

UNINFORMED REFORM: THE ATTEMPT TO ABOLISH THE HOSPITAL MANAGERS' S.23 DISCHARGE POWER UNDER THE MENTAL HEALTH ACT 1983

ABSTRACT

Under s.23 of the Mental Health Act 1983 a person can be discharged by the managers of the hospital from compulsory care. The limited evidence indicates that the s.23 power is normally delegated to a specially appointed panel who hold a hearing. Unfortunately, notwithstanding the implications for the liberty, autonomy, and dignity of the compelled person, very little is known about how this process operates. Nonetheless, since 1996 there has been a sustained effort to abolish the power. In view of this, the proposal to reform the 1983 Act contained in the Queen's Speech January 2017, and the subsequent establishment of the Independent Review of the Mental Health Act in October 2017, I critique the claims made in the abolition debate, and establish the conceptual gaps therein. I argue that a much more developed understanding of the power is required before any change is made to the law in this area.

KEYWORDS

Administrative justice; Discharge; Hospital Managers; Legislative Reform; Mental Health Act 1983, s.23; Mental Health Tribunal

I INTRODUCTION

In England, in addition to discharge by a Responsible Clinician,¹ and the successful application for discharge by a Nearest Relative,² there are two other routes to discharge from compulsory care under the Mental Health Act 1983 (MHA 1983). The first is the Mental Health Tribunal ('the Tribunal'). The Tribunal sits in panels of three members, is chaired by a legal professional, and benefits from the presence of a medical wing member. A compelled person can request a Tribunal hearing *once* in any detention period; it is a periodic power of discharge.³ The second is a Hospital Managers' hearing under s.23 MHA 1983 ('the Managers').⁴ Like the Tribunal, the Managers tend to sit in panels of three,⁵ assess the written and oral evidence received against the relevant admissions criteria that justify compulsory care,⁶ and provide reasons for their decision.⁷ There are restrictions on who can be

¹ Mental Health Act 1983, s.23(2)(a)-(c).

² *ibid.*, see also s.25.

³ A table of eligibility periods is provided by Mental Health Law Online <http://www.mentalhealthlaw.co.uk/Eligibility_periods> accessed 6 September 2017.

⁴ Throughout the paper the panel considering the use of s.23 are referred to as 'the Managers', capitalised as written. They can almost always be distinguished from the managers of the hospital, the hospital managers (not capitalised). See further, Section II below.

⁵ See *R (T-T) v The Hospital Managers of the Park Royal Centre* [2003] EWCA Civ 330 [4], [9], [26] (Pill LJ); [29-30] (Laws LJ); [36-37] (Arden LJ); and in the High Court [2002] EWHC 2803 Admin [8], [27] (Forbes J); the legislation also specifies a *minimum* of three persons, MHA 1983 s.23(4).

⁶ This varies depending on the order in question, see Department of Health (DH), *Mental Health Act 1983: Code of Practice* (London: HMSO, 2015) paras. 38.11-38.23.

⁷ On the requirement for Managers to give adequate reasons see *R (O) v West London Mental Health NHS Trust* [2005] EWHC 604 (Admin) ('O'); and on their quality, *R (SR, by her Litigation Friend) v Huntercombe Maidenhead Hospital v MR (Nearest Relative)* [2005] EWHC 2361 (Admin) especially [22]-[30] ('SR'); Mental Health Act Commission (MHAC), *Thirteenth Biennial Report 2007-2009: Coercion and consent* (London: TSO, 2009), paras.

appointed in terms of their independence,⁸ but there is no statutory requirement that those appointed as Managers possess any legal or medical expertise.⁹ Unlike the Tribunal, a person can request a hearing as many times as practicable in any given detention period; it is a continuing power.

In this paper I examine the arguments made in support of and against, the effort to abolish the s.23 mechanism between the mid-1990s and the passage of the Mental Health Act 2007 (MHA 2007). My main aim is to challenge the poor quality – on both sides – of the evidence provided in support of these arguments, and thus critique the way in which the question of abolition **has been** handled by the legislative process. In so doing I touch upon discussion of the wider history of the Managers’ powers, the relationship between the Managers and the Tribunal, and a number of other matters of interest vis-à-vis the Managers, but my observations are necessarily confined to **my examination of the approach to reform**. It should also be borne in mind that, although the abolition debate appeared to end with the passage of the MHA 2007, leading commentators have continued to call for the abolition of the Managers’ s.23 power.¹⁰ Taken in conjunction with the government’s willingness to resume the effort of reforming the MHA 1983, it is evident that s.23 abolition remains a live issue.¹¹ However, as I discuss in what follows, abolition of s.23 is inadvisable. This is not because a positive case can be made for not doing so. Instead, it is because there is such a paucity of evidence regarding how the s.23 process operates, who sits as a Manager, and the policies relating to the administration of the

2.93-2.94. On the giving of reasons by the Tribunal see *JLG v Managers of Llanarth Court & Secretary of State for Justice* [2011] UKUT 62 (AAC), [3(v)], and also [6]-[9] (*‘JLG’*).

⁸ DH (n 6), paras.38.6-38.7.

⁹ But note *ibid.*, para.38.8.

¹⁰ For example, R. Jones *Mental Health Act Manual* (London: Sweet & Maxwell, 2016), v-vi.

¹¹ Queen’s Speech, full text at <<https://www.gov.uk/government/speeches/queens-speech-2017>> accessed 6 September 2017; and the Independent Review of the Mental Health Act, details at <<https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>> accessed 10 January 2018.

power by NHS trusts and independent hospitals (administration of the system is devolved to individual organisations).¹² Furthermore, there is little case law,¹³ and the understanding of s.23 in Parliament is, at best, mixed.¹⁴ The same can also be said of the professions.¹⁵ In consequence, efforts aimed towards either retaining or abolishing s.23 are undermined by the present impossibility of supporting them with anything more than assertion and anecdotal evidence. Against this backdrop the Managers are rendered 'relatively invisible',¹⁶ and as such it is not possible to make a positive case for either abolition or retention of s.23, and so I will not do so.

The fact that the s.23 power has largely escaped academic, parliamentary, and judicial consideration, might lead one to believe that it is a relatively minor outcrop in the landscape of mental health law. Such a view would be incorrect. Although it is not known how many hearings take place a year, the government estimated that over 10,000 s.23 hearings were held in 2003/04, a similar figure to the number of tribunals convened.¹⁷ On any measure this entails a significant volume of quasi-judicial activity, and gives some sense of the scale of the s.23 process. Unfortunately, this estimate was not

¹² A fact highlighted, but not elaborated upon in P Gregory, 'Who can best protect patients' rights?' (2000) 24 *Psychiatric Bulletin* 366-367, 366-367.

¹³ An almost complete list can be found at http://www.mentalhealthlaw.co.uk/Category:Hospital_managers_hearings accessed 6 September 2017.

¹⁴ See section IV(A) below.

¹⁵ See A Fraser and M Winston, 'NHS managers and clinical management' (1992) 16 *Psychiatric Bulletin* 567-568; P Power-Smith and M Evans, 'Managers Tribunals' (1993) 17(1) *Psychiatric Bulletin* 47-48; Gregory (n 12); H Kennedy, 'Managers' hearings: dialectic and maternalism' (2000) 24 *Psychiatric Bulletin* 361-362.

¹⁶ P Bartlett and R Sandland, *Mental Health Law: Policy and Practice* (Oxford: OUP, 4th edn, 2014), 503.

¹⁷ This has to be deduced from the headline figure by subtracting the number of tribunal hearings (12,735) from the total combined number of Managers' and Tribunal hearings (22,800) in Joint Committee on the Draft Mental Health Bill, *Volume I: Report*, (Session 2004-05, HL 79-I/HC 95-I), paras. 307 and 301.

based on any data because ‘no formal statistical returns for [Managers’ hearings]’ are collected.¹⁸ Furthermore, the only other information available on the intensity with which s.23 is used are the limited data which were occasionally gathered by the Mental Health Act Commission (MHAC).¹⁹ The Care Quality Commission (CQC) does not appear to have gathered any data, and only occasionally mentions the Managers in their annual reports.²⁰ Whatever the precise figure, given that the number of uses of compulsory powers under the 1983 Act has increased year-on-year over the last decade, it is likely that there has been a concomitant increase in s.23 activity.²¹ Having regard to the probable scale of the activity concerned – no one contested the government’s 2004 estimate – and the particular gravity of the issues involved – no less than the liberty, autonomy and bodily integrity of individuals – s.23 represents anything but a minor issue. In view of this, and the fact that the debate has hitherto been conducted in the absence of either a conceptual framework, or data, my arguments in this paper

¹⁸ DH evidence to the Joint Committee on the Draft Mental Health Bill in *Volume II: Oral and Written Evidence*, (Session 2004-05, HL 79-II/HC 95-II), EV491; MHAC also stated it did not gather data, see MHAC, *Twelfth Biennial Report 2005-2007: Risk, Rights Recovery* (London: TSO, 2007), para. 4.96; but cf Correspondence on Gregory (n 12), published unsigned in (2001) 25(6) *The Psychiatrist* 237-238.

¹⁹ Examples include MHAC, *Eighth Biennial Report 1997-1999*, para. 4.88 which stated that 3,598 hearings were held in 1997/98; and MHAC (n 18), fig. 55, p.180; local data may have been gathered, see C Williamson and C Vellenoweth, *Directors Guide: Duties of managers for the review of detention under the provisions of the Mental Health Act* (London: National Association of Health Authorities and Trusts, 1996), p.23; also C Williamson, *Members’ Information Pamphlet No.2: Hearing patients’ appeals against continued compulsory detention* (Birmingham: National Association of Health Authorities, 1985), 12-13; C Williamson, *NAHAT Information Pamphlet Number 1: Hearing patients’ appeals against continued compulsory detention* (United Kingdom: National Association of Health Authorities and Trusts, 2nd edn, 1991), 17.

²⁰ For example CQC, *Monitoring the Mental Health Act in 2014/15* (London: HMSO, 2015), 59.

²¹ CQC, *Monitoring the Mental Health Act 2015/16* (London: HMSO, November 2016), 18, showing year-on-year increases in detentions under the MHA 1983 between 2008/09 (30,913) and 2014/15 (54,225).

are as much an invitation to proponents of both positions to pause ahead of the possible legislative reconsideration of the matter,²² as they are a critique of their claims.

With these issues in mind, it is now possible to consider the three sites of contention in the abolition debate. First, that the Managers lack expertise; secondly that they are not independent, and, finally, whether the process duplicates the efforts of the Tribunal.²³ I will examine the serious weaknesses in the evidential base underpinning debate in these areas below. However, in view of the Managers' 'invisible' character, a brief discussion of their nature and history is warranted.

II THE HOSPITAL MANAGERS AND THE EFFORT TO ABOLISH THEM

Due to historical reforms which, viewed today, seem to have been designed to confuse the uninitiated from the outset,²⁴ the Managers tend not to be the managers of the hospital.²⁵ Instead, the available evidence suggests that they are normally specially appointed by the organisation – the managers – who then delegate the s.23 power to review the legality of compulsory care to those persons – the Managers.²⁶ Thus, a hearing before the Managers does not constitute an appeal against compulsory care, instead they review the decision of the clinical team and consider whether to exercise a

²² Queen's Speech (n 11).

²³ These claims are a common feature of all abolition arguments, but are most succinctly encapsulated in DH, *Improving Mental Health Law: Towards a New Mental Health Act* (Cm 6305) (London: HMSO, 2004), para. 3.58.

²⁴ See section IV(A) below. See also *South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Dr Whitworth v The Hospital Managers of St George's Hospital v AU* [2016] EWHC 1196 (Admin), [19] (Cranston J) ('AU').

²⁵ See DH (n 6), chapters 37 and 38.

²⁶ *ibid.*, para. 38.4.

delegated, discretionary power to discharge.²⁷ They **make** a decision on behalf of, not a recommendation to, the delegating organisation.²⁸ Consequently, the Managers' review process exists outside of the tribunal system and, as such, the only recourse open to those dissatisfied with the decision of the Managers is judicial review by the High Court.²⁹ Alternatively, given the continuing nature of the s.23 power, it is always open to the compelled person to make a fresh s.23 hearing application. Beyond this, it is sufficient for now to say that the Managers' discretionary power allows them to discharge persons from numerous compulsory care provisions *against* medical advice,³⁰ even where the criteria permitting compulsory care provided in the 1983 Act *are* met.³¹ It is the *sine qua non* of a decision to exercise the Managers' s.23 discharge power that it runs contrary to professional medical opinion.³²

The origins of the parliamentary effort to abolish the Managers can be found in the statement on mental health services made by the then Secretary of State for Health, Stephen Dorrell MP, to the Commons in February 1996.³³ He discussed, *inter alia*, the 'disquiet about the arrangements that allow

²⁷ See A Eldergill, *Mental Health Review Tribunals Law and Practice* (London: Sweet & Maxwell, 1997), 144; see also MHAC, *The First Biennial Report of the Mental Health Act Commission 1983-1985*, para. 8.13.

²⁸ See Williamson and Vellenoweth (n 19), 16-17.

²⁹ Alternatives, such as one Managers' panel overturning the decision of another may be problematic, see MHAC (n 18) para. 4.95; the application must also be made to the High Court, not the Upper Tribunal, see *AU* (n 24) [40] (Cranston J).

³⁰ *DH* (n 6), para. 38.2. But see also section III(B) below.

³¹ See *R v Riverside Mental Health Trust, ex parte Huzzey* [1998] 43 BMLR 167, p.173 (Latham J) ('Huzzey'), see also *SR* (n 7) [19]-[20].

³² N Turner, *HyperGuide to the Mental Health Act*, News Items, 18 September 1996, <<https://web-beta.archive.org/web/19970716201321/http://www.hyperguide.co.uk:80/mha/news1.htm>> accessed, 16 August 2017.

³³ Stephen Dorrell MP, HC Deb 20 February 1996 vol.272. cc.175-187.

hospital managers to discharge patients from detention’³⁴ He focussed solely on the example of Glen Grant, who was released from Cane Hill Hospital, Surrey.³⁵ Grant had been convicted of multiple, violent crimes, which took place shortly after a panel of Managers discharged him from hospital against medical advice.³⁶ Dorrell established a Working Group to consider the operation of the discharge power,³⁷ and stated that he hoped that their recommendations would enable him to propose ‘adequate safeguards [re s.23] to command public confidence’³⁸ Debate on the statement when it was repeated in the House of Lords was less measured.³⁹ Lord Strabolgi, for example, decried ‘the so-called anonymous lay [Managers]’ who ‘have overruled the views of professional doctors’, and demanded ‘Who are they? Why are they allowed to remain anonymous? Why are they allowed to overrule the professionals?’⁴⁰ There was also some confusion as to the legal basis of the Managers’ power. At one point the minister, Baroness Cumberlege, seemed to suggest that, whereas the Tribunals’ power was contained in the MHA 1983, the Managers’ was not.⁴¹

The Working Group’s Report, published in July 1996, was at most agnostic about the removal of the s.23 power, conceding only that future consideration should be given to whether having two routes

³⁴ *ibid.*, c.176.

³⁵ According to Turner (n 32); other sources suggest he was discharged from Broadmoor, see D Brindle ‘Mental health “lay” appeals to be axed’, *The Guardian*, 18 September 1996; for other examples of incidents following release by Managers see Fraser and Winston (n 15) and Power-Smith and Evans (n 15).

³⁶ Turner (n 32).

³⁷ MHAC, National Association of Health Authorities and Trusts (NAHAT), NHS Federation, Royal College of Psychiatrists, *Working Group Report on Managers’ Review of Detention Under the Mental Health Act* (July 1996).

³⁸ Dorrell (n 33) c.185; see also Baroness Cumberlege, HL Deb 20 February 1996 vol 569 c.1001.

³⁹ Lord Hayhoe’s brief intervention is the exception, HL Deb 20 February 1996 vol 569 cc.1003-1004.

⁴⁰ Lord Strabolgi, HL Deb 20 February 1996 vol.569 c.1001.

⁴¹ Cumberlege (n 38) c.1003; the Managers’ discharge power is found in s.23 MHA 1983.

of challenge was 'beneficial'.⁴² However, although the Secretary of State had said he intended to be guided by the Group's findings,⁴³ his proposals were more forthright.⁴⁴ He did not feel that there was 'a valid role for lay managers in this area'.⁴⁵ The basis of his argument was that, because of the 'completely separate' tribunal route, the Managers' power was apt to 'create confusion for patients and duplication of effort [for professionals]'.⁴⁶ The Secretary of State promised to legislate to abolish the power.

In the event, the Conservative Party lost the 1997 General Election and the impetus behind the abolition effort faltered. However, in October of the following year the Labour Government established an Expert Committee to review the **legislation relating to** mental health.⁴⁷ Chief among the Committee's recommendations, when it reported in 1999, was the creation of a 'multi-disciplinary tribunal' which would authorise and review the legality of the initial medical decision to detain shortly after it was made.⁴⁸ In view of the creation of a new version of the Tribunal, the Committee concluded that the Managers should 'cease to be a feature of future mental health legislation'.⁴⁹ Echoing the views of the former Secretary of State for Health, the Committee contended that because the purported

⁴² MHAC *et al* (n 37), 10-11.

⁴³ Dorrell (n 33) c.177.

⁴⁴ Issued in a press release on 17th September 1996. The full text of the statement is available via Turner (n 32).

⁴⁵ *ibid.*

⁴⁶ *ibid.*; the situation was probably not helped by conflation of terminology, for example Power-Smith and Evans (n 15) 47-48; and that some authorities set up the managers as a 'shadow Tribunal' see S Blumenthal and S Wessely, *The pattern of delays in Mental Health Review Tribunals* (London: Department of Health, HMSO, 1993), para. 4.2.4.

⁴⁷ Richardson Committee, *Report of the Expert Committee Review of the Mental Health Act 1983* (London: HMSO, November 1999), 'The Expert Committee'.

⁴⁸ *ibid.*, paras. 16-24.

⁴⁹ *ibid.*, para. 12.1; also para. 33.

duplication of effort ‘tended to impose considerable burdens on the clinical team’, while producing ‘little obvious benefit to the patient in terms of early discharge’, and because the dual route for review was ‘confusing for patients’, the power should be abolished.⁵⁰ The Committee failed to provide evidence to substantiate their claims.⁵¹ However, it did acknowledge that there was some support for the continuation of the Managers’ role because it provides ‘an important lay element’ as well as ‘a link with the local community’ in ‘a uniquely informal’ setting that allows ‘the patient ... to hear the opinion of the care team’.⁵²

The White Paper, *Reforming the Mental Health Act*, as well as the draft Bill and consultation documents that were published in 2002, also demonstrated support for an independent tribunal and the removal of the Managers.⁵³ Again, however, the evidential basis for these claims was limited.⁵⁴ This is unsurprising given the brevity of the discussion regarding the Managers in the White Paper.⁵⁵ The 2002 Bill was opposed on many fronts, though not because of the proposals relating to the Managers. The government took time to reconsider their position and in 2004, again reflecting the 2002 Draft

⁵⁰ *ibid.*, paras. 5.127-5.128; a view supported by the government, see DH, *Reform of the Mental Health Act 1983: Proposals for Consultation* (Cm 4480) (London: HMSO, 1999), paras.7.8 and 10.6.

⁵¹ For limitations of the 1996 Working Group’s evidence (n 37) upon which some of the claims may have been based, see sections IV(B) and V below.

⁵² Expert Committee (n 47), para. 5.128; see further Williamson (1985) (n 19), 3-4; Williamson and Vellenoweth (n 19), 17-18.

⁵³ Home Office and DH, *Executive Summary to Reforming the Mental Health Act – Part 1: The new legal framework* (Cm 5016) (London: HMSO, 2000), para. 7.7; DH, *Mental Health Bill Consultation Document* (Cm 5538-III) (London: HMSO, 2002), para. 2.3.

⁵⁴ *ibid.*, Home Office and DH, para. 9.

⁵⁵ *ibid.*, para. 7.7.

Bill and the arguments made by the Expert Committee, returned with new proposals which retained the aim of removing the Managers' s.23 powers as part of the creation of a new tribunal.⁵⁶

The 2004 Bill proved to be ill-fated and was followed by a more modest amending Bill in 2006.⁵⁷ In the interim, all efforts to abolish the Managers' s.23 power appear to have fallen by the wayside, though criticism of the power had continued in the background.⁵⁸ The Managers' only appearance in the 2006 Bill, later the MHA 2007, was a clause to correct a previous legislative oversight in relation to NHS foundation trusts and s.23.⁵⁹ Having briefly outlined the context in which the effort towards securing abolition has taken place, I will now consider the first of the abolitionists' contentions, the question of the Managers' expertise.

III EXPERTISE

Before the Joint Committee on the Draft Mental Health Bill (the Joint Committee) in 2004 the Institute of Mental Health Act Practitioners (IMHAP) observed that one of the central requirements for a person to be considered eligible to sit as a Manager was that they should have 'suitable experience and qualifications'.⁶⁰ The government has also acknowledged that that the Managers generally do possess relevant 'experience and expertise'.⁶¹ Nevertheless, this has not prevented proponents of abolition, including the government, from promoting the assertion that 'the "lay" managers usually

⁵⁶ DH (n 23), paras. 3.57-3.58.

⁵⁷ Government Statement available in J Roll and M Whittaker, House of Commons Library, 'The Mental Health Bill [HL] Bill 76 of 2006-2007', Research Paper 07/33, 15-17.

⁵⁸ Independent Review into the Care and Treatment of Mr Anthony Hardy (September 2005) ('Hardy Review'), paras. 7.6.1-7.6.7

⁵⁹ See MHA 2007, s.45; also section IV(B) below

⁶⁰ IMHAP in evidence to the Joint Committee (n 18), EV101.

⁶¹ Home Office and DH (n 53), para. 7.7; see also DH (n 23), para. 11.15; but note MHAC, *Seventh Biennial Report 1995-1997* (London: HMSO, 1997), para. 3.1.4.

have no mental health background or experience’⁶² For abolitionists, “lay person” can mean either a person who is neither medical doctor nor a legal professional, or specifically not a psychiatrist. The arguments of both those in favour of and opposed to abolition can, at present, have little status beyond that of conjecture because there are no publicly available statistics detailing the educational and professional background of those sitting as Managers, and so it is not possible to say whether the Managers are “lay people” in the sense of having no relevant professional experience of mental health or law. The opponents of abolition fare a little better as regards principled justifications for offering an alternative process **to the Tribunal**, for example, that it is community orientated,⁶³ but their claims are otherwise similarly underdeveloped and not supported by evidence.

Additionally, the proponents of abolition have never been clear about what they mean by expertise.

It is therefore necessary to discern what is meant by “expertise” in this context. In short, two conceptions of expertise emerge from the arguments made in the abolition debate. First, that the relevant experience which qualifies a person to sit as a Manager, when coupled with the specific training undertaken, and experience gained by participating in the s.23 process, render that person an expert in that process.⁶⁴ Alternatively, that only those specially trained in specific professions — law and medicine — possess the necessary expertise to enable them to consider whether discharge is appropriate.⁶⁵ The former view enables a wider category of persons to participate in the decision-making process, whereas the latter confines this to the legal-medico professional sphere.

⁶² Kennedy (n 15); also Blumenthal and Wessely (n 46), para. 4.2.4; but see *AU* (n 24), [10] (Cranston J); and Williamson and Vellenoweth (n 19), p.18.

⁶³ IMHAP (n 60), EV101.

⁶⁴ For example, Nottinghamshire Healthcare NHS Trust in Joint Committee on the Draft Mental Health Bill, *Volume III: Written Evidence*, (Session 2004-05, HL 79-III/HC 95-III), EV1023-EV1024; see also IMHAP (n 60), EV101; *AU* (n 24), [10] [33-34] (Cranston J); *JLG* (n 7), [7].

⁶⁵ See, for example, DH (n 23), paras. 3.54-3.58; Joint Committee (n 17), Annex 4, Clause 35(a), Government Response, 194; and Clause 54(a), Government Response, 203.

III(A) Expertise in Risk Assessment?

Although abolitionists question the expertise of the Managers in general, which, as I have said, is difficult to assess in the absence of evidential support, their specific concern regarding expertise is directed towards whether the Managers are capable of properly assessing risk. The germ of this claim is found in the events surrounding Grant's aforementioned release in 1996.⁶⁶ At the time, the criticism directed at the Managers was especially concerned with their failure to keep the public safe from harm due to a purported inability to assess risk.⁶⁷ The implication was that, whereas psychiatrists and lawyers are regularly required to make an assessment of risk as part of their professional duties, and so have extensive experience in this area, the Managers are not, and so do not. Of course, it is inaccurate to say that psychiatrists and lawyers always arrive at the right decision, or that, once they have reached a conclusion they are implacably opposed to amending it. This much was demonstrated by Peay's research which showed that the behaviour of professional mental health decision-makers, and the conclusions they draw change when they interact with colleagues.⁶⁸ For example, social workers and psychiatrists considering whether discharge or the renewal of compulsion is appropriate demonstrate 'a range of strategies' when negotiating decisions on renewal of compulsory care.⁶⁹

There is nothing nefarious about professionals changing their mind in response to discussion, indeed the MHA 1983 requires consultation between professionals.⁷⁰ Nonetheless, Peay's research demonstrates that although psychiatric professionals claim that they alone are 'imbued with the

⁶⁶ See again, (n 35), and Dorrell (n 33)

⁶⁷ R Pacitti, 'Political Footballs? Stephen Dorrell's threat to the hospital managers' (1997) 83(Jan/Feb) *Openmind* 6-6, 6; see also comments from Jim Callaghan MP and Dorrell's reply, HC Deb 20 February 1996 vol. 272 c.185; and Lord Strabolgi (n 40), c.1001 giving a sensationalist example of 'dangerous mental patients [who] have been allowed back into the community, without adequate supervision, to murder and rape.'

⁶⁸ J Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Oxford: Hart, 2003), 63.

⁶⁹ *ibid.*, 62.

⁷⁰ For example, under MHA 1983 s.20.

necessary “exclusive” expertise’, the value of the social worker’s professional views on ‘appropriateness [of compulsory care] and best practice’, are also important.⁷¹ Such views, like those of numerous other categories of professionals involved in mental health care, are informed by experience in deploying their expertise in particular contexts. The interaction of these views necessarily requires negotiation since different professional groups do not understand the MHA 1983 in the same way.⁷² Thus, while professional expertise is a necessary component in assessing suitability for compulsion or discharge, and by implication the risks associated with such a decision, Peay’s research indicates that it is inappropriate to confine consideration to medical expertise alone. With this consideration of the behaviour of professional decision makers in mind, I can now turn to consider the question of risk.

When recommending compulsory care, or the continuation of it, the care professionals must be of the opinion that, *inter alia*, the person poses a risk to the safety of themselves or others.⁷³ As such, the ability to assess risk is an integral, though conceptually challenging,⁷⁴ component of the review process. The question of assessing the Managers’ ability to gauge the risk of harm is made more complicated by the categories of persons who can be reviewed by the Managers. On the one hand, the Managers are not permitted to review the compulsory care of those under s.37/41 restriction orders, only the Tribunal may do this.⁷⁵ However, this does not mean that the Managers are prevented from reviewing the compulsory care of individuals who are claimed to be “dangerous”. An individual subject to compulsory care under s.3 MHA 1983 for example, can be discharged by their Nearest

⁷¹ Peay (n 68), 65; for further discussion and expansion see Nicola Glover-Thomas and Judith Laing, ‘Mental Health Professionals’ in Lawrence Gostin, Peter Bartlett, Phil Fennell, Jean McHale, and Ronnie Mackay (eds.) *Principles of Mental Health Law and Policy* (Oxford: OUP, 2010), 275-324.

⁷² *ibid.* Peay, 79.

⁷³ See, for example, MHA 1983 s.3(2)(c); Huzzey (n 31), 173 (Latham J); and DH (n 6), paras. 38.15-38.23.

⁷⁴ E Perkins, *Decision-Making in Mental Health Review Tribunals* (Gateshead: Policy Studies Institute, 2003), 67-68.

⁷⁵ MHA 1983 ss.37 and 41.

Relative.⁷⁶ To prevent this, the Responsible Clinician can issue an s.25 barring order indicating that the patient would pose a danger (a higher threshold than a risk) to themselves or others.⁷⁷ The appropriateness of this order, and thus the claim of dangerousness, may then be reviewed by the Managers.⁷⁸ Similarly, the Managers may also review the compulsory care of individuals who came into the mental health system from the criminal justice system via a s.37 order;⁷⁹ that is, forensic, but not restricted patients. Thus, the Managers may, like the Tribunal, encounter individuals posing a serious risk to the safety of themselves or others. On the one hand this demonstrates the importance of considering whether the Managers can properly assess risk, while on the other it shows that this aspect of the review mechanisms available under the MHA 1983 are somewhat incoherent.

Of course, fixating on risk in the abstract may be inappropriate. Speaking before the Joint Committee, IMHAP argued that focussing on the Managers' ability to assess risk was wrong, because risk could never be eliminated, 'no amount of new legislation can improve foresight'.⁸⁰ Instead, IMHAP called for a focus on the benefits of having multiple review routes. They argued that the impact on risk to others from eliminating the Managers' powers would be 'minimal', and would be 'outweighed by the protection afforded to citizens', that is, the reduction of the risk that the rights of those subject to compulsory care would be overridden.⁸¹ In any event, in a rebuttal to the contention that Managers were poor judges of risk, IMHAP argued, albeit without empirical evidence, that the Managers 'have an excellent record in terms of risk when compared to consultants or patients' responsible medical officers and Mental Health Review Tribunals'.⁸² Additionally inquiries into instances where tragedy

⁷⁶ This power is also to be found in s.23 MHA 1983.

⁷⁷ See further *Huzzey* (n 31), 173 (Latham J); *SR* (n 7), [4-7] (Jackson J).

⁷⁸ *ibid.*, *Huzzey and O* (n 7).

⁷⁹ *i.e.* without an s.41 restriction.

⁸⁰ IMHAP (n 60), EV103; also *Pacitti* (n 67), 6.

⁸¹ *ibid.*, EV104.

⁸² *ibid.*, EV114; also *AU* (n 24), [41] (Cranston J); see also *Pacitti* (n 67), 6.

has followed discharge by the Managers have similarly indicated that the Managers are competent to make reasonable judgments about risk, provided the care professionals make available the information necessary to make an informed decision.⁸³ Unfortunately, little evidence exists to justify either the contention that the Managers represent a significantly riskier safeguarding process than the alternatives, or that they are less risky.

We might also consider that, if experience in assessing risk is valued, then experience of conducting reviews may improve the ability of a reviewer to assess risk. The case law supports this position, suggesting that the Managers' value lies partly in their experience of conducting reviews. The courts have indicated that because the task of the Tribunal, and by implication that of the Managers **who apply the same statutory criteria**, is of a relatively repetitive nature, this will breed a degree of expertise as regards 'the nature of [the] task'.⁸⁴ That is, once a decision-maker grasps the requirements of the review, they are able to participate in the process in a way that ensures the care team are made to appropriately justify their decision to continue compulsory care. Consequently, it can be argued that reviewers gain competence to independently weigh the expert evidence put to them and the question of risk against the legal criteria by virtue of their on-going experience of conducting reviews.⁸⁵

Although these arguments do not necessarily support the view that Managers are the *best* equipped people to make these decisions, it calls into question the abolitionists' claim that specific professional expertise is required to review decisions.⁸⁶ In the absence of empirical evidence to enable a comparison of the ability of, for example, the Tribunal and the Managers to assess risk, it is not presently possible to justify the position of either side. While each might have some anecdotal

⁸³ See Hardy Review (n 58), 7.5.5-7.5.26, but as regards the particular case of Anthony Hardy see paras. 7.6.1-7.6.7.

⁸⁴ *JLG* (n 7), [7], and a similar point was made in relation to Managers: *AU* (n 24) [10], [33-34] (Cranston J).

⁸⁵ See also III(B) below; it has been suggested that an absence of *legal* training can disadvantage Managers, Hardy Review (n 58), paras. 7.63-7.64.

⁸⁶ See also *DH* (n 23), para.3.58.

evidence based on their individual experience of how effectively they have assessed risk in the past, no comprehensive picture exists.

(III)(B) A More Expert Tribunal?

The argument in the first part of this section has shown that there is currently no way to distinguish between the risk-assessment abilities of the professionals, the Tribunal or the Managers. A separate abolitionist contention is that the Tribunal is more expert than the Managers. In demonstrating that this argument is logically flawed, I will show that conceptually there is, at minimum, the potential for the Managers to possess the requisite expertise to conduct reviews of compulsory care under the MHA 1983.

As I noted at the start of section III, abolitionists argue that the Managers lack the expertise to challenge the clinician authorising compulsion because they are not themselves experts in the field of mental health medicine; they are not clinicians.⁸⁷ This argument overlooks the membership of the Tribunal which, although there have been changes in the scope of the powers accorded to it, has remained stable in terms of its composition since it was established under the Mental Health Act 1959 (MHA 1959).⁸⁸ Thus, if medical expertise is a prerequisite for effective review, this must also disqualify the legal and third member of the Tribunal from interrogating the evidence presented by the Responsible Clinician (and, arguably, the other professional report authors).⁸⁹ The same logic could be applied to the proposition that legal expertise is a prerequisite for understanding the legal

⁸⁷ But read in full DH (n 6), para. 38.37; leaving aside our lack of knowledge of *who* sits as a Manager, see above at III.

⁸⁸ See MHA 1959 s.3 and sch.1; compare with MHA 1983 Part V and sch. 2, and MHA 2007 s.38.

⁸⁹ In many respects this runs contrary to other areas of the law dealing with medical expertise. For example *Bolitho v City and Hackney Health Authority* [1998] AC 232, 241-242 (Lord Browne-Wilkinson).

framework.⁹⁰ Quite where the abolitionist argument leaves the (so-called) lay third member of the panel is unclear.

The abolitionists are thus seeking to subscribe to two contradictory propositions, only one of which can be true. First, each member of a tribunal is capable of interrogating the legal and medical evidence offered by the care team, can do so on the basis of their own expertise and experience, and is not reliant on the views of the medical or legal member respectively.⁹¹ Or, secondly, that *only* the relevant professional member is capable of interrogating the discipline-specific evidence presented, for example by the clinician, and so all conclusions reached by the Tribunal about the accuracy of, for example, the clinician's medical opinion are *de facto* the sole conclusions of that member. If the former proposition is preferred, then it must also be concluded that anyone with suitable experience is capable of interrogating the legal and medical evidence. If the latter is preferred, then the process is a charade in which one professional opinion competes with another. What is more, it implies that the third member is there merely to make up the numbers. Put this way, the proposition that medical expertise is essential, and that no other knowledge is appropriate appears a little farcical, and is out of line with the expectations of tribunals established by the Leggatt Review.⁹²

The unattractive illogic of the latter proposition suggests that the former should be preferred in the absence of contrary evidence. The *MHA Code of Practice* (the *Code*) appears to be in agreement with this view.⁹³ While the *Code* states that the Managers 'will not normally be qualified to form clinical assessments of their own', the same paragraph indicates that they will be required to 'reach an independent judgment based on the evidence that they hear' and that if there is disagreement among

⁹⁰ See again (n 85).

⁹¹ See also Perkins (n 74), 27-30, 41-48.

⁹² Perkins (n 74), 126, citing Leggatt, Report of the Review of Tribunals, *Tribunals for Users: One System, One Service* (London: HMSO, 2001), para. 1.2.; and again (n 89).

⁹³ DH (n 6).

the care professionals, they may 'seek further medical or other professional advice'.⁹⁴ Any disagreement between the original and additional opinion can only be resolved by the independent judgement of the Managers. Such a statement is, at minimum, a tacit acknowledgment that the Department of Health accepts that the Managers are qualified to assess professional opinion.

Notwithstanding that the logic of this aspect of the abolitionist argument is flawed on its own terms, it also requires the acceptance of a false premise. That is, the terms of the argument misconstrue the nature of the legal context. If one steps outside of the unrealistically narrow conditions established by the Tribunal/Managers dichotomy – that to prove their worth, the Managers should be compared to the Tribunal – two things become clear. First, that even if the Managers lack specific expertise in mental health, or the law, lay people are accorded significant powers elsewhere in the legal system, for example, in the magistracy and jury system. Secondly, it is also a mere assertion that the Managers are lay people who possess insufficient professional experience, given that we know very little about their composition. Both on its own terms, and when viewed in a less contrived context, the requirement of expertise set for the Managers as compared with that expected of the Tribunal is untenable.

Although those speaking in defence of the Managers' power have met the criticisms made of them regarding the expertise of the panel members with little concrete evidence, the same is true of those opposed to the Managers' exercise of the s.23 discharge power. Furthermore, no evidence has been offered which rebuts the proposition that the Managers are capable of producing good decisions, in the sense of decisions being aware of the relevant risks, reasoned, rational, and proportionate. This is not to say that professional expertise is not also essential; both the Tribunal and the Managers rely on the details provided by each of the report authors to give them access to all the information needed to reach a decision, but the available evidence does not show that a narrow understanding of professional expertise (law or medicine) is essential to understanding whether an argument for

⁹⁴ *ibid.*, para. 38.37.

continued compulsory care satisfies the legal requirements of the MHA 1983. In consequence, relying on this argument to support legislative reform in this area cannot be justified.

IV INDEPENDENCE

The positions assumed by both abolitionists and their opponents demonstrate that it is difficult to substantiate either view of the Managers' expertise. Arguments have also been made on two other grounds: independence and duplication. The independence argument is less straightforward than that concerning expertise. This is because the parliamentary understanding of the Managers' position relative to the managers was, as I will show below, unsettled from 1990 until 2007. This situation was likely both created and subsequently compounded by the failure of Parliament to articulate either the practical or principled basis for the independence of the Managers' created by the statutory framework. Notwithstanding this absence, the Managers' independence has been presented by proponents of the power as an important reason for retention.⁹⁵

Taken in conjunction with the wider ignorance about the Managers, the lack of either a concrete or conceptual basis for their independence is problematic. For example, it made it possible for the government to argue that because the hospital managers are the body authorising compulsory care, they could not be independent for the purposes of review.⁹⁶ The government failed to recognise that there is a difference between the hospital managers and the Managers, but their claim went unchallenged. The oversight was convenient because at the time the government were proposing that the Tribunal should become the body responsible for authorising *and* reviewing compulsory care. Their claim about the supposed lack of distinction between the Managers and the managers allowed the government to present the old system as flawed, and the new system as better, because it would be carried out by an independent judicial body. The lack of a principled and practical understanding

⁹⁵ See IMHAP (n 60), EV101.

⁹⁶ Referring to the managers of the hospital, Joint Committee (n 17), Annex 4, Clause 247(q), Government Response, 246.

of the Managers' role thus permitted the government to avoid acknowledging the contradiction between their statement about the Managers' independence, and the proposal to combine authorisation and review into a single process.

As the central contention of this paper is that we should not make significant changes to the framework of safeguards in the MHA 1983 without properly understanding the systems we seek to alter, I propose to explore the official understanding of the Managers' independence with a view to unpacking the implications of **it** for the abolition debate. I do not propose to enter **into** debate about the substantive value of such independence, because that presupposes that we have a clear understanding of the extent to which s.23 practice deviates from the official understanding, which we do not. Instead, I seek to establish what independence they are thought to have under the MHA 1983. This entails considering two things. First, having regard to the legislative development of the s.23 power, is the direction of travel towards growing independence on paper? Secondly, if yes, what is the purported nature of that independence?

IV(A) Historical Development of Independence

It has not always been the case that the managers and the Managers were separate entities. In view of the fact that the s.23 discharge power, and earlier incarnations of it were always exercised locally, the precise moment of transition from relative overlap to relative separation between managers and Managers varied depending on local circumstance as much as the legal framework. However, as I discuss below, by the time with which I am concerned in this paper, the mid-1990s to the mid-2000s, the transition was largely complete. To understand how the legal framework established a space for independence in principle, it is necessary to briefly consider the origins of the s.23 discharge power.

It is often contended, incorrectly, that the origins of the Managers' **s.23 power** lie in the MHA 1959.⁹⁷ In fact, the power of discharge today exercised by the Managers historically attached to the Justices of

⁹⁷ For example, the Expert Committee (n 47) para. 12.1; and also Hardy Review (n 58), note 71 at 116

the Peace in Quarter Session who, as part of their responsibilities for administering what passed for local government in the nineteenth century, sat on the Visiting Committees of the local county asylums. The Justices were not only closely implicated in the administration of the asylums,⁹⁸ but also possessed a power of discharge.⁹⁹ At the time it was also the function of the Justices, as magistrates, to certify persons as suitable for admission to an asylum. In this way, those authorising admission, continuation of compulsory care, and discharge were one and the same, and cannot be said to have been independent. The motivation behind providing the Visiting Justices with a power of discharge likely had little to do with safeguarding individual rights, but rather, as with their other powers, the administration of public funds associated with the asylums.¹⁰⁰

Little changed following the passage of the Local Government Act 1888 and the Lunacy Act 1890. The 1890 Act transferred the powers held by the Visiting Justices to the County Councils created by the 1888 Act, including responsibility for administering asylums as well as exercising a power of discharge.¹⁰¹ Many of the members of the County Council Visiting Committees were Justices who had previously sat on the old Visiting Committees, and who were then re-appointed as *ex officio* members of the County Councils.¹⁰² There may have started to be some disaggregation from the

⁹⁸ For discussion see P Bartlett, 'Legal madness in the Nineteenth Century' (2001) 14(1) *Social History of Medicine* 107-131, 126; K Jones, *Asylums and after: a revised history of the mental health services: from the early 18th century to the 1990s* (London: Athlone Press 1993), 71, 77, 81; A Suzuki, 'The politics and ideology of non-restraint: the case of the Hanwell Asylum' (1995) 39 *Medical History* 1-17, 6-11.

⁹⁹ *ibid.*, Jones, 92.

¹⁰⁰ *ibid.*

¹⁰¹ See Local Government Act 1888, s.3(vi), and also ss.44, 86 and 111; Lunacy Act 1890, ss. 77, 169-176

¹⁰² See J P D Dunbabin, 'The politics of the establishment of county councils' (1963) 6(2) *The Historical Journal* 226-252, 249, 249; B Forsythe, J Melling and R Adair, 'Politics of lunacy: central state regulation and the Devon Pauper Lunatic Asylum, 1845-1914' in B Forsythe and J Melling (eds.) *Insanity, Institutions and Society, 1800-1914: A social history of madness in comparative perspective* (London: Routledge, 1999), 80; J Melling and R Turner 'The

County Council as a consequence of the Mental Treatment Act 1930, which permitted individuals who were neither elected nor *ex officio* members of the County Council to be co-opted onto the Visiting Committees,¹⁰³ but there was inconsistency between localities here.¹⁰⁴ However, the 1930 Act marked the first time that the independence of those who were not involved in the management of the hospital, but had the power to discharge them, was made legally *possible*.

The National Health Service (NHS) Act 1946, which created the NHS, removed the power of discharge from the local authority Visiting Committees, but only to transfer it, along with other powers and responsibilities including the administration of mental hospitals,¹⁰⁵ to Hospital Management Committees (HMCs).¹⁰⁶ The MHA 1959 retained this arrangement.¹⁰⁷ Like the Visiting Committees before them, HMCs were ultimately responsible for the day-to-day administration of the hospitals, and could delegate their authority to sub-committees, including to co-opted external members. It remains unclear whether those reaching decisions about exercising the power of discharge were also involved in hospital administration, again, local practice is likely to have varied because of the lack of centrally promulgated guidance, but the power to delegate was certainly available.¹⁰⁸

road to the asylum: institutions, distance and the administration of pauper lunacy in Devon, 1845-1914' (1999) 25(3) *Journal of Historical Geography* 298-332, especially, 332; but this trend was not universal, see S Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998* (Woodbridge, Suffolk: Boydell Press, 2003), 112.

¹⁰³ Mental Treatment Act 1930, s.7(4); see also, Ministry of Health ('MH'), *Report of the Committee on Administration of Public Mental Hospitals* Cmnd. 1730 (London: HMSO, 1922), 70-71

¹⁰⁴ See Melling and Turner (n 102), see also *ibid* MH, 71

¹⁰⁵ As they were renamed under s.20 of the Mental Treatment Act 1930.

¹⁰⁶ NHS Act 1946, s.78(a) and sch.9 (Part 1).

¹⁰⁷ MHA 1959 s.47, especially s.47(4), and s.59

¹⁰⁸ DHSS, Home Office, Welsh Office, *Review of the Mental Health Act 1959* (Cmnd 7320) (London: HMSO, 1978), paras. 3.18-3.19.

The 1959 and 1983 MHAs replicated the position under the NHS Act 1946 and its predecessors, albeit in a consolidated form, including the ability to delegate the discharge power to a sub-committee.¹⁰⁹ Although the discharge power contained in s.47 predated the MHA 1959 Act, the Report of the Percy Commission (1957) was evidently concerned at the lack of detail surrounding how it was to be executed. To this end, the Report went into some detail about how the HMC procedure should be structured, at least as regards the question of renewal orders, which were to be conducted by interview.¹¹⁰ It is not clear, however, whether it was anticipated that this procedure would also extend to challenges to compulsory care made outside of the renewal cycle.¹¹¹ Notwithstanding the consideration given by the Commission, the limited evidence suggests that the procedural requirements of the regime under the s.47 MHA 1959 were limited. A Review undertaken prior to the passage of the Mental Health (Amendment) Act 1982 (MHAA 1982) and the MHA 1983 indicates that, although s.47 was thought to provide ‘an important safeguard’,¹¹² there was wide variation in each Area Health Authority (AHA) as regards procedure, appointment of external Managers, and the involvement of both AHA managers and appointed Managers in reaching a decision.¹¹³ Indeed, when the possibility of reforming the MHA 1959 was under consideration in the late 1970s, the Government thought it would be necessary to establish a formal procedure, in part to combat the aforementioned variation in practice.¹¹⁴

¹⁰⁹ MHA 1959 s.47, especially s.47(4), and s.59; MHA 1983 s.23, especially s.23(4), ss.142B and 145.

¹¹⁰ Percy Commission, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957* (Cm 169) (London: HMSO, 1957), paras 434-436.

¹¹¹ Hardy Review (n 58) at note 71 suggests it may have been, but this is not clear in the Commission’s own Report, *ibid* paras 421-427.

¹¹² DHSS *et al* (n 108), para. 3.19.

¹¹³ *ibid*.

¹¹⁴ *ibid.*, paras. 2.16, 3.19.

It is not clear whether this concern resulted in any noticeable change in practice, though the continued devolution of the power to the most local level, coupled with the lack of guidance on these procedural aspects, to the present day, makes the likelihood of any change having occurred slim. There is a lack of data regarding whether delegation took place in practice following the passage of the 1983 Act, which itself echoed the wording of the MHA 1959 provisions,¹¹⁵ and contemporaneous official sources are in dispute with one another as to whether delegation was permitted.¹¹⁶ As such, it is again difficult to establish whether delegation to external independent persons occurred. The confused picture in the years following the passage of the MHA 1983 may have been due to the failure of Parliament to consider the Managers' discharge power during the passage of the MHAA 1982,¹¹⁷ and the lack of a standardised procedure for carrying out hearings.¹¹⁸

However in the first half of the 1990s, the picture became a little more settled with the evident expectation that delegation to external persons was ordinary.¹¹⁹ Nonetheless, while delegation

¹¹⁵ MHA 1983 s.23, especially s.23(4), ss.142B and 145.

¹¹⁶ Some argued that it was not permitted, see Williamson (1985) (n 19), 4-5, 7, in contrast to Department of Health and Social Security (DHSS), *Memorandum on Parts I to VI, VII and X of the Mental Health Act 1983* (London: HMSO, 1983) para. 63; and DHSS *et al* (n 103), para. 3.18.

¹¹⁷ There were only very brief exchanges for example, House of Commons Special Standing Committee on the Mental Health Act Bill 1981-92 (22nd April - 29th June 1982) in *Parliamentary Debates, House of Commons Official Report, Standing Committees, Session 1981-82, Volume XI* (London: HMSO),; 10th May 1982, cols.23-24, some of which disclose a lack of understanding 29 April 1982 cols.171-172

¹¹⁸ This led others to suggest an unofficial framework, see C Williamson, 'Patients' appeals against compulsory detention: a systematic procedure for applying the Mental Health Act 1983' (1984) 80(4) *Hospital and Health Services Review* 179-181; the official guidance remained sparse see (DHSS), *Memorandum on Parts I to VI, VII and X of the Mental Health Act 1983* (London: HMSO, 1987) para. 63.

¹¹⁹ See Williamson (1991) (n 19), 4; and also MHAC, *Sixth Biennial Report 1993-1995* (London: HMSO, 1995), para. 3.7.

occurred, this does not mean that those in receipt of the delegation were independent of those delegating s.23 authority. For example, there was no requirement in the first or second editions of the *Code* that those exercising the s.23 power should be independent of the compelling authority.¹²⁰ Furthermore, although the principle was included in the third edition,¹²¹ the emphasis in the text was on the final decision resting with the compelling authority.¹²² Taken in conjunction with the patchy practice of delegation throughout the twentieth century, the development of the *Code* in the 1990s would appear to support the abolitionist contention that the Managers are not independent. In particular, that they appear to lack decisional independence¹²³ – the ability to make decisions free from external influence. However, this view is confounded by the contemporary practices described in Hansard.

An examination of the parliamentary record indicates that, from at least 1990, Parliament's intention was understood to be that individual organisations gave the Managers decisional independence. In two periods, 1990-1994 and 2003-2007, the Managers were *not* independent of the managers. However, Parliament's reaction to this state of affairs indicates that this was not the intended position. Before exploring this further, two caveats must be noted. First, the legislation only affected those organisations which had transitioned to the new administrative structure created by the Acts in question.¹²⁴ Second, and more significantly, although within the two periods, as I show below, Parliament's legislative actions suggest it intended that the Managers possess decisional independence,

¹²⁰ See DH and Welsh Office, *Mental Health Act Code of Practice* (London: HMSO, 1st edn, 1990); and *Mental Health Act Code of Practice* (London: HMSO, 2nd edn, 1993).

¹²¹ DH and Welsh Office, *Mental Health Act Code of Practice* (London: HMSO, 3rd edn, 1999), para. 23.1.

¹²² *ibid.*, paras. 23.3-23.4.

¹²³ Applied to judicial processes generally by P Gerangelos, *The Separation of Powers and Legislative Interference in Judicial Processes: Constitutional Principles and Limitations* (Oxford: Hart, 2009), 1.

¹²⁴ NHS and Community Care Act 1990 which created NHS Trusts, and the Health and Social Care (Community Health and Standards) Act 2003 which created NHS Foundation Trusts.

in the years between 1994 and 2003 and especially in 1996, Parliament took a different view **when debating the Managers**.¹²⁵ This suggests that Parliament's intention was unsettled throughout the period from 1990 to 2007.

The root cause of the difficulties between 1990-1994 and 2003-2007, lies in the failure to amend s.145 of the MHA 1983 to reflect administrative changes to the structure of the NHS. As enacted, s.145 provided that a hospital was an organisation operating under the NHS Act 1977,¹²⁶ and defined the managers of the hospital as the corporate body itself. This definition is relevant because only those fulfilling these criteria, and those to whom the power can be delegated, can exercise the MHA 1983 s.23 power. Thus, who or what constitutes a manager is important. In 1990 and again in 2003, the NHS underwent reorganisations which had the effect of creating new organisations (managers) *not* covered by s.145.¹²⁷

The NHS and Community Care Act 1990 (NCCA 1990) created, among other things, NHS trusts with boards that included Non-Executive Directors.¹²⁸ In view of previous reorganisations, one would have expected the 1990 Act to have replicated the existing authority to delegate s.23 powers, and to have amended the definition of 'manager' in s.145 MHA 1983 accordingly. Yet, buried within Schedule 9 of the 1990 Act lay three seemingly innocuous words – 'the directors of' – to be inserted into s.145 MHA 1983.¹²⁹ The amendment was presented with a collection of other amendments as 'minor changes to existing legislation consequential on the setting up of [NHS] trusts';¹³⁰ a housekeeping,

¹²⁵ Consider again the statements regarding Glen Grant, HC Deb 20 February 1996 vol 272 cc.175-87 and HL Deb 20 February 1996 vol 569 cc.991-1004.

¹²⁶ NHS Act 1977.

¹²⁷ See again (n 124).

¹²⁸ NCCA 1990 s.5, and especially s.5(5)(a).

¹²⁹ NCCA 1990 Act s.66 and Sch.9 para.24(9).

¹³⁰ Lord Sanderson, HL Deb 14 May 1990 vol.519, cc.142, 145; see also s.66(1) NCCA 1990.

continuity amendment.¹³¹ The amendment was subsequently considered summarily and left to stand when the Lords' amendments were returned to the Commons.¹³²

The words had far-reaching consequences. In view of the historical format of s.145, the specification of trust directors, not the trusts themselves, as the Managers, and the absence of any indication that the authority could be delegated, the only way to read the words was to require that the directors *personally* carry out the s.23 process. Following a written question from Liz Lynne MP, the then Under-Secretary of State for Health John Bowis MP responded that primary legislation would be necessary to correct the 'problem'.¹³³ From 1990 until the passage of corrective legislation in 1994,¹³⁴ the three words created severe difficulties for the Chairs and Non-Executive Directors of all NHS trusts treating people under the 1983 Act.¹³⁵ There were only a handful of such managers in each trust,¹³⁶ and they had other responsibilities connected with its administration. Unsurprisingly, the shortage of persons authorised to use the s.23 powers caused considerable delays in holding hearings in some organisations.¹³⁷ The Mental Health (Amendment) Act 1994, removed the phrase 'the directors of'

¹³¹ The accompanying secondary legislation supported this assumption, see NHS Trusts (Membership and Procedure Regulations 1990) SI 1990 no. 2024, see also Williamson and Vellenoweth (n 19), 13-14.

¹³² See HL Deb 27 June 1990 vol.175 c.460I see also Amendment no.674 in House of Commons Standing Committee E on 22 February 1990 (morning session) which was left to stand there and at Report stage.

¹³³ HC Deb 9 July 1993 vol.228 c.292.

¹³⁴ Mental Health (Amendment) Act 1994.

Curiously the *Code of Practice* (2e) in force at the time makes no mention of the issue, and almost replicates exactly the first edition in this regard, see DH and the Welsh Office (n 120).

¹³⁶ A maximum of 11, see again SI No. 2024, Part II(2) (n 131); see also Williamson and Vellenoweth (n 19), 13.

¹³⁷ See NHS Management Executive Letter TEL 93/2 and HL Deb 20 January 1994 vol.551 cc.776-782 for detail; and also Williamson and Vellenoweth (n 19), 13.

and so allowed the trusts as corporate bodies to be defined as the managers, reflecting earlier practice.¹³⁸

What is important about these changes, beyond the evident lack of proper legislative scrutiny, is the unintentional, but palpable shift the NCA 1990 appears to have caused in ordinary practice. Previously, not only was it possible to delegate the power to specially appointed persons, as suggested above,¹³⁹ but it appears that Parliament thought it *ordinary* to do so.¹⁴⁰ This conclusion is only further confirmed by Parliament's reaction to the consequences of the NCA 1990. Hansard details the various difficulties that arose 'owing to a mistake in the drafting of Schedule 9.'¹⁴¹ For example, in some trusts the problems were so extensive that Non-Executive Directors 'had to leave their sickbeds to conduct appeals'.¹⁴² Parliament's legislative response amending s.145 shows that it had always intended that the new trusts *would be in the same position* as their predecessor authorities.¹⁴³

Regrettably, lessons were not learnt from the 1990-1994 debacle. Schedule 4 paragraph 53(c) of the Health and Social Care (Community Health and Standards) Act 2003 inserted new material into s.23 of the 1983 Act which explicitly, and inexplicably, distinguished NHS foundation trusts from all other forms of hospital organisation as regards defining the manager. Once again the provisions prevented anyone *but* the Chair and Non-Executive Directors from exercising the s.23 discharge power. An

¹³⁸ See further Lord Jenkin, HL Deb 20 January 1994 vol.551 c.778.

¹³⁹ See (n 119).

¹⁴⁰ See debate on the Bill correcting this problem, Baroness Cumberlege HL Deb 20 January 1994 vol.551 c.780; and Williamson and Vellenoweth (n 19), 13; see also Joint Committee (n 17), note 327 at 99.

¹⁴¹ Lord Jenkin (n 138) c.777; see also Baroness Jay at c.779.

¹⁴² *ibid.*, Lord Jenkin cc.777-778.

¹⁴³ *ibid.*, c.777, *emphasis added*.

opportunity to correct the problem was missed in the passage of the NHS Act 2006.¹⁴⁴ Instead, Schedule 7 paragraph 15(3) of the 2006 Act restated the position under the 2003 Act.

Confirmation that it had not corrected the issue can be seen during the Second Reading debate in the House of Lords on the new Mental Health Bill 2006. During the debate, Baroness Meacher was moved to lament that there was:

... an urgent need to deal with the unsustainable position of foundation trusts that cannot delegate the functions of Mental Health Act managers from non-executive directors. That is a small technical point, but one that is causing absolute havoc around the country.¹⁴⁵

Evidently no one disagreed with Baroness Meacher because the amendments to correct the difficulty enjoyed an undisturbed passage throughout the rest of the parliamentary process.¹⁴⁶ As in 1990-1994, the 2003-2007 difficulties indicate that Parliament understood ordinary practice to be that the hospital managers tended to delegate responsibility to specially appointed Managers.

In these two periods it is clear that the legislative intention of Parliament regarding ss.23 and 145 MHA 1983 was understood as being that the Managers were independent of the organisation delegating the s.23 power. Nonetheless, Parliament's intention was unsettled when the whole period from 1990-2007, taking in the events of 1996,¹⁴⁷ is considered. Had either side in the abolition debate examined the variability of Parliament's intentions in more detail, this might have provoked a more substantive

¹⁴⁴ Royal assent 8th November 2006, in force from 1st March 2007.

¹⁴⁵ Baroness Meacher, HL Deb 28 November 2006, vol.687 c.708; see also MHAC (2005-2007) (n 18), paras. 4.98-4.100.

¹⁴⁶ The last mention of the relevant provision, Clause 44, is to be found in the House of Commons Public Bill Committee on 15 May 2007 at c.389. The provision was dealt with summarily alongside Clauses 45 and 46 and left to stand as part of the Bill. The correction to the legislation can be found in MHA 2007, s.45.

¹⁴⁷ See Section II, above

discussion about the principled justifications for Parliament's variable position; Hansard discloses no such consideration. As I have emphasised throughout my examination of this debate, both sides are hampered by the lack of evidence and a conceptual framework to support their claims. This is likely to be both a cause as well as a consequence of the unsettled parliamentary picture in this period.

Taking an even wider historical perspective, from 1990 to 2016, it can be seen that while Parliament's intention may have appeared to be unsettled in the 1990s, because of the discussion in 1996 regarding Grant and the establishment of the Working Group, this was something of an aberration. Following the passage of the MHA 2007, s.45 of which corrected the difficulties caused by the 2003 Act regarding delegation in foundation trusts, it appears that the parliamentary position is that the managers may delegate the s.23 power to external persons. The 2016 judgment in *AU* not only confirms that s.23(6) specifically enables delegation in foundation trusts, but that the parliamentary intention behind s.23 as a whole was to establish 'an independent decision-making entity' to which power could be delegated.¹⁴⁸ Although the court did not reflect on the fact that s.23 does not itself preclude hospital managers from acting as Managers, the court's interpretation of the statute indicates that where the power is delegated the body should be independent of the organisation. Whatever the precise implications of *AU* for managers, the broader legislative and judicial view indicates that delegation of power is ordinary, and that the purpose of this is to establish decisional independence.

IV(B) Independence in Practice

The foregoing discussion establishes the route by which the practice of delegating discharge authority to external persons has become normal practice, though neither Parliament nor any other body has presented any justification for this course of action. Furthermore, notwithstanding the **official position reinforced by the** MHA 2007 and the judgment in *AU*, it remains unclear whether the Managers capitalise on their apparent independence in practice. Independence in this context requires more

¹⁴⁸ *AU* (n 24), [26] (Cranston J).

than a theoretical capacity for decisional independence, it requires that Managers are able to form an independent view that meets the requisite legal standard in practice.¹⁴⁹

To answer this question it is again useful to begin with some historical context. The ability of those exercising the s.23 power, or its earlier incarnations, to think independently of medical professionals was not considered a desirable feature by the Macmillan Commission (1926), the Royal Commission which preceded the Mental Treatment Act 1930. The Commission stated that the Visiting Committees should be '*guided largely by the advice of the medical superintendent*' when considering discharge.¹⁵⁰ This was not a radical position.¹⁵¹ Thirty years later, the Percy Commission, which informed the MHA 1959, took a different view and, in the context of a discussion around the creation of the Mental Health Review Tribunal, considered that reliance of HMCs on the advice of the medical superintendent was problematic should the patient require a formal legal justification for their compulsory care.¹⁵² However, seen in the light of the wide powers of discharge that the Commission argued should continue to vest in the HMCs,¹⁵³ their criticism might be seen as a call to strengthen the independence of HMC members.

¹⁴⁹ An indication of what this entails can be found in *R (on the application of H) v Ashworth Hospital Authority* [2002] EWCA Civ 923, at paras. 76-82, which outlines what constitute acceptable reasons for the Tribunal.

¹⁵⁰ Macmillan Commission, *Report of the Royal Commission on Lunacy and Mental Disorder* (Cm 2700) (London: HMSO, 1926) pp.76-77, para 194(a) *emphasis added*; the Visiting Committees were a predecessor body of the Managers.

¹⁵¹ See MH (n 103), 60 (but note 62), and also P Fennell, 'Mental Health Law: History, Policy and Regulation' in L Gostin, P Bartlett, P Fennel, J McHale, and R Mackay (eds.) *Principles of Mental Health Law and Policy* (Oxford: OUP 2010), 3-70, paras. 1.53-1.54, 1.81.

¹⁵² Percy Commission (n 110), para. 439. The HMCs were a product of the NHS Act 1946, which incorporated the powers previously vested in the Visiting Committees of the County Council into the HMCs, see especially NHS Act 1946, sch.9 (re changes to the Lunacy Act 1890).

¹⁵³ *ibid.*, Percy Commission, paras. 421, 424-427, 434-436; MHA 1959, s.47 and MHA 1983 s.23.

The Percy Commission's views were not universally accepted. Some of the contributions to the parliamentary debates which followed their 1957 Report suggested that lay persons (i.e. non-psychiatrists) should not be permitted to exercise an independent judgement. Reginald Sorensen MP (unsuccessfully) asserted that if lay persons were allowed to be independently minded, the result would be 'lamentable'.¹⁵⁴ Instead, he argued that 'the doctor *must* be relied upon to give advice which laymen should accept'.¹⁵⁴ This was a more extreme position than the already high-bar proposed by the Macmillan Commission, which had recommended (also unsuccessfully) that only the unanimous approval of the whole Visiting Committee, rather than the ordinary panel of three, would be sufficient to override the decision of the doctor.¹⁵⁵ Quite what purpose would be served by having the clinician's view reviewed by persons who would ultimately have to defer to the clinician was not explained. More recently, it has been recognised that deciding to discharge against medical advice 'is virtually the definition of a discharge at a Managers' hearing'.¹⁵⁶

This historical summary gives some sense of the tensions involved in the exercise of the s.23 power, but it does not tell us whether the Managers typically do override the decision of the clinician today. In the absence of other evidence, the best available indicator of the Managers' ability to form an independent view are the rates of discharge by Managers. Unfortunately, even on this fundamental point, only very limited statistical evidence is available.¹⁵⁷ The first of the sources available is the Report of the 1996 Working Group. The Group conducted a study involving a small, though nominally representative, number of hospitals and concluded that 'the number of patients discharged against medical advice ... is very small (5 per cent)', with even fewer discharged following an s.20 MHA 1983 renewal ('2 per cent').¹⁵⁸ This figure is in keeping with that reported by IMHAP before the Joint

¹⁵⁴ Reginald W Sorensen MP, HC Deb 06 May 1959 vol.605 c.467, *emphasis added*.

¹⁵⁵ Macmillan Commission (n 150), para. 148.

¹⁵⁶ Turner (n 32); see also MHAC *et al* (n 37), p.9; cf Kennedy (n 15), 361.

¹⁵⁷ *ibid.*, Kennedy.

¹⁵⁸ MHAC *et al* (n 37), p.4; the non-generalisable nature of the study is outlined at 3.

Committee in 2004 that 'approximately 3-4% of hearings' result in the lifting of the section.¹⁵⁹ It is regrettable that the statistical evidence to support IMHAP's claim was not produced.¹⁶⁰ The picture is further confused in view of the fact that the figures of both the Working Group and IMHAP are lower than those produced by MHAC for 1997-1998 (8.4 per cent discharge rate at contested hearings).¹⁶¹

Each of the figures above is limited by the fact that they provide only a snapshot and disclose no sense of the trend over time. A study by Singh and Moncrieff is more chronologically comprehensive.¹⁶² Their study covered 1997-2007, but it did not distinguish between those discharges granted by the then Mental Health Review Tribunal and those by the Managers. As such, it is hard to discern which element of the total discharge rate recorded, approximately 12 per cent, is attributable to the Managers.¹⁶³ Although there is inconsistency between **each** of the studies discussed, they all suggest that the rates of discharge are lower than we might expect if Managers were regularly challenging the views of clinicians.¹⁶⁴

This conclusion is simplistic because it ignores other factors which may explain the low rate of discharge. First, none of the studies recorded the number of discharges following a *request* for a

¹⁵⁹ IMHAP (n 60), EV101.

¹⁶⁰ For example, whether there was a difference between s.20 renewals and other hearings.

¹⁶¹ Either where the person requests a hearing to challenge compulsory care, or challenges an s.20 renewal. 1995/96 324 discharges, 1996/97 232 discharges, 1997/98 302 (8.4%) discharges. Note that 'the total number of contested Reviews is not known' for 1995/96 and 1996/97 so a percentage rate of discharge could not be given. See MHAC (1997-1999) (n 19), para. 4.88; MHAC (2005-2007) (n 18), fig.55, 180.

¹⁶² D K Singh and J Moncrieff, 'Trends in mental health review tribunal and hospital managers' hearings in north-east London 1997-2007' (2009) 33 *Psychiatric Bulletin* 15-17.

¹⁶³ *ibid.*, 15.

¹⁶⁴ Prior to the passage of the 1983 Act, it was also believed that the then s.47 discharge power under the MHA 1959 was 'in practice ... little used', see DHSS *et al* (n 108), para. 2.16.

hearing but preceding the hearing itself. One anecdotal, though dated, example of discharge ahead of a requested hearing is discussed in Hansard,¹⁶⁵ but more recent, comprehensive statistical data is limited. The only publicly available example is an MHAC study of five service providers in 2006/07.¹⁶⁶ The study indicates a discharge rate at hearings of 5 per cent from 443 hearings, a similar figure to those above, but it also says that 195 discharges were made prior to the hearing. Taken with other figures in the table, the total number of requested hearings was 732, it can be seen that in approximately 27 per cent of cases, a patient was discharged prior to their hearing, but following a request for a hearing. This undermines the contention of the Expert Committee and the government that the s.23 process is of 'little obvious benefit to the patient in terms of early discharge'.¹⁶⁷ If a request prompts a clinician to discharge a person from compulsory care, this suggests that they perceive the Managers to constitute an informed, reasonable decision-making body that, given access to the same evidence as the clinician, is capable of reaching the same conclusion that a person no longer meets the criteria for compulsory care. In the event that a clinician were not to discharge a person, a body which was not capable of thinking independently would be unlikely to reach such a decision, and would instead rubber-stamp the clinician's view.

Secondly, it should be acknowledged that while requests might be made for s.23 hearings, some of these will have little prospect of success.¹⁶⁸ A person who lacks sufficient insight into their mental health may bring a weak case, leading the Managers to agree that compulsory care should continue.

¹⁶⁵ Christopher Price MP, HC Deb 22 February 1979 vol.963 c.702 discussing how he supported a friend in and s.47 MHA 1959 HMC process at the Maudsley Hospital.

¹⁶⁶ MHAC (2005-2007) (n 18), fig.55, 180.

¹⁶⁷ Expert Committee (n 47), para. 5.127; a view implicitly supported by the government, see DH (n 50), para. 10.6.

¹⁶⁸ Peay's research outlines the types of cases – including hopeless cases – which have historically come before the Tribunal, see J. Peay, *Tribunals on Trial: A Study of Decision-Making Under the Mental Health Act 1983* (Oxford: Clarendon Press, 1989), 147-150, 177-191.

Added to this is the assumption that all professionals are acting in good faith, and have cogent, evidenced reasons to make the case for compulsion. Thus, in addition to their safeguarding role, the Managers' hearings also serve as a means to locate those cases where an inadvertent error in reasoning has been made, or where a case falls into the grey area where either a decision to discharge or to continue compulsory care could be justified.¹⁶⁹

These observations of the probably operational parameters of the Managers' s.23 power yield only a relatively narrow range of cases likely to lead to discharge. On the other hand, given it is estimated that many thousands of Managers' hearings take place annually,¹⁷⁰ a 3-5 per cent discharge rate at hearing, plus a substantial number of discharges following a request for a hearing, amounts to many hundreds of cases a year. This is significant when it is considered that every such case represents a decision to protect the liberty of the person subject to compulsion. Taken together with the expectation that the decision-making power will often be delegated to external persons, the possible discharge rates by the Managers suggest that they possess many characteristics that render them independent. At this stage however, it is only possible to say that the abolitionist contention that the Managers lack independence as regards their personnel and decision-making capacity is in doubt. We need more information about who sits as a Manager, and how the s.23 process operates before we can compare them to, *inter alia*, the Tribunal and Responsible Clinician's discharge power, and thus take a more considered view as to what reform of the statutory framework, if any, is required. What should be noted though is that the above only considers the outcome of the Managers' process, and not the possible value of the process itself, which is addressed in the next section.

¹⁶⁹ Williamson and Vellenoweth (n 19), 18.

¹⁷⁰ See (n 17) – (n 19).

V DUPLICATION

From the foregoing discussion it is clear that, primarily due to a lack of data and other evidence, understanding of the s.23 power is limited. This has led to underdeveloped, often unsubstantiated claims regarding both the independence and expertise of the Managers, and poorly informed arguments being made whenever reform is contemplated. This difficulty also afflicts the third limb of the abolition argument: that the Managers duplicate the process and, thus, the effort of the Tribunal.¹⁷¹ As I said above,¹⁷² while the Tribunal and the Managers appear to share certain procedural characteristics, this does not preclude the possibility that they are substantively different. In consequence, although abolitionists could point to the Report of the Working Group which found that 68 per cent of those subject to compulsory care applied to both mechanisms,¹⁷³ this figure oversimplifies the duplication question.

First, the Group did not explore why two purportedly duplicative processes had been permitted to continue to co-exist despite major reform – the passage of the MHA 1983. The membership of the Group was such that it was well-placed to speculate on this point, even if it could not provide concrete answers.¹⁷⁴ Raising these questions may have provoked the kind of substantive consideration of the purpose of review mechanisms under the MHA 1983 which I have already demonstrated has not occurred. Secondly, the Report oversimplifies the nature of a person's mental health. The fact that 68 per cent of those subject to compulsion surveyed used both mechanisms says nothing about when their applications to each were made. If they were not proximate in time, then the fact that they

¹⁷¹ See for example, Blumenthal and Wessely (n 46), para. 4.2.4; MHAC *et al* (n 37), 4, 9; Stephen Dorrell's press release, available in Turner (n 32); DH (n 50) para.7.8; Committee of Leeds Consultant Psychiatrists' evidence in Joint Committee (n 64), EV883.

¹⁷² See Sections I and II

¹⁷³ MHAC *et al* (n 37), 4, 9-11.

¹⁷⁴ *ibid.*, Annex I.

applied to both mechanisms is unlikely to have caused any duplication, because a person's mental health is dynamic and so may change between hearings, requiring new reports to be produced.¹⁷⁵

Finally, the Group did not interrogate the reasons why a person might apply to both processes. The absence of investigation suggests that the Group assumed that because the procedure and nature of the power are *superficially* similar – in that both permit discharge – the value and purpose of the routes to the individual and to the legal system must be *substantively* the **same**.¹⁷⁶ In view of the fact that neither society nor the legislative process, have ever considered the intended function of the s.23 discharge power, nor that of its antecedents, this assertion is difficult to substantiate. In consequence, the figure of 68 per cent offered by the Report does not provide a complete picture. To further demonstrate why this is the case these limitations can be examined in more detail. This will show that, to date, the duplication argument has been presented in a binary way, when the situation is considerably more nuanced.

V(A) A More Local Power

I have already shown above that the s.23 power predates the earliest incarnation of the Tribunal. Furthermore, if the deliberations of the Percy Commission are examined, it is possible not only to reconfirm that what became the Managers' power of discharge predates the 1959 Act, but also that a specific concern was expressed that the proposed *tribunal* would duplicate the discharge power possessed by the *Managers'* (then HMCs').¹⁷⁷ The tribunals proposed by the Commission, and found in the 1959 Act, were based along the geographical boundaries of the 14 Regional Hospital Boards created under the NHS Act 1946. They were in this sense local, but decidedly less so than the HMCs which were associated with individual hospitals or groups of hospitals within a Board's area. The Commission was concerned about the legitimacy of a body with a jurisdiction covering a larger

¹⁷⁵ See Hardy Review (n 58) para. 7.5.11.

¹⁷⁶ An example of conflating form and substance can be found in Power-Smith and Evans (n 15), 47-48.

¹⁷⁷ Percy Commission (n 110), para. 768.

geographical area to exercise a *continuing* power of discharge equivalent to that of the HMCs. Indeed, this may be the historical reason why the Tribunal and its predecessors were entrusted only with a *periodic* power of discharge, even if today the practicalities of case management are likely the main factor.¹⁷⁸ In the light of modern contentions that the Managers duplicate the functions of the Tribunal, it is ironic that the Tribunal created under the 1959 Act was not imbued with a continuing power of discharge because it was thought that they would be seen as duplicating the role of a more local body.¹⁷⁹ This suggests that the type of power exercised by the Managers and the Tribunal was historically intended to be different, at least in terms of the locus of their legitimacy.

While this shows that historically the difference between the two powers was concerned with issues of local legitimacy, this does not preclude it from being viewed as a procedural, case management issue today. Thus, the modern understanding of the nature of the two powers merits some further examination.¹⁸⁰ In *AU Cranston J* concluded that the apparent intention of ‘the Parliamentary design is to confer wholly separate discharge powers’ on the Tribunal and Managers,¹⁸¹ such that one need pay no attention to the other.¹⁸² This difference would be of little consequence if a Managers’ hearing and a tribunal are scheduled to be held close together, because the criteria applied by each is the same. In anticipation of the concern that proximity in time would duplicate the liberty safeguarding element of the process, the *Code* stipulates that the Managers have a discretion not to hold a hearing or, impliedly, to defer holding a hearing if the Tribunal ‘has recently considered the patient’s case or is

¹⁷⁸ There were more than 33,000 Mental Health Tribunal hearings in 2016, see <<https://www.gov.uk/government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-october-to-december-2016>> accessed 16 August 2017.

¹⁷⁹ Percy Commission (n 110), para.768; also of interest is David Atkinson MP, HC Deb 18 May 1982 c.322.

¹⁸⁰ Though see Blumenthal and Wessely (n 46); and also for Managers’ hearings, see MHAC (n 61), para. 3.1.4; MHAC (n 7), para. 2.91.

¹⁸¹ *AU* (n 24), [40] (Cranston J); contrast with Kennedy’s remarks (n 15), 361.

¹⁸² *ibid.*, *AU* [13], [35-37], [40-41] (Cranston J).

due to do so in the near future.’¹⁸³ Procedurally, therefore, there is a means to avoid unnecessarily holding review hearings. There is no data available on how frequently a refusal to hold a hearing on temporal proximity grounds occurs.

Taken in combination, the fact that the Percy Commission considered that the nature of the legitimacy of the Managers’ established, and the Tribunal’s proposed powers should be different, and that the Code provides a framework to avoid duplication, suggests that the situation is more complex than the abolitionists’ duplication objection implies. However, given that it is the Managers’ s.23 power that has been the target of abolition attempts, it is worth examining whether the implementation of s.23 has the potential to produce value that the Tribunal cannot, in order to justify the claims of those in favour of retaining s.23.

V(B) The Nature of the Process

Whatever the apparent difference in the nature of the discharge powers, abolitionists could argue that the means by which the s.23 power is implemented – the nature of the process – provides credence to their duplication claim. Superficially, the two routes are the same. Both require the same written reports, hear oral evidence, sit as a panel, and make decisions on the same criteria. However, just because both mechanisms employ what is a functionally similar process with similar possible outcomes does not mean that they have the same value and meaning in substantive terms, or that the power is exercised for the same purpose. To understand why the abolitionists claim is potentially problematic, it is helpful to consider two aspects of the Managers’ operational context. First, proponents of retaining the s.23 power contend that the Managers are a locally orientated body with a particular interest in supporting their community. Secondly, they claim that the Managers represent a less formal, more accessible process for the individual subject to compulsory care, which may be considered

¹⁸³ DH (n 6), para. 38.13; also *R (on the application of Zhang) v Whittington Hospital* [2013] EWHC 358 (Admin), [44] (Geraldine Andrews QC, sitting as a Deputy High Court Judge).

important in view of the power disparity between them, and those exercising powers under the MHA 1983.

In its evidence submitted to the 2004 Joint Committee, the Hospital Managers' Committee of the North East London Mental Health Trust (NELHMC) said that the Managers' continuing power of discharge enables them to follow up on the long-term care of patients, and to ensure that progress is being made on their care, because they could instigate a hearing on their own initiative.¹⁸⁴ They stated that the independent, though somewhat collegial position of the Managers **relative to the organisation being reviewed** allowed them to 'exert pressure' to secure funding for care from the compelling authority where the Tribunal was thought to be 'unwilling to do so', though examples of what this might entail were not given. The Managers' motivation for undertaking such activities was attributed to their 'local community interest,' which the Tribunal, as a centrally regulated process, was said to lack.¹⁸⁵ This assertion was not rebutted by those arguing for a Tribunal-only system. Nor, though, did proponents of retaining s.23 articulate why being less local should make one disinterested in compelling an organisation to provide appropriate care promptly. The tension between the relative values of centralised, standardised operations and local, community-responsive decision-making can only be debated when more is known about the how the Managers operate locally.¹⁸⁶

Those in favour of retaining Managers' hearings have also argued that they afford the compelled person the opportunity to ask questions of their care team, to hear questions put by the Managers, and to

¹⁸⁴ The Committee of all those acting as Hospital Managers for the Trust, not a Hospital Management Committee under the NHS Act 1946.

¹⁸⁵ See NELHMC evidence to Joint Committee (n 64), EV829; on the local community element see also Nottinghamshire Healthcare NHS Trust, EV1024; Songhai, EV1061; and also Expert Committee (n 47), para. 5.128; Gregory (n 12), 367; MHAC, *In Place of Fear? Eleventh Biennial Report 2003-2005*, paras. 4.128-4.130.

¹⁸⁶ The 1996 Working Group wished to establish only 'some consistency in approach' between Trusts; MHAC *et al* (n 37), 2; also consider Williamson (1985) (n 19), 2.

have those questions answered.¹⁸⁷ The implication is that the Tribunal process, while it might permit the panel members to challenge the care team, does not necessarily enable the compelled person to participate.¹⁸⁸ Additionally, while the Expert Committee did not endorse the view, it noted that some of the witnesses appearing before it argued ‘that a [Managers’] hearing provides a uniquely informal occasion at which the patient is able to hear the opinion of the care team’.¹⁸⁹ Conversely, it has been argued that, the risk of moving to a Tribunal-only system, as was proposed in 2004 and as must be the implicit aspiration of those in favour of abolition of the Managers’ power, is that the process could become ‘more formal, more adversarial, more rooted in the rules’ and that this ‘will tend to exclude the patient’.¹⁹⁰ These are not trivial concerns. The legal process *must* be sensitive to its context, and be conscious that at the centre of the legal framework is a person subject to, or at risk of being subject to, compulsory medical care. Just as the value of preventing inappropriate compulsion through formalised judicial protection is high, so too is the ability of the individual person to engage with that process.¹⁹¹ A process which is too legalistic, and inhibits the participatory opportunity that the Managers’ hearing purports to represent, may doubly disempower individuals, leaving them excluded by both legalism and their subordination to the powers of the MHA 1983. Of course, due to a lack of data, it is difficult to assess the extent to which individuals are empowered and supported to speak at Managers’ (or Tribunal) hearings, or how often, and why they do not attend. It is similarly unclear whether people are regularly supported by relatives, Independent Mental Health Act Advocates, legal representatives or others.

¹⁸⁷ Expert Committee (n 47), para. 5.128.

¹⁸⁸ Gregory (n 12), 366.

¹⁸⁹ Expert Committee (n 47), para. 5.128; see MHAC (n 27), para. 8.13; the benefit of informality is supported in Williamson and Vellenoweth (n 19), 19-20; for comparison see Peay (n 168), 44.

¹⁹⁰ See A Davies evidence to Joint Committee (n 63), EVI 101; see also Williamson (1991) (n 19), p.15; but see also Peay (n 168), 42.

¹⁹¹ But see Hardy Review, para. 7.6.4, which places emphasis primarily on the value of legal protection.

Notwithstanding the limited empirical basis for such a claim, it appears that the Managers may have a separate value to their purely adjudicative function which is distinct from, and therefore not replicated by the Tribunal. However, the operation of the NELHMC hearings and other positive experiences discussed in this section may have been the result of the governance arrangements within the organisations concerned at that particular time. Equally, there may well be undesirable practices and instances of poor training in other organisations.¹⁹² The effectiveness of the s.23 power, whatever function is ascribed to it, will be dependent on the local constitutional arrangements, conventional practices and pro forma employed. Information on these matters is not readily available. This difficulty arises because administration of the s.23 power is comprehensively devolved to individual organisations, and little information is available on the degree of consistency which exists between their practices nationally. In consequence, broad, simplistic statements by either side as to the relative merits and demerits of the Managers' process belie the evident complexity of such a decentralised mechanism. Both the proponents and opponents of abolition fail to take account of the complexity of the system to which they have addressed their remarks. This has been enabled by a lack of public understanding and a lack of data. The true nature of the s.23 process remains hidden, and thus any attempt at legislative reform in this area will be hopelessly uninformed.

VI CONCLUSION

My observations in this paper may have offered incidental support to those opposed to the abolition of the s.23 discharge power, but it is hard not to also be critical of the proponents of retaining s.23 in its current form. The Joint Committee noted that it is a characteristic of all aspects of mental health services that there is a lack of data on how they operate,¹⁹³ and this is emphatically true in relation to the Managers. The absence of data and wider understanding has contributed to a general lack of awareness, certainly in centrally organised legislative and public policy circles, as to just what the

¹⁹² IMHAP (n 60), EV114.

¹⁹³ Joint Committee (n 17), para. 429.

Managers are, and what their function is. This has, in turn, allowed the weakly supported arguments made by both sides to go largely unchallenged.

In view of the lack of examination of the more principled issues at stake in the s.23 process where reform has been considered in the past, much of the discussion above has only been able to reflect upon the extent to which suitable evidence can be found to justify the claim that s.23 complies with or contravenes the core function of any review mechanism; an assessment of the probity of decision making. The inability of the evidence to support discussion beyond this largely procedural question, such that it might consider questions of, *inter alia*, legitimacy and access to justice, demonstrates the failure of both proponents or opponents of abolition to engage with the substantive issues raised by the s.23 process. Indeed, the argument around expertise, independence and duplication has largely assumed that it is the primary, perhaps even the sole, function of the Managers to protect the liberty of the person subject to compulsory care, and that this is best achieved by a review of the criteria to be satisfied to justify the imposition of a compulsory order. The failure of Parliament and others to articulate and justify the function of the Managers means that alternative possibilities have never been examined. This perhaps also explains why the question of whether the Managers' s.23 power should be retained or abolished has been presented as a binary choice to be made in the shadow of the Tribunal, and conducted in a way which ignores the evident complexity of the situation, and seriousness of the subject matter concerned.

Precisely what the Managers *should* be is a different question to that which I have addressed in this paper. We can speculate as to the other functions which an independent review mechanism could fulfil. If it were construed as purely a mechanism for protecting liberty, then the existence of a less formal, more accessible, independent process like the Managers' could be said to relieve some of the burden that would otherwise fall on the Tribunal; diminishing, rather than duplicating the work of the Tribunal. If the Managers' are to be distinguished from the Tribunal, then a community membership might be claimed to offer a means of regulating the behaviour of clinicians by exposing professional norms to community values. This would have parallels with the role of juries and the magistracy elsewhere in the legal system.

As well as providing protection to individuals subject to compulsory care, the mechanism could also provide protection for individual organisations delegating the s.23 power.¹⁹⁴ For example, by ensuring decision-making is internally consistent. It could also be said to protect organisations from poor decisions by care professionals leading to unlawful compulsory care, and that the compulsory order in place represents the least restrictive option available. One way in which the Managers might guarantee compulsory care is appropriate is by utilising their power to call a hearing on their own initiative to monitor those subject to compulsory care over a period of time outside of the s.20 renewal process and without a patient request, to follow up on actions proposed by the clinical team in previous hearings. However, whether the Managers could be of more specific benefit to either individuals subject to compulsory care or to the compelling organisations in the ways outlined above is not something that can be answered using the available evidence.¹⁹⁵

Notwithstanding their apparent invisibility,¹⁹⁶ the Managers constitute a significant component of the mental health review system.¹⁹⁷ Despite this, I have shown that there have been regular attempts to reform this aspect of the law without regard for the almost complete lack of evidence to justify such action, and thus little or no understanding of how the Managers operate, what works well, and what we could eliminate or modify. Given the disempowerment and loss of autonomy entailed by subjecting a person to compulsory care, notwithstanding the good intentions connected with this action, the failure to understand the mechanisms by which individuals can productively engage with and also challenge their care is to be deplored. Similarly, the failure to develop a better understanding of this process entails a failure to develop standards of good practice as regards the conduct of the s.23

¹⁹⁴ A point made by Ronnie Watson, Mental Health Act Coordinator for Turning Point, personal correspondence on file with the author.

¹⁹⁵ For further inspiration as to the possible functions the Managers might fulfil, see Peay's discussion of the same issue as regards the Tribunal, (n 168), Chapter 8

¹⁹⁶ Bartlett and Sandland (n 16), 503.

¹⁹⁷ See Section 1, especially (n 17).

process and ancillary operations (such as the training of Managers). By extension, this permits poor practice to continue and prevents the sharing of best practice. This is unprofessional and unethical. Not only is it problematic from a principled point of view, poor practice on the part of the Managers in the conduct of hearings, and any failure to provide adequate reasons may also contravene public law principles, such as reasonableness and proportionality. This increases the possibility of legal challenges to the decisions of the Managers at unnecessary cost to the public purse.

Whatever the particular motivations of those in favour of abolition, which is a separate matter, the claims of both sides have been shown to be insufficiently robust in terms of either their data or underlying principled position. The only means to remedy this situation is a comprehensive effort on the part of users and observers of the s.23 process, as well as legislators and the government, to consolidate what existing local data there is and to increase our understanding of this fundamental aspect of the 1983 Act. Our current collective understanding of the process is no basis upon which to conduct further reform of the law in this area.