Psychiatric Bulletin (1989), **13**, 375–384

Correspondence

Restriction orders

DEAR SIRS

Graham Robertson's interesting and provocative article on restricted hospital orders (*Psychiatric Bulletin*, January 1989, **13**, 4–11) provides an excellent historical account and much useful information, but it has one major omission: any mention of Regional Secure Units (RSUs).

His graph (Fig. 1, p. 7) shows a steady decline in restricted patients admitted to local hospitals from 1973–1977, then a gradual rise, accelerating in 1981. The first interim RSUs opened in 1976 in Liverpool and Manchester, and by 1981 permanent RSUs were being completed. This is likely to account for the increase from around 30 to around 60 admissions per year, extrapolating from the graph. This was at a time when Special Hospital Restriction Orders were declining, so it is no longer true that the "open door policy ... of local hospitals" made "the notion of secure containment a nonsense".

A restriction order makes relatively little difference to a patient's life within a Special Hospital, but usually has a considerable effect on his freedom in local hospitals, including in an RSU. This is because the Responsible Medical Officer (RMO) normally only has power to grant parole (freedom to leave the unit without staff escorts) within the grounds of the hospital. Leave to go outside the grounds, to work, or to move to a hostel or other accommodation in the community has to be obtained from the Home Secretary – or a Tribunal.

Except for a brief period when an unusually restrictive Minister was responsible for these decisions, co-operation between C3 Division of the Home Office and consultant forensic psychiatrists has normally been good. I have valued the opportunities to discuss the progress of these potentially dangerous patients with the staff of C3, and to share with them the responsibility for difficult decisions, which potentially puts the public at risk. During the Mellor era I persuaded the Courts to make unrestricted hospital orders on three patients who had committed homicide, and while there were no disasters, I found that even with the support of my multidisciplinary team I felt rather exposed in deciding when to allow freedom outside the hospital and when to discharge them, and in managing them as out-patients without the benefits of the conditional discharge provisions.

Dr Robertson may be correct in arguing that the restriction order is an illogical compromise. However, it seems reasonable that Courts should not have the power to order the detention of a patient in hospital who has not committed an imprisonable offence, and in my opinion the restriction order is a successful British compromise. It does restrict doctors as well as patients, but for RSU forensic psychiatrists, who have sufficient restriction order patients to develop a regular working relationship with C3 Division, the frustrations and delays are minor compared with the benefits of shared responsibility for decisions, independent assessments of difficult cases where mistakes can be lethal, and invaluable continuing care with control during the patient's aftercare – the only community treatment order we have at present.

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DEAR SIRS

I am grateful to Dr Campbell for pointing out a major omission in my article on the Restricted Hospital Order, namely the lack of any reference to the possible role and effect of Regional Secure Units. These units have indeed provided valuable new local facilities for secure containment. However, this does not invalidate my contention that open door policies make secure containment a nonsense – the units referred to are locked.

Having worked at C3 for a time, I share Dr Campbell's high opinion of the staff in this Home Office Division. I was extremely impressed by their obvious concern for the needs of both patients and responsible medical officers. I would also accept his description of the restriction order as being "a successful British compromise".

In my paper, I argue that courts should have the power to send but not to sentence to hospital and I cannot accept the point he makes regarding imprisonable offences.

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Psychosurgery, the Mental Health Act Commission and the Law

DEAR SIRS

The Mental Health Act (MHA) Commission has recently been challenged in the High Court by a patient for the first time and the decision of the Commissioners to refuse treatment by the subcutaneous implantation of goserelin was reversed (Dyer, *British*

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Medical Journal, 1988, **297**, 640). Goserelin was indicated in this case for a major sexual problem because the more usual medication, cyproterone, was ineffective. The case was considered under Section 57 of the MHA (1983) and, as psychosurgery also comes under this Section, the judgment could well have relevance for the operations carried out in this Unit.

In a previous letter (Bridges, *Bulletin of the Royal College of Psychiatrists*, 1984, **8**, 146–148) I reported that, "The decision of the medical Commissioner as to whether a patient should be allowed to have psychosurgery or not is final. We were told by the Commission that a further opinion is not possible when our offer of an operation has been vetoed". This was said to be so even when the patient is not on a Section, can give informed consent and wishes to have the operation. Therefore it is gratifying to find that the Commissioners do not have infallibility and cannot with impunity go against the wishes of the patient and the advice of the patient's medical advisers. However, taking Commissioners to the High Court is rather an extreme method of achieving this. There should therefore now be an appeals procedure set up by the Commission in order to avoid the need for recourse to the courts at an early stage.

Lord Justice Stuart Smith's judgment was interesting to us in other ways as well. He observed that the Act has the words "capable of understanding" and not "understands", the issue being "capacity and not actual understanding", "it is capacity to understand the likely effects of the treatment . . .". It seems to me that this very desirably returns the patient's rights to him or her. That is, provided patients are "capable of understanding" they can choose to accept or reject the offer of psychosurgery, as they wish. At the moment the three Commissioners exert a good deal of control and they spend a long time seeking evidence of understanding rather than simply testing for capacity to understand. For example, the operation has been postponed in more than one case because the patient did not sufficiently understand the need for post-operative rehabilitation, according to the Commissioners. Yet the issue of rehabilitation is surely not specifically relevant to consent for an operation which is carried out primarily to relieve suffering and not primarily to facilitate rehabilitation. Delaying the operation deliberately extends the distress.

Indeed, the Commissioners visiting our patients seem to take into account a wide range of factors which seem hardly appropriate to us. This has been confirmed by the Commission's Draft Code of Practice (1987) which states that "under Section 57 the appointed doctor will expect the RMO to show that . . . other circumstances are favourable such as premorbid personality, support by family and/or others . . . there has been a full and up to date multidisciplinary assessment, including psychological, nursing, social, domestic, physical and vocational". While all this information may not be actually irrelevant, most of it is certainly peripheral and no doubt is mainly intended to keep multi-professional teams occupied and involved. Is it all legally necessary?

In the "goserelin" case the opinion of the medical Commissioner seemed to be just as unhelpfully prolix. He stated that, "I did not support the treatment proposed for the Applicant by Dr S. for various clinical reasons; I was concerned about the apparent absence of psychotherapeutic, behavioural or rehabilitative components to his assessment and treatment; the weakness in his multi-disciplinary approach to his assessment and treatment; the lack of objective assess ment (apart from testosterone levels); the inadequate consents for the existing drug treatments. . . ." Just what is the direct relevance of psychotherapy, behavioural therapy and rehabilitation to simply reducing socially destructive sexual drive by means of goserelin? Is the "multidisciplinary approach" compulsory? If all this input was other than mostly a waste of time, the goserelin might not be needed.

The Commission should now clarify the legal situation in the light of this judgment. My totally inexpert legal assessment causes me to suggest to the Commission that it is only necessary to establish that there is a capacity to understand and while the more important side effects should certainly be discussed with the patient, detailed information is unnecessary. In the now famous Sidaway case (*The Times* Law Report; 24 February 1984) the three Appeal Judges stated clearly that "The doctrine of 'informed consent' forms no part of English law". Hitherto the Commission has insisted on the fully informed consent of our patients, even although many are so depressed that their concentration is very poor and hence their memory of the side effects described to them is limited. Solely to placate the Commissioners we have sometimes advised referring colleagues that the patient should be taught the side effects and the need for rehabilitation *by rote* in order to win the lottery and be accepted for surgery. In view of these observations the present lengthy and compulsory interviews between one very depressed patient and three Commissioners surely can now be shortened and conducted less like a demanding oral examination.

In the "goserelin" judgment it was observed that "all three Commissioners were agreed that the Applicant did not have sufficient understanding of the nature of the treatment . . . for a certificate of consent to be issued. He did not understand that the primary site of action of the drug was on the brain . . . and believed only the testes were affected directly. . . ." It seems that these three Commissioners might not agree to psychosurgery unless the patient knew which neurone tracts were involved and unfortunately we are also unclear about this. It needed the judge to guide the Commission towards more sensible

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practices by observing that, "I cannot accept that the patient must understand the precise physiological process involved before he can be said to be capable of understanding the nature and likely effects of the treatment and can consent to it".

The decision as to whether any surgery, including psychosurgery, is appropriate for a patient or not is entirely and exclusively a medical one and it can only properly be made by clinicians personally responsible for the continuing care of the patient. The 'goserelin" judgment included an elegant observation in this context: "It is not entirely clear why it is appropriate for non-medically qualified people to be consulted on the desirability of medical treatment, having regard to the likelihood of it alleviating the patient's condition or preventing its deterioration". And that is really all that we need to be concerned about. Would the Commission please acknowledge this?

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Editorial note: see Mental Health Act Commission. (Louis Blom-Cooper), *Psychiatric Bulletin*, June 1989, **13**, 309–310).

Consent to ECT

DEAR SIRS

I read with interest 'Patients' perceptions and knowledge of electro-convulsive therapy' (*Psychiatric Bulletin*, April 1989, **13**, 161–165). In a study of patients' views on ECT following a course of treatment (Benbow, 1988) only six (12%) of 54 patients had a full understanding of the procedures involved in ECT. Another 13 (25%) had some partial knowledge, and 33 (64%) had no idea or only knew about the general anaesthetic. These figures are similar to those reported by Malcolm, and must be a cause for concern among those psychiatrists who prescribe ECT.

Despite our procedures for informed consent, it appears that patients have little understanding of what ECT involves. Although one may feel intuitively that a fuller understanding of ECT should assist in alleviating patient anxiety this has not been demonstrated, nor has the optimum method of seeking consent. Patients who were shown a videotape to inform them about ECT during the process of seeking consent were less sure that they had sufficient information on which to decide whether to accept treatment than those who were not shown it (Baxter *et al*, 1986). A number of questions arise from these observations: what do our patients want to know about the treatment? Are psychiatrists justified in forcing knowledge on patients who may not want it? Does a greater understanding of ECT increase or decrease the likelihood of a patient consenting to receive treatment?

These are important issues, but difficult to confront. At present we operate using various individual practices. Although consent is a contentious issue, it cannot be avoided and those psychiatrists who prescribe ECT might be advised to review their consent procedure and the way in which patients and their relatives are informed about the treatment.

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How much protection is provided to medical practitioners by the Mental Health Act 1983?

DEAR SIRS

Section 139 of the Mental Health Act 1983 can give a limited immunity from prosecution in both civil and criminal proceedings for actions purporting to be done in the pursuance of the Act by requiring leave before commencing actions. There are exceptions to this protection for actions which have been performed in bad faith or without reasonable care. Under Section 139 it is necessary for a patient to seek leave of the High Court before civil proceedings can commence. Criminal proceedings can only be brought by the Director of Public Prosecutions or with his consent. Proceedings for offences under the Mental Health Act 1983, i.e. forgery, false statements (Section 126), ill treatment of patients (Section 127), assisting patients to absent themselves without cause (Section 128), or obstruction (Section 129) are solely initiated by the Director of Public Prosecutions.

Although Section 139 gives protection to individuals in this way it does not give any protection either to the Secretary of State or to a health authority. A patient does not require leave from the High Court or the consent of the Director of Public Prosecutions if he wishes to sue these bodies. How much protection

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