Suicide Judgment: a Victory for Human Rights?

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There has been a lot of press coverage in the last two years about suicides amongst psychiatric patients in England. This has been accompanied by a particular focus on suicides of patients who had absconded from hospital; and the associated dangers of patients being granted hospital leave[1].

One case in particular has resulted in a new court ruling. Back in 2005 a young woman killed herself shortly after being granted two days leave by Stepping Hill Hospital NHS Trust in Stockport, Cheshire. She had been voluntarily admitted following a number of suicide attempts. Her parents took the hospital authorities to court claiming negligence. The first judge ruled that the NHS Trust in question had no duty to protect the young woman's life as she was not officially detained under the Mental Health Act 1983. So they took their case to the Supreme Court.

7 years later, in February 2012, the Supreme Court judge ruled that NHS psychiatric hospital staff must do more to protect all patients from committing suicide. The decision was significant because previous case law drew a distinction between mental health patients who were detained compulsorily under the Mental Health Act and 'voluntary' patients. Hence, in previous legislation, only those who were compulsorily detained came under Article 2 of the European Convention on Human Rights (ECHR)[2] which stipulates that '*Everyone's right to life shall be protected by law*'. Following the Supreme Court ruling, the NHS now has a positive duty to protect *all* psychiatric patients (both detained and voluntary) against the risk of suicide under Article 2 of the ECHR (i.e. a duty to protect all patients' right to life).

The Supreme Court decision has been widely welcomed as addressing the injustice caused by distinguishing between detained and voluntary psychiatric patients. It has been called a 'landmark victory' for voluntary psychiatric patients by Human Rights organisations across Europe[3]. At a time when Human Rights legislation is under fire from the UK Coalition Government, the Supreme Court ruling is seen to demonstrate its potential to protect the most vulnerable in society. Those welcoming the ruling have a point and we certainly wouldn't want to join with the right-wing media's attack on Human Rights legislation. However, we feel rather more cautious about its potential implications. Our argument is not against the ruling itself, but concerns more the socio-political and economic context within which it will be interpreted and applied.

We have enormous sympathy and respect for the parents, friends and families of people who have committed suicide following hospital leave or absconding. We certainly believe that mental health services should do all they can to prevent suicide. However, as we face increasing funding cuts to UK public services with the ensuing job losses, drastic restructuring of services, as well as uncertain and disheartening employment conditions for staff, rulings such as the one by the Supreme Court, whilst well-meaning and progressive in principle, may actually result in even more coercion than that already existing within NHS psychiatric services. *Unless*, that is, rulings are combined with a recognition of people's 'positive right' to truly therapeutic environments when in crisis[4]. Without this, decisions like the one by the Supreme Court may only result in more coercion, surveillance and policing in NHS psychiatric wards.

The Care Quality Commission has already reported that psychiatric wards in England have become more security focused, with low-secure settings imposing blanket rules, such as mobile phone bans, that are difficult to justify for all patients and risk breaching other aspects of human rights law[5]. In England we have also seen the use of both the powers of the Mental Health Act (sectioning) and Community Treatment Orders rocket beyond all expectations in the last few years[6]. Characteristically, Tony Zigmond, the UK Royal College of Psychiatrists lead on mental health law,

has expressed concern that some mental health services in England are becoming so focused on the risk of patients harming themselves or others that they make excessive use of compulsion and coercion in an attempt to allegedly 'protect and keep at risk patients safe'[7]. Zigmond has argued for a more consensual approach to treatment, and more space set aside in hospitals for patients to use as sanctuaries in times of crisis. He has even advocated that people should be given the option of using hospital to come off psychiatric medication if they need to. These are important and radical suggestions with far reaching implications for the mental health system. Even better would be more non-hospital based therapeutic communities and non-medical crisis services such as the Leeds Survivor-run crisis house.

We have to make sure that places of detention (whether 'voluntary' or not) are genuinely safe and therapeutic, not just places to administer drugs and manage behaviour. Unfortunately, psychiatric wards are notoriously unsafe and un-therapeutic environments. By way of illustration, a recent investigation by the BBC's Sunday Politics London revealed a 'shocking number of rapes and sexual assaults in London's Mental Health Trusts'[8]. In March 2012 they reported more than 500 allegations of rape and sexual assault on inpatient wards across London between 2008 and 2011. In this context some might consider it a deep irony that NHS hospitals are considered in the Mental Health Act 1983/2007 (Sections 135 and 136)[9] and in UK Home Office policy literature[10] 'places of safety' for people when they are in acute crisis.

There is actually little evidence regarding the protective effect of potentially coercive security measures, such as surveillance and close observation, in psychiatric wards [11]. In some wards in Bradford's Lynfield Mount Hospital they decided to re-focus in-patient treatment. They cut down on the use of routine formal observations in favour of increasing the availability of and support for staff to facilitate meaningful engagement and therapeutic activities for the service users. They reported positive results and increased patient satisfaction[12]. Absconding rates almost halved, self-injury decreased and staff sickness and absence rates dropped. Malcolm Rae, a nursing officer for mental health at the Department of Health, called the Bradford approach 'purposeful engagement rather than custodial ritual'. Unfortunately, it is 'custodial ritual' that appears to be the norm in NHS psychiatric wards as Dina's story below illustrates.

Absconding from an acute ward and the danger of suicide: Dina's story

Back in 2009 (from the end of January to the end of April) I was compulsorily detained under the Mental Health Act 1983/2007 in an acute psychiatric ward in North Manchester NHS Hospital. I absconded twice within a week in my first month there - fairly soon after my admission - even though I was allegedly on close 1:1 observation, especially at night. This was because I was acutely suicidal when I was first admitted and that was the reason for my sectioning.

Thinking back on the experience of 1:1 observation at night, I remember a quite imposing big woman sitting outside my single room for the entire night. She was constantly flicking through a magazine and her job was merely to prevent me from leaving my room; she would not engage with me in any other way. I guess I experienced the woman as a prison officer or a security guard. I did not experience any care or concern whatsoever for me and my distress in her act of watching me. Nobody introduced the woman to me or explained her role. Being watched by a complete stranger at such a close proximity to my (bed)room (supposedly a private space) for the entire night felt quite exposing, threatening, intrusive and oppressive. This was bound to exacerbate my already heightened vulnerability and acute lack of internal security that my suicidality had left me with.

Reflecting on my experience of being observed on the acute ward, I can relate to the idea of observation as 'a custodial ritual' rather than meaningful and 'purposeful engagement' (as discussed above in relation to Lynfield Mount Hospital). I was encountering a formal observation system established as a measure to enhance 'physical/environmental (i.e. external) security'[13] on the ward, which– paradoxically - operated at the expense of my internal security. I imagine the woman

observing me must have been an unqualified nursing assistant at best, or somebody 'off the street' at worst-in either case badly paid to do night shifts in the mad house.

Very early on during my detention I sensed the complete lack of therapeutic care on the ward. Ward staff rarely (if at all) engaged meaningfully and therapeutically with the patients; staff's interactions with the patients occurred mainly during the administration of medication and the odd bingo night! I remember staff mainly sitting in the nurses' office and talking, eating and drinking coffee or looking at a computer when they were not administering medication.

From my case records it appears that I was very agitated, acutely distressed and constantly knocking on the nurses' office door to tell staff that I wanted to go home or that I wanted to go to the vending machine outside the ward. Staff apparently perceived me as 'intrusive'- it seemed that my acute agitation and distress was construed as a kind of childlike 'intrusion', an irritation, by those very people supposedly responsible for alleviating and containing my distress. As a result, I was sent to my room (to have 'a time out') or, in a few instances, I was physically restrained. I now wonder whether the absence of staff's meaningful engagement with the patients was - partly at least - due to staff's own inability to tolerate acute mental distress and their ensuing need to defensively detach themselves from it.

Nobody had explained to me what 'sectioning' meant and how long my sections were likely to last. I just figured out by trial and error that I could not even go to the hospital grounds without permission. I felt disorientated, powerless, unsafe and terrified to the extent that I became incontinent. It was that kind of environment that I was desperate to abscond from.

And I still managed to abscond even though I was on close observation, heavily medicated, very distressed and so disorientated that I did not really know where the hospital was in relation to familiar areas of Manchester. The hospital was in north Manchester and I lived in south Manchester at the time - almost 2 hours from the hospital on public transport. The first time I absconded (which I don't remember) I apparently managed to get the bus from the hospital and go to Manchester Piccadilly station and then go home! The second time was night time and I remember it; I got into a taxi, paid £10 and went home quite late. Once the hospital staff realised I was missing and phoned my home asking after my whereabouts, a police car was sent to take me back to hospital. It still both saddens and infuriates me when I picture myself taken back to hospital in the middle of the night in 'police custody' like a criminal.

Both times I absconded anything could have happened to me - I could have been run over by a car or I could have killed myself. But nobody on the ward asked me - as far as I can remember - about my suicidality in a meaningful and therapeutic way: why I had wanted to take my life, what exactly I was feeling and thinking. I guess I was just asked whether I wanted to harm myself and a box was ticked. I wouldn't call this competent and meaningful risk assessment.

In reflecting on all this I have found the distinction between 'environmental/physical security' and 'relational security' on psychiatric wards really helpful[14]. Measures currently used to enhance environmental/physical security in mental health wards include constructional features (e.g. fenced garden areas), alarm systems, formal observation systems (e.g CCTV monitoring; scheduled staff observations), swipe card systems for controlled access to wards, or making wards 'locked' wards. Using the threat of compulsory detention for voluntary patients if they attempt to leave the hospital or withholding patients' leave are also measures used to allegedly 'keep patients safe'.

However, genuine safety and security in mental health wards cannot be achieved merely through interventions targeting the dimension of physical/environmental security[15]. An essential dimension of safety/security in mental health wards concerns relational security which can create a sense of attachment and connection for staff and patients alike. Relational security is thought to be enhanced through high staff-to-patient ratios, increased face-to-face meaningful contact between staff and patients, achieving the right 'balance between intrusiveness and openness' and establishing clear relational boundaries on staff's part, as well as promoting understanding, trust, respect and therapeutic rapport between patients and staff[16]. It is also thought to be improved by staff being

appropriately trained and aware of individual patients' histories and areas of vulnerability and risk, as well as involving patients in planning their own care.

As my story highlights, I felt that this kind of relational security was totally absent from the ward I was detained in. This I think explains my profound experience of a lack of genuine safety and security on that ward, as well as my ensuing absconding. Evidently, physical/environmental security provisions cannot substitute for relational security.

In conclusion, following a Supreme Court ruling, the NHS now has a positive duty to protect all psychiatric patients (both detained and voluntary) against the risk of suicide under Article 2 of the ECHR (i.e. a duty to protect all patients' right to life). This is undoubtedly an important development in the arena of human rights legislation. However, unless the ruling in question is combined with a recognition of people's 'right' to truly therapeutic environments when in crisis, it may only result in more surveillance and policing in NHS psychiatric wards – particularly in the current socio-political and economic climate in the UK. If there is more focus on increasing physical security and less on developing relational care and security in mental health wards, this is likely to lead to more compulsion, coercion and oppression. Intensifying coercion, in turn, is bound to undermine patients' sense of internal safety/security and may lead to higher rates of absconding with its associated dangers including that of suicide, as Dina's story so effectively highlights.

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