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Most trainees did not report any experience with systemic/family therapies. However, a majority of trainees had attended interview skills training courses and case discussion/Balint groups.

Information from college tutors suggested that all responding hospitals offered interview skills training and an active case discussion/Balint group. Psychotherapeutic skills were included in educational contracts of trainees in a smaller majority of responding hospitals. Individual-therapy training and supervision (in supportive-dynamic and/or cognitive modalities) was available (locally or through regional psychotherapy departments) in all responding hospitals, but systemic therapy experience was limited to only few hospitals in the region.

The findings suggest that resources are available to introduce trainees to psychotherapy at a basic level, but may be less adequate to meet individual and systemic therapy training needs of more senior trainees. There is a need to develop a regular and accessible system of supervision of trainees in individual (especially cognitive) and systemic therapies in the region.

BATEMAN, A. & HOLMES, J. (2001) Psychotherapy training for psychiatrists: hope, resistance and reality. *Psychiatric Bulletin*, **25**, 124–125.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) Requirements for psychotherapy training as part of basic specialist psychiatric training (Bateman, A.W. (convenor), Anderson, H., Bhugra, D., Freeman, C., Hughes, P.). London: Royal College of Psychiatrists.

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Re: Unpacking Personality Disorder

I read with interest Peter Snowden and Eddie Kane's Editorial on personality disorder (*Psychiatric Bulletin*, November 2003, **27**, 401–403). It appears to me that personality disorder will be broken down into multiple subtypes in the future. The two particular subtypes I have become aware of are those with personality disorder who also meet the criteria for adult attention-deficit hyperactivity disorder (ADHD) and have had childhood ADHD. This type will need the underlying ADHD to be treated. The second type is an autistic psychopathy which was described by Hans Asperger. It appears to me that a small number of patients with personality disorder meet the criteria for autistic psychopathy or Asperger syndrome, and these will require treatments focusing more on theory of mind skills and empathy deficits (Fitzgerald, 2001).

FITZGERALD, M. (2001) Autistic psychopathy. *Journal of the American Academy of Child and Adolescent Psychiatry*, **40**, 870.

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the college

The Royal College of Psychiatrists and the Law

Colleagues will be aware of the College's submissions in relation to planned legislative changes such as the Draft Mental Incapacity Bill and the Draft Mental Health Bill.

It is very much less common for the College to become directly involved in court cases. This has happened, to a greater or lesser extent, in three recent and important cases.

Colonel Munjaz and Mersey Care National Health Service Trust and S. and Airedale NHS Trust and (1) The Secretary of State for Health and (2) The National Association for Mental Health (MIND)

This was a Court of Appeal hearing in relation to the two cases mentioned above. Both cases related to the legality of seclusion and the status of the Mental Health Act 1983 Code of Practice. In the former case (Colonel Munjaz), the patient had taken action against Ashworth Hospital because the seclusion policy and practice at Ashworth was not in line with the Code of Practice. In the latter case (S.), the patient took action against Airedale Hospital because of the specific circumstances in which he was kept in seclusion, again being outside the parameters set out in the Code of Practice. In both circumstances, the patients had lost their cases in the High Court and both had appealed. The Court of Appeal heard both appeals together.

The National Association for Mental Health (MIND) was extremely concerned about the judgements because both Judges had appeared to diminish the importance of the Code of Practice. MIND approached the College, through me, to ask if we would be prepared to make a statement that could be included in their submission. I made a formal witness statement on behalf of the College, giving examples as to why we thought it essential that the Code should be considered the usual standard of practice other than in defined circumstances and for good clinical reasons.

The final judgement concluded that the policy in Ashworth was unlawful and Airedale were not justified in keeping Mr S. in seclusion for the length of time that they had done so. The Judgement made mention of the College's submission and said the following:

> 'hence we conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient. They may identify good reasons for particular departures in relation to groups of patients who share particular well-defined characteristics, so that if the patient falls within that category there will be good reason for departing from the Code in his case. But they cannot depart from it as a matter of policy and in relation to an arbitrary dividing line which is not properly related to the Code's definition of seclusion and its requirements'.

The Queen (on the application of I.H.) and (1) Secretary of State for the Home Department and (2) Secretary of State for Health and (3) East Midland and North East Region Mental Health Review Tribunal and (4) The Royal College of Psychiatrists and (5) Nottinghamshire Health Care NHS Trust

This was heard in the House of Lords.

I.H. was a patient in Rampton Hospital detained under Section 37/41 Mental Health Act 1983 (MHA). A Mental Health

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Review Tribunal (MHRT) determined that he be conditionally discharged subject to supervision from a forensic psychiatrist in the community (subsequently this was referred to as a 'community psychiatrist'). The local forensic psychiatrists were unanimous in their view that I.H. could not be managed safely in the community and therefore declined to accept supervisory responsibility for the patient. Consequently, I.H. remained in Rampton.

The Human Rights Act 1998 states that all patients detained under the MHA must be able to access a Court (MHRT in England and Wales) to review the legality of their detention and to order their release if the detention is not warranted.

In this case, the wish of the Tribunal (that I.H. should be discharged from hospital) was effectively thwarted because no psychiatrist would agree to accept supervision of I.H. in the community and he therefore remained in hospital. I.H. challenged this as a breach of the Human Rights Act 1998.

The Human Rights Act 1998 only applies to governments and public institutions. It does not apply to private companies or individuals (this is because the European Convention on Human Rights was established as a means of trying to prevent a recurrence of what happened in Nazi Germany). The questions, which needed to be resolved, were:

(a) Was I.H. unlawfully detained once the tribunal had determined that he could be given a conditional discharge?

(b) Does a Trust, Health Authority or Tribunal have the authority to order a psychiatrist to accept supervisory care of a patient given a conditional discharge?

(c) Is that part of a psychiatrist's work that relates to the MHA, work which would be deemed as 'public' rather than 'private'? If so, then a psychiatrist is, at least in part, a public authority within the meaning of the MHA (referred to as 'hybrid public authority').

(d) If the patient was unlawfully detained but the MHRT does not have the authority to discharge the patient then does there need to be a declaration of incompatibility between the MHA and the Human Rights Act 1998 (requiring the Government to amend the MHA)?

The implications should any organisation be able to order a doctor to treat a patient whom the doctor did not feel able or competent to treat would, self-evidently, be considerable. Despite a considerable financial burden the College requested, and was given permission, to intervene. Because the Judgement would significantly affect all doctors, the British Medical Association was approached to make a financial contribution (and have agreed a sum amounting to approximately 25% of the total). The College intervened, both with written and oral submissions.

The Judgement is primarily that as the patient continues to meet the Winterwerp criteria of unsound mind (the test for legal detention within the European Convention on Human Rights) his continued detention in hospital was not unlawful. (The European Convention does not require a State to provide community treatments which would enable a patient to be discharged from hospital.)

Their Lordships determined that they should not comment on whether or not a psychiatrist was a hybrid public authority until such time as there was a case that requires this to be determined and this was not so in the present case. However they did say:

> 'the duty of the Health Authority, whether under Section 117 of the 1983 Act or in response to the Tribunal's order of 3/2/2000, was to use its best endeavours to procure compliance with the conditions laid down by the Tribunal. This it did. . . . It had no power to require any psychiatrist to act in such a way which conflicted with the conscientious professional judgement of that psychiatrist'.

Their Lordships expressed gratitude to the Royal College of Psychiatrists for its submissions. We are waiting to hear if the Appellant is to appeal to Strasbourg.

Regina (P.D.) *v.* West Midlands and North West Mental Health Review Tribunal

This was heard in the High Court. Colleagues will be aware of the difficulties in providing medical members for the MHRT. In this case, the medical member of the MHRT was employed by the same Trust as was detaining the patient. The Trust, the Merseycare National Health Service Trust, controls a large number of hospitals. The medical member of the Tribunal had no connection with the hospital which held the patient. He had never worked in the hospital, nor did he know the claimant or any of the medically qualified or other witnesses at the hearing. The question was whether or not there was the possibility of 'subconscious bias' on the part of the medical member of the Tribunal. There was no suggestion that he had actually been biased.

On this occasion our intervention was restricted to informal discussions with our President. The College was asked if it would like to intervene formally, but given the costs associated with our intervention in the case of I.H. it was felt that we had to acknowledge limits on the College's purse.

The Tribunal rules state that no member of the Tribunal can be a member or officer of a Health Authority which has the right to discharge the patient. The patient claimed that the medical member was, as a Hospital Consultant, an officer of the Authority.

The Judge stated that an officer was defined in the *New Shorter Oxford English Dictionary* as 'a person holding office and taking part in the management or direction of a society or institution' and that, therefore, an employee was not automatically an officer unless they were also a manager or office holder. There was therefore nothing unlawful with this Tribunal. The Judge went on to state 'thus, to my mind, the fair-minded and independent observer would conclude that there was no real possibility of bias on the part of the Consultant. Indeed, it is not easy to conceive in many cases in which there are more indicators of absence of bias than when a medical member of a Tribunal hears a case in which his or her employer is a party'.

Tony Zigmond Vice President, Royal College of Psychiatrists

Meeting the Mental Health Needs of Adults with a Mild Learning Disability

Council Report CR115
£5.00 24 pp.

It is generally recognised that people with learning disabilities have a higher rate of psychiatric disorders than the general population. A total of 98% of people with a learning disability function in the range of mild learning disability.

Principles of normalisation and Government policy in the UK state that, wherever possible, people with learning disabilities should use mainstream mental health services. However, these lack the resources, skills and expertise to manage this group of patients. Although there are not many examples of good practice, either in the UK or from around the world, intensive case management and collaborative systems of care appear to be beneficial for people with mild learning disabilities.

The following recommendations are made to facilitate a collaborative system of care for this group of patients.

(1) **At a local level:**

(i) Each district should have jointly agreed protocols between learning disability services, adult mental health services, primary care Trusts and social

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