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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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services. Managers of learning disability services should make sure that the needs of this group are on the agenda of Partnership Boards and Local Implementation Groups for the National Service Framework (NSF) for Mental Health. Consultants in psychiatry of learning disability should ensure that there is a mental health service available for them.

(ii) There should be protocols to share expertise and resources such as day activities, respite, therapy groups, rehabilitation facilities and outreach teams. Regular clinical meetings between learning disability and mental health teams could allocate resources and draw up care plans.

(iii) Trusts providing psychiatry of learning disability services should ensure that the Royal College of Psychiatrists' guidelines regarding workforce, i.e. one whole time equivalent consultant in learning disability psychiatrist per 80 000 population, is implemented.

(iv) Many people with mild learning disability can benefit from psychological treatments. Learning disability professionals should specifically work with other mental health colleagues to meet this need.

(v) There should be representation from learning disability service providers on the NSF for Mental Health Implementation Groups to ensure that people with learning disabilities benefit from the initiative.

(vi) Lead clinicians from learning disability and mental health should be identified to have a coordinating role.

(vii) People with mild learning disabilities might need support to access some of the mainstream services. Principles of intensive case management could be used as they have been shown to be effective for this group.

(2) **At the Strategic Health Authority:**

(i) The Strategic Commissioning Group should be charged with ensuring the development of services for people with learning disabilities with severe complex needs.

(3) **Continuing professional development (CPD)**

(i) Joint CPD and audit meetings with psychiatrists from other faculties and academics will improve liaison with forensic, old age, child and rehabilitation psychiatrists to ensure a seamless service.

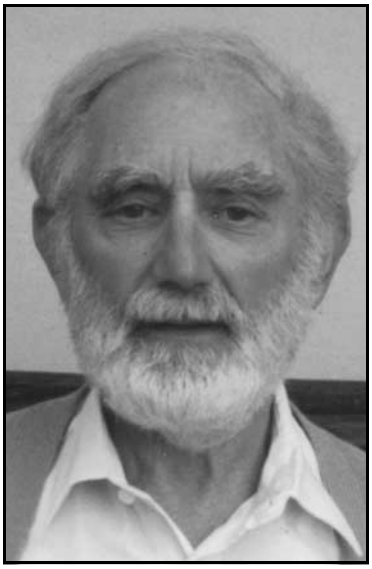
(ii) There should be opportunities for consultant psychiatrists to obtain competencies to look after the mental health needs of adults with a mild learning disability.

(4) **Training:**

(i) There should be more opportunities for senior house officers and specialist registrars in psychiatric specialties to obtain experience in working with adults who have mild learning disabilities and a mental illness.

(ii) Staff in both learning disability and mental health services should have training in psychological approaches adapted for use with people with mild learning disabilities.

# obituaries



## Julius Merry

Formerly Honorary Professor, University of Surrey and Consultant Psychiatrist, Epsom District Hospital

Professor Merry was born on 1 June 1923 in the East End of London, then a depressed, poverty-stricken ghetto. His parents were Jewish émigrés from eastern Europe, whose surname was Lustigman, the name Julius carried until expediency obliged him to change it.

His father, the only breadwinner in the family, was a skilled tailor who was subject to the seasonal employment and sweat-shop conditions prevalent in the non-unionised tailoring trade prior to the first world war. Money was, therefore, always tight. The lingua franca was Yiddish, the language Julius and his young brother spoke until they were taught English at elementary school.

Academically, Julius shone from the beginning to such an extent that at the end of primary school, he was offered a scholarship to Christ Hospital School, a public school by then located at Horsham, Sussex. But the very title of the school, not to mention the medieval garb the pupils were obliged to wear, were anathema to his unsophisticated, intensely Jewish parents, so the offer was politely rejected. Instead, Julius was entered at Cowper Street boys school in London's East End, a school famed for the large number of bright Jewish boys it spawned. Its alumni had made their mark in academia, in the law, and, particularly, in medicine (the science division of the sixth form was dubbed 'the medical sixth').

However, Julius, for reasons not known, decided to leave school at 14 years of age and briefly tried his hand at the printing trade. For a while, he even toyed with joining the RAF. Not before long, he saw the error of his ways and was allowed to return to school to continue his education. Later, in 1941, he entered University College Medical School to graduate MB.BS(Lond) in 1946 with first-class honours. It was then that he found his career blocked by the cancer of anti-Semitism. Repeatedly, his applications for jobs were turned down until a sympathetic member of a committee that had failed him took him aside and advised him to change his name. This he decided to do, and he took steps to change his surname to Merry, an adaptation of its original German.

But in c. 1946, National Service was still compulsory and by that time, Julius had undergone profound religious, moral and political changes. He had rejected the tenets of Judaism and had become an avowed atheist; his political beliefs swung hard left and he had become, and remained, a convinced Marxist. Further, he had rebelled against war in any form and had become a conscientious objector. Inevitably, he was 'called up' and inevitably



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