

The Mental Health (Patients in the Community)

Act 1995

A clinical analysis

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Around the time that a psychiatric patient, Ben Silcock, climbed into the lions' enclosure of London Zoo, and Christopher Clunis was convicted of the homicide of Jonathan Zito, the Department of Health (DoH) published a *Ten Point Plan* (Department of Health, 1993a). This included a proposal for additional legislation, purportedly to reduce the risk of further such events. Notably, the *Ten Point Plan* was published well in advance of the influential Ritchie Report on the care and treatment of Christopher Clunis (Ritchie *et al*, 1994). It is also notable that the proposal for community mental health legislation, the introduction of supervision registers (Department of Health, 1994a) and the issuing of DoH guidance on discharge (Department of Health, 1994b) all seemed to arise largely in response to publicity about a very small number of "homicide in the community" cases, whereas many years of substantial numbers of suicides (and much smaller numbers of homicides) by mentally ill patients in the community evoked no such similar response. This may give a clue to a possible political, rather than solely clinical, purpose of the main provision of the government's Mental Health (Patients in the Community) Act.

Although the Ritchie Inquiry included in its recommendations legislative reform to allow 'recall' of patients discharged from detention in hospital, all of the recent inquiries after homicide, including Ritchie, have concentrated on recommendations that are directly clinically and service related, including identification of resource and training inadequacies (see Shepherd, 1995; Steering Committee, 1995). This contrasts with calls (for example, by the Royal College of Psychiatrists, 1993) for a degree of compulsion in the community aimed at reducing the frequency of relapse and the need for subsequent compulsory hospital admission of a small group of treatment-refusing patients (Burns *et al*, 1995). The core conclusion of this paper is that, within the bounds of legislation which is consistent

with the European Convention on Human Rights, legal rules are unlikely to compensate for inadequate community resources or professional skill and training.

THE PURPOSE OF THE ACT

The purpose of any community mental health legislation *ought* to be improved patient care, improved patient outcome and (perhaps also) improved societal outcome. However, there is no evidence of any detailed analysis or reasoning on the part of the DoH suggestive that "aftercare under supervision" (ACUS) will achieve these outcomes. Even the DoH's internal review of community mental health legislation options (Department of Health, 1993b) gave little *a priori* clinical support for the legislation which was eventually enacted. This suggests that the Act may be directed as much, if not more, towards a political purpose as to a clinical one. A further possible clue to this conclusion is contained within the terminology. Hence, in a similar vein to the government's insistence on calling registers of patients at risk "supervision registers", rather than, for example, "priority registers", the Act introduces the term "aftercare under supervision". "Supervision" gives the impression to the public of significant protection. However, whatever protection *can* be achieved must surely rely largely upon resources and training.

Some would argue that legal control is a necessary adjunct to adequate community services, both to protect the patient from him or herself and to protect the public, and, clearly, one could argue to strike the civil rights balance in favour of such control. Indeed, both the Ritchie proposal for a power of 'recall' (Ritchie *et al*, 1994) and the Royal College of Psychiatrists' earlier call for a "community supervision order" (Royal College of Psychiatrists, 1993) were argued on the basis of the additional need for legal control, if only to protect some patients from the effects of their own lack of insight

(Burns *et al*, 1995). However, these legal options were discarded by the DoH as being inconsistent with Article 5 of the European Convention on Human Rights (Department of Health, 1993b). With the exception of convicted patients, it is unlawful within the European Convention to detain a patient (perhaps even including forcibly conveying them as the new Act allows) unless they suffer from a mental disorder warranting detention, impliedly in hospital (*Winterwerp v. The Netherlands*, 1979). The DoH acknowledged this essential legal barrier to any frankly coercive treatment in the community.

Leaving aside the moral and civil rights debate relating to *real* coercive legal control, is aftercare under supervision (ACUS) likely to offer *some* control? A proper and broader question is whether it will offer therapeutic advantage to patients, in terms of "therapeutic jurisprudence", that is, the therapeutic effect of particular legal rules (Wexler, 1991).

BACKGROUND LEGAL HISTORY AND PRINCIPLES

Both the 1959 and 1983 Mental Health Acts were concerned almost solely with detention for treatment *in hospital*, and with mechanisms for legally admitting and discharging patients into and from hospital. Both Acts, perhaps particularly the 1983 Act, also originated substantially in a civil rights movement (Gostin, 1975, 1977), as well as in a desire to 'normalise' the lives of psychiatric patients so that they could be treated in as similar a way as possible to patients suffering from other medical conditions. The Acts focused substantially on individual patients and their needs for treatment, rather than on society and its need for protection (with the exception of inclusion of the tertiary criterion for admission of "protection of others"). Otherwise, the 1983 Act was constructed on the basis of pragmatism rather than principle (Hoggett, 1993). Both Acts also reflected what a distinguished legal expert on mental health law has called "a deep divide" between treatment in hospital (with the potential for effective legal control) and treatment in the community (with little such potential control) (Hoggett, 1990). This divide is probably inescapable. Hence, if a patient is well enough to be in the community then, certainly in terms of the common law capacity to consent to treatment (*Re C*, 1994), he or she is likely to be well enough not to be coerced. The probable truth of this

is emphasised by the fact that the legal standard which applies even for detention and compulsory treatment in hospital does not satisfy the common law principle of 'incapacity' (*Re B*, 1995). By implication, coercion in the community would be applied to patients likely to fall even further short of common law incapacity. Since community care is itself concerned substantially with 'normalisation' of patients' lives, it seems inescapable, therefore, that this will be accompanied by a strong tendency towards normalisation of civil rights. In law patients will *have* such rights and in practice many will exercise them, sometimes in order to refuse or modify recommended treatment.

WILL 'ACUS' IMPROVE CLINICAL OUTCOME?

Numerous homicide inquiries and the *Confidential Inquiry into Homicides and Suicides* (Steering Committee, 1995) have all repeatedly stressed adequate resourcing, training of staff, communication between staff and agencies, education in the proper use of the Mental Health Act, 1983, and specific targeting of resourcing and training on disturbed and difficult patients, as likely to deal with a large proportion of the problem of inadequate clinical outcome and risk management, which both clinicians and the government perceive. Specifically in relation to behaviourally disturbed patients, there has, in fact, been diminished availability of low secure beds (Department of Health & Home Office, 1992) and a likely lack of widely available staff training and resourcing. This has understandably fed an attitude of rejection of such patients (Coid, 1991), often combined with premature and inappropriate discharge from hospital. Recent homicide cases such as Clunis (Ritchie *et al*, 1994), Buchanan (Heginbotham *et al*, 1994), Robinson (Blom-Cooper *et al*, 1995) and Mitchell (Blom-Cooper *et al*, 1996), as well as other similar cases which have been the subject of inquiries, all clearly suggest service problems relating specifically to the behaviourally disturbed. At one stage Christopher Clunis actually *asked* for care (Ritchie *et al*, 1994).

As regards legal aspects, misuse (or underuse) of the Mental Health Act 1983 by doctors and social workers in relation to detention of patients has probably been a substantial cause of inadequate care. There is much anecdotal evidence that the existing powers to detain patients have not been fully used. Indeed, illustrative of this is the

fact that it was thought necessary by the Mental Health Act Commission (1994) to include in the most recent edition of the *Code of Practice* emphasis on the "interest of health" criterion for admission, thereby merely restating the primary legislation. This probable underuse of the Act has arisen partly from lack of education and training (Eastman, 1994) and has probably resulted in distortion by professionals of the civil rights balance away from that which Parliament intended. Hence, in circumstances of inadequate acute and locked-bed numbers, excessively brief admissions and (sometimes understandable) professional reticence about admitting behaviourally disturbed patients, it seems likely that psychiatrists and other professional staff have tended to use a simple 'snapshot' approach to determining the legal detainability (or not) of patients, using also a relatively crude criterion of whether the patient presents specifically with florid psychotic symptoms. In other words, "does the patient have *florid* symptoms, *today*?" This contrasts with the recommendations of the *Code of Practice* (Mental Health Act Commission, 1994).

No one, including the Government, can at present do other than hypothesise from first clinical principles about the likely effects of ACUS. It is reasonable, therefore, to try to predict by clinical analysis the likely clinical outcome of utilisation of ACUS. Given all of the above, it seems unlikely, *prima facie*, that ACUS will offer patient and public safety, or improved clinical outcome in other ways. Indeed, it may well be that ACUS will sometimes be antitherapeutic (Eastman, 1995a) and will therefore both fail to offer control and be counterproductive in relation to what *can* work with patients, that is, good community care. It may, therefore, have a negative effect even on patient and public safety. The rest of the paper will suggest some more detailed reasons why this particular set of hypothetical conclusions is likely to be valid.

WHY IS ACUS LIKELY TO BE INEFFECTIVE?

Likelihood of benefit

In order to apply for ACUS, the responsible medical officer (RMO) of a patient currently liable to be detained under the 1983 Act must agree with Section 1(1)25A(4)(c) of the new Act that "being subject to aftercare under supervision (ACUS) is likely to help to secure that he [the patient] receives the

aftercare services to be so provided". In order to make such a statement the doctor must make a clinical judgement about both the effectiveness and inherent clinical power of ACUS itself, and its effectiveness in relation to his/her particular patient. If clinicians come to believe or experience that the power is, in general, clinically ineffective (or even counterproductive), then in the vast majority of cases it will not be possible to say that the criterion for making the order is satisfied, albeit that the wording is extraordinarily vague ("is likely to help to secure. . ."). Hence, the wording of the Act contains the basis of the potential clinical unavailability of ACUS.

'Power to convey'

The core clinical justification of the hypothesis that ACUS will be largely ineffective, and perhaps even counterproductive, as regards the Government's stated purpose, lies in the only real ACUS 'power' over patients which is contained in the Act. The 'power to convey' vests in the 'supervisor' (usually a community psychiatric nurse) the power of arrest, including the use of reasonable force. A highly detrimental, and sometimes dangerous, effect is likely to arise from community psychiatric nurses (CPNs) forcing unwilling patients into their cars and taking them to day centres or hospitals, where they are then asked to take treatment which they have (presumably) already refused. The alternative, of the 'community responsible medical officer' (CRMO) or supervisor instructing the police to convey patients, is likely to be little different in its therapeutic effect. Both actions will essentially tend to be inconsistent with properly exercised assertive care, which rests on painstaking and careful building of a relationship with the patient. Hence, ACUS, if fully enforced, is likely to work against proper clinical care and effect. Also, how many times does the supervisor attempt to convey a treatment-resistant patient to another place where they can then again (potentially) refuse treatment? Even the guidance on the Act (Department of Health, 1996) seems to recognise (at paragraph 49) the potential futility of the power to convey by requiring, before enforced conveyance can occur, belief by the supervisor that such conveyance is likely to change the mind of the patient about accepting medical treatment. The only other circumstance in which enforced conveyance can occur, according to the

guidance, is where “the patient has got into a situation which is putting him or her, or other people, at risk and he/she needs to be taken home urgently”.

Treatment-reluctant patients are more likely to respond to the offer of a ‘carrot’ than to the use of a ‘stick’, especially a stick which is a very limp one and which may therefore be worse than no stick at all. The ‘limp stick’ problem can be put in a more clinical way. Psychiatric care is commonly about limits and boundaries. Telling a patient you can forcibly convey him/her to a place to offer treatment but cannot forcibly treat him/her gives a highly confusing message, particularly if it is also stated that you can only convey him/her if you think it will change his/her mind. What is a ‘commonly sensible’ patient to make of such a statement?

A ‘section’ on staff not patients

Marginally ambivalent or treatment-resistant patients who are well enough to be in the community can often (and ultimately perhaps can only) be kept in care by adequately resourced assertive care. Even though the very fact of a legal order may result in compliance with medication and other care on the part of some patients, in the absence of any real coercive effect it is almost certainly unrealistic to rely on this as an effective mechanism for improved clinical outcome and safety. Certainly, patients who are highly resistant to care are the least likely to be affected by ACUS, assuming that they are informed about the real lack of power to coerce treatment and the need to ensure that any consent to treatment is ‘genuine’, as is required by the Guidelines accompanying the Act (Department of Health, 1996). Indeed, the most difficult, dangerous (to self or others) and treatment-resistant patients, about whom clinicians and the government ought to be most worried, will probably include many of those least likely to respond to such a ‘treatment non-power’. By contrast, conditional discharge from detention under Sections 37 and 41 of the 1983 Act for patients who have been convicted of serious offences, which allows for Home Office control by dint of the ‘power of recall’, is probably the only type of legal power that can assert any effective control over highly treatment-resistant patients and yet still be consistent with the European Convention on Human Rights. The threat of recall, which would otherwise contravene Article 5 of the

European Convention, does not do so in relation to restricted patients because the original order amounted to a sentence consequent upon a criminal conviction.

Impracticality of coercion

The core problem is, however, that it is not practically possible to exert legal control over patients in the community, as it is patients in hospital. Coercion by threat of recall to hospital (as can occur for patients previously detained under Section 37/41 of the Act) is not at all equivalent to legally required treatment in the community. How do you control a patient, for example, in relation to “education, occupation or residence”? Suppose, for example, the patient behaves against the rules of a hostel in which he is legally required to live and the hostel discharges him. Even the length of the Act (nearly 5000 words, mostly devoted to ACUS) suggests legal weaving around a difficult, if not impossible purpose. Ultimately, the “deep divide” (Hoggett, 1990) is a real one. As an alternative to legally unavailable coercion in the community, the government has introduced a power which, even accepting the restrictions on application of the Act represented by the accompanying guidance, seems at risk of amounting to fudged pseudo-coercion.

Apart from enforced conveyance, the only other ‘sanction’ arising from refusal by the patient of medical treatment, social care, education or occupation is the requirement that the supervisor ensures that a case conference is called, with consideration of re-admission (addressed, if necessary, in the terms of the Mental Health Act 1983). However, such a ‘sanction’ amounts to no more than a legal requirement of ordinary good care. Hence, ACUS looks less like effective ‘sectioning’ of the patient than ‘sectioning’ by staff of themselves. This is so because ACUS adds a legal sanction to the ordinary proper practice of community psychiatry and, specifically, to the delivery of the package of care specified in a particular patient’s order. However, if the problem is *lack* of good practice (as well as inadequate resources), then new legislation is likely to be a far less effective way of increasing clinical skills and knowledge of the existing law than is professional education. If evidence were to emerge which suggested otherwise, then that would indeed be a severe indictment of the clinical professions.

Absence of reciprocity

It can be argued that, like supervision registers (Harrison, 1994), the Act unreasonably restricts civil rights (specifically in regard to the power to convey) and to no therapeutic advantage (Thompson, 1995). It can be seen therefore, to fail to satisfy any “principle of reciprocity” (Eastman, 1994, 1995a) by failing to offer the right to adequately resourced care in exchange for further infringement of civil rights. This is not dealt with by the argument of the Chief Medical Officer (Calman, 1995) that the wording of the core criterion for making the order, that is, that ACUS “is likely to help to secure that he or she receives the aftercare services *so provided*” (my italics), itself ensures reciprocity. What is at stake is *adequate* resources (Eastman, 1995b). Presumably Calman did not mean that ACUS would be a means to ensuring that health and social services provide the proper services, or did he? This is the only other basis upon which he could make his assertion.

THE CUSP OF “THE DEEP DIVIDE”

Let me turn now to the *cusp* of “the deep divide”. There are different potential legal interpretations of the ‘threshold’ for hospital detention. Blom-Cooper *et al* (1995) pointed out that the 1983 Act requires (assuming tertiary conditions are also satisfied) mental illness only “of a nature *or* degree” as to warrant detention in order for such detention to be legal. They then seem to argue that the mere diagnosis of chronic relapsing psychotic illness, combined with refusal of symptom-abating medication, will always immediately imply that the patient is potentially “liable to be detained”, even though overt symptoms may still not have re-emerged and the psychosis has not yet ‘re-ripened’ (their term). Solely in terms of clinical constructs there may be a justification for this view. Hence, schizophrenia is indeed a chronic illness often maintained less symptomatic or non-symptomatic mainly by medication. However, unlike other chronic physical conditions, there is an additional civil rights dimension (patients are not forcibly detained for chronic physical conditions). The courts will have to decide (probably soon) whether, either for the patient’s benefit or (more rarely) for society’s benefit, such a psychiatric patient’s right to refuse treatment for their chronic

illness should hold sway or not. If anything like the Blom-Cooper *et al* interpretation of the 1983 Act is determined by the courts to be legally correct (and does not contravene the European Convention), then ACUS will become irrelevant to patients who resist community treatment. Such patients will know that they are always potentially liable to be detained as soon as they refuse medication, and this will exert constant pressure on them to continue to take medication.

EXTENDED LEAVE

The latter point leads naturally to consideration of another, much smaller, part of the Act which potentially lengthens to 12 months the maximum period of 'extended leave' from hospital while still on Section (a third part removes the right of a patient to be no longer deemed detained under the 1983 Act if he/she remains 'absconded' for greater than 28 days). What is the situation here from the point of view of clinical care, and also ethics and law?

Ignoring the Blom-Cooper *et al* interpretation of the 1983 Act, if a patient no longer requires and warrants treatment in hospital, and if the criterion for (even) being 'on leave' is based on the notion of treatment in hospital, it might be questioned how one can reasonably have a patient on leave for many months on the basis of 'liability' to be detained? Again, "the deep divide" operates, or perhaps should operate. If a patient is living effectively in the community, can any tribunal hold that they are liable to be detained simply because, if they stopped taking medication, a different situation might occur? The Mental Health Act 1983 is largely to do with treatment in hospital (not treatment that *might* be in hospital but is currently in the community). Of course, if Blom-Cooper *et al* (1995) are correct then the whole psycholegal scenario is altered. Indeed, against the foregoing argument is the suggestion that *liability* to detention is a very different legal concept from detention *per se*, and that that justifies prolonged periods of leave.

CONCLUSIONS

Ultimately, mental illnesses (like any other illnesses) are treatable only through clinical means, and the quality of mental health care is dependent upon professional skill and resources. The added dimension of public risk has to be accepted, once community care has been taken to its most effective, and

risk to the patient and others is at its "irreducible minimum" (Eastman, 1996b). Indeed, it could be argued that ACUS is an illustration of an internationally common tendency of states to try to use legislation (sometimes inappropriately) to solve personal and social ills (Applebaum, 1994). Similarly, the risk to self arising from some (possibly impaired) ability to decide for oneself can, and perhaps should, be dealt with only on the common law basis of (in)capacity. In law, either someone has the capacity to decide for him/herself or he/she does not. The case of *Re B* (1995), concerning forced feeding of a personality disordered, detained patient, emphasises that, even for the draconian step of compulsory treatment without consent in hospital, there is already a much lower threshold for coercive intervention within the Mental Health Act 1983 than is represented by the common law basis of incapacity. To extend coercion (even fudged pseudo-coercion) into the community would imply an even lower threshold for infringing civil rights.

The DoH argues that ACUS will give a legal framework for community care. To any extent that it might do so, it will be mainly in relation to professional staff and not much in relation to patients. Perhaps some responsibility must be accepted by psychiatrists for sometimes failing to use existing legal provisions for detention fully, and for failing to develop and maintain within community psychiatry the skills necessary to reduce risk in the community to its irreducible minimum. However, as regards the contribution of law, training in legal psychiatry (particularly in relation to detention in hospital under the Mental Health Act 1983) is likely to contribute much more to patient welfare and to public and patient safety than is ACUS.

Although doctors can often properly campaign on behalf of their patients' health care needs, the situation is different where the issue is patients' legal rights to decide themselves. In those circumstances it can be cogently argued that, constitutionally, the proper role of doctors in relation to public policy (for example, as it underpins mental health legislation) is to give clinical advice about the likely implications of any particular rule that is proposed, and to link such implications with other non-legislative factors which influence healthcare outcome. To the doctor a legal power over patients is merely one clinical tool, to be judged in its efficacy as such. It is certainly not the proper

role of a doctor (other than as an ordinary citizen) to campaign for particular powers or their absence. Indeed, previous calls by some psychiatrists for more powers over patients expose the profession to the risk that future clinical failures will engender governmental responses of the sort "you asked for more powers and we gave them to you". This emphasises the importance of proper professional debate, and clinical scepticism if appropriate, about the new Act. Sensibly, the Registrar of the Royal College of Psychiatrists has written that the Act, which became legally effective on 1 April 1996, represents:

"the worst of both worlds. The mentally ill will be subject to the power of 'arrest' and to no apparent purpose. Psychiatrists remain deeply sceptical and believe that the act will not provide the extra public safety which the government is hoping for." (Thompson, 1995)

Others have already offered a similar clinical view (Turner *et al*, 1996). Indeed, there is much evidence that ACUS remains opposed by nearly all the groups that are required to implement it or are affected by it.

Currently ACUS can only be the subject of hypothetical debate as regards its clinical effects. Ultimately, the effectiveness or otherwise of it can, like any other clinical tool, be known only by research. A test of the government's good faith in believing that ACUS will be clinically, rather than largely politically, effective will be their willingness to encourage and fund psycho-legal research into the effects of ACUS on clinical outcome.

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