PART I — INTRODUCTION AND OVERVIEW

1. Introduction and overview

The Constitution of the United Nations Educational, Scientific and Cultural Organisation, written in 1946, begins with the words, "Since wars begin in the minds of men, it is in the minds of men that the defences of peace must be constructed." Every war and act of cruelty that ever took place, and every work of art or act of love and devotion, was conceived within, and executed at the instigation of, a small object weighing about three pounds — the brain. Although a person's conduct is the external expression of internal processes taking place within his brain, it would not be practical to see every harmful act as the product of faulty thought processes which necessitate medical intervention and excuse the individual of legal responsibility. All functional systems of morality assume that individual actions reflect deliberate choices. The law, as the social expression of the common moral code, presumes that individuals possess reason and foresight (sufficient capacity to understand the nature and possible consequences of their acts); self-control (sufficient capacity to refrain from unlawful or harmful acts); and so, also, free will (the individual could have omitted to act as he did). By liberty we can only mean a power of acting or not acting according to the determination of the will. This hypothetical liberty is universally allowed to belong to everyone who is not a prisoner and in chains.[1] Those capable of acting are responsible for their actions and omissions, and, being responsible for them, accountable to others for their behaviour. The counterpart of freedom and autonomy is accountability for acts freely and autonomously done. While it is difficult to see how a society could function on any other basis, because social existence depends upon co-ordination and co-operation, which in turn requires restraint in individual action,[2] these principles have required qualification in cases where an incapacitated adult is unable to assume this burden of legal responsibility. Such incapacity, and the ways of dealing with it, may take many forms. In terms of the criminal law, a fair trial is only possible if the defendant has sufficient understanding to participate in the trial process and "if punishment is to be justified at all, the criminal's act must be that of a responsible agent: that is, it must be the act of one who could have kept the law which he has broken."[3] Alternatively, it may consist of a lack of capacity to understand the nature of some act or transaction of sufficient importance that an individual may only legally undertake it if he understands the consequences of committing himself and freely consents to that. For example, the act of marriage, the making of a gift, will or contract, the conduct of litigation, the election of a legislative body, and the giving of consent to intrusive medical treatment. The purpose of the restrictions here is generally to protect the individual from exploitation, to protect others, or to ensure the proper performance, for the benefit of all, of public duties. Not surprisingly, the law has responded to the problem that some citizens lack capacity to act by curtailing their freedom of action, sometimes in conjunction with giving others the responsibility of making important decisions for

[1] D. Hume, *An Enquiry concerning Human Understanding* (ed. Sir L.A. Selby-Bigge, Oxford University Press, 1893), p.95.

[2] R.W.M. Dias, *Jurisprudence* (Butterworths, 5th ed., 1985), p.112.

[3] H.L.A. Hart, *Punishment and the Elimination of Responsibility* (The Athlone Press, 1962), p.5.

them. Ultimately, whether individuals "should be allowed certain lib[illegible]es at all depends on the priority given by society to different values and the crucial point is the criterion by which it has to be decided that a particular liberty should or should not be allowed, or that its exercise is in need of restraint."[4] In extreme cases, where an individual lacks sufficient capacity to appreciate that his actions are seriously jeopardising his own welfare or that of others, the law countenances his detention and treatment without consent. As will be seen, it is with this issue, and the circumstances which justify or necessitate such deprivation of liberty, that mental health review tribunals are concerned.

INFORMAL TREATMENT AND COMPULSION

The law concerning persons who suffer from mental disorder is a vast subject and practically every area of law makes some special provision for persons whose capacity or responsibility for their acts is impaired. For the sake of convenience, the law concerning mentally disordered persons may be said to fall into five broad categories: detention and restraint; the administration of medicine and other treatments; the management of property and legal affairs; legal capacity and responsibility under criminal and civil law; constitutional rights and obligations. The main statute which deals with the subject of mental disorder, the Mental Health Act 1983, includes provisions relating to the first three of these areas but this book is concerned only with the first of them: detention and restraint and the legal process by which patients compelled to receive treatment or care may have the necessity or justification for that reviewed by mental health review tribunals. It is important at the outset to distinguish these independent judicial bodies from another statutory body called the Mental Health Act Commission. The latter is a non-judicial, quasi-independent, body which arranges visits to detained patients and the investigation of certain complaints made by or in respect of them. Thus, tribunals are inferior courts which review whether a particular patient should remain subject to compulsion whilst the Commission, which is part of the National Health Service, is concerned with ensuring that patients who are detained are treated humanely and according to the law.

TREATMENT ON AN INFORMAL BASIS

The vast majority of people who receive in-patient psychiatric treatment are treated without resort to compulsory powers and they are known as "informal patients." Although informal patients are sometimes still referred to as "voluntary patients," the terms are not synonymous. A significant number of informal patients lack sufficient capacity to consent to their admission, are mentally incapable of organising their own discharge, or remain in hospital informally only because compulsory powers will be invoked if they refuse treatment or attempt to leave. Informal admission may be particularly disadvantageous for people who are mentally incapacitated in that the necessity for their being in hospital, and the treatment and care which they receive there, are not susceptible to periodic external review by the Mental Health Act Commission or a mental health review tribunal. Whilst the use of compulsory powers deprives the person affected of certain legal rights, it also confers other rights in substitution. Since these are framed as duties exercisable by third parties on the patient's [illegible]alf, they may in practice more than compensate the patient for the loss of rights the existence of which he is unaware or, if aware of them, incapable of exercising. Although most formal patients understandably wish to be informal, there are nevertheless a number of patients who are incapable of understanding or exercising the legal rights which constitute the practical benefits of being an informal patient.

COMPULSORY TREATMENT AND CARE

In 1954, a Royal Commission was appointed to review the existing law concerning mental illness and mental deficiency. It reported in 1957[5] and many of its recommendations were adopted in the Mental Health Act 1959. This statute was later amended by the Mental Health (Amendment) Act 1982 but the basic legal framework remained unchanged. The present statute is largely a consolidating Act but it has itself recently been amended by the Mental Health (Patients in the Community) Act 1995 and the Crime (Sentences) Act 1997.

Repeal of certification procedures

Under the Lunacy Act 1890 and related legislation, the order of a justice of the peace, or some other judicial authority, was generally necessary before a person could be compulsorily admitted to hospital or received into guardianship. The Royal Commission of 1954–57 advocated the repeal of these certification procedures. In their place, it recommended that a person's detention or reception into guardianship should be legally authorised upon an application for that being accepted by the hospital to which admission was sought or, in the case of guardianship, accepted by the social services authority concerned. The Royal Commission's opinion was that,

> "... a sufficient consensus of medical and non-medical opinion on the need to compel a patient to accept hospital or community care would normally be provided through [1] an application for the patient's admission made by a relative or mental welfare officer, ... [2] two supporting medical recommendations, [3] the acceptance of the patient as suitable for the form of care recommended, and [4] the continuing power of discharge vested in the nearest relative, the hospital or local authority medical staff, the members of the hospital management committee or local authority, and the Minister of Health. To refer the application and medical recommendations to a justice of the peace before the patient's admission would not in our view provide a significant additional safeguard for the patient ..."[6]

Creation of mental health review tribunals

The most distinctive feature of the post–1959 application procedures is that the individual is deprived of his liberty following an application for his detention being made not to a court but to the managers of a hospital. Similarly, reception into guardianship, and the imposition of supervision following a patient's discharge from hospital, respectively involve the acceptance of an application by the relevant local social services authority and Health Authority. The procedures cannot properly be described as administrative because, in constitutional terms, they involve the detention or restraint of one of the Queen's subjects. But, equally, it would be inaccurate

4 R.W.M. Dias, *Jurisprudence* (Butterworths, 5th ed., 1985), p.109.

5 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954–57*, Chairman—Lord Percy, Cmnd. 169 (1957).

6 *Ibid*, p.148.

to describe them as a judicial process for no judicial authority, such as a magistrate, is involved. Because the proposed new procedures did not involve any judicial body, the Royal Commission recommended that where, *after the event*, a patient desired a formal review of the justification for his detention or guardianship this need should be met by the establishment of new independent review bodies.[7] Their establishment would give those patients who desired it opportunities to have the justification for the use of compulsion investigated by a strong independent body consisting of both medical and non-medical members.[8] In the Royal Commission's view, the functions of such a tribunal would be confined to reviewing the continuing need for compulsion:

> "We should make it clear that these review tribunals would not be acting as an appellate court of law to consider whether the patient's mental condition at the time when the compulsory powers were first used had been accurately diagnosed by the doctors signing the recommendations, or whether there had been sufficient justification for the use of compulsory powers at that time, nor to consider whether there was some technical flaw in the documents purporting to authorise the patient's admission ... The review tribunal's function would be to consider the patient's mental condition at the time when it considers his application, and to decide whether the type of care which has been provided by the use of compulsory powers is the most appropriate to his present needs, or whether any alternative form of care might now be more appropriate, or whether he could now be discharged from care altogether."[9]

When compulsion is justifiable — guiding principles

The Royal Commission of 1954–57 also spelt out the circumstances in which it considered that the use of compulsory powers was justified. Paragraph 317 of its report states:

> "We consider that the use of special compulsory powers on grounds of the patient's mental disorder is justifiable when:
>
> **a.** there is reasonable certainty that the patient is suffering from a pathological mental disorder and requires hospital or community care; and
>
> **b.** suitable care cannot be provided without the use of compulsory powers; and
>
> **c.** if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself; and
>
> **d.** there is also either—
>
> **i.** good prospect of benefit to the patient from the treatment proposed — an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others;
>
> **ii.** a strong need to protect others from anti-social behaviour by the patient."

[7] *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), pp.148–149.

[8] *Ibid*, p.12.

[9] *Ibid*, pp.150–151.

The terms of the subsequent Mental Health Act 1959 gave expression to the Commission's views about when compulsion is necessary or justified and, during the Parliamentary debate of 5 May 1959, the Minister of Health explained the Government's aims in relation to the new civil procedures in the following terms:

> "We had in mind all the time to try and assemble a structure which would reflect the balance of the considerations we must have in mind. They are, firstly, the liberty of the subject, secondly, the necessity of bringing treatment to bear where treatment is required and can be beneficial to the individual and, thirdly, the consideration of the protection of the public. All through I have tried steadily to keep in mind that what we are trying to do is to erect as balanced a structure as we may which can give effect to all those things in harmony with each other."[10]

Applications founded on diagnosis and risk

The present statute by and large adopts the same approach. The criteria for making an application for a person's detention or guardianship, and the criteria to be applied by a tribunal when determining whether any patient must be discharged, always comprise at least two grounds. The first of these grounds (the diagnostic ground) requires considering whether the patient is suffering from a mental disorder the nature or degree of which makes in-patient treatment appropriate or, as the case may be, warrants his reception into guardianship or detention for assessment. The second ground (the risk ground) requires considering whether the individual's detention, restraint or treatment is "necessary" or "justified" on his own account (specifically for his health, safety or welfare) or that of others (in order to protect them). The criteria which comprise the second ground are therefore directed towards the issue of risk — specifically, the likelihood of undesirable consequences if the individual is allowed a citizen's usual freedom to decide how to act and what medical treatment or social care to accept. The risks involved in restoring a patient's liberty to him may consist of a likelihood of significant deterioration in his health, a risk to his physical safety, or a risk to others. In some cases, others may be at risk from the individual quite independently of whether or not he is mentally disordered at a given moment in time. There may be a general risk of domestic violence and an offender cured of his mental disorder may still be disposed to commit crime. Hence, the need for both statutory grounds and, unless psychopathy is an issue, the duty to release a person who though a threat to others is not mentally disordered or, if he is, the danger does not arise from this fact. Assessing risk in the context of mental disorder (the second question) therefore also requires forming a judgement about the extent to which any identified risks are a feature or consequence of mental disorder (the first question). Whether a patient's detention is justified or necessary in a particular case will often partly depend upon what arrangements have been, or can be, made for his treatment outside hospital. The patient's willingness to accept appropriate treatment as an informal in-patient, and his capacity to adhere to any agreed treatment programme and discharge plan, will also be highly relevant. But, to summarise, the circumstances in which an individual's liberty may be interfered with under the 1983 Act are that he has a serious mental disorder and, in consequence of this, is either at significant risk or others are at significant risk from him.

[10] *Hansard*, H.C. Vol. 605, col. 276.

Assessments of risk

It can be seen that the assessment of risk is an integral part of any decision to invoke or to rescind compulsory powers and tribunals must assess the likely risk to the patient's health and safety and the risk to others if he is discharged. Risk cannot be avoided and all decisions to discharge or not to discharge involve the assumption of a risk. In the case of a decision to discharge, the risk is that the individual will use his greater freedom in a way which is injurious to himself or others. The risks involved in not discharging may similarly include an increased likelihood of harm to the patient or others but, more often, consist of the possibility that a citizen is detained who could safely be discharged. In other words, there is a risk of injustice, and a lawyer ought to be as concerned to eradicate injustice as a doctor is to eradicate disease. A tribunal which declines to discharge cannot be faulted insofar as no one will ever know whether its assessment of the patient's case was right or wrong. The person who is not released is thereby prevented from demonstrating that if released he would have resettled safely in the community. However, the converse is not also true. A tribunal which discharges risks catastrophe and, if the patient then either attempts or commits suicide, or some serious offence against a third party, public criticism. Yet, however careful the assessment of the nature and extent of the risks involved in discharge, it is inevitable that some patients will later take their own lives or, more rarely, commit a serious offence outside hospital. These events also happen in hospitals, and in respect of patients granted leave or discharged by their consultants. The occurrence of such tragedies does not *per se* demonstrate any error of judgement on the part of those who discharged or supervised the patient. The public cannot be made entirely safe from the risk of offending and, arguably, cannot properly expect any higher measure of protection before persons committed to hospital are released compared with those sent to prison. It must also be borne in mind that all in-patients are themselves members of the public and at increased risk of being victims of violence for as long as they are detained on a psychiatric ward. Thus, the tribunal system aims to ensure both that members of the public are not unnecessarily detained and also that members of the public are protected from people who must necessarily be detained. Balancing these different considerations is a formidable task.

Persons unable to appreciate or avoid obvious risk

While the public must be realistic about the problems involved in assessing risk and deciding what is an acceptable risk, it is equally important that tribunal members do not add to their burden in cases involving non-offenders by balancing risks which are constitutionally matters for the citizen to weigh in his own mind. The purpose of invoking compulsory powers is not to eliminate that element of risk in human life which is simply part of being free to act and to make choices and decisions. Rather, their purpose is to protect the individual and others from a particular and somewhat limited kind of risk — that which arises when a citizen is of unsound mind and his judgement of risk, or his capacity to control behaviour he knows puts himself or others at risk, is in consequence of this markedly impaired. The key issue is the patient's judgement and appreciation of his situation, the way in which he will use his liberty if it is restored to him and he is again free to make decisions for himself. It cannot be over-emphasised that a citizen who has not offended against society is generally entitled to place a high premium on his liberty, even to value it more highly than his health. Within certain limits, he is as entitled as the next man to

make what others may regard errors of judgement and, in particular, to behave in a way which a doctor regards as irrational in the sense that it does not best promote his health. Thus, a person may chain-smoke cigarettes even though the risks involved in this activity, both to the individual and others, are significant and potentially life-threatening. Although the individual's judgement is partially impaired by his addiction, nevertheless he is able to fully comprehend the medical advice and so, in this sense, is able to rationally assess and assume, or not, the risks involved in exercising his freedom to follow or ignore that advice. Likewise, a patient who has been receiving treatment for mental disorder is not to be compelled to follow medical advice simply because he disagrees with all or part of that advice, provided the choices he proposes making if set at liberty are not manifestly irrational. Accordingly, if the medical opinion is that a patient needs to continue taking medication and this should be given in depot form, it is not irrational *per se* for the patient to prefer to take prophylactic medication orally simply because from a medical viewpoint this is the treatment of second choice. If the patient can rationally explain that for him the slightly increased risk of relapse is outweighed by the disadvantages for him of injections, and other persons are not at risk, such a way forward represents a reasoned balance of the risks involved.

MENTAL HEALTH ACT 1983

Several powers exercisable under the 1983 Act authorise a person's detention while others permit only some restriction of liberty short of this, such as the appointment of a guardian or the imposition of supervision in the community. The statutory framework is such that a person may not be detained for more than 72 hours unless the managers of a hospital have accepted an application for his admission to hospital (under Part II of the Act) or his detention there has been authorised by a criminal court or by the Home Secretary (under Part III of the Act). The Act does not define what is meant by detention but, in an Australian case, it was said that the word "refers to the case of a person lawfully held against his will, one who is not free to depart when he pleases."[11] Nor are the powers of the patient's detainers specified in any detail. However, a power to detain implies a power to physically restrain if need be (otherwise the patient could leave when he wished) and protecting others, including other patients, implies a power to segregate the patient from them. The better view is therefore that, if the occasion requires it, using reasonable force to restrain a detained patient, or to remove him to a separate seclusion room, represents a lawful exercise of the *statutory* power of detention. On this point, the House of Lords has held that a statutory power to detain and treat a patient implies a power to use reasonable force on occasion in order to ensure that control is exercised over him.[12] The circumstances in which the common law permits the restraint or treatment without consent of a person not lawfully detained under the Act are limited. His detention may be justified if immediately necessary to prevent a breach of the peace[13] and it is similarly lawful to restrain, and if need be detain, a "furious" or

11 *Paul v. Paul* (1954) V.L.R. 331.

12 Dicta of Widgery C.J. adopted by the House of Lords in *R. v. Bracknell JJ. ex p. Griffiths* [1976] A.C. 314 at 318.

13 *R. v. Howell* [1982] Q.B. 416; *Albert v. Lavin* [1982] A.C. 546; *McConnell v. Chief Constable of Greater Manchester Police* [1990] 1 W.L.R. 364.

"dangerous" "lunatic" whose state of mind is such that he is a danger to ...self and others.[14] Furthermore, a doctor may administer to a patient who lacks the capacity to give or to communicate consent to that treatment whatever treatment is judged in his best interests as being necessary to preserve his life, health or well-being or to ensure improvement or prevent deterioration in his physical or mental health.[15]

WHERE TO FIND THE LAW AND GUIDANCE

The legislation concerning the detention, restraint and release of persons detained under the 1983 Act is set out in the table below.

1983 ACT — MAIN LEGAL MATERIALS AND PRACTICE GUIDELINES

Primary legislation

- Mental Health Act 1983, *as amended by*
- Mental Health (Patients in the Community) Act 1995
- Crime (Sentences) Act 1997

Secondary legislation

- Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 (S.I. 1983 No. 893), *as amended by*
- The Mental Health (After-care under Supervision) Regulations 1996 (S.I. 1996 No. 294)
- The Mental Health (Hospital, Guardianship and Consent to Treatment) (Amendment) Regulations 1996 (S.I. 1996 No. 540)
- The Mental Health (Hospital, Guardianship and Consent to Treatment) Amendment Regulations 1997 (S.I. 1997 No. 801)

Secondary legislation on mental health review tribunals

- Mental Health Review Tribunal Rules 1983 (S.I. 1983 No. 942), *as amended by*
- The Mental Health Review Tribunal (Amendment) Rules 1996 (S.I. 1996 No. 314)
- The Mental Health Review Tribunals (Regions) Order 1996 (S.I. 1996 No. 510)

Guidance on the legislation

- Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X (D.H.S.S., 1987).
- Mental Health Act 1983: The Code of Practice published pursuant to section 118 of the Act (Department of Health and Welsh Office, 2nd ed., 1993).

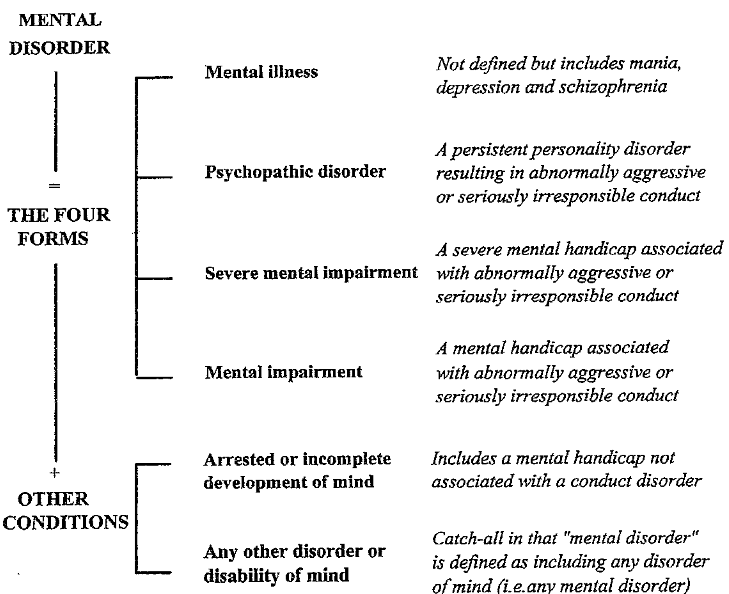
[14] *Brookshaw v. Hopkins* (1772) Lofft. 240 at 243; *Anderton v. Burrows* (1830) 4 Car. & P. 210 at 213; *Re Greenwood* (1855) 24 L.J.Q.B. 148; *Fletcher v. Fletcher* (1859) 1 El. & El. 420; *Scott v. Wakem* (1862) 3 F. & F. 328 at 333; *Symm v. Fraser* (1863) 3 F. & F. 859 at 882–883; *Re Shuttleworth* (1846) 9 Q.B. 651; *Re Gregory* (1901) A.C. 128; *Black v. Forsey and others*, 1987 S.L.T. 681.

[15] See *Re F* [1990] 2 A.C. 1; [1989] 2 W.L.R. 1025; [1989] 2 F.L.R. 376.

Jones' comprehensively anno... *Mental Health Act Manual* (Sweet & Maxwell, 5th ed., 1996) contains all of the relevant legislation to September 1996.[16] Guidance on the correct interpretation and implementation of the statutory provisions may be obtained from various sources: case law; the Department of Health's Memorandum on the 1983 Act; the Code of Practice prepared by the Mental Health Act Commission and published by the Department of Health; the Commission's biennial reports; legal textbooks and articles; professional legal advice.

DEFINING MENTAL DISORDER (CHAP. 2)

The legal purpose served by defining mental disorder and its various forms is to define as far as practicable the group of citizens to whom the different statutory provisions apply, and the circumstances in which resort may be made to compulsory powers. According to section 1 of the 1983 Act, the term "mental disorder" means "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind." Provided that the other statutory conditions are satisfied, a person who suffers from "mental disorder" generally may be detained for assessment for up to 28 days. For certain purposes, the Act then distinguishes four particular "forms" or classes of mental disorder: mental illness, psychopathic disorder, severe mental impairment, and mental impairment. In particular, a person must suffer from a condition which falls within at least one of the four specific statutory classes before he can be detained for prolonged treatment, received into guardianship, or placed under statutory supervision following discharge. The reader should refer to chapter 2 for a precise definition of these various terms but the following diagram describes their essential features.



[16] It is also helpful to be familiar with the main statutes concerning the provision of health and social services: the National Health Service Act 1977, Medical Act 1983, Registered Homes Act 1984, National Health Service & Community Care Act 1990, Health Authorities Act 1995.

During the year ending 31 March 1996, 8670 — or 98.2 per cent. — the 8826 patients admitted to NHS hospitals for treatment under Part II of the Act were classified as suffering from mental illness. Of the remainder, 85 were classified as mentally impaired (1 per cent.), 55 as having a psychopathic disorder (0.6 per cent.), and only 16 as suffering from severe mental impairment (0.2 per cent.). Of those admitted under Part III of the Act, 1225 were classified as mentally ill (92.3 per cent.), 57 as mentally impaired (4.3 per cent.), 44 as having a psychopathic disorder (3.3 per cent.), and only one patient as suffering from severe mental impairment (0.1 per cent.). Looked at overall, this means that about 14 of every thousand persons compulsorily admitted to hospital suffered from mental impairment, 10 from a psychopathic disorder, and less than two from severe mental impairment.[17]

RELEVANT PERSONS AND BODIES (CHAP. 3)

It is useful to have some understanding of the legal functions of those people and bodies involved in the detention and compulsory treatment of patients. However, at this stage, it is really only necessary to know two things. Firstly, that important statutory powers are vested in a person's nearest relative and who is a person's nearest relative is most often determined by referring to a list of relatives set out in section 26. Secondly, several statutory powers may only be exercised by an approved social worker (or ASW), that is by a social worker approved to exercise them after completing special training.

FOUR KINDS OF LEGAL AUTHORITY FOR COMPULSION

For present purposes, the 1983 Act can be seen as providing four quite distinct kinds of authority for a person's compulsory detention or restraint—

Civil applications — As recommended by the Royal Commission of 1954–57, it is lawful to detain a person in hospital, or to subject him to guardianship or supervision in the community, following the acceptance of an application made by his nearest relative or an approved social worker and founded on medical evidence.

Short-term powers — The purpose of certain short-term powers is to detain an individual for up to 72 hours so that the need to make an application can be assessed or the necessary application procedures completed.

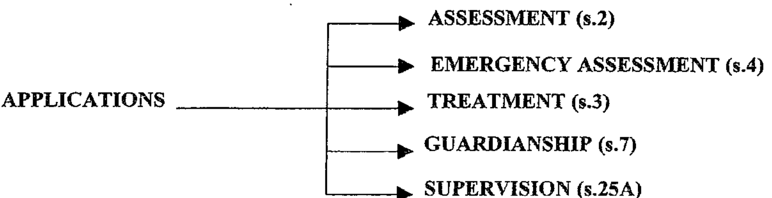
Criminal court orders — Various orders set out in Part III of the Act are exercisable by a criminal court in respect of a defendant who suffers from, or who appears to suffer from, mental disorder.

Directions of the Home Secretary — The Home Secretary, who has responsibility for the Prison Medical Service, may direct that a person in custody be transferred to hospital for psychiatric treatment.

[17] Statistical Bulletin 1997/4, Department of Health (1997).

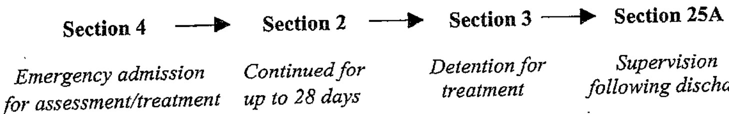
CIVIL APPLICATIONS U... ER PART II (CHAP. 4 & CHAP. 6)

Part II of the Act provides for five different kinds of application. With the possible exception of persons detained in an emergency, under section 4, the acceptance of any such application gives the person affected an immediate right to apply to a mental health review tribunal.



A person's nearest relative or an approved social worker may apply under section 2 for that person to be detained in hospital for up to 28 days so that his mental state can be assessed and any treatment given which is assessed to be necessary. Such an application must be founded on two medical recommendations but practice shows that, in urgent cases, fulfilling this requirement may occasionally lead to undesirable delay in effecting the admission. Section 4 therefore sets out an emergency procedure whereby a person may be admitted for assessment on the basis of a single medical recommendation. If this procedure is adopted, the authority to detain the patient ceases after 72 hours unless the second section 2 recommendation has by then been received. Provided a further recommendation is received within that time, the individual's detention may continue for the remainder of the 28-day section 2 period. Subject to a single caveat which need not be referred to here, detention beyond 28 days is only permissible if a fresh application, one made under section 3, has been accepted by the managers of the hospital. Their acceptance of an application under this section authorises them to detain the person concerned for a further six months. Where necessary, that authority to detain the patient may be renewed for a second period of six months, and thereafter for one year at a time. When a patient is detained in hospital for treatment, section 25A now provides that an application may be made for him to be supervised in the community when he leaves hospital. Finally, and quite separately, an application may be made under section 7 for a person to be placed under the guardianship of a local social services authority or a private individual for up to six months. As with section 3 applications, a supervisor's authority and a guardian's authority lapse after six months unless renewed for a further six months and thereafter at yearly intervals. It should be noted that some patients are admitted to hospital under section 3, there being no legal requirement to first assess under section 2 before deciding that prolonged treatment is necessary. It is also important to realise that the powers conferred by the five different types of application are not mutually exclusive. In the first place, a person detained in hospital may be transferred into guardianship, and vice-versa. Secondly, it is common for one application to be replaced by another. For example, section 4 might be used to admit a person to hospital in an emergency. If the second medical recommendation required by section 2 is then received on the following day, within the permitted 72 hour period, the patient may be detained for the remainder of the 28 day period which commenced with his admission to hospital. A section 3 application

will follow if, before the 28 days expires, it becomes clear that a more prolonged period of detention and compulsory treatment is necessary. If it then becomes apparent that the patient will require statutory supervision after he ceases to be detained under section 3 and leaves hospital, a supervision application may at that point be made.



SHORT-TERM POWERS NOT EXCEEDING 72 HOURS

The application procedures just described require both the presence of the individual whose mental health is in issue, so that he may be assessed and examined, and sufficient time to arrange the attendance of those persons who must interview and examine him. Problems will occur where access cannot be obtained to a person's home in order to conduct an assessment of his need for admission; where the seriousness of a person's mental condition only becomes apparent at a time when no doctor or approved social worker is immediately available; or where an informal patient attempts to leave hospital in circumstances which suggest that it is necessary to make an application for him to be detained there. The Act therefore makes provision for a number of short-term powers of detention, which enable a person to be detained so that his mental state and situation may be assessed and/or any necessary application made. The person's detention not having been authorised in any of these cases by the acceptance of a formal application, the Act does not authorise his treatment without consent. That being so, any medication administered without the consent of an individual detained under one of these powers is only lawful if justifiable under the common law. Because of the short-term nature of the powers, persons so detained have no right to apply to a mental health review tribunal. Consequently, apart from the following brief remarks and occasional references in the text, the powers are not considered further.

Detention of in-patients under section 5(2)

If it appears to the doctor in charge of an informal in-patient's treatment that an application ought to be made under section 2 or 3 of the Act, he may furnish a written report to that effect to the managers of the hospital. Upon furnishing such a report, the patient may be detained in the hospital for a period of 72 hours. The doctor in charge of the patient's treatment may nominate one other registered medical practitioner on the hospital staff to deputise for him in his absence, that is to exercise this power as and when necessary.

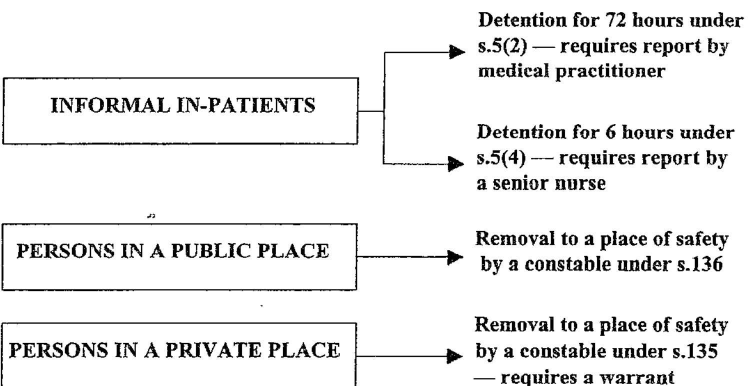
Detention of in-patients under section 5(4)

It is not uncommonly the case that neither the doctor in charge of an informal patient's treatment or his nominated deputy is present on the ward when some event occurs which seems to make it clear that the patient needs to be detained. Section 5(4) therefore empowers nurses of appropriate seniority to authorise an informal

patient's detention for up to [illegible] hours. More particularly, if it appears to such a nurse, *firstly,* that a patient is suffering from mental disorder to such a degree that it is necessary for his health or safety, or for the protection of others, to immediately restrain him from leaving the hospital, and, *secondly,* that it is not practicable to secure the immediate attendance of a doctor for the purpose of furnishing a report under section 5(2), the nurse may record that fact in writing. The patient may then be detained in the hospital until the doctor in charge of the patient's treatment or his nominated deputy arrives, subject to a maximum period of detention of six hours. If the doctor who attends then authorises the patient's detention under section 5(2), the 72-hour detention period under that section is treated as having commenced at the time when the nurse made his record under section 5(4).

Removal from private premises to a place of safety under section 135

Section 135 empowers a magistrate to authorise a police constable to remove a person from private premises to a place of safety. A warrant may be issued if, having heard oral evidence from an approved social worker, it appears to the magistrate that there is reasonable cause to suspect that that a person believed to be suffering from mental disorder is *either* living alone and unable to care for himself *or* is being ill-treated, neglected, or kept otherwise than under proper control, in the premises specified. The constable who removes the patient must be accompanied by an approved social worker and by a registered medical practitioner. Once removed, the individual may be detained at a place of safety — usually a hospital or police station — for a period not exceeding 72 hours.



Removal from a public place to a place of safety under section 136

If a police constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may remove him to a place of safety if he thinks it necessary to do so in that person's interests or to protect others. The individual may be detained there for a period not exceeding 72 hours, for the dual purpose of, *firstly*, enabling him to be examined by a registered medical practitioner and to be

interviewed by an approved social worker and, *secondly*, of making a[illegible] necessary arrangements for his treatment or care. These arrangements not uncommonly involve making an application under Part II for the person's admission to hospital.

PART III OF THE ACT (CHAP. 5)

Part III of the Mental Health Act 1983 comprises various provisions relating to "patients concerned in criminal proceedings or under sentence," and they are briefly summarised in the following table. The orders and directions made under these sections do not involve the nearest relative or an approved social worker making an application to the court. Rather, the magistrates court, Crown Court, or Home Secretary, makes the order if satisfied both as to the medical evidence and the propriety of doing so.

PART III OF THE MENTAL HEALTH ACT

Section	*Purpose*
	Court orders made during the course of the criminal proceedings
35	Remand to hospital for a report on the accused's mental condition.
36	Remand of accused to hospital for treatment.
38	Admission to hospital to determine whether a hospital order is an appropriate disposal.
	Court orders which bring criminal proceedings to an end
37	1. Guardianship order; 2. Hospital order
41	Restriction order — imposed where necessary to protect the public from serious harm.
	Directions by warrant of the Secretary of State
47	Transfer to hospital of a person serving a term of imprisonment who is in need of treatment.
48	Transfer to hospital of a non-prisoner in urgent need of treatment.

ORDERS MADE BY A CRIMINAL COURT

As can be seen from the table above, the orders which a criminal court may make during the course of criminal proceedings are of two kinds.

Orders which do not dispose of the case before the court

In the first group are those orders which do not dispose of the case before the court. For example, a criminal court may remand a defendant to hospital for a report on his mental condition, in order to assist it in deciding how most appropriately to deal with him. In each instance, the matter not having been disposed of, the case will come back before the court and, because it retains jurisdiction over the defendant, his detention in hospital remains a matter for that court. Consequently, the patient has no right to apply to a tribunal for his release.

Orders which do dispose of [illegible] case before the court

In the second group are those orders which dispose of the case before the court and are alternatives to the normal sentencing options. As to these, section 37 provides that a court may direct that an offender be admitted to hospital for treatment or be received into guardianship. With minor exceptions, these orders have the same consequences as do applications for admission for treatment and guardianship under Part II of the Act. That is, they authorise the patient's detention or guardianship for up to six months, after which the continuance of the compulsory powers requires periodic renewal. The making of a guardianship order or a hospital order being a final order which brings the criminal court proceedings to an end, the defendant may not go back to the court which imposed the order to seek its termination. They are, however, orders of potentially indefinite duration and the patient is therefore given a right to periodically apply to a tribunal for his discharge.

Restriction orders

What is most noteworthy about Part III of the Act is the power of the Crown Court under section 41 to restrict the operation of the normal statutory provisions concerning the return to the community of a patient whom it sends to hospital under section 37. The court may do this by attaching to the hospital order what is known as a restriction order. Such an order may only be made if it appears to be necessary in order to protect the public from serious harm. As has been noted, the purpose of these restrictions is to restrict the circumstances and ways in which the patient may be allowed outside hospital. This objective is achieved in several ways. In the first place, the Home Secretary is involved in the management, but not the treatment, of a restricted patient. Such a patient may not be permitted to be absent from the hospital, or transferred to a less secure hospital, without the Home Secretary's consent. Nor, in effect, may he be discharged from hospital otherwise than by the Home Secretary or a mental health review tribunal. Furthermore, conditions may be attached to any discharge and a patient who fails to comply with these conditions, or whose mental health deteriorates, may be recalled to hospital by the Home Secretary. No fresh order is necessary.

DIRECTIONS OF THE HOME SECRETARY

The next situation that must be catered for is that of persons in prison whose mental health deteriorates to such an extent that they require treatment in a psychiatric hospital. The Home Secretary is responsible for the prisons, including the Prison Medical Service, and he has long had a power to transfer to hospital prisoners whose cases fulfil certain criteria.

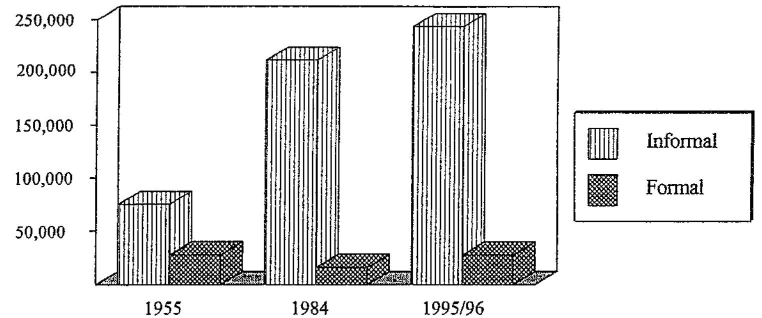
Transfer directions and restriction directions

Under section 48, the Home Secretary may transfer a person awaiting trial before a criminal court — known as a "transfer direction" — but, if he does so, he must also direct under section 49 that the defendant shall be subject to the restrictions just described — called a "restriction direction." Under section 47, he may similarly transfer a person serving a sentence of imprisonment. Whether a restriction direction is also given under section 49 is in this case a matter for his discretion. Patients who are transferred from custody to hospital by direction of the Secretary of State may be detained for a potentially indefinite period and arrangements must be made for their

detention to be independently reviewed. The Act therefore again provia... ..at they may apply to a tribunal for a review of the justification for their detention.

Effect of the directions

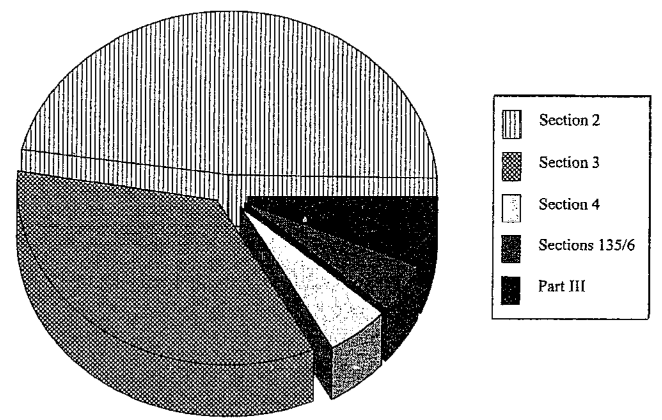
The general position is that, unless restrictions were also imposed (see below), a transferred patient is treated as if a hospital order had been made by a criminal court, which, in turn, means that his position is similar to that of a section 3 patient. A tribunal which considers his case may, and sometimes must, discharge him in exactly the same circumstances as any other person detained for treatment on this basis. If restrictions were imposed — and their imposition is mandatory in the case of persons awaiting trial — then the powers of a tribunal which considers the patient's case are further restricted. This limitation recognises that there are two authorities for the patient's detention: a court has authorised his detention in prison and the Home Secretary has authorised his detention in hospital. The basic position is that a tribunal may with the Home Secretary's consent discharge a serving prisoner into the community but persons awaiting trial must, unless granted bail, remain detained, either in hospital or in prison. In the latter case therefore, the tribunal's function is essentially limited to advising on the issue of whether the person still needs to be detained in hospital rather than in prison.



THE USE MADE OF POWERS OF DETENTION

As can be seen from the following table, most patients admitted to hospital for psychiatric treatment are admitted there informally — that is, without any formal application, order or direction being made authorising their detention there. Thus, during the year to 31 March 1996, only 26,215 (that is 9.7 per cent.) of the 271,000 patients admitted to NHS psychiatric hospitals were admitted under the 1983 Act. This compares with about 27 per cent. in 1955. However, those bare statistics do not tell the whole story. Many more of the patients compulsorily admitted in 1955 remained detained for a considerable period of time. On 31 December 1955, only 42,900 (that is 28 per cent.) of 153,100 hospital in-patients were persons who today would be regarded as informal patients. Although the Department of Health no

longer keeps records of ho\ .any in-patients are detained at the end of each statistical year, probably some 85 per cent. of in-patients are nowadays in hospital informally.

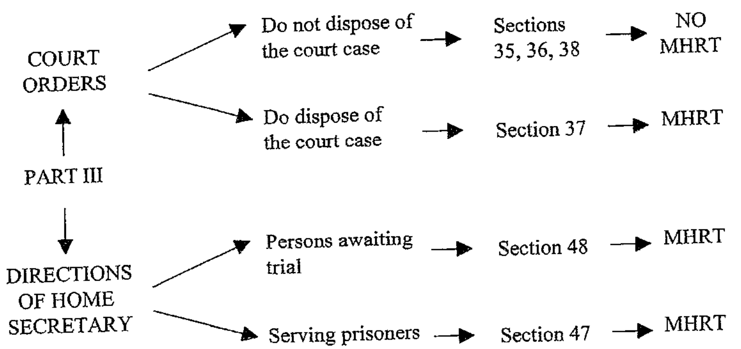


Number of formal and informal admissions to hospital during 1955, 1984 and 1995/96

Sources: Statistical reports published by Department of Health and predecessor bodies.

Use of Part II and III

In terms of the usage made of the various powers, the vast majority of patients are detained under section 2 or 3. During the year 1995/96, 12,833 of the 27,453 patients admitted to hospital were detained under section 2 (46 per cent.) and a further 9,538 under section 3 (35 per cent.).[18]



Formal admissions to hospital under the Mental Health Act 1983 during 1995–96

Source: Statistical Bulletin 1997/4, Department of Health, March 1997

[18] It should be noted that the Department of Health's statistics do not include the use made of section 5.

MENTAL HEALTH REVIEW TRIBUNALS

Any power given to one person over another is capable of being abused, the more so if the latter is not free to escape his detainer and if his word is not given the same weight as that of other men. Tribunals which review the grounds for an individual's detention, guardianship or supervision under the 1983 Act are but one of the ways in which the law seeks to ensure that individuals are not unjustifiably or unlawfully detained or otherwise ill-treated. In the first place, each statutory power is only exercisable, that is only available, if certain conditions laid down by Parliament in the statute appear to be satisfied. Secondly, the powers may only be exercised by an authorised person, such as the patient's consultant or nearest relative, a court, an approved social worker, or a senior nurse. Thirdly, no person may be detained for more than 72 hours except on the basis of written or oral medical evidence and only then if some application has been accepted or an order or direction made. Fourthly, those involved in depriving a fellow citizen of his liberty must exercise reasonable care, certify their opinion that the statutory conditions are satisfied, and, in most instances, specify the circumstances and reasons justifying those opinions. Fifthly, those detaining an individual may only use reasonable force and it is a criminal offence to ill-treat or to wilfully neglect a patient: an unqualified power to control, restrain or discipline a person receiving hospital treatment would be unacceptable and the law does not permit the arbitrary use of power. Sixthly, if the conditions of detention are so poor as to amount to a breach of the hospital's duty of care to the patient, damages will be recoverable for any injury resulting from that negligence. Seventhly, patients who are unnecessarily or unjustifiably detained have access to a tribunal, whilst those unlawfully detained have available to them the remedies of habeas corpus and judicial review, and possibly the prospect also of release by a tribunal. Eighthly, complaints about the way in which a patient was or is being detained or treated are potentially investigable by a number of complaints bodies including the Mental Health Act Commission, which periodically visits psychiatric hospitals. Finally, patients have the protection of the European Convention on Human Rights and Fundamental Freedoms, as applied by the European Court of Human Rights, which protection has in recent times tended to prove more effective than the domestic remedies afforded them.

MHRTs — LAW AND PROCEDURE

With the possible exception of section 4 patients, all patients detained in pursuance of an application made under Part II may apply to a tribunal for their discharge. Similarly, unless the court which made the order has not yet disposed of the patient's case, all patients detained for treatment under Part III may make an application. The cases of patients detained for treatment are also periodically referred to a tribunal if no application has been made for a certain period of time. At its simplest, tribunal proceedings consist of a beginning (the making of an application or reference), a middle (the procedure for dealing with it), and an end (the determination of the application or reference).

Jurisdiction and powers

Being a creature of statute, a mental health review tribunal has no inherent jurisdiction. As is normal, the 1983 Act defines when a person may apply, when his

case must be referred, and th[illegible]wers of such a tribunal. More particularly, the law is to be found in Part V of the Act — which comprises sections 65–79 — and the basic framework is quite simple. Sections 66–71 determine when a person may apply and when his case must, or may, be referred. A tribunal's powers in unrestricted cases are then set out in section 72 and their powers in restricted cases are found in sections 73 (patients subject to restriction orders), 74 (patients subject to restriction directions), and 75 (conditionally discharged restricted patients).

Procedural rules

The procedure adopted by tribunals — matters such as the preparation of reports and the conduct of the hearing — is governed by rules made under the Act, the purpose of which is to ensure that each case is dealt with fairly and in a uniform manner. Although there are many different routes whereby a person may come to be detained or subject to guardianship under the Act, it would be unnecessarily complicated and serve no obvious purpose to draft separate procedural rules for dealing with each case just because this is so. All patients who are subject to guardianship or who are detained otherwise than under section 2 are detained either for an indefinite period or for renewable periods of like duration, that is for six or twelve months at a time. That being so, the Mental Health Review Tribunal Rules 1983 are drafted so as to be generally applicable to all cases other than those involving patients detained for assessment. For the sake of convenience, the rules are divided into seven parts, followed by two schedules. Of these—

- Part I of the rules defines the meaning of terms used in the rules.
- Part II deals with preliminary matters such as the form of the application, the preparation of reports, and the appointment of a tribunal.
- Part III contains various general provisions such as the disclosure of documents, the directions which a tribunal may make, the transfer of proceedings from one tribunal to another.
- Part IV deals with the way in which a hearing shall be conducted.
- Part V regulates the procedure following the hearing (the making, recording and communication of a tribunal's decision, the giving of reasons for that decision) and also includes miscellaneous provisions concerning time limits, the service of notices, and irregularities.
- Schedule 1 sets out in detail the contents of the reports required under Part II.

Proceedings involving patients detained for assessment

In the case of patients detained for assessment, the authority for their detention will in the normal course of events expire after 28 days and the Act therefore provides that a tribunal shall hear any application made by or in respect of such a patient within seven days of its receipt. This requirement necessarily means that the usual

procedures for dealing with tribunal applications, for instance the cont... of the reports which must be prepared, need to be somewhat abbreviated. Part VI of the rules therefore includes various provisions which apply only to tribunal proceedings involving patients detained for assessment and it also provides that certain rules applicable in all other cases shall not apply or only in a modified form.

MHRTs — WHERE TO FIND THE LEGAL PROVISIONS

	Class of patient	Power of discharge	Applications and references	Tribunal procedure
Unrestricted patients	*Patients detained for assessment*	Section 72(1)(a)	Sections 66–69(1)	Part VI of MHRT Rules 1983
	Patients detained for treatment	Section 72(1)(b)		MHRT Rules 1983
	Patients subject to guardianship	Section 72(4)		
	Patients subject or liable to supervision	Section 72(4A)		
Restricted patients	*Patients liable to be detained under a restriction order*	Section 73	Sections 69(2)-71	
	Patients liable to be detained under a restriction direction	Section 74		
	Conditionally dis-charged restricted patients	Section 75		

A TRIBUNAL'S POWERS (CHAP. 7 & CHAP. 8)

The decisions by which a tribunal may determine an application or reference — its powers — are limited by statute. Although it is common to leave their consideration until last they should as with any form of legal proceedings be addressed first. Before advising a patient whether to apply to a tribunal it is necessary to first consider if it has power to grant the form of relief sought. And, if an application is then made, the case strategy and preparation should focus on persuading the tribunal to exercise some power which it may lawfully exercise. Although there are several different routes by which a person may come to be liable to detention, guardianship or supervision under the Act, the purposes for which compulsory powers may be invoked and the reasons which justify their continuance are rather fewer. That being so, the Act divides the cases which a tribunal may consider into seven main categories for the purpose of defining its decision-making powers.

Unre... cted patients (Chapter 7)

1 Patients detained for assessment

2 Patients liable to be detained for treatment without restrictions

3 Patients subject to guardianship

4 Patients subject to after-care under supervision

Restricted patients (Chapter 8)

5 Patients liable to be detained for treatment and subject to a restriction order

6 Patients liable to be detained for treatment and subject to a restriction direction

7 Restricted patients who have been conditionally discharged

Patients detained in hospital for assessment

A tribunal's powers when dealing with the case of a patient admitted to hospital under section 2 are set out in section 72. A tribunal must discharge a patient whom it considers satisfies the statutory criteria for being discharged set out in section 72(1)(a) — "mandatory discharge." Where the mandatory discharge criteria are not satisfied, it may still discharge the patient at its discretion if it considers that is appropriate having regard to all the circumstances of the case — "discretionary discharge." A tribunal which discharges a patient may direct that the discharge take effect on a specified future date, rather than forthwith, regardless of whether discharge is mandatory or discretionary. A tribunal which does not discharge may, with a view to facilitating a patient's discharge on some future date, recommend that he be granted leave of absence, transferred to another hospital, or transferred into guardianship. In the event that its recommendation is not complied with, the tribunal may further consider the case. In summary, a tribunal is obliged to discharge if the relevant statutory criteria are satisfied, may in other cases discharge at its discretion and, where it does not discharge, may make certain statutory recommendations with a view to facilitating discharge in the future.

Unrestricted patients liable to be detained for treatment

The majority of patients who are detained in hospital for treatment are not subject to special restrictions. Whatever the original authority for such a patient's detention, the Act provides that tribunals shall apply the same discharge criteria and have the same powers in all cases involving unrestricted patients detained for treatment. A tribunal's powers are similar to those in respect of patients detained for assessment, so that the cases of all unrestricted patients are dealt with in a comparable way. In particular, a tribunal is required to discharge a patient who satisfies the statutory criteria for being discharged set out in section 72(1)(b), may at its discretion discharge a patient where this is not so and, if it does not discharge, may make the same kinds of recommendations as in a section 2 case. Discharge may, as before, either be forthwith or on a specific future date. There are, however, three important differences. When deciding whether to exercise its discretionary power of discharge, a tribunal must have regard to certain statutory matters set out in section 72(2). Furthermore, a tribunal which does not discharge may recommend that a supervision application be made; and it may also direct that the form of mental disorder from

which the patient is recorded as suffering on the authority for his de[illegible]ion be amended, so as to show that he is suffering from some other form. A similar power of reclassification would be superfluous in section 2 cases because all patients detained for assessment are classified as suffering from "mental disorder" generally rather than from one or more of its particular forms.

Patients subject to guardianship

Somewhat different statutory criteria and powers are required where a tribunal reviews the case of a patient who is subject to guardianship. Section 72(4) provides that a tribunal shall discharge a patient from guardianship if the criteria set out there are satisfied. As before, a tribunal also possesses a discretionary power to discharge a patient whom it does not consider satisfies the criteria for mandatory discharge. Because a guardianship application or order specifies the form of disorder from which the patient has been found to suffer, a tribunal has the same power to reclassify a patient whom it does not discharge from guardianship as it does an unrestricted patient detained for treatment. There the similarities end. A tribunal has no power to direct a patient's discharge from guardianship on a specified future date so that any discharge must take effect forthwith. Moreover, a tribunal which does not discharge a patient from guardianship has no power to make statutory recommendations with a view to facilitating his future discharge from guardianship. In part, this is because the recommendations which a tribunal may make when reviewing a patient's liability to detention would be irrelevant or inappropriate in guardianship cases. Recommending leave of absence would be otiose because a guardianship patient cannot be granted leave of absence. Similarly, recommending transfer to hospital would contravene the original statutory premise that a tribunal's functions in unrestricted cases are limited to discharging patients or facilitating their discharge. Except in so far as recently provided for by the 1995 Act, a tribunal has no power to further restrict a person's freedom.

Patients subject to after-care under supervision

The powers of a tribunal dealing with the case of a patient who is subject to after-care under supervision, or who is to be so subject when he leaves hospital, are the same as in guardianship cases. The tribunal must direct that the patient shall cease to be so subject if it is satisfied that the statutory criteria set out in section 72(4A) are not complied with. If this is not the case, the tribunal may still at its discretion direct that the patient shall cease to be subject to supervision. Where a tribunal does not direct that a patient shall cease to be subject or liable to supervision, it may reclassify the form of disorder from which he is recorded as suffering. As with guardianship, it has no power to make any statutory recommendations with a view to facilitating a patient's discharge from statutory supervision at a later date.

Patients admitted to hospital for treatment under a restriction order

The essence of a restriction order is that the usual powers by which a patient detained for treatment in pursuance of a hospital order may be discharged or granted greater freedom are restricted. This principle extends to tribunals so that its usual powers either do not apply or only in a restricted way. The single superficial similarity is that a tribunal must discharge a patient who satisfies the same statutory

criteria as apply to unrestrict[illegible] patients who have been detained for treatment. Because a tribunal has no discretionary power of discharge in restricted cases, it must discharge a patient whom it is satisfied meets the criteria for being discharged and not discharge a patient unless it is satisfied that is the case. Where a restriction order patient satisfies the mandatory discharge criteria, the discharge may be absolute or subject to conditions. The effect of conditional discharge is that the orders remain in force and the patient may be recalled to hospital for further treatment, for example if he relapses or fails to comply with the conditions of his discharge. Absolute discharge is mandatory where a tribunal is satisfied that it is not appropriate for a patient whom it must discharge to be liable to recall in this way and its effect is to bring both the hospital and restriction order to an end. Where a patient is conditionally discharged, it may be impossible for the conditions imposed on his discharge to be satisfied immediately. For example, where it is a condition of discharge that he resides at a supervised hostel but no suitable place is available. The Act therefore provides that a tribunal may defer a direction for a patient's conditional discharge until such time as it is satisfied that suitable arrangements have been made which meet the conditions imposed — "deferred conditional discharge." If it later transpires that arrangements cannot be made which allow the conditions attached to the patient's discharge to be satisfied, the tribunal's direction for the patient's discharge will eventually be deemed never to have been made. A tribunal's power in restriction order cases to defer the coming into force of a conditional discharge direction should not be confused with its power to direct the discharge of an unrestricted patient on a specified future date. In the latter case, the tribunal's direction discharging the patient is effective and complete the moment it is made; it is not provisional upon future events. A tribunal which does not discharge a restriction order patient from hospital has no power to make recommendations of the kind it may make in unrestricted cases and probably no power to reclassify. In summary, a tribunal may only discharge a restriction order patient who satisfies the statutory criteria for being discharged. Where that is not the case, and the patient is therefore not discharged, the tribunal has no power to make statutory recommendations nor, probably, to reclassify him.

TRIBUNALS' POWERS

	Unrestricted patients			Restricted patients
Powers and duties	Detained for assessment	Detained for treatment	Subject to supervision or guardianship	Detained for treatment under a restriction order
Mandatory discharge	•	•	•	•
Discretionary discharge	•	•	•	
Discharge on specified future date	•	•		
Statutory recommendations to facilitate discharge	•	•		
Recommendations re making supervision application		•		
Power to reclassify		•	•	?

Patients removed to hospital for treatment under a restriction direction

Section 47 provides that the Secretary of State may by warrant direct the transfer to hospital of a patient who is serving a sentence of imprisonment. Section 48 similarly provides that the Secretary of State may remove to hospital certain other categories of detained persons, such as defendants remanded in custody pending trial. In each case, the Secretary of State may, and in some cases must, also make a restriction direction under section 49. A tribunal's powers are further restricted where it considers the case of a patient who is liable to be detained for treatment and subject to a restriction direction. In essence, it must approach the case as if the patient were subject to a restriction order rather than a restriction direction. It must therefore apply the discharge criteria applicable in such cases and reach a finding as to whether, if that were the case, it would be obliged to direct the patient's absolute or conditional discharge. It must notify the Home Secretary of its finding. What then happens depends upon whether the patient is liable to be detained under section 47 or 48.

RESTRICTION DIRECTION CASES

Tribunal's findings, etc.	Section 47 patients	Section 48 patients
▪ *Patient does not satisfy the discharge criteria.*	Patient remains in hospital.	
▪ *Patient satisfies criteria for conditional discharge — MHRT recommends that patient not be remitted to custody as a result of its finding.*	Tribunal directs patient's conditional discharge if Secretary of State gives notice within 90 days that it may do so; otherwise patient remains in hospital.	Patient remains in hospital.
▪ *Patient satisfies criteria for conditional discharge — MHRT makes no recommendation about remission to custody.*	Tribunal directs patient's conditional discharge if Secretary of State gives notice within 90 days that it may do so; otherwise patient transferred to prison.	Patient remitted to custody — 90 day rule does not apply.
▪ *Patient satisfies criteria for absolute discharge.*	Tribunal directs patient's absolute discharge if Secretary of State gives notice within 90 days that it may do so. Otherwise patient transferred to prison.	

Restriction direction patients detained under section 48

Where a tribunal notifies the Home Secretary that a restricted patient detained under section 48 satisfies the criteria for absolute discharge, the Secretary of State must direct that the patient be remitted to prison or such other institution in which he might have been detained had he not been removed to hospital. Where a tribunal

instead notifies the Home Secretary that the patient satisfies the criteria for conditional discharge then, similarly, the Secretary of State shall remit him to custody under section 74 unless the tribunal also "recommended" that the patient should continue to be detained in hospital.

Restriction direction patients detained under section 47

Section 47 patients are in a somewhat more favourable position. Where a tribunal notifies the Secretary of State that the patient satisfies the criteria for absolute discharge, the tribunal shall so discharge the patient if, within the following 90 days, the Secretary of State serves notice on the tribunal that the patient may be absolutely discharged. Otherwise, at the expiration of that period, the managers of the hospital must transfer the patient to prison or to such other institution in which he might have been detained had he not been removed to hospital. Where a tribunal notifies the Secretary of State that a patient satisfies the criteria for conditional discharge, it may also "recommend" that he continue to be detained in hospital if the Secretary of State does not give notice that he may be conditionally discharged by the tribunal. If the Secretary of State serves notice on the tribunal within 90 days that the patient may be so discharged, the tribunal shall direct his conditional discharge, failing which the managers must transfer the patient to prison at the expiration of that period unless the tribunal "recommended" otherwise.

Conditionally discharged restricted patients

Where a tribunal considers the case of a restriction order or restriction direction patient who is not liable to be detained because he has been conditionally discharged, its ordinary power of discharge is self-evidently irrelevant — the patient has already been discharged. Section 75 therefore provides that a tribunal may do one of four things when dealing with such a case: make no direction at all, in which case the patient remains discharged on the same conditions as before; vary an existing condition of his discharge; impose a new condition of discharge; or direct that the restriction order or direction shall cease to have effect.

The limits of a tribunal's powers (Chap. 9)

Chapter 9 deals with three issues which are mainly of interest to lawyers. These are the burden and standard of proof in tribunal cases; whether a tribunal may have regard to irregularities in the authority for the patient's detention, guardianship or supervision; and the extent to which tribunal directions are binding.

TRIBUNAL PROCEDURE

The procedure to be adopted by tribunals when dealing with cases is that set out in the Mental Health Review Tribunal Rules 1983 although, as with all tribunals, the rules must be applied in accordance with the principles of fairness known as the rules of natural justice.

Commencing the proceedings (Chap. 10)

Where authorised by the Act, an application may be made by a patient, his nearest relative or by the person presently exercising the nearest relative's statutory functions. Rights of application vary according to the authority for the patient's

detention, guardianship or supervision. Patients' cases may also be refe[illegible] to a tribunal. Part V requires the hospital managers and the Secretary of State to do this if the patient has not had a tribunal for a certain period of time. It also gives the Secretary of State a discretion to refer cases at other times. Where an application is received from a section 2 patient, the tribunal must hear it within seven days. In other cases, there are no similar time limits. The tribunal will give notice that the proceedings have been commenced and decide whether it has power to postpone considering the case. If a prior application or reference is outstanding in respect of the same patient, the tribunal may join the proceedings. If the patient moves to the area of another tribunal during the proceedings, his case may be transferred to that tribunal. In certain circumstances, an application or reference may be withdrawn or deemed to be withdrawn.

Obtaining reports on the patient (Chap. 11)

In cases involving detained patients, the managers of the relevant hospital are what is known as "the responsible authority." The rules impose on the responsible authority and, in cases involving restricted patients, the Home Secretary, a duty to furnish a statement about the patient to the tribunal. The extent of this obligation, and the information and reports which the statement must include, are set out in the rules but, broadly speaking, a medical and a social work report is required in all cases. The grounds upon which part of a statement may be withheld from a patient, or a nearest relative applicant, are that the material's disclosure would adversely affect the patient's health or welfare or that of others. Rule 12(1) provides that the parties may submit written comments on the statement to the tribunal. Chapter 11 includes consideration of various matters relevant to the preparation of medical and social circumstances reports, including the legislation relating to the provision of social services; patients' finances; the preparation of independent reports and their disclosure.

Risk assessment and discharge planning (Chap. 12)

As has already been noted, the statutory criteria to be applied by a tribunal when determining whether a patient must be discharged always comprise at least two grounds, the second of which is directed towards the issue of risk. In particular, the likelihood of undesirable consequences if the individual is allowed a citizen's usual freedom to decide how to act and what medical treatment or social care to accept. Chapter 12 sets out the general principles of risk assessment and, in particular, assessments of the risk of suicide, homicide or serious violence. The remainder of the chapter is concerned with discharge planning, the aim of which is essentially to minimise acceptable risks. In relation to unrestricted patients, this involves considering the relationship between the plethora of enactments, directions, guidelines and codes concerning the discharge of patients and their after-care, following which the guidelines concerning the discharge and supervision of restricted patients are summarised.

Directions and other pre-hearing matters (Chap. 13)

Following the receipt and disclosure of the responsible authority's statement or that of the Secretary of State, the other formal stages in the proceedings prior to the hearing are giving notice of the proceedings; directing that further information or

reports be furnished when appropriate; giving any other directions necessary to ensure the speedy and just determination of the application; appointing the tribunal members; conducting the pre-hearing medical examination; and giving notice of the hearing. Each tribunal has a legal chairman whose most important functions are to exercise the tribunal's powers under the rules in relation to such preliminary or incidental matters.

The hearing (Chap. 14)

Hearings take place at the hospital where the patient is liable to be detained, most often in the board-room or a committee room. Rules 21 and 22 set out the basic hearing procedure. From a legal viewpoint, the issues to be considered are whether the hearing should or must be held in private or public; who is entitled, or may be required, to attend or appear; who may be excluded; the pre-hearing deliberations; the hearing itself and taking the evidence; the effect of irregularities in the conduct of the proceedings, including any failure to comply with the rules; the power to adjourn; and sanctions.

The tribunal's decision and appeals (Chap. 15)

The manner in which a tribunal reaches its decision, the recording of that decision and the reasons for it, and their communication to the parties, are subject to various procedural requirements set out in the rules. A decision may be set aside if the tribunal had no power to make it, it was founded on an error of law, it was reached in an unfair manner, it was irrational, or the reasons given for it were inadequate or unintelligible. If a tribunal's decision is legally flawed, it may be challenged by asking the tribunal to state a point of law for the High Court's determination or by way of judicial review. Habeas corpus is also considered in this chapter.

LEGAL REPRESENTATION (CHAP. 16)

Representation before tribunals is the norm and some 90 per cent. of patients in Wales are now legally represented. Rule 10 of the 1983 rules is concerned with representation, and it provides that an authorised representative may take all steps which his client is required by the rules to take and do all such things as his client is authorised by them to do. The other chapters of this book are in the form of a textbook, aiming to give a balanced and impartial account of the legal and medical considerations relevant to all practitioners, including tribunal members. The representative's role is not at all neutral, since it is to present a case for discharge in accordance with the client's instructions, and this one chapter therefore departs from that approach. Its aim is simply to assist lawyers in the preparation and presentation of tribunal cases, and the chapter commences with a detailed outline of the material covered. It is, however, worth emphasising two subjects here, for the benefit of those instructed to undertake their first case late in the day.

Formality and manner

Practitioners new to the field are often anxious about how they should approach and deal with people who have a serious mental health problem. In terms of professional conduct, the principles are the same as for any client attending the office — to serve

the client without compromising the solicitor's integrity or his overriding du[illegible]o the court and the judicial process. On a personal level, being able to take proper instructions, helping the client to formulate what it is he wants, and then pursuing those objectives in a constructive way, may require more empathy than is usually necessary in most other legal fields. It should be borne in mind that detained patients often feel uncomfortable and disadvantaged in a formal situation such as a interview. They may have low self-esteem, since much mental ill-health takes root in such ground, and, in other cases, a poor self-image is a necessary fertiliser of disease. The individual's false belief that his opinions are of no significance is potentially reinforced by being detained and so compelled to accept the views of others; by his subordinate status as a layman in discussion with a professional adviser; and by his status as an ill and irrational patient receiving a rational, sane, visitor. The client may be perplexed by the recent turn of events or by the ward routine. Containment on an acute psychiatric ward is a frightening, and in itself largely untherapeutic, experience at the best of times, the more so if the person is unfamiliar with the environment. Helping the client to relax and gaining his trust, by appreciating his predicament and treating him at all times respectfully and as an equal, are therefore prerequisites to making progress. The ways of responding to the individual's sense of humiliation at being categorised as mentally abnormal depend very much on how he himself has reacted to this slight. In some cases it helps to acknowledge that mental health is, like physical health, a relative term and that we are all at some level both well and ill, normal and abnormal, at any one time. With people who are seriously depressed, their feelings are often best understood as a bereavement — in some cases, a result of the death of another important person but more often their own death or the loss of something important within them. In cases involving mania, it is similarly valuable to appreciate that grandiosity cloaks feelings of inadequacy or depression — time and again, people in a manic phase say that they are not truly careless or content whatever their behaviour may superficially suggest. Whatever social approach is adopted, the use of medical adjectives to define the person rather than the condition affecting him is insulting, and akin to describing a person with leprosy as a "leper." To refer to someone as a "schizophrenic" or as a "paranoid schizophrenic" is to imply that his personality has been so distorted by the illness that the latter is now the feature which most tellingly defines him as a person. By implication, it is more accurate to describe him in this way than to say that he is a person who has an illness called schizophrenia. From there, it is quite easy for a lawyer to drift into seeing his contribution, and legal presumptions about human liberty, as having only a marginal relevance. To summarise, the usual principles governing the solicitor-client relationship apply and few problems will arise provided the solicitor is courteous and avoids being patronising.

Taking instructions

It is generally possible to take detailed instructions and a detailed interview avoids unpleasant surprises later. Where time permits, it is useful to maintain a reasonably comprehensive case summary. By observing and listening to the client and others, the representative can be aware of the strengths and weaknesses of his case, the likely content of the reports and oral evidence, and any inconsistencies between the client's account and objectives and what is observed. Except in wholly exceptional circumstances, the usual rules governing the solicitor-client relationship apply. The

Guide to the Professional Con[illegible]ct of Solicitors states that a solicitor is under a duty to keep confidential a client's affairs, but a solicitor also owes a duty to act in the best interests of the client. Whether departing from a solicitor's duty of confidentiality towards his client may ever be justified on this ground is disputed. Because many clients are willing to discuss their mental experiences more freely with their solicitor, partly because of the cloak of privacy, it is often the case that the solicitor is aware of mental phenomena not recorded in the case notes as being present and not aired at the hearing. The general view is, however, that a solicitor remains bound in all situations by the normal duty of confidentiality. If the solicitor knows that the patient is experiencing certain symptoms of mental disorder, he may not positively assert that that is not the case, even if this is the responsible medical officer's evidence. That would amount to misleading the tribunal. Accordingly, the position is analogous to that where a solicitor knows that a defendant in criminal proceedings has previous convictions. He may not describe him as being of good character simply because the court knows of none. The qualified view is that in wholly exceptional circumstances a solicitor would be justified in disclosing something told to him in confidence. For example, if a tribunal was clearly proceeding on the erroneous basis that there was no immediate significant risk of suicide or homicide. Finally, on the matter of professional conduct, the tendency of a few solicitors to practise their clients must be deplored. This form of contempt consists of telling the client which answers to questions invariably asked by tribunals are commonly interpreted as pointers towards discharge.

MEDICAL ISSUES

Because tribunal proceedings are a mixture of law and medicine, a purely legal approach to the work is unproductive, even for lawyers; it is not sufficient to understand only the legal part of what is a medico-legal subject. The rote-learning of definitions is, however, unhelpful. It is more useful to develop an appreciation of the concepts embraced by the terms; otherwise, what the individual propounds is not always clear even to himself. Furthermore, the tendency to regard legal and medical terms as having value-free fixed meanings, rather than as expressing concepts, is misplaced and merely reflects a failure to appreciate the problems which all professions experience in reaching agreement about ideas. In dealing with medical terms and concepts, priority has generally been given in the text to the views of leading British medical practitioners, such as Robert Kendell and Graham Bradley, and to definitions contained in internationally recognised medical publications such as the *International Classification of Diseases*.

MENTAL HEALTH AND MENTAL DISORDER (CHAP. 17)

Medical science approaches mental disorders as diseases which can be studied objectively in terms of abnormal cell structures and chemical imbalances. The practice of medicine consists of the application of knowledge concerning human biology to the prevention and treatment of illness. This is often referred to as the biomedical approach to mental disorder. Psychiatry is that branch of medicine concerned with the study, diagnosis, treatment and prevention of mental disorder.

Personality

Personality, as it is commonly understood, is what makes one individual different from another. It is the ingrained patterns of thought, feeling, and behaviour characterizing an individual's unique lifestyle and mode of adaptation, which result from constitutional factors, development, and social experience. An individual's personality both determines and reflects his unique adjustment to his environment, including the unique way in which he becomes mentally ill. Not all conditions characterised by abnormal mental functioning are, however, conceived of as an illness. Certain forms of mental disorder are categorised simply as being disorders of the personality. Here, the individual's abnormal mental state is considered to be the manifestation of his normal — if compared to other people abnormal — personality rather than the product of an illness overlying and distorting that personality.

The brain and the mind

The brain is the organ of the body within which thoughts, feelings, emotions, perceptions, sensations and moods are generated, experienced and memorised in response to stimuli received from the world outside it (the body and the environment). What we call mental states are functional states resulting from the complex interaction of our brain with the world outside it. By analogy, breathing is the interaction of air and the lungs. Although the concept of a mind is fundamental to the law, it is simply a term used either to describe either the brain's present functioning (synonymous in this sense with the individual's "mental state") or to describe its tendency to function and respond to events outside it in certain habitual ways (the individual's mind in this sense being synonymous with his personality). Ryle has observed that it is a striking feature of the brain that it does not have unlimited access to its own workings, so that the brain may submit itself to analysis and other forms of treatment over a lengthy period in an attempt to discover the cause or aims of its own processes.

THE BRAIN, MIND AND PERSONALITY

- *Brain* — The organ of the body within which thoughts, feelings, emotions, perceptions, sensations and moods are generated, experienced and memorised in response to stimuli received from the world outside it (the body and the environment).
- *Mind* — The way in which the brain functions, both in the present (an individual's mental state) and its tendency to function and respond to events outside it in certain habitual ways (the individual's personality — his tendency to certain mental states).
- *Mental state* — An individual's contemporaneous thoughts, feelings, emotions, perceptions, sensations, and mood.
- *Personality* — The whole system of relatively permanent abilities and tendencies distinctive of a given individual's brain.

Normal and abnormal health

A diagnosis of mental disorder implies a departure from a state of health and any consideration of what constitutes an individual's personality or mind necessarily leads on to the question of what constitutes an unhealthy or abnormal personality or mind. In practical terms, mental health may be described as that standard of mental functioning necessary for a person to perform the activities which are expected of him, according to the norms of the society in which he lives. Disability or handicap arising from disease, illness, or injury must be absent. For the scientist, the problem of defining what is abnormal is particularly acute when considering mental phenomena and, in such cases, distinctions between normal and abnormal states are ultimately arbitrary and prescriptive. However one defines what is normal, most individuals will be found to conform to the norm in relation to some but not all of their mental characteristics so that, when taken in aggregate, most of us fail to escape some departure from the norm. What we regard as illness or disorder appears to shade insensibly into normality so that abnormality may be the result of disease in some cases and in others the expression of variability.

Disorders

The term "disorder" is not an exact term but simply implies the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. In practice, the classification of certain disorders as mental or psychiatric is largely determined by the historical fact that these conditions have generally been treated by psychiatrists.

Illnesses

An "illness" may be seen as the difference between a person's current state of being and functioning and his state of health immediately prior to the onset of a decline in his health, whether subjectively or objectively apparent. It represents an interference with the individual's ability to discharge those functions and obligations that are expected of him. In conventional usage, "mental illness" is more specific than "mental disorder" because the latter term includes abnormal behaviour associated with or resulting from an individual's personality or limited intelligence.

MENTAL HEALTH ———— **MENTAL DISORDER**

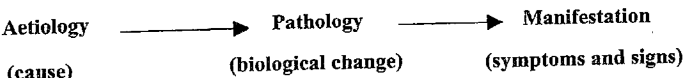
Mental Illness

Personality Disorder

Mental Impairment

Diseases and the disease model

The term "disease" may be taken to refer to a deterioration of health which results from disordered biological processes. More specifically, disease is a process involving undesired and unwilled changes either in the anatomy of the body or in the way a part of the body functions. A disease may also be described as an illness but not all illnesses are diseases — that is, not all illnesses are attributable to changes in the structure of the body, such as the brain, or to the way in which those structures function. The medical model of illness is dominated by the concept of disease, which may be depicted symbolically as a sequence —



Viewing this sequence in reverse, the patient's disease comprises symptoms and signs which are the manifestations of certain pathological changes in the structure or functioning of his body, changes initiated by a particular cause or causes (the aetiology). Many diseases are caused by exposure of the individual to environmental influences and social deprivation, and the characteristics of each individual, and each disease, are the results of the interplay of two basic factors: inherited genetic constitution and environment.

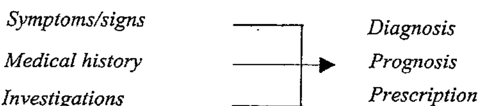
Aetiology

Aetiology is literally the study of causes and the aetiology of a disease consists of the postulated causes that initiate the disease process, control of which may lead to its prevention. Because the disease model holds that pathological bodily changes are the direct cause of the patient's symptoms and signs, the aetiology is therefore a step removed from this stage and refers to the causes of that pathology (disease process). Ideas about what causes mental disorder depend on how mental health and, by elimination, mental disorder are defined. Cause is inferred and involves a retrospective interpretation of the likelihood of an association between events. Failure to realise that what is regarded as having caused a person to become unwell depends on the perspective of the onlooker has led to many sterile debates about the causes of different kinds of mental disorder.

ASSESSING THE PRESENCE OF MENTAL DISORDER (CHAP. 18)

A person may be diseased but symptom-free, which is another way of saying that, following the onset of disease, pathological changes within the body may or may not make themselves evident. When they do, they are described as "manifestations" which, by medical custom, are usually distinguished as "symptoms and signs." A sign is an objective indication of a disease or disorder that is observed or detected by a doctor upon examining and interviewing the patient, in contrast to a symptom which is noticed or reported by the patient. However, in common usage, the term "symptoms" also includes objective signs of pathological conditions. The severity of a symptom can be rated on a number of different criteria, such as frequency, intensity, duration, tolerability or degree of incapacitation. The mental state

examination is equivalent to the detailed physical examination in general medicine and assessment is the process of collecting information relevant to the diagnosis, management, and treatment of a patient's clinical condition. It includes distinguishing or recognising the presence of a disease or disorder from its manifestations. The recording of a patient's symptoms, and the conduct of any special investigations, is initially undertaken to identify the type of disorder from which he suffers — symptoms being pointers towards the underlying pathology, and, following on from this, pointers both to the most appropriate form of treatment and the likely response to that treatment.



CLASSIFYING AND DIAGNOSING MENTAL DISORDER (CHAP. 19)

Diagnosis forms part of the assessment process and, in general usage, the term refers to the process of identifying the specific mental disorder from which the patient suffers. A diagnosis is a short-hand way of describing what is wrong with a patient and it involves assigning the patient's case to a particular known class, such as schizophrenia, by reference to an accepted classification of mental disorders. Classification is the grouping of things according to a logical scheme for organising and classifying them. Phenomena are assigned to designated classes on the basis of perceived common characteristics and particular diagnostic classes should be associated with particular prognoses and outcomes. The way in which the classification tree is constructed affects the results produced so that a person may meet the criteria for a diagnosis of schizophrenia set out in one classification but not another. Although acknowledged not to be particularly satisfactory, the symptomological approach to classification is by default used in psychiatry. Clusters of symptoms may be observed to occur in conjunction and to develop or remit according to a broadly identifiable pattern, persisting for a characteristic length of time. These clusters of symptoms therefore occur together as identifiable constellations or syndromes — "syndrome" being a Greek word meaning "running together." The syndrome can be named and classified, *e.g.* schizophrenia. Whether certain recognised syndromes do in reality represent distinct disease processes depends upon the correctness of the observations and inferences made about the way certain symptoms coalesce, as well as on the validity of this kind of disease reasoning. As matters presently stand, conditions such as schizophrenia are ultimately concepts the validity of which has yet to be demonstrated. The diagnostic methods used by different clinicians are not always comparable so that a patient's diagnosis but not his condition may change over time. This is because diagnoses are subject to therapeutic fashions and innovations and depend upon the classification and operational criteria being used. Providing a classification is used appropriately, it must ultimately be conceded that it embraces a different population of patients than do other competing operational criteria. Most studies suggest that agreement about the presence or absence of physical signs is not very good, much of the agreement being due simply to chance.

TREATMENT AND OUTCOME (CHAP. 20)

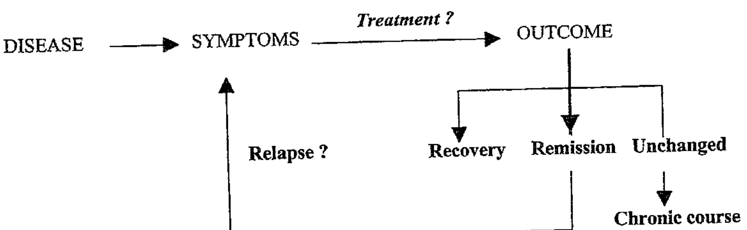
A prognosis is a medical assessment of the probable course and outcome of a patient's condition. It is assumed that each disease has a certain natural course although this can sometimes be interfered with by treatment. Consequently, the diagnosis of a particular disease enables the clinician to make an assessment of the likely outcome —a prognosis— and also to choose an appropriate form of treatment. While a diagnosis should provide therapeutic and prognostic indicators, in psychiatry these are often relatively weak and the actual outcome may differ from that prognosed.

Onset and course

The onset, course and duration of a disorder are often described as either acute or chronic. The term "acute" describes a disorder or symptom that comes on suddenly, may or may not be severe, and is usually of short duration. "Chronic" describes a disorder or set of symptoms that has persisted for a long time, rather than being of sudden onset and short duration; there is little discernible change in the symptomology from day to day.

Outcome

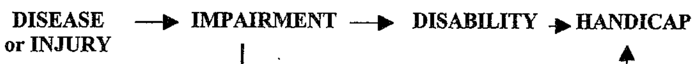
The outcome may be recovery; a complete or partial remission of the symptoms, sometimes followed by relapse; or characterised by chronicity, with little or no change in the presence or intensity of the patient's symptoms. Recovery (or "cure" where recovery follows treatment) describes the elimination of the disease or disorder producing the patient's symptoms. Remission denotes a temporary disappearance or reduction in the severity or symptomology of a disease or a period during which this occurs. A proportion of patients recover, or their symptoms remit, naturally for reasons other than any treatment administered to them. The residual phase of an illness is the phase that occurs after remission of the florid symptoms of the full syndrome. Relapse describes the recurrence of a disorder after an apparent recovery or a return of the symptoms after their remission. Sequelae are the complications of a disorder. For example, the sequelae of a cold may include bronchitis.



DESCRIBING THE OUTCOME

Describing the consequences for the individual

The *International Classification of Impairments, Disabilities and Handicaps* uses the terms impairment, disability and handicap to describe the consequences for the individual concerned of a disease or injury. All three concepts depend on deviations from norms. The sequence underlying illness-related phenomena is presented as follows:



An impairment is a permanent or temporary loss or abnormality of bodily structure or function. The fact that part of the body is impaired may or may not affect the individual's ability to perform different activities, but, if so, the impairment has a disabling effect. A disability is a restriction or lack of ability to perform *an activity* in the manner or within the range considered normal for a human being as a result of impairment. As in horse racing, the state of being handicapped is relative to others, so that a handicap is any disadvantage resulting from an impairment or disability which limits or prevents fulfilling *a role* that is normal for that person.

The treatment of mental disorder

The alleviation of suffering and the cure of the underlying condition causing the patient to suffer are the main goals of medicine. The treatment of mental disorder can be divided into five broad categories: surgical (psychosurgery); physical (ECT); chemical (psychotropic drugs); psychological (nursing, psychological and social therapy); and complementary ("alternative" remedies). Procedures such as seclusion and continuous observation are not generally regarded as forms of treatment, merely ways of isolating or protecting a patient who requires treatment. To treat a person suffering from disease or disorder is not the same thing as to cure him. Most drugs prescribed to treat psychiatric disorders are equivalent to the chemical sprays used by gardeners to control the more extreme, unwanted, external manifestations of a diseased or poorly nourished plant. There are few if any specific treatments in psychiatry. Depressive, schizophrenic and manic illnesses may all respond to ECT; schizophrenic and manic illnesses both respond to neuroleptics; depressive and anxiety states both respond to cognitive psychotherapy; and so on. Likewise, a seemingly common disorder may respond to a number of different treatments.

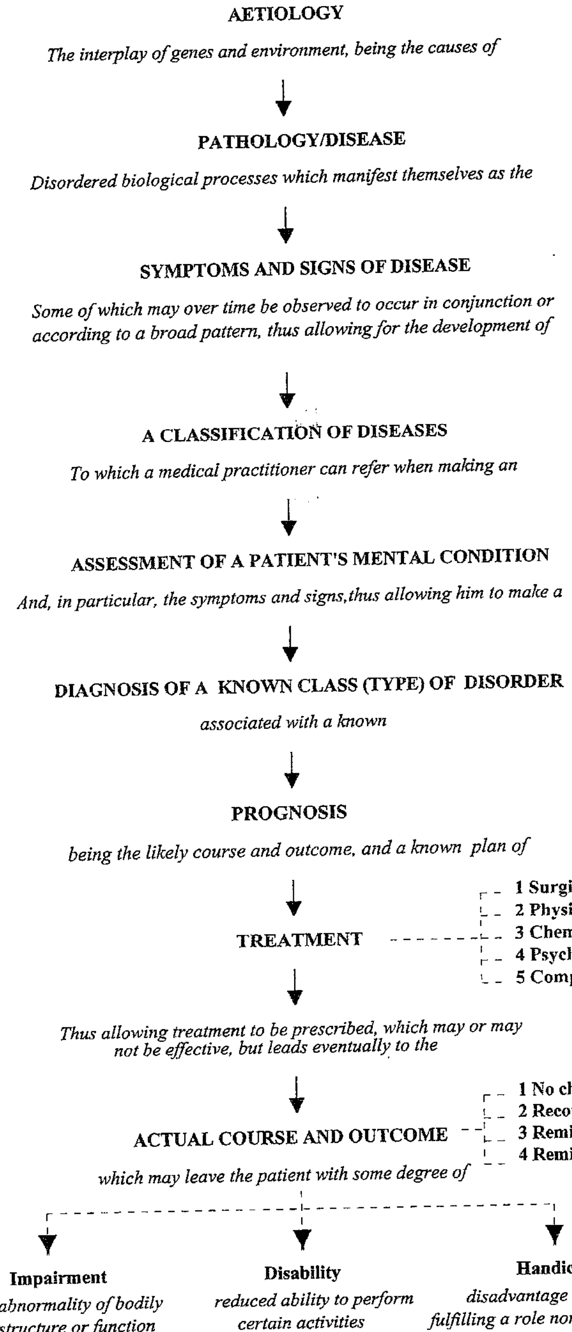
Psychosurgery

Psychosurgery is little used and largely reserved for the management of patients with chronic obsessional and depressive disorders which have not responded to prolonged treatment with more usual therapies.

Electro-convulsive therapy

Electro-convulsive therapy is generally considered to be the first line of treatment where a depressive illness is associated with life-threatening complications, such as failure to eat and drink or a high risk of suicide, or the patient is unable to tolerate antidepressant medication in high doses.

REVISED BIOMEDICAL MODEL



Medication

The traditional division of psychotherapeutic drugs according to their actions is as follows: (1) antipsychotics, (2) antidepressants, (3) antimanics, (4) antiepileptics, (5) anxiolytics, and (6) hypnotics. Optimizing the results of drug therapy involves applying the five Ds : diagnosis, drug selection, dose, duration and dialogue. A prescribed drug may bring about a satisfactory response, have inadequate effect, or have intolerable side effects. Treatment failure is determined by treatment aims and expectations. In the case of compliant patients, the two most important causes of treatment failure involving psychotropic drugs are underdosing and an inadequate therapeutic trial of a drug. Different patients require different amounts of a drug for optimal therapeutic effect. No standard dose exists and the correct dose must be determined empirically. The British National Formulary contains recommended guideline maximum doses for most drugs, with separate guidance for special categories of patients such as the elderly, children and pregnant women. Although virtually all available drugs are equivalent in overall efficacy, they differ immensely in how well they are tolerated and how lethal they are in overdose. Accordingly, the most important reasons to choose a drug are often its relative side-effect profile and safety. Ways of dealing with adverse effects include withdrawing the medication causing the undesired effects and (if necessary) substituting an alternative drug for the target condition; reducing the dosage; and treating the unwanted symptoms.

SUMMARY OF BASIC CONCEPTS

The final chapters consider those medical conditions most commonly encountered in tribunal proceedings: personality (psychopathic) disorders; mood disorders; schizophrenia; and a range of organic disorders. Some compromises are inevitable. The approach adopted here is to consider in detail those conditions most commonly encountered in tribunal practice, rather than to consider, in correspondingly less detail, all those conditions which may sometimes be encountered. Before moving on, it is, however, helpful to draw together the main concepts, and a flowchart showing the various sequences of the biomedical model appears on the previous page. When an individual has been denied his liberty, clarity of thought is essential and the medical evidence said to warrant such an interference may be systematically scrutinised with this flowchart in mind. Sometimes, of course, the patient's behaviour is so grossly disturbed that the predominant issue is straightforward, being whether his behaviour can be managed outside a hospital setting or without resort to compulsion. However, in many cases, the issues are more subtle. They revolve around questions such as the prognosis and the likelihood of any improvement made being maintained; the causes of the current episode of illness and whether relapse is likely because those causes remain unaddressed; whether the symptoms justify the diagnosis and, if not, whether an alternative diagnosis is associated with a more favourable prognosis; whether the patient is disabled or handicapped and the required level of support outside hospital. While tribunals sometimes assert that they are not concerned with the diagnosis, because there is no dispute about the fact that the legal form of mental disorder from which the patient suffers is mental illness, it can be seen that this is not correct. If the medical evidence has any weight as medical evidence, rather than as a mere record of observed behaviour, this additional weight can only stem from an acceptance of the validity of the biomedical model. This is the structure supporting the doctor's inferences and opinions about the likely medical and social consequences of not accepting his opinion, and the foundation of his claim to expertise. If a medical practitioner's opinion deserves this expert status,

but it is then established that a particular patient's condition has been misdiagnosed, the grounds upon which the patient's detention and compulsory treatment have been justified at best require reformulation. For the biomedical model dictates that a certain diagnosis is associated with a particular treatment plan and prognosis, that is a particular mode of proceeding. Materially different facts necessitate materially different conclusions.

PERSONALITY DISORDERS (CHAP. 21)

The concept of personality implies a certain cohesion and consistency of the personality as a backdrop upon which the vicissitudes of illness and other circumstances may make transitory patterns, but the underlying features remain constant. The terms "personality disorder" and "behaviour disorder" are often used interchangeably, mainly because the nature of an individual's personality is frequently inferred from his behaviour. However, any particular kind of profoundly disturbed behaviour can be exhibited by more than one personality group with different mechanisms pertaining to each. Moreover, whether or not an abnormality of personality actually manifests itself in the form of disordered behaviour, and is defined as a personality disorder, depends to a considerable extent on social circumstances. Definitions of personality disorder are usually value-based. A person is considered to have an abnormal personality if he has to an excessive extent a personality trait which is considered to be undesirable (*e.g.* aggression) or possesses insufficiently a trait considered necessary for a person to be normal (*e.g.* empathy). The section of the International Classification of Mental and Behavioural Disorders (ICD–10) which deals with "disorders of adult personality and behaviour" subdivides them into various types according to clusters of traits that correspond to the most frequent or conspicuous behavioural manifestations. These sub-types are considered to be widely recognised as major forms of personality deviation.

Paranoid personality disorder

A paranoid personality disorder is characterized by excessive sensitivity to setbacks and rebuffs; a tendency to bear grudges; suspiciousness and a pervasive tendency to misconstrue the neutral or friendly actions of others as hostile or contemptuous.

Dissocial personality disorder

A dissocial personality disorder is a personality disorder which usually comes to attention because of a gross disparity between behaviour and the prevailing social norms and is characterized by callous unconcern for the feelings of others; gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations; incapacity to maintain enduring relationships, though having no difficulty in establishing them; very low tolerance to frustration and a low threshold for discharge of aggression, including violence; incapacity to experience guilt and to profit from experience, particularly punishment; marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society. From a medical viewpoint, the term "dissocial personality disorder" is synonymous with psychopathic disorder. There has never been any consensus about whether psychopathic disorder is an illness with social consequences which can be treated medically or a social condition which needs to be managed or addressed in a non-medical environment. These differences of opinion are linked to different ideas about responsibility and free will and the extent to

which the personalities of some people do not enable them to resist or to refrain from anti-social conduct. Various treatment strategies have been suggested although none of them has been shown to be effective in a controlled evaluation. The options include psychotherapy and treatment in a therapeutic community.

MOOD DISORDERS (CHAP. 22)

In mood disorders, the fundamental disturbance is a change of mood to elation or depression (with or without associated anxiety). This mood change is normally accompanied by a change in the overall level of activity and most other symptoms are either secondary to, or easily understood in the context of, such changes. Most of these disorders tend to be recurrent and the onset of individual episodes is often related to stressful events or situations. Mood disorders tend to be cyclic in nature, with stable seasonal fluctuations in the incidence of suicide, and many depressed people experience diurnal variation of mood.

Mood and affect

A distinction is often drawn between an individual's mood and his affect. A person's affect is how he appears to be emotionally affected by a particular idea or mental representation; for example, he is happy, sad or indifferent upon being given certain news. Mood is the pervasive and sustained emotion which colours an individual's whole personality and perception of events.

Unipolar and bipolar disorder

Depression and mania may be viewed as lying at two opposite poles and classifications of mental disorder generally distinguish between unipolar and bipolar mood disorders. According to the classical model, the disturbed mood of some people will be confined to either depression or mania — unipolar disorder. The mood of other individuals is more variable, sometimes located at one pole (depression), sometimes at the other (mania). Mood disorders characterised by fluctuations of this kind are referred to as bipolar disorders and the patient's history characteristically includes one or more episodes of both depression and mania. However, it now seems to be the case that some 80–90 per cent of patients experiencing mania will eventually experience a full depressive episode, although the converse is not also true — only 10 per cent of patients suffering from depression will later have a manic episode. It is therefore relatively rare for patients to suffer only from repeated episodes of mania and even these patients resemble those who have at least occasional episodes of depression in terms of their family history, premorbid personality, age of onset, and long-term prognosis. Because this is so, patients who experience a second manic episode are, according to the ICD–10 classification, reclassified as suffering from a "bipolar affective disorder" rather than from recurrent manic episodes, despite the absence of any history of intervening depression.

Depressive episodes

The classification of depressive episodes specifies three levels of severity — mild, moderate, and severe. Severe depressive episodes are of two kinds — severe depressive episode without psychotic symptoms and and severe depressive episode with psychotic symptoms The management of severe depressive episodes may

necessitate hospital admission and, if there is a significant risk of suicide, continuous observation. In-patient treatment almost invariably includes medication or ECT. Cognitive therapy or some other kind of psychological treatment may be indicated and several trials suggest that the relapse rate following cognitive therapy is lower than after drug treatment alone. In rare, intractable, cases psychosurgery is occasionally offered. The outcome for mood disorders is generally more favourable than for schizophrenia.

Manic episodes

Manic episodes are characterised by elevated mood and an increase in the quantity and speed of physical and mental activity. They usually begin abruptly and last for between two weeks and four of five months, with a median duration about four months. The risk of recurrence is high, particularly if the first episode occurs before the age of 30 years, although recovery is usually complete between episodes. Three degrees of severity of manic episode are specified in the ICD classification, all of which share the common underlying characteristics of elevated mood and an increase in the quantity and speed of physical and mental activity: hypomania; mania without psychotic symptoms; and mania with psychotic symptoms. Treatment may require hospitalisation and three different drugs are widely used — chlorpromazine, haloperidol and lithium. The first line of treatment in an acute manic episode is antipsychotic medication (*i.e.* chlorpromazine or haloperidol), often in conjunction with an anti-manic or mood-stabilising drug, such as lithium.

SCHIZOPHRENIA AND RELATED PSYCHOSES (CHAP. 23)

The majority of people detained under the Mental Health Act 1983 are diagnosed as suffering from a form of mental illness known as schizophrenia. Schizophrenia is commonly thought of as a psychiatric term for a range of experiences which the majority of the population describe as "madness." Beyond the public perception, what schizophrenia is is difficult to define and it is impossible to point to any single defining pathology, symptom or cluster of symptoms, common to all people so diagnosed. It is therefore important to realise at the outset that schizophrenia is a model the validity of which has yet to be demonstrated. For introductory purposes, the description of schizophrenia in the International Classification of Diseases gives an idea of the broad range of experiences associated with the diagnosis:

> "The schizophrenic disorders are characterised in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect ... The most intimate thoughts, feelings, and acts are often felt to be known to or shared by others, and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts and actions in ways that are often bizarre. The individual may see himself or herself as the pivot of all that happens. Hallucinations, especially auditory, are common and may comment on the individual's behaviour or thoughts ... Perplexity is also common early on and frequently leads to a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual. In the characteristic schizophrenic disturbance of thinking ... thinking becomes vague, elliptical, and obscure, and its expression in speech sometimes incomprehensible. Breaks and interpolations in the train of thought are frequent, and thoughts may seem to be withdrawn by some outside agency. Mood is characteristically shallow, capricious, or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism, or stupor. Catatonia may be present."

Paranoid, hebephrenic and catatonic schizophrenia

Three sub-types of schizophrenia have classically been recognised: paranoid, hebephrenic and catatonic. However, the persons assigned to each of the three categories show a marked variability both in terms of their symptoms and outcomes. Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are absent or relatively inconspicuous. Hebephrenic schizophrenia is a form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate, thought is disorganised, and speech is incoherent. There is a tendency to social isolation. Catatonic schizophrenia is dominated by prominent psychomotor disturbances that may alternate between extremes such as hyperactivity and stupor, or automatic obedience and negativism. Constrained attitudes and postures may be maintained for long periods. Episodes of violent excitement may be a striking feature.

Course, outcome and treatment

Historically, schizophrenia was believed to run a progressive downhill course while affective disorders relapsed repeatedly but recovered fully each time. However, the outcome varies between prolonged recovery, an intermittent course, and prolonged psychosis of severe or mild degrees. Approximately one-third of patients diagnosed as suffering from schizophrenia completely recover from their illnesses, one-third show an intermediate outcome, and in one-third of cases the illness takes the traditional deteriorating course. It is not possible to predict which patients will respond to antipsychotic medication, or to distinguish those patients who will make a natural recovery from those who will require medication in order to improve. It appears that the number of patients receiving medication who relapse within a given period is about half that of patients taking a placebo. Nevertheless, medication probably only postpones rather than prevents relapse. Medication and social intervention appear to produce the best outcome and psychotherapy adds little. The major therapeutic effects of antipsychotic drugs are seen when used to treat acute psychoses. Their effects include a reduction of positive symptoms such as hallucinations, delusions and thought disorder. There is also a normalisation of psychomotor disturbance (excitement or retardation) and information processing. Antipsychotics are also used in the long-term treatment of patients in remission (maintenance therapy).

ORGANIC DISORDERS (CHAP. 24)

Chapter 24 describes the brain and nervous system and deals with organic disorders commonly arising in old age, such as dementia; epilepsy; endocrine disorders; and toxic disorders.

Disorders commonly affecting older people

Older people experience the same range of mental disorders and mood disorders contribute up to half the workload of a comprehensive psychogeriatric service. Compulsory admission is used for about five per cent of people aged 65 or over who come into psychiatric wards. Delirium is a state of acute mental confusion

characterized by impairment of consciousness which manifests itself as reduced clarity of awareness of the environment. It is quite common among older people, particularly those with concurrent physical illness. Dementia is not a single disease but a generic term covering numerous conditions that have certain clinical features in common. More particularly, it is a syndrome associated with a variety of diseases in which there is degeneration and atrophy of the brain. The characteristics of a dementing illness are global intellectual impairment (impairment of several aspects of cognition at the same time) and preservation of clear consciousness. Memory impairment and loss of intellectual capacities are severe enough to interfere with social or occupational functioning. In the majority of cases, the type of dementia is established as Alzheimer's disease, which is found at post-mortem in 60 per cent of deceased hospitalized patients previously diagnosed as having dementia. Cerebro-vascular disease including strokes is established as the cause in a further 20 per cent of cases and a combination of the two in another 10 per cent. Both diagnoses are presumptive and must await confirmation after death.

Epilepsy

About 4–6 persons per thousand suffer from epilepsy and patients are said to have epilepsy if they have a chronic condition characterised by recurrent seizures. Seizures are characterised by abnormal electrical activity in the brain. Anti-convulsive drugs form the mainstay of treatment.

Endocrine disorders

The endocrine system consists of a collection of glands that produce hormones, secreting them directly into the bloodstream. A hormone is a chemical messenger which, having been formed in one organ or gland, is carried in the blood to a target organ or tissue where it influences activity. Endocrine disorder can be accompanied by prominent mental irregularity and epochs of life marked by endocrine change, such as pregnancy and the menopause, appear to be associated with special liability to mental disturbance. With some endocrine disorders, such as myxoedema and Addison's disease, the psychiatric abnormalities are regularly intrusive to such a degree that there is a constant risk of mistaken diagnoses.

Toxic psychoses

The taking of certain drugs and the abuse of alcohol may adversely affect the user's mental state. It may initially be unclear whether the ingestion of illegal drugs has triggered an episode of mental illness, which may then be prolonged, or whether the symptoms will begin to subside once the drug exits the body. Prolonged high doses of amphetamines may lead to a mental state indistinguishable from paranoid schizophrenia. Some studies suggest that excessive use of cannabis over long periods of time can cause psychiatric disturbance but the evidence is inconclusive. The effects of cocaine are similar to those of amphetamines and it blocks the re-uptake of dopamine. Euphoria is usually the predominant change of mood associated with LSD but this may be followed later by sudden swings to depression, panic or a profound state of desolation. The psychoses which follow are usually of schizophrenic type. Wernicke's Encephalopathy is an *acute* organic reaction to severe thiamine deficiency, often resulting from alcoholism combined with an inadequate food intake. Wernicke's Encephalopathy may progress to the *chronic* condition known as Korsakoff's psychosis, from which only about 20 per cent. of patients recover. Here, there is profound impairment of recent memory.

NAL REMARKS

A free man is he that is not hindered from doing that which he has the will to do. By liberty we mean a power of acting or not acting according to the determination of the will and this hypothetical liberty is universally allowed to belong to everyone who is not a prisoner and in chains.[19] Mere incapacity to attain a goal is not lack of freedom, it being nonsense to say that a person is not free to do that which he is in any case incapable of doing. Liberty is therefore the area within which an individual can act unobstructed by others and coercion implies the deliberate interference of other human beings within the area in which they would otherwise act.[20] The words freedom and liberty are interchangeable and to coerce a man is to deprive him of freedom.[21] The wider the area of non-interference the wider a person's freedom and the disagreement historically has been about how wide this area should be. The goal is equality of liberty insofar as circumstances permit. Complete liberty, that is anarchy, where the individual free from any control or restriction is free to do or not to do according as he chooses, leads but to boundless interference with others, the suppression of the weak by the strong, injustice, inequality. The fulfilment of some of our ideals (such as justice) makes the fulfilment of others (such as liberty) impossible, such that the notion of total human fulfilment is a formal contradiction. No one can be absolutely free and all must give up some of their liberty to preserve the rest, but total self-surrender is self-defeating. Furthermore, the liberty of some at times depends on the restraint of others in that the freedom of some must at times be curtailed to secure the freedom of others. Where there is no law there is no freedom or justice and certain actions are worse for us than the amount of restraint needed to repress them. The "extent of a man's, or a people's, liberty to choose to live as they desire must be weighed against the claims of many other values, of which equality, or justice, or happiness, or security, or public order are perhaps the most obvious examples."[22] Whether individuals "should be allowed certain liberties at all depends on the priority given by society to different values and the crucial point is the criterion by which it has to be decided that a particular liberty should or should not be allowed, or that its exercise is in need of restraint."[23] In the context of legislation concerning mental health, the importance to members of society of individual liberty, of protecting them from harm arising from laws which permit considerable freedom of action, of protecting incapacitated persons from exploitation or self-harm, of alleviating suffering and illness, and of restoring to health those members of society whose health has declined, are all legitimate aims, in that they reflect values embraced by virtually all members of society. But "we are faced with

[19] D. Hume, *An Enquiry concerning Human Understanding* (ed. Sir L.A. Selby-Bigge, Oxford University Press, 1893), p.95.

[20] John Stuart Mill, *On Liberty* (Wm. Collins Sons & Co. Ltd., 1962, first publ. 1859), p.135. Mill was of the opinion that the "only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant ... Over himself, over his own body and mind, the individual is sovereign." This passage, often quoted in articles on mental health legislation, seems to have most often been read from a secondary source, because no reference is ever made to the important qualification which forms the first sentence of the very next paragraph: "It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties ... Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury."

[21] Sir Isaiah Berlin, *Four Essays on Liberty* (Oxford University Press, 1969). The summary here is largely based on the essay, "Two Concepts of Liberty," first published in 1958.

[22] *Ibid.*, p.170.

[23] R.W.M. Dias, *Jurisprudence* (Butterworths, 5th ed., 1985), p.109.

choices between ends equally ultimate, and claims equally absolute, the [illegible]lisation of some of which must inevitably involve the sacrifice of others. Indeed, it is because this is their situation that men place such immense value upon the freedom to choose."[24] The temper of our own times is such that the current emphasis in mental health practice is very much on public safety, rather than individual liberty, and recent mental health legislation is to be construed with regard to this fact. Nevertheless, the enduring impression left after spending many years visiting psychiatric wards is not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which, if mentally beneficial, often produces severe physical discomfort, and may physically disable for life, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation. Equally remarkable is their striving to be free members of society after many years outside society, even when many other higher faculties are profoundly impaired. A hospital is not a prison but for the individual concerned both involve detention and a complete loss of that right most important to him, so that Byron's words — "Eternal spirit of the chainless Mind ! / Brightest in dungeons, Liberty ! thou art" — are often an apt description of the individual's predicament. This desire for autonomy, and many people cannot conceive of a life which is worthwhile and fulfilling without such self-determination, is not to be confused with any desire to abuse liberty, and so not to be caught up in the contemporary controversies about how the law should respond to those who show a disregard for the law and for civic responsibility. On the one hand stands liberty, a right which the law should always favour and guard, on the other licence, a use of liberty to contravene the law, which the law must of necessity always punish. While it is not infrequently necessary to deprive an individual of his liberty on the ground of mental disorder, and one must have the courage to do that where necessary, one must always be appreciative of the enormity of the act — of the fact that the right enjoyed by those others present, and denied to this individual, is the most important right known to English law. While there is broad agreement that tribunals have carried out their functions conscientiously, the conduct of an independent review months after the commencement of a person's detention can never adequately compensate him for the loss of the right to judicial hearing before the event. Nor, when a person has been detained under an administrative procedure, can it be just to provide that he is not entitled to be released unless he can satisfy a court of law that there are no grounds in law for detaining him — if his detainers cannot show the existence of grounds for his detention then it is objectionable to continue to detain him merely because he cannot demonstrate their absence.

[24] Sir Isaiah Berlin, *Four Essays on Liberty* (Oxford University Press, 1969), p.168.

PART II — THE LAW