjusting to life once released as normal or predictable experiences for patients in the community. The perception of these issues as problematic was based on the assumption that 'the perceived costs of a wrong decision to release are less than the perceived costs of a wrong decision to deny parole' (Thomas 1986:1275). There was an immediate assumption that patient incidents in the community resulted from bad decisions to discharge the patient. This implied the Tribunal took unnecessary risks, making 'bad' decisions to grant conditional discharge, whilst the Unit's more cautious decisions were generally 'good'. At one level this could be seen as a normal aspect of how officials in their formal role approached an area of work. They might well take a different view if they occupied a different position in the system, but they spoke from the position of Home Office decision-makers and so were firmly entrenched within the logic of that mandate and responsibility. At another level, however, the opposition between the Home Office and the Tribunal was striking. In the following section I consider how

structural factors led to such an oppositional relationship between these alternate decision-making bodies.

### ***First Bite of the Cherry***

The system itself ensured that the decision-making of the Home Office and the Mental Health Review Tribunal operated under different mandates. But did this necessarily situate the two as opposing, competitive forces? Did the structural relationship between the two agencies make it inevitable that the Home Office would perceive Tribunal decisions as 'bad'? Was this reflective of the underlying responsibility of the bureaucracy to maintain public confidence in the system, resulting in mistrust of any decision not made within the bureaucracy? Or was it simply that any decision by the Tribunal was going to be suspect in the eyes of the Home Office, because of its own continuous discretion to release patients as and when it thought appropriate?

This last, structural reason emerged as a plausible account for the mistrust by the Home Office of Tribunal decisions. The Home Office automatically had first bite of the cherry, so to speak, because it could discharge restricted patients at any time. As Dell and Grounds found, consultants were 'likely to be highly selective in choosing cases to recommend to the Home Secretary, and from these the Home Office can pick the best cases for release' (Dell and Grounds 1995:xiv). Thus the Mental Health Unit's cases were selectively the safe cases (Holloway and Grounds 2003). Yet there was no recognition amongst Home Office staff that the system itself determined that the Tribunal would be considering the discharge of riskier patients. In other words, if the Home Secretary had not already released those patients himself, they were likely to pose greater risks than the executive was comfortable with. There was also no acknowledgment by the Home Office that Tribunal decision-making revolved around the criteria for compulsory detention under the *Mental Health Act 1983*, which differed in emphasis from the Home Secretary's mandate of public protection. (This is not to suggest that the Tribunal ignored the public protection agenda – an issue I shall address shortly.)

As such, the conflict between decision-makers was a structural inevitability: it stemmed from the primary conceptualisation of restricted patients in terms of risk. Because a restriction order was in place solely for the purpose of public protection, any patient-related incident in the community automatically raised concern at the Home Office about the public's exposure to risk. Consequently, patients were understood primarily in terms of dangerousness or deviance (Scheff 1999). The logic of responsibility that underpinned the Mental Health Unit's mandate meant that when a patient's behaviour in the community was considered a problem, officials immediately looked to see who had released them. When the decision-maker was the Tribunal, officials ascribed the incident as an example of bad decision-making by the alternative authority in the system.

Predictably, the mistrust with which the Home Office viewed Tribunal decisions resulted in a belief that the Home Office did a better job than the Tribunal. Unit staff consistently expressed the view to me that the Home Office had a better knowledge of individual cases than the Tribunal, because the latter only had a snapshot of patients at the particular time of their hearing. Unit officials claimed that they made better decisions as a result of having ongoing knowledge about patients. Earlier I suggested that ascribing 'bad' decisions to the Tribunal was a mechanism of blame. This ascription of blame was often motivated by a sense of relief that it had not been the Home Office which had authorised the 'mistaken' discharge. Staff never wanted to have missed something that might lead to anybody getting hurt. Additionally, their bureaucratic setting made Unit staff aware of the potential for scandal that could arise from a public incident and they were wary of such eventualities, even as a result of decisions made by others.

So far the discussion has focussed on the relationship between the Mental Health Unit and the Tribunal. As I discussed in Chapter Two, I was unsure at the start of the project to what extent the Tribunal would be a significant actor in my thesis, given my focus on the Home Office, and the ostensible separation of the two organisations. Yet the perceptions of Home Office staff towards the Tribunal, and their impact upon the workload of the Mental

Health Unit, illustrated a number of important points about the official and unofficial mandates of the Home Office.

What emerged was that part of the protection the Home Office offered the public was not just from restricted patients themselves, but from 'bad' decisions by other actors in the system. The Home Office took seriously its legislative responsibility for public protection, and its bureaucratic responsibility for maintaining public confidence in, and protecting the political sensibilities of, the system. This led to a sense of responsibility for other elements of the system, as though the Home Office was a lead agency even though the Tribunal was an independent, statutory body in its own right and medical practitioners were engaged by local health trusts. Protecting the public was not only seen as a matter of controlling 'risky' patients. It also necessitated monitoring other people in the system and undoing their decisions as the executive felt necessary. Monitoring the decisions of others in the system was an unofficial but integral part of the mandate of the Home Office. I turn now to examine how this played out with other actors in the system.

### ***Other Actors***

Many staff at the Mental Health Unit believed that other actors in the system misunderstood the role of the Home Office. Unit staff were keenly aware of mistrust from clinicians towards the executive, particularly regarding its ability to make decisions without clinical training or expertise. For example, one official told me of a case where the routine reports about a patient's progress had not been received. The Unit investigated the matter and discovered that the care team had been 'allowing the patient to dictate his own conditions, and regarded the [Unit's] concerns as exaggerated'. This demonstrated poor confidence on the part of the treating team in the validity of the Home Office's concerns. As Unit staff had anticipated, the patient's mental state eventually deteriorated. The patient's parents became very concerned and when the police were called, the patient was found to have been hoarding weapons in circumstances similar to that of the patient's index offence. The patient was ultimately recalled. According to Unit staff, 'the care team learnt their lesson';

namely the effectiveness in preventing harm of the Home Office's vigilance in monitoring restricted patients in the community.

Another official commented that even the Department of Health did not really understand the role of the Mental Health Unit and the Home Secretary. To counteract a poor understanding of (or confidence in) the Home Office, the Unit held an open day every two months for mental health care teams and anyone working with mentally disordered offenders, including clinicians, social workers and Mental Health Act administrators (who were hospital-based staff with responsibility for ensuring the procedural requirements of the *Mental Health Act 1983* were met). These 'away days' were an attempt to show clinical practitioners how the Unit made its decisions, to improve working relationships between Unit staff and clinicians, and to build confidence in the Unit. For the Home Office, the test of its relationship with stakeholders was the extent to which clinicians sought release via the Home Secretary rather than the Tribunal. Indeed, building this relationship was so important that the work of the Mental Health Unit's management team included visiting the regions for which they were responsible to promote the Home Office as the preferred avenue for release of restricted patients.

At the beginning of this chapter I noted the view that executive decision-making was overly cautious. Mohan *et al* have also suggested that:

the increasing use of [Tribunals] for the discharge of restricted hospital order patients reflects a growing conservatism at the Home Office, such that it has become preferable for possibly controversial decisions to be taken by this independent body without ministerial involvement (1998:63).

This analysis implied that the Home Office preferred the Tribunal to be the discharging authority, particularly in cases considered to be of high risk. However my data did not accord with this view. The Unit encouraged care teams to approach the Home Secretary directly rather than the Tribunal, and was actively trying to increase the rate of applications for discharge that came to the Home Office. This self-promotion was part of a concerted effort to shift the emphasis in the Home Office from being reactive to active. Unit staff spoke to me about a range of other policy changes, including more time

spent chasing up reports not received for regular review of discharged patients, and corresponding with care teams to encourage applications for conditional discharge.

In part, this effort was motivated by the Home Office's perception that clinicians, like the Tribunal, were insufficiently concerned with public protection. That view was evident from the following excerpt in the Unit's Casework Manual:

We should remember that ours is the only input to decision making which is made exclusively from the perspective of public safety. We should never hesitate to press any reservations we have on that score even though the care team is reluctant to address them. They have different priorities: professional pride, pressure to take forward rehabilitation, not to allow precious beds to be clogged up by lack of progress. They have a different perspective too. They have to live with the patient in their hospital; may have come to empathise with them, and will be more readily influenced by the patient's recent good behaviour; may be less keen to provoke their reaction when confronted with things the patient would rather forget or keep under wraps; may be less likely than us to remember the full details of the offending behaviour, and to realise that any recent minor incident looks like behaviour in the run-up to the offence. So we should not hesitate to ask the uncomfortable questions, which it may not be in the immediate interest of the care team, much less that of the patient, to answer (Mental Health Unit Casework Guide, March 1998, 1A.8ii).

This excerpt indicated the extent to which the Home Office constructed its responsibility in the system solely in terms of the public protection agenda. It was a consequence of the executive's official mandate, but there was scope for Home Office staff to interpret the framework as they saw fit. However, there was a particular perception among Home Office staff that the mandate for public protection was an isolated one; and that no other actors in the restricted patient system shared that responsibility. Earlier I talked about the Home Office perceiving itself to be a lead agency in the system. Despite the fact that practitioners were generally health service employees, the Unit conducted ongoing monitoring of care teams and practitioners in much the same way that it monitored patients and Tribunal decisions. Ostensibly this was to ensure that the risks posed by restricted patients were being adequately managed, particularly in the community. But in practice it led to subjective assessments of applications depending on who they came from.

Home Office literature explained that its staff made decisions based on the applications of clinicians and practitioners; it did not substitute their assessments for its own (Potts 1995 and also MHU Casework Guide 1998). At the same time, Unit staff were genuinely concerned that clinicians were not providing public protection. This provided the impetus for closely monitoring the actions of care teams. Only one staff member believed that doctors were also responsible for controlling risk and that they did it very well. Indeed this person claimed that there was a cultural problem at the Unit because of the general perception that the Home Office was the only agency concerned with risk.

Informal opinions developed in the Unit about the clinicians and treating teams they trusted or in whom they had confidence. These opinions had a significant impact upon how Mental Health Unit staff conducted their assessments. For example, Unit staff placed confidence in the information they received based on the source of the evidence, as well as the type. One Unit staff member explained how social workers in the community tended to be more reliable than doctors in terms of risk management, because psychiatrists who worked in the community often had less experience with forensic patients than those who worked in secure hospitals. As a result, officials considered these psychiatrists to be less aware of the risks to the public and to be more patient-focussed, which contrasted with the Home Office's own preoccupation with public protection. Another Unit worker concurred that, when dealing with conditionally discharged patients, social worker's reports were often more reliable because they saw the patient more often in the community, and therefore their monitoring was better. Consequently, when assessing the progress of a patient in the community, some staff placed greater weight on the evidence contained in social worker reports than they did on the reports of psychiatrists whose evidence they claimed to be less relevant to public protection. In this way experience across the Unit had led to a set of wisdoms based upon knowledge of - and familiarity with - staff providing patient care. These were pieces of common knowledge that were generally held to be true by Unit staff and which, although informal, formed part of the Unit's decision frame.

One of the emerging issues here was how Home Office assessments of applications included a judgement about the source of the information as well as the content of the information. In addition to examining the contents of the risk and clinical information provided in an application, decision-makers at the Mental Health Unit took account of who had provided the information; where they were from (regionally and institutionally); and their record in terms of the care and management of other restricted patients. This accorded with Perkins' observation that there were different layers of subjectivity involved in assessing evidence about detained patients (2003). Earlier in the chapter I discussed how detailed knowledge of a patient's case was seen as integral to the ability of Unit staff to make decisions. The faith of officials in this in-depth knowledge extended to a reliance on the relationships they had established with care teams and legal practitioners. For example, one Unit official talked about 'good care teams' in whose work he had confidence, as opposed to 'bad care teams' about whose applications he was far more cautious. Another official had his own criteria for assessing the quality of clinical risk assessments received in support of applications for leave and discharge, including whether the application addressed victim issues. At the same time, he stated that he was generally supportive of care teams. In his view the Home Office should not look at management plans or at the work of hospitals, but should instead concentrate its energies on the supervision of conditionally discharged patients in the community.

These examples pointed to a slippage between official policy and actual practice within the Unit. In theory, the Unit received evidence from care teams about risk, and then made a decision about whether that risk was acceptable. However, in practice, staff made judgements about the source of risk assessments and other clinical evidence, as well as its content. These judgements led to different levels of confidence attached by Unit staff to the applications they received.

These unofficial assessments of care teams were also evidence of broader concerns about systemic problems in the consistency of mental health care for restricted patients. As I shall discuss later, the reform of the *Mental Health Act 1983* brought to light widespread concern about the quality of mental

health care available at the time (see Chapter Six). It was not surprising that these concerns were rarely acknowledged publicly by government officials and politicians. Nevertheless, it became clear during my fieldwork that Home Office staff were concerned about evidence of poor mental health care in some areas. One official stated that, in the ten years prior to 2005, there had been seven homicides by released restricted patients, compared with 63 homicides per year by non-restricted patients receiving compulsory treatment under the *Mental Health Act 1983*. He attributed the homicides by non-restricted patients to errors of communication between people involved in the care and management of civil mental health patients. In the eyes of the Home Office, this meant that the homicides could have been prevented. This had led to another piece of wisdom told to me by staff at the Unit, that 'Part Three patients were Part Two patients the system had failed'. Restricted patients were classified under Part Three of the *Mental Health Act 1983*. Civil patients received compulsory treatment under Part Two of the 1983 Act. The statement indicated that some Mental Health Unit officials felt that restricted patients who were former civil patients had been failed by the system.

A body of evidence supporting this view had been collected through inquiries after homicides by people who had previously been receiving mental health care (see for example Peay 1996; South East Coast Strategic Health Authority *et al* 2006). These inquiries had been mandated for any homicide by a person receiving compulsory mental health treatment, and investigated the care and treatment that patients had received to see whether and how future incidents could be prevented systemically. Avoiding systemic failures in communication between the various agencies who worked with patients was an ever-present aspect of the decision frame that was applied to restricted patients, particularly between care teams in hospital and the community, and across other agencies (see for example South East Coast Strategic Health Authority *et al* 2006). By virtue of its unique position in monitoring restricted patients, the Unit had a bird's eye view of the systemic approach to individual cases and was in a position to take steps when it perceived the care and treatment of patients was deficient. The Home Office's monitoring role both reinforced the importance of the executive's

discretion and the extent to which that discretion led it to monitor other actors in the system, not just patients.

Monitoring was extremely important both to the official and unofficial mandates of the Home Office in the system. Officially, the department's role was to monitor restricted patients to protect the public from harm. Unofficially, the Mental Health Unit also monitored practitioners, the experts charged with patient care and treatment. The Home Office could have justified such monitoring as upholding its responsibility for maintaining public confidence in the whole system. Yet the role was conspicuously unofficial precisely because it was not stated in any of the Home Office's public material, or even in internal policy and procedure manuals of the Mental Health Unit. It was represented by Unit staff I spoke with as a natural part of the Home Secretary's mandate. Yet it was noteworthy for a number of reasons, not least because the people being monitored were professionals within the bureaucratic framework of the health system. As such they did not fall within the traditional reach of the Home Office over either civil servants or other actors in the criminal justice system.

The exercise of this unofficial mandate could be understood within the context of broader shifts to deprofessionalise the criminal justice system. In Garland's view, criminal justice agencies 'are no longer permitted the professional autonomy and discretion with which they were once entrusted'.

Agencies like the police, probation and prisons that were once given statutory powers and responsibilities ... and a degree of freedom to get on with it, are now increasingly subject to state-imposed standards and guidelines, and are closely monitored and inspected to ensure that they comply. The long-term trend towards professional autonomy and the delegation of penal powers has been abruptly reversed, and the state has begun to tighten its grip upon criminal justice agencies and employees (Garland 2001:120).

The assessment of care teams, as well as their evidence, was one indication of this shift. It was a matter of pride for some Mental Health Unit staff that they could assess risk as a 'normal person', without requiring professional expertise. While their assessments were based upon the evidence of professionals, that professional opinion was not enough to determine a

decision if, for example, it was believed that the public would have expected a longer period in detention to ensure public safety.

However, monitoring the system as a whole was also the consequence of another process that had been taking place over decades: the shift towards a new type of 'presentation of self' in criminal justice policy (Newburn 2002). Previously I introduced the idea of symbolic politics as a way of understanding certain characteristics of how the public protection agenda was met by the executive. Assessing risk as a 'normal person' the way one official described was another important aspect of the Home Office's decision frame. Staff were not assessing these risks on the basis of any statistical probabilities of re-offending but in terms of the risks to the Home Office (including to its reputation) if something negative happened.

The symbolic importance of the executive's discretion in the system had been established over decades, at least since the *Mental Health Act 1959*. However during that time there had been two significant shifts. One shift was in relation to the media, whose ever-increasing attention to criminal justice issues could cause irreparable damage to the reputation of the Home Secretary and the system as a whole. (Several Home Secretaries lost their position because of scandals related to the release of offenders throughout the period of my research).

The second shift had been the move away from believing that the problem of crime had a solution, and that the criminal justice system could control it. As Garland has observed, modern penality was stuck with the perception that punishment had lost its purpose, or that its purpose had become contradictory and confused (1990). This peculiarly modern phenomenon contrasted sharply with the clearly established and articulated purposes of punishment of earlier periods of penal policy, as evident by the Durkheimian and Foucauldian accounts of punishment discussed in Chapter One. Simon and Feeley have observed somewhat harshly,

the virtual absence of successful new representations of crime. Current penology provides neither policies that succeed nor words that succeed. It not only does not 'solve' the crime problem, it does not even provide reassurances that something significant is being done (1995:150).

More moderately, Reiner has argued that the notion that crime can be solved has steadily declined over decades to the point where the Home Office no longer has confidence in its ability to control crime (2007). For Reiner, this is one explanation for the ongoing interest in controlling fear of crime.

Consequently, as Newburn argues, there has been an important shift in the focus of Home Office policy towards how it reflects back on the system, rather than its outcomes.

Decisions are taken, policies implemented, not simply because of their potential impact but, of course, because of how they will be perceived and 'received by a particular electoral community'. They are important for what they 'say' both about political parties and about individual politicians. This has always been so. Arguably, however, it is increasingly the case that individual politicians are exploiting the capital that can be made out of 'symbolic action' (Newburn 2002:175).

The exercise of executive discretion in the restricted patient system took place in the context of this declining bureaucratic and political confidence in its ability to control crime. As I have argued, this confluence of pressures led Home Office decision-makers to resort to the rhetorical processes of symbolic politics in an attempt to reassure people's fears of the risk posed by restricted patients. Within this framework, the role of the professional was complex and often contradictory. On the one hand, professional expertise was secondary to more generalist, non-expert processes of assessment. On the other hand, the nature of managing an 'offender' population within a health system required government officials to defer in some way to the professional expertise of clinicians. I suggest that it was the hybrid nature of the restricted patient system - sitting at the intersection of the management of dangerous offenders and the therapeutic aim of rehabilitating people detained for compulsory treatment of their mental disorder - that led to the contradiction of a system which required professional expertise but was not necessarily dependant upon it. For example, clinical reports were always

called for in any 'incident' such as a failure to return from leave or a family member reporting strange behaviour by a patient on discharge. This was an example of the established 'standard operating procedures and legitimated rules and structures' that were necessitated by mental health law's reliance upon psychiatric evidence to provide explanations for the actions of mentally disordered offenders (DiMaggio and Powell 1983). Yet those reports were not assessed on clinical grounds but on the basis of a broader appeal to the public interest. The process was one of assessing risk to the public by the public, wherein the expertise required for the decision resided not with the professional but with the lay persons' representative who was embodied by the staff of the Mental Health Unit.

The discussion so far has focussed on how Home Office decision-makers viewed the experts and alternative decision-makers of the restricted patient system. I have explored how informal mandates to monitor various actors within the system emerged alongside the formal mandate to monitor restricted patients in the interests of public protection. I turn now to consider how these other actors perceived the role of the Home Office.

### ***From the Other Side: Practitioners Views on the Home Office***

From the outset of my research, I found clinical and legal practitioners to be generally accepting of the role of the Home Office in terms of protecting the public. One lawyer in a practice who represented many restricted patients stated that 'the Home Office has a role in relation to protecting the public. I think that we would really accept that'. He described the Home Office's role as one of 'public guardianship'; and his reference to 'we' indicated his perception that most legal practitioners shared this view. Indeed recognition that the Home Office had an important role in protecting the public was widespread amongst non-government representatives I interviewed and observed. However, equally widespread was concern about the balance between public protection and patient rights. The lawyer said,

I think [the Home Office] are entitled to have a view. I mean, is this chap going to go and get unwell and do things to other people? You know, are people waiting at a bus stop safe, and this sort of thing? But OK, they express their views, and the court in effect made another decision.

This lawyer claimed that the Home Office could not strike the right balance, as he saw it, because of its preoccupation with public protection. For him this justified the widely-held view that only a Tribunal or similar independent structure should be the primary decision-maker over restricted patients; a view maintained by practitioners in my research despite evidence that the Tribunal was itself an extremely cautious decision-maker (discussed further in Chapter Seven).

I asked another lawyer involved in law reform in the system about the Home Office making decisions without professional training in the area. His reply confirmed the views of Home Office staff themselves that they added value through their familiarity with cases and the system as a whole:

they do have a considerable amount of expertise in mental health. And having worked with them in the field they do know what they're talking about. But I think while they don't have a good expertise in terms of clinical evidence or judgment, I think nevertheless they have built up a lot of casework knowledge which is very useful to have really.

This lawyer went on to say that even though the Unit might seek to promote transparency, the nature of the system pitted people such as lawyers against the Home Office. This would always produce conflict over particular cases.

My findings were largely consistent with Dell and Grounds, who found that Home Office supervision of patients in the community was generally considered useful by clinical practitioners, particularly in terms of the Home Office's support of their work and the ability to discuss anxieties clinicians had about particular cases with Home Office staff (1995). But in that study, clinicians voiced concerns similar to those the Home Office expressed to me, about how changes in care teams or other continuity issues led practitioners to miss the signs of past behaviour that could be indicative of certain risks. Interestingly, Dell and Grounds also found that staff changes and discontinuity at the Home Office caused considerable consternation amongst care teams (1995). This finding supported the Home Office's perception that it could add value to the system by taking on the role of lead agency; and to the recognition by staff at the Mental Health Unit that issues of continuity of

staff and resourcing were integral to effective care and treatment of restricted patients.

However, underneath this surface layer of acceptance, there was much frustration about how the Home Office exercised the powers of executive discretion. Many practitioners claimed that the Home Office was completely unsympathetic to their own role. This applied to both psychiatrists and lawyers to differing extents. For example, some psychiatrists claimed that there was an increasing expectation on them to shoulder responsibility not just for assessing risk, but also for determining the acceptability of risk in terms of public protection. This, of course, was the essence of the Home Office's own role, and the one area in which government and non-government practitioners were generally in unanimous agreement.

Lawyers were also concerned about the Home Office's attitude towards their role in the system. One lawyer interviewed exclaimed, 'lawyers are seen as the second coming of Satan!' He stated that this was at its worst in the difficulties experienced by some lawyers to get hospitals to refer clients to them. Only enlightened advocates or hospital staff would recommend lawyers who routinely represented patient interests, as opposed to recommending those firms who worked on behalf of the government. While this may sound conspiratorial, it was indicative of the inherent conflict between legal practitioners and government decision-makers in the system.

Lawyers asserted that they had to use the tools of the law against the discretionary powers of the Home Office. For example, if a patient was unwell and continued to stay in hospital, he or she was unlikely to be discharged. But solicitors could challenge hospitals to justify their decision for ongoing treatment, thereby opening a dialogue about the mental state of the patient, and appropriate care and management. Even as they saw the necessity of this process to ensure that patients were detained lawfully, legal practitioners expressed frustration at the 'games' they were required to play because of the nature of executive discretion. In this regard, the area of tension most often cited by non-government actors in this research was how the Home Office responded to the challenges of managing risk in the community.

### Getting risk right

Psychiatry has long been an administrative as well as a clinical science (Rose 2002b:216).

Practitioners were rarely critical of the fact that the Home Office assessed the expert reports of clinicians about risk. The question of risk has always been important to psychiatric practice, and all practitioners interviewed recognised risk to be a major element in the care, treatment and progress of patients. Instead, practitioners levelled their concerns at the cautiousness and consequent slowness of Home Office decision-making, because of its approach to risk. In the views of a number of practitioners I spoke to, the problem lay in the conflation of probabilities of risk with the desire to predict and prevent individual behaviour.

Risk assessment revolves around assessing the probability of a range of possibilities. It does not translate into a prediction about how one particular patient will behave and it is not intended to be relied upon as the sole basis for determinations about a patient's leave, transfer or release. Yet, in the view of one legal practitioner I interviewed, the Home Office's conservative approach to risk automatically produced a presumption against applications for less secure conditions of detention or discharge. She said, 'my understanding of the Home Office's position is that they want to be absolutely sure that it's safe to move somebody on before they move on. And you can't ever be absolutely sure'. For her, the worst effect of this approach was not upon applications for discharge, because they could be submitted to the Tribunal, but on attempts to move patients from more to less secure settings in preparation for release. In her judgement, this demonstrated the Home Office's difficulty in grasping the difference between manageable risk and zero risk. While she thought the Home Office would prefer to be told that a patient had zero risk of reoffending that was a literal impossibility.

She attributed significant delays in patient progress to the Home Office's 'default position' of maintaining the *status quo* and opposing applications for patients to be discharged to the community. Consequently the Home Office was seen always to be advocating further hurdles to discharge. Another lawyer made the following comments about the Mental Health Unit.

They're civil servants, they have no medical qualification whatsoever, and it is always going to be the case that if you get enough reports which express perfectly valid hesitations and reservations and things that you need to look out for and so on and so forth, it is the work of but a moment to extract these and say 'well that's gotta be sorted out before the person moves on'.

Ultimately, this approach led to the system slowing down and patient numbers burgeoning.

In the internationally renowned MacArthur studies on risk, Monahan *et al* advocated an interactional approach to violence risk assessment, wherein 'the same variable could be a positive risk factor for violence in one group, unrelated to violence in another group, and a protective factor against violence in a third group' (Monahan *et al* 2001:90). Practitioners who criticised the Home Office suggested that it failed to recognise the inherent problems with risk assessment *per se*, specifically that it was an inexact science, and that it was most reliable in relation to whole populations, not individuals. Practitioners I spoke to worried that the political imperative for risk assessment seemed to ignore these principles, assuming that a risk assessment could be easily obtained; would be comprehensive and accurate; and that a positive assessment (establishing the presence of risk) was grounds for refusing less restrictive conditions of detention or discharge.

At the same time, practitioners were generally accepting and even supportive of the Home Office's mandate to protect the public. Practitioners had not considered how executive decision-makers might work other than on the basis of probabilities. In fact, the concerns of practitioners about how the Home Office approached risk would have been likely to persist even if risk were the sole criterion for determining access to the community by any authority. As Peay has argued,

if the assessment of risk were to provide the basis for compulsory measures it would be incumbent on society to 'get it right'. If there is not a real probability of risk, but rather an attributed perception of it which prompts intervention, then the moral arguments favouring it are altogether less compelling. Moreover, if there were no real probability of danger then we would be infringing the liberty of a few, without any concomitant increase in the well-being of the many (except perhaps by falsely reducing their fear) (1989:207).

Yet practitioners in my research claimed that the process of risk assessment was used to justify a policy of containment through ongoing preventive detention. One psychiatrist told me about a conference at which a Home Office official had,

let slip [words to the effect of] ... 'well, I don't know what all this business is about using mental health law because very soon we won't need to use mental health law'. Now of course what she didn't seem to realise as she was saying it was that the implication was that if you did need to use it, you'd use it. Which I thought was quite interesting because I thought that was quite clear that she was saying 'well of course we'll use mental health law for public protection even when there's no benefit for the individual' ....

Here again, the objection was how mental health law was used to advance the public protection agenda. It was not problematic that the Home Office should work in the interests of public protection, but it should do so appropriately. This was the crux of many of the criticisms of the exercise of executive discretion: that the assessment of individual risks became the basis on which to deny patients progress through the system. Inevitably this led to the question of how much the system was one of preventive detention, an issue I shall address shortly.

One of the arguments developed by Monahan and Steadman during the MacArthur risk studies was that the same finding could be used to support a number of different positions (Monahan *et al* 2001). Likewise, the same statistical data were used to support opposing sides of the debate about treatment versus control in the restricted patient system. In an interview with me, a senior Home Office official argued that the low recidivism rate of restricted patients demonstrated how successful the executive was in exercising its discretion to protect the public. However a lawyer I interviewed argued that the same data on reoffending supported the argument that patients should be discharged earlier.

The overall recidivism rate is extraordinarily low, I mean it's something like three percent over five years or something. ... it seems to me that what that must mean is that many people are being kept in who don't need to be. ... And you know the Home Office no doubt would say, 'well, you know, we're not making mistakes because very few people get out and re-offend', but they are making mistakes but they're just making an invisible mistake where people aren't getting out who could

safely be let out. And if one accepts that people are in hospital for treatment rather than punishment then that's an error'.

Another clinician interviewed for this research had managed forensic patient units in the UK and overseas. He commented,

our patients generally get out after four to six years. We have a zero re-offending rate, which I think is dreadful. It means we are being too conservative. I would like to have a five to ten percent re-offending rate, which would be one-fifth of the general re-offending rate.

For these practitioners, reoffending rates that were significantly lower than those of comparative populations reflected over-cautiousness in the system. Moreover, some psychiatrists perceived re-offending as a natural event, not something that should be viewed as a failure. It would have been difficult for the Mental Health Unit to sustain such a position, especially in the face of anxieties about safety from the victims and families of patients, or in media and popular discourse. Nevertheless these different perspectives showed that the same data could be interpreted in directly contradictory ways, depending upon the standpoint being adopted.

For executive decision-makers, reoffending data provided a source of institutional legitimacy (DiMaggio and Powell 1983). As Mason and Mercer argue, 'the hue and cry over those patients incarcerated for many years who, in effect, would not have re-offended pales into insignificance in relation to public and political outrage regarding a released patient who does re-offend' (Mason and Mercer 1999:103; see also Padfield *et al* 2003; Wood 1993). Practitioners were also aware of the political imperative for the executive to meet the public's expectations, as well as to provide public protection. One lawyer I interviewed stated:

I think you do have to take on board that this is a serious public concern and no matter what we say about the best way to deal with people who are a danger to others, the public are always going to take this 'lock 'em up' attitude and the Government have got to respond to that to some extent.

Another lawyer claimed that conservative decision-making by the Home Office derived from its responsibility to juggle political pressures, including popular punitiveness, with the individual needs of restricted patients.

Consequently, in her view, the reality was that the system did not provide people with the least restrictive care necessary to treat their illnesses.

*The fine line between risk prevention and preventive detention*

I have argued that the perceived excess of caution shown by the Home Office raised the spectre of how much the system was one of preventive detention. I did not find this to be the case in the official mandate of the executive. There was nothing in the express letter of the laws and policies set down, or in the formally ascribed roles of each government actor, that required the system to detain people preventively. It was in the effects of how the Home Office operated that this emerged as a possibility.

Part of the perceived conservatism of the Home Office related to its requirement for system-wide support for changes in a patient's status or location, which practitioners stated was a significant hindrance to progress through a restriction order. As one lawyer argued to me,

the Home Office say 'that everyone's got to agree before we're going to agree. We're not going to agree to it unless everyone else agrees.' And there's always somebody not agreeing. And it can take years. ... Broadmoor are saying, you know, in 2000, this person's ready to move, and in 2005 there they still are. ... whatever the HO may say about the public interest ... the law relating to detention and transfer and so on and so forth is perfectly clear: people should be treated in the least restrictive alternative possible; people should only be detained in the interests of their own health and safety or the protection of others ....

Another lawyer perceived the Home Office's slowness in making decisions to be an attempt to avoid making decisions for release at all. He stated, 'they're unwilling to discharge on their own. My view certainly is that they prefer to cover themselves with the Tribunal doing it'. A legal policy officer supported this claim stating that most practitioners and clinicians saw the need to reform the system away from executive decision-making in order to deal with its slowness and inefficiencies. People repeatedly mentioned that the Home Office would be unwilling to discharge if a Tribunal had been convened. This contrasted directly with the Mental Health Unit's presentation of itself as actively encouraging applications for discharge. Yet it did suggest that the Home Office's unwillingness to discharge certain patients might result in their

remaining detained well beyond the period when such detention ceased to be warranted under the *Mental Health Act 1983*.

Many lawyers described frustration at the Home Office's cautious approach to risk. The following scenario told to me in an interview with a lawyer illustrated a problem lawyers encountered routinely.

I mean I had a case last week where, there'd been some administrative problems with the client who's been on overnight leave for some time, and the Tribunal was going to convene and I phoned the Home Office and said 'well, why don't you just discharge him?' 'Oh well, there's a Tribunal coming up isn't there.' I said 'well look, you know, you could read this recommendation for leave, you haven't objected, you haven't put statements in in relation to these extra reports at all. Why don't you just discharge him?' 'Well, you know, we've had problems finding the file.' You know, you get the feeling that the HO doesn't like to discharge if it doesn't have to.

Other people also spoke of cases where a clinical team and independent experts all supported an application, but the Home Office would not make a determination if there was a Tribunal coming up. Despite staff at the Unit saying they encouraged applications to the Home Secretary rather than to the Tribunal, practitioners claimed that the Home Office preferred the Tribunal to discharge a patient because it avoided the executive taking responsibility for any ensuing problems.

Delays in patients moving through and out of the system also led to a pattern of institutionalisation for restricted patients who had been detained for chronically long periods of time. One participant talked about the problems facing aged restricted patients, for whom the world outside the hospital had changed significantly since they were first detained. In the time taken to move some patients through the system to the point where they could be released, they had become institutionalised and alienated from the nature of the world outside the hospital, such that there was now a significant risk presented to them by the possibility of being released.

It became clear that where the Home Office was not satisfied about the proposed management of identified risks, it would oppose applications for leave or release on that basis. The consequent prolonged detention was

punitive for the patient, who had no power over the availability of resources in their own care and treatment, yet whose liberty was dependent upon them. From the point of view of the Home Office there was a clear logic to this: if a patient's risks could not be satisfactorily managed in the community, he or she should not be discharged. The effect was to turn preventing risk into preventive detention. In this way at least, the Home Office's approach appeared to be diametrically opposed to that of treatment in the least restrictive conditions, a principle that was advocated as fundamental even in the context of executive discretion, and by those concerned with systemic reform (see for example Dell and Grounds 1995; Richardson 1999).

*Decision-making bypass: understanding the role of psychiatrists*

The dangerousness debate in the criminal justice sphere suggests that we are not sufficiently expert to justify indefinite detention on protective grounds (Peay 1989:207).

A psychiatrist who had trained in England and worked overseas commented to me that the English system was 'better in theory but worse in practice' in terms of how executive discretion operated. Part of the problem, in his view, was that English psychiatrists were complacent about the role of the executive. As my data have shown, clinical practitioners were generally accepting of the role of the Home Office in the system. This was in contrast with literature that criticised the executive's discretion; and even with my own experience of an Australian forensic mental health jurisdiction where practitioners had despised the role of the executive. Indeed one psychiatrist I interviewed stated, 'in the sort of democracies we live in it's probably difficult to envisage a system which didn't involve political involvement'. But for many participants in my research, the question of how the executive performed its role was more than a matter of striking the right balance between care and control. Another area where clinical practitioners were particularly concerned about the Home Office was the perceived over-reliance on clinicians to take the responsibility for decisions about appropriate levels of risk. Psychiatrists were particularly concerned that the criminal justice system, including the Home Office, expected clinicians to be the ones not only required to assess risk but to determine whether it was 'reasonable' in terms of risk exposure to the public. Psychiatrists were responsible for their patients: they could and

should identify risks and propose how to manage them. But, they argued, the ultimate decision about whether levels of risk were acceptable should be made by elected representatives or those appointed to act on behalf of the public such as judges (Mullen 2002; Maden 2007).

Another psychiatrist I interviewed believed that doctors should never be charged with making the decision to release their patients if there was a risk to the public. In his view, doctors could not take responsibility for judging whether a certain level of risk was acceptable, particularly because it was not the role of clinicians to protect the public. He claimed that this was the role of the Home Office or the Tribunal. The same clinician asserted that part of the de-professionalisation of decision-making in the system was consequent upon a decline in public trust in the ability of psychiatrists to manage the risks of their patients. He argued that doctors needed to win back that public confidence in the system, but the way to do so was by meeting the concerns of the community in adequately managing patients in the community; not through over-exaggerating the utility of psychiatric expertise in decisions about release.

Clinicians I spoke with frequently suggested that the role of psychiatry was exaggerated in legal environments. In one interview a psychiatrist told the following anecdote which illustrated the point.

Lord Woolf gave the opening address in 2001 to the [Royal College of Psychiatrists] annual conference ... And he gave a wonderful ... demolition of the White Paper for the Mental Health Bill, on a civil rights basis, and the audience could have hugged him, and at the end, he said, 'of course when it comes to risk, we very much rely on you'. And there was stunned silence. Now Lord Woolf was, I think, a very liberal Lord Chief Justice, rather sensible, balanced, often outspoken, and yet even he felt unskilled when it came to mental disorder, and assumed that we were more skilled than we actually are.

This example indicated the extent to which the law expected psychiatrists to determine the appropriateness of the levels of risk to which the community was exposed. Many of the psychiatrists I spoke with expressed the view that the balance in courts had shifted too far in favour of clinical evidence, which was privileged over other forms of knowledge. While psychiatrists in my research clearly believed they had useful information for the courts, they felt

that the extent to which that information was relied upon was too great. As one stated, 'I think there's quite a strong risk of courts if you like paying too much attention to what psychiatrists and psychologists who are prepared to go into court say.'

In Chapter One I explored the critiques of 'mentally disordered offender' as a category, particularly on the basis of the randomness with which offenders were allocated to it and its various applications (see for example Prins 1995; James *et al* 2002; Peay 2007). The privileging of psychiatric evidence in court further reinforced this categorisation by assuming that the offenders in question were of a different order to those who usually came before the court, thereby justifying the court's reliance (or over-reliance, in the views of my research participants) upon psychiatric perspectives. According to the clinicians that I spoke to, the arbitrary application of the category of 'mentally disordered offender' was compounded by the fact that it left experts trained in law (judges, for example) feeling ill-equipped to deal with an issue that they thought was a medical problem. Yet for those clinicians providing evidence and information to the court, the decision about risk - upon which a restriction order was based - was an inherently legal one.

I had anticipated that practitioners would be opposed to executive discretion because of the systemic over-crowding attributed to executive caution. Not surprisingly, the picture that emerged from my data was much more nuanced and complex. Certainly, practitioners were concerned that mental health law was being used to further the public protection agenda at the expense of individual patients' progress and rights to liberty. At the same time clinicians were concerned that the executive should accept their expert opinion, but also its limitations. Psychiatrists claimed that there was too much responsibility being foisted upon them in terms of determining the acceptability of levels of risk. Whilst they were capable of assessing risk and proposing how to manage it, the actual decision was a matter of public interest. This was a political and representative decision that psychiatrists did not feel competent to make.

*Sympathy for the Home Office's role*

Despite the many frustrations experienced by practitioners in the system, a lot of the people I spoke to said that, overall, the Home Office had good intentions. People noted that relationships between the Home Office and practitioners had been improving as the Mental Health Unit became more flexible and willing to review its decisions. A number of participants commented that, despite their lack of clinical knowledge, Unit staff were often very familiar with patient cases. For some practitioners, this familiarity facilitated speedy responses, particularly when challenging initial decisions to reject an application. Two lawyers in separate interviews cited recent examples where they had challenged the Home Office's rejection of a leave application for their clients. The Home Office had heard their submissions and reversed the decisions, reflecting what these lawyers perceived to be a newfound openness and flexibility in the decision-making process.

Practitioners did not believe that the Home Office was intractable, asserting that personal contact was extremely important between Unit staff, patients and care teams. As one lawyer explained to me, 'the [Responsible Medical Officer], sometimes in conjunction with ourselves, has made sure the Home Office come to case conferences and they're clearly reassured. They meet the patient, which is often a very good thing, humanises the whole situation, and softens their response'. Here then was an alternative viewpoint on the informal relationships that informed the way Unit staff assessed applications for discharge. Personal interaction was valued by everyone as beneficial to the flow of communication and the ultimate objective of moving patients through the system.

Favourable regard for the Home Office persisted even in the face of the Unit's initial caution towards applications for discharge. This was summed up by the following statement made in an interview.

And they always will let you know where the applications are within the system ... I mean they could argue, well, 'we want something further in writing', or 'there's confidentiality issues with the RMO' and so on. So they are genuinely fairly helpful in that way, within the confines of their role which as I say I accept, protection of the public.

Those engaged in lobbying government, advocacy and law reform were also largely sympathetic to the Home Office's role. One representative of a mental health charity I interviewed acknowledged the validity of the public protection agenda but also claimed that it was influenced by people outside the Home Office's control. In her view, this external influence was driven by factors like the intense competition between news agencies, whereby major daily newspapers needed to maintain and increase sales through sensational stories of dangerous mentally disordered offenders. She did not mind the Home Office having a role protecting the public, but claimed that it had become too politicised in the interests of systemic reputation rather than patient rights.

My analysis of relationships between people across the restricted patient system indicated the complexity of the issues at stake and the wide range of opinions about them, both between organisations and within them. Home Office decision-makers accepted the expertise of clinicians and lawyers, but claimed that the executive's concern lay in an alternative direction to those of other actors. The Home Office asserted this agenda irrespective of opposition it encountered throughout the system. Other actors accepted the agenda in theory but claimed that the practice did not always strike the right balance. Moreover, some participants in my research had reservations that the right balance could be struck at all when decision-making lay in the hands of the government. There was one issue that surfaced consistently from each different organisation or group of practitioners I spoke with: the perception that other people did not understand their role or responsibilities. In the next section I explore how this perceptual problem foreshadowed the problems experienced when the Home Office implemented a policy for inter-agency co-operation.

### **MAPPP-ing Interagency Cooperation in the Management of Restricted Patients**

Over the past two chapters it has become clear that not only did the Home Office prioritise public protection over other objectives (like rehabilitation of patients), but it perceived its own concern with public protection to be unique across the system. Yet, as my data show, both clinical and legal practitioners

were acutely aware of the effect of the public protection agenda on Home Office decisions. If they were not themselves preoccupied with public protection, its impact upon decision-making meant that practitioners could not afford to ignore it if they were to see their clients and patients make progress through the system. However there was another aspect to this broad acceptance of the public protection agenda. My research took place at a time when the Home Office was 'rolling out' its policy of 'multi-agency public protection'. I turn now to examine what effect this had on the restricted patient system.

Discussing the new crime prevention approach developed in the USA and especially in the UK in the final two decades of the 20th century, Garland noted a range of buzz words created around new strategies of crime control, including 'partnership', 'public/private alliance', 'inter-agency cooperation', 'the multi-agency approach', 'activating communities', creating 'active citizens', 'help for self-help' and the 'co-production of security' (2001:124). He argued that the primary objective of these new strategies was 'to spread responsibility for crime control onto agencies, organizations and individuals that operate outside the criminal justice state and to persuade them to act appropriately' (Garland 2001:124). The development of Multi-Agency Public Protection Arrangements (MAPPA) was a good example of this new approach to crime control.<sup>23</sup> Many of Garland's buzz words peppered the language of MAPPA policy. More directly, the establishment of MAPPA illustrated the dualism of redefining the state's role in criminal justice away from delivering law, order and crime control and towards managing risk, while simultaneously dissolving that responsibility for risk across an ever-increasing list of agencies engaged in the care and control of the populations in question.

In multi-agency public protection collaborations, shared decision-making between agencies was regarded as essential to assessing and managing the risk posed by sexual and violent offenders (Home Office 2004). The MAPPA

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23 The acronyms MAPPA (Multi-Agency Public Protection Arrangement) and MAPPP (Multi-Agency Public Protection Panel) were used interchangeably by participants. In practice, MAPPPs are the meetings that bring different agencies together under the policy of MAPPA.

policy was enacted by the *Criminal Justice and Court Services Act 2000*. It required police and probation services to work together in managing the risks these individuals posed to the public. Restricted patients whose index offence involved sexual or violent offending were always covered by this policy, and in 2003 it was extended to agencies who might not formally be in the criminal justice system but who worked with offenders (Home Office 2004). This included hospital and community care teams working with restricted patients. Turner and Colombo note how relationships between criminal justice and mental health professionals 'flourished' particularly in relation to the management of the 'critical few' of high-risk, violent and sexual offenders, through multi-agency collaborations which sought to 'encourage an open exchange of information, skills, and ideas amongst professionals with different disciplinary backgrounds' (2005:34). The question this raised for my research was as follows: if the terms of reference for MAPPA were dealing with dangerous and violent offenders, how did the policy respond to restricted patients who were substantively patients not offenders?

One of the first challenges raised by the incorporation of restricted patients into MAPPA policy had been how and what information practitioners could share with other agencies. During my research, Home Office staff talked about the law on information-sharing as 'impenetrable'. There was already a responsibility to alert the police to restricted patients who fell within a prescribed set of conditions (for example patients with a certain history of sex offending who had been conditionally released). There was also a specific responsibility on clinicians to share information with other risk management agencies (such as police) where they considered there might be an issue of public safety. But the onus was on clinicians to select what information they should share and when. Thus the practical implications of balancing patient confidentiality with public protection were a matter for clinical discretion.

Turner and Colombo note that:

confidentiality is a central principle of Western health care, with the relationship between health professionals and members of the public founded on reciprocal trust. This is of particular relevance to the work of [Multi-Agency Public Protection Panels] for two principal reasons. Firstly, because breaching client confidentiality can have a significant impact on the longevity and quality of the relationship between

practitioners and mentally disordered offenders - more significant in light of the fact that the MAPPPs client group generally comprise of those who, in the past, have found it difficult to engage with mental health and social services. And secondly, because of the significant ethical dilemma the issue of confidentiality presents to clinicians involved in MAPPPs who must constantly balance interests of public protection against responsibilities towards their clients. For the police: 'the risk posed is far greater than the confidentiality issue.' This is true up to a point. However, the reality is usually far more complex, for if breaches in confidentiality result in a break down in therapeutic trust then ultimately both the public and mentally disordered offender will suffer (2005:35).

In Turner and Colombo's study, the police occasionally acknowledged the importance of patient confidentiality, but police also suggested that mental health practitioners hid behind the notion of patient confidentiality when they did not want to reveal certain information (2005). In other words, police believed that practitioners who did not want to provide information to the police, or did not want to make a decision that might affect their patient detrimentally, would cite patient confidentiality as an excuse. Timmermans and Gabe have described as 'agency misalignment' the inability of practitioners and organisations to understand the terms and objectives of other agencies with whom they are supposed to be collaborating (Timmermans and Gabe 2003). As Turner and Colombo put it, the 'inherent friction' between mental health and criminal justice professionals meant that there was an 'entrenched difference between agency groups in terms of beliefs, values and actions resulting from contrasting professional backgrounds, training and experiences' (Turner and Colombo 2005:34). Their research found that 'the spectrum of agencies involved in MAPPA "speak different languages, use different jargon and different tools of assessment"' (*ibid*).

The MAPPA policy was in its infancy at the time of my research, and very few people had direct experience of the Panels. Yet the inability of different people to understand each other's perspective was immediately evident from the comments practitioners made to me. One psychiatrist I interviewed relayed a clinical colleague's first experience of a MAPPP.

She said 'it was like a tennis match really' and she described how the ball just got batted between two sides and each didn't understand the

strokes of the other. Um, you know, the police couldn't understand why the hospital wasn't detaining the person and the hospital couldn't understand why the police couldn't understand why they weren't detaining the person and why they weren't doing something else. Now as they get to know each other better maybe they'll all end up huddling around the net having forgotten that they're actually on two sides of the net.

There was also concern that the 'MAPPA culture' would influence the therapeutic decisions clinicians made. Almost a decade ago, mental health charity Nacro had warned about the risks of adopting 'defensive practice' from the USA into the UK, whereby practitioners made decisions in order to avoid future blame, rather than in the best interests of the patient (Jewesbury 1998). It appears that Nacro's warning went unheeded in the area of mentally disordered offenders. I have discussed the analysis of defensive practices at the parole board, where decision-making turned on the 'worst case scenario', rather than the most likely outcome (Padfield *et al* 2003:199). Similarly, in their research into MAPPA Turner and Colombo found that,

the dispersal of risk and responsibility is, however, likely to remain problematic whilst mental health practitioners feel pushed into defensive practice by a media that highlights rare tragedies and creates a culture of blame. A Forensic Social Worker respondent highlighted this and candidly disclosed: 'If I'm honest part of information sharing is a back covering exercise ... when things go terribly wrong and the inquiry sits, if you weren't around the table, then your agency is vulnerable. And as a professional you're vulnerable' (2005:35).

The MAPPA approach raised important questions about the underlying status of restricted patients and the responses the system was capable of making. How could the therapeutic interests of restricted patients remain paramount in a climate where the professionals responsible for patient care and treatment were forced to consider their patients only in terms of risk to the public? The very status of 'patient' could be called into question in this context.

At the same time some people were positive about the MAPPA policy. One psychiatrist believed that MAPPA facilitated the representation of public interest in decision-making. In his view, doctors' concerns for their patients were not mirrored by equal concern for the protection of the public. He

believed there was a need for representation of the public interest in decisions about risk and that the MAPPA policy made this a more measured aspect of decision-making by people other than the Home Office. He also claimed that MAPPA provided the impetus to share responsibility for decision-making across agencies, and that shared responsibility for risk management was best practice in psychiatry. This was supported by Street's finding that restriction orders enabled a unique sharing of responsibility across different agencies and decision-makers in the system (1998). For the practitioner quoted above, MAPPA involved an element of protection for doctors, for example being able to consult non-clinical practitioners about a particular patient plan.

Clinicians were clearly engaged in coordinating risk management in the interests of public protection. Indeed, while the Home Office believed that some clinicians were not at all concerned about protecting the public, some people I encountered in my research were concerned that practitioners were becoming too preoccupied with public protection. One clinician I spoke to worried that the public protection imperative would become so widely-accepted that clinicians would forget their responsibilities to patient confidentiality.

I think the whole notion of multi-agency management is sort of interesting and variously problematic. My gut feeling about it originally was that I was opposed to it. I think that I am being brought round to it in relation to some particularly difficult cases where there are factors that are not just mental health factors that relate to offending, and where it does make sense for agencies to cooperate with each other. But then what still worries me is that the health service won't keep its boundaries properly in terms of what information it passes over. That it won't do it on the basis of ... 'significant risk of serious harm to the public therefore I must or can disclose', but it will do it on some sort of fudged 'need to know' basis as if we were all looking after the patient, whereas actually police officers don't look after the patient. ... My suspicion is that generally as time goes on there will be ... loosening ... and people will forget what the real rules are. They'll be busy so they'll hand over discharge summaries.

This anxiety was echoed by Turner and Colombo, who asked: '.... will mental health practitioners' important contributions to MAPPPs inevitably see them slipping further into the sphere of public protection at the expense of therapeutic care?' (2005:34). As long as patient health and public protection

remain dichotomous objectives, it was difficult to see how the outcome would be otherwise.

Earlier I discussed the tension expressed by psychiatrists in gaining acceptance for their professional expertise in the assessment of risk by the Home Office, while simultaneously seeking to distance themselves from expectations that psychiatry would take responsibility for determining what level of risk was acceptable to the public. The involvement of psychiatrists in MAPPA was another example of the blurring of the roles, responsibilities and utility of psychiatry in the management of mentally disordered offenders. As Peay notes, 'the tensions are evident, and not only in respect of information sharing, but also in respect of the very relevance of psychiatric knowledge to the broad ambit of general offending' (2007:499). In the symbolic politics of criminal justice, people who might once have been considered elements of crime control are now considered risk managers. Several senior Home Office officials described the police and other criminal justice agencies as risk managers who supported the objectives of the Mental Health Unit. These officials compared such risk management agencies favourably against the Department of Health and other actors whose objectives did not prioritise public protection. Yet the initial inclusion and subsequent compulsion of psychiatrists to participate in MAPPA policy placed a legal responsibility on psychiatrists to adopt that preoccupation with public protection. The implementation of MAPPA indicated how firmly psychiatrists had become situated within the spectrum of 'risk management authorities' and lent further support to my thesis of the symbolic politics of protection in the restricted patient system.

### ***Patients and the public: an intractable opposition?***

In this chapter I have explored one of the consequences of how the Home Office constructed the public protection agenda. I have shown that, by perceiving itself to be the sole protector of the public in relation to risk, the Home Office relegated the expertise of care teams and alternative decision-makers outside of its own decision frame. This led Home Office staff to downplay the reliability of assessments about risk from the Mental Health Review Tribunal and care teams pursuing applications for leave or discharge

of restricted patients. At the same time, the Mental Health Unit was engaged in actively promoting the Home Secretary as the preferred authority to receive applications for leave or discharge. All this could be explained by the Unit's exhaustive commitment to the public protection agenda. However the perception that it was only the executive that was concerned with public protection was not supported by my data. Moreover, that perception created some significant challenges for the exercise of executive discretion in the system.

I have documented a perception at the Home Office that other actors in the system did not take account of public protection, and therefore made riskier decisions. Two particular challenges emerged from this perception. The first was in relation to the Tribunal. Legislatively, the Tribunal was *required* to take account of risk to the public by the *Mental Health Act 1983* [section 73 (1)(a)]. It was one thing to suggest that the Tribunal did not place sufficient weight on the question of public protection, quite another to argue that the Tribunal did not consider public protection at all. Additionally, the perception of the Tribunal making risky decisions had led to the Home Office monitoring, and sometimes seeking review of, Tribunal decisions. As I shall discuss further in Chapter Seven, this informal monitoring brought into question the independence of the Tribunal, which was charged with safeguarding patient's rights in the mental health system.

Secondly, concern by Home Office officials about the capability of particular care teams translated into an informal mandate to supervise clinical practitioners in the system. Again, these concerns were informed by the perception that clinicians paid insufficient attention to public protection. Yet, from my data, clinicians routinely paid attention to the question of public protection when considering the preparedness of their patients to spend time in the community.

Thus the perception that the Home Office was the only agency considering the protection of the public was an important point of contention across the system. Both the Tribunal and clinical practitioners considered the matter of public protection in all decisions about the care, management and discharge

of restricted patients. Ironically, the mere fact that this point of contention existed disproved the Home Office's perception that it was the only actor with regard for public protection. Within the importance of protecting the public which was acknowledged by all, the disparity lay in how different actors felt that public protection should be assessed. Both legal and clinical practitioners I spoke to believed that the way the Home Office undertook its deliberations undermined the responsibility of the mental health system to ensure that patients were detained in the least restrictive circumstances, and with appropriate treatment including the opportunity for rehabilitation in the community.

Despite the contention around public protection, and for all the theoretical arguments against executive discretion, non-government actors were not uniformly opposed to the fact of the Home Secretary's authority. Opinions were far more dynamic and complicated than mere opposition. On the one hand, there was a degree of confidence in how the Home Office carried out its work. This was evident in the opinions of non-government actors, including practitioners and advocacy organisations, many of whom had confidence in the individuals and processes employed by the Home Office; who found the Mental Health Unit to be approachable and reasonable; and who acknowledged and appreciated the Home Office's role in supervision generally.

These same actors, however, were concerned by the extreme cautiousness they perceived in Home Office decision-making, which resulted in an inordinate length of time taken in processing decisions; and the fact that applications for patients considered appropriate for less secure conditions of detention were generally rejected at first instance by the Home Office. As one psychiatrist put it during an interview, the Home Office was simply failing to exercise its discretion to release restricted patients.

That statement struck at the essence of the tension between the executive function - as embodied by the work of the Mental Health Unit - and the therapeutic objective of other actors in the restricted patient system. As long as public protection was seen as oppositional to individual patient needs, there could be no midpoint for compromise on both agendas. As long as

restricted patients were understood primarily in terms of their risk to the public, their individual needs would always be secondary. And as long as the executive authority was implemented by the Home Office, the interpretation of public protection would prioritise the control of dangerousness over therapeutic care.

Clinicians and practitioners repeatedly claimed that the prioritisation of controlling dangerousness ran counter to the intentions of the *Mental Health Act 1983* and the mental health system itself. Yet the approach of the Home Office was firmly rooted in the executive discretion granted it by that same legislation. It was in recognition of the high degree of public interest in this area and because the tenor, scope and scale of that interest might shift over time that the Home Secretary was given decision-making authority in the first instance. This produced an intractable impasse which simultaneously legitimised each side's positioning with reference to the *Mental Health Act 1983* and institutional mandates.

The last two chapters have set out the role and work of executive decision-making in the restricted patient system; and the relationships between the various actors in the system. Much of this discussion has turned on the question of the public protection agenda. This brings me to the central questions of my thesis: what was the public protection agenda, and whose interests did it serve? In the next chapter I consider 'the public' being served by executive discretion, and how.

## CHAPTER 5

### CONSTRUCTING 'THE PUBLIC'

#### Introduction

My analysis so far has explored the role and function of the Home Office Mental Health Unit, and relationships between the Home Office and other groups in the restricted patient system. I have established that the formal mandates of the executive were to provide public protection and to maintain public confidence in the system. These formal mandates operated alongside the informal mandates of monitoring other actors in the system and avoiding scandals and negative attention on the system. Each of these aspects of my analysis has revolved around the emerging distinction between individual patients and members of the public. It is a distinction that brings me to my focal question: what was meant by 'the public'? How was it constructed, and how did these constructions vary across different actors in the system? The present chapter addresses these questions in turn.

There is a considerable body of work examining who constitutes the public which provides the theoretical framework for my discussion. However empirical analysis of how the public is constructed in the daily decision-making processes of government is rare; even more so when applied to decisions about the release of offenders assessed as high risk. Moreover, the political climate which shapes approaches to law and order and penal policy is in a constant state of flux. Policy shifts had been attributed to the changing nature of public opinion, perceptions of that opinion, and the relationship of both those issues to criminal justice policy (Simon and Feeley 1995; Garland 2001; Reiner 2007). In the present chapter these theories about the social construction of public opinion provide the analytical framework for my examination of how the Home Office took account of the public in its decision-making about the discharge of restricted patients.

The construction of the public was a very important issue for my research. Only by answering it could the interaction between public protection and the

exercise of discretion over restricted patients be wholly understood. The amorphous 'anyone and everyone' of people in communities where restricted patients had been discharged, and of society more broadly, was one element that was particularly important to investigate, because it legitimated the lay status of Unit staff themselves. This over-arching notion of the public as everyone outside the system gave Home Office staff a representative function in terms of making decisions for and on behalf of the public. Decisions were made with regard to the best interests of the public, and simultaneously as though Home Office staff were representatives of the public themselves.

An additional layer of the public was represented by the media. As Ardon has described, the notion of public interest is frequently drawn on by the media to legitimate their requests for information and to put pressure on those unwilling to provide it (Ardon 2007). The media were important elements of the 'surrounds' within which the Unit made decisions about restricted patients (Hawkins 2003). In particular, media interest in the restricted patient system played directly into yet another unstated but central aspect of the Unit's role in protecting the political interests of the system, and ultimately of the Minister. However the effect of this attention could only be understood through an examination of what actually constituted the public interest. Who defined it, and how were the perceived interests of the public met?

To some extent, in the eyes of Home Office decision makers the public was constructed around people personally engaged in restricted patient cases, and specifically around victims. Seen within the broader policy framework of New Labour, this meant that victims played a particularly important role in the construction of the public. In many ways they were the central embodiment of the public. This was evident in the routine referencing of victims in anecdotes and examples drawn on by Mental Health Unit staff to describe the system and the challenges to it from the public protection agenda.

## Constructing the Public Interest

Those features of the world outside which have to do with the behaviour of other human beings, in so far as that behaviour crosses ours, is dependent upon us, or is interesting to us, we call roughly public affairs. The pictures inside the heads of these human beings, the pictures of themselves, of others, of their needs, purposes, and relationships, are their public opinions. Those pictures which are acted upon by groups of people, or by individuals acting in the name of groups, are Public Opinion with capital letters (Lippmann 1922:18).

As Lippmann's classic work on public opinion demonstrated, 'the formal political structure exists in a social environment, where there are innumerable large and small corporations, and institutions, voluntary and semi-voluntary associations, national, provincial, urban and neighbourhood groupings, which often as not make the decision that the political body registers' (Lippmann 1922:14). Central to Lippmann's thesis was the notion that decisions were based on 'pictures' of the world, of experience and of opinion. The notion of legal, bureaucratic decision-making suggests a framework of rational policies and systems, underpinned by the rule of law, in which decisions are made. But this is only part of the picture. Missing is the important element of public interest in the decisions being made. By definition the civil service is obliged to act in the interests of the public, but the extent to which those interests determine how the civil service acts or reacts is often determined by the political and public dynamics of the day (Rock 1986 and 2004; Stenson and Edwards 2004). Even when sociological inquiry has engaged with policy shifts and trends in contemporary criminal justice, the influence of the public, or the construction and effects of the public interest upon those shifts, has received little more than casual reference. The failure to interrogate such notions more fully has left a gap in our understanding of the 'broad environment, particular context, and interpretive practices' of decision-makers (Hawkins 2003:189).

The need for legitimacy in the eyes of the public is an essential characteristic of bureaucratic decision-making. As Thomas argues:

the problem of justice follows logically from the symbolism of formal rationality in decision-making, when it is expected that decisions in individual cases will be grounded in general rules faithfully applied to specific cases. From this perspective, it can be argued that a basic

difference in the decision frames of legal institutions is the extent to which the decision-making process is governed by the need to avoid threats to legitimacy (Thomas 1986:1284).

The question of how the public were constructed was crucial to the legitimisation of the government's approach in the restricted patient system, and was an element which distinguished the Home Office from other legal decision-makers in the restricted patient system, such as the Tribunal.

Judicial authority operates within principles like the rule of law. These principles involve policies and procedures which enable judicial decision-making based upon legal facts, without being subjected to influence from a more general notion of public opinion. Of course, the judiciary is not immune to external factors (Thomas 2003), and scrutiny of it ranges from academia to the media, politics and the public. Moreover judges must often make decisions in the interests of public protection. But the very independence of judges comes from their operating at one level removed from the public and political processes of criminal justice; from at least the perception of immunity to such processes. By contrast, ministers are held to account through the democratic process. The point here is that in the structures of decision-making, the role of the public can be an important distinction between political and judicial decision-making even in the same contexts of law or criminal justice.

For the Home Office, the public were the objects of executive authority: both in the policy imperative to provide public protection, and to maintain public confidence in the system. The public underpinned the more detailed, subtler aspects of the Home Office's mandate such as maintaining public confidence in the system and protecting the Secretary of State from any political fallout. In this context, the consideration of the public interest was not just an incidental factor. Rather, it was the direct object of the decision-making processes of Home Office staff. Shortly I shall discuss the form that public interaction with the restricted patient system took. Firstly, however, I want to consider how the executive's approach to the public manifested itself throughout the system.

One of the interesting distinctions between how criminal justice and mental health actors operated in the restricted patient system was their approach to the public. Executive discretion was firmly based within the political context of public policy, legislative process and electoral popularity. Locating the authority for that discretion within the brief of the Secretary of State for the Home Department also brought into the picture principles like the rule of law and natural justice, which were part of the decision-frame of criminal justice decision-making. These principles contrasted strongly with the health system, which operated on the basis of individual patient needs and professional rather than political judgement. In the health system, the personal doctor-patient relationship was primary, and was sustained through fundamental health care principles such as the confidentiality of patient information. Patient progress was perceived in terms of the individual, without reference to other interested parties such as the patient's family, victims or local community. These core systemic differences informed how each actor responded to the notion of public interest, as well as to the application of that interest in particular patient cases. As such, the role of the public was a variable of decision-making that operated differently between bureaucratic and judicial staff within the restricted system as well as between legal and health approaches to restricted patients.

There have been many studies of how the public are constructed in the eyes of people whose work is dependent upon or responsive to public concern. One notable study examined journalists and the news media in the late 1950s. De Sola Pool and Shulman examined how media subjects thought about their audiences in terms of what they wrote (de Sola Pool and Shulman 1959). They found that journalists constructed their audiences in three ways: in terms of the specific characters of a story; by taking a sympathetic view towards general people who might be affected by this or similar experiences; and in terms of a desire to punish perpetrators of bad acts, whom they termed 'fakers' or 'crooks' (de Sola Pool and Shulman 1959:147). Moreover, they found that journalists' thoughts about their audiences were much more a matter of personality than of mood, remaining fairly constant over a period of

time and any variance in the issues they were reporting. In their view, the process of constructing an audience,

involved adopting dissonance reduction strategies to sustain an established mental picture of the world. Each respondent had a basic fantasy which related him to the world, either as a recipient of rewards from it or as a battler against it. His actions as a communicator sought to sustain this image (de Sola Pool and Shulman 1959:156).

In many ways, the process they described resonated with how Home Office decision-makers constructed the public in relation to restricted patients. As will become evident, there were individual differences in terms of how staff conceptualised the needs of patients and their families, and of the public as a broader subject of the system. These differences appeared more closely related to the personality of the official than to an issue of mood at the time of the decision. Differences in approach were clearly acknowledged by staff who recognised the extent of their own discretion in how they arrived at a particular decision. Even so, the way in which they constructed the public was very much a product of individual engagement with people outside of the formal actors of the system like practitioners and patients. Those outside the system included families of patients, victims and members of the communities in which patients lived or spent time. De Sola Pool and Shulman found that newsmen might report news badly if it did not serve their imagined purpose (de Sola Pool and Shulman 1959). Their findings reflected the desire by decision-makers to reassure concerned citizens that they were being protected, even if that reassurance was primarily symbolic.

The difference in approach to how the public was constructed was no more evident than in the issue of providing patient information to victims. Up until the late 1990s, the Probation Service was responsible for liaising with victims where the offender was convicted. No-one had responsibility for victims where the person who committed the offence was not formally categorised as an offender, including restricted patients. Although restricted patients had been convicted of an offence, their formal status was as patients. This meant that the sort of information victims expected about offenders was covered by the principle of medical confidence (Peay 1996; Rock 1996). One clinician explained this premise during an interview with me.

I start from the position that these are patients. And I think that's something that other agencies don't understand. ... That police officers can't understand why a doctor would want to resist giving information about a patient, forgetting that if they went to their GP and the GP told lots of other people that they have a sexually transmitted disease, they might be a bit upset about it. But they can't somehow see that mental health care is as intimate as that, and almost more intimate on occasion. So I start from the position that, well, if you're in the mental health system you're part of the medical system and therefore you have a right to medical confidentiality.

However as victims were increasingly able to gain access to information about offenders, so pressure grew from those who perceived the restricted patient system as an anomaly in that regard (Rock 2004).

The response to victims who sought information about restricted patients had changed over time. Mental Health Unit officials had increasingly been contacted by victims directly, or via their elected representatives, seeking information about where a restricted patient was detained and whether they were to be released. The practice had slowly emerged whereby officials would release what they called 'basic information', such as the fact of somebody's detention or rough geographical location so that victims could know whether their offender was in their area or not, and whether there was anything in place to protect the victim.

After some years the Unit sought legal advice on victim access to information about restricted patients. I was denied access to this advice, but was informed that it had supported the existing practices of the Unit and had legitimated the expectations of victims to have information 'for peace of mind', as long as that information did not infringe medical confidentiality. This was subsequently put into legislation through the *Domestic Violence Crime and Victims Act (DVCVA) 2004*, which enabled victims to make submissions to any relevant determinative authorities in all offender cases, including restricted patients (DVCVA 2004:section 37). That legislation also required victims to be notified about conditions of discharge; details of any conditions relating to contact with the victim or family; notification of the date a restriction order was to cease; and 'to provide that person with such other information as the [probation] board considers appropriate in all the circumstances of the case' (DVCVA 2004:section 38). Whilst the law

stipulated that the Probation Service was the agency responsible for liaising with victims in these matters, the onus was on decision-makers including the Secretary of State to notify the Probation Service of any relevant information for victims.

One Mental Health Unit official observed that it was extremely important to explain to victims how the system worked, because if they did not understand this, they would believe the person discharged was still the perceived monster who had, for example, murdered their relative. Of course, the restricted patient population included some people who had committed horrific offences. There were also patients for whom a history of mental health treatment and supervision had neither prevented nor anticipated the severity of the crimes they came to commit (see for example the report of the Independent Panel of Inquiry into the triple homicide by Jason Mitchell in Blom-Cooper *et al* 1996). But there was also a widespread view that the opposition of some victims to the discharge of their offender could be alleviated through the provision of information about the patient.

An example given by a practitioner I interviewed illustrated this point. A patient had attacked officers in a police station during a period of severe mental illness many years earlier. The patient was now much better and had repeatedly sought leave to test his readiness for discharge into the community. These leave applications had been repeatedly rejected by the Home Secretary in the face of strong objections by officers at the police station where the index offence took place. As the practitioner explained to me,

we ended up having a sort of conciliation meeting between the police officers and the patient, with the social worker from our service ... And it, as far as I could see, completely defused the situation because they saw this 'monster' who'd gone down in the annals of their police station as being the most violent man for twenty years, as a sweet young kid actually, who's very well now and has a rather nice demeanour. So it can be, in a sense that was pragmatic, the legal response would be to say to the Home Office 'you have absolutely no right to do this' and so on. The pragmatic response which I said to the patient was 'look, you're going to have to live in this area. You're probably better off pragmatically meeting them.' And that was the right thing to do, I think.

In this case, the impression the police had of the patient had not changed since the index offence, except perhaps to worsen through the exaggeration of folklore and anecdote. In the end, meeting the patient enabled the officers to understand how different the man being discharged would be from the man who had committed the offence, and that allayed their fears about (and ultimately their objections to) his release. Interestingly, in the clinician's narrative there was no sense that the police, the public and the victims might all have occupied the same standpoint. There certainly wasn't any indication that the clinical team viewed the police as 'insiders' of the restricted patient system, for example because of police responsibilities for public protection.

General information about restricted patients was one thing. But as I discussed earlier, the question of patient-specific information posed some significant problems for practitioners and the Home Office. I was interested in how Unit staff actually navigated the complex territory of determining what was confidential patient information and what information could reasonably be provided to victims. What emerged was that Mental Health Unit staff saw themselves as something of a proxy for the public. In previous chapters I have discussed how for Unit staff, the fact of being lay rather than professional actors in the system was integral to their sense of function. The importance of this self-perception was that it suggested a representation of the public; what Lippmann would have described as a process of adapting the various permutations and combinations of public opinion to a smaller, manageable model (Lippmann 1922).

One of the ways Home Office decision-makers attempted to do this was through empathy by putting themselves in the position of victims, as they saw it. One official told me,

the difficulty is that you're getting into areas of patient confidentiality. Leave, for example, is regarded as part of a patient's rehabilitation. And there are arguments that if you started getting victims involved in leave decisions, where do you draw the line between the doctor saying 'this is for rehabilitation' and the victim saying 'well we want to know anyway'. And so we get around that at the moment by taking it upon ourselves to look at the victim issues and have exclusion zones or whatever.

In examples like this one, staff tried to put themselves in the position of the victim to imagine what information the Unit had access to that could alleviate the victim's concerns. In practice, the staff of the Unit assumed a representative role not only of the executive, but of the public as well, determining which issues victims would want information about, and then providing certain information accordingly. Up until the point of my research, there was no institutionalised method of communication between victim representatives and Home Office decision-makers in the restricted system. This meant that staff of the Mental Health Unit relied upon one-to-one contact with victims to inform their understanding of what victims generally wanted.<sup>24</sup> The correlation between assessments of what victims wanted and what victims actually wanted was beyond the limits of this study, but the question of extending victim-focused initiatives in criminal justice to the area of mentally disordered offenders is something to which I shall return.

As Lippmann argued, decision-makers face a series of structural limitations regarding how to incorporate public interest in bureaucratic decision-making. These included,

artificial censorships, the limitations of social contact, the comparatively meagre time available in each day for paying attention to public affairs, the distortion arising because events have to be compressed into very short messages, the difficulty of making a small vocabulary express a complicated world, and finally the fear of facing those facts which would seem to threaten the established routine of men's lives (Lippmann 1922:18).

In the restricted patient system, the public interest had always been a paramount concern. As Peay has argued,

since a proportion of patients on restriction orders ... have committed very serious crimes and may indeed have avoided a life prison sentence because of their mental disorder, determining whether to discharge will be of significant interest to applicants, the public, and sentencers (1989:10).

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24 The *Domestic Violence, Crime and Victims Act 2004* extended the role of Probation Service Victim Liaison Officers to the restricted patient system. This formalised the processes and contact between agencies and victims. At the time of my research it was still too early to tell if and how the new arrangements were going to affect the Mental Health Unit's contact with victims.

Indeed the public interest justified the executive's authority in the system. Examining these issues through a criminological lens, I was interested in how the rise of law and order politics had shifted, or perhaps simply clarified, the processes through which the public's interest was perceived, and public protection provided (Reiner 2007).<sup>25</sup> Clinicians sometimes criticised the Home Office for assessing clinical evidence without professional expertise. But for staff at the Mental Health Unit, it was their public expertise that enabled them to make decisions in the public interest. In their view, they did not need clinical expertise; that was what care teams provided.

Of course, as Mead argued, institutions are 'organized forms of group or social activity - forms so organized that the individual members of society can act adequately and socially by taking the attitudes of others toward these activities' (Mead 1934:261). Thus in some ways this perception of being representatives of the public was simply instructive of social processes more generally. Yet civil servants do not serve a representative function directly, but on behalf of elected members of parliament. In the *realpolitik* of the bureaucracy, 'civil service responsibilities are not simply to the government of the day; they should include responsibility to Parliament, and to the constitution' (Public Administration Select Committee 2007:3). In this sense civil servants have to mediate between the demands of the political executive and the expectations of the public in the development of policy; the provision of services; and, as is the focus of this study, in decision-making. At the same time, staff of the Mental Health Unit had regular contact with members of the public which must in some way have contributed to their generalisations about the public. I turn now to examine some of these interactions, and how they shaped Home Office decision-making.

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25 While some have argued that public opinion has taken on an even greater role as a 'privileged source' in criminal justice (Garland 2001:13), the appropriateness of this thesis to understanding policy developments in the UK is still debatable (see for example Gottschalk 2006).

## **How was 'The Public' Conceptualised?**

### *The general public*

In Chapter Two I set out my working definition of 'the public'. That definition did not include decision-makers such as the Home Office and the Tribunal; health and legal practitioners; or patients. It did include families and carers; victims and their families; mental health and other non-government organisations that were involved in issues relevant to, but not focussed on, the restricted patient system; and anyone else that might have had involvement with a restricted patient at some point (for example neighbours or local businesses where a patient lived). I was interested in Lippmann's notion that public opinion is a pragmatic construction made up of multiple sources and Mead's observations about the generalised other (Lippmann 1922; Mead 1934). From these perspectives I wanted to analyse how Home Office decision-makers conceptualised the public whom they were mandated to protect.

Initially, the self-perception of representativeness among Unit staff introduced another layer to my own conception of the public, through an anonymous body of people who might never be individually identified, but who could be exposed to risk simply by being in the vicinity of restricted patients. This included members of the communities that restricted patients lived in or visited. It also pointed to anyone and everyone who did not have a formal, acknowledged involvement in the system. In this way it expanded the working definition I had applied at the outset to include the broadest possible conception of the public.

On the one hand, this definition operated as a catch-all for anyone and everyone who might constitute membership of the public. But it also took practice further away from structured, categorical actors into a nebulous, all-encompassing population. This was another indicator of the shift away from expertise towards a greater emphasis on common knowledge, a sign of the way in which 'the bureaucracies of the criminal justice system have had to become more responsive, more attuned to the interests of individual

consumers and stakeholders, and less assured in their definition of what constitutes the public interest' (Garland 2001:117).

How did the policies and practices of the Unit make provision for such a broad range of possible interests being brought to bear by the public? One way was to allow for flexibility or deviation from standard practice when cases fell outside the ordinary or the expected. The recall policy discussed in the previous chapter provided a good example of this. The formal procedure, established in case law, required medical evidence at the time of recall (*K v The UK 1998*). But the Mental Health Unit's interpretation of the case law maintained the overriding priority of ensuring public protection above any strict interpretation of the principles of compulsory treatment.

Unless recall is necessary as an emergency measure (for example, where the patient presents a clear, immediate, serious risk of harm to others), there must be an up to date report on a patient's mental condition prior to recall. This report must confirm that the patient is mentally disordered (but not necessarily that his mental state has deteriorated). This report may in the first instance be given over the telephone if the case is urgent (Mental Health Unit 2003:13).

I came across numerous cases where patients were not in regular contact with care teams, suggesting that current clinical information might be difficult to obtain in the event of a proposal to recall the patient. The Unit's policy took cognisance of this by reminding staff that the supremacy of the public protection agenda remained, and that recall action was permitted in the absence of clinical evidence where that mandate was threatened. In this way, the documented policy reflected the letter of the law, while the practice relied upon a more fluid process of legal interpretation, enabling the Unit to meet its responsibilities to the public.

Beyond the amorphous 'anyone and everyone' of the public, I was interested to know what other types of individuals or members of the public the Unit came into contact with. One routine form of contact was correspondence from the public. This could be to Ministers, to the Unit directly, or in the form of parliamentary questions raised on behalf of constituents. Each of these types of correspondence constituted a performance indicator at the Unit, and

each had a target for completion. Sometimes the Unit received vitriolic letters, whose authors laid claim to public representativeness even when they were directly involved in restricted cases. For example, a Home Office official showed me one letter by the father of a homicide victim, complaining about therapies offered to prisoners when, in his view, there was an absence of support for victims. Despite the demonstrated shifts towards greater support for victims in the criminal justice system, the letter represented the popularly held view that offenders received better treatment than victims. For decision-makers, these letters often required an individual response to the victim, and sometimes to the patient or their care team. Communication from victims was not simply interpreted as the expressions of an individual. Its content also had to be monitored for any potential scandal that might damage the reputation of the system.

The public was also constituted through other forms of expression. For example public polling on the criminal justice system and projected voting behaviour; and newspaper and other media reports about restricted patients all fed into the picture of what the public wanted. If there was significant media interest in the release of a restricted patient, the political implications would depend upon whether the release had been ordered by the Home Office or the Tribunal. As I discussed previously, risks perceived by the Unit included how decisions might be publicly received. One Unit staff member told me how, politically, there was a difference between discretionary leave authorised by the Resident Medical Officer and a decision taken under the authority of the Home Secretary. Unit staff had a role in minimising the political effect of decisions as well as safeguarding public confidence in the system. This role contributed to how the public was conceptualised, as those perceptions could be reflected in media reports and public commentary.

Beyond these generalised conceptions of the public, there emerged a very clear pattern of interaction with two key categories of people with whom Unit staff had contact. These were the families of patients and victims.

*Specific manifestations of the public*

There is an important body of work examining the experiences of prisoners' families which draws parallels between their experiences and those of victims and witnesses in the criminal justice system (for a detailed review and analysis of this literature see Condry 2007). There is also a long-established movement of mental health service users and their families who describe themselves as 'survivors' either of the mental health system or the stigma associated with it, and in some cases as victims (see for example Tait and Lester 2005; Thornicroft 2006; Nacro 2007). As this literature demonstrates, ostensibly clear terms like 'patient', 'victim' and 'offender' often belie the complexities of relationships, interaction and histories that constitute lived experience.

The interaction between the categories of 'victim' and 'family member' was another example of the hybridity of the principles of criminal justice and health in the restricted patient system. In Chapter One I discussed how the restricted patient population encompassed a high proportion of homicides amongst its offence statistics. Mentally disordered offenders were also more likely to have killed family members or acquaintances than other offenders (Department of Health 2001). The impact of mental disorder on many of these offenders' lives (and on their offences) meant that a large proportion of victims were also family members and/or carers of the patient. As such, boundaries between victims and family were significantly blurred. Victims' interests were often directed at concern about the patient's therapeutic progress as well as preventing further harm to themselves or others. To illustrate, I observed one official considering a compassionate leave application where a patient had sought to return home to visit a sick relative. The index offence had been committed against another family member, so the Unit asked the Victim Liaison Officer to check whether the victims objected to the proposed leave. The official was sympathetic to the sensitivities for the victim, but also to the desire of other family members who wanted the patient to be able to attend the family at this time. The Unit's responsibility was to provide information about the proposed leave to the victim and to obtain input about the victim's wishes. The official was awaiting the victim's submission before determining the leave application. However

the official was planning to suggest to the victim that she absent herself from the home during the patient's visits, if that was necessary to enable the patient to go home.

Another official from the Unit explained to me that staff were always considering how much it was reasonable for victims to 'dictate the process.' For example, I observed one staff member responding to a leave application by a patient convicted of rape. The patient had been married at the time of the offence and had two children, one of whom he was permitted to see under supervision by the Family Court. However the children's mother had a new partner who was concerned about the risks posed to his step-children by their father, and he had contacted both the Home Office and the detaining hospital about the matter. The Mental Health Unit took a dim view of his intervention for a number of reasons. Firstly, officials perceived the step-father to be 'obsessed' with the patient and noted that the children's mother had not raised similar concerns with them. Moreover, the father did not live in the area of his family, and visits to his daughter were only permitted under supervision. The Unit proposed to approve the leave, but to include conditions re-enforcing the orders of the Family Court. In the words of an official, the purpose of these conditions would be to 'safeguard us to an extent from any future enquiries from family members'. Thus, for the Unit, the risks involved in this case were as much about negative publicity that an anxious victim could bring upon the system as they were about specific risks posed by the patient. The conditions served a utilitarian purpose for any future contact with the public that might be necessary.

### ***Victim Involvement***

Victims have been prevalent in the specific examples discussed so far in this thesis. The frequent reference to them by Home Office staff could have been in response to the interest that I expressed at the outset of my fieldwork. However the extent to which case anecdotes routinely referred to victims individually or as a population within the system suggested something more than that. It was clear that this group carried particular weight within staff perceptions of the public, and of the Home Office's role within the system. For instance, one Unit member commented that doctors could be resistant to

the Home Office's concerns about victims, seeing them as irrelevant and unimportant to restricted patient cases, but, for the Home Office, victim issues went to the heart of the questions of risk and protection of the public.

Indeed it began to seem as though 'the public' was most clearly and directly conceptualised by Home Office staff through contact made in correspondence or phone calls from victims. Yet, as I have argued, the terms 'victim' and 'offender' suggest simple, discrete categories that were far more complicated in reality. In the restricted patient system, victims might have been unknown to the patient. Equally, they might have been family members or carers who continued to be concerned about the patient's therapeutic progress, even as they entertained concerns about their own safety. Victim status was even further complicated in cases where a successful insanity defence meant that the person who committed the act was acquitted of criminal responsibility for an offence.<sup>26</sup>

There has been considerable criminological interest in the typology of victim-offender relationships, and the notion of victims and offenders as dichotomous categories has been widely criticised (see for example Von Hentig 1940; Davies *et al* 1996; Zedner 2002; Stubbs and Tolmie 2005; Walklate 2007). Moreover, as Rock has pointed out, "victim" itself is not necessarily considered an appealing term. It is contradictory, connoting ... images of pariah and saint' (Rock 2002:14). Yet general conceptions of victims and offenders as ideal types still abound (Christie 1986), and there is very little empirical evidence of how victims feel about the people who victimised them, or the systems (criminal justice and otherwise) with which they come into contact as a result. As Rock posits:

what is the significance of being a victim (as opposed to being the occupant of some other or no well-defined role at all); how are identities distinguished, selected and enacted as, say, angry, campaigning, chastened, fearful, self-reproachful, cynical, nonchalant or resigned victims; how do those selves interplay with the wider biography of the victim and with retrospective and prospective readings of his or her identity; how much are they stereotyped and how much the result of reflective consideration and remodelling by the

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26 As discussed in Chapter One, successful insanity defences were relatively rare in England and Wales at the time of this research.

victim himself or herself; how are they shaped by readings of the offender and his or her motives and, reciprocally, of the offender's readings of the victim's behaviour; how do they sit with beliefs about fate and agency in human affairs; what practical, existential and moral consequences flow from the acquisition of victim selves; what parts do others play in formulating those interpretations; when and how would a victim seek their support, take action or call upon outsiders, amongst them the police; and when, most importantly, is victimisation an enduring signifier? In short, when and with what consequences does a person understand himself or herself to have become some existential entity called a victim (Rock 2002:18)?

My research did not seek to answer these questions directly. However, what was emerging from my data was the strong effect that those who identified as victims had upon Hawkins' notion of the 'surround' of Home Office decision-makers (Hawkins 2003). I was curious about what decision-makers understood by the notion of victim, and to what extent this conceptualisation influenced their broader notion of 'the public', within the restricted patient system.

The Home Office at large presented a very clear perception of victims that was evidenced by the language of its policies and publications at the time. Statements such as 'reforming the justice system so that the needs and rights of victims and witnesses are placed at the heart of what we do' and 'your rights as a victim' littered Home Office press releases, publications and policies released during the period of my fieldwork. Perhaps the most significant statement in this regard was New Labour's policy of

rebalancing the criminal justice system in a way that gives the law-abiding public much greater involvement in the criminal justice services they receive. That starts with ensuring *the needs of victims must be at the heart of what the criminal justice system does* (Home Office 2006, emphasis in quotation).

No longer could it be said that victims were 'forgotten' by the criminal justice system (Shapland *et al* 1985). Indeed, as Walklate notes, 'a concern with and for the victim of crime has become not just a symbolic reference point in government policy but the dominant one' (Walklate 2007:7). From policy and public statements by the Home Office, attention to victim-related concerns

and a focus on victims in policy were being reflected at the highest levels of Home Office visibility. However it was unclear to what extent these slogans reflected novel approaches in the work of the Home Office rather than rebranding the same practices under new slogans. At the same time, these slogans had some very clear implications. As civil liberties lobby group Liberty has argued, the notion of 'rebalancing' implied the idea of positioning the criminal against the presumption of innocence, in favour of victims and against the interests or rights of offenders (Chakrabarty 2007).

Chapter One reported the strong criticism levelled at the Home Office that criminal justice policy was being politicised in line with a perceived rise in public punitiveness and against the collected evidence of a vast body of criminological research. Indeed, the 'politicisation of the civil service' was a concern that underpinned broader debates about the relationship between the bureaucracy and the executive at the time, informed by the widespread perception that 'the old version of the "public service bargain" in which there was an implicit division of responsibility between ministers and civil servants has become confused' (Public Administration Select Committee 2007).

Yet these messages from the Home Office were not evidence of some new process in the presentation of public policy. The interaction between public opinion and policy has always been fluid. In fact, it is 'the ability of the person to put himself in other people's places that gives him his cues as to what he is to do under a specific situation. It is this that gives to the man what we term his character as a member of the community; his citizenship, from a political standpoint' (Mead 1934:270). This 'community' is not itself neutral or objective-free. There are social 'rules' that determine which issues capture the public imagination and which do not, as Lippmann explained.

There is a description of some aspect of the world which is convincing because it agrees with familiar ideas. But as the ideology deals with an unseen future, as well as with a tangible present, it soon crosses imperceptibly the frontier of verification. In describing the present you are more or less tied down to common experience. In describing what nobody has experienced you are bound to let go. ... The formula works when the public fiction enmeshes itself with a private urgency. But once enmeshed, in the heat of battle, the original self and the

original stereotype which affected the junction may be wholly lost to sight (Lippmann 1922:109).

In the symbolic politics of law and order, the 'public fiction' was both produced and re-enforced by the representation of victims and offenders as distinct, disparate categories. In turn, this informed the ability of executive decision-makers to put themselves 'in other people's places' and offer the reassurance to victims that I discussed in the last chapter. However, as my data have suggested, the binary opposition between victims and offenders that was reflected in Home Office policy statements contrasted strikingly with the close level of interaction between victims and offenders in the restricted patient system. It seemed that the oppositional notion of victims and offenders was more a manifestation of the idea of a disembodied public than recognition of the interests of victims themselves.

The gap between perceptions of victims and what victims themselves wanted was no more evident than in the gap between the rhetoric of the Home Office and advocacy for victims by The Zito Trust. It was the only charity that specifically represented the interests of victims of mentally disordered offenders. The Zito Trust described its work in the following terms.

We respond to primary and secondary victims of mentally disordered offenders, to carers of mentally disordered offenders, to those who feel they may be at risk of becoming a victim, and to people who have concerns about service provision in the community or at work. In some cases of homicide we have actively helped the families of both the victim and the offender. Families on both sides are victims, in our view (The Zito Trust 2006).

In this description, The Zito Trust attempted to provide a nuanced account of the lived experiences of victims, as people equally supportive of 'the offender'. In many ways the work of the Trust reflected the symbolic politics of the restricted patient system, and it was referred to variously as a victim organisation and a mental health charity in political and media discourse (see for example BBC 2006).

Yet their attempt to complicate the categories of victim and offender failed to influence the dominant representation of victims in New Labour policy, which

persisted with its imagery of a binary opposition between the two. The objectives of victims themselves seemed to take second place next to the political agenda of the day, such that 'victims and witnesses came ineluctably to take some part of their character from their relation to the twin imperatives of crime reduction and public confidence' (Rock 2004:38).

Earlier in this chapter I discussed how the release of patient information emerged informally in Mental Health Unit practice, in response to the perceived imbalance between victims who could obtain information about offenders but not restricted patients. As Rock has described it,

the matter was particularly harrowing for an anomalous and distressed group of secondary victims, represented by such organizations as Justice for Victims and The Zito Trust. And there was the question of consistency: it was, thought Home Office Ministers, indefensible, intellectually as well as politically, to treat patients differently from other sentenced prisoners and, they protested, 'our commitment to the rights of victims and protection of public is a matter of public record' (Rock 2004:163-5).

The idea that not releasing information about restricted patients was 'indefensible' indicated the *realpolitik* of the policy environment in which executive discretion over restricted patients was exercised. Withholding such information was defensible precisely on the basis that it had always been, in the interests of patient confidentiality. Yet the external pressures from members of the public who claimed to speak on behalf of victims made it much harder to continue to exempt restricted patients from policies that applied to offenders. In turn, this reality clearly indicated the extent to which the Home Office identified restricted patients primarily as offenders.

By the time I was conducting my fieldwork, the position in practice had been formalised as a policy to provide victims with information about restricted patients. This policy extended to the Department of Health, who had recognised victims of crime as an interest group within their own policy domain. In particular, a Mental Health Unit official explained that confidence in the process had been being undermined because victims were so dissatisfied with the system. The extent to which this assertion had produced significant policy change also reflected the political effectiveness of The Zito

Trust. Members of lobby group the Mental Health Alliance spoke with some chagrin about a meeting convened by the Department of Health following the report of the Joint Scrutiny Committee on the draft Mental Health Bill 2004 (discussed in detail in Chapter Six). While the Alliance was not invited, the meeting was attended by The Zito Trust along with some other non-government organisations. Likewise, a Home Office official spoke of a separate meeting on the needs of victims that had been organised by The Zito Trust and a member of the Metropolitan Police. It was attended by all ministers from the Home Office and by Health Minister Rosie Winterton (responsible for the review of the *Mental Health Act 1983*). In the official's view the meeting had been 'quite a coup' and demonstrated the significant political influence of The Zito Trust.

Vengeful sentiments are often attributed to victims and their advocates (Stanko 2000; Zedner 2002), and quotations from victims such as 'nobody worries about the victims at all these days' have been used to embellish reports of 'scandalous' decisions to release restricted patients (Johnston 2005). Similarly, the dominant media representations of victims of restricted patients were generally vengeful. Indeed many have remarked on the return of vengeance to popular and policy acceptability within the new penology (see for example Garland 2001; Downes and Morgan 2002). Yet the extent to which these sentiments accurately reflect the nature of victims' interests or concerns has been questioned (Rock 2004), and evidence from the British Crime Survey has suggested that victims are no more punitive than anyone else (Hough and Roberts 1998; Reiner 2007).

As the victim organisation most focused on the area of mentally disordered offenders, The Zito Trust did not actively propound vengeful sentiments.<sup>26</sup> Its policy platform focused upon systemic reform to improve health care for patients as the best prevention of harm. The victim lobby within the mental health law reform process was generally believed to be on the 'side' of the

26 While The Zito Trust had a relatively high profile and attracted a share of media attention, there were other groups available to make more dramatic, headline-grabbing comments. For example, the home page of the web site for the Victims of Crime Trust featured the following quotation from the News of the World: 'There are 100 support groups to help criminals. But just ONE for these murder victim's families (The Victims of Crime Trust) ...' (<http://www.voc.webden.co.uk/>, emphasis in quotation).

government, in supporting greater control over patients in the community. Yet the control agenda supported by victims was never ascribed to vengeful or punitive sentiments, either by those representing the interests of victims, or of government or non-government organisations. On the contrary, one clinician felt that the vengeance portrayed in relation to victims was actually propagated by government as it sought a mandate to impose greater restrictions on patients. He stated that victim sentiments were 'used by government' for political mileage, when in fact victims almost always wanted treatment to make the patient better. Rock has argued that whilst victims sought to assert their agenda in addition to those already in New Labour's policy framework, the government response was simply to subsume victim interests within 'frames that actually served other policies and politics' (Rock 2004:39). Once again, that approach perpetuates the notion of 'ideal' types of victims and offenders and obscures the character of victims and their objectives within the system. Its legacy could be seen in the ongoing attempt to 'rebalance' criminal justice, as though the system were comprised of individual, categorical interests evenly spaced along a continuum, rather than the deeply complex lives of victims, offenders and their families.

The upshot of victim involvement in the restricted patient system was that victim rights to information about discharge and the ability to make representations to decision-makers were extended to restricted patient cases under the *Domestic Violence, Crime and Victims Act 2004*. In addition to formalising victim status for the purpose of obtaining information on restricted patients, this also required the Tribunal to engage directly with victims for the first time. But, as I shall explore in the next section, that policy did not necessarily make a practical difference to the operation of the system.

### ***How did Other Actors View Victim Involvement in the System?***

Despite The Zito Trust's careful articulation of their objectives as systemic reform rather than seeking vengeance on patients, there was a general concern amongst non-government actors that victim involvement could produce punitiveness towards patients. In part, this was an acknowledgement of the high public profile and media attention that particular cases attracted, and the disrepute they brought upon the system as

a whole. For example, Taylor and Gunn had expressed the following concern about the work of The Zito Trust.

In spite of its best endeavours to be as sensitive to the needs of people with a mental illness as to those who have died at the hands of a very few of them, in practice it may have served most prominently to highlight the killings and a drive to more restrictive care (Taylor and Gunn 1999:9).

Taylor and Gunns' comment here illustrated fears that increased attention to victims would increase the stigmatisation of mental health patients. Thus, while The Zito Trust did not necessarily advance a punitive agenda, its work was seen by some to feed the symbolic politics which fuelled the prioritisation of control over care. The Trust's agenda was constructed as much as anything else out of the fears and projections that were commonly held about mental health patients, however ill-founded the public expression of those fears might have been. Yet, other actors in the system showed little initial interest in the development of victim-focused policies. In Chapter Six I will show that the Mental Health Alliance did not address this agenda in its advocacy for the draft Mental Health Bill 2004. Moreover, legal and clinical practitioners seemed to have given very little consideration to the question of whether and how formal victim interaction might affect the system and the progress of patients through it.

In a number of interviews, my questions about victim involvement seemed to prompt the first serious consideration of the matter. In 2005 the Mental Health Review Tribunal announced that it was implementing procedures to bring it in line with the provisions extending victim involvement to restricted patient cases (MHRT 2005). This policy involved notifying victims of hearings for restricted patients and permitting victim submissions on leave or discharge applications. This was the first time that the Tribunal was undertaking to engage routinely with victims in its hearings. Yet when I conducted my fieldwork, most research participants across government and beyond were unaware of these procedures, and practitioners who were aware of their existence were unfamiliar with their detail. As I probed this issue during interviews, practitioners began to give greater consideration to the effect that this policy might have on the system. Generally, they felt both

that victims should not influence Tribunal decisions and that the new policy would have no substantial effect in that regard. As one lawyer put it in an interview with me,

if I was faced with a situation where suddenly I saw a victim statement before the Tribunal, I would immediately ... seek to have it put aside. And certainly if I thought in any way it was involved in swaying the Tribunal in its decision, then I think it would be a matter for judicial challenge.

Interestingly, the new policy did not stipulate what weight the Tribunal was to place upon victims' submissions. Lawyers consistently stated that victim statements should have no bearing on decision-making about restricted patients. This indicated how accustomed legal practitioners working in the mental health system were to operating without formalised victim participation. By contrast, criminal justice processes had established Victim Personal Statements, where a record from victims was included in the official papers of a case file, which might come before police, prosecution and defence lawyers and courts (Home Office 2001).<sup>28</sup> My research was completed before there was any evidence of how the Tribunal's victim policy was actually implemented, what affect it had upon Tribunal decisions, and whether it would be challenged or resisted in other ways by legal practitioners.

Many practitioners conveyed both a professional and a personal view about victim involvement in the restricted patient system. I have discussed how professionally they were concerned about the relevance and legal validity of considering victim statements when making decisions about restricted patients. Personally, practitioners expressed the belief that formal engagement by victims at the point of decisions about leave or discharge was counter-productive for the victim's own recovery. Many lawyers I interviewed argued that the most important time for formal intervention by a victim or their family was after the court had made a restriction order. Such intervention, in their views, should include an explanation about the restricted patient system and what would happen to the patient going through it. The

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28 Although the effect of Victim Personal Statements has been the subject of some questioning (see for example Morgan and Sanders 1999).

following excerpt from one interview with a lawyer was typical of responses on this issue.

If the last time that the patient was seen by the victim or the victim's family, they were sort of highly dangerous and extremely mad and very frightening ... that's the image that remains with them. ... to do work at the very very beginning to explain what's happened to that person, where they've gone, what they're going to have to go through, not in any way that breaches confidentiality but just in a way that explains the process, might be useful.

To some extent this reflected a sanguine view of the effects of therapeutic intervention. Equally however, it was supported by the examples given earlier, where psychiatrists and Home Office officials who took time to explain the restricted patient system to victims found that victim concerns were significantly alleviated, even to the point where they no longer objected to a patient having leave in the community.

One of the reasons The Zito Trust advocated victim involvement in Tribunal hearings was that victims often had important information about the patient that would benefit clinical interventions. Lawyers concurred with this sentiment, but felt that such information should be obtained initially, when the patient first entered the system, when the experience was fresh in everyone's mind, and when it would have the greatest impact on the patient's treatment plan. One practitioner suggested that it might be useful for care teams to hear from victims when a patient was first admitted because,

for treatment purposes it would obviously be extremely helpful for the treating team to really understand the dynamics of what was going on. Because it may well be that the only side they get is the patient's side and he might not have a very good recollection of it or be able to express it very well.

Legal practitioners also said it was important for leave and discharge planning to know the status and interests of victims at the very outset. One stated that a number of cases had been held up unduly because all the discharge preparation had taken place, at a great cost of time, referrals and assessments, only to be rejected by the Home Office because of the presence of victims in the vicinity of the proposed area. In such a case, it was

vital for both the lawyer and the treating team to be aware of any victim involvement from the outset of the restriction order.

Clinicians expressed sympathy for the position of victims, but saw continuing victim interest as a conundrum for victims as well as for patients. In the words of one psychiatrist I interviewed,

I suppose that I would accept that a victim probably has a right to know that somebody has been released, because of the argument they might meet somebody. Whether it's good for them to know that the person's been released is another matter. It might actually make them fearful when they need absolutely not to be fearful.

This clinician shared the concerns of lawyers discussed above, and illustrated a clinical perspective on the benefit or otherwise of victim involvement in restricted patient cases. It demonstrated an approach to victim involvement determined by what was in a victim's best interests, rather than a victim's right to information. The paternalism inherent in such an approach has been widely criticised as a form of secondary victimisation by denying victims access to the information they seek (see for example Newburn and Merry 1990). Consequently the position increasingly adopted by criminal justice practitioners including police and victim organisations had been that it was best to afford victims a choice rather than presume to know what information was in their best interests (Maguire and Kynch 2000).

It became clear that there was a notable difference between how the Home Office and practitioners viewed the involvement of patients in the restricted patient system. For Home Office staff, victims constituted a sector of the public with whom they had a lot of contact in the form of phone calls, correspondence and organised representation from groups like The Zito Trust and others. As a result victims had significant influence on the executive's conceptions of the public, in whose interests their mandate operated.

By contrast, victim interests were taken by practitioners essentially to be a political issue. This allowed practitioners to relegate any engagement with victims to the Home Office, despite the fact that victims were increasingly

involved in formal processes like the Tribunal and case conferences. The emerging focus on victims bore little relation to how practitioners conceived of the Home Office's focus on the public protection agenda. This proved something of a paradox. On the one hand, non-government actors relegated engagement with victims to the Home Office. Non-government organisations clearly recognised the extent to which public protection consumed the Home Office. Yet practitioners had not reconciled the interaction of these two aspects of the executive's mandate. Specifically, there was little consideration of how victim involvement might shape Home Office perceptions of the broader public, amongst the non-government participants in my research. As a result, those outside of government were unable to counter effectively the concerns about risk that they constantly confronted when seeking leave or discharge, and which consistently formed the basis of their criticisms of the Home Office.

### ***Did Patients Constitute Members of the Public?***

So far family members have featured as a complex but nevertheless acknowledged constituency within the various constructions of 'the public'. This left the question of where patients themselves sat on the spectrum of public interests. Patients could have been considered in terms of their own vulnerability, as there is considerable evidence that mental health service users have higher rates of victimisation than others. Colombo investigated the victimisation of mental health service users in terms of non-criminal acts such as harassment or exploitation by family members, and in terms of criminal offences including repeat victimisation (Colombo 2007). Despite the dominant view that mental health service users were themselves risky individuals, he found that they were subject to the same risks of crime and victimisation as the general population; that their mental illness might render them even more vulnerable to certain forms of victimisation; and that they were particularly susceptible to systemic failures to take their victimisation seriously because of their underlying status as mentally disordered. Nevertheless, Colombo argues, because society is less able to acknowledge and absorb the risks to patients than it is the risks from patients, the public protection agenda is aimed at protecting 'innocent us' against dehumanised, risky others (Colombo 2007).

Indeed, some research has indicated that patients have specific fears of crime and victimisation related to the very fact of their being restricted patients. Ardron's research into the effects of media representations on restricted patients in a medium security unit showed that fear of violence when on leave in the community was a common preoccupation of patients, a number of whom had experienced hospitals cancelling their leave to minimise problems such as the risk of adverse publicity while the patient was out on leave (Ardron 2007). Participants at the Home Office told me similar stories of protecting patients from the victims who were actively protesting against them outside hospitals and in the community. One official explained that the decision to permit leave was made with regard to the risk of the patient being exposed to harm as much as it was to the damage in public confidence that could be caused by any adverse attention in the case. Another staff member spoke of a case where a hospital had sought escorted leave for a patient convicted of murder. The proposed leave was to be spent in a place far from the geographical region in which the victim's family lived. The Minister had been unwilling to approve the leave because the victims were so opposed to any leave that they had threatened media attention in the case. Unit staff met with the patient's care team to see for themselves how the patient was progressing, and re-submitted the recommendation to the Minister detailing the distances involved between the location of the proposed leave and the residence of the victim's family. The leave was eventually approved. In this way staff had sought to placate concerned victims and the possibility of the negative attention they might bring to bear on the case, yet had still supported a recommendation for leave from the patient's care team. They had also used their own, detailed knowledge of the case to convince the Minister that there were no unreasonable risks to the public by the proposal.

However, on the whole, the exclusivity with which Home Office staff interpreted their mandate consistently asserted the consideration of public protection over patients' interests. Only one official described patient welfare as integral, rather than incidental, to the process of decision-making about leave or release. For the majority of Unit staff, the interests of the public were

diametrically opposed to those of patients. Given such a binary opposition, there simply was no capacity within the Home Office's decision frame to consider patients as members of the public. For example, answering how the public profile of a case fed into the Unit's risk assessment, one official told me how the Unit was at the interface between politics and patients. Cases were assessed on the basis of objective criteria, but additional factors needed to be taken into account, such as the likelihood of the public attending a site where a patient would be, or of media attention when a patient was on leave. As a result, events had to be managed with respect to the public's confidence in the system. Thus, in practice, the Unit was perpetually analysing the perceived risks of decisions so as not to undermine confidence in the system, as well as assessing any physical risks posed to the public.

Undoubtedly this approach was informed by popular perceptions of the supposed dangers posed by mentally disordered offenders. As I have already discussed, the Home Office was acutely aware of the political liability that was manifest in negative media attention. Suggestions that the Home Office was 'soft on crime' could be levelled just as easily for its approach to mentally disordered offenders as for other offender populations. Yet there was reputable evidence to counter such perceptions. The report of the Joint Scrutiny Committee on the Draft Mental Health Bill noted that 'it should not be overlooked that prison staff and fellow prisoners are members of the public' (2004:vol 1, para 272). While the comment was specifically in relation to prisoners transferred to hospital for compulsory treatment of their mental disorder, the implications applied to offender populations across the board.

The Home Office's construction of the interests of patients in opposition to the public was also strongly contested by practitioners in the system. One lawyer stated during an interview, 'I understand their position, which is protecting the public, but actually the concept of the public that they ought to be addressing includes the patient, who's a member of the public'. She referred to the Home Office's mandate 'to build a safe, just and tolerant society for everyone in the UK' as evidence of this (Home Office 2007). She argued that this meant 'justice for all, not just justice for some', and that the

Home Office had a role to treat all people fairly, not to divide them into categories and treat them accordingly.

Essentially, her view reflected those of many practitioners I spoke to, who argued that patients should not be seen in terms of risk alone, but should also be acknowledged as requiring protection. Yet again, this standpoint failed to recognise how, at the level of government, the interests of victims had become influential in notions of 'the public', and by extension in the risks faced by the public. There simply was little scope for the Home Office to construct the public as inclusive of patients, when it continued to conceive of victims and offenders as mutually exclusive categories.

### **The Politics of Protection**

Politics is interesting when there is a fight, or as we say, an issue. And in order to make politics popular, issues have to be found, even when in truth and justice, there are none - none in the sense that the differences of judgment, or principle, or fact, do not call for the enlistment of pugnacity (Lippmann 1922:106).

Within the already tricky terrain of public protection, there were certain areas that were considered the most difficult or sensitive and required the highest authority over them, in the form of a ministerial decision. These were generally described by Home Office participants as the cases that involved a high degree of risk, difficult victim issues, or 'really nasty stuff'. Such characterisation implied that there were some decisions that presented even greater levels of risk than usual. But to whom was this exposure directed? What set these determinations apart from the plethora of decisions that were constantly being made to protect the public from risk?

Some matters were sent for ministerial approval as standard practice. One official explained that a matter would go back to a minister if it had had previous ministerial involvement. Sometimes ministers had requested for applications in particular cases to come directly to the minister for determination. These included cases where either the patient or the victim was particularly high profile, or where the incident had been an issue of interest to constituents in the Minister's electorate. Ministers were also sent

cases where greater than usual activity by solicitors suggested to Mental Health Unit officials that judicial review was being considered.

Beyond the cases of particular victims or patients, another area that was considered to have a high profile was matters involving diplomatic relations. One brief being prepared for the Minister during my fieldwork concerned a woman who had killed her husband because she thought he was going to take her baby daughter back to his home country of Pakistan. Initially perceived as delusional, Mental Health Unit staff had come to believe that the woman's fear might have been well-founded because her husband had been so troubled by her mental illness. Here was another example of how a decision-maker's familiarity with a case gave him or her a sense of particular insight into the issues at stake. The case was notable because of the widespread support the patient had received from her local community. Her parents were supporting her, looking after their daughter's child during her detention. The patient's social worker had made contact with the family and with networks in the community including the family's mosque. All were supportive of the patient and the Unit were now considering favourably her application for leave for a home visit. However, the case was perceived as being particularly sensitive because of the involvement of the Pakistani community. The decision was referred to the Minister so that he was forewarned of any public attention that might arise from the case.

As these examples indicate, the formal mandate to protect the public was frequently mirrored by the informal mandate to protect the system from reputational damage and, most particularly, to protect the Minister. Edelman once suggested that,

administrative agencies are to be understood as economic and political instruments of the parties they regulate and benefit, not of a reified 'society', 'general will', or 'public interest'. At the same time they perform this instrumental function, they perform an equally important expressive function for the polity as a whole: to create and sustain an impression that induces acquiescence of the public in the face of private tactics that might otherwise be expected to produce resentment, protest and resistance (Edelman 1964:56).

The political sensitivities of the restricted patient system were inextricably linked to the vulnerabilities of individual ministers and the government itself. While officials in the civil service have always been responsible for protecting their ministers from embarrassment, the criminal justice system comes under particularly intense media scrutiny on a daily basis for decisions that might lead to a public outcry or calls for ministerial action. Earlier in this chapter I discussed the concerns voiced by some that these processes were leading to an increasingly politicised civil service. Yet, in the restricted patient system, this shift was unavoidable. The high profile of serious and violent offenders was consequential on the role of Mental Health Unit staff in protecting the Home Secretary. Unit staff were keenly aware of the damage to the reputation of the system, and implicitly to the Home Office, that could arise from negative media attention. Thus officials were sensitive to any case that might attract public attention even outside the realm of concern for safety, and would routinely refer these to Ministers for a final determination.

The official view from the Unit was that the potential for adverse media publicity could irritate staff and the system, but would not directly influence the decisions that were made. However, on further probing, it became clear that the consideration of how a decision might affect public confidence in the system necessarily had to take account of any possible media attention. Staff identified some matters that warranted ministerial determination because of their political sensitivity, not necessarily because of particular risks to the public. In some cases it was a risk from the public, for example in the public attention that certain patients attracted. Consequently, these were decisions that exposed the system, and ultimately the Minister, to reputational damage.

A good example here was a matter that arose in relation to Peter Sutcliffe, a restricted patient who had been convicted of the murder of 13 women from 1975-1980. Dubbed the 'Yorkshire Ripper' in media and public accounts (see for example BBC 2001), he was one of the highest profile restricted patients at the time of my research and was subjected to persistent media attention throughout the history of his criminal trial and ultimate status as a restricted

patient.<sup>29</sup> During my fieldwork, media attention was focussed on a decision by the Home Secretary to grant leave for Sutcliffe to visit the site where his father's ashes had recently been scattered. The decision was publicly attacked for being insensitive to his victims. The Home Office defended the decision on the grounds that this would give him 'closure' having been denied compassionate leave to attend his father's funeral (Jay and agencies 2005; Johnston 2005). Media reports indicated that the decision had been made by one Home Secretary and reaffirmed by the next after a new Minister was appointed to the portfolio. Unit staff were not surprised that the matter had attracted such attention. They confirmed to me that the decision had been made and subsequently reaffirmed by two successive Home Secretaries, which was itself an indication that the Home Office had anticipated widespread public interest ahead of the decision. Nevertheless they had decided to approve the leave anyway because, in the words of the then Home Secretary David Blunkett, "it was the right and proper thing to do" (Jay and agencies 2005). The Unit regularly had to judge applications for patients to enter the community in the face of a risk of harm to the public or a risk of symbolic harm to the reputation of the system. But the added sensitivity of this case, where the index offence had been of great public interest and the patient and his victims remained extremely prominent, necessitated direct ministerial authority for the ultimate decision.

In another case referred to the minister, the patient had been convicted of the murder of one woman and had seriously injured another woman who had come to the aid of the first victim. The offender was a foreign national and a repatriation request had been successfully negotiated with the diplomatic mission of the patient's country of origin. The patient was Muslim and was reported to have been holding a copy of the Quran during the attack. The offence had received considerable media attention at the time, added to

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29 Although a sentenced prisoner, Sutcliffe was moved to Broadmoor Hospital in 1984 under a transfer direction (*Mental Health Act 1983:section 47*). As is usually the case with transfer directions, a restriction order was imposed vesting decisions on his discharge with the Home Secretary (section 49). Consequently Sutcliffe formally became a restricted patient. I have not focused on transferred prisoners specifically because their discharge from hospital usually results in a return to prison, unless they remain detained in hospital after the expiry of their prison sentence. Because of the particularly long period of Sutcliffe's detention in hospital, decisions about his release into the community have continued to be made by the Mental Health Unit (to date only in relation to leave).

which the BBC had been making a documentary in the police station where the accused was charged. Interestingly in this case, victim interests were not perceived to be a cause for caution in considering the patient's discharge. The murder victim's family lived in Eastern Europe and it was believed, although not known for sure, that there was no family in the UK. The victim's family were known to have opposed the mental health disposal of the case and believed the offender should have received the death penalty, despite the fact of there being no such punishment in the UK. The police and Crown Prosecution Service had had contact with the family, but the Mental Health Unit had not. The ability of the victim's family to attract public attention to their opposition was limited because of their geographic isolation from the media as a result of being outside the UK. Meanwhile the second victim (who had survived the attack) took a sympathetic approach to the offender, having stated in court and to local media that she believed the offender should receive appropriate treatment. The case was referred to the Minister because of the history of media interest at the time of the offence. The referral included a proposed media strategy outlining 'lines to take' should there be further media interest in the case. These included not commenting on the individual case but outlining the provision for repatriation under the *Mental Health Act 1983*; and only releasing 'if pressed' the details of the hospital at which the patient was currently detained, the country of proposed repatriation, and that the Home Office were satisfied with all the arrangements that were in place. Significantly here, victim involvement presented a low risk of scandal or public outcry at the decision to discharge the patient for repatriation.

These two examples indicated a range of cases where the Home Office anticipated public and media interest but approved an application anyway. The first case had resulted in considerable criticism of the Home Secretary; ultimately there was no media attention in the second case. Contrary to the criticisms of some practitioners, the Home Office did not oppose leave or discharge at the slightest hint of negative public attention. At the same time, both cases indicated that potential media attention had a direct effect upon the decisions made. In the Sutcliffe case, the patient had been denied the opportunity to attend his father's funeral on the grounds that the public outcry

would have been too great. A balance was constantly being sought by officials between how much public pressure the system could withstand in the face of decisions to approve applications from restricted patients. Where a decision was likely to attract media attention, plans would involve a strategy for dealing with media attention, should it arise. These precautions reassured the Minister that any unwanted attention had been anticipated and planned for; thereby safeguarding the reputation of the system.

Behind the scenes of individual case decisions, a broader part of the Unit's 'risk management' strategy utilised the established relationship between the Home Office and the media. As was common practice throughout the civil service, the Home Office had developed networks with the police and media, and had a Press Office dedicated to working with the media. While these strategies might not necessarily make the media biddable, demonstrated by the many scandals focused on the Home Office, such relationships were noteworthy as an indication of the extent to which the bureaucracy was able to engage with the media. While mental health organisations utilised media strategically where they could, there was an absence of such well-developed relationships between media and the mental health sector, as evidenced by the stigma still attached to people with mental disorder (Colombo 2007).

Tangential to the Unit's responsiveness to media attention was a concern about sources of 'inside' information. One staff member told of non-qualified nursing staff who were believed to have been leaking patient details to the press in particular cases. The evidence for the allegation included a notable upsurge of such stories at Christmas time, suggesting that people were making money to spend at Christmas. In one case the leaks had been to a particular paper from a private medium secure unit, so it was believed by officials that a journalist had secured a contact at the hospital. Other research had also pointed to information leaked by hospital staff about restricted patients (Ardron 2007). In summing up the Home Office's relationship with the media (and indeed the public more generally), an official told me that the Unit could not control the publication of such information or 'leaks', but it could work strategically with care teams to manage the situation and possible outcomes.

## Conclusion

By focusing on the construction and effect of public interest in the restricted patient system, this discussion has considered not just how discretion is exercised, but what constrains it (Gelsthorpe and Padfield 2003; Hawkins 2003). Even as Home Office decision-makers talked about 'the public', a clear picture emerged of to whom they were referring. There was the broad, amorphous 'anyone and everyone'. These were unidentified members of the general public whose very anonymity indicated successful leave or discharge. They would often only be identified in the event of a problem arising, for example a member of the community making a complaint to police about the behaviour of a patient when on leave from hospital. It was this construction which served to legitimate the status of Unit staff as lay workers in the system, because it allowed staff to claim to be representative of a general public in the interests of whose safety the Home Office acted. This broad construction of the public also encompassed the 'voting public', to whom the executive were democratically and ultimately accountable.

The second type was readily identified in the many examples from patient cases that arose during interviews and observations. This was the public as represented by victims and their families and by the families of patients. They were members of the public by virtue of the fact that they were not professionals or practitioners working in the system. Yet they had a direct interest in that system, usually motivated by the one particular case with which they were personally involved. These were interested parties who were routinely cited by Unit staff when I questioned them about how the public affected Unit decision-making.

Thirdly, the formal acknowledgement of the public protection agenda by the Home Office overlay another, equally important function of civil servants: to protect the political sensibilities of the system, and ultimately the Minister, from negative attention. This led to a consideration of media interests as an inseparable component of the public interest in particular cases. The likelihood of media attention did not necessarily mean that a leave application would be rejected. But the media, like victims, emerged as integral to the

constructions of the public which informed the decision frame of Home Office decision-makers.

## CHAPTER 6

### PATIENT RIGHTS VS PUBLIC PROTECTION: REFORMING THE *MENTAL HEALTH ACT 1983*

#### Introduction

The reform of the *Mental Health Act 1983* was a long and hotly contested process. It began years before my doctoral project and continued throughout my fieldwork, resulting in amendments to the *Mental Health Act 1983* and a new *Mental Health Act 2007*. In fact, there were still aspects of the reform underway at the time of writing, including the finalisation of a Code of Practice to accompany the new legislation.<sup>30</sup> The process of reform was lengthy, complicated and fascinating enough to warrant its own thesis. In this chapter I focus on one aspect of the reform process: the role of the Joint Scrutiny Committee that reviewed the draft Mental Health Bill 2004. The Scrutiny Committee was appointed by the House of Lords and House of Commons in July 2004 to examine the draft Mental Health Bill 2004 and to report to both Houses by March 2005. Because of their interest in proposed reforms to the mental health system, the Scrutiny Committee had attracted the attention of many of the people and organisations I was seeking to contact. As such, it provided an ideally contained site to meet potential participants in my fieldwork.

The Scrutiny Committee ended up serving a number of very important purposes in my research. Methodologically, the Scrutiny Committee became the key recruiting ground for participants. Empirically, the draft Bill was the clearest indication of the government's agenda on dangerousness, and the Scrutiny Committee provided an avenue to hear the government argue and defend its case. Analytically, it demonstrated precisely how the dynamics and politics of the restricted patient system operated. Sociologically, the process

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<sup>30</sup> Amendments to the *Mental Health Act 1983* were introduced in 2007 and a new Act was introduced into parliament. At the time of writing the *Mental Health Act 2007* was scheduled for implementation in Autumn 2008.

surrounding it was remarkable for the way that issues relating to mentally disordered offenders were integral to many of the debates that took place.

It was therefore ironic that forensic patients received very little direct attention throughout the entire law reform process and there was almost none paid to restricted patients specifically.<sup>31</sup> Protection of others was already an established principle in the care of forensic patients who were receiving compulsory treatment under the *Mental Health Act 1983*. However, there was considerable government anxiety about those believed to be dangerous but who did not meet the criteria for detention under the *1983 Act*. In particular, as I shall show, the question of how to control people believed to have a dangerous and severe personality disorder was absolutely central to the government's policy objective. It was these people who drew the government's attention in its agenda for the reform of the *Mental Health Act 1983*.

In this chapter I shall examine the proceedings of the Scrutiny Committee to consider firstly, how the government's agenda to control dangerousness emerged through mental health law reform; and secondly, how non-government actors responded to that agenda. It is not my intention to analyse the history, process or outcomes of the mental health law reform process. Rather, I shall examine the Scrutiny Committee as a specific aspect of that reform, in order to explore the interaction between the dynamics of the mental health and criminal justice systems and the executive's mandate for public protection. Throughout the chapter I shall draw on data from documentary analysis and observation of the written and oral submissions to the Committee; the Committee's Reports; and my interviews with people from government, practitioners and non-government organisations involved in the restricted patient system.

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31 As I set out in Chapter One, 'forensic patient' is a collective term that refers not only to mentally disordered offenders receiving treatment in hospital, but also to mental health patients for whom there is a high risk or evidence of dangerousness. These patients are often treated in secure hospitals. It is a broader term than 'mentally disordered offender' and includes - but is not limited to - restricted patients. I use it in the present chapter because much of the discussion revolves around people considered to be dangerous but who do not necessarily have a record of criminal conviction.

During my research, some of those I spoke with felt that the process of reform had been mishandled, as evidenced by the eventual withdrawal of the draft Mental Health Bill 2004. However, I contend that the government's agenda and the responses it invoked were wholly illustrative of the complexity of the terrain, and were both a product of and a contributing factor to the ongoing tensions between government and non-government perspectives on the balance between public protection and the interests of patients. The reform of the law was a fascinating process because it simultaneously reflected those tensions and became subject to them; an inevitable consequence of the various - and some would say competing - priorities of government, practitioners and non-government organisations in the mental health system.

### **The Process of Reform**

The reform of the *Mental Health Act 1983* was a complex tale that was dotted with inquiries, committees, reports and submissions, many of which reached contradictory conclusions (see Appendix 3 for a timeline of the reform). The contrasting agendas that emerged throughout the process demonstrated the tension between the use of compulsory powers for medical treatment and the rights of individuals subjected to that treatment. It was a tension that sat at the heart of mental health law and attempts to reform it, but was starker in relation to mentally disordered offenders. I do not seek to argue about the merits or otherwise of compulsory powers in the mental health system. My interest lies in how these issues interacted with the policies and politics of managing dangerousness. In that regard, the issue that was most relevant to my thesis was how forensic patients featured in the law reform process.

### ***The Role of Forensic Patients in the Reform Process***

The process of reform had its roots in a growing call for review of the legislation, including a 1997 forum on mental health law and enforcement funded by the Department of Health and convened by Dr Nigel Eastman and Dr Jill Peay.<sup>32</sup> In 1998 an Expert Committee was established by the

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32 The proceedings of the forum were published in *Law without enforcement: integrating mental health and justice* (Eastman and Peay 1999).

Department of Health and chaired by Professor Genevra Richardson in order to 'advise on how mental health legislation should be shaped to reflect contemporary patterns of care within a framework which balances the need to protect the rights of individual patients and the need to ensure public safety' (Richardson 1999:1). Commonly referred to as the Richardson Report, the Expert Committee's report was influential in setting an agenda for reform. In the end, many of its key recommendations were sidelined in the government's own proposals for law reform. However, and of particular relevance to my purpose, the Richardson Report shaped the non-government agenda for reform. This was partly a result of the wide consultation undertaken by the Expert Committee and was evident in the issues that were pursued and the arguments that were marshalled by the non-government lobby.

Given their brief to produce a scoping study, the Expert Committee had limited capacity to examine any aspects of the law in detail. Regarding the offender provisions, the Expert Committee's recommendations included that the powers of the executive be extended to the Mental Health Review Tribunal; and that the Home Secretary should maintain his or her monitoring and take on a more important role in the provision of evidence to the Tribunal. The Expert Committee also made some general recommendations in relation to principle and the shape of future legislation. Beyond that, it urged a separate review of the forensic provisions so that more detailed recommendations might be made. In steering away from further review of the forensic provisions Richardson cited the complexity of the terrain, including a number of different pieces of legislation that were neither wholly coherent in themselves nor compatible with other laws that effected the system; and the fact that the Expert Committee had been convened by the Department of Health, whilst the offender provisions came under the auspices of the Home Office. A review of the offender provisions was never undertaken. Nevertheless, offender provisions were included in proposals for reform of the *Mental Health Act 1983* in the ensuing years. In this way, the path was laid for reform of the legislative provisions covering mentally disordered offenders without specific consideration of how they should change.

The Richardson Report was published by the Department of Health simultaneously with the Green Paper, which was the Department's own and strikingly different agenda for law reform (these differences are discussed further below). Subsequently there was also a White Paper and then the first draft Mental Health Bill in 2002. Following consultation and a review by the Joint Parliamentary Committee on Human Rights, the 2002 Bill was revised and a second draft Mental Health Bill 2004 was released. It was the second draft Bill which went before the Scrutiny Committee and which forms the central focus of the present chapter. By that time, the reform process had already involved extensive discussion and debate between government and stakeholders, including patient groups, practitioners and non-government organisations. None of these processes related specifically to the care or management of restricted patients, yet all of them included offender provisions within the broader debates about the shape reformed mental health law was to take.

Importantly, a split had emerged between the Richardson Report and the government's agenda for law reform. The following (abridged) excerpt from Professor Richardson's evidence to the Scrutiny Committee provides some indication of the nature of that split:

We started with a very strong commitment to the principle of non-discrimination on grounds of mental disorder. ... It followed from this emphasis on non-discrimination that we attached considerable importance to the principle of respect for patient autonomy. ... By contrast, the Government, and I am not quite sure whether I should be talking about the Department of Health or the Home Office here, has focused on the prevention of harm or the reduction of risk without ever really engaging with the issues of non-discrimination or patient autonomy. And, as a result, the guiding principles described in our report and those considered in the Bill are very different and, perhaps most significantly, the conditions for the use of compulsory powers in the two documents differ really quite significantly (Joint Scrutiny Committee 2005b at evidence 1).<sup>33</sup>

Essentially, the split between patient autonomy on the one hand, and risk and public protection on the other set the terms for the central opposition in the debate on reform of the *Mental Health Act 1983*. One psychiatrist I

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33 Further details of the recommendations of the Richardson Report are included in Appendix 3.

interviewed suggested that it had been bad politics to appoint the Expert Committee under Richardson, whose views on mental health law were well known, if the government was not interested in following that model. Ultimately, these opposing agendas informed the positions that were adopted respectively by the non-government opponents of the proposed legislation (including mental health organisations and legal and clinical practitioners) and by the government. That tension continued throughout the various stages of reform and still had not been resolved by the time my research was completed.

### ***The Role of the Joint Scrutiny Committee [draft Mental Health Bill (2004)] in my Research***

The Joint Scrutiny Committee was under way at the time I commenced my fieldwork. This proved to be highly serendipitous as it provided a contained site in which to make contacts across the forensic mental health system. Initially, I approached the Scrutiny Committee merely as a recruiting ground for participants. Unexpectedly, the Scrutiny Committee also yielded important data in its own right. This was unexpected because at first glance the Scrutiny Committee had minimal relevance to the central concerns of my thesis. The vast majority of its deliberations were on the civil provisions contained in the draft Bill 2004, and even where mentally disordered offenders were considered, there was little attention paid specifically to restricted patients. However, as I read the submissions made by non-government organisations about the draft Bill, it became clear that there was strong criticism levelled against the government for being preoccupied with controlling dangerousness over and above the interests of patient treatment and care. Here, then, was an indication of the conflict between mental health and criminal justice in the process of law reform.

Throughout my fieldwork I examined the government's agenda for reform, particularly as it was seen by non-government actors. What emerged from these interviews was a strong sense that the government was influencing the shape of mental health law in the direction of harsher measures of detention, against the traditional mental health principle of a patient's right to undergo

care and treatment in the least restrictive conditions. As one psychiatrist I interviewed put it,

the government is trying wherever it can to retain and even gain more and more control over the risk agenda. ... So clearly that's the political flavour of the decade. And you'd expect that to be played out, be it with mentally disordered people or not mentally disordered people.

That perception of the Home Office's influence was evident in Professor Richardson's testimony (above), when she qualified her reference to the government by saying that she was not sure whether to direct her comments to the Department of Health or the Home Office. The psychiatrist quoted above later went on to qualify his assessment in the following way.

I mean the Home Office is very fond of talking about working in partnership with the Department of Health. Well, I actually think that's rubbish. I think that the Home Office is the main partner and I think there are a lot of tensions between those two departments. And why wouldn't there be because one is avowedly interested in public protection and doesn't give that much bother about mental health and the other is avowedly interested in mental health. And maybe that tension is unavoidable with the legislation that we have and the power that the Home Office therefore has over restricted patients.

As my data will illustrate, Home Office officials participating in my research were unanimous that they did not require significant legislative change to meet their mandate for public protection in the restricted patient system. The extent to which the policy dictates of the mental health system were being driven by a risk agenda spoke to my central interest in the interaction of criminal justice and mental health policy. Observing the submissions made by a wide range of people involved in the mental health system, and the responses of the Scrutiny Committee to them, enabled a closer study of these perceptions and how they shaped policy directions. It also provided a clear example of how and why the government sought to hold on to its executive discretion in relation to restricted patients. Accordingly, the extent to which the Scrutiny Committee engaged with the law and management of forensic patients became an important component of my research, both methodologically and empirically.

### ***The Key Players Before the Scrutiny Committee***

The complexities of the issues and the variety of actors engaged in debate about the law made it impossible to represent the reform as a single, unified process on either the government or non-government sides. The government was actually represented by a number of different actors with a range of views throughout the process. The most obvious representatives of government were ministers and state departments, and here there were at least two in the form of the Department of Health and the Home Office. There were also a number of statutory authorities, like the Mental Health Review Tribunal, giving evidence on the draft Bill. These groups did not necessarily represent a formal government viewpoint, but equally they could not be termed 'non-government'. Finally, not one but two parliamentary committees had considered the reform of the *Mental Health Act 1983*. In addition to the Scrutiny Committee discussed in this chapter, the parliamentary Committee on Human Rights had also examined the draft Mental Health Bill (2002) (the predecessor to the legislation that came before the Scrutiny Committee). Not surprisingly, and as I shall discuss further, the range of different representatives for the government sometimes produced contrasting views within the position ascribed to the government as a whole.

Similarly, caution should be exercised in perceiving the lobby of non-government stakeholders as singular and uniform. The Mental Health Alliance was the dominant force within the non-government lobby. It was formed by non-government organisations specifically in relation to the reform of the *Mental Health Act 1983*. The Alliance included practitioner and patient representative organisations as well as mental health charities and advocacy groups. It comprised some organisations which were also represented individually in the proceedings, plus many more whose membership of the Alliance was their sole engagement with the reform process. The Alliance presented itself as the major non-government actor in the reform process and its agenda was based broadly on the recommendations of the Richardson Report. However, because it was a strategic alliance brought together around a specific piece of law reform, there were some compromises for pragmatic reasons made on particular issues by those within the Alliance. A number of

these compromises related to forensic patients and, I argue, reflected the lack of political power that mentally disordered offenders had within the much larger civil mental health population.

There were also non-government organisations engaged in the reform process that did not join the Alliance. The key organisation for my purpose was The Zito Trust. As discussed in the previous chapter, The Zito Trust represented the interests of victims in the law reform process and did not support the agenda for reform advocated by the Richardson Report (and by extension the Alliance). As shall become evident, the politics of victim involvement were revealing about the position of victims within criminal justice policy more widely.

Without dwelling on the entire range of interests and agendas reflected in the reform process, it is important to note that the organisation of agendas around the Scrutiny Committee further complicated a law reform process that was already remarkable for the plethora of practitioner and policy ideologies that were in contention. Each ideology determined how those actors perceived the politics within the system. My particular interests were in how the government established an agenda to control dangerousness; and how the non-government lobby responded to that agenda, specifically with reference to the position of mentally disordered offenders. The rest of the chapter considers these issues in turn.

### **The Government's Agenda for Reform**

The tension between rights and risk was absolutely fundamental to the various agendas for reform advanced by government and non-government actors. The priority the government placed upon managing risk of harm through the control of dangerous people was an integral aspect of its agenda. As one Home Office official told me in an interview,

the reason we, the Home Office, want there to be powers to manage people in the community is to enable them to get treatment under compulsion before they get to the stage of relapsing. ... The Home Office's major concern with the new legislation is to have a measure of compulsion that enables people to be required for example to take

their medication before they get to the stage of going and burning down their neighbours or more likely killing themselves.

These comments referred specifically to the attempt to introduce compulsory treatment in the community, a complicated issue which I shall not discuss here. But it was a helpful elucidation of the priority the government placed upon control of dangerousness in the community. I was interested in how this priority took shape in the law reform process.

In the following section I shall explore two examples of how the government's agenda for reform demonstrated its priority with controlling dangerousness through mental health law. The first example was the desire for flexibility in the application of the draft Bill, in order to maximise the possibility of using preventive detention to control dangerousness. The second example was the objective of maintaining executive discretion in the restricted patient system. For each case I shall set out how the issue was represented by the government and the responses of others involved in the reform process.

### *i. Flexibility within mental health legislation*

The objective of flexibility within the new legislation was neither stated in government submissions nor in the legislation itself. Nonetheless, from the examination of government witnesses during the proceedings of the Joint Scrutiny Committee it quickly emerged as a government priority. The key way this priority manifested itself was in the debate about principles. In the draft Mental Health Bill 2004 the government signalled that it intended to set out the following principles to guide decision-making under the legislation:

- a) patients are involved in the making of decisions,
- b) decisions are made fairly and openly, and
- c) the interference to patients in providing medical treatment to them and the restrictions imposed in respect of them during that treatment are kept to the minimum necessary to protect their health or safety or other persons (draft Mental Health Bill 2004: Clause 1).

However, the government did not include the detail of how these principles would appear, leaving that to be determined once the Bill itself had been finalised. The absence of legislatively codified principles had exercised the standing parliamentary Committee on Human Rights, which had reviewed the

earlier draft Mental Health Bill 2002. At that time, the government had suggested a Code of Practice as a compromise, but the Committee on Human Rights was concerned at the capacity of a Code to 'give sufficient protection to the human rights of patients in the decision-making processes envisaged' (Joint Committee on Human Rights 2002:para 22).

The problem with the proposed Code of Practice was that it did not contain any measures to make it enforceable. In their submission to the Scrutiny Committee on the 2004 draft Bill, practitioners, and non-government organisations repeatedly condemned the absence of clear principles and advocated for them to be codified in law. But the government clung to its position, as was evident in the following exchange when the Scrutiny Committee questioned Health Minister Rosie Winterton about why general principles were not included in the draft Bill.

Ms Winterton: We might want to look at whether it was necessary to alter the emphasis of some of the principles and it is easier to do that with the Code of Practice. ...

Tim Loughton (Committee member): Minister, we are talking about principles here; we are not talking about latest trends and fashion. A principle is a principle. It is not there to reflect something; a principle is there to underpin the rights of whoever, as you say. ...

Ms Winterton: In a sense, the issue here is about the Code of Practice being able to reflect the way that the Bill itself is applied in practice. ... We would want to see within the Code of Practice, if there were instances, where some principles about how people are treated have changed. You could look, for example, at the issue of people being treated in the community, where in a sense there is a slightly different principle now, about, so far as possible, looking at how people can be treated in a way that is nearest to their home, nearest to their family, et cetera. There are some principles there that may change (Joint Scrutiny Committee 2005b:Questions 818 and 819 respectively, oral evidence, 19 January).

Non-government representatives making submissions to the Scrutiny Committee argued that the government was avoiding enshrining principles in the law so that they would not be binding. When the Committee pressed the Health Minister further, she asserted a desire for flexibility within the Bill in order to ensure that it could maintain currency in the event of changing priorities, such as the appropriate exercise of the powers of compulsory

treatment. While the Committee doubted that these principles would change over time, the Minister maintained the possibility that they could shift, thereby justifying the government's preference for keeping guiding principles as an accompanying - rather than a component - aspect of the legislation. The debate about principles demonstrated a clear desire on the part of the government for flexibility in the application of the legislation.

However from my research at the Home Office, it appeared that the government had not always been strongly opposed to principles being enshrined in the legislation. One official told me that an earlier draft of the Bill had in fact included principles, but that these had been removed from the Bill because of concern about whether they could be applied universally. As he put it, the Home Secretary would be guided by principles but was nevertheless a law unto himself. As such, the Home Secretary might opt out of particular principles if it was felt that they conflicted with the executive's mandate to protect the public. This example seemed to strike at the heart of the difference in perceptions of government and non-government practitioners about the executive's mandate. While the executive's authority derived from the *Mental Health Act 1983*, the official's comments implied that not even the criteria for compulsory treatment under the *Act* would prevent the Home Secretary from continuing the detention of a patient if it was felt to be in the interests of public protection. As my data have shown repeatedly, that was how the executive's mandate was understood by officials in the Home Office. By contrast, practitioners I interviewed continually returned to the criteria for compulsory detention as the primary principle from which all other considerations should flow, including public protection.

The desire for flexibility in the law was one example of how the government sought to use the reform of the *Mental Health Act 1983* to enhance its capacity to control dangerous behaviour. The government had been facing mounting pressure about people who posed a danger to others but were not subject to the mechanisms of control (including preventive detention and compulsory treatment) available under the *Act*. A number of particularly high profile cases had propelled the issue of controlling dangerousness into the public consciousness. One such case was the murder conviction of Michael

Stone in 2001. Stone was convicted for the 1996 murder of a woman and her daughter and the attempted murder of her second daughter (BBC 2001b). Popular press tended to characterise Stone as a 'psycho' and a 'mental patient', but in fact his condition had been highly complex and difficult for services to respond to. In the words of an Independent Inquiry into his care and treatment, Stone 'presented with a combination of problems, a severe antisocial personality disorder, multiple drug and alcohol abuse, and occasionally, psychotic symptoms consistent with the adverse effects of drug misuse and/or aspects of his personality disorder' (Francis *et al* 2000:4). Despite these complexities, Stone was frequently cited in media and other public statements as an example of someone with a dangerous and severe personality disorder (DSPD).

Public perceptions of DSPD were important for two reasons. Firstly, DSPD was not a diagnosable psychiatric illness, meaning that psychiatrists were not able to treat it and - by extension - that it did not meet the criteria for detention under the *Mental Health Act 1983*.<sup>34</sup> The notion that psychiatrists were refusing to treat people with DSPD simply because they did not come within the formal system of classification for psychiatric disorders led to the so-called 'treatability' debate. Psychiatrists pointed out that, while there might be services and interventions that could control the risks posed by people who were dangerously and severely personality disordered, they were not necessarily psychiatric interventions that people could be compelled to accept under mental health law. However those who believed that psychiatrists were shirking their responsibilities because they did not want to work with dangerous people argued that the law should be changed so that psychiatrists had no choice but to detain them.

The treatability debate was a contentious issue that imbued the preoccupation with dangerousness throughout the law reform process and was a major source of tension between government, practitioner and non-government stakeholders. Indeed Richardson cited the clinical uncertainty

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<sup>34</sup> Conditions treatable under psychiatry are set out in a number of key texts, most notably the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2000).

around DSPD as one of the reasons for avoiding the provisions covering mentally disordered offenders in her review (1999:para 15.4). Yet the high profile of the Stone case was the catalyst for a lot of public interest in the issue of controlling dangerousness. It went to the heart of the political sensitivity of public protection and underpinned the government's agenda for controlling dangerousness through mental health law. Significantly, the Stone case proved not to be an example of a person denied care and treatment within the existing terms of the law. In fact, the Stone Inquiry found that, 'if he did commit these crimes, [there is] no evidence that they would have been prevented if failings in provision of treatment, care, supervision or other services to Mr Stone had not occurred' (Francis *et al* 2000:4). Even more pointedly, the Inquiry stated, 'this is emphatically not a case of a man with a dangerous personality disorder being generally ignored by agencies or left at large without supervision' (Francis *et al* 2000:5). Nevertheless, even if Stone was the wrong case to flag difficulties about dangerousness and service provision under the criteria of treatability, his case was instrumental in building the pressure on the government to find mechanisms for controlling dangerous people.

This brief discussion of the Stone case does not do justice to the complicated arguments that underlined the treatability debate. My intention has been simply to set out some of the impetus for the high level of media attention and the sustained public interest that were attracted by the question of how to control dangerousness. The profile of Stone's case and the surrounding issues of controlling dangerousness flowed directly into the government's agenda for mental health law reform. In response to the psychiatric arguments that DSPD could not be treated under the *Mental Health Act 1983*, those seeking tighter controls for dangerous people argued that the law should be changed. That standpoint was motivated by the assumption that detention of dangerous people was necessary for the protection of others and further that such preventive detention was permitted under mental health law. It was a position that failed to appreciate the purpose and application of mental health law, whose powers of detention served the specific purpose of containment to facilitate treatment of a mental disorder.

Mental health law was not intended to provide a containment mechanism in its own right.

The conditions for detention under the *Mental Health Act 1983* were very clear.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that –

(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and

(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section (*Mental Health Act 1983*:section 2).

However the purpose of mental health law (to provide clear conditions within which people with mental disorder could be treated compulsorily) and the ability of psychiatrists to treat particular conditions classified as a mental disorder were poorly understood by the general public. In the public sphere the debate was represented as psychiatrists and hospitals refusing to 'treat' dangerous people simply because they did not meet the criteria for compulsory treatment under the 1983 Act.

It was in this context that the government attempted to establish a mechanism for controlling dangerousness in mental health law. In outlining its agenda, the government noted: '[t]he challenge to public safety presented by the minority of people with severe personality disorder, who because of their disorder pose a risk of serious offending' (Home Office and Department of Health 1999:4). As Minister Winterton explained in oral evidence to the Scrutiny Committee: 'very often people with personality disorder can be helped to manage, for example, aggression, or can be assisted in terms of depression that might be going alongside it' (Joint Scrutiny Committee 2005b:Question 834, oral evidence, 19 January). That point had been

conceded by the Committee on Human Rights in relation to the earlier draft Bill (2002). With respect to the government's obligations under the European Convention on Human Rights, the Committee had noted that, 'the availability of effective therapeutic treatment is not necessary' for detaining a person with mental disorder in order to protect the person or the public from an objectively identified risk (Joint Committee on Human Rights 2002: para 35). In other words, detaining people with DSPD in order to guard against risk of dangerousness did not contravene European human rights law. However the government still had a problem: at home, detaining people with DSPD in order to guard against risk did contravene the *1983 Act* because compulsory treatment was permitted only if it was 'likely to alleviate or prevent a deterioration' of the patient's condition (*Mental Health Act 1983*:part 2, section 2b). Consequently, the government sought to change the principle of treatability from referring to who and what was treatable, to a concept of availability of treatment. In this shift the meaning of 'treatment' was itself transformed from one of therapeutic intervention and benefit to one of care or control.<sup>35</sup>

In my interviews with Home Office staff, I asked about the attempt to change the existing framework of treatability. The government's agenda to control dangerousness was neatly summed up by one official who commented that there had been dangerous patients suffering from psychopathic disorder who couldn't be detained under the *1983 Act*, which created big problems for how the government should respond to those cases. As another Home Office official observed, the definition of treatment in case law had now become so wide that the minimum requirement was that a patient was not getting worse. This meant that detention itself amounted to treatment. Consequently, the political imperative for controlling dangerousness could be met if such a person was diagnosed with a mental disorder. These had been the issues that provided the impetus for the government's agenda to control dangerousness through reform of the *Mental Health Act 1983*.

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35 The government supported its argument for changing the principle of treatability with evidence emerging simultaneously from a number of pilot programs assessing whether the risk posed by people with dangerous and severe personality disorder could be reduced when they were detained and cared for within therapeutic settings.

One psychiatrist I interviewed was scathing in his assessment of the implications of the change to the treatability criteria. He commented,

I would have thought that the Home Office was laughing all the way to the bank. Because every time a civil rights lawyer goes to the Court of Appeal or the House of Lords to argue the interpretation of the Act in favour of a liberal result, the court goes in the opposite direction. To such an extent that I sometimes wonder why it is that the Home Office is so determined to have a new Mental Health Bill when the courts have done most of the work for them. They've recently decided, haven't they, that the Act, when it says treatment in hospital, actually means treatment *at* hospital. Well that's an extraordinary notion. I thought that the *Mental Health Act* was all about taking people's liberty away and locking them up in hospital or not. Now I gather that it's not, it's about treatment *at* hospital. Um, it seems to me it's probably only a small step before it becomes treatment 'by' hospital (emphasis in quotation).

Evident in this criticism was the strong belief amongst practitioners that the central principles of mental health law were being abandoned in the government's quest to control dangerousness. Some clinicians advanced vehement opposition to expanding the treatability criteria in the law reform process. Professor Nigel Eastman, a forensic psychiatrist and professor of law and ethics, argued before the Scrutiny Committee that 'you should never use civil powers for preventive detention where there is no therapeutic benefit' (Joint Scrutiny Committee 2005b:Question 493, oral evidence, 8 December). He defended therapeutic benefit as the definitive principle of treatability because it clarified the role of mental health intervention and established important boundaries around who could be subjected to compulsory treatment (Joint Scrutiny Committee 2005:para 139). The Scrutiny Committee agreed, recommending that the legislation include a 'test of therapeutic benefit' in relation to the criteria of treatability (2005:para 141). However the government rejected that recommendation, noting: '[i]t is not, and has never been, the Government's intention that the Bill should be used to detain people solely for the purpose of taking them out of circulation without offering them appropriate treatment' (Department of Health 2005:14). Thus the government were caught between the challenge of controlling people who posed a risk of dangerousness to themselves or others and the purpose of mental health law which was to set out clear conditions within which people could be detained for clinical intervention in their mental health.

One psychiatrist I interviewed expressed a particularly interesting assessment of the context in which DSPD had become such a priority for the government. In his view, bringing DSPD within the framework of the *Mental Health Act 1983* was an attempt by the government to punish psychiatrists for not taking seriously the dangerousness and violence of a minimal number of mentally disordered patients. He believed that changing the treatability criteria in order to include DSPD was a response to the perception that psychiatrists had not accepted and responded adequately to community concerns about dangerousness. His assessment also provided an interesting perspective on the question considered throughout this thesis as to whether or not the executive held an exclusive mandate for public protection. In his view, psychiatry always had to give regard to the protection of others, but the decision about what level of risk was acceptable was best made by the courts. Yet the political imperative had seen the government push for psychiatrists to have greater involvement in decisions about the reasonableness of levels of risk to which the public was exposed.

The present discussion began with the point that the government was seeking a more flexible piece of legislation in order to assist with its objective of controlling dangerousness. In its review of the draft Mental Health Bill 2004, the Scrutiny Committee disagreed with the government's objective of flexible principles. The Committee found that 'it is essential that fundamental principles be set out on the face of the Bill. It is not appropriate to leave fundamental guiding principles to the codes of practice' (Joint Scrutiny Committee 2005:para 64). The Committee went on to list the principles it believed ought to be codified (*ibid* 2005:paras 65-71), and the weight that ought to be placed on them (*ibid* 2005:para 72). The government eventually accepted that principles should be codified in the legislation. However it did not agree with the detail of the principles recommended by the Committee, arguing that they should resist 'over-codification' (Department of Health 2005:9). Ultimately, principles appeared in a Code of Practice in the *Mental Health Act 2007*.

My discussion of the treatability debate has been a summation of a very long and complicated saga. I have attempted to explore the interaction between a political imperative to control dangerousness; a belief within government that mental health law could provide a mechanism for that control; and very strong resistance, particularly from psychiatric practitioners, to such reform. It was the interaction of all of these factors that informed the government's desire for 'flexibility' in the principles that set out the application of the proposed new law. In other words, the attempt to maintain flexible principles guiding the application of mental health law was motivated by the over-riding objective of detaining people who presented a risk of serious harm to others, including those with dangerous and severe personality disorder, under the powers of a Mental Health Act.

### ***ii. Maintaining current decision-making over restricted patients***

The exercise of discretion by the executive in decisions about restricted patients was one of the few areas of the law reform process that focussed specifically on the forensic provisions of the *1983 Act*. I have discussed the various criticisms of executive discretion previously (see Chapter One). As those discussions demonstrated, momentum to remove executive discretion from the system had been building since the enactment of the *1983 Act*. There was widespread concern that over-cautious executive decision-making was preventing the flow of patients who, it was thought by clinicians, were ready to progress to less secure settings, particularly those in high security hospitals. According to practitioners I spoke with, this meant that some patients remained detained for too long in high security settings, which also blocked others from being admitted to those locations which would best support their care and treatment.<sup>36</sup> At the same time jurisprudence from European human rights law was increasingly finding fault with the operation of the executive's powers in relation to its obligations under the European Convention on Human Rights. Given this mounting opposition to executive discretion, and the fact that the executive maintained its exclusive decision-making powers in the draft Bill 2004, I anticipated the role of the executive in

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36 At the time of writing, there had been a rapid increase in medium-secure hospital beds. Home Office officials explained that this increase reflected the need for greater capacity to accommodate patients requiring long-term medium-secure environments.

the restricted patient system to be a significant point of discussion for the Scrutiny Committee. To my surprise, there was minimal discussion of the fact of executive discretion *per se*. Instead, debate addressed the extent of that discretion, and the possibility of sharing it with the Mental Health Review Tribunal.

Submissions to the Scrutiny Committee had focussed on the nature and scope of executive authority and its appropriateness within the new legislative framework that was being proposed as well as within broader contexts such as safeguarding patient's human rights. Forensic psychiatrist Professor Eastman commented that there was 'absolutely no logic to the Home Office retaining its power over the transfer of patients between different hospitals and different hospital units, when the core of the care plan which the tribunal operates is the location of the care plan' (Joint Scrutiny Committee 2005b: Question 457, oral evidence, 8 December). In other words, he found it illogical that the Tribunal should be responsible for reviewing the lawful detention of patients, but be unable to take action to ensure the appropriateness of that treatment such as by ordering their transfer to an alternative hospital. Similarly, the Mental Health Alliance also argued for 'the power to order transfers and leave of absence extended to the Mental Health Tribunal' (Spencer-Lane and Bell 2005). Notably, these submissions did not pursue an end to executive discretion. Instead they sought to extend to the Tribunal powers that were concentrated in the Home Office's unique authority over the progress of restricted patients through the system.

The interests of people who were both mental health service users and involved with the criminal justice system were represented largely by two charities: the UK-wide Revolving Doors Agency, which was dedicated to improving the lives of people caught up in a cycle of crisis, crime and mental illness; and Nacro, a charity working in England and Wales whose objective was preventing crime by addressing social exclusion and respecting human rights. Both organisations were asked by the Scrutiny Committee if they had a view on the role of executive discretion over restricted patients (Joint Scrutiny Committee 2005b: Question 457, oral evidence, 8 December).

Surprisingly, neither of these organisations had an opinion to express. Nacro replied that they did 'not feel strongly that the executive power should be taken away from the Home Office' but did advocate the sharing of decision-making power with the Tribunal (*ibid* at Question 523). Revolving Doors Agency stated that they had no position on the issue as they did not deal with restricted patients (despite the fact that they worked with mentally-disordered offenders) (*ibid*). Both groups were fairly non-committal about the fact of the executive's discretionary powers, concentrating instead on the possibility of sharing those powers with the Tribunal, rather than removing them from the executive.

Even though the cessation of executive discretion was a formal policy of the Alliance, the lack of will to pursue it was an interesting reflection of the political marginality of forensic patients. Many Alliance members chose not to pursue the end of executive discretion in the strategic interests of other objectives that they felt were more important or were more likely to succeed. In an interview with me, one representative of the Alliance explained that their policy was for the Tribunal to become the sole decision-making body in relation to restricted patients, but that the Home Secretary should be required to make representations to the Tribunal. He accepted that the government was not going to relinquish its role in public protection, as implied by its ongoing discretion. He stated:

I can completely understand, from a Government point of view, that they're not going to want to let go of restricted patients. ... And I think we do understand that when it comes to the Bill we're going to have to compromise significantly because we're just not going to get what we see as being a perfect Bill.

Therefore, it was tactically more realistic to argue for expanded Tribunal decision-making than an end to the power vested in the Home Secretary. In another interview, a psychiatrist also involved in the scrutiny proceedings affirmed that 'in the sort of democracies we live in it's probably difficult to envisage a system which didn't involve political involvement'. Consequently, he said, it was important to focus on working effectively within that framework rather than challenging its very existence. He commented:

I've never worked in a system where there wasn't executive discretion ... I suppose that what I would be in favour of would be ... strengthened powers to tribunals, so that the Home Office if you like was a party to these issues, but was not definitive.

Essentially it was this pragmatic view that marked the Alliance's approach to mentally disordered offenders, and particularly restricted patients, throughout the Scrutiny Committee's hearings. As I have already discussed in previous chapters, this pragmatism was a product of the intersection between professional practice and political decision-making that resulted in such competing objectives throughout the restricted patient system.

It was also a consequence of the intractability of the dilemmas facing the various actors involved in the care, treatment and supervision of restricted patients. My earlier discussion of the public interest in controlling people with dangerous and severe personality disorder illustrated the challenge for the government between the appropriate application of mental health law and the public protection agenda. As the data discussed in previous chapters have suggested, non-government actors within the system were well aware of - and sympathetic to - the political realities of the executive's position.

Those political realities carried over into how non-government actors pursued their agenda for law reform. Lobbying from the non-government sector did not seek an end to executive discretion. Rather, it was limited to extending to the Tribunal the decision-making authority about leave, transfer between hospitals and reductions in the level of security under which restricted patients were detained. Once again the Scrutiny Committee supported the non-government agenda here, recommending that 'the Mental Health Tribunal be given the power to order the transfer and leave of absence of restricted patients' (Joint Scrutiny Committee 2005:para 277).<sup>37</sup> But as the following statement shows, the government rejected this recommendation on the grounds that it offered inadequate protection to the public.

The Tribunal must always base its decision on evidence about the state of the applicant's mental health. It cannot take decisions purely on the basis of the risk of harm. This is not a system that would attract

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37 Notably, the Scrutiny Committee did not recommend an end to executive discretion.

the confidence of courts or of the public (Department of Health 2005:27).<sup>38</sup>

Only one Scrutiny Committee recommendation attempted to restrict executive discretion and it was raised in relation to the management of transferred prisoners. These were sentenced or remanded prisoners who needed to undergo compulsory treatment in hospital. I do not deal with this patient group much in my thesis. Suffice to say that people remanded in custody were a high proportion of the forensic patients monitored by the Home Office Mental Health Unit and constituted the second-biggest population under their supervision after restricted patients. In the existing legislation, the Home Office had the discretionary power to transfer these patients into hospital (*Mental Health Act 1983*:sections 47-48). But the Committee on Human Rights had noted that treating such a prisoner in a prison psychiatric wing rather than an 'appropriate therapeutic environment' could breach the European Convention on Human Rights (2005:para 67). As a result the Scrutiny Committee recommended that:

where those exercising the functions of clinical supervisor form the view that a prisoner or person on remand meets the conditions ... and recommend that he is transferred to hospital, the Bill proper contain a duty requiring the Home Secretary to order his transfer to hospital (2005:para 264).

The government opposed the recommendation on the grounds that the Home Secretary's duty to protect the public justified and required unfettered discretion and that the Committee's proposals would be unlikely to improve the provision of psychiatric care to transferred prisoners anyway (Department of Health 2005:25).

In the absence of direct attempts to end executive discretion, there was some scrutiny of how that discretion was exercised. Dissatisfaction about Home Office decision-making over restricted patients was expressed by legal advocates (Joint Scrutiny Committee 2005:para 275); hospitals (Joint Scrutiny Committee 2005b:Memorandum from West London Mental Health NHS Trust (DMH 243) at 3.5); and during my interviews. Before the Scrutiny Committee, Home Office Minister Paul Goggins was asked whether there

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38 I return to this statement below, in discussing this agenda of public protection.

were 'examples of the Home Office rejecting risk assessments made by professionals and substituting its own estimates of risk in relation to discharge?' (2005b:Question 857, oral evidence, 19 January). He replied:

Clearly the judgment about discharge is made by the Mental Health Tribunal and the Home Secretary can make representations at that point, but in the end it is for the Tribunal to decide. What we then do of course ... in partnership with those in the mental health field is to supervise and to monitor those particular individuals and where there is deterioration, where they then become once again a risk to the community, then it is of course quite appropriate that they can be recalled (*ibid*).

The Minister's response here was almost a *non-sequitur*, focusing on the Tribunal when the Committee had asked about the processes of executive decision-making. Of course, giving oral evidence can be a difficult process. But the answer conveyed a lack of clarity between the role of the Tribunal, which had power only to discharge restricted patients, and the role of the Home Secretary, whose authority included the power to discharge but also extended to all other aspects of the process. The Minister's response was also interesting for acknowledging the work of the Tribunal in assessing risk. There were two ways his comments could have been interpreted. One was that the executive recognised that the Tribunal considered risk as a central aspect of its own decision to discharge restricted patients. However this recognition would have contrasted with the statements made by government representatives repeatedly during my research and elsewhere, that the Tribunal did not consider public protection in its decision-making. Elsewhere the government had noted:

The tribunal is not constituted to perform risk assessments, but to protect the patient's rights. It is only on the basis of independent risk management for restricted patients that they can be diverted from prison sentences. The current system works exceptionally well with low rates of recidivism, and effective protection for the rights of restricted patients. The Secretary of State does not intend to give up a system which works well (Joint Scrutiny Committee 2005:Annex 4 - Schedule of detailed comments on the draft Mental Health Bill with responses from the Government, 127(a)).

An alternative interpretation would be that the Minister's reply was an acknowledgment that the executive monitored the Tribunal's decisions in case the Tribunal got it wrong in terms of public protection, in response to

which the Home Secretary could exercise the power to recall a patient. This second interpretation would have supported the evidence I discussed in Chapter Four, that the Tribunal was routinely monitored as part of the executive's function across the system.

Once again, the government was caught at the intersection of treatment and control, conscious of its own priority in protecting the public from harm. The matter could not be reduced to one of merely selecting treatment over control or vice versa. Yet the legal framework traditionally approached treatment from the perspective of patient rights and clinical responsibilities; while the government's approach prioritised control. Faced with the inevitable impasse of these competing priorities, the government could only seek to continue its discretion and resist that discretion being granted to any other body whose objectives might conflict with the government's own.

As noted in Chapter Three, the case of *MM* was resolved after the completion of my fieldwork. Here, a restricted patient challenged the legality of two recall orders issued by the Home Secretary, in March and September 2006 respectively (*MM v SSHD 2007*). The Home Office Mental Health Unit stated that it had sought confirmation from the treating psychiatrist of the Home Secretary's intention to recall *MM*. The psychiatrist's position was that the decision had already been taken by the Home Secretary when the Unit consulted him. The legal point turned on whether the doctor 'expressed positive agreement that recall was appropriate or merely refrained from expressing disagreement' (*MM v SSHD 2007*:para 28). The substantive question was whether the standard for up to date medical evidence was met by the communication that took place between the Home Office and the treating psychiatrist prior to the patient's recall.

Ultimately, the Court found that the standard had been met; and that the appellant's submission on what constituted up to date medical evidence was too stringent. The Court drew the following conclusion.

For the Home Secretary to recall a patient who has been conditionally discharged by a [Tribunal], he has to believe on reasonable grounds that something has happened, or information has emerged, of

sufficient significance to justify recalling the patient. As I have said, it is not in dispute that he must have up-to-date medical evidence about the patient's mental health. Since in the nature of things the patient will have a [Responsible Medical Officer], it is hard to imagine that (save in the most exceptional circumstances) the Home Secretary would recall the patient without first seeking the RMO's clinical opinion whether it is appropriate for the patient to be detained for treatment. But I do not think that it would be appropriate for this court to lay down some form of test of general application extrapolated from the particular circumstances of this case (*MM v SSHD 2007*:para 50).

MM's case was an important indication of how little the framework of law from the European Convention on Human Rights protected restricted patients (including the *Winterwerp* criteria on detention discussed in Chapter Three). Domestically, the Court's conclusion prioritised the executive's role in protecting the public by down-playing the stringency with which the criteria for detention needed to be met. In doing so, it endorsed the executive's own interpretation of the primacy of the public protection agenda, within which factors like the criteria for detention and the evidentiary basis for those criteria were being considered. The Court also supported the Home Secretary's unique authority in this regard, by resisting the opportunity to set down any further criteria or qualification to the exercise of that discretion.

### **Not One of Us! The Place of Forensic Patients within the Non-Government Lobby**

#### ***The Tenor of the Risk Debate***

The discussion so far has examined how the government's preoccupation with risk shaped its agenda for mental health law reform. As I have shown, the origins of this preoccupation lay in the desire to control dangerousness through existing criminal and mental health law, prompted by at least one extremely high profile case of an offence committed by a person with a history of dangerous behaviour. However, the preoccupation with dangerousness was also predictable within the so-called modern risk culture, in which 'the concept of risk becomes fundamental to the way both law actors and technical specialists organise the social world' (Giddens 1991:3, as outlined in Chapter One). Simon and Feeley argue that, while 'public officials have long sought to control the dangerous classes', the modern risk society has manifested itself in crime policy in particular ways, including the

perception that it is the responsibility of governments to protect people from risk, even as governments have realised how incapable they are of achieving this (1995:149). The sociological literature about risk was helpful for understanding the tensions in the management of mentally disordered offenders, where psychiatrists and policy-makers repeatedly clashed over the meaning and utility of risk technologies. Analyses of risk and its influence over public policy were even more relevant for understanding the agenda for controlling dangerousness and the way it came to imbue not just criminal justice but also mental health policy.

The extent to which risk should operate as a definitive paradigm within the restricted patient system was a source of constant tension between various actors. The belief that risk was central was evident in the government's attempts to maintain its discretionary authority over restricted patients and to assert the detention powers of mental health law in the control of dangerousness. Yet practitioners rejected the notion that a risk-based approach offered a clear, definitive solution to the problem of dangerousness. As O'Malley has argued,

clinical risk thus appears not as a stable type of risk, but as an unstable assemblage in which diagnostic uncertainty and predictive risk may be aligned in significantly different ways. These alignments may change according to such considerations as the resistance of practitioners, discoveries of the 'unreliable' nature of planned techniques, and so on (2004:25).

Certainly in the restricted patient system, the uncertainty of the technologies of risk and the difficulty of relying solely upon them for predictions about individual forensic patients put clinical practice at odds with the political imperative of controlling risk as closely as possible. Moreover, as Douglas and Giddens (amongst others) have shown, risk is a culturally constructed entity as much as it is a reliable matter of numbers and probability (Giddens 1991; Douglas 1992, as discussed in Chapter One). These differences of construction further increased the likelihood that there would be some divide between clinical understanding of risk technologies and their utility from the perspective of executive decision-making.

There was an even bigger split between government and non-government actors over the relevance of the risk-based approach to the entire population covered by mental health law. Even accepting that a risk-based approach might be necessary for those patients who posed a risk of serious harm to themselves or others, non-government actors criticised the government for allowing those 'high end' patients to have a disproportionate impact upon mental health policy. In the final discussion of this chapter, I will explore this tension from the perspective of symbolic politics, examining how risk shaped the positions of various actors, and to what extent mentally disordered offenders generally, and restricted patients specifically, occupied a central position within that debate.

Criticisms of the government's approach were expressed most succinctly by a lawyer I interviewed who represented restricted patients before Tribunals and the Home Office. He said:

the whole approach of the government is risk driven. [The Richardson Report] was basically starting with a therapeutic approach, and dealt with risk through a benefit/therapeutic approach. An alliance between patients and those ... care teams, the hospital and the community. The government has taken a populist, risk-driven approach upfront and put therapy at the back. And that's why Richardson was thrown out the window, and why definitions of mental disorder were left much wider. And why the initial reaction has been on constraint rather than treatment in relation to the Act. I think there's some aspects of the Act, including some Tribunal stuff, which is better. Or possibly more liberal. But I think the philosophy behind the Act is regrettably regressive ....

From my discussion of the law reform process so far, the government's agenda was informed by its preoccupation with managing a small but high-risk group of people who posed a serious danger to themselves or others. But the dominance of the risk agenda reflected a circular argument. The Home Office's experience of mental health law came from its statutory responsibility in the restricted patient system. That experience with restricted patients may well have contributed to the government's perception that mental health law was a mechanism for controlling dangerousness as an end in itself. At the same time, forensic patients generally were absent from many of the stated aims of government policy and from the lobbying undertaken by

non-government and practitioner stakeholders. It is the position of forensic patients within the non-government lobby for law reform that I consider next.

### ***The Position of Forensic Patients in the Non-Government Lobby***

We welcome the improved safeguards for patients but remain concerned that there is an over-emphasis on compulsion and 'high risk' patients, which perpetuates the myth that mentally disordered people are dangerous when, in reality, only a tiny minority could be so categorised (Joint Scrutiny Committee 2005b:Memorandum from Nacro (DMH 156) at 9).

This statement was contained in Nacro's written submission to the Scrutiny Committee, and was echoed by the Revolving Doors Agency during its oral evidence (Joint Scrutiny Committee 2005b:Question 520, oral evidence, 8 December). Indeed the notion of high risk or high-end patients was frequently used by non-government stakeholders to refer to the patients who dominated the government's agenda. Yet those advocating against the government agenda did very little to engage directly with issues relating to the management of mentally disordered offenders, or with the validity of defining those patients solely in terms of dangerousness. On the contrary, the general strategy of non-government organisations was to distance mentally disordered offenders from the majority of the mental health patient population.

Certainly, some participants in the reform process objected to what they implied was a punitive sentiment in the draft Bill 2004 in its attempt to strike a new balance between treatment and public protection. Professors Eastman and Maden, both forensic psychiatrists, opposed the inclusion of public protection issues in mental health legislation (Joint Scrutiny Committee 2005b:Question 461, oral evidence, 8 December). Professor Maden stated: 'mental health legislation ... is meant to set out circumstances in which compulsory treatment may be appropriate, it is not meant to be a complete strategy for dealing with dangerous people' (*ibid*). Meanwhile Professor Eastman was concerned that 'the core of this Bill, particularly in the civil bits ... is that it encourages an extraordinary blurring of the social roles of the justice system and doctors, and other mental health professionals' (*ibid* at Question 463). These statements reflected the anxiety of many psychiatrists

that clinicians would be turned into custodians through the proposed legislative reform. In response, the Scrutiny Committee told of a policeman who had expressed the view that the provisions of the draft Bill would give him a welcome opportunity to take dangerous people off the streets, whether they had committed criminal offences or not (*ibid* at Question 458). The policeman's view had illustrated precisely the disjuncture between the various professional and policy voices speaking in the law reform debate and was an example of the gap in approach between the various agencies involved (as discussed in Chapter Four).

Clinical practitioners before the Scrutiny Committee argued that psychiatry had always attended to questions of risk and protection of the public. This view was enshrined in clinical imperatives, as evidenced by the literature discussed in Chapter One and the opinions of practitioners interviewed for my research. Obviously their position might differ from policy officials and politicians who, informed by political imperatives, had both a different role and consequently a different interpretive framework from which they approached questions of law and its reform. Yet even within these structurally embedded forms of knowledge, there was a tension between how much weight should be placed upon questions of risk and to whom the categorisation of high risk patients should be applied. Criticisms of the criteria for compulsion provided a good example of this impasse, as in Professor Eastman's arguments before the Scrutiny Committee.

The risk criteria are set at incredibly low levels. For many it is protection of others, but from what and at what level and how likely and so on? But even for the so-called dangerous group, where there is supposed to be a substantial risk of serious harm, I am not convinced it is that high a threshold ... from my own experience of the courts and decisions on what 'substantial' means, it simply means 'having substance and more than trivial'. Therefore, 'a substantial risk of serious harm' means a bit of risk of serious harm. I think there is a real issue about catching all sorts of people ... within this bill by virtue of this extraordinarily low threshold, and the lack of exclusions, the lack of therapeutic benefit test and so on ... (2005b:Question 490, oral evidence, 8 December).

The Mental Health Alliance agreed.

The major change in the Bill, which we believe to be its fundamental flaw, is the new broad definition of mental disorder coupled with wider and less flexible conditions for compulsory treatment. We believe that this is likely to lead to a significant increase in the numbers liable to compulsion across the board. .... It is under criminal justice, where the conditions for compulsion are even wider than for civil patients, that this increase is likely to be most evident – particularly in under resourced forensic mental health services (Spencer-Lane and Bell 2005).

Both these positions indicated the extent to which practitioners and non-government organisations sought to distinguish between the civil and forensic populations being treated under the Bill. As a consequence, forensic patients were consistently relegated to a categorisation as 'dangerous' which marked them as different from civil patients. At the same time, the non-government sector consistently argued that the criteria for civil and criminal justice patients receiving compulsory treatment in the community should be the same. Maca, a national mental health charity who worked in partnership with other organisations, argued that it should not be possible to:

give compulsory treatment to people who could not otherwise be made subject to it, and whose mental disorder is not considered to have been a factor in their offending behaviour, nor likely to lead to future offending behaviour (Joint Scrutiny Committee 2005:p 91 at para 269).

In summary, practitioners and non-government organisations consistently argued that the criteria for compulsory treatment under the Act should be the same for anyone, regardless of whether they were a civil or forensic patient. Simultaneously, these actors tried to distance the majority of the patients they represented from mentally disordered offenders and particularly from restricted patients. This tension was evident in the following excerpt from Nacro's evidence to the Scrutiny Committee.

Clearly there are issues about the scope of the Mental Health Review Tribunal and the fact that it cannot order that leave or transfer be initiated. There are some benefits in the Home Office having an overall view of restricted cases because we are only talking about restricted cases. It is a very small number and it does relate to the patients who present the greatest risk to others (2005b:Question 523, oral evidence, 8 December).

Undoubtedly, restricted patients were among the proportion of people receiving compulsory mental health treatment who represented high levels of

risk of harm to others. However Nacro's description of restricted patients as a uniquely high risk category distanced the healthcare needs of restricted patients from those of the civil mental health patient population, while simultaneously obfuscating its own role in representing the interests of restricted patients in the law reform process.

It was widely acknowledged to me during my fieldwork that restricted patients were not well-represented by non-government organisations engaged in the reform process. A number of interviewees attributed this to the reform agenda established by the Richardson Report (1999), and the absence of any dedicated consideration of the offender provisions within the *Mental Health Act 1983*. As stated above, the Richardson Report had argued that the offender provisions within the 1983 Act fell under the responsibility of the Home Office, and recommended that they be examined as a separate case (Richardson 1999:para 15.6). As the Expert Committee under Richardson were engaged by the Department of Health, they had perceived the specific criminal justice provisions as tangential to their main concerns. There may also have been a far more pragmatic reason for why the Expert Committee did not spend more time on offenders. Mentally disordered offenders featured in the third section of the Act, after the civil provisions. This meant that the Expert Committee would have spent a long and arduous period of time deliberating over the legislation already when it eventually got to the forensic sections. The same might well have been true of the Scrutiny Committee. Either way, the failure to review the offender provisions of the *Mental Health Act 1983* in detail resulted in the marginalisation of offender patients generally, and restricted patients specifically, in successive legislative proposals.

Beyond the structure of the law reform process, the political reality was that mentally disordered offenders were a difficult group to lobby for. One representative from a non-government organisation I interviewed explained to me that some non-government organisations would not touch restricted patient issues because they were dependent upon public funding. The inevitable stigma associated with mentally disordered offenders meant that restricted patients were simply excluded from the client group of that

organisation. The prioritisation of resources across mental health care also worked against the interests of restricted patients. As a result, restricted patients were not prioritised on anyone's agenda for advocacy or lobbying. This was no more evident than in the absence of restricted patients from submissions by mental health organisations to the Scrutiny Committee, even from those who represented mentally disordered offenders such as the Revolving Doors Agency (2004).

One lawyer I interviewed believed that it was inappropriate that risk should dominate the legislation just because of restricted patients, stating:

and I quite agree to that extent that the draft Mental Health Bill has been sort of high-jacked by the Home Office, essentially, whose inserted its definitions of risk and concerns about risk into the civil population where it's not really a big issue.

However in his view it was neither useful nor valid to relegate particular categories of mental health patient to a status as uniquely dangerous in an effort to isolate them from the broader patient population. Nonetheless, as he explained, most organisations within the Mental Health Alliance did not work with or for restricted patients, so the issue was not central to their objectives before the Scrutiny Committee.

A member of the Mental Health Alliance agreed with that assessment during another interview with me:

... all the criminal justice groups in the alliance don't really have that much interest in restricted patients which is crazy when you think about it. ... I mean you could develop the sort of stuff ... about whether you sort of have a criminal justice system which is supported by psychiatry and you go down that sort of line. And within that debate you've then got the restricted patients who are kind of separated from the general Part 3 [offender] patients who are very much seen as their own little breed really and someone almost that people don't want to touch. I think one of the problems is that the organisations within the Alliance are also service providers ... they have a very broad remit to cover a lot of people and there's always been a lack of places in the community who are going to take restricted patients. I mean no one really wants that sort of person. The residents are going to be up in arms or something like that so it's the same sort of problem. I think they do tend to be just dealt with by statutory services and contact outside of those is quite limited. And therefore within the Alliance we just don't get that sort of expertise.

These examples point to the extent to which forensic patients were absent from the client group that most mental health organisations and practitioners were focussing on in their advocacy for law reform. Undoubtedly, forensic patients were a substantially smaller part of the mental health patient population than civil patients. At the time I conducted my fieldwork the restricted patient population numbered 1306 (according to statistics provided to me by the Home Office Mental Health Unit). The Royal College of Psychiatrists have reported that as many as 9 out of 10 prisoners suffers from a diagnosable mental disorder in a population numbering over 72,000 (Royal College of Psychiatrists 2006); and the National Association for Mental Health (Mind) has estimated that mental health problems amongst the general population effect between one in four and one in six people (Hatloy 2005). Thus restricted patients constituted a very small minority of people with mental disorder, both in and out of the criminal justice system.

Nevertheless, restricted patients were the group of mental health patients with whom government decision-makers, particularly in the Home Office, had the most contact. It was understandable, therefore, that government perceptions of those receiving compulsory treatment were informed by their first hand experience of assessing the risks posed to the community in the discharge from hospital of people with mental disorder. Consequently for the government, care and treatment under the 1983 Act were inextricably bound with questions of risk and controlling dangerousness. But those who based their rejection of the government's agenda on the premise that forensics were a small minority of the total population covered by the legislation failed to recognise the broad-based political imperative to control dangerousness. The symbolic politics of public protection had transferred the rhetoric of managing dangerousness from one specific department to the whole of government (Newburn and Jones 2005). That imperative rendered the executive immune to criticisms that the government's health agenda had been hijacked by the Home Office's priority on public protection.

One non-government actor engaged in law reform distanced itself from restricted patients for very different reasons. As noted above, The Zito Trust did not join the Mental Health Alliance, being the only non-government body

that openly supported the government's agenda. The Zito Trust proposed a number of legislative reforms in the interests of victims, which were largely supported by the government. These reforms all related to mentally disordered offenders, and included access to information about discharge of restricted patients from hospital. As discussed in Chapter Five, such access to information about restricted patients was made years after it had been available to victims of offenders sent to prison. Importantly, The Zito Trust also supported the government's agenda for compulsory care in the community; a proposal which, when put by the government, was fiercely contested by the Alliance. The political sensitivities of the system were particularly evident around victims' issues. Despite its vehement opposition to the policy of compulsory community care, the Alliance never took issue with The Zito Trust directly. In an interview with me, one member of the Alliance suggested that this was because of the high degree of public and political sympathy for The Zito Trust, and therefore the risk to the reputation of anyone who opposed it. The Alliance had a hard enough time counteracting the stigma associated with mental health service users, without also appearing to oppose the interests of victims. Realistically, lining up against the victim lobby was seen as too damaging to the reputation of the Alliance, no matter how central were their points of disagreement. Consequently, the Alliance also had to be careful of how it campaigned on behalf of forensic patients, when The Zito Trust was advocating against the Alliance's policies in that regard.

The prominence of victim-related issues in parallel developments elsewhere in the criminal justice system was also likely to have influenced the government's agenda for mental health law reform. The government's concern with victims of crime, reflected in other provisions being developed at the time such as the Victim's Charter, affected their approach to legislation enhancing the executive's control over forensic patients. The increasing focus on victims was another aspect of government policy that non-government organisations and practitioners did not engage with at all during the law reform process. In fact it was telling that during my research there were a number of participants who had given almost no thought to the role and effect of victims in forensic mental health.

Clearly, there were a number of reasons as to why forensic patients (and restricted patients as a sub-population within that group) did not feature prominently in the advocacy by non-government organisations engaged in the law reform process. Essentially, the reasons came down to the tactical acknowledgement that forensic patients were a small proportion of the overall population covered by the *Mental Health Act 1983*, and were a political liability with the potential to tarnish as dangerous the reputation of the entire patient population.

Yet it would have been possible to ameliorate the construction of restricted patients as such a risky population simply by using the government's own data. At the time of my fieldwork, less than 8% of discharged patients were reconvicted of a standard offence, and less than 1% were reconvicted for a grave offence within 2 years (Ly and Howard 2004, discussed further in the next chapter). The government drew on these low reconviction rates to indicate that the restricted patient system operated successfully. However, and as I discussed in Chapter Four, practitioners used the same low reconviction rates to argue that executive decision-making was overly cautious. Whichever side the speaker took, there was considerable evidence to support the argument that restricted patients had a reasonably low rate of re-offending. Yet, throughout the law reform debate, terms such as 'high-end' continued to be applied collectively to all forensic patients without attempting to deconstruct that categorisation.

Non-government organisations attempted to distance forensic patients from general mental health users in order to refute the government's agenda on controlling dangerousness through mental health law. In doing so, the non-government lobby conflated forensic patients, including restricted patients, with people who did not necessarily have a history of offending, but whose mental disorder was associated with violence or dangerousness. That approach contradicted the Alliance's own policy that mentally disordered offenders ought to be treated the same way as civil patients under the draft Bill. It was inconsistent to argue that everyone treated compulsorily under mental health legislation ought to have the same rights, while simultaneously

asserting that one sector of the patient population posed disproportionately greater risks than all others.

I do not mean to suggest that assessing and managing risk was not an important factor in patient care and treatment. Moreover, forensic patients were so-called because they had a history of offending or of violent or dangerous behaviour. The question was not whether or not risk should be a component of patient care, but to what extent it should determine the overall framework for compulsory treatment. The problem with non-government arguments against the dominance of risk was that they accepted the construction of risk as a defining characteristic of one section of the mental health patient population, while at the same time insisting that all patients be treated the same under the legislation. Fearing that a label of 'dangerous' would tar everyone with the same brush, those opposing the government's agenda merely strengthened the division between forensic and civil patients and so failed to challenge the dominant perception of dangerousness as a central characteristic of mental health patients. At the conclusion of the Scrutiny Committee hearings, the Alliance's policy of treating all patients alike under the Bill had failed to win the support of the government. Minister Goggins made it expressly clear that offenders receiving treatment under the *Act* would not have the option to receive that treatment voluntarily (Joint Scrutiny Committee 2005b:Question 855, oral evidence, 19 January).

Essentially, the government's approach to the reform of mental health law was to create a mechanism that would support the executive's mandate for public protection. The principles of mental health law had always included the protection of others. But in the government's approach, the potential for containment under the *Mental Health Act 1983* provided a possible avenue for preventive detention of people who posed a risk of danger to others. Resolving the problem of dangerousness was a greater priority than adhering to the traditional principles of the compulsory treatment criteria. I put that assessment to a Home Office official during an interview after the completion of the Scrutiny Committee's hearings. He said that the government had lost the argument about public protection largely because it had been too timid to acknowledge that the legislation was about preventing harm. The

government's intentions had been legitimate, he said, in wanting people to be treated when they needed it before they reached a crisis and harmed themselves or others. Yet mistrust of the government's agenda of public protection had been heightened by the failure to identify the provision of increased resources to support effective treatment. Accepting that the Mental Health Alliance had interpreted the government's agenda for harm prevention as against the interests of patients, the official stated that the opportunity to ensure that the law provided adequate public protection through effective treatment of mental disorder had been lost.

### **Conclusion: Forensic Patients as the Silent Subjects of Law Reform**

One of the broader questions underpinning my research was whether the status of 'patient' retained its primacy or whether restricted patients were generally regarded as offenders by executive decision-makers. That question was prompted by the precarious status that restricted patients occupied, subject to compulsory treatment under mental health law, but supervised by a criminal justice department. In this chapter I have argued that, while restricted patients were marginalised by the non-government sector, and ignored by the government, they were in fact instrumental to the law reform process. They shaped the agendas on both sides, yet were never directly acknowledged. In my concluding comments I draw together the data I have presented here to consider the implications of my analysis.

Legal theorists and non-government organisations alike have argued that the government's agenda for law reform was dominated by its preoccupation with risk. My data suggest that this agenda was clearly evident through the government's desire for flexibility within the legislation; and through the strong hold the government maintained on its executive discretion over restricted patients, at the exclusion of any expanded role for the Tribunal. I was interested in whether the effect of the risk agenda on mental health law had a broader relevance for the criminal justice system. Reform of the *Mental Health Act 1983* offered the possibility of establishing a framework for coercion and control of people on the basis of potential behaviour and assessed risk of dangerousness. Such a framework would operate beyond the existing powers of the criminal justice system, which required a person to

be charged with an offence before they could be detained. The coupling of the executive's central mandate of public protection with the fact that protection of others was an already-established principle within mental health law made the reform of the *Mental Health Act 1983* an ideal opportunity for the government to strengthen its mechanisms for detaining people who posed a risk of dangerousness. The draft Mental Health Bill 2004 was important because it demonstrated the extent to which the government was willing to redress this gap (as the government perceived it) through mental health law.

The ability of the government's opponents to resist effectively the government's agenda was seriously diminished by their failure to recognise the symbolic politics of public protection, which led to the dominance of what had been perceived of as a Home Office priority in what was ostensibly health legislation. The symbolic importance of public protection transcended the traditional boundaries of policy portfolios and bureaucratic departments. The preoccupation with controlling dangerousness, and the timing of mental health law reform, made the *Mental Health Act 1983* the ideal vessel to support the government's much-needed mechanism for control.

Meanwhile, forensic patients were consistently represented as dangerous, reinforcing the fear and stigma that attached public perceptions of mental health care users with dangerousness. Those advocating for and on behalf of mental health patients failed to effectively resist these constructions of dangerousness, even though the government's own data on low reconviction rates could have been used to argue that many of those under ongoing executive discretion were being detained unnecessarily. Patient advocates chose instead to try and distance forensic patients from the vast majority of people covered by mental health law. While understandable, that strategy meant that the government's critics never wholly engaged with the political preoccupation with dangerousness.

Moreover, as previous chapters have shown, the law itself created ambiguity by constructing two alternative decision-making authorities in the executive and the Mental Health Review Tribunal, each with a separate basis for

discharging restricted patients. While the complexities of balancing public fear with public opinion made it difficult to establish cast-iron, rational processes, the realities of decision-making often militated against the application of universalistic principles like least restrictive care in favour of case-based decision-making and in the interests of public protection.

Yet there was one other avenue of the law which purported to offer an alternative resolution of these challenges. It was a widely-held view amongst people I interviewed that the *Mental Health Act 1983* was only reviewed because it had become incompatible with the *European Convention on Human Rights* and the *Human Rights Act 1998* (see also Richardson and Thorold 1999). In my final substantive chapter I consider how the human rights framework interacted with the issues of care and control in the restricted patient system, and whether it provided any resolution to this ostensibly dichotomous paradigm.

## CHAPTER 7

### PROTECTING PATIENTS?

### HUMAN RIGHTS AND THE RESTRICTED PATIENT SYSTEM<sup>39</sup>

#### Introduction

So far my thesis has argued that the Home Office defined its overall role in terms of public protection and that it perceived all other considerations as secondary to that priority. The centrality of public protection was evident in the perception of Mental Health Unit staff that their responsibility to the public was a specific and unique task of the Home Office. The belief that other actors did not share the responsibility for public protection further strengthened the resolve with which Home Office staff approached this objective. The protection priority was also demonstrated by the dominance of controlling dangerousness in the government's agenda for the reform of the *Mental Health Act 1983*.

The executive's discretion in the restricted patient system derived from the *Mental Health Act 1983*, which was a legal framework 'based on the prevention of risk to self and others and grounded in notions of social protection and medical paternalism' (Richardson 2007:76). Nonetheless, patients had rights too, and these were enshrined in a number of statutes. So far I have focussed on the *Mental Health Act 1983*. Now, I turn to the rights that were set out in the European Convention on Human Rights (1950) and were subsequently incorporated into English law through the *Human Rights Act 1998*. The question I shall consider is how the Home Office balanced its emphasis on public protection with the principle of patient rights. The public protection agenda derived from the Home Office's legislated mandate but, as I have already shown, some of the constructions it relied upon - including those of patients, of 'the public' and of protection - were a product of internal processes. Essentially, Home Office decision-makers understood 'the public'

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<sup>39</sup> I am grateful to the Monash Centre, Prato, for hosting me during the initial drafting of this chapter.

as a population exclusive of restricted patients themselves. How, then, did they strike the balance between public protection and the rights of patients?

My final chapter explores the notion of human rights as constructed in the restricted patient system. The language and processes of human rights were part of the many elements that informed the decision frame of executive discretion in the release of restricted patients, and warranted attention for that reason alone. However they were also an interpretive framework in their own right, constructing subjects in particular ways which, in turn, had a structural impact upon the system. In this chapter I focus on how restricted patients were constructed through the framework of human rights law. I suggest that the language of human rights provided an alternative construction of patients to that of 'risky individuals', as already discussed. Yet, I argue, the framework of human rights also led to a further entrenchment of the perceptions at the Home Office that the protection of the public was something separate from and distinct to the protection of patients. In other words, the human rights framework re-enforced the notion that patients were not a constituency within the greater public to whom the Home Office was responsible.

### **Establishing Rights for Patients: The Origins of Tribunal Decision-Making**

Under the *Mental Health Act 1959*, the Mental Health Review Tribunal had no authority to discharge restricted patients; the executive had sole discretion over their supervision and release. Executive discretion has always been justified on the grounds that the risks restricted patients posed to themselves or others made their release a matter of public interest. In 1979, the Dutch case of *Winterwerp* before the European Court of Human Rights established the need for objective medical evidence of mental disorder of a sufficient nature or degree, and its continued existence, to justify deprivation of liberty (*Winterwerp v The Netherlands* 1979). Two years later in the same court, the case of *X v The UK* (1981) established that the restricted patient system contravened article 5 of the European Convention on Human Rights which requires that 'the lawfulness of ... detention be decided [speedily] by a court' (article 5:4). It became necessary to have a judicial body not just reviewing

the basis for detention, but also with the power to discharge in the event that deprivation of liberty for compulsory treatment did not meet the *Winterwerp* criteria (Jones 2004). The new *Mental Health Act 1983* addressed these inconsistencies by granting the Tribunal - in addition to the Home Secretary - the right to discharge restricted patients.<sup>40</sup>

In the literature, the system prior to 1983 is presented as one of indefinite detention, initially at Her Majesty's pleasure, and subsequently at the government's discretion (Verdun-Jones 1989; Richardson 1993; 2005). Prior to the 1983 Act, those pursuing mental health law reform were not necessarily interested in human rights *per se*. However there was certainly unease at the absence of safeguards for patients in the system and it was believed that the 1983 Act would improve this situation by ensuring a procedural mechanism to protect the rights of patients through Tribunal decision-making. As practice under the 1983 Act developed, however, scholars pointed to the inadequacy of the protections offered by the Tribunal. Two concerns were principal in these critiques. The first was the burden of proof required to demonstrate that a patient was not detained lawfully: patients had to show that they were no longer suffering from a mental disorder warranting compulsory treatment in hospital in order to be released. This relied upon the extremely difficult task of proving a negative (Eastman and Peay 1999). The matter was resolved when the English and Wales Court of Appeal (EWCA) made a declaration of incompatibility between the *Mental Health Act 1983* and the European Convention on Human Rights, which resulted in a change to domestic law through statutory instrument (*R v MHRT 2001*).<sup>41</sup> As a result, the problem was addressed by reversing the burden of proof so that hospitals now had to prove that a patient met the criteria for ongoing detention (as opposed to patients having to prove that they no longer met it).

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40 The Tribunal already existed in relation to mental health patients in the civil system.

41 By declaring the *Mental Health Act 1983* to be incompatible with the European Convention on Human Rights, the EWCA indicated that it could not interpret the 1983 Act in accordance with the requirements of European human rights law. In order to address this problem of incompatibility, the government changed the Mental Health Tribunal Rules by way of statutory instrument.

The second key concern was that the Tribunal had no power to move patients through the system towards release, including *via* transfer to other hospitals. The power to order (or otherwise facilitate) the steps necessary to aid a patient's rehabilitation towards release was vested entirely in the hands of the Home Secretary. This remained central to criticisms of the system, and was still the situation when I completed my doctoral research. Thus, ten years after the 1983 Act, Richardson warned that while the acquisition of the new power to discharge by the Tribunal was 'without a doubt ... of immense formal significance ... its significance in practice should not be overestimated' (Richardson 1993:285; see also Richardson and Thorold 1999). Despite these criticisms, the Tribunal is consistently presented in much of the literature as the appropriate body to be making these decisions, and as the major safeguard for patients in the system. For example and as discussed in previous chapters, recent efforts to reform the *Mental Health Act 1983* did not take issue with the fact of executive discretion as fundamentally limiting the ability of the Tribunal to guard the interests of patients. Even if one accepts that there were pragmatic reasons why non-government organisations did not actively seek an end to executive discretion in the reform of the 1983 Act, in the literature the Tribunal continues to be regarded as an effective safeguard for restricted patients. The present chapter contradicts that perception through an empirical analysis of the construction of patient rights and the extent to which those rights are protected in the restricted patient system.

In terms of the measurable effects of the *Mental Health Act 1983*, there has been a marked shift in the process of release. Home Office data show that the Tribunal is now responsible for making almost 90% of release orders (Johnson and Taylor 2002).<sup>42</sup> However, a Home Office official interviewed for this research stated that while the 1983 Act had dramatically changed the process of decisions to discharge restricted patients by giving it to the Tribunal, nothing had changed in terms of the proportion of restricted patients who were discharged every year. The following data enable a consideration

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42 From 1991-2001 the number of restricted patients in hospital ranged from 2107 to 3002 (Johnson and Taylor 2002). During this time there was an average of 324 discharges per year (*ibid*).

of the claim that there had been no increase in the number of patients being discharged from the system following the granting of decision-making power to the Tribunal.

**Table 1: Restricted patients discharged (d/c) by Home Secretary or MHRT, 1975-1984<sup>43</sup>**

|                             | 1975         | 1976       | 1977       | 1978       | 1979       | 1980        | 1981       | 1982       | 1983       | 1984        |
|-----------------------------|--------------|------------|------------|------------|------------|-------------|------------|------------|------------|-------------|
| <b>TOTAL detained</b>       | 2018         | 2017       | 1930       | 1912       | 1884       | 1864        | 1812       | 1816       | 1780       | 1708        |
| <b>D/c to the community</b> | N<br>(%*)    |            |            |            |            |             |            |            |            |             |
| <b>Home Secretary</b>       | 171<br>(10)  | 136<br>(8) | 152<br>(9) | 142<br>(8) | 147<br>(9) | 151<br>(10) | 146<br>(9) | 128<br>(8) | 100<br>(8) | 63<br>(6)   |
| <b>MHRT</b>                 | -            | -          | -          | -          | -          | -           | -          | -          | 5<br>(0)   | 110<br>(6)  |
| <b>TOTAL discharge</b>      | 199*<br>(10) | 160<br>(8) | 176<br>(9) | 162<br>(8) | 172<br>(9) | 180<br>(10) | 171<br>(9) | 148<br>(8) | 150<br>(8) | 208<br>(12) |

\* Difference between number discharged and total discharged accounts for people absolutely discharged, who are included in the total.

**Table 2: Restricted patients discharged (d/c) by Home Secretary or MHRT, 1994-2003<sup>44</sup>**

|                             | 1994       | 1995       | 1996       | 1997       | 1998       | 1999       | 2000       | 2001       | 2002       | 2003       |
|-----------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| <b>TOTAL detained</b>       | 2288       | 2478       | 2549       | 2650       | 2749       | 2842       | 2858       | 2969       | 2989       | 3118       |
| <b>D/c to the community</b> | N<br>(%*)  |            |            |            |            |            |            |            |            |            |
| <b>Home Secretary</b>       | 43<br>(2)  | 24<br>(1)  | 35<br>(1)  | 29<br>(1)  | 34<br>(1)  | 34<br>(1)  | 23<br>(1)  | 27<br>(1)  | 24<br>(1)  | 32<br>(1)  |
| <b>MHRT</b>                 | 147<br>(6) | 140<br>(6) | 136<br>(5) | 163<br>(6) | 173<br>(6) | 162<br>(6) | 212<br>(7) | 196<br>(7) | 223<br>(7) | 263<br>(8) |
| <b>TOTAL discharged</b>     | 211<br>(9) | 178<br>(7) | 181<br>(7) | 197<br>(7) | 213<br>(8) | 205<br>(7) | 242<br>(8) | 236<br>(8) | 269<br>(9) | 217<br>(7) |

\* These figures represent discharged patients as a percentage of the total restricted population. All figures rounded to the nearest whole percentage.

43 Data sourced from 'Statistics of Mentally Disordered Offenders, England and Wales 1975-1985', provided by Mental Health Unit, Home Office.

44 Data sourced from (Ly and Howard 2004).

Caution should be exercised with respect to some of these data. For example, in both tables the base population was made up of detained restricted patients. Therefore it excluded patients already on conditional discharge and residing in the community. However, from the percentage figures (last row) in each table, it appears that patients released as a percentage of the detained restricted patient population fluctuated by around 10% in the 10 years preceding and immediately following the introduction of the 1983 Act. In the decade from 1994 the percentage was approximately the same; if anything, it was slightly less. These data supported the suggestion that the rate of release remained constant following the shift from discharge at the authority of the Home Secretary to the sharing of that responsibility with the Tribunal.

As I discussed previously, Home Office participants perceived the Tribunal as incautious. Yet, the Tribunal was legislatively required to have regard for the safety of the patient and the public [*Mental Health Act 1983:section 72:1(a)(ii)*]. Additionally, research contradicted the perception of Tribunal cautiousness. Specifically, some research suggested that Tribunals often sought to justify decisions not to release patients based on their concern about the risks posed to the patient or the public regardless of whether they could have equally found that the patient no longer met the criteria for detention under the 1983 Act (Peay 1989; Holloway and Grounds 2003; Perkins 2003). Perkins found that

there was a recognition that the MHA 1983 gave tribunal members the freedom to take risky decisions. In the observed tribunals, however, the risks of 'getting it wrong' seemed so great that members appeared to gather evidence to justify not discharging rather than actively pursuing the possibility of discharge (2003:109, see also Holloway and Grounds 2003).<sup>45</sup>

With the notable exception of Peay (1989), most of the research conducted on the Mental Health Review Tribunal has been on the civil jurisdiction, and therefore did not cover restricted patients specifically. However, given the preoccupation with risk in relation to forensic patients as outlined earlier, it

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45 Perkins' study did not cover Tribunals for restricted cases. However, as discussed in Chapter One, decision-making in relation to restricted patients was likely to be more cautious, not less.

was likely that these critiques applied equally to restricted cases, if not more so.

The idea that a preoccupation with risk prevented Tribunals from discharging patients even when they no longer met the criteria for detention was reflected in the evidence of a number of practitioners involved in my research. One lawyer I interviewed who represented restricted patients at Tribunal hearings commented:

I mean Tribunals aren't, there is real caution in the way Tribunals operate. In restricted cases they are, I mean they're judges or recorders who sit on Tribunals. And they're not trying to find all the arguments they can to release somebody. Some judges and some Tribunals are very cautious. And sometimes they're right to be, on the facts. But it's not a, it doesn't operate as a court, from that point of view.

The conservatism of quasi-judicial decision-making processes had also been observed in comparable bodies such as the Parole Board. Padfield *et al* note: 'we were struck by the cautiousness of the decision-making ... The Parole Board's responsibility to "protect the public" too easily swamps the rights of the individual prisoner, whereas it is part of their "core function" to test whether the prison and probation services are respecting the rights of the prisoner' (2003:114). While it may not have been surprising that tribunals and Parole Boards erred on the side of caution, it was not in keeping with the intention of the law. The *Mental Health Act 1983* placed the emphasis on the presumption to discharge unless there was a risk of serious harm to the patient or to others. This implied quite a different process to that actually followed by decision makers on the Tribunal. An important additional point was that both the Parole Board and the Tribunal were much less likely to be criticised publicly and politically for being too cautious than for being too liberal. I have already observed this phenomenon in relation to the Home Office (a consequence of having the 'first bite of the cherry' in discharging patients as discussed in Chapter Four). Because the patients coming before the Tribunal were necessarily the most difficult cases, they were likely to pose significant concerns about risk to the public or other contentious issues. This factor may have explained the conservatism of Tribunal decisions to discharge, but it was equally an important reality for any consideration of the

Tribunal as an effective safeguard for patients. I shall return to this issue shortly.

To summarise the discussion so far, the Tribunal obtained the power to discharge restricted patients to meet the European Convention requirement for independent review of detention. Critics of executive discretion claimed that this would increase the rate of discharge for a section of the patient population who no longer met the criteria for detention under the 1983 Act, yet who had not been released by the executive because of concerns about public protection. As the data presented here indicate, no such increase in discharges occurred. Simultaneously, an emerging body of literature argued that the current powers of the Tribunal were insufficient to deal with the inappropriate detention of forensic patients who were unable to progress to less secure conditions of detention because hospital beds were being blocked by the slow flow of patients into the community. The Tribunal had no power over the steps that would speed up the flow; accordingly it could not safeguard patients who might be unnecessarily detained as a result. The question that emerged for my research was to what extent the *Mental Health Act 1983*, designed to improve the protections for restricted patients, actually did so.

The impetus for the legislative reform that resulted in the 1983 Act provides an important context for one of two key points I make in this chapter. The changes to the 1983 Act were necessitated by the requirements of compliance with the European Convention on Human Rights. Yet there are important questions to ask about how substantive these changes actually were. Firstly, were human rights reforms limited to legislative and policy changes, having had little actual effect in improving the protection of the human rights of restricted patients? How were the subjects of human rights frameworks constructed? And what effect did the mobilisation of international instruments of human rights have on executive decision-makers' own responsibilities to uphold the rights of patients? The following discussion considers these issues further.

### ***Constructing Patient Rights***

In Chapter Five I discussed how Home Office decision-makers' constructions of the public often excluded restricted patients. That discussion laid an important basis for the question at the heart of the present chapter. If the Home Office phrased its responsibility entirely in relation to the public, but conceptions of 'the public' excluded patients, what did Home Office decision-makers perceive to be their responsibility to patients?

In my interviews and observations of Home Office officials they talked of a balancing act in which the therapeutic benefit to patients was balanced with the interests of the public in each and every decision. Yet, at the same time, there was a clear priority that lay with the protection of the public over the interests of patients. When I asked Mental Health Unit staff how they maintained patient rights within the priority on protection, it proved to be the one area of my fieldwork where the views of Mental Health Unit staff contrasted with each other. While they had been entirely consistent about the Home Office's responsibility for the public protection agenda, there was far more variance in considering its responsibility to patients.

One official stated that the Home Office's only duty was public protection and therefore the official had no responsibility to patients. In his view, responsibility for patients lay entirely with care teams. The official would explain that to patients to ensure there was no confusion about the Home Office's role. Interestingly, he felt that care teams had a dual responsibility to patients and to the public when considering whether patients were ready for discharge to the community. But such duality of role was not something he shared as a Home Office official. He understood his duties to be devoted entirely to protecting the public.

The perspectives of other Mental Health Unit staff differed here. For example, another official claimed that meeting the interests of patients was vital to ensuring the public were protected. In her view, public protection was best served by ensuring that restricted patients were well supervised, and that went to the heart of patient interests. Her perspective echoed the sentiments

of staff who were concerned about patient welfare when decisions to permit leave exposed patients to the risk of negative public or media attention, as discussed in an earlier chapter. Staff were particularly sensitive to cases where victims or other members of the community were vociferous in their opposition to a patient spending time in the community, because that opposition could jeopardise the patient's safety in the community, or in seeking transfer or release. Clearly, the interests of patients were a high priority within the decision frame of some Home Office staff, but not for all. Thus within the bureaucratic mandate of public protection, the way in which patients or members of the public were defined was not simply a matter of interpreting the law, but was also dependent upon subjective processes that differed between officials. The variation in responses from Home Office staff about their responsibilities to patients led me to wonder how these processes influenced the perception of patient rights.

At the official level of executive decision-making, due attention was paid to the language and legislation of human rights. As I have discussed, there was a particular shift perceived with the introduction of the *Mental Health Act 1983*. One senior official explained that the restricted patient system rested upon a balance between the rights of the patient and the protection of the public. Under the previous *Mental Health Act 1959*, this balance had been developed entirely within the Home Office: the Home Secretary alone had had to weigh the cost of depriving a patient of their liberty with the protection of the public. According to this official, when the Tribunal obtained the power to discharge patients, the Home Secretary was relieved of the responsibility for the rights of patients. The balance was now maintained *via* a clear division of labour, wherein the Tribunal was responsible for the rights of patients, and the Home Office was responsible for the protection of the public. Unit staff did not refer to case law or statute to support this explanation of the division of labour. Their analysis was a product of how Home Office staff viewed the system, and was informed predominantly by the priority placed on public protection within their own bureaucracy.

In the words of one official I interviewed, everything the Home Office did in the restricted patient system was human rights-oriented. In his view the

restricted patient system was a leader in human rights terms because, he believed, England was the only country in the world where a mentally disordered person could be convicted of a very serious offence, anything short of murder, and be diverted from punishment into a system of therapeutic care.<sup>46</sup> When I asked what effect the European Convention on Human Rights had on the restricted patient system, he replied that it was 'absolutely fundamental', because it had led to the *1983 Act* that gave the Tribunal the responsibility to protect the human rights of restricted patients. In many ways his comments reflected how the European Convention worked. Before incorporation, challenges to an action on the basis of human rights had to be determined in Strasbourg. Once the European Convention was incorporated into English law through the *Mental Health Act 1983*, English mental health law was brought into line with the European human rights framework (or at least its procedural requirements). Eventually, following the enactment of the *Human Rights Act 1998* all new legislation had to be certified for its compliance with the European Convention.

Another important way in which the European Convention had had an impact upon the restricted patient system was through the case law that emerged. One official said that this case law had fettered the discretion of the Home Office. In his assessment the human rights framework was reasonable in principle, but quite difficult to operate in practice. He gave the example of recall of patients on conditional release in the community. As discussed in Chapter Three, case law from the European Convention had established that a patient could never be recalled - except in an emergency - without a medical opinion that the individual was mentally disordered (*K v The UK 1998*). While this interviewee accepted the reasoning of the judgment, he was deeply concerned at the consequential constraint on the operations of the Home Office. As I have shown repeatedly, there was a clear perception amongst Home Office staff that they were the only ones in the system who considered public protection. This was despite the legislative requirement on the Tribunal to do so; the professionally established practice of clinicians

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46 In fact other jurisdictions do have this provision in their laws, for example the Australian jurisdiction of Victoria has introduced similar powers to defer convicted offenders from prison for compulsory treatment in hospital.

having due regard to public safety; and the evidence that the Tribunal was equally conservative about risk when making decisions to discharge patients. Despite all that, Home Office staff expressed unease that the human rights framework might restrict their discretion to act in the interests of public safety. Once again, I was back to the question of how Home Office staff balanced the prioritisation of public protection with the protection of rights required by the human rights framework.

Consistently, when speaking with Mental Health Unit staff, they explained this balance through the existence of the Tribunal. In other words the balance did not take place *in* the Home Office. Rather, it was achieved across the system by the Home Office priority on public protection, and the Tribunal balancing that with its own responsibility for patient's rights. Thus Home Office staff conceived of human rights entirely within a legal and procedural framework. In the perceptions of many staff, the rights of restricted patients were guaranteed merely by the existence of the Tribunal, including its authority to discharge.

Yet, the Home Office was aware of the limits of the Tribunal's power: its own commissioned research had strongly criticised the operation of the Tribunal's review mechanism, particularly in relation to recall. In their study of the discharge and supervision of restricted patients, Dell and Grounds found that 'less than 8% of patients had tribunals within the first three months of recall; 33% waited four or five months; 51% waited between six months and a year, and three waited for over a year', data which they argued rendered the compulsory tribunal process post recall 'a totally inadequate safeguard' (1995:xiii). They stated:

This is a matter which warrants urgent attention. The Home Secretary's authority to recall is an immensely powerful weapon, giving him unfettered discretion to remove people from the community and to detain them in hospital. Those who advise him are instructed to err on the side of caution, and they administer the system on the understanding that a tribunal will soon meet to review the need for the patient's detention. In practice, however, this safeguard is a chimera since people can be detained for an unlimited length of time, waiting for a tribunal to convene. The situation is clearly unacceptable (Dell and Grounds 1995:xiii).

The denial of rights brought about by delayed Tribunal hearings was compounded by other factors such as the debatable nature of the Tribunal's independence (evidenced by the Home Office's ongoing review and willingness to challenge Tribunal decisions as discussed in Chapter Four). Despite Dell & Grounds' clear criticisms of the exercise of the Home Secretary's recall powers ten years earlier, by the time of my research the Home Office was continuing to construe the protection of patient rights entirely through the Tribunals' decision-making powers.

Clearly, the Home Office was not accountable for the operations of the Tribunal. But as the available research called into question the effectiveness of the Tribunal as a safeguard, this undermined the position of Home Office staff who disavowed their own role in protecting or promoting the rights of patients. Undoubtedly, those rights were enshrined in European human rights law. The question at issue was how the processes and procedures of the system ensured them.

The Tribunal, the Home Office and the Department of Health were all autonomous bodies, and such agencies would not usually take kindly to interference in their operations and duties. Nevertheless, the bureaucratic mandates in the restricted patient system appeared to be slightly more fluid than usual. Firstly, as I established in Chapter Four, the Home Office was the lead department within the restricted patient system. While Health was responsible for the facilities in which restricted patients were detained, the Home Office had the responsibility for executive decision-making authority throughout the system. Therefore, it housed the Mental Health Unit which conducted the supervision and monitoring of all patients and, as I have shown, of care teams and the Tribunal as well. Secondly, the Home Office frequently reviewed Tribunal decisions, and brought about judicial review if it felt those decisions were seriously lacking (again, see discussion in Chapter Four). Equally, as I examined in Chapter Six, there was a strong suggestion that the Home Office (or at least its priorities) were very much engaged in the Department of Health's review of the *Mental Health Act 1983*. What these data suggested, however, was that interaction with other bureaucratic mandates took place in the interests of public protection only. There was no

indication from my data that these engagements took place, or ought to have done, in protecting or promoting the human rights of restricted patients. On the contrary, many of the Home Office staff I spoke with relied solely on the Tribunal to ensure that patient rights were protected.

The construction of human rights protections was maintained within a limited, administrative framework. When I pressed a Mental Health Unit official on whether the Home Office had a responsibility to restricted patients, he said there was one, but that it was not explicit. He returned the question to one of the balance of the system:

we [the Home Office] are on one extreme of the spectrum: our primary concern is risk. The Tribunal is at the other: their primary concern is human rights. But everybody is operating the same balance.

He reiterated the view that because the Tribunal was there to protect patient rights, the Home Office could be that much more focussed on the question of risk. For example, if a Home Office decision not to discharge was challenged on human rights grounds, there could be no argument that the prioritisation of risk undermined patient's rights, because there was an alternative avenue for release. In other words, the balance was preserved elsewhere. This gave Unit officials the ability to act as they saw appropriate in the interests of public protection, safe in the knowledge that there was a structure in place (albeit elsewhere in the system) to protect patient rights. Essentially, this balance came down to the proportionality of infringing the rights of an individual restricted patient against the likely harm to others if the infringement was inadequate.

These data posed a serious challenge for my analysis, as they appeared to suggest that the executive was ignorant of (or ignoring) the extent of its obligations to protect and promote the human rights of patients within the restricted system. The government was still subject to the requirements of the European Convention, notwithstanding the existence of the 1983 Act, nor the determinative authority of the Mental Health Review Tribunal. In particular, detention had to meet the criteria set out in *Winterwerp v The Netherlands* (1979). As Jones states: 'In *Winterwerp* the European Court of Human Rights held, *inter alia*, that in order for the detention of a person of

unsound mind to be lawful the mental disorder from which the patient is suffering must be of a kind or degree warranting compulsory confinement' (Jones 2004:para 1-047, p.38). At the Home Office, the '*Winterwerp* criteria' were set out in the Mental Health Unit's manual on precedents, entitled 'Summary of relevant caselaw', and provided to me during my fieldwork. That document reported on *Winterwerp* in the following terms:

The European Court established the criteria that must be met for deprivation of liberty on the grounds of mental disorder. These are:

- Objective evidence of mental disorder
- That the disorder is of a nature or seriousness that justifies detention
- That the disorder persists at the time of the review.

Clearly, then, the Mental Health Unit was cognisant of the fact that there were clear criteria for detention for compulsory treatment of mental disorder as established by European human rights law, and further that restricted patients were subject to it. Nevertheless, within that criteria, the executive interpreted 'nature or seriousness that justifies detention' to facilitate what it perceived as its over-riding responsibility for public protection.

In this thesis I have not undertaken a critical assessment of how the human rights framework came to construct problems and offer solutions in the restricted patient system. Such an approach would presume that rights were a straightforward and clearly superior framework, when in fact there was a much more complicated process involving the negotiation between rights and protection. These would be fascinating directions for analysis, but would constitute another topic entirely.<sup>47</sup> Neither did I set out to criticise how the Home Office constructed its responsibilities in terms of patients. Its powers were born of statutory authority and were the legacy of decades of concern for the public interest in difficult decisions about release. I was interested in how human rights operated within the restricted patient system, because it seemed to lie at the heart of the question of whether protection of the public

47 For example, Zagor cites immigration law as an example of ongoing uncertainty between the application of individual and collective rights, despite the assertions to the contrary of many human rights and legal scholars (2006).

was necessarily antithetical to the interests or rights of patients. Structurally, the Home Office was bound to the framework of human rights as dictated by the European Convention and the *Human Rights Act 1998*. These in turn stipulated procedural and policy requirements on the executive. Yet within this context there was still discretion in how and whether rights were conceived as within or parallel to the public protection agenda. As my data show, Home Office decision-making constructed patient rights in parallel to the public protection agenda. Yet there were alternative possibilities in this regard, as I shall explore further below in relation to other practitioners in the system.

A growing body of literature has challenged criminology to recognise the 'changes in the structure and parameters of penal communications' (Pratt *et al* 2005:xv). The notion of 'penal communications' conveys the sense that the expansion of penalty has been so great as to constitute its own context, its own process of communication, quite apart from how penalty is applied in criminal justice or criminology. For example, the places where penal policy is designed and shaped include not just government departments but non-government organisations, academia and other research environments, the media and public opinion. Similarly, the implementation of contemporary penal policies is taking place not just in a plethora of detention facilities, but in an ever-expanding range of community-based initiatives. Consequently, as a number of authors have argued, progressive penal politics, and criminology's engagement with those politics, need to engage with the changing nature of public interest and its effect on policy and practice in this area (Garland 1990; Brown 2005; Ryan 2005). I was interested in the work of the Home Office within these growing demands on government and the civil service. The level of public pressure and expectation on the Home Office had increased significantly in recent years. One example of this was the furore during the period of my research over the release of prisoners who, under the government policy at the time, should have been considered for deportation and were instead released (see for example Weaver 2005). The outcry included a prolonged attack directly challenging the competency and

efficiency of the Home Office.<sup>48</sup> Ministers can be slow to defend their departments, and civil servants working in such environments may be mindful of the consequential risk to their own jobs. Their commitment to a particular philosophy about how the system should operate may be metered by these preoccupations. Additionally, the bureaucracy is ever mindful of scandals, and concern to avoid them has often resulted in changes to criminal justice policy (Pratt 2005).

At the same time, the legal structures stipulated by human rights conventions and laws meant that breaches of those rights could not be ignored. However, by defining patients in opposition to the public, and its constitutive groups such as victims, the Home Office enabled itself to define the interests of patients outside its mandate to protect the public. It could do this without jeopardising the legality of its decision-making because, as excerpts from my interviews above illustrate, it relied upon the Tribunal to protect and promote the rights of restricted patients. The Home Office's construction of the public protection agenda did not just prioritise it over the rights of patients, but to the exclusion of them. As Unit staff stated, this was justified on the grounds that the human rights framework had established a whole other mechanism independent of the Home Office to protect patients.

The perspective of different groups in the restricted patient system was crucial to understanding how all actors in the system interacted around the framework of human rights. Home Office officials were clearly moulded by the environment within which they operated, an environment which was influenced by political, social and economic factors: the politics of criminal justice policy, the public interest in the management of high-risk offenders, and the economics of the resources necessary to provide adequate care and treatment to restricted patients. While these influences may have affected all actors throughout the system, the extent to which that influence took shape varied. In the next section I discuss the views of other actors within the system and how they varied from those of the Home Office, not just in terms

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48 The then Home Secretary Charles Clarke was eventually forced out of the Ministry. The next Home Secretary, John Reid, was subsequently quoted as stating that the Home Office was 'not fit for purpose', bringing the department into another round of public criticism and media condemnation (see for example Richards 2006).

of the description of rights, but in how they perceived the effect of those constructions on decision-making about restricted patients.

### ***Alternative Perspectives: the Views of Non-Government Actors***

As I have established throughout this thesis, non-government actors<sup>49</sup> in the restricted patient system were generally sympathetic to the Home Office's role in protecting the public. However, they strongly disagreed that its brief alleviated the Home Office's responsibility to safeguard the rights of patients. Some people said that 'public protection' included the protection of patients. For others, the public protection agenda was intended to be balanced with the rights of patients, not against them. Finally, there were those who claimed that the Home Office's approach to rights was a narrow interpretation that ignored the fundamental principles at the heart of both mental health and law.

One lawyer who represented restricted patients argued that the problem with the Home Office's conceptualisation of the public was that it excluded patients. She stated that its approach to public protection impeded the progress of patients through the system because it was neither methodical nor constructive in its decisions about patient applications:

[i]t seems to me that what they're doing is wrong because they are impeding people's progress, and that's one thing, but they are also, as a result of that, preventing other people who are seriously in need of treatment, from getting into hospital ... [later in the interview] whatever the Home Office may say about the public interest ... the law relating to detention and 'transfer' ... is perfectly clear. People should be treated in the least restrictive alternative possible; people should only be detained in the interests of their own health and safety or the protection of others'.

As I showed above, one official had stated that everything the Home Office did was 'ECHR-sensitive'. This meant that everything done under the *Mental Health Act 1983* had to be compatible with the European Convention, and subsequently the *Human Rights Act 1998*. However, practitioners interpreted what it meant to be 'human rights friendly' differently from Home Office staff.

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49 To re-iterate, I use 'non-government actors' to refer collectively to mental health and other non-government organisations, legal practitioners, clinicians, care teams and hospitals.

For the lawyer quoted above, the human rights framework was intended to ensure adequate care of patients through the system, including their progress towards release. Therefore, in her view, even if the Home Office was acting lawfully, it was not necessarily operating within the spirit or overall objectives of the human rights framework.

Another lawyer was particularly concerned about the human rights of people in prison suffering mental disorder. In an interview with me this lawyer stated that the UK had argued successfully before the European Court of Human Rights that the mere existence of the restricted patient system meant that there was no further onus on the government regarding people suffering from mental illness in prison. In other words, the fact that courts could order a person to be detained in hospital following his or her conviction meant that when the courts chose not to make this order, there was no further onus on the government to ensure the prisoner received appropriate treatment in prison. This was the case despite the fact that evidence of mental disorder was not necessarily introduced in court, even where relevant to explaining the commission of an offence.<sup>50</sup>

Other lawyers I interviewed also told me of cases where the Mental Health Unit had rejected an application in the first instance, but had been amenable to submissions from lawyers who disagreed with the Unit's position, and had even reversed decisions following such correspondence. Lawyers observed that these examples were indicative of a cultural shift that had taken place at the Home Office in response to the human rights framework. In particular, lawyers expressed the view that the Home Office did not want to make decisions that got them into trouble in terms of human rights law. A number of lawyers had found the Home Office more receptive to their submissions as a result. However, some lawyers believed that the increased receptiveness was motivated more by a desire to avoid appeals to European human rights law, than by a genuine concern to safeguard the rights of restricted patients.

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50 For example, one lawyer I interviewed told an anecdote of a defendant who was brought to trial from hospital each day and returned to hospital each night. Because the defendant chose not to raise a mental illness defence, the court never knew that he was receiving mental health treatment in hospital. The example illustrated the point that evidence of mental disorder was selectively used in court proceedings even when it was central to understanding the state of the accused.

For example, they felt that there was insufficient concern about delays in decision-making in the system. Whilst delays were more often encountered at the Tribunal than with the Home Secretary, the inability to review detention could result in an extended period of unlawful detention for a patient. Thus some lawyers suggested that the human rights framework provided no more protection of patient's rights in practice, than had existed before the 1983 Act.

Of course, tensions between legal practitioners and a decision-making body are not in themselves remarkable, even if it was unusual (in a legal context) for the decision-maker to be the executive. One might argue that lawyers who accused the executive of acting in bad faith in terms of human rights were simply doing their job, advocating as hard as they could in the interests of their clients. Equally, it could be argued that the very presence of the Home Secretary as a parallel decision-maker to the Tribunal was in itself a safeguard for patient rights, ensuring an alternative avenue to review discharge in the event that Tribunal proceedings were delayed or otherwise unavailable. I shall discuss this further below.

The perspectives of psychiatrists differed subtly from those of lawyers. Psychiatrists practising in this system were often extremely well-informed about its socio-legal dimensions (see for example Eastman and Peay 1999; Buchanan 2002; Mullen 2002). Many of the psychiatrists interviewed or cited in my thesis had pursued legal or criminological studies and had published widely on the social, legal and clinical aspects of risk assessment and management of forensic patients. Nevertheless their engagement with the question of human rights was understandably a practitioner-oriented view of the patient, as compared with the legal standpoint taken by lawyers and (to some extent) the Home Office. This further demonstrated how the particular position and environment from which actors operated in the system structured their viewpoints differently.

For example, one psychiatrist I interviewed found the Home Office assertion that the restricted patient system was amongst the most human rights friendly to be 'disingenuous' because the same system that enabled a hospital order following a conviction for manslaughter also facilitated

'preventive detention through indeterminate detention well beyond what would have been the tariff in the original offence, in a homicide'. He argued:

you have to look at the reality of how it operates, not just the formality of the law. And it then depends on how mental health processes function, tribunals function, and also how the Home Office functions in terms of exercising its discretion ... because if they don't properly exercise discretion but rather they see this as a tug of war between them and the Tribunal, um, well, if they think it's a human rights-friendly system it doesn't look as if their heart's in the right place with regards to the human rights of those that they're [targeting].

This rejection of the 'formality of the law' implied that ensuring the human rights of patients required adherence to principles as well as to structure; that intention and outcome mattered as much as process. Even then, this practitioner noted that 'the European Convention isn't very good at protecting the rights of the mentally disordered'. His view was supported in the literature. For instance Richardson has noted that the European Court of Human Rights 'has made a significant contribution to improving the procedural safeguards available to detained patients in England and Wales, but has played little part in questioning any more substantive aspects of our mental health law' (Richardson 2005:129). In other words, protecting the human rights of patients required more than the mere existence of institutions like the Tribunal, even if its role was to safeguard patient rights.

Introducing the Human Rights Bill in the House of Lords, the then Lord Chancellor said, 'our courts will develop human rights throughout society. A culture of awareness of human rights will develop' (Hansard 1997). In his analysis of the effect of the *Human Rights Act 1998* on the Home Office, Rock describes how the *Act* was 'intended by the Government to lend authority to a renewed discourse of rights and citizenship which had hitherto been somewhat alien to the British constitution' (Rock 2004:218). Rock shows that this legislative intention was mirrored by a cultural shift from Ministers down through their departments, as the basic framework through which they viewed their work and responsibilities shifted in the direction of human rights (*ibid*). The idea that human rights shaped the culture of the system in which decisions were made resonated in the restricted patient system. One woman I interviewed had extensive experience in policy and

lobbying work for non-government organisations active in the sector. In her opinion, the European human rights framework 'made a huge difference'. However, she said, this was particularly on issues relating to the correlation between a patient's incapacity to consent to treatment because of their mental disorder and the particular process applied to detain them in hospital. In her view, case law on these issues had produced a shift in the opinion of the executive about the use of preventive detention, such that there was now great concern about how and when it could be used appropriately. She said that these were positive changes and that they were cultural, affecting approaches and behaviour generally, as well as in individual cases.

Her view was supported by a psychiatrist I interviewed who had experience in both the restricted patient system and in comparative jurisdictions including Australia. He felt strongly that the effect of European human rights law on the English system made a significant difference to the culture of the system, as well as to the specific legal parameters of how the system operated. He told me of an Australian case in the jurisdiction of New South Wales (NSW) where a forensic patient had escaped from hospital, was re-captured and was subsequently detained in a maximum-security prison because the Commissioner of Corrective Services assessed him to be a security risk.<sup>51</sup> As a forensic patient he was legally required to be detained in a hospital. Accordingly, the NSW Mental Health Review Tribunal advised the Minister for Health, in whom the formal authority over forensic patients was vested, that the patient should be transferred from prison to hospital. Indeed legal advice from the Department of Corrective Services itself had found the patient's detention in prison to be unlawful. Yet no action was taken to transfer the patient. This interviewee commented that, had this happened in England, the patient could have appealed through the human rights framework. Indeed, he believed that the mere threat of 'taking a case to Europe' affected the culture of the system in England and Wales so much that such a case would be unlikely to occur there in the first place. However, the absence of an equivalent to the European Convention on Human Rights in Australia meant that the executive was not held to account with respect to principles of

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<sup>51</sup> The Department of Corrective Services manages prisons and community sentences in NSW.

human rights in its decision-making about forensic patients. Consequently, he concluded, the presence of a human rights framework in England provided essential parameters to the exercise of executive discretion over restricted patients.

What emerged from these data was the perception across government officials, practitioners and non-government organisations that human rights played an important role in shaping the restricted patient system. Interestingly, though, there were stark differences amongst these various actors about the nature and consequences of the human rights effect. In the concluding discussion of this chapter I focus on the effects of the construction of human rights: firstly on restricted patients; and secondly on the executive as decision-makers.

### ***Unintended Consequences? The Impact of the ECHR on Constructions of Patient Rights***

A central tenet of my thesis has been that some of the protection offered by executive discretion in the restricted patient system was best understood as an example of symbolic politics, wherein decisions and policies were as important for what they said about the system as for their outcomes (Newburn 2002:175). The way in which the language and framework of human rights constructed their subject depended upon certain symbolic associations of their own, including agency and entitlement. However as Peay notes, any sense of agency by restricted patients was constantly undermined by the executive's authority over them and by the hospitals within whose walls they were detained.

Patients generally have no right to a particular form of treatment, but equally health care professionals have an ethical and legal duty to provide care of a particular standard. The relationship is perhaps best conceived as an axis of entitlement and duty. However, the situation is further complicated by the way in which mental health law sustains the anomalous position whereby patients with mental health problems who retain their capacity (but who are not subject to the Mental Health Act 1983) have an absolute right to refuse treatment but those suffering with similar problems who are subject to the 1983 Act have no right to refuse treatment for their mental disorders even if they retain all of the elements required to satisfy the notion of legal

capacity. Yet those very same people will enjoy an absolute right to refuse treatment for their physical disorders (Peay 2003:139).

Similarly, any sense of entitlement (for example to particular levels of service or to liberty from the hospital environment) was considered within strictly legal parameters which were, as I have been illustrating, frequently contested. As such, it was difficult for restricted patients to gain access to the mechanisms (such as courts) which would establish the nature and extent of their rights. Most importantly, the rights already established for people detained under mental health law were undermined in the case of restricted patients, because they were continuously being balanced against the priority on protecting the public that dominated the decision frame of the Home Office.

This is not to say that the executive deliberately undermined the rights of patients. The situation was far more complex than that. The tension between the human rights of patients and the public protection was a problem rooted in the intersection of law and the system that supported it. That tension was complicated even further by the fact that there were actually a number of different laws and a number of different systems operating, sometimes intersecting, sometimes in parallel. By way of example, I return once again to the Mental Health Review Tribunal as an alternative decision-making avenue to the Home Secretary. The right to review detention and the extension of decision-making power over the discharge of restricted patients had been granted to the Tribunal in order to satisfy the legal requirements for safeguarding patient's rights. However the systemic problem of Tribunal delays was at best a denial of procedural fairness. At worst it created the potential for prolonging the infringement of a patient's human rights, if it was found that the person was being unlawfully detained. Delays at the Tribunal were a problem over which the Home Office did not have control. However, attributing the safeguarding of patient rights to the Tribunal in the face of a well-established critique of its process undermined the protection of patient's rights across the system. As a result, the question returned to one of how the executive exercised its discretion in balancing the rights of restricted patients with the public protection agenda.

In previous chapters I have discussed the contrast between the health system operating on a model of individual patient need, and the legal principles of due process that underpinned criminal justice. One of the ways the health model of individual need took shape was through the adoption of a particular language that attempted to subvert the stigma often experienced by mental health patients. In the UK mental health patients often used the term 'service user' to describe themselves. Those who lobbied in the interests of people with mental disorder were often termed 'consumer advocates'. In other countries terms like 'stakeholder' or 'mental health consumer' served the same purpose. This nomenclature established a framework in which patients claimed legitimacy in the public and political eye, through a form of health citizenship expressed through rights, entitlements and how they were treated and protected within the remit of mental health law. This was evident in the law reform process discussed in Chapter Six, where members of the Mental Health Alliance and others giving evidence to the Joint Scrutiny Committee described themselves as 'service users' rather than patients, or 'service providers' rather than clinicians, clinics or hospitals.

These terms imply a certain type of relationship between doctors or other health staff and their patients; between 'service provider' and 'service user'. The implications are that the service is of a known quantity; that it is a service that was sought by the consumer; and that the provider has the skills, expertise and resources to provide the service to a particular standard. It is a language that suggests choice on the part of the consumer, and is intended to empower mental health patients by resisting the stigma associated with compulsory mental health treatment.

However Richardson (amongst others) has argued that stigma is inherent in a legal system which provides a framework for compulsory treatment of patients even when they have the capacity to consent to that treatment but choose not to (Richardson 2007). She argues that, whilst one might agree with the principle that therapeutic need outweighs individual autonomy in some cases, it is inherently discriminatory to apply that principle to the case of mental disorder but not physical disorder (*ibid*, see also Dawson and Szmukler 2006; Thornicroft 2006).

Goffman also talked about this issue, although in different terms, when he discussed the tensions in the relationship between a patient and their psychiatrist.

In many psychiatric settings, one can witness what seems to be the same central encounter between a patient and a psychiatrist: the psychiatrist begins the exchange by proffering the patient the civil regard that is owed a client, receives a response that cannot be integrated into a continuation of the conventional service interaction, and then, even while attempting to sustain some of the outward forms of server-client relations, must twist and squirm his way out of the predicament (Goffman 1961:320).

Here, Goffman illustrates how terms like service 'provider' and 'receiver' ignore the coercive power in the hands of psychiatrists administering compulsory treatment under mental health law. While coercive treatment is not an inevitable outcome in mental disorder, the fact of its potential must be acknowledged as a significant factor in shaping the relationships between psychiatrists and their patients in hospital. In that context, a language of empowerment is unlikely to challenge the underlying, structural discrimination towards mental health patients that is built into the system.

Challenging the structural discrimination of the mental health system was even harder in the case of restricted patients. With some notable exceptions, mentally disordered offenders had generally been convicted of a criminal offence which was likely to have eroded some of their basic entitlements, such as the right to liberty.<sup>52</sup> Forensic patients often entered the mental health system from a position of curtailed liberty (to varying degrees), which was then compounded by compulsory mental health treatment. The extent of their empowerment as consumers was further challenged by problems with the availability and quality of forensic mental health treatment (as discussed in Chapter Six). For these reasons, the implications of autonomy in the terminology of 'service user' were significantly marginal when applied to the context of the restricted patient system in England and Wales.

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52 Exceptions include people found unfit to stand trial and those found not guilty by reason of insanity. However both findings may still result in a period of detention, including indefinitely.

In their study of patient satisfaction in medium secure units (where many restricted patients are detained), Carlin *et al* note the following.

Levels of user involvement and satisfaction are central to government policy in health service provision and user satisfaction is recognised as a valuable measure in evaluating the performance of NHS services. [Yet] ... The concept of the user as a 'consumer' and evaluator rather than passive recipient of NHS services is more readily accepted in some areas of medical service provision, such as primary care, than in psychiatric services, in which less emphasis has been placed on surveying user opinion (Carlin *et al* 2005:715).

Their study found that involuntary patients were less likely to report satisfaction with services than voluntary patients (Carlin *et al* 2005). Further research indicates that restricted patients suffer more stigma than other mental health patients, including particularly negative media attention (Ardron 2007); and fears and experiences of victimisation in the community peculiar to their status as restricted patients (Colombo 2007). As my own research has shown, these dynamics were not just indicative of patient relationships with health care professionals and in hospital. They also underpinned the nature and extent of the attention paid to restricted patients by the mental health consumer lobby. In the previous chapter I suggested that the strength of the civil mental health lobby did not extend to supporting or advocating for the needs of mentally disordered offenders generally, and particularly not for restricted patients. Such distancing was also evident in the literature (see for example Richardson 2005). Thus, while conceptions of patients as service users whose rights could be established applied in theory to restricted patients, in practice they were precluded from many of these entitlements by the combination of their compulsory treatment, their indefinite detention, and by the stigma associated with being offenders and mental health patients.

This brings me to the first conclusion of my analysis in this chapter. The purpose of my discussion here has been to establish the terrain upon which the human rights of restricted patients were asserted. In both the construction of rights and the conditions necessary to obtain those rights, restricted patients were disadvantaged by virtue of their legal status as indefinitely detained; by their symbolic identity as dangerous people and accordingly subject to executive discretion; and by their political isolation as a result of

the difficulty or unwillingness of many mental health organisations to advocate on behalf of forensic patients. The rights of restricted patients were themselves symbolic, in much the same way I have argued that the public protection was. A conception of rights informed the decision frames of legal and clinical practitioners, and indeed of the executive, far more than the extent to which rights had actually been tested and established before the courts. Certainly, some rights had been established in law, but these were to a small degree. In reality the extent and nature of human rights for restricted patients was greatly limited. Nevertheless conceptions of rights continued to occupy an important place symbolically, in terms of how different actors in the system approached their responsibilities for, and obligations to restricted patients.

Mental health policy has been much-criticised for being rhetorically focussed on patient care but not actually achieving the objectives of treatment or rehabilitation. These criticisms have tended to focus on issues such as care in the community, or mental health service consumer empowerment (see for example Chapman *et al* 1991; Pilgrim 1991). In the restricted system, I suggest, the notion of patient rights was another example of a rhetorical principle that was difficult to sustain in practice. Patient rights were acknowledged in law; accepted in the narratives told by officials and practitioners; and even protected in theory, through the symbolic safeguard provided by the Tribunal. But in practice, patient rights were overshadowed by the routine priority placed on the public protection agenda, within the framework of executive decision-making.

The second conclusion of my analysis relates to the effect of the construction of rights on executive decision-making. As I have shown, Home Office decision-makers repeatedly conferred on the Tribunal the responsibility for protecting patient rights. This was a consequence of the particular approach taken by the executive towards the public protection agenda. According to Home Office staff, the assertion of a human rights framework *via* the establishment of a quasi-judicial structure guaranteed the protection of the rights of restricted patients. This guarantee was not perceived as complementary to the work of the Home Office. On the contrary, there

seemed to be a much more fundamental shift in the conceptualisation of human rights by the executive; specifically what those rights were, and whose responsibility it was to uphold them. In this shift, the extension of Tribunal powers into the domain of restricted patients facilitated a perceived handover of responsibility for those rights entirely: from the executive, in the authority of the Home Office, to the Tribunal. This was despite evidence of some significant problems in the efficacy of the Tribunal in protecting the rights of restricted patients, including delays in Tribunal hearings and over-caution in relation to risk.

Relegating the protection of patient rights to another body enabled a complete reconfiguration of how the executive constructed its role in the system, away from attention to the rights of patients, to primary preoccupation with the protection of the public. In the perspectives of my research participants, the *Mental Health Act 1983* had resulted in a notable change in this regard. Clearly, these perspectives were the product of the particular environment in which the Home Office operated. Alternative perspectives suggested that Tribunals were not free from consideration of the protection of the public. In assessing the appropriateness of a discharge from hospital, the Tribunal had to consider the safety and protection of the public. Similarly, and as one interviewee noted, clinicians had a responsibility to consider the safety of the public when they recommended a patient for leave or release. Moreover, the notion that the Home Office was concerned with patient rights under the previous legislative regime could well be contested by those outside the government. Nevertheless, in the way they conceptualised the system and their responsibilities within it, Home Office participants constructed a dichotomy between the rights of patients and the protection of the public; and defined their own responsibility solely in terms of the latter.

These observations suggested two important points regarding the human rights of restricted patients. Firstly, there were a range of interpretations about what it meant to operate within a human rights framework. The views of Home Office staff consistently reflected the primary responsibility to the public. Beyond that, however, some officials felt a responsibility towards the

rights of patients that was not shared by all their colleagues. Meanwhile, other actors in the system did not see these responsibilities as mutually exclusive. Moreover, practitioners generally saw the question of human rights as broader than the specific instruments available in law. They believed patient rights to be a central tenet of the principles of mental health law and argued that intention and outcome were as integral as process in safeguarding these rights.

Consequently there were two alternate constructions of human rights at play in the restricted patient system. The first was essentially an administrative interpretation of human rights by decision-makers acting on behalf of the executive, in which rights were de-limited by the structure of legislation and the stipulation of case law. The second view constructed the scope of human rights as a framework which, in the views of non-government actors, should have shaped all decision-making, even within the context of the public protection agenda.

While the responsibility for public protection was enshrined in statute, my study of executive discretion has suggested that the meaning or practice ascribed to protecting the public was very much a matter of interpretation, both by the various institutions and individuals engaged in the restricted patient system, and even across different people working within the same institutions. It was the prerogative of the executive in whose authority and responsibility the discretion to protect the public lay, to determine who was protected, and how. Yet the Tribunal was also required to consider the safety of the public; and as I have shown, it was extremely cautious in this regard. As a result, both the Tribunal and the Home Secretary made decisions about restricted patients detained under the specific criteria of the *Mental Health Act 1983*, yet both placed significant emphasis on public protection in their decision-making (albeit often to a different extent and outcome). It was likely that the competing constructions of human rights I have outlined would continue to exist as long as there was a tension between the principles of patient rights on the one hand and the public protection on the other. However, while the decision-making power to discharge patients was vested

in the two alternative bodies of the executive and the Tribunal, it was a tension that might never be resolved.

## CONCLUSION

### *Précis*

The role of executive discretion in the restricted patient system derived from the executive's mandate to protect the public. My research explored how 'the public' was constructed and what 'protection' meant in terms of executive decision-making. I found that the executive construed its mandate as separate to the objectives of care and treatment under the *Mental Health Act* 1983. That is to say that the executive perceived its function solely in terms of public protection, and that it perceived itself as the only actor in the restricted patient system who was concerned with this objective. Moreover, those making decisions on behalf of the executive constructed a notion of 'the public' that was exclusive of patients. That conception created a divide between the interests of patients and of the public within the decision frame of executive discretion.

The *Mental Health Act* 1983 included the principle of public protection alongside the healthcare objectives of compulsory treatment. But it was the discretion to interpret how it exercised its own mandate that led the executive to an exclusive preoccupation with protecting the public. The interests of care and treatment were continuously subsumed within that preoccupation. The tension between public protection and patient rights was both produced and reinforced by the structure of the restricted patient system. It was also a tension that imbued the relationships between - and the decisions made by - all actors in the system.

In the contemporary context of law and order politics and increasingly punitive populism, the interaction between criminal justice and other systems is an apposite concern for criminology. My study of the restricted patient system points to important shifts in the utility and purpose of mental health legislation that expanded the frameworks available for preventive detention in the interests of public protection. While there may be a close correlation between serious or violent offending and dangerousness, they are not the

same thing. The significance of the mental health system and the government's agenda to reform it was that it offered a mechanism for preventive detention of dangerous people regardless of whether or not they had previously committed a serious or violent offence.

### **Research Questions**

My doctorate commenced as an inquiry into the role and effect of executive decision-making in the restricted patient system. The first part of my inquiry was readily explained by reference to statute, in the form of the *Mental Health Act 1983*, and by the policies of the Home Office: the role of the executive was to protect the public. From this stated objective of executive discretion flowed the much more interesting questions of what the public protection agenda was; who it protected; and how that protection was achieved. My specific research questions were as follows.

1. How was the central conception of 'the public' constructed and to what extent did that construction have an impact upon decisions made about restricted patients?
2. How did the executive meet its mandate of public protection?
3. How did the various actors view the role and effect of the executive in the restricted patient system?

An extensive body of literature formed the conceptual tools of analysis for this research. It included the criminological literature on detention, prevention, public protection and victim involvement in criminal justice; existing research and analysis of the restricted patient system in England and Wales; theories of risk and management of mentally disordered and serious offenders; and socio-legal approaches to decision-making. I used this literature to explore the extent to which symbolic politics provided one account of public protection in the restricted patient system.

### **Findings**

In the restricted patient system there were a number of actors involved in decision-making and each had a different decision frame. For example, the therapeutic benefit of the individual patient was the dominant objective

guiding decisions by psychiatrists and other clinical practitioners to apply for leave or discharge, while the Mental Health Review Tribunal was charged with safeguarding the rights of restricted patients. But it was the exercise of decision-making power by the executive over applications for leave and discharge that formed the subject of my study. The dominant objective in the executive's decision frame was public protection. Consideration by the executive of the public protection was enshrined in statute, *via* the *Mental Health Act 1983*. However the extent to which that agenda should have been the sole priority of executive decision-makers was a matter on which the views of actors varied throughout the system. The dominant perception of those I spoke to at the Home Office was that the public protection agenda was exclusive to other considerations; and that it was unique to the role of the Home Office. According to Home Office participants in my research, protecting the public was not an objective they shared with other actors in the system.

Moreover, public protection as defined by the executive seemed to be understood in opposition to the interests of patients. Those interests included both the formal rights of restricted patients as set out in mental health and human rights law; and the therapeutic progress of patients receiving care and treatment. In arguing that executive conceptions positioned public protection in opposition to patients' interests, I am not suggesting that the rights of patients were deliberately undermined or violated in order to protect the public. The mandate of public protection enshrined in the *Mental Health Act 1983* vested in the executive the discretion to conceive that agenda as it saw fit. The construction of these various elements of mental health law as competing with each other was a logical consequence of the legal structure of the system, particularly given the two alternative routes for decision-making by the executive and the Mental Health Review Tribunal. However, I conclude that the opposition between patients and the public was also a consequence of the exercise of discretion within the climate of law and order politics that marked public policy at the time (Garland 2001; O'Malley 2004b; Lacey 2007; Reiner 2007). While government decision-makers perceived the system to balance the rights of patients with the public protection, they saw

that balance to have been achieved by virtue of the executive and the Tribunal operating as parallel avenues for decision-making.

By contrast, other actors in the system perceived the *Mental Health Act 1983* to require a balance between public protection and patient rights even within the context of executive decision-making. They rejected the executive's construction of the public as exclusive of patients and argued that the effect of the priority on public protection was to undermine the treatment and rehabilitation of patients.

The question of where the balance lay between patient rights and public protection became a central concern of my thesis. I found that the balance was largely symbolic. It was spoken of frequently by decision-makers representing the executive and was central to the decision frames described by both government and non-government participants in the research. But when it came to decisions about leave or discharge by the executive, the interests of individual patients were continually subsumed within the dominance of the public protection agenda. In practice, the nature of the executive's discretionary powers, coupled with the executive's mandate for public protection, produced an imperative to control patients through the prolonged use of preventive detention. These decisions resulted in the routine prioritisation of preventive detention in the interests of public protection over clinical recommendations for less secure detention or discharge. As such, the notion of balance operated symbolically, featuring in how executive decision-makers spoke about the system more than in their exercise of discretion.

The key marker of symbolic politics in the restricted patient system was the preoccupation with control over care. Practitioners suggested that the rejection of leave and discharge applications in the interests of protecting the public was short-sighted, because it resulted in the stalling of patient treatment and rehabilitation; a consequence that practitioners believed was counter to effective public protection in the long-term. Moreover, practitioners suggested that the preoccupation with public protection sometimes resulted

in patients not being treated in the least restrictive environment possible, which was a key principle of mental health law. For example, applications for leave or discharge were often granted with an accompanying measure that restricted the clinical regime being proposed in order to facilitate closer monitoring by the Home Office of the patient's behaviour in the community. Conditions were sometimes attached to patient discharge even though they carried little direct force. Conditions were relatively meaningless when challenged directly. Much of their power was coercive; a finding which supported Dell and Grounds' analysis that the threat of recall was used by the executive as a mechanism to control patient behaviour (1995).

The function of conditions of discharge was a good example of how symbolic politics operated in the system. Conditions of discharge attempted to reduce the likelihood of particular incidents associated with a patient's medical or offending history. For example, if a patient was known to become mentally unwell when he or she drank alcohol, the conditions of their discharge might include abstinence from alcohol and random screening to test the person's compliance. However conditions of discharge also operated as a mechanism of reassurance for the public. Victims were often assured that they would not encounter a restricted patient in public because of conditions on that patient's movements. As my data showed, these conditions carried little weight in practice. Nonetheless they were important symbolically as evidence that the executive had listened to and acted upon the concerns of victims in its decision-making about restricted patients.

I do not argue that meeting the public protection agenda was purely symbolic. There were clear indications of direct action by the Secretary of State to protect the public. These included maintaining a certain level of security while a patient was detained or issuing an order for a patient's recall based on the deterioration of their mental state. However, these direct actions were accompanied by the exercise of a symbolic politics which operated simultaneously, serving to reassure the public that decision-making was being undertaken in their best interests. The symbolism of this

reassurance against public fear was as important as the actions taken to protect the public in the face of threats to their safety.

### ***The patient/public divide***

Not everyone I observed or interviewed subscribed to the notion that patients' interests and public protection were diametrically opposed. Some practitioners and a minority of Home Office officials expressed the view that protecting the public was best achieved through ensuring the therapeutic progress of patients. That stance raised the question of whether or not restricted patients constituted members of the public themselves. According to legal and clinical practitioners in my research, restricted patients were detained solely for treatment of their mental disorder. Yet for government decision-makers, the executive's discretion derived from concern about protecting others if these patients were released. As a result, restricted patients were constructed by the executive predominantly in terms of the danger they posed to the public. Essentially, this construction required making a distinction between patients and the public. In many ways it was a distinction produced by the legislative structure itself. Yet for those actors who were responsible for the care and treatment of restricted patients, their decision frame placed the priority on patients as individuals with health needs, even as they operated within the same framework of mental health law as the executive.

Defining restricted patients in terms of dangerousness reflected the particular logic which underpinned the executive's mandate for public protection. Nevertheless, the perception of restricted patients as risky individuals also imbued the perspectives of others outside the sphere of government, most notably those of non-government organisations involved in law reform. Concerned about the harshness of measures proposed to control risk in the reform of mental health law, non-government actors attempted a strategic distancing of the majority of the population receiving compulsory treatment for mental disorder from the small proportion of that population who constituted forensic patients. While such distancing was understandable within the broad political objectives of mental health advocacy, it served to re-

reinforce the dominant representation of restricted patients as risky individuals. I do not mean to argue that risk was irrelevant for restricted patients. The very nature of their restriction derived from an assessment of the risks they posed to the public. However, I do argue that the representation of restricted patients as uniquely risky was a product of the political climate at the time. That climate saw the government trying to tackle fear of crime and its effect on public perceptions of law and order (Reiner 2007). Within such pervasive constructions of risk and dangerousness, any notion of the rights of restricted patients was even further relegated to the domain of symbolic - rather than practical - consideration.

When determinative authority was extended to the Mental Health Review Tribunal, the executive interpreted this as a signal that its primary and exclusive responsibility was to protect the public. In other words, if the rights of patients were protected by the Tribunal, they no longer needed to be considered within the executive's decision frame. I have shown how this interpretation led the Home Office to focus solely on public protection. Although the Tribunal's responsibility was undoubtedly to safeguard patient rights, other actors in the system contested the idea that the executive no longer had any responsibility for the rights of patients. Non-government actors including clinical practitioners and lawyers asserted that the executive was still responsible for ensuring that patients were detained lawfully under the *Mental Health Act 1983* and in accordance with European human rights law. That responsibility increased, according to practitioners and lobbyists, in the face of the mounting evidence of the apparent ineffectiveness of the Tribunal as a safeguard for patient rights.

Another way that symbolic politics operated in the system was in the way 'the public' was constructed through specific groups who came to the attention of Home Office decision-makers. These groups included the victims and, to a lesser extent, the families of restricted patients. The reliance on particular groups to reflect the concerns of the general public went along with the presentation of policy changes that took place during the course of my research. Those policy changes reassured the construction of victims and

offenders as opposing categories, in contrast to the close relationships (including familial) that existed between victims and offenders in the restricted patient system. A consequence of these public statements was that policy itself represented the interests of victims and offenders as oppositional, even though such oppositions were not reflected in the perceptions of practitioners or the experiences of many of the victims and offenders who were involved in the restricted patient system.

### ***The purpose of detention***

A considerable body of contemporary criminological literature has been concerned with criminal justice policy shifts under the symbolic politics of law and order. I used these theories to examine how the interaction between mental health and criminal justice in the restricted patient system was illustrative of a similar effect. I suggested that criminal justice was increasingly turning to alternative frameworks like mental health law to resolve problems that were beyond the scope of criminal justice. One such problem has been how to contain people who pose a danger to others, but who have not committed an offence to warrant a criminal sanction. While the strategy of containment was an attractive option, and might appeal to the punitiveness of contemporary penal populism, there was the potential for it to conflict with traditional principles of criminal law such as proportionality. By contrast, the framework of mental health law offered an existing mechanism of preventive detention, as it was an essential element of the provisions for compulsory treatment. I am mindful of Garland's caution not to 'exaggerate or extrapolate' about the broader application of criminal justice policies (Garland 2001:21), and I do not seek to suggest that the reform of the 1983 Act or the processes of the restricted patient system were the blueprints for an entirely new criminal justice system. Rather, I suggest that the agenda of controlling dangerousness resulted in some slippage between the traditional boundaries of criminal justice and mental health policy.

The utility of detention in criminal justice lay in its sanction against and deterrence for crimes committed, whereas in health it was a mechanism to enforce therapeutic intervention. Applying the framework of mental health law

to the agenda of controlling dangerousness indicated a blurring of those traditional boundaries under the policy priority of public protection. As Mitchell put it, 'in the absence of any legally sanctioned method of extending prison sentences, a medically sanctioned method will suffice' (Mitchell 2003:82, emphasis in quotation). Mechanisms of detention in the interests of public policy were increasingly evident in a range of areas.<sup>53</sup> The restricted patient system was another example of public policy moving beyond the parameters of criminal justice and utilising the powers of detention in alternative legislative frameworks to meet an ever-expanding agenda of risk prevention, security and public protection.

### ***The exercise of discretion***

There was a wide degree of acceptance throughout the system of the executive's priorities and a degree of satisfaction with how the executive carried out its role. However criticisms of the exercise of that discretion consistently focused upon the question of how to balance patients' interests with public protection. As long as patients and the public were seen as binary opposites, the political agenda of the executive and the health agenda of practitioners might never be reconciled. Yet one practitioner I interviewed argued that the tendency of the Home Secretary to reject applications for leave or discharge indicated a failure to exercise the executive's discretion. His comment alluded to an alternative conception of the function of executive discretion, wherein the objective of public protection could be met through the rehabilitation of patients in the community instead of through prolonged detention. That possibility supported the comments of some Home Office officials who suggested that patient progress in treatment was in the interests of public protection. However that view was held only by a minority of officials.

The cornerstone of my argument about symbolic protection was the extent to which the executive sought to assuage public fears in its decision-making.

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53 For example the extended detention of immigration and asylum seekers; the preventive detention of terrorism suspects; and the introduction of Control Orders, in which extended terms of suspicion enabled surveillance or control of people in the absence of their prosecution before a court.

Yet, if public protection was actually about managing public fear, then the interests of patients and the interests of the public could have been constructed in much closer alignment. In Chapter Five I discussed the example of the patient who met with victims at the police station where he had committed his index offence. That example illustrated how victims' fears could be exacerbated by their lack of knowledge about the progress of treatment for restricted patients. Here, the fears of the victims dissipated once they met and understood the progress made by the restricted patient. The example pointed to the possibility of an alternative conception of executive discretion wherein the objectives of patient rehabilitation and public protection could have been constructed in tandem with each other, rather than in opposition.

### ***The role of rights***

So far I have talked broadly of patient interests including, but not limited to their human rights. My data revealed a very interesting effect of European human rights law on the restricted patient system. For the Home Office, compliance with human rights law was achieved when decision-making authority was extended to the Tribunal. This measure ensured the protection of patient rights through the establishment of a dedicated structure and process as required by law. In turn, Home Office decision-makers perceived that they were no longer responsible for the protection of patients' human rights, which was something they had already been finding hard to balance with the public protection agenda. Yet, as the discussion in Chapter Seven showed, there was considerable evidence that the Tribunal was an inadequate safeguard for the rights of patients. Even if the formal structure of the system met the requirements for the protection of patient rights, the realities seemed to raise serious doubts about how those rights were balanced with the priority on public protection in practice.

Equally, non-government bodies relied upon the formal construction of human rights to protect the interests of restricted patients, even though pursuing those interests was beyond what those organisations could afford to pursue within their own advocacy for patients of mental health services. Once

again, the symbolic value of rights appeared firmly entrenched in the language applied to the explanations given about how the restricted patient system worked. Yet the extent to which those rights were instructive in the decisions made and the outcomes of the system appeared far less definitive.

## Conclusions

The restricted patient system was not designed to be punitive. However it was one of preventive detention. Decisions about leave and discharge were predominantly made on the criterion of preventing risk of harm to others through prolonged containment and close control, rather than through treatment and rehabilitation. While executive authority derived from the *Mental Health Act 1983*, the application of that authority prioritised public protection over all other principles of mental health law. Yet there were a number of other principles that could have operated in parallel with the executive's objectives of public protection. Traditionally, mental health law comprised the dual objectives of compulsory treatment in the least restrictive circumstances alongside the protection of the patient and the public. The exercise of executive authority could have presented those principles as coterminous; the executive could have approached the discharge of patients to test their readiness for the community as a component of public protection, not a challenge to it. As Peay reminds us, such dual considerations had informed the executive's decision frame in the past.

Even before the 1983 Act, if patients were *not* suffering, there would have been no basis for continuing detention even if they remained a risk to the public. However, where in the Home Secretary's opinion, such a risk to the public existed, the view was repeatedly taken that the absence of the disorder had to be established *beyond all doubt* before patients would be discharged. Thus ... the conflict between individual and societal rights was resolved, in practice, by Home Secretaries adopting, on the one hand, a narrow view of individual rights and, on the other, a broad interpretation of what society should rightfully be protected from (Peay 1989:12).

My research suggested that by 2005 the executive's consideration of the criteria for detention under the *Mental Health Act 1983* was subordinated to the concern for public protection. Where once compulsory treatment was

weighed alongside public protection by executive decision-makers, now the preoccupation with public protection dominated to the point of over-riding the therapeutic benefits of ongoing detention for individual patients.

By conceptualising the public protection agenda in opposition to the interests of patients, executive decision-making necessarily resulted in patient rights and interests being subsumed within decisions in the interests of public protection. As a result, the balance between patient rights and public protection was largely symbolic. However, symbolic politics played a central role even within the considerations of public protection which structured the executive's decision frame. In a climate of heightened fear of crime, a large part of the public protection agenda came to focus on reducing those public fears. As such, the symbolism of how the executive was seen to exercise its discretion became as important as the extent to which it provided tangible public protection.

## LEGISLATION

*Criminal Justice and Court Services Act 2000*  
*Criminal Procedure (Insanity and Unfitness to Plead) Act 1991*  
*Domestic Violence, Crime and Victims Act 2004*  
*European Convention on Human Rights 1950*  
*Freedom of Information Act 2000*  
*Human Rights Act 1998*  
*Mental Health Act 1959*  
*Mental Health Act 1983*  
*Mental Health Act 2007*  
*Mental Health Bill 2002*  
*Mental Health Bill 2004*

## CASES

*B v Mental Health Review Tribunal and Secretary of State for the Home Department (2002), EWHC Admin 1553*  
*Diodlo v MHRT for South Thames Region (1996), 36 BMLR 145*  
*K v The United Kingdom (1998), European Court of Human Rights*  
*R (on the application of H) v MHRT (2001), EWCA Civ 415*  
*The Queen on the Application of MM v Secretary of State for the Home Department (2007), [2007] EWCA Civ 687*  
*Winterwerp v The Netherlands (1979), 6301/73, European Court of Human Rights*  
*X v The UK (1981), European Court of Human Rights*

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## APPENDICES

### Appendix 1: Table of Fieldwork Participants

| PARTICIPANTS CONTACTED               | INTERVIEW | OBSERVATION |
|--------------------------------------|-----------|-------------|
| <b>Home Office</b>                   |           |             |
| Mental Health Unit                   | 3         |             |
| Probation and Parole Service         | 2         |             |
| Victim and Confidence Unit           | 1         |             |
| <b>TOTAL</b>                         | 6         | 9           |
| <b>Mental Health Review Tribunal</b> | 3         | 3           |
| <b>Clinical Practitioners</b>        |           |             |
| Psychiatrist                         | 5         |             |
| Nurse or Social Worker               | 2         |             |
| <b>TOTAL</b>                         | 7         | -           |
| <b>Lawyers</b>                       | 4         | 1           |
| <b>Non-Government Organisations</b>  |           |             |
| Mental Health                        | 2         |             |
| Victim                               | 2         |             |
| <b>TOTAL</b>                         | 4         | -           |
| <b>TOTAL</b>                         | <b>24</b> | <b>13</b>   |

This table reflects the location of people who participated in my research, categorised according to their position within the restricted patient system, either as a member of a government department, as a practitioner, or as a representative of a non-government organisation.

## Appendix 2: Leave Guidance

The 'Guidance for Responsible Medical Officers' was a document prepared by the Mental Health Unit and available to care teams and clinicians involved in the management and supervision of restricted patients. It served the purpose of advising clinicians how to make applications for leave for patients detained in hospital. Attached to it was a checklist of 'points considered by the Home Office in examining the cases of restricted patients'. The checklist is included here in its entirety. The following version was issued in March 2006 and was almost identical to the version contained in the MHU Casework Manual of 1998.

### **CHECKLIST OF POINTS CONSIDERED BY THE HOME OFFICE IN EXAMINING THE CASES OF RESTRICTED PATIENTS**

**The role of the Home Office in the management of restricted patients is to protect the public from serious harm. To carry this out effectively, the Home Office needs to know:**

- i) why a patient has been dangerous in the past;
- ii) whether they are still dangerous (if so, why; if not, why not and in what circumstances they might be dangerous again), and
- iii) what the treatment plan is.

The following list is not exhaustive, but it is intended to cover some of the points that may need to be addressed when reporting to the Home Office or seeking the Secretary of State's consent to Section 17 leave, trial leave or conditional or absolute discharge. Not all points will apply to all patients; but all sections (not just that covering the main diagnosis) that apply to a particular patient should be completed. Attaching relevant reports is always encouraged.

Reports to the Home Office should reflect the views of the multi-disciplinary team. Please indicate whether the team has been consulted.

#### **For all patients**

1. Should the patient still be detained and for what reason?
2. If yes, which level of security does the patient need?
3. What is the team's current understanding of the factors underpinning the index offence and previous dangerous behaviour?

4. What change has taken place in respect of those factors (i.e. to affect the perceived level of dangerousness)?
5. What are the potential risk factors in the future (e.g. compliance with medication, substance abuse, potential future circumstances, etc)?
6. What are the patient's current attitudes to:
  - the index offence,
  - other dangerous behaviour and
  - any previous victims?
7. What is the outward evidence of change (i.e. behaviour in hospital, on leave, attitudes towards staff and patients and potential victim groups)?
  - how has the patient responded to stressful situations?
  - describe any physical violence or verbal aggression.
8. Have alcohol or illicit drugs affected the patient in the past and did either contribute to the offending behaviour? If so,
  - is this still a problem in hospital?
  - what are the patient's current attitudes to drugs and alcohol?
  - what specific therapeutic approaches have there been towards substance abuse?
9. Which issues still need to be addressed, and
  - what are the short and long-term treatment plans?
10. What is known about circumstances of the victim, or victim's family?

#### **Patients with mental illness**

11. How is the patient's dangerous behaviour related to their mental illness?
12. Which symptoms of mental illness remain?
13. Has stability been maintained under differing circumstances? Under what circumstances might stability be threatened?
14. Has medication helped and how important is it in maintaining the patient's stability?
15. To what extent does the patient have insight into their illness and the need for medication?
16. Does the patient comply with medication in hospital?
  - Is there any reluctance?
  - would they be likely to comply outside?

#### **Patients with personality disorder**

17. What are the individual characteristics of the personality disorder?
18. What have been the treatment approaches to specific problem areas?
19. Is the patient now more mature, predictable and concerned about others? Please give evidence.

20. Are they more tolerant of frustration and stress? Please give evidence.
21. Does the patient now take into account the consequences of their actions and learn from experience? Please give evidence.

**Patients with mental impairment**

22. How has the patient benefited from treatment/training?
23. Is their behaviour more acceptable? Please give evidence.
24. Is the patient's behaviour explosive or impulsive? Please give evidence.
25. Does the patient now learn from experience and take into account the consequences of their actions? Please give evidence.

**Patients with dangerous sexual behaviour (all forms of mental disorder)**

26. Does the patient still show undesirable interest in the victim type?
27. Describe any access to the victim type and the patient's attitude towards this group?
28. What form has sexual activity in hospital taken?
29. What do psychological tests or other evaluation indicate?
30. What is the current content of fantasy material?

**Patients who set fires (all forms of mental disorder)**

31. What interest does the patient still have in fires?
32. Have they set fires in hospital?
33. What access do they have to a lighter or matches?
34. In what way do fires appear in current fantasy material?
35. Does the patient have insight into previous fire setting behaviour?

**And, finally**

36. Please give any other relevant information that would be useful to the Home Office.

**Appendix 3: Timeline of reform - the *Mental Health Act 1983***

1997: Department of Health think tank on reform of mental health law

1998: Department of Health establishes Expert Committee to conduct Scoping Study for the review of the *Mental Health Act 1983*, chaired by Genevra Richardson

1999: Publication of the report of the Expert Committee (Richardson 1999). Key recommendations include: a formal, independent inquiry into the offender provisions (section 3) of the 1983 Act; that ongoing attention be paid to the human rights of offender patients; that offenders be treated under the same legislative framework that applies to civil patients; that the MHRT be granted the power to order leave and transfer (this recommendation included condemnation of the current system of executive-only power as failing human rights obligations); support for the Home Office's role in protection of the public; an advisory and expertise role for the Home Office, with decision-making vested in the MHRT; and that the Home Office continue responsibility for monitoring in the community.

Publication of Green Paper on the Reform of the *1983 Act* at the same time as the Richardson Report.

2000: Publication of White Paper on Reforming the *1983 Act*

2002: Introduction of draft Mental Health Bill (2002) and consultation document

Publication of House of Lords, House of Commons Joint Committee on Human Rights Report on the draft Mental Health Bill (2002)

2004: Introduction of revised draft Mental Health Bill (2004)

2005: Publication of House of Lords, House of Commons Joint Scrutiny Committee report on the draft Mental Health Bill (2004)

Publication of the Government's response to the Joint Scrutiny Committee's report

2006: Government announces draft Mental Health Bill 2004 abandoned in place of proposed reforms to *MHA 1983* via Mental Health Bill 2006

2007: *Mental Health Act 2007* receives assent, amending *MHA 1983* and the *Mental Capacity Act 2005*