

have the effect of making the diagnosis less likely, the clinician often ignores this evidence.⁶¹

- Even if no inappropriate emphasis is placed on particular clinical findings, a clinician's inexperience may nevertheless result in failure to consider the correct diagnosis in the first place.
- Conversely, clinical experience may occasionally be disadvantageous. While analytical methods are slower but potentially more accurate, particularly for the complicated cases, the doctor who is experienced in the task in hand is more likely to use intuitive methods with a resulting advantage in speed. Nevertheless, "it is as well to remember that whilst experience can be the mainstay of diagnostic skill, overreliance on it can lead to nothing more than making the same mistake with increasing confidence."⁶²

DISADVANTAGES OF DIAGNOSIS

Kendell has summarised some of the main disadvantages involved in giving a patient a diagnosis.⁶³ In the first place, most psychiatric diagnoses have pejorative connotations. A diagnosis of schizophrenia or psychopathic disorder may have a particularly harmful effect on the patient's self-esteem and the attitude and behaviour of others towards him. Secondly, attaching a name to a condition may create a spurious impression of understanding. However, to say that a person has schizophrenia "actually says little more than that he has some puzzling but familiar symptoms which have often been encountered before in other patients."⁶⁴ Thirdly, all too often doctors reify the diagnostic concept and treat the "disease" instead of trying to relieve their patient's symptoms, anxieties and disabilities.

DIAGNOSTIC FORMULATIONS

A diagnostic formulation is not the same thing as a diagnosis. For the reasons given, a diagnosis may be an inadequate means of conveying what the clinician regards as the essence of the patient's predicament — why he broke down, in that particular way, at that particular time. A diagnostic formulation involves considering and then specifying these important elements of the case in a short account. Formulation and diagnosis are equally necessary, but for quite different purposes — "... the idea that a diagnosis can, or should, be replaced by a formulation is based on a fundamental misunderstanding of the nature of both. A formulation which takes account of the unique features of the patient and his environment, and the interaction between them, is often essential for any real understanding of his predicament, and for planning effective treatment, but it is unusable in any situation in which populations or groups of patients need to be considered."⁶⁵

⁶¹ G.A. Gorry, *et al.*, "The diagnostic importance of the normal finding" *New England Journal of Medicine* (1978) 298: 486-489; G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993), p.55. Indeed, it is of fundamental importance in tribunal proceedings to establish and list all of the operational criteria which are not present in the particular case. All too often, a long interview is summarised in two lines stating that features *a* and *b* were elicited during examination, while the fact that features *c* to *m* were not elicited is implied but goes unrecorded.

⁶² G.W. Bradley, *Disease, Diagnosis and Decisions* (*supra*), p.68.

⁶³ R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.278.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*, p.277.

20. Treatment and outcome

INTRODUCTION

It has been noted that assessment is the process of collecting information relevant to the diagnosis, management, and treatment of a patient's clinical condition. 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 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. Conclusions can then be reached about the causes, probable course, and treatment of the condition in question. All diagnostic concepts ultimately stand or fall by the strength of the prognostic and therapeutic implications they embody. However, while a diagnosis should provide therapeutic and prognostic indicators, in psychiatry these are often relatively weak.

Aetiology Pathology Symptoms Diagnosis Prognosis Treatment Outcome

It is therefore 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 choose an appropriate form of treatment and to make an assessment of the likely outcome (a prognosis). The actual outcome may differ from that prognosed. Various terms are used to describe the consequences of an illness in terms of the individual's ability to carry out his normal activities (e.g. disability and handicap) and the effect which treatment, including the body's own treatments, has on the underlying disease process (e.g. remission).

PREDICTING THE COURSE AND OUTCOME

A prognosis is a medical assessment of the probable course and outcome of a patient's condition. Certain disorders have been found to have a natural course and outcome and to respond best to certain treatments. By noting the timing of critical events for each patient with a particular disease — for example, dates of diagnosis, the development of further manifestations, and death — its progression can be subdivided into phases. When summarised over many patients, estimates of the typical sequence of events, the "natural history" of the illness, can be constructed.¹

¹ R.S. Greenberg, *Medical Epidemiology* (Appleton and Lange, 1993), p.7.

For example, 90 per cent. of people with small cell carcinoma of the lung will die within five years of the condition developing. However, even when the ultimate outcome may be predicted with some confidence, the actual sequence of events can vary widely among patients because such predictions are based on the experience of other patients.²

DESCRIBING ONSET, COURSE, DURATION AND OUTCOME

The onset, course and duration of a disorder are often described as either acute or chronic. The outcome may be recovery; a complete or partial remission of the symptoms, sometimes followed by relapse; or chronic, with little or no change in the presence or intensity of the patient's symptoms.

Onset and duration

The term "acute" describes a disorder or symptom that comes on suddenly, may or may not be severe, and is usually of short duration. In the context of severe mental illness, the ICD-10 classification defines acute onset as "a change during a period of a fortnight or less from a state without psychotic features to an obviously abnormal psychotic state." When such a change occurs with a period of 48 hours, the onset is said to be "abrupt."³ "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 symptomatology from day to day:

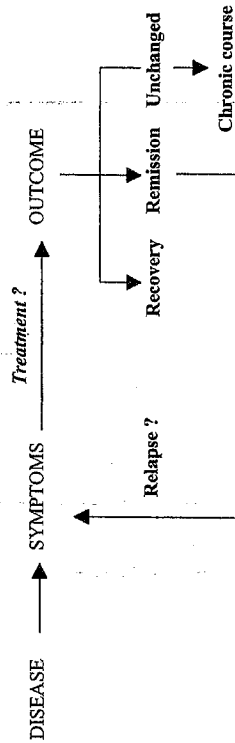
"The onset is usually insidious; there may be a gradual progression of symptoms, or more permanent problems may develop as the sequel to a number of acute episodes. Confidence and hopes are undermined; the experience is usually difficult to account for, no end is in sight, and self-perception — the sense of identity — is assaulted by changes in the body and its functional performance ... the persistence of problems implicitly reveals limitations in the potency of medical treatment, so that professional advice is often accepted with less assurance ... The prevalence of chronic conditions may be high, but their incidence is relatively low ... the multidimensional quality of problems encountered in people with chronic illness tends to promote needs-based appraisals, which carry with them potentially inflationary consequences for health and welfare services."⁴

The term "sub-acute" is sometimes used to describe a disorder which runs an intermediate course in time, between acute and chronic. Classically, acute onset culminates in a crisis so that acute conditions are severe in terms of their intensity while the severity of chronic conditions lies in their duration and limited response to treatment.⁵ It should, however, be emphasised that chronic conditions may have intermittent acute exacerbations.

² R.S. Greenberg, *Medical Epidemiology* (Appleton and Lange, 1993), p.6.
³ *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD-10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), pp.99-100.
⁴ *International Classification of Impairments, Disabilities, and Handicaps: A manual of classification relating to the consequences of disease* (World Health Organisation, 1976), p.24.
⁵ Thus, "professional usage of the words remains closer to their etymology. Thus 'acute' means 'ending in a sharp point', implying a finite duration, which, classically, culminates in a crisis. On the other hand 'chronic', which is derived from a word meaning 'time', indicates 'long-continued.'" *Ibid.*, p.23.

DESCRIBING THE OUTCOME AND RESPONSE TO TREATMENT

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 symptomatology 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, e.g. the sequelae of a cold may include bronchitis.



THE CONSEQUENCES FOR THE INDIVIDUAL

According to the World Health Organisation, the disease model of mental disorder (1038) is "incomplete because it stops short of the consequences of disease. It is the latter, particularly, that intrude upon everyday life, and some framework is needed against which understanding of these experiences can be developed; this is especially true for chronic and progressive disorders."⁶ The *International Classification of Impairments, Disabilities and Handicaps* therefore uses the concepts of impairment, disability and handicap to describe the consequences of disease or injury.⁷ All three of these concepts depend on deviations from norms.⁸

IMPAIRMENT, DISABILITY AND HANDICAP

The sequence underlying illness-related phenomena is presented as follows:⁹



⁶ *International Classification of Impairments, Disabilities, and Handicaps: A manual of classification relating to the consequences of disease* (World Health Organisation, 1976), pp.10-11.
⁷ *Ibid.* In this section of the text, I have departed from the way in which the International Classification treats the issue of bodily injury, such as the loss of a limb, but the changes are not particularly significant.
⁸ *Ibid.*, p.33.
⁹ *Ibid.*, pp.11, 25-27.

The sequence of events presented in this graphic may be interrupted at ... stage: an impaired person may never become disabled and, likewise, a disabled person may not become handicapped. Indeed, the value of presenting the concepts in this way is that "a problem-solving sequence is portrayed, intervention at the level of one element having the potential to modify succeeding elements."¹⁰

IMPAIRMENT, HANDICAP AND DISABILITY

- **Impairment** An impairment is a permanent or temporary loss or abnormality of bodily structure or function.
- **Disability** A restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being
- **Handicap** Any disadvantage resulting from an impairment or disability which limits or prevents fulfilling a role that is normal for that person. Handicap describes the disadvantages resulting from impairment and disability.

Occurrence of organic injury or the onset of disease

The individual develops some intrinsic abnormality, which may be described as a disease or an injury and have been present at birth or acquired later.

Organic injury or disease resulting in impairment

The damage to the body, whether arising from injury or pathological processes, may or may not be apparent. If the changes make themselves evident they are described as "manifestations," which are usually distinguished as "symptoms and signs." Either the individual himself becomes aware of the manifestations, in the form of clinical disease or organic disorder, or a relative or third party draws attention to them. The individual has become or been made aware that the performance of some part of his body is impaired — he is unhealthy or "ill." An impairment is therefore a permanent or temporary loss or abnormality of bodily structure or function.¹¹ It represents the occurrence of an anomaly, defect or loss in a limb, organ or tissue or the defective functioning of part of the body, including the systems of mental function.¹² For example, mental impairment is a limitation of intellect or a limitation of the capacity to use that intellect successfully in the world.

Impairment resulting in disabilities

The fact that part of the body is impaired may or may not affect the individual's ability to perform different activities — if so, the impairment has a disabling effect.

¹⁰ *International Classification of Impairments, Disabilities, and Handicaps: A manual of classification relating to the consequences of disease* (World Health Organisation, 1976), p.30.

¹¹ *Ibid.*, p.27.

¹² *Ibid.*

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.¹³ Disability represents a departure from the norm in terms of performance of an individual, as opposed to the performance of a bodily organ or mechanism. Whereas impairment is concerned with individual functions of the parts of the body, reflecting potential in absolute terms, disability is concerned with compound or integrated activities expected of the person or body as a whole, such as are represented by tasks, skills, and behaviours.¹⁴ Any consequential disabilities may be temporary or permanent, reversible or irreversible, progressive or regressive. By focusing on activities, the idea of disability is concerned with the practical consequences of bodily impairment in a relatively neutral way.

Impairment or disability leading to being handicapped

The fact that a person's body is impaired or his ability to perform certain activities is affected may have adverse social and economic consequences. 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.¹⁵ The degree of handicap experienced will depend on the individual's situation, the support available and the attitudes of other people. A person with severe schizophrenia who has the support of a family or social network may be considerably less disadvantaged than a person whose illness is less severe. Because of the stigma attached to mental illness and compulsory treatment, reflected in a lowering of the individual's status and opportunities within society, a detained patient who has recovered may still be handicapped. For example, a person once diagnosed as having schizophrenia will be at a serious disadvantage when it comes to competing with others for employment, even if the diagnosis was erroneous or he has subsequently fully recovered. Although the individual is no longer impaired or disabled, he is handicapped.

Premorbid handicap, primary handicap and secondary handicap

In the context of mental illness, Wing has usefully distinguished between premorbid handicap (disabilities pre-existing the illness), primary handicap (disabilities which arise directly from the illness itself) and secondary handicap (disabilities arising from having been mentally ill, e.g., dependency and loss of skills as the result of institutional care, lethargy and the other effects of drugs, and the effects on employers and relatives).¹⁶

¹³ *International Classification of Impairments, Disabilities, and Handicaps: A manual of classification relating to the consequences of disease* (World Health Organisation, 1976), p.28.

¹⁴ *Ibid.*

¹⁵ *Ibid.*, p.29.

¹⁶ J.K. Wing, *Schizophrenia: towards a new synthesis* (Academic Press, 1978).

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. However, the main or immediate professional objective in a particular situation may be management, treatment or cure. The management of seriously disturbed behaviour can involve the use of detention, restraint, seclusion, continuous observation, and sedating drugs. Procedures such as seclusion, restraint and continuous observation are not forms of treatment, merely ways of isolating or protecting a patient who requires treatment. The treatment of mental disorder can be divided into five broad categories: surgical (psychosurgery); physical (ECT); chemical (psychotropic drugs); psychological (nursing, psychotherapy and social therapy); and complementary (various "alternative" remedies). There are few if any specific treatments in psychiatry. For example, depression, schizophrenia and mania may all respond to ECT while schizophrenic and manic illnesses both respond to neuroleptics.¹⁷ Equally, therefore, a seemingly common form of mental disorder may respond to a number of different treatments. Thus, Lader notes that depressive disorders may respond to a range of treatments including ECT, sleep deprivation, antidepressants of a diverse chemical nature, neuroleptics and lithium.¹⁸ To treat a person suffering from disease or disorder is not the same thing as to cure him. Many psychotropic drugs are equivalent to the chemical sprays used by gardeners to control the more extreme, unwanted, external manifestations of diseases which affect plants. They may alleviate the symptoms but are generally ineffective in eradicating the underlying causes. Consequently, the manifestations return if treatment is suspended. Virtually every treatment decision involves, or should involve, a counterbalancing of risks and benefits. Hippocrates cautioned doctors to first do no harm to their patients, observing that "there are some patients we cannot help but no patients we cannot harm."¹⁹

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. Section 57 of the 1983 Act (273) applies to detained and informal patients alike and it provides that (except in urgent cases) the patient's informed consent is required for any surgical operation which involves destroying brain tissue or the functioning of such tissue. The section contains a number of additional safeguards, including the involvement of the Mental Health Act Commission. In practice, the need for the patient's informed consent means that it is exceptional for a detained patient to receive such surgery.

OPERATING CENTRES

Until its closure in 1995, most psychosurgical operations were performed at the Brook Hospital. Stereotactic techniques — a stereotaxic device being a metal

¹⁷ R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell and A.K. Zealley, Churchill Livingstone, 1993), p.280.

¹⁸ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 1990), pp.10-11.

¹⁹ G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley and Sons, 1993), p.10.

rectangular frame which fits around the head — allow a precise localisation of the intended lesion, usually by the implantation of radioactive yttrium-90 seeds. In a stereotactic subcaudate tractotomy, the seeds are implanted in the *substantia innominata* below the head of the caudate nucleus. Limbic leucotomy involves disrupting some of the connections between the frontal lobe and the limbic system by placing lesions in lower medial quadrant of the frontal lobe; the cingulum is also lesioned. Diagrams of the different areas of the brain are included in chapter 24.

Operating Centre	Nature of operation
Brook Hospital	Stereotactic subcaudate tractotomy
Pindersfield Hospital	Stereotactic bifrontal tractotomy
Atkinson Morley's Hospital	Limbic leucotomy
University Hospital of Wales	Bilateral anterior capsulotomy

PATIENT CHARACTERISTICS

During the period 1 July 1993 to 30 June 1995, 30 patients (22 female) were referred to the Mental Health Act Commission with a view to psychosurgery. The number of operations subsequently performed was 24, four of the remaining six patients withdrawing their consent to surgery. A recent retrospective survey by the Commission of 34 patients who received surgery revealed that two of them had been diagnosed as having a bipolar affective illness, 18 as suffering from depression, 12 from an obsessional disorder, and two from anxiety states. Some two-thirds of these patients had been aged between 31 and 50 at the time of their operations.²⁰

OUTCOME

Information about outcome of psychosurgery, based on reports by the patients' responsible medical officers, is contained in two of the Mental Health Act Commission's biennial reports: the second biennial report (spanning the period 1985-87) and sixth biennial report (1993-95).²¹

Outcome reported by responsible medical officer	Second Biennial	Sixth Biennial
Significant improvement	17 cases (35%)	9 cases (26%)
Some improvement / "modest" improvement	10 cases (20%)	17 cases (50%)
No significant change or deterioration	10 cases (20%)	8 cases (24%)
No information received	12 cases (25%)	—
Total number of cases	49 cases (100%)	34 cases (100%)

²⁰ Mental Health Act Commission, *Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), p.49 and Appendix 4.1.

²¹ See Mental Health Act Commission, *Second Biennial Report, 1985-87* (H.M.S.O., 1987), p.21; Mental Health Act Commission, *Sixth Biennial Report, 1993-95*, *supra*, p.49.

The patient groups were necessarily small and the Commission's findings should be interpreted cautiously. As to the outcome of the patients referred to in the second biennial report, the Commission reported that "some" of the patients said to have "significantly improved" did not improve "for some time after the operation," raising the possibility that other factors may by then have influenced the outcome. Furthermore, where a "modest" improvement was reported, this was not always sustained. The fate of the remaining 12 cases is also problematic and might indicate that there was either an unfavourable or an insignificant outcome to report. As to the more recent findings set out in the sixth biennial report, the patients' perception of their outcomes, also surveyed on this occasion, were less favourable. Of the 30 patients who replied, 11 (37 per cent.) reported no change in their mental state, 12 (40 per cent.) some improvement, and only 7 (23 per cent.) a significant improvement. It should lastly be borne in mind that seven of the 34 patients were operated upon at sites other than the Brook Hospital, using different techniques.

STANDARD LEUCOTOMIES

Occasionally, practitioners are involved in a tribunal case involving a patient who received a standard leucotomy during the 1940s or early 1950s and brief details of this procedure are contained in the footnote below.²²

ELECTRO-CONVULSIVE THERAPY

Electroconvulsive therapy (ECT), also called electroplexy, was introduced in the late 1930s and has subsequently become the subject of some public controversy. Clinically, the treatment 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. It tends to be reserved as a second-line treatment for other patients, used where there has been inadequate response to an adequate trial of drugs. Urgent cases aside, the Mental Health Act provides that ECT may not be administered to a patient detained for assessment or treatment unless he understands its nature, purpose and likely effects and consents to receiving it or, where this is not so, its administration has been authorised by an independent doctor appointed by the Mental Health Act Commission (149, 277). There are approximately 138,000 ECT treatments in Britain each year.

²² In 1942, Freeman and Watts described an operation (the standard leucotomy) for dividing the white matter in both frontal lobes of the brain. The editor of *The Journal of Mental Science* suggested in 1944 that any mental illness of long standing duration, apart from chronic mania, epilepsy and general paralysis, could be considered for leucotomy. However, patients were also selected for the operation who had not had previous treatment of any sort. By 1954, leucotomies had been performed on upwards of 12,000 people within the United Kingdom. The procedure carried, on average, a four per cent mortality rate and risked permanent damage to the patient's personality. By 1961, the Ministry of Health review of leucotomies in England and Wales estimated that 3.1 per cent. of all patients were acknowledged to have been harmed by the operation to the point where it prevented subsequent discharge. See David Crossley, "The introduction of leucotomy: a British case history" *History of Psychiatry* (1993) iv, 553-564; W. Freeman and J. Watts, *Psychosurgery: Intelligence, Emotion and Social Behaviour following Prefrontal Lobotomy for Mental Disorders* (Charles C. Thompson, 1942); G.W.T.H. Fleming, "Prefrontal leucotomy" *Journal of Mental Science* (1944) xc, 491; G.C. Tooth and M.P. Newton, *Leucotomy in England and Wales 1942-1954* (Ministry of Health Reports on Public Health and Medical Subjects, No. 104, H.M.S.O., 1961).

THE ADMINISTRATION OF ECT

There is historical evidence that seizures caused by the administration of drugs or photic stimulation were effective therapeutically.²³ However, electricity is now preferred as the seizure-inducing agent because of its relative safety and ease of administration. ECT was originally given unmodified but it is nowadays preceded by the injection of a general anaesthetic and a muscle relaxant which minimises the actual convulsions produced. The technique consists of giving a general anaesthetic, followed by an intravenously administered muscle relaxant injected through the same needle as the anaesthetic, the needle being left in the vein between injections. Once the muscle relaxant has caused complete relaxation, and the patient has been adequately oxygenated — by means of a face mask and bag connected to a cylinder of oxygen — a brief electric pulse is passed between padded electrodes. These are moistened with a saline solution and placed either over both temples (bilateral ECT) or over one temple and a point on the scalp on the same side of the head (unilateral ECT). The amount of electricity necessary to induce a generalised seizure (the "seizure threshold") depends on many factors. ECT is generally administered twice weekly and the usual number of treatments is between six and eight, depending upon the clinical response of the patient.

UNILATERAL AND BILATERAL ECT

It is usual practice in the United Kingdom to administer ECT unilaterally to the non-dominant hemisphere, usually the right side of the head. This position of the electrodes is thought to reduce to a minimum post-ECT confusion and the slight retrograde amnesia (1070) which accompanies any seizure.²⁴ Although some clinicians also consider unilateral ECT to the non-dominant hemisphere to be as effective as bilateral ECT for depression,²⁵ a number of studies have found it to be slower acting and less successful. Consequently, the recent APA Task Force on ECT recommended bilateral ECT where rate of response was most important and unilateral ECT where minimising the risk of cognitive side-effects was the overriding factor.²⁶ There is, however, no consensus. Because of post-treatment confusion and amnesia, some clinicians take the view that bilateral ECT is best reserved for patients who do not show the expected improvement with unilateral treatment.²⁷

HOW ECT WORKS

How or why ECT is effective remains unclear and it is therefore an empirical treatment. Because simulated ECT can be an effective treatment for depression,²⁸ this suggests that repeated general anaesthesia may be efficacious and the benefits of ECT only partly derive from the induced seizure.

²³ The use of convulsive therapy to treat mental disorder is ancient. A Roman treatment for headaches involved placing a Mediterranean torpedo fish (which produces 100-150 volts) across the patient's brows and camphor-induced convulsions for melancholia were used by Oliver in 1785. *Essential Psychiatry* (ed. N. Rose, Blackwell Scientific Publications, 1988), p.184.

²⁴ G.L. Ahern, et al., "Selected Topics in Behavioural Neurology" in *Manual of Clinical Problems in Psychiatry* (ed. S.E. Hyman and M.A. Jenike, Little, Brown and Co, 1990), p.115.

²⁵ *American Psychiatric Association Task Force on Electroconvulsive Therapy. The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training and Privileging* (APA, 1990).

²⁶ *Essential Psychiatry*, supra, p.184.

²⁷ See P.G. Janicak, et al., "Efficacy of ECT: a meta-analysis" *American Journal of Psychiatry* (1985) 142, 297-302.

INDICATIONS

ECT may be used to treat patients with depression marked by psychotic symptoms, stupor, failure to eat or drink or a risk of suicide, and those whose conditions have not responded to antidepressants. It is also used in cases of catatonia, schizoaffective depression, manic states unresponsive to drug treatment, post-partum affective psychosis, and following serious adverse reactions to medication (e.g. neuroleptic malignant syndrome and drug-induced extrapyramidal disorders).

As a first-line or second-line treatment

The treatment is generally considered to be the first-line treatment if a fast response to treatment is necessary to relieve intense suffering or to save the patient's life (depressed patients who are suicidal or not eating or drinking; patients with manic frenzy leading to exhaustion). It tends to be reserved as a second-line treatment in other situations, used where there has been inadequate response to an adequate trial of drugs; in particular antidepressants for the treatment of a depressive disorder.²⁹

COMBINING ECT WITH OTHER TREATMENTS

Electroconvulsive therapy is often given to patients who are receiving drug treatments, often because a drug regime has been established before a decision to employ ECT is made. Many drugs alter seizure thresholds or alter the duration of a generalised seizure so that the efficacy of electroconvulsive therapy may be affected.³⁰ If ECT is ineffective and, especially, if convulsions do not occur or are very brief, any drug regime should be reviewed.³¹ More deliberately, ECT may be combined with lithium for treating manic states, with antidepressants for depressive illness, and with antipsychotics in treating schizophrenia. Although tricyclic antidepressants and phenothiazines enhance seizure activity, their concurrent use with ECT does not improve its efficacy or reduce the number of applications which are needed to treat depressive illnesses. There is, however, "fairly good evidence" that ECT combined with antipsychotic drugs is more effective in relieving acute schizophrenic episodes than ECT or drugs alone.³²

EFFICACY

There is indisputable evidence that ECT is a highly effective treatment for severe depressive illnesses (particularly those associated with psychotic delusions) and for the other conditions for which it is a first-line treatment.³³ In particular, patients

²⁹ T. Lock, "Advances in the practice of electroconvulsive therapy" *Advances in Psychiatric Treatment* (1994) vol. 1, 47-56 at p.47.

³⁰ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 1990), p.27.

³¹ *Ibid.*

³² *Ibid.*

³³ Assuming, of course, that the ECT is properly administered. The first ECT audit to the Royal College of Psychiatrists in 1981 stated that about one in three ECT clinics was ill-equipped, the staff poorly trained, and the treatment ineffective. Approximately one in four treatment applications was unlikely to result in therapeutically effective seizures. See J. Pippard and L. Ellam, "Electroconvulsive treatment in Great Britain" *British Journal of Psychiatry* (1981) 139, 563-568, summarised in T. Lock, "Advances in the practice of electroconvulsive therapy" *Advances in Psychiatric Treatment* (1994) vol. 1, 47-56 at pp. 48-49.

treated with ECT, or a combination of ECT and medication, have shown a more rapid and complete response in the short term (the initial 4-6 weeks of treatment) than patients treated only with drugs or without medication. However, whether ECT is more effective than vigorous, higher dose, drug treatment remains uncertain; as is the issue of whether ECT has any longer-term advantages over alternative drug treatments after the initial 4-6 week treatment period.³⁴ Recovery after six to nine treatments administered over two to three weeks is often followed by relapse. Although relapse is not a specific disadvantage of ECT, being a feature of all treatments of depression, Klerman has estimated that 65 per cent. of depressed in-patients and out-patients relapse to some extent within the first year.³⁵ For this reason, maintenance drug treatment following ECT is generally considered to be as necessary as it is when antidepressants are continued for three months or more following improvement on medication alone.³⁶ As with drug treatment, a sudden onset and short duration of illness is an indicator of good outcome.³⁷ ECT tends to be an ineffective treatment for patients who suffer from reactive depression; or from mild, long-term depression with hypochondriasis; or for whom anxiety is a primary problem; or who have an underlying personality disorder.³⁸

SAFETY

The major risk involved in ECT is not the application of the current or the resulting seizure but the accompanying anaesthetic procedure. The contraindications are therefore those of high anaesthetic risk. The morbidity rate of one death per 50,000 treatments is similar to that of general anaesthesia in minor surgical procedures.³⁹ There is no evidence that ECT causes structural brain damage or that it is associated with the development of spontaneous seizures.⁴⁰

SIDE-EFFECTS

ECT produces confusion, amnesia, and recent memory loss. More specifically, ECT produces an anterograde amnesia (an inability to recall newly learned material) that may last for a few hours after the treatment as well as a retrograde amnesia in the form of an inability to recall events occurring just prior to the treatment. Mild anterograde deficits may persist for a number of weeks following a full course of ECT therapy but long-term deficits are unusual. Unilateral ECT causes fewer side

³⁴ T. Lock, "Advances in the practice of electroconvulsive therapy" (*supra*), p.48. For reviews of research data in relation to specific syndromes, see Royal College of Psychiatrists' Special Committee on ECT, *The Practical Administration of Electroconvulsive Therapy* (Gaskell, 2nd ed., 1994).
³⁵ G.L. Klerman, "Long-term treatment of affective disorders" in *Psychopharmacology: A Generation of Progress, 1967-1977* (ed. M.A. Lipton, et al., Raven Press, 1978), pp.1303-1311.
³⁶ W. Appleton, *Practical Clinical Psychopharmacology* (Williams and Wilkins, 3rd ed., 1988), p.117.

³⁷ T. Lock, "Advances in the practice of electroconvulsive therapy, Advances in Psychiatric Treatment" (1994), vol. 1, pp. 47-56 at p.48.

³⁸ Practical Clinical Psychopharmacology, Third Ed., William Appleton (Clinical Professor of Psychiatry, Harvard Medical School), Williams and Wilkins, Baltimore, 1988., p. 117-118.

³⁹ B.A. Kramer, "Use of ECT in California 1977-1983" *American Journal of Psychiatry* 142, 1190-1192. See T. Lock, "Advances in the practice of electroconvulsive therapy" (*supra*), p.47.

⁴⁰ See e.g. R. Abrams, *Electroconvulsive Therapy* (Oxford University Press, 2nd ed., 1992). Nevertheless, despite the fact that magnetic resonance imaging of the brain has found no evidence of structural brain damage, it, of course, remains possible that ECT causes some subtle damage — just as psychiatrists argue that subtle brain changes may be responsible for schizophrenia although they are not apparent from scanning.

effects and, in consequence, some clinicians recommend beginning with the unilateral ECT, but switching to bilateral, if four to six or more unilateral treatments prove ineffective.

MEDICATION

The administration of medication for mental disorder to patients detained for assessment or treatment is regulated by Part IV of the Mental Health Act 1983 (273). Medicines used in the treatment of mental disorder are variously referred to as psychotropic drugs, psychoactive drugs, or as psychotherapeutic drugs and these general terms are synonymous. Psychotropic drugs are traditionally divided into six classes according to their actions: (1) antipsychotics, (2) antidepressants, (3) anti-manics, (4) antiepileptics, (5) anxiolytics, and (6) hypnotics. The drugs used to treat schizophrenia and other psychotic states, referred to here as antipsychotics, may sometimes be called major tranquilisers or neuroleptics. However, the term "major tranquiliser" is misleading because it suggests that these drugs are similar to "minor tranquilisers" such as diazepam. Furthermore, for conditions such as schizophrenia, the tranquillising effect is of secondary importance and whether a particular drug has a major tranquillising effect depends on the dose administered. The word "neuroleptic" refers to the effect of antipsychotic drugs on motor activity rather than their clinical effects and so, according to some authorities, is less appropriate than the term antipsychotic.

PSYCHOTROPIC DRUGS

- Anti-psychotics Drugs, such as chlorpromazine, used to treat schizophrenia and other psychotic states
- Anti-depressants Drugs, such as amitriptyline, used to treat depression.
- Anti-manics Drugs, such as lithium, used to treat mania.
- Anti-epileptics Drugs, such as carbamazepine, used in the treatment of epilepsy.
- Anxiolytics Drugs, such as diazepam, used to treat anxiety states.
- Hypnotics Drugs, such as temazepam, used to treat insomnia.

THE REGULATION OF MEDICINES

The availability of medicines is controlled on the basis of their safety, quality and efficacy, in accordance with the Medicines Act 1968 and EEC directives. The Secretary of State for Health, acting on behalf of the various Ministers who together constitute "The Licensing Authority," is responsible for the control of medicines for human use. The UK Medicines Control Agency (MCA), which reports to the Secretary of State, is the executive body which regulates the pharmaceutical sector and implements policy. A statutory advisory body called The Medicines Commission advises the Licensing Authority through the Secretary of State on all matters relating

to the implementation of the Medicines Act, and on medicines in general. Applications from the pharmaceutical industry for product licences for medicines are made to the UK Medicines Control Agency, which assesses the drug's likely benefits and risks. A product licence authorises the holder to manufacture or import, and to sell or supply, the stated medicinal product. Different arrangements apply where authority for the clinical trial of a new product is sought. The Committee on Safety of Medicines (CSM) is responsible for encouraging the collection and investigation of reports on suspected adverse reactions to medicines already on the market. Under a new scheme administered by the Association of the British Pharmaceutical Industry, which came into force in 1996, patients are able to get information both about a medicine's safety and adverse effects and the scientific studies used to obtain approval for it.

Clinical trials

All new active substances are subjected to clinical trials designed to determine their safety and efficacy, as are some established medicines if a new clinical use is claimed for the product. The "development of the clinical trial is a product of the application of modern scientific method to clinical medicine. The purpose of the clinical trial is to provide clinicians with information that will help them prescribe appropriate, timely treatment for their patients."⁴¹ The Licensing Authority may grant a clinical trial certificate (CTC) authorising a trial, which certificate then remains valid for a period of two years. However, over 90 per cent. of all clinical trials are now conducted under a clinical trial exemption scheme (CTX) introduced in 1981.⁴² Where an exemption from the need to hold a clinical trial certificate is granted, this exemption generally remains valid for three years. Details of the proposed drug trial ("the protocol") are then considered by the Medical Research Ethics Committee at each hospital where it is proposed to conduct the research. The efficacy of the new drug is determined by giving it to a group of patients with the target condition (e.g. major depressive illness) and a placebo or well-established drug treatment to a second control group of similar patients. The trial may include a wash-out period, the duration of which depends on the previous treatment and the tolerance to withdrawal of medication. A randomised, controlled clinical trial of one therapy versus another is the accepted standard by which the usefulness of a treatment is judged. In a single-blinded study, the treatment assignment — trial drug or placebo — is not known to the patients. In a doubled-blinded study, the treatment assignment is not known either to the patients or to their doctors. It is only revealed if there are serious or unexpected side-effects or when the study is completed.

Clinical trials involving detained patients

Tribunals periodically consider the cases of detained patients who are, or have recently been, involved in the clinical trial of a new drug. Difficult legal and ethical considerations arise when detained patients are included in clinical drug trials. Half of the patients in the trial will normally be receiving a placebo or a trial drug the efficacy of which is unproven and essentially theoretical. Necessarily, this often

⁴¹ R.S. Greepberg, *Medical Epidemiology* (Appleton and Lange, 1993), pp.68-69.

⁴² See The Medicines (Exemption from Licences) (Clinical Trials) Order 1981. As to trials using products for which product licences have been granted, see The Medicines (Exemption from Licences) (Clinical Trials) Order 1974.

entails first withdrawing an established drug previously prescribed for a patient. This drug may be known to suit him and, in some cases, have improved his condition so that discharge is anticipated in the near future. Not surprisingly, patients who change from an antipsychotic to a placebo relapse significantly more frequently.⁴³ In terms of the legalities, patients entitled to a tribunal hearing will be detained under section 2 or for treatment. A patient detained under section 2 has no right to refuse treatment given under the direction of his responsible medical officer but does have a right to refuse a placebo and treatment which is directed by some other person, such as a researcher. After an initial three month medication period, a patient who is detained for treatment may generally only be given psychotropic medication if he is capable of consenting to it and gives consent or, if he is incapable of giving consent, or refuses consent, its administration has been authorised by a doctor appointed by the Mental Health Act Commission (149, 277). A certificate authorising treatment may only be given by such a doctor if he is of the opinion that, having regard to the likelihood of the particular treatment alleviating or preventing a deterioration of the patient's condition, it should be given. The fact that the new drug's likely benefits and adverse effects are not firmly established, and the patient may not receive the drug at all if he is in the placebo group, is therefore problematic. As far as a tribunal is concerned, these issues are matters to be taken into account when considering whether or not to exercise its discretionary power of discharge. A tribunal must consider whether the patient's continued detention for treatment is justified if the power to give compulsory treatment is being used in a way which undermines the purpose of his detention, which is to treat him so as to be able to end his detention.

A. DRUG'S ACTION

Pharmacodynamics is the study of the effects of drugs on the body whereas pharmacokinetics is the study of the body's effect on drugs.

Pharmacodynamics (potency, tolerance, etc.)

Pharmacodynamics is the study of the effects of drugs on the body and the mechanism of drug action.⁴⁴ The major pharmacodynamic considerations include receptor mechanisms, the dose-response curve, the therapeutic index, and the development of tolerance, dependence, and withdrawal phenomena.⁴⁵ The potency of a drug refers to the relative dose required to achieve a certain effect. Thus, only 5mg of haloperidol are generally required to achieve the same therapeutic effect as 100mg of chlorpromazine. Both drugs are, however, equal in their maximum efficacies, that is the maximum clinical response achievable by their administration. As a rule, the lower potency drugs produce more sedation, orthostatic hypotension, and anticholinergic effects than the high potency drugs, which cause more frequent and severe extrapyramidal symptoms. The therapeutic index is a relative measure of a drug's toxicity. For example, lithium has a low therapeutic index in the order of 3-4, being

⁴³ S.R. Hirsch, *et al.*, "Outpatient maintenance of chronic schizophrenic patients with long-acting fluphenazine: double-blind placebo trial" *British Medical Journal* (1973) i, 633; G.E. Hogarty, *et al.*, "Drugs and sociotherapy in the aftercare of schizophrenic patients" *Archives of General Psychiatry* (1974) 31, 603.

⁴⁴ *Melloni's Illustrated Medical Dictionary* (Penguin Publishing, 3rd ed., 1993), p.369.

⁴⁵ H.I. Kaplan and B.J. Sadock, *Synopsis of Psychiatry* (Williams and Wilkins, 7th ed., 1994), p.867.

the ratio of toxic to therapeutic dose. A person may become less responsive to a particular drug as it is administered over time, which is referred to as tolerance. The development of tolerance is associated with the appearance of physical dependence, that is the necessity to continue administering the drug in order to prevent the appearance of withdrawal symptoms.

Pharmacokinetics (absorption, distribution, metabolism, excretion)

Pharmacokinetics is the study of the body's effects on drugs, which determines whether the drug gets to its site of action and in what concentrations.⁴⁶ It involves studying the passage of a drug through the body; the extent and rate of absorption; its distribution, localisation in tissues, metabolism, and elimination.

Absorption and distribution

The principal divisions of pharmacokinetics are drug absorption, distribution, metabolism and excretion. Orally administered drugs must dissolve in the fluid of the gastrointestinal tract before the body can absorb them. Some antipsychotic drugs are available in injectable depot forms that allow the drug to be administered only once every 1-4 weeks. The distribution of a drug to the brain is determined inter alia by the blood-brain barrier. The volume of distribution can vary with the patient's age, sex and disease state.

Metabolism and excretion

The liver is the principal site of metabolism and the most important organ for the excretion of drugs and drug metabolites is the kidney. Clearance is a measure of the amount of drug excreted per unit of time; if some disease process or other drug interferes with the clearance of a psychoactive drug, it may reach toxic levels. A drug's half-life is defined as the amount of time it takes for one-half of a drug's peak plasma level to be metabolised and excreted from the body.

ROUTE OF ADMINISTRATION

Medicines come in a variety of forms depending upon the condition to be treated and the way in which this may be done. The purpose of these various forms of medication is to carry the active constituent (the drug) to the area where it is most needed and to avoid or minimise unwanted effects on other areas of the body. Enteral administration (literally, through the intestine) includes oral, buccal, sublingual and rectal administration. Prescribing tablets or capsules has obvious disadvantages if it is unclear whether the patient is able or willing to take them as prescribed. Parenteral routes — by which the drug is taken into the body otherwise than through the alimentary canal — include intramuscular, intravenous and subcutaneous injections and topical administration. Injections introduce medication through the skin into blood vessels or subcutaneous tissues, muscles and other tissues in the body. A general advantage over oral medicines is certainty about whether or not the drug has been received as prescribed. Against this, injections are unacceptable for many patients. Consequently, in practice, this clarity may be

⁴⁶ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.109.

limited to knowing that the patient has not attended for an injection. It is again defaulted on the treatment. The real choice is often between compromising on oral medication by consent or compulsory treatment by injection. In the absence of any legal or practical framework allowing indefinite compulsory out-patient treatment, defaulting on injections in due course becomes an option for all discharged patients. In such cases, a consultant's unwillingness to contemplate what he considers to be the second-line treatment may lead to no treatment and early relapse.

Oral (PO) administration

Drugs may be taken orally in tablet, liquid or capsule form. Liquid administration may be preferred for detained patients if it is suspected that the patient has not been swallowing prescribed tablets and disposing of them later. The abbreviation SL stands for sublingual.

Intravenous (IV) injection

Intravenous administration is the quickest route to achieve therapeutic blood levels, but it also carries the highest risk of sudden and life-threatening adverse effects. The drug enters the systemic circulation quickly so that it has a rapid effect, making the route useful in emergencies. Adverse effects may, however, occur equally rapidly. Once administered "it is difficult to recall the drug; in comparison stomach washouts and emetics can be used following oral overdosage."⁴⁷ Other disadvantages include the risk of sepsis, thrombosis and air embolism. The drug may be accidentally injected into the tissues surrounding the vein, or into the artery, leading to necrosis and spasm respectively.⁴⁸

Intramuscular (IM) injection

Intramuscular administration is often used for the relief of acute symptoms in disturbed patients and for administering long-acting depot injections of antipsychotic drugs for maintenance therapy. Depot injections are administered by deep intramuscular injection at intervals of one to four weeks. The disadvantages of intramuscular administration include its painfulness, leading to non-compliance, and a risk of damaging structures such as nerves.

PRESCRIPTION AND ADMINISTRATION OF DRUGS

Kaplan summarises the clinical principles underlying drug prescription as involving applying the five Ds: diagnosis, dialogue, drug selection, dose, and duration.⁴⁹ The World Health Organisation has published a book setting out the factors to be considered by medical practitioners when prescribing psychoactive drugs.⁵⁰

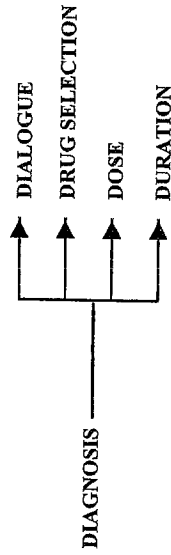
⁴⁷ B.K. Puri and P.J. Tyrer, *Sciences Basic to Psychiatry* (Churchill Livingstone, 1992), p.108.

⁴⁸ *Ibid.*

⁴⁹ H.I. Kaplan and B.J. Sadock, *Synopsis of Psychiatry* (Williams and Wilkins, 7th ed., 1994), chap.

33.

⁵⁰ *Psychoactive Drugs: Improving Prescribing Practices* (ed. H. Ghobe and I. Khan, World Health Organisation, 1988).



DRUG SELECTION

The patient's diagnosis, his history of responding to particular drugs, the psychiatrist's familiarity with different drugs, their side-effects and routes of administration will all be factors taken into account when it comes to selecting a drug from those available to treat the target condition. Many of the drugs available within a particular class are equivalent in overall efficacy but differ immensely in how well they are tolerated and how lethal they are in overdose. Where this is the case, the most important reasons to choose a drug will be its relative side-effect profile and safety.⁵¹

Polypharmacy

Multiple prescriptions, commonly known as polypharmacy, are to be avoided unless clearly indicated. This is because "changes in clinical state are difficult to judge if medication is constantly altered and side-effects and drug interactions are likely to be more common than if a single drug is used."⁵² It is generally recognised that the use of several drugs simultaneously is undesirable because it is not easy to decide which constituents of such combinations should be altered when a change in clinical state occurs, the incidence of unwanted effects and drug interactions increases, and patient compliance with treatment declines as it becomes more complex. Yet it is common for such cocktails to develop, often unwittingly, and a constant effort has to be made to prevent this happening.⁵³

Therapeutic uses of antipsychotics

Antipsychotic drugs have a range of uses, including the management of severe anxiety, so that in this respect the term is somewhat misleading.

Use as an antipsychotic

The major therapeutic effects are seen when used to treat acute psychoses. The effects include a reduction of positive symptoms such as hallucinations, delusions and thought disorder. There is also a normalisation of psychomotor activity (excitement or retardation) and information processing. Although the sedative effects are immediate, the antipsychotic effects take up to three weeks to become evident in the case of schizophrenia.

⁵¹ *Psychoactive Drugs: Improving Prescribing Practices* (ed. H. Ghobe and I. Khan, World Health Organisation, 1988).

⁵² M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.19.

⁵³ *Ibid.*, p.26.

Use as a form of maintenance therapy

Maintenance doses are generally about 60 per cent. of the level required to resolve the symptoms in the initial phase. Because maintenance treatment may need to be long-term, slow-release depot injections are often used. Their only real purpose is to ensure compliance. In its most common form, the antipsychotic drug is prepared as an ester, most frequently as a decanoate, although pipothiazine is given as the palmitate salt and fluspirilene is given in aqueous injection at weekly intervals.⁵⁴

Use as a short-term treatment or form of management

As a short-term measure, they may be used to alleviate severe anxiety and to quieten, *i.e.* manage, disturbed patients whatever the underlying psychopathology.

Use in the treatment of agitation and anxiety

Because of their sedative effect and the fact that they do not produce pharmacological dependence, the drugs are often used in low doses as hypnotics or to treat mild agitation and anxiety.

DOSE AND DOSAGE

Different patients require different amounts of a drug for optimal therapeutic effect. Consequently, no standard dose exists and the correct dose must be determined empirically. Usually, increasing the dose of a drug increases the effect although below and above a certain range there is little change with dose and "paradoxical" effects may even appear. Some tricyclic antidepressants, notably nortriptyline, show antidepressant action over a restricted dose range: either side of this therapeutic window the therapeutic action weakens and disappears.⁵⁵

Micro-dose maintenance treatment

Patients relapse significantly more frequently if antipsychotic drug dosage is cut below the level necessary to produce dopamine receptor blockade — an approach sometimes known as micro-dose maintenance treatment.⁵⁶

British National Formulary (BNF) guideline doses

The British National Formulary is published twice a year by the British Medical Association and the Royal Pharmaceutical Society of Great Britain. It contains recommended guideline maximum doses for most drugs, with separate guidance for special categories of patients such as the elderly, children and pregnant women.⁵⁷ The Royal College of Psychiatrists has given the following advice about prescribing doses above BNF upper limits.

⁵⁴ B.K. Puri and P.J. Tyrer, *Sciences Basic to Psychiatry* (Churchill Livingstone, 1992), p.126.

⁵⁵ M. Lader and R. Harrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.75.

⁵⁶ J.M. Kane, *et al.*, "Low-dose neuroleptic treatment of chronic schizophrenia" *Archives of General Psychiatry* (1983) 40, 893.

⁵⁷ The British National Formulary (B.N.F.) is very reasonably priced and readily available. American guidelines should be treated with caution because of a tendency to give drugs in "heroic" dosages.

Advice of Royal College of Psychiatrists on doses above BNF upper limit

British National Formulary (March 1997) 33, 159

"Unless otherwise stated, doses in the BNF are licensed doses — any higher dose is therefore unlicensed ..."

1. Consider alternative approaches including adjuvant therapy and newer or atypical neuroleptics such as clozapine.
2. Bear in mind risk factors, including obesity — particular caution is indicated in older patients especially those over 70.
3. Consider potential for drug interactions ...
4. Carry out ECG to exclude untoward abnormalities ... repeat ECG periodically ...
5. Increase dose slowly and not more than once weekly.
6. Carry out regular pulse, blood pressure, and temperature checks; ensure that patient maintains adequate fluid intake.
7. Consider high-dose therapy to be for limited period and review regularly; abandon if no improvement after 3 months (return to standard dosage)."

RECORDING THE PRESCRIPTION

Various standard abbreviations are used to record a patient's prescription, the most common of which are listed in the table below.

PRESCRIBING MEDICATION — ABBREVIATIONS

Rx	Recipe, treat with	b.d.	bis die (twice daily)
t.d.s.	ter die sumendus (3x daily)	q.d.s.	quater die sumendus (4x daily)
o.m.	omni mane (in the morning)	o.n.	omni nocte (every night)
PO	Per orum (by mouth)	nocte	at night
PRN	pro re nata (as/if required)	sd/stat	single dose
bu	buccal	iv	intravenous injection
mp	implant	pr	per rectum
im	intramuscular injection	sl	sublingual
tabs	tablets	caps	capsules
mg	milligram	µg	microgram
g	gram	ml	millilitre
mmol/L	milli-mole-litre	mg/L	milligrams per litre

INPATIENT PRESCRIPTIVE CARDS

The medication prescribed for each patient, and the medication actually administered, will be recorded on a prescription and administration card kept on the ward. This card will be found either in the patient's notes or in a separate ward file containing all such cards. The format varies from hospital to hospital but is normally similar to the example set out on the previous page. Some cards include separate sections for recording depot injections and medication given during periods of leave. Discontinued drugs are shown by drawing a line through the prescription box and a similar line through the adjacent recording panels. As a matter of good practice, if a statutory certificate has been issued under Part IV of the Act, authorising a drug's administration to a detained patient, it should be attached to the card (277). This enables nursing staff to verify that the treatment may lawfully be given.

Recording the medicine's administration

The nurse who administers the prescription inserts his initials in the relevant box on the prescription and administration card to show that the dose has been given. Where the medication was refused, there will normally be an entry in the clinical or nursing notes explaining the precise circumstances. The list of approved abbreviations should be set out on the first page of the card. The following table lists a number of common abbreviations in case this is not so.

Administration of medication — Abbreviations

A	Absept	O	Out of stock
D	Drowsy	S	Sleeping
L	Leave medication given	DOC	Doctor consulted / advised
R	Refused	ECT	Electroconvulsive therapy

ADVERSE EFFECTS OF PRESCRIBED DRUGS

Paracelsus once observed that everything is poisonous and it is only in the dose that a poison differs from a remedy. Most drugs have effects in addition to the main therapeutic action and these usually detract from any benefit derived from the treatment.⁵⁸

Adverse events associated with a drug

Adverse events known to be generally associated with a particular drug may be categorised, in descending order of adversity, as representing a hazard, a contra-indication, a side-effect, or a precaution. Adverse events may occur as a single episode or be ongoing or recurrent and the eventual outcome for the patient may be recovery, persistent residual effects, or death. In any particular case, it may

⁵⁸ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.22.

INPATIENT PRESCRIPTION AND ADMINISTRATION CARD

Surname Hospital No. Consultant Date of admission
 First Names Date of Birth GP Special Diet

Drug idiosyncrasies	Reaction
Drug	

ONCE ONLY MEDICATION

Pharmacy	Date	Drug	Dose	Time	Route	Signature	Given by

TTO's Sent to Pharmacy	TTO's Received on Ward
DATE	DATE

REGULAR PRESCRIPTIONS

Drug (Approved Name)				Date and Month	
Dose 1	Dose 2	Start Date 1	Start Date 2	Time	
Doctor's signature	Review Date 1	Review Date 2	Pharmacy	6	
Additional instructions				10	
				13	
				18	
				22	

AS REQUIRED DRUGS

Drug (Approved Name)		Date
Dose	Max Freq	Route
Signature	Review / Stop	Pharmacy
Additional Instructions		Dose / Route
		Given by

be difficult or impossible to establish whether an adverse event is a consequence of medication administered to the patient. The relationship between an adverse event and a prescribed drug may be categorised as definite, probable, possible, unlikely, or unrelated, depending on the temporal relationship between the therapy and the reaction and other relevant factors, such as the nature of the patient's illness, any concomitant remedies, and the patient's history (whether similar adverse effects followed the prescription of the same or similar drugs in the past). A known response pattern to the suspected drug or reasonable temporal association with drug administration, which disappears or decreases following a cessation or reduction in dose, would indicate a definite or probable relationship.

Adverse effects for the particular patient

Adverse effects following the prescription of medication include the emergence of new symptoms or complaints during treatment, an increase in the severity or frequency of pre-existing symptoms or complaints, abnormal laboratory results, physical abnormalities, and the occurrence of accidents related to medication. The maximum severity of any adverse effect or effects experienced by the patient may be described as mild (slight discomfort but no limitation of usual activities); moderate (significant discomfort and/or some limitation of usual activities); severe (intolerable discomfort or pain and/or inability to carry out usual activities); or catastrophic (fatal, life threatening or permanently or severely disabling). Likewise, a particular patient's tolerability for the drug may be described as excellent (absence of any reported or noted adverse event); good (very few insignificant events); moderate (some adverse events of mild to moderate severity); poor (the patient feels uncomfortable); or very poor (moderate to serious adverse events).

CLASSIFYING ADVERSE REACTIONS

The adverse effects of medication are often categorised according to the physiological system affected by the drug.

Extrapyramidal system effects

The term "extrapyramidal system" describes a system of neural pathways that control and integrate motor functions and also some cognitive functions. Drug-related movement disorders such as parkinsonism, akathisia, dystonia, tardive dyskinesia, and tremor are all extrapyramidal symptoms. They can be measured using rating scales such as the Simpson extrapyramidal Scale. Extrapyramidal effects are dose related, with an onset usually within two or three weeks.

Akathisia

Akathisia is described by Lader and Herrington as "the most distressing neurological effect" of antipsychotic medication. It is a common extrapyramidal side-effect particularly in response to piperazine phenothiazines. There is uncontrollable agitation and restlessness, an inability to sit still, sometimes with shuffling and rocking. Although commonest after a week or two of treatment, it can appear later and it is not greatly relieved by antiparkinson medication.⁵⁹ The severity of the symptoms can be measured using rating scales such as the Akathisia (Barnes) Scale.

⁵⁹ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.235.

It has been documented that treated akathisia can lead to combativeness, assaults, suicide by violent means, and homicidal attacks on others.

Dystonia

Dystonia denotes abnormal muscular rigidity causing painful muscle spasms, usually fixed postures or strange movement patterns (1067). Such movements usually take the form of a twisting or turning motion of the neck, the trunk, or the proximal parts of the extremities. They are powerful and deforming, grossly interfering with voluntary movement, and perverting posture. The "earliest neurological effect during a course of (antipsychotic) treatment is acute dystonia which may even be seen after a single dose of a high-potency compound such as fluphenazine or haloperidol. It occurs in about 2.5 per cent of patients treated with antipsychotic drugs and it is commoner in men and children than in women. The features are diverse and often bizarre and include torticollis,⁶⁰ retrocollis, facial grimaces and distortion, tongue protrusion, dysarthria ... and oculogyric crises ... The antipsychotic medication must be discontinued or its dosage reduced."⁶¹

Parkinsonian symptoms

Parkinson's disease is caused by depletion of dopamine in the basal ganglia and a drug-induced reduction of dopamine causes the same symptoms: stiffness of limbs, paucity of movement and facial expression (hypokinesia), coarse tremor of the hands and the head at rest, and dribbling. Parkinsonism (sometimes called "pseudoparkinsonism") usually occurs after the first week and in older patients.⁶²

Tardive dyskinesia

Dyskinesia (literally, bad or difficult movement) is a general term covering various forms of abnormal movement which typically involve uncontrollable movements of the trunk or limbs, cannot be suppressed, and impair the execution of voluntary movements. Tardive dyskinesia — tardive meaning late, tardy — generally occurs some 2-5 years after commencing treatment with antipsychotics, although onset may occur upon withdrawing the drug. It is characterised by continuous writhing movements of the head and tongue and postural changes. These effects are not dose related and anticholinergic drugs merely exacerbate the problem. The antipsychotic drug should be slowly withdrawn. Unfortunately, in most cases, this does not lead to any improvement in the patient's condition and, indeed, the syndrome is sometimes made worse. Because it has a different cause and treatment to the other extrapyramidal symptoms, some writers do not classify tardive dyskinesia as an extrapyramidal system effect.

Autonomic nervous system effects

The internal environment of the body is controlled and regulated in part by the autonomic nervous system and in part by hormones. The autonomic nervous system (literally, self-regulating) is involved in involuntary, automatic, reflex activities carried out and co-ordinated in the brain below the level of consciousness. It is divided into two parts, the sympathetic and parasympathetic —

⁶⁰ Torticollis, also known as wry neck, is twisting of the neck, causing the head to be rotated and tilted into an abnormal position.

⁶¹ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.234.

⁶² *Ibid.*, p.22.

- Drugs which inhibit the action of parasympathetic nerves, by the blockade of muscarinic acetylcholine receptors, are said to have **anticholinergic or antimuscarinic effects**. The resulting symptoms include dry mouth, increased salivation, nasal congestion, constipation, blurred near vision, glaucoma, urinary hesitancy or retention, sexual dysfunction, sweating, flushing, vomiting, and diarrhoea. These effects tend to be prominent early in treatment and are a major source of non-compliance.

- The effects of antipsychotic drugs on the sympathetic nervous system are due to their **alpha-adrenergic blocking effect**. These effects may be manifested as postural (orthostatic) hypotension, hypothermia, tachycardia, dizziness, and sexual dysfunction.

Postural hypotension

Postural hypotension is seen most often with aliphatic phenothiazines, mainly chlorpromazine, at high doses or when given intramuscularly. Antidepressants and phenothiazines "frequently induce postural hypotension usually after about three weeks of treatment. This is particularly troublesome in the elderly whose ability to regain balance is impaired, with consequent falls, injury and occasional stroke."⁶³

Endocrine and metabolic effects

The endocrine system consists of a collection of glands that produce hormones. 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. The effects of antipsychotic drugs on the endocrine system may include impotence, the absence of menstruation (amenorrhoea), the growth of breasts in men (gynaecomastia), and the discharge of milk from breasts (galactorrhoea).

Behavioural toxicity

A psychotropic drug may cause behavioural changes, which are sometimes quite subtle, and this phenomenon is loosely referred to as "behavioural toxicity." Examples include confusional reaction, excitement or agitation, increased motor activity, insomnia, drowsiness and lassitude.

Cardiovascular effects

The effects of drugs on the cardiovascular system include tachycardia (an attempt by the body to compensate for postural hypotension), dizziness and circulatory collapse.

Other effects

Other effects include skin-rash, urticaria, decreased appetite, headache, photophobia (an abnormal or uncomfortable sensitivity or intolerance of the eyes to light which may be a reaction to antipsychotics), "bronzing" of the skin, jaundice, ocular disorders, lowering of the seizure threshold.

⁶³ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.23.

Sedation

The blockade of central histamine (H₁) receptors has a sedative effect. Antipsychotic drugs have antihistaminic properties and this contributes significantly to their sedative action, which may or may not be desired. The degree to which a patient is sedated may be rated on the following scale: falls into sleep and/or remains sleeping most of the time; dozing most of the time or falls back in a dozing state after being approached; slightly slowed down; fully awake and able to perform daily activities.

Neuroleptic malignant syndrome

Neuroleptic malignant syndrome (NMS) is a rare but sometimes fatal reaction to antipsychotic medication, characterised by fever, severe muscular rigidity, autonomic instability and altered consciousness. The drugs most often implicated are haloperidol, chlorpromazine and fluphenazine.⁶⁴

THE CONTROL OF ADVERSE EFFECTS

When a distressed tribunal patient quite reasonably complains about the adverse effects of a prescribed drug the symptoms he describes are usually anticholinergic or extrapyramidal effects. In other words, the complaint relates to the autonomic nervous system or some kind of movement disorder. In some cases, the extrapyramidal effects would, if not a side-effect of medication, be features of a neurological condition so that it is not unreasonable for the patient to question whether the cost of alleviating his "psychiatric" symptoms — the emergence of "neurological" symptoms — represents an overall alleviation of his distress. If it is necessary to override a detained patient's legitimate concerns about the possible effects of antipsychotic medication, and it is not always necessary or beneficial to do so, the safe option is to prescribe as cautiously as the particular situation allows. Although it is impossible to know precisely how a particular patient will respond to a particular medication, both with regard to its efficacy and its adverse effects, "many unwanted effects derive from their recognised psychopharmacology and they are therefore predictable and dose-dependant."⁶⁵ The ways of retrospectively 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 (symptomatic therapy). Because many unwanted effects derive from their recognised psychopharmacology and are dose-dependant, they "should be managed initially by dosage reduction so long as this is compatible with continued efficacy. Should this not be possible, a different psychotropic drug should be substituted ... If a solution cannot be found in this way an antidote to the unwanted reactions might be added but is less desirable because all drugs have unwanted effects (for example, antiparkinson agents are anticholinergic) and the problems of polypharmacy develop."⁶⁶ For example, while procyclidine, orphenadrine, benztropine and benzhexol are anticholinergic drugs which improve tremor and stiffness, they can produce antimuscarinic effects of their own in higher dosage.

⁶⁴ G. Addonizio, *et al.*, "Neuroleptic malignant syndrome: review and analysis of 115 cases" *Biological Psychiatry* (1987) 22, 1004-1020.

⁶⁵ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.23.

⁶⁶ *Ibid.*

ANTIMUSCARINIC (ANTICHOLINERGIC DRUGS) — B.N.F. 4.5.

BNF guideline doses

Drug	Proprietary	BNF guideline doses
Benzhexol Hydrochloride	<ul style="list-style-type: none"> • Artane (tablets) • Broflex (syrup) 	1mg daily gradually increased; usual maintenance dose 5-15mg daily.
Benztropine Mesylate	<ul style="list-style-type: none"> • Cogentin (tablets, injection) 	By mouth 0.5-1mg daily, maximum 6mg daily, usual maintenance dose 1-4mg daily. By IM or IV injection 1-2mg, repeated if symptoms reappear.
Biperiden	<ul style="list-style-type: none"> • Akineton (tablets, injection) 	By mouth 1mg b.d., gradually increased to 2mg t.d.s. with usual maintenance dose of 3-12mg daily. By IM or slow IV injection, 2.5-5mg up to four times daily. 150mg daily gradually increased, maximum 400mg daily.
Orphenadrine Hydrochloride	<ul style="list-style-type: none"> • Biorphen (elixir) • Disipal (tablets) 	By mouth 2.5mg t.d.s., usual maximum 30mg (60mg exceptionally). Acute dystonia: IM injection, 5-10mg, maximum 20mg daily; IV injection, 5mg and the occasional patient may need 10mg or more and require 30 minutes to obtain relief.
Procyclidine Hydrochloride	<ul style="list-style-type: none"> • Procyclidine (tablets) • Arpicolin (syrup) • Kemadrin (tablets, injection) 	

Source: *British National Formulary* (British Medical Association and Royal Pharmaceutical Society of Great Britain, September 1997), 34, 222.

CAUSES OF TREATMENT SUCCESS AND FAILURE

In general terms, a prescribed drug may bring about a satisfactory response, have an inadequate effect, exacerbate the patient's condition, or have intolerable side effects. What constitutes treatment failure is determined by the treatment aims and expectations: eliminating hallucinations, improving socialisation, decreasing hyperactivity, improving self-care, eliminating assaultiveness, etc. It also depends on the perspective of the individual making the judgement. Not infrequently what the doctor considers to be a "good" outcome the patient does not.

Underdosing and inadequate therapeutic trial

From a clinical viewpoint, the two most important causes of treatment failure involving psychotropic drugs are underdosing and an inadequate therapeutic trial of the drug. For most psychotropic drugs, three weeks is the minimum period of treatment needed to determine whether it will prove effective. Although some patients may show some immediate improvement in agitation or anxiety when started on an antipsychotic drug, these effects are mainly the result of non-specific sedation. The actual impact of the drugs on psychotic symptoms develops with regular administration over a period of several weeks. Although failure to respond to a particular drug, or a worsening of the patient's condition, may indicate that the dosage is too low, it may also reflect a mistaken diagnosis. The effect on mood of antidepressant medication similarly increases over time and it may take a number of weeks before maximum benefit is achieved.

Cau. of treatment failure

What constitutes success or failure depends on the aims and expectations of the individual making the judgement. If a patient expects or hopes that a particular drug will cure him of his illness, rather than alleviate the worst symptoms, he but not his doctor may later consider that the treatment was a failure. What constitutes failure therefore depends upon how failure is to be measured, e.g. failure to restore normal health or failure to improve patient's function in certain key areas.

The treatment prescribed is not an effective treatment of the misdiagnosed underlying condition. Unless a patient's condition naturally remits, or the same treatment is conventionally used both for the real illness and the misdiagnosed condition, failure to alleviate the symptoms is a likely consequence of misdiagnosis. Any natural or fortuitous recovery may be misinterpreted by the clinician as confirmation of his erroneous diagnosis so that, if relapse later occurs, the same diagnosis is made and the same treatment prescribed.

Treatment may be ineffective if the prescribed drug has not been administered or taken as prescribed, e.g. patient has defaulted on the treatment by holding some or all of his oral medication under the tongue, later disposing of it. In drug trials, insufficient compliance with treatment is sometimes taken to constitute missing more than 50 per cent. of the prescribed dose in two consecutive weeks. Lack of co-operation is not invariably related to therapeutic or adverse experiences.

The degree of response to a drug is highly variable. There are many possible reasons for this, including pharmacokinetic differences and differences in biological sensitivity. For example, a study of the plasma concentrations of the antidepressant nortriptyline in 25 patients receiving a standard oral dose found a thirty-fold range.

If the patient is taking more than one prescription or also taking unprescribed drugs, the resulting drug interactions may reduce (or, indeed, potentiate) the effect of one or more of the substances. Common drug interactions are listed in the BNF (1142).

The dosage may be too high or too low or the patient have developed a tolerance for the drug in question.

• **Semantic**

• **Misdiagnosis**

• **Non-compliance**

• **Biological variability**

• **Drug interactions**

• **Inadequate dosage**

• The milieu

The milieu within which the drug is taken influences its effect, e.g. the ward atmosphere, a family home with high expressed emotion, or a poor doctor-patient relationship. Research conducted at the John Hopkins University indicated that registrars possessing the qualities of empathy, genuineness and warmth had a higher success rate in treating depressed people than colleagues who did not possess these skills.

• Inadequate period of treatment

The lack of response may be due to the fact that there has been insufficient time since the drug's prescription for it to have a therapeutic effect. The antipsychotic action of neuroleptics takes about six weeks to develop. The mood-elevating effect of tricyclic antidepressants is not evident for about a fortnight and then takes four to six weeks to develop fully.

• Early withdrawal of treatment

A treatment will fail if it has to be discontinued because of intolerable adverse effects, unacceptable laboratory results, or the emergence of an intercurrent illness or condition (such as pregnancy) which requires treatment incompatible with that prescribed.

• Other clinical reasons

Maximum therapeutic effect may often be clinically undesirable.

• Treatment ineffective

The treatment may have been mistakenly licensed or approved as an effective treatment for the target condition.

• Condition untreatable

The condition may be untreatable at present, i.e. no effective treatment is currently available.

Insight and reasons for non-compliance

Relapse rates amongst discharged in-patients have been estimated to be more than 50 per cent. in the first year and 70 per cent. in the second year after hospitalisation.⁶⁷ It has also been estimated that 25–50 per cent. of out-patients omit sufficient of their medication to impair therapeutic efficacy.⁶⁸ A "medication-therapeutic alliance" is essential because only if the clinician wins the patient's co-operation will he take medication following discharge.⁶⁹ Lader has summarised a number of factors or situations which contribute to poor co-operation: complicated drug regimes, unpleasant side-effects, lack of insight into the nature of the illness and its treatment, opposition to the use of medication to treat mental illness, the need to continue with medication for some time after symptoms have been suppressed, and delay in the

⁶⁷ N. Sulliger, "Relapse" *Journal of Psychosocial Nursing Mental Health Services* (1988) 26(6): 20–23.

⁶⁸ M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.21.

⁶⁹ W.S. Appleton, *Practical Clinical Psychopharmacology* (Williams and Wilkins, 3rd ed., 1988), p.21.

onset of relapse after stopping medication, so that the patient thinks he is well without drugs.⁷⁰ The reasons given by patients for medication non-compliance in one recent survey included the following factors: do not see the need for medication; side-effects; forgot to take medication; felt better and stopped taking it; medication not effective; do not want to be on medication; got tired of taking it; like the high feeling; Lord told me not to take it; do not want poison in my body; my spouse does not like me on medication; no transportation to pharmacy; do not want to take medication every day. The nurses' perceptions of the reasons for these patients' non-compliance were considerably less varied. Some of the reasons given by patients were interpreted by them as mere camouflage for a belief that the medication was unnecessary. Half of the defaulting patients were considered to hold this belief.⁷¹

Causes of treatment success

The factors affecting treatment success are to some extent the reverse of those applicable in relation to treatment failure. However, with regard to psychotropic drugs, it is important to realise that "inevitably, guesswork is a major element in this activity, and any good which comes from it is at least partly attributable to spontaneous drifts in the severity of illness and to non-specific processes in the treatment situation."⁷² It is important therefore that the contribution of natural processes, both biological and social, is not overlooked⁷³ and drug responses are undoubtedly influenced by placebo effects.⁷⁴ Spontaneous remission may partly account for the fact that a patient does not respond to a particular drug when he seemed to have responded to in the past.

PSYCHOLOGICAL TREATMENTS

There are many different kinds of psychological treatments available, including behaviour therapy, cognitive therapy, psychoanalysis, family therapy, psychotherapy, counselling, group therapy, self-help groups, and social skills training. The first three of these are particularly important in relation to the treatment of severe psychiatric disorders. Other kinds of assistance, such as general social work support, are not treatments as such although important prophylactically. Similarly, marital therapy may be beneficial in terms of improving a patient's social situation but does not have any significant effects on symptoms.

BEHAVIOUR THERAPY

Behaviour therapy seeks to modify learned maladaptive behaviour patterns and it may be used to treat conditions such as compulsive disorders, eating disorders, and phobias. The approach is based on the principles of learning theory, in particular operant conditioning and classical conditioning, which are sometimes collectively

⁷⁰ M. Lader and R. Herrington, *Biological treatments in psychiatry (supra)*, p.21.

⁷¹ V.E. Lund, et al., "Helping the Medicine Go Down: Nurses' and Patients' Perceptions About Medication Compliance" *Journal of Psychosocial Nursing* (1991) Vol. 29, No. 7, 6–9.

⁷² M. Lader and R. Herrington, *Biological treatments in psychiatry* (Oxford Medical Publications, 2nd ed., 1990), p.12.

⁷³ *Ibid.*

⁷⁴ *Ibid.*, p.27.

referred to as associative learning.⁷⁵ Classical conditioning is that first demonstrated by Pavlov. If event A (the sounding of a bell) is habitually followed by event B (the bringing of food), which event initiates the behavioural response C (salivation), it will commonly be found that the occurrence of event A itself eventually initiates the behavioural response C. Operant conditioning is a form of learning in which a voluntary behaviour is engaged in because its occurrence is reinforced by being rewarded. Such behaviour is independent of stimuli and was termed operant behaviour by Skinner.⁷⁶ Behaviour may be reinforced positively, by way of reward, or negatively, by eliminating or withdrawing an unpleasant consequence previously associated with a particular form of behaviour.

Token economy programmes

The treatment of chronic schizophrenia may include the use of token economy programmes, in which tokens are awarded for desirable behaviour which can then be used to buy ward privileges. This is normally portrayed as an example of positive reinforcement because a desired behavioural response is followed by a rewarding event, with the aim of strengthening and making more frequent that behaviour. However, the fact that the "privileges" — being allowed out of bed, being allowed notepaper and stamps, being allowed cigarettes, etc. — must first be withdrawn before they can be offered as prizes means that the benefits of compliance are usually viewed by the patient as a restoration of rights rather than as rewards, which undermines the proposition. In other words, the association of events formed in the patient's mind is that certain behaviour leads to compulsory hospitalisation and a withdrawal of rights rather than that a cessation of the behaviour leads to reward. Not surprisingly, resentment is common and the legality of withdrawing what many people would regard as basic rights by designating them as privileges has yet to be challenged in the courts. Although section 63 of the Mental Health Act 1983 provides that a detained patient's consent is not required for treatment given under the direction of his responsible medical officer, it must be doubtful whether the more draconian regimes could survive an application to the European Court of Human Rights.

COGNITIVE THERAPY

Cognitive therapy is based on the assumption that an individual's affect and behaviour are largely determined by the way in which he structures the world. The focus is therefore on maladaptive patterns of thinking. The cognitive approach includes four processes: (1) eliciting automatic thoughts; (2) testing automatic thoughts; (3) identifying maladaptive underlying assumptions; and (4) testing the validity of maladaptive assumptions.⁷⁷ It is often found that a patient's automatic thoughts form patterns which represent maladaptive general assumptions that guide the patient's life, as in the following abbreviated example of a flowchart compiled by Beck⁷⁸ —

⁷⁵ Cognitive learning, which forms the basis of cognitive therapy, is a more complicated process and refers to the process by which information perceived by the brain is interpreted in the context of previous information in order to solve problems.

⁷⁶ B.K. Puri and P.J. Tyrer, *Sciences Basic to Psychiatry* (Churchill Livingstone, 1992), p.280.

⁷⁷ H.I. Kaplan and B.J. Sadock, *Synopsis of Psychiatry* (Williams and Wilkins, 7th ed., 1994), p.861.

⁷⁸ See A.T. Beck, *et al.*, *Cognitive therapy of depression* (Guilford, 1979), p.33.

PRIMARY ASSUMPTION



SECONDARY ASSUMPTION



AUTOMATIC THOUGHTS



AFFECT

If I'm nice (suffer for others) bad things (divorce) won't happen to me

It is my fault when bad things happen (because I wasn't nice)

I ruined my children's lives by getting a divorce. I never have good times. It's because I'm not nice.

Sadness and depression

The behavioural techniques used to modify cognitive dysfunction include schedules of activities, assignments, cognitive rehearsal, role playing and diversion techniques. Cognitive therapy has been applied mainly to depressive disorders, in relation to which studies have clearly shown that it is effective and, in some cases, superior or equal to medication alone. It can be used in conjunction with medication to treat major depressive disorders. Medication appears to be ineffective in changing depressive attitudes and there is increasing evidence that the mere alleviation of symptoms is less effective in preventing relapse than combining drugs with other forms of treatment. Cognitive therapy has also been used to treat other conditions, such as obsessive-compulsive disorders and paranoid personality disorders, and it has an important role to play in improving compliance with prescribed medication. For example, where the patient's limited adherence reflects difficulty acknowledging either that he is mentally unwell or that he may have to rely on medication for much of his life.⁷⁹

PSYCHOANALYSIS

The brain does not have unlimited or unconditional access to the material stored by it and, according to Freud, a purely biomedical approach to mental disorder can never be satisfactory. Psychoanalysis aims to provide psychiatry with the missing psychological foundation; to lay open the origin, mechanism, and interrelation of the symptoms which make up the clinical pictures; and to discover the common ground upon which a correlation of bodily and mental disorder becomes comprehensible:

"The second difficulty you will find in connection with psycho-analysis is not, on the other hand, inherent in it, but is one for which I must hold you yourselves responsible, at least in so far as your medical studies have influenced you. Your training will have induced in you an attitude of mind very far removed from the psycho-analytical one. You have been trained to establish the functions and disturbances of the organism on an anatomical basis, to explain them in terms of chemistry and physics, and to regard them from a biological point of view; but no part of your interest has ever been

⁷⁹ See A.T. Beck, *et al.*, *Cognitive therapy of depression* (Guilford, 1979), p.72.

directed to the mental aspects of life, in which, after all, the development of the marvellously complicated organism culminates. For this reason a psychological attitude of mind is still foreign to you, and you are accustomed to regard it with suspicion, to deny it a scientific status, and to leave it to the general public, poets, mystics, and philosophers. Now this limitation in you is undoubtedly detrimental to your medical efficiency; for on meeting a patient it is the mental aspects with which one first comes into contact, as in most human relationships, and I am afraid you will pay the penalty of having to yield a part of the curative influence at which you aim to the quacks, mystics, and faith-healers whom you despise.

... It is true that the psychiatric branch of medicine occupies itself with describing the different forms of recognisable mental disturbances and grouping them in clinical pictures but in their best moments psychiatrists themselves are doubtful whether their purely descriptive formulations deserve to be called science. The origin, mechanism, and interrelation of the symptoms which make up these clinical pictures are undiscovered: either they cannot be correlated with any demonstrable changes in the brain, or only with such changes as in no way explain them. These mental disturbances are open to therapeutic influence only when they can be identified as secondary effects of some organic disease.

This is the lacuna which psycho-analysis is striving to fill. It hopes to provide psychiatry with the missing psychological foundation, to discover the common ground on which a correlation of bodily and mental disorder becomes comprehensible. To this end it must dissociate itself from every foreign preconception, whether anatomical, chemical, or physiological, and must work throughout with conceptions of a purely psychological order, and for this very reason I fear that it will appear strange to you at first.⁸⁰

Abreaction and free association

Psychoanalysis attempts to integrate previously repressed ideas or experiences with conscious material so as to relieve the underlying causes of the patient's symptoms. The patient gradually becomes aware of previously unacknowledged significant connexions between thoughts and behaviour. Before this happens, resistance to dealing with noxious psychic material is almost inevitably encountered and the transference to other people of certain emotions and fantasies is also common. Abreaction is a process by which repressed material is brought back into consciousness. Free association is a method which involves relaxing the patient and getting him to express the thoughts and emotions which then spontaneously flow through his brain. Psychoanalysis is not available under the National Health Service but it may be used in private clinics and hospitals to treat anxiety disorders, phobias, obsessive-compulsive disorders and some forms of depression.

FAMILY THERAPY

Familial factors are involved in the development of schizophrenia. Family-orientated treatments may include a brief educational programme, a relatives' group, and family sessions including the patient and key relatives (1264).

⁸⁰ S. Freud, *Introductory Lectures on Psychoanalysis* (trans. J. Riviere, George Allen and Unwin, Rev. ed., 1929), pp.15-16.

PSYCHOLOGICAL THERAPIES

- **Behavioural therapy**
Based on the principles of learning theory, in particular operant conditioning and classical conditioning. Seeks to modify learned maladaptive behaviour.
British Association for Behavioural and Cognitive Psychotherapies, Dept. of Clinical Psychology, Northwick Park Hospital, Watford Road, Harrow HA1 3UU. Tel. 0181 869 2325.
- **Cognitive therapy**
Focuses on maladaptive patterns of thinking patterns behind the individual's affect and behaviour. Available on the NHS.
- **Cognitive analytical therapy**
Combines cognitive therapy with psychotherapy. Average of 16 sessions. Available on the NHS.
British Association of Cognitive Analytic Therapists, Munro Clinic, Guy's Hospital, London SE1 9RT. Tel. 0171 955 4822.
- **Counselling**
A form of psychotherapy in which a person who faces a specific challenge is helped to clarify and find solutions to the problem.
British Association for Counselling, 1 Regent Place, Rugby, Warwick CV21 2PJ. Tel. 01788 550899.
- **Family therapy**
Regards the family as the patient. Behavioural methods are commonly used.
The Institute of Family Therapy, 43 New Cavendish Street, London W1M 7RG.
- **Gestalt therapy**
Involves acting out conflicts and feelings, often in a very physical way.
Gestalt Centre, 64 Warwick Road, St. Albans AL1 4DL. Tel. 01727 864606.
- **Hypnotherapy**
A form of psychotherapy in which the patient goes into a voluntary state of deep relaxation. Repressed feelings are brought to conscious level and explored.
The National Register of Hypnotherapists and Psychotherapists, 12 Cross Street, Nelson, Lancs BB9 7EN. Tel. 01282 699378.
- **Primal therapy**
Based on the idea that certain behaviours result from suppressed primal frustrations. Not available on the NHS.
London Association of Primal Psychotherapists, 18a Laurier Road, London NW1 1SH. Tel. 0171 267 9616.
- **Psychoanalysis**
Aims to bring repressed conflicts into consciousness. Not available on the NHS.
Institute of Psychoanalysis, 63 New Cavendish Street, London W1M 7RD. Tel. 0171 580 4952. Sessions per week for up to 5 years. Cost £50 per hour.
- **Psychotherapy**
A general term. Variants include personal construct therapy, analytic psychotherapy and hypnotherapy.
British Association of Psychotherapists, 37 Mapesbury Road, London NW2 4HL. Tel. 0181 452 9823.

Sources: A. Neustatter, *Independent on Sunday*, 17 March 1996, pp. 11-12; Essential Psychiatry, Ed. N. Rose, Blackwell Scientific Publications, Oxford, 1998. The qualification of practitioners in the various fields varies and many private practitioners are unregulated.

Complementary or alternative remedies for mental disorder include homeopathy, acupuncture, hypnotherapy, dietary regimes, aromatherapy, movement and exercise therapies, such as dance therapy. Apart possibly from acupuncture, there is no evidence that these approaches are, properly speaking, remedies when it comes to major psychiatric disorders, although some of them have a role to play as one part of an overall treatment programme. In a tribunal context, their relevance is mainly limited to the fact that seriously ill young patients not uncommonly voice a preference for such alternative "natural" remedies. While this is understandable, given the range of adverse effects associated with psychotropic medication, it is almost invariably unrealistic. Furthermore, nature's answer to major psychiatric disorder during the period before modern drug therapy was all too often death. Thus, while the safe approach to prescribing toxic drugs is a cautious one, it must also be acknowledged that the movement from institutional to community care since the 1950s was largely made possible by the development of antipsychotic drugs.

SECLUSION

Seclusion (solitary confinement) is defined in the Code of Practice as the supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm.⁸¹ The practice first became commonplace in the early 1840s as mechanical restraint fell into disrepute.⁸² It is not a procedure that is specifically regulated by the 1983 Act although it may sometimes constitute medical treatment as defined by section 145. Many hospitals have nevertheless discontinued the practice, including some regional secure units which are able to manage disturbed patients by the use of intensive care areas. In 1995, the Mental Health Act Commission noted that the overall use of seclusion on open wards had declined to relatively low levels. It was, however, more frequently employed in high dependency units and Special Hospitals but to a decreasing extent.⁸³ Seclusion is unused in general psychiatry hospitals in Scotland and the Mental Welfare Commission for Scotland is against the practice.

THE CASES FOR AND AGAINST SECLUSION

Some of the respective arguments for and against seclusion were examined in the *Report of the Committee of Inquiry into Complaints about Ashworth Hospital (the "Ashworth Report")*.⁸⁴

⁸¹ *Mental Health Act 1983: Code of Practice* (Department of Health and Welsh Office, 2nd. ed., 1993), para. 18.15.

⁸² See P. Fennell, *Treatment without consent* (Routledge, 1996), pp. 20-21. According to the Report of the Metropolitan Commissioners in Lunacy for 1843, at pp.145-146: "Seclusion or solitary confinement is now getting into general use in the treatment of the insane, and great numbers of the proprietors of public and private asylums throughout the country are fitting up and bringing into use solitary cells, and padded rooms for violent and unmanageable lunatics."

⁸³ Mental Health Act Commission, *Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), p.31.

⁸⁴ *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, Cmnd. 2028 (1992). See chapter xxii.

The case for seclusion

"... seclusion retains its supporters among those committed to the highest standards of psychiatric care and treatment, although these supporters would wish to see its use reduced to an irreducible minimum. They argue, with force, that seclusion effectively controls disturbed behaviour, and prevents disturbance from escalating and spreading, by isolating the person or persons involved. It offers a safe and non-stimulatory environment in which the person or persons may 'cool off'.⁸⁵

Other arguments for continuing to permit the practice include that its prohibition would lead to more locking of wards, to the development of more secure facilities, to the prescription of higher levels of medication (particularly on acute intensive care units), and to greater use being made of control and restraint.⁸⁶ Furthermore, hospitals might be reluctant to accept from the prison service, or from high or medium secure units, patients who require a high degree of security or who are thought to be potentially violent.

The case against seclusion

"Critics of seclusion have consistently argued that it is an inhuman and degrading way to respond to a crisis; that it is too often used for minor disturbances or transgression of rules; that people are kept in seclusion longer than is necessary to control the initial unmanageability; that it is used as a sanction by staff seeking to impose control over patients; and that little or no attention is paid to psychological and physical effects of isolation on those who are mentally fragile.⁸⁷

Patient surveys have confirmed that seclusion is widely disliked by patients, being perceived by them as a punishment and causing feelings of depression and of being trapped and abandoned. Its use may also increase persecutory delusions and hallucinations.⁸⁸ The Ashworth Committee concluded that the evidence pointed strongly to the fact that seclusion lacks any therapeutic value. It recommended that legislation should provide that, during the patient's waking hours on the ward, a patient shall not be denied human contact and be kept in isolation in a room, the door of which is fastened or held so that he or she is unable, contrary to expressed desire, to leave the room at will. The report recommended the phasing out and ultimate ending of seclusion over a two to three year period—

"We adhere ... to the principle that seclusion is unnecessary, ought not to be used in the care of mentally disordered people, and should be prohibited by statute.⁸⁹

⁸⁵ *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, Cmnd. 2028 (1992), at p.204.

⁸⁶ According to the Ashworth Report, "certainly, staffing would have to be stepped up on those, not very frequent, occasions when the behaviour called for three or four nurses staying with the patient, exercising restraint techniques, for some little time. We take the view that such moments provide a good opportunity for nursing staff to understand the springs of aggressive human behaviour and to learn to predict when the patient is likely to become assaultive, given certain environmental and personal factors. Human contact in the shape of skilled nursing is, perhaps, more essential at times of crisis intervention than in periods of patient calm." *Ibid.*, p.205.

⁸⁷ *Ibid.*, p.204.

⁸⁸ R. Cope, Royal College of Psychiatrists' Forensic Section Meeting, 12 February 1993.

⁸⁹ *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, *supra*, pp.205-206.

Nursing attitudes

Some nursing approaches to the ethical problems involved in using seclusion have summarised by Morris⁹⁰.

"McCoy (1983)⁹¹ argues that an ethical dilemma arises when a nurse contemplates the use of seclusion. It is where to draw the line between the infringement of personal liberty for a difficult or potentially dangerous patient and the probable benefits of the other patients on the ward from that infringement. Pilette (1978)⁹² strongly objects to decisions on seclusion being made on this basis. She rather harshly comments that in such a utilitarian approach essentially anything that disturbs the tranquillity of the mental ward is punishable by seclusion. Morrison (1987)⁹³ considered seclusion to be associated more with the traditional custodian mode of psychiatric nursing than with current nursing ideologies ... Gibson (1989)⁹⁴ remarks that if one accepts that the use of seclusion is largely determined by staff levels, then one must accept that this is a misuse of seclusion as the client would not need the intervention of seclusion if staffing levels were satisfactory."

Seclusion and restraint

It is noticeable that the current debate about seclusion mirrors in many respects that in the 1840s about the use of mechanical restraint. Some of the observations in the Report of the Metropolitan Commissioners in Lunacy for 1844 are particularly pertinent:

"Those who profess the entire disuse of restraint, employ manual force and seclusion as parts of their method of management, maintaining that such measures are consistent with a system of non-restraint ... But in cases where he is held by the hands of attendants, or when he is for any excitement or violence forced by manual strength into a small chamber or cell, it is said that restraint is not employed, and the method adopted in these cases, is called the 'non-restraint system.' ... it is difficult to understand how this also can be reconciled with the profession of abstaining from all restraint whatsoever, so as to be correctly termed 'Non-restraint.' It seems to us that these measures are only particular modes of restraint, the relative advantages of which must depend altogether on the results."⁹⁵

Those who advocated never using any mechanical restraint contended that their practice was the most humane and the most beneficial to the patient, soothing instead of coercing him during irritation, and encouraging him when tranquil to exert his faculties, in order to acquire complete self-control; that a recovery thus obtained was likely to be more permanent; that mechanical restraint had a bad moral effect in that it degraded the patient in his own opinion; that mechanical restraint was liable to great abuse from keepers and nurses, who would often resort to it for the sake of

⁹⁰ B.E. Morris, "Seclusion: Does the previous literature reflect the same message as the recently published Code of Practice?" *Forensic Psychiatric Nursing Journal* (1990) 3, 6-7.

⁹¹ S.N. McCoy & S. Garrisson, "Seclusion — The process of intervening" *Journal of Psychosocial Nursing and Mental Health Services* (1983) 21, 8-15.

⁹² P.C. Pilette, "The Tyranny of Seclusion: A Brief Essay" *Journal of Psychosocial Nursing and Mental Health Services* (1978) 16(10), 19-21.

⁹³ P. Morrison, "The Practice of Seclusion" *Nursing Times* (1987) 83(19), 62-66.

⁹⁴ B. Gibson, "The Use of Seclusion" *Nursing* (1989) 3(43).

⁹⁵ *Report of the Metropolitan Commissioners in Lunacy for 1844* (Bradbury & Evans, 1844), pp.137-138.

avoiding trouble to themselves and that patients could be controlled as effectually without mechanical restraint, as with it. Those who adopted non-restraint as the general rule, but made exceptions in certain extreme cases, affirmed that it was necessary to possess a certain degree of authority or influence over the patient; that the occasional use of slight mechanical restraint had in many cases promoted tranquillity; that it prevented the patient from injuring himself or others; that the patient's safety and tranquillity were not the only considerations; that the expense of recruiting more attendants was impracticable; and that minor mechanical restraint was preferable to the act of "forcing him into a place of seclusion, and leaving him at liberty to throw himself violently about for hours altogether." Furthermore, "when a Patient is forced into and secluded in a small room or cell, it is essentially coercion, in another form and under another name; and ... it is attended with quite as bad a moral effect, as any that can arise from mechanical restraint."⁹⁶

THE CASES FOR AND AGAINST ALLOWING SECLUSION

Arguments for allowing seclusion

- It effectively controls disturbed behaviour.

- It prevents disturbance from escalating and spreading.

- It offers a safe and non-stimulating environment within which the secluded person may "cool off."

- Other patients have a right to be protected from disturbed behaviour, including not being distressed by witnessing disturbed behaviour.

- Nursing staff have a right to be protected from assault and physical confrontation.

Arguments against allowing seclusion

- Seclusion is unnecessary given reasonable staffing levels and the use of intensive care areas.

- Seclusion is inhuman and degrading and little or no attention is paid to the psychological and physical effects of isolation on those who are mentally fragile.

- The evidence strongly suggests that seclusion lacks any therapeutic value. Human contact in the shape of skilled nursing is more essential at times of crisis intervention than in periods of patient calm.

- Seclusion may, moreover, be counter-therapeutic, being perceived as punishment, causing depression and feelings of being trapped and abandoned, and an increase of persecutory delusions and hallucinations.

- There is an inevitable tendency to abuse the practice so that it is used for minor disturbances or transgression of rules and allowed to continue after the immediate crisis has passed.

⁹⁶ *Report of the Metropolitan Commissioners in Lunacy for 1844* (Bradbury & Evans, 1844), pp.157-159.

- Prohibiting the use of seclusion may have the effect of increasing reliance on high doses of medication.
- Prohibiting the use of seclusion may lead to more locking of wards and to more locked wards being developed, and thus an overall decline in the liberty enjoyed by patients.
- Prohibiting the use of seclusion may lead to greater use of control and restraint techniques.
- Prohibiting the use of seclusion may have the effect that open/low secure wards are more reluctant to accept potentially violent patients from prisons and from high or medium secure units.
- The argument that prohibiting seclusion would simply lead to an increase in other equally undesirable practices (more locking of wards, more locked wards, high levels of medication, greater use of restraint) is spurious. Adequate nursing levels will ensure against this and the hospital budget should make provision for this.

THE CODE OF PRACTICE

The Mental Health Act 1983 and the regulations made under that Act are both silent about the practice of seclusion but it is a practice which is subject to guidance in Chapter 18 of the Code of Practice. This chapter, which deals with issues concerning patients who present particular management problems, emphasises the importance of distinguishing between the need to control patients who pose an immediate threat to themselves or those around them and the need to keep some detained patients in a secure environment.⁹⁷ In most cases, the Commission has found that any use made of seclusion is consistent with its guidance although the frequency of use in some units specialising in learning disability or acquired brain injury has caused the Commission some concern.⁹⁸ The Commission has also had reservations about practice in secure private hospitals which lack residential 24 hour medical cover and justify seclusion as a beneficial form of treatment.⁹⁹

The definition of seclusion

Seclusion is defined in the Code as the supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm. Previously, the Mental Deficiency Regulations 1948 and the Mental Treatment Rules 1948 provided that a patient "shall be deemed to be kept in seclusion if at any time between the period commencing at 8am and ending at 7pm he is isolated in a room the door of which is fastened or held so that he is unable to leave the room at will, but not if he is isolated in a room in which the lower half of the door is so fastened or held but the upper half left open."¹⁰⁰ Seclusion has elsewhere been

⁹⁷ *Mental Health Act 1983: Code of Practice* (Department of Health and Welsh Office, 2nd ed., 1993), para. 18.1.

⁹⁸ Mental Health Act Commission, *Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), pp.31-32.

⁹⁹ *Ibid.*, p.110.

¹⁰⁰ Mental Deficiency Regulations 1948, reg. 24(2); Mental Treatment Rules 1948, r.57(2).

defined as "the supervised confinement of a patient specifically placed alone in a locked room for a period at any time of the day or night for the protection of self or others from serious harm"¹⁰¹ and as the act of temporarily locking a disturbed patient in a locked room.¹⁰²

Inadequacy of definitions

The definition in the Code is inadequate. According to it, if a patient is not being supervised then he is not being secluded and, similarly, he is not being secluded if he is in solitary confinement as part of a behaviour modification programme. Likewise, the definition in the 1948 Regulations is not entirely satisfactory. The issue is whether the patient is being confined to a particular room, not the time of day, or whether the room within which he is being isolated is also his bedroom. Nor is it helpful to distinguish between seclusion and "time-out" for these purposes.¹⁰³ Seclusion is solitary confinement. Confinement means that the person is not free to leave the cell or room in which he is confined and a definition of solitary confinement would be as follows: "solitary confinement" means the confinement of a patient alone in a room at any time of the day or night and a patient is confined to a room if he may not leave that room at will."

When seclusion may be permissible

The sole aim of seclusion is to contain severely disturbed behaviour which is likely to cause harm to others.¹⁰⁴ Even then, it should not be used if there is a risk that the patient may take his own life or otherwise harm himself¹⁰⁵ or if increased staffing would deal with the problem. It is an emergency measure, a last resort, to be invoked only after all reasonable steps have been taken to avoid its use, and only then as little as possible and for the shortest possible time.

When seclusion should not be used

Seclusion should never be used where there is a risk that the patient may take his own life or otherwise harm himself.¹⁰⁶ It is not a treatment technique. It should not

¹⁰¹ *Review of Special Hospitals Seclusion Procedures* DHSS, 1985, para. 3.6.

¹⁰² W. Campbell, et al., "The Use of Seclusion" *Nursing Times* (1982) 1821-1825.

¹⁰³ The element of deprivation of liberty is the same and both can involve the detention and restraint of an individual which is justified as a form of behaviour therapy. Thus, Gostin commences a sentence in his textbook with the words, "Short term seclusion, sometimes referred to as 'time out' or 'cooling down'" (L. Gostin, *Mental Health Services - Law and Practice* (Shaw & Sons Ltd.), para. 20.08A.

¹⁰⁴ *Mental Health Act 1983: Code of Practice* (supra), para. 18.15. The Ashworth Report refers to the use of seclusion to protect the patient from serious self-harm: "If seclusion is to continue as a permissible instrument of patient-care, we are of the view that it should be definably restricted to those cases where there is a clear and present danger to the life and limb of the patient, or others on the ward." *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, Cmnd. 2028 (1992), p.204.

¹⁰⁵ As to this, see also the observations in the Ashworth Report: "seclusion should never be used for suicidal patients or patients who threaten to harm themselves. If a patient is thought to have a potential for self-injurious behaviour the proper management response is to remain in contact with the patient and not thrust the patient out of sight or out of immediate care." *Ibid.*, p.203.

¹⁰⁶ Almost all policies now state that seclusion should only be used if there is no other way of dealing safely with a patient who is posing a serious physical risk to himself or others. However, there is ultimately no agreement about whether seclusion can ever be justified as a way of dealing with the risk of self-harm. The Commission's view is that the patient's despair indicates a need for intensive therapeutic contact, not isolation.

feature as part of any treatment programme, be used as a punitive measure or to enforce good behaviour,¹⁰⁷ as a response to staff shortages, or because property is being damaged.¹⁰⁸ Notwithstanding these injunctions, the reasons for seclusion are sometimes recorded in terms such as, "Placed in seclusion after making several attempts to leave the ward. Secluded due to this reason and insufficient staff."

Policies and procedures

Hospitals should have clear written guidelines on the use of seclusion. The policy should aim to promote alternative approaches to the care and treatment of disturbed behaviour and to limit the use of seclusion to exceptional circumstances.¹⁰⁹ These guidelines should distinguish between seclusion and time-out,¹¹⁰ ensure the safety and well-being of the patient in a dignified and humane environment; contain instructions on environmental standards; define the roles and responsibilities of all staff members; set down procedures for monitoring, recording, reviewing and following up decisions to seclude; and make provision for any care and support to a patient rendered necessary by their seclusion.¹¹¹ In general terms, every clinical team should assess whether or not the ward can cease to use the practice and, if continuing to use it, they should promote alternative responses to disturbed be-

¹⁰⁷ As to this, see p.203 of the Ashworth Report: "We believe that seclusion is seen by staff as a way of correcting or managing deviant behaviour. This deviant behaviour may be interpreted as anything that interferes with the smooth running of the ward or challenges the authority of staff. Thus, patients may be secluded for failing to obey instructions, or failing to carry out ward tasks, or for venting anger or abuse on another. We believe this to be unacceptable. We believe that seclusion has become so familiar a management technique that staff have ceased to question its use ... We believe that corrective isolation has no place in modern psychiatric services ... [Although] it is accepted that there is no place for seclusion as a punitive or disciplinary measure, ... there is suspicion from time to time that patients are secluded as a disguised punishment for violent behaviour."

¹⁰⁸ *Mental Health Act 1983: Code of Practice* (Department of Health and Welsh Office, 2nd. ed., 1993), para. 18.15. The Ashworth Committee emphasised that "seclusion must never be used to deal with patients' self-harm, as a response by nursing staff to verbal abuse or a single-blow assault by a patient, nor for non-compliance with a task of ward routine, and never for failing to obey instructions from nursing staff. We mention these seemingly obvious 'don'ts', because in the course of our Inquiry we have come across instances when seclusion was employed for these reasons." *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, Cmnd. 2028 (1992), p.206.

¹⁰⁹ See e.g. *The Use of Seclusion and the Alternative Management of Disturbed Behaviour within the Special Hospitals: A Policy Statement* (The Special Hospitals Service Authority, 1993).

¹¹⁰ According to the Code of Practice, hospital guidelines should include a clear definition of time out and procedures for noting and monitoring its use on individual patients (para. 19.10). The important principles of time out are: (a) to enable the patient, if his behaviour is changed, to lead a less restricted life within his usual surroundings or any other setting to which he is likely to go; (b) to form part of a programme where the achievement of positive goals is as much a part of the treatment plan as reducing unwanted behaviour (para. 19.11). It is "a behaviour modification technique which denies a patient for a period (lasting from a few seconds to no more than 15 minutes) opportunities to participate in an activity or to obtain positive reinforcers following (normally immediately) an incident of unacceptable or unwanted behaviour, and which then returns the patient to his original environment. Time out should never include the use of a locked room. Time out should be clearly distinguished from seclusion, which is for use in an emergency only and should never form part of a behavioural programme. All staff working in units which use behaviour modification techniques must be familiar with the principles of time out and the distinction between time out and seclusion. Time out should not normally take place in a room which is used for seclusion on other occasions. It should be seen as one of a range of planned methods of managing a difficult or disturbed patient, and not as a spontaneous reaction to such behaviour" (para. 19.9). To the legal mind, time-out is a variant of seclusion and appears to be merely the adult equivalent of sending a poorly-behaved child to his room.

¹¹¹ *Mental Health Act 1983: Code of Practice*, supra, para. 18.16.

haviour, share responsibility for the reduction or future eradication, audit the reasons for its use, and participate in reviews of incidents leading to seclusion.

The decision to seclude

The decision to use seclusion can be made in the first instance by a doctor, the nurse in charge of the ward, a nursing officer or senior nursing officer. Where the decision is taken by someone other than a doctor then arrangements must be made for a doctor to attend immediately.¹¹² A lack of 24 hour medical cover means that secluded patients within the hospital "can be considered to be at 'high risk'."¹¹³

Living conditions of secluded patients

Seclusion should be in a safe, secure and properly identified room, where the patient cannot accidentally or intentionally harm himself. The room should have adequate heating, lighting, ventilation and seating, and any bed should be fixed. It is a matter for local judgment what the patient is allowed to take into the room but he should always be clothed.¹¹⁴ The room should offer complete observation from the outside while also affording the patient privacy from other patients.¹¹⁵ This is generally achieved by placing a curtain on the outside of the seclusion room door.

Observation of the patient during seclusion

The aim of observation is to ascertain the state of the patient and whether seclusion can be terminated. A nurse should be readily available within sight and sound of the seclusion room at all times and present at all times with a patient who has been sedated.¹¹⁶ If the patient has not been sedated, the level of observation should be decided on an individual basis but a report must be made every 15 minutes.¹¹⁷

Reviewing the need to continue seclusion

Time spent in seclusion should be as short as is necessary to control the patient. If seclusion needs to continue, a review should be carried out in the seclusion room by two nurses every two hours, with a review every four hours by a doctor. If seclusion continues for more than eight hours consecutively, or for more than 12 hours intermittently over a period of 48 hours, an independent review must take place with a consultant and a team of nurses and other health care professionals not directly involved with the patient's care. Where there is no agreement on how to proceed, the matter should be referred to the unit general manager.¹¹⁸

Seclusion records

Detailed records should be kept in the patient's case notes of any periods of seclusion, the reasons for secluding the patient, and any subsequent activity.¹¹⁹ These

¹¹² *Mental Health Act 1983: Code of Practice* (Department of Health and Welsh Office, 2nd. ed., 1993), para. 18.17.

¹¹³ *Mental Health Act Commission, Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), p.111.

¹¹⁴ *Mental Health Act 1983: Code of Practice*, supra, para. 18.21.

¹¹⁵ *Ibid.*, para. 18.22.

¹¹⁶ *Ibid.*, para. 18.18.

¹¹⁷ *Ibid.*, para. 18.19.

¹¹⁸ *Ibid.*, para. 18.20.

¹¹⁹ The keeping of a seclusion register was first recommended by the Metropolitan Commissioners in Lunacy in 1843 and was a legal requirement during the period 1845-1960.

records should cross-refer to a special seclusion book, or seclusion file, which contain a step-by-step account of the seclusion procedure. The principal entries should be made by the nurse in charge of the ward and the record should be countersigned by a doctor and a unit nursing manager.

Monitoring seclusion

The managers should monitor and regularly review the use of seclusion.¹²⁰ This is only possible if the seclusion records are sufficiently specific to enable the monitors to ascertain the reasons for its use and if they specify times of commencement and cessation. It is patently insufficient to record "hostility to staff" as the reason for a patient being placed in seclusion for three consecutive days. Staff incident reviews should seek to establish the sequence of internal and external events which led to the incident and how can these events can be controlled in future. Being able to explain and understand the patient's behaviour, and the indicators and precursors to violence, may help the patient and staff to develop strategies for controlling that behaviour in other ways.

THE LAW CONCERNING SECLUSION

The law concerning seclusion may be considered under the following heads: (1) the Mental Health Act 1983; (2) the common law and related powers; (3) the European Convention on Human Rights.

Mental Health Act 1983

In the Commission's second biennial report, it was said that the practice of seclusion not being directly addressed by the Mental Health Act 1983 the justification for it must be sought at common law.¹²¹ However, various sections of the Act authorise a person's detention for medical treatment. The first question must be whether, as a matter of law, confining a patient in a particular room constitutes part of his detention, part of his treatment, or is part detention and part treatment. This is not an easy question. Fennell describes seclusion as continuing "to occupy a 'twilight zone' between medical treatment and coercion."¹²² Hoggett similarly observes that—

"In a hospital such as Broadmoor, where the secure and highly disciplined environment is itself regarded as a therapy for the patients, the dividing line between what is permitted in the name of treatment and what can only be justified in the name of detention is particularly difficult to draw. But neither concept could be used to justify any and every regime, however harsh, arbitrary or excessive."¹²³

Seclusion as an authorised form of detention

The word "detention" is not defined by the statute. However, in the Australian case of *Paul v. Paul*, it was said that the word "refers to the case of a person lawfully held

against his will, one who is free to depart when he pleases."¹²⁴ The House of Lords has held that the power to detain a patient embraces the use of reasonable force on occasion in order to ensure that control is exercised over patients:

"Although the Act deals comprehensively with the circumstances in which and the method by which an effective detention order can be made, and deals in some detail with the management and control of the patient's property, it does not, perhaps understandably, deal specifically with the powers of nurses in the hospital, or the detailed control of the patients who are inmates for the time being. There can however in my judgment be no doubt that the conception of detention and treatment necessarily implies that the staff at the hospital, including the male nurses, can and on occasion must use reasonable force in order to ensure that control is exercised over the patients."¹²⁵

"[Hospital] orders are made where the mental disorder of the named person 'warrants the detention of the patient in a hospital for medical treatment' ... and that necessarily involves the exercise of control and discipline."¹²⁶

A person may only be detained in hospital under Part II of the Act if that is necessary or justified for his own health or safety or to protect others. Detention implies restraint (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 therefore is that, if the occasion requires it, using reasonable force to remove a patient to a separate room, and detaining him there, represents a lawful exercise of the statutory power of detention.

The limits of the detainer's powers

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 people. An unqualified power to control, restrain or discipline a person receiving treatment in hospital would be unacceptable and the law does not allow power to be used arbitrarily. It is noteworthy that it is not a condition of admission under section 3 that it is necessary for the patient's health or safety, or to protect others, that he is detained. The condition is that it is necessary for these reasons that he receives in-patient treatment, which treatment cannot be provided unless he is detained. The purpose of the statutory powers is that they enable necessary treatment to be given to a patient whose behaviour is putting himself or others at risk, the aim being to eliminate the risk of harm, or further harm, being done. This is the statutory objective, not the imposition of discipline, control and force for their own sake. A hospital is not a boot camp and the use of restraint is not a statutory objective. Both it, and the power of detention, are means, not ends. It is simply the case that detention and restraint may sometimes be necessary to the successful completion of a programme of hospital treatment. The patient's recovery, like that of any other patient, depends on the maintenance of a safe, calm, therapeutic environment, and this is only possible if medical and nursing staff can control violent behaviour. However, there must be no malice, no ill-treatment or

¹²⁴ *Paul v. Paul* (1954) V.L.R. 331.

¹²⁵ Dicta of Widgery C.J. adopted by the House of Lords in *R. v. Bracknell J.J.*, *ex p. Griffiths* [1976] A.C. 314 at 318.

¹²⁶ *Ibid.*, per Lord Edmund-Davies, at 335G, H.L.

¹²⁰ *Mental Health Act 1983: Code of Practice*, *supra*, para. 18.23. Experience shows that the use of seclusion diminishes sharply as soon as it is monitored and this has also been the case with the use of solitary confinement in prisons.

¹²¹ Mental Health Act Commission, *Second Biennial Report, 1985-87* (H.M.S.O., 1987), p.55.

¹²² P. Fennell, *Treatment without consent* (Routledge, 1996), p.225.

¹²³ B. Hoggett, *Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), p.142.

wilful neglect,¹²⁷ and any force used must be reasonable in the circumstances. Re-straint greater in degree, more severe in character, or longer in duration than necessary for the security and care of the patient is an offence.¹²⁸ Furthermore, 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 for any injury resulting from that negligence will be recoverable. There will not, however, be an action for false imprisonment. In *R. v. Deputy Governor of Parkhurst ex p. Hague* [1992] 1 A.C. 58, the House of Lords rejected the submission that a person whose detention has been properly authorised will be unlawfully detained if the conditions in which he is detained become intolerable.

Seclusion as a form of treatment

In practice, the reason for a patient's seclusion may sometimes not be a need to manage disturbed behaviour which is putting other people at immediate and significant risk. Rather, its use is justified as a form of medical treatment. It may be said that the decision to seclude reflects the fact that patient's mental state settles in a non-stimulating environment or that its use forms part of a behaviour modification programme. For example, the Commission's Sixth Biennial Report observed that the use of seclusion in certain secure private hospitals "is viewed as a beneficial form of treatment for their particularly difficult group of patients."¹²⁹

Historical note

The justification of seclusion as a form of treatment was particularly prevalent in the nineteenth century. Indeed, it was initially championed by non-restrainers not as a more humane alternative to mechanical restraint but as one of a range of more enlightened treatments. In 1843, the Commissioners wrote that:

"Seclusion is found to have a very powerful effect in tranquillising and subduing those who are under temporary excitement or paroxysms of violent insanity ... As a temporary remedy, for very short periods, in case of paroxysms and of high excitement, we believe seclusion to be a valuable remedy. We are convinced, however, that it should only be permitted for short periods, and that it should not be permitted as a means of managing and treating those persons who are permanently violent or dangerous."¹³⁰

That any seclusion should be for a short period only was emphasised in 1854 when the Commissioners made the disuse of prolonged solitary confinement a priority, the achievement of which would be "an important improvement in the treatment of the insane."

Sections 63 and 145

The admission criteria permit a person's detention where medical treatment in a hospital is justified or necessary for that person's own health or safety. The

¹²⁷ Under section 127(1) of the 1983 Act, it is an offence for any hospital manager or employee to ill-treat or wilfully to neglect an in-patient receiving treatment for mental disorder.

¹²⁸ *R. v. Roberts*, Commissioners 8th Report, p.37. Such excessive restraint was held in that case to be an offence at common law punishable on indictment. There is no reason to think that such conduct would not amount to ill-treatment within section 127.

¹²⁹ Mental Health Act Commission, *Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), p.110.

¹³⁰ *Report of the Metropolitan Commissioners in Lunacy for 1843*, pp.145-146, referred to P. Fennell, *Treatment without consent* (Routledge, 1996).

definition of medical treatment. section 145 provides that the term "medical treatment" includes nursing and also care under medical supervision, but it does not exclude anything. Section 63 provides that a patient's consent is not required for any form of medical treatment for mental disorder which is not specified in that Part of the Act, provided it is given by or under the direction of the responsible medical officer.

Nurses isolating the patient in an emergency

The emergency seclusion of a patient by nursing staff in order to protect others cannot constitute a section 63 treatment. It is not an action undertaken as a form of medical treatment given under the direction of the responsible medical officer. The aim here is the immediate protection of the patient or others by means of the patient's isolation, not medical treatment for that person's mental disorder.

Behaviour modification programmes

The use of seclusion as part of a behaviour modification programme has a greater claim to being a medical treatment provided under the direction of the responsible medical officer. Indeed, it has been contended that the practice of seclusion (from 2-40 minutes) is integral to certain behavioural modification programmes.¹³¹ Such programmes may combine the use of seclusion with other similar forms of "treatment." In two cases reported by the Commission in its Third Biennial Report, the medical notes indicated that if the patients displayed certain forms of behaviour they were to be placed in seclusion for a period, followed by a further period of detention on the secure ward. One of the patients had been secluded for three hours followed by 45 hours on the secure ward and the other for 30 minutes followed by 47 hours 30 minutes on the secure ward. The plans were written up in the form of a behavioural programme and endorsed by the responsible medical officer.¹³² As to the legal status of these programmes, Hoggett's opinion is that:

"Expecting patients to conform to very high or artificial norms of behaviour, to fit into the system for the system's sake rather than their own, or to be punished for their misdeeds prior to their admission to hospital ... can scarcely qualify as medical treatment under the widest definition. But a carefully designed programme of behaviour modification ... which will meet the needs of the particular group of patients for whom it is designed obviously can qualify."¹³³

If there is a legal distinction between placing a patient in solitary confinement in order to protect himself or others and secluding him in order to discourage the repetition of unwanted behaviour, it is that the former has as its end the protection of the patient or others from harm, and this end is achieved through and legally justified as an exercise of the power of detention, whilst the latter has as its end the therapeutic purpose of alleviating the patient's mental disorder, which is achieved by giving him compulsory "treatment" without his consent under section 63. When it comes to some psychopathic disorders, the distinction between discipline and therapy is not entirely clear, the therapy appearing to consist of nothing more than

¹³¹ See e.g. Mental Health Act Commission, *Sixth Biennial Report, 1993-95* (H.M.S.O., 1995), p.111.

¹³² Mental Health Act Commission, *Third Biennial Report, 1987-89* (H.M.S.O., 1989), p.53.

¹³³ B. Hoggett, *Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), p.144.

instilling discipline in a previously undisciplined adult.¹³⁴ Nevertheless, the first kind of seclusion is justified in terms of protection whereas the second kind is justified on the ground that (like medication) it will improve the patient's mental state. The justification claimed for the latter being the patient's benefit, "...all unnecessary severity, all confinement other than that for the purpose of the unhappy person's recovery" will be subject to censure," per Lord Mansfield in *R. v. Coate* (1772) Loftt. 73.

Seclusion to prevent self-harm

Secluding a patient in order to prevent self-harm is a procedure which has a recognisable medical objective, being the preservation of the patient's physical health and safety. If the seclusion is directed by the responsible medical officer then whether it is a section 63 treatment depends on whether it constitutes a medical treatment "for the mental disorder from which he is suffering." In *B. v. Croydon Health Authority* [1995] 1 All E.R. 683, the Court of Appeal held that the definition of medical treatment in section 145 included a range of acts ancillary to the core treatment. Treatment, in the form of tube feeding, to alleviate the symptoms of mental disorder, in the form of a refusal to eat in order to inflict self-harm, was just as much a part of treatment for the disorder as that directed to remedying its underlying cause. It therefore fell within the ambit of the power conferred by section 63 and could be administered to the patient without her consent. The court dismissed the argument that, whilst force-feeding may be a prerequisite to a treatment for mental disorder, or it may be treatment for a consequence of the mental disorder, it cannot be said to be treatment for that disorder. Furthermore, in the court's opinion, it would be strange if a hospital could, without a suicidal patient's consent, give him treatment for the underlying mental illness but not without such consent be able to treat the consequences of a suicide attempt. In the court's judgment, the term "medical treatment ... for mental disorder" in section 63 included such ancillary acts. With this judgment in mind, it may be that the courts would hold that a responsible medical officer's decision to seclude a suicidal patient, in order to prevent self-harm, and the treatment of injuries following an episode of self-harm, are both "just as much a part of treatment for the disorder as that directed to remedying its underlying cause" and they fall within the ambit of section 63.

Seclusion as a tranquil environment

Applying the judgment in *B.* to the situation of profoundly agitated patients who are secluded because their confinement in a non-stimulating environment is considered to be clinically appropriate, it may again be the case that this constitutes a section 63 treatment if given under the direction of the responsible medical officer. The more so because the immediate and primary aim is to alleviate the patient's mental state. As with all other kinds of medical treatment, the responsible medical officer prescribing this "treatment" owes the patient a duty of care (in his capacity as his consultant) and this must include taking reasonable care to ensure that the regime is not in fact harmful to the patient's health.

¹³⁴ Indeed, the two terms may be synonymous, the preference for one term over the other being determined only by the patient's location (prison-discipline, hospital-treatment).

The common law and related issues

Seclusion involves the detention of an individual, time-out at best a restraint, and treatment without consent is *prima facie* an assault. These three actions potentially involve committing the torts of false imprisonment, trespass to the person and battery. If there is no statutory authority for such acts, the question becomes when, if ever, the common law or some other statutory power provides a legal justification:

- It is lawful at common law to restrain, and if need be detain, a "furious" or "dangerous" lunatic whose state of mind is such that he is a danger to himself and others.¹³⁵
- It is lawful to administer to a patient who "lacks the capacity to give or to communicate consent to that treatment" whatever treatment is judged in the best interests of the patient as being "necessary to preserve the life, health or well-being of the patient" or "to ensure improvement or prevent deterioration in her/his physical or mental health."¹³⁶
- It is lawful to use reasonable force in self-defence or to defend other persons or property and a person "may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting the lawful arrest of offenders or suspected offenders or persons unlawfully at large."¹³⁷
- It is justified to detain a person if that is immediately necessary to prevent a breach of the peace. Such a breach occurs where "harm is actually done or is likely to be done to a person or in his presence to his property or a person is in fear of being so harmed through an assault, an affray, an unlawful assembly or other disturbance."¹³⁸ "Every citizen in whose presence a breach of the peace is being, or reasonably appears to be about to be, committed has the right to take reasonable steps to make the person who is breaking or threatening to break the peace refrain from doing so; and those reasonable steps in appropriate cases will include detaining him against his will."¹³⁹

The common law should not be used to justify protracted periods of seclusion and these powers of detention and restraint are subject to a reasonableness test. For the use of force to be reasonable, the force used must be no more than is in fact necessary to accomplish the object for which it is allowed and the reaction must be in proportion to the harm threatened. Acts which involve unreasonable force include gross over-reaction to a situation, the continuation of force once the need for it is over, retaliation, punishment. Thus, Hogggett says that¹⁴⁰:

¹³⁵ *Brookshaw v. Hopkins* (1772) Loftt. 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. Watkin* (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*, 1987 S.L.T. 681.
¹³⁶ *Re F* [1989] 2 W.L.R. 1025 at 1064, 1067, 1078, 1080, 1085, 1088.
¹³⁷ Criminal Law Act 1967, s.3(1). As Hogggett notes, this power applies only to the prevention of crime which is actually in progress or about to be committed. *B. Hogggett, Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), p.140.
¹³⁸ *R. v. Howell* [1982] Q.B. 416. A breach of the peace can occur on private property. *McConnell v. Chief Constable of Greater Manchester Police* [1990] 1 W.L.R. 364.
¹³⁹ *Albert v. Levin* [1982] A.C. 546.
¹⁴⁰ *B. Hogggett, Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), p.141.

"A prolonged period of confinement or sedation would not be permitted under these principles, even if it was in fact necessary to prevent the patient doing *coercim*. This is because of the second element in 'reasonableness', which is that the reaction must be in proportion to the harm threatened ... these common law principles should not be used as a substitute for the procedures laid down in the Mental Health Act, which have replaced the hospitals' common law powers to detain the insane (*Black v. Forsey*, 1988 S.L.T. 572)."

The European Convention

Article 3 of The European Convention on Human Rights and Fundamental Freedoms provides that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment." The suffering occasioned or the humiliation or debasement involved must attain a particular level before it can be classified as inhuman or degrading punishment contrary to Article 3. The "assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc."¹⁴¹

The conditions of seclusion

The case of *A. v. United Kingdom* (1980) 3 E.H.R.R. 131 concerned a complaint that the conditions and circumstances of a patient's seclusion in Broadmoor Hospital in 1974 amounted to inhuman and degrading treatment, contrary to Article 3. The patient alleged that he had been deprived of adequate furnishing and clothing, that the conditions in the room had been insanitary, and it had been inadequately lit and ventilated. A friendly settlement was reached with an *ex gratia* payment to the patient of £500 being made by the Government.

Seclusion not usually violation of Art. 3

In *Dhoest v. Belgium* 12 E.H.R.R. 135, the Commission noted that it would not normally consider the segregation for security, disciplinary or protective reasons, of persons committed to hospital in the course of criminal proceedings as constituting inhuman treatment or punishment. In "making an assessment in a given case, regard must be had to the surrounding circumstances including the particular conditions, the stringency of the measure, its duration, the objective pursued and its effects on the person concerned."¹⁴²

Need continuously to review detention arrangements

In *McFeely v. United Kingdom* 3 E.H.R.R. 161, the Commission had previously held that prison authorities, when faced with what is regarded as an unlawful challenge to their authority, must nevertheless maintain a continuous review of the detention arrangements employed with a view to ensuring the health and well-being of all prisoners with due regard to the ordinary and reasonable requirements of imprisonment. In *Dhoest*, it held that the same reasoning applied *mutatis mutandis* to mental health patients detained in a custodial mental institution under provisions similar to restriction orders under the 1983 Act.¹⁴³

¹⁴¹ *Ireland v. United Kingdom* 2 E.H.R.R. 25, at para. 162. See also *Tyrer v. United Kingdom* 2 E.H.R.R. 1; *B. v. United Kingdom* 6 E.H.R.R. 204, at para. 172.

¹⁴² *Dhoest v. Belgium* 12 E.H.R.R. 135, at 142 (para. 117), Committee of Ministers.

¹⁴³ *Ibid.*, at 143 (para. 121).

CONCLUSIONS AND SUMMARY

Having regard to the above and the disagreements concerning this difficult and contentious subject, it is submitted that—

1. Where a serious incident cannot be managed by talking with, and calming, the patient and some restraint is unavoidable, the relative advantages of solitary confinement, control and restraint, emergency medication, and transfer to a locked facility depend altogether on the results; the aim must be to choose that method of dealing with the immediate threat to others which is likely to be least distressing for the particular patient, and so least damages his therapeutic relationship with those using force;
2. Further research into the possible advantages and disadvantages of these different kinds of restraint should be a priority;¹⁴⁴
3. Because, in certain undesirable situations, solitary confinement may conceivably be the least undesirable way of managing dangerous behaviour, it is premature to advocate its prohibition by legislation or setting a target for phasing out the practice;¹⁴⁵
4. Solitary confinement should be regulated within very narrow margins by a gradual yielding to a growing consensus of opinion, and by statutory rules;¹⁴⁶

¹⁴⁴ If seclusion has a therapeutic value, the question then becomes how the use of the practice can be properly regulated so that it is only used as a form of treatment in situations where it is known to have some therapeutic benefit. Otherwise, acknowledging its therapeutic value might provide a cloak for its use as a way of managing disturbed behaviour. If the answer is that seclusion has no therapeutic value then one is left with the problem that the law appears to regard it as a form of medical treatment which does not require a detained patient's consent, provided his consultant has authorised it. If the answer is uncertain, the first aim will be to obtain more reliable information through research, e.g. as to the therapeutic outcome following the use of seclusion and medication levels on wards not practising seclusion.

¹⁴⁵ There are four possible approaches: (1) to enact primary legislation prohibiting the seclusion of patients; (2) to enact primary legislation limiting its use to certain clearly defined situations; (3) to regulate the practice more effectively by means of secondary legislation made under the present statute; (4) to do nothing.

¹⁴⁶ This approach, which aims to limit the use of seclusion within very narrow margins, is essentially that successfully adopted in the nineteenth century in relation to the use of mechanical restraint. In 1927, the Board of Control asserted that although restraint had never been abolished "by a gradual yielding to a growing consensus of opinion, and by statutory rules, it has been regulated within very narrow margins." *Fourteenth Annual Report of the Board of Control for the Year 1927*, HMSO, London, 1928, pp.73-77. Apart from defining in any future statute the circumstances in which a patient may be secluded, defining seclusion, renaming it solitary confinement, and the use of a prescribed register and forms, are possible ways of ensuring that the practice is very much a last resort. There are weighty arguments in favour of making regulations which once more define what constitutes seclusion and which prescribe that a common form of seclusion record be kept. Firstly, if all hospitals are required to adhere to a common method of recording its use, it will be easier to see whether a particular hospital, ward, nurse or medical practitioner may be relying too heavily on the practice. Secondly, the use of a common register will enable the Commission to obtain accurate data across England and Wales about the use of seclusion, which will be useful in later deciding whether legislation is necessary. Thirdly, experience in the prison system shows that less use is made of solitary confinement when the practice is properly regulated. The need to keep records at all, the need to record reasons, and the existence of a system for scrutinising its use, all discourage its use.

5. More particularly, the 1983 Regulations should be amended s. to require a prescribed seclusion register and forms to be kept⁴⁷;
6. Furthermore, any use of solitary confinement as a form of medical treatment for mental disorder should be regulated under Part IV;
7. The Code of Practice should abandon the term "seclusion" for "solitary confinement," defined as "the confinement of a patient alone in a room at any time of the day or night and a patient is confined to a room if he may not leave that room at will";
8. The circumstances in which a patient may be isolated in a room on the ground that his behaviour is putting the safety of others at immediate risk should in due course be defined and regulated by statute⁴⁸;
9. Nurses' and other professionals' powers of restraint, including the use of solitary confinement, should be put on a clearer statutory basis at that time.

⁴⁷ The maintenance of a seclusion register was a legal requirement between 1845 and 1960. Article 94 of the Mental Treatment Rules 1930 required all institutions for mental patients to keep a "register of mechanical restraint and seclusion", the precise form of which was set out as Form 9 in the schedule to those rules. These provisions also applied to poor law establishments by Article 48(1) of the Public Assistance Order 1930, which was in the following terms: "Every case in which a person of unsound mind or a person alleged to be of unsound mind is placed in a padded room or is otherwise compulsorily secluded, shall be recorded in a book in the form 6 in the First Schedule, which may be included in the register of mechanical restraint, and the book shall be produced to every commissioner or inspector of the Board of Control visiting the institution." It is worth noting that section 32(2)(c) now provides that the regulations made under the Act may in particular make provision for requiring such bodies as may be prescribed to keep such registers or other records as may be prescribed in respect of patients who are liable to be detained or subject to guardianship or after-care under supervision.

⁴⁸ For example, by enacting a section along the following lines: *Solitary confinement.* 134A.—(1) A patient shall not be placed or kept in solitary confinement unless either— (a) his solitary confinement is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others; or (b) his being placed or kept in solitary confinement is a medical treatment which has been authorised by a certificate in writing given under section 58(3) above. (2) A member of the Mental Health Act Commission may at any time direct that a person who is being kept in solitary confinement otherwise than under subsection 1(b) above shall immediately cease to be so confined and, where he does so, he shall record his reasons for doing so in writing. (3) A full record in the form prescribed by regulations of every case of solitary confinement shall be kept from day to day and a copy of the records and certificates made under this section shall be sent to the Mental Health Act Commission at the end of every quarter. (4) In this section— "solitary confinement" means the confinement of a patient alone in a room at any time of the day or night and a patient is confined to a room if he may not leave that room at will; "patient" means a person suffering or appearing to be suffering from mental disorder. (5) This section applies to all hospitals and residential care homes in England and Wales. (6) Any person who wilfully acts in contravention of this section shall be guilty of an offence. 145(1) In this Act, unless the context otherwise requires— "medical treatment" includes ... the solitary confinement of a patient whose solitary confinement has been authorised by a certificate in writing given under section 58(3) above and excludes all other instances of solitary confinement; "solitary confinement" has the meaning given in section 134A and the term includes seclusion and other cognate expressions.

21. Personality disorders

INTRODUCTION

Not all conditions characterised by abnormal mental functioning are conceived of as an illness. Certain forms of mental disorder are conceptualised and therefore categorised as disorders of the personality. The individual's mental state is here considered to represent his normal, although compared with other people abnormal, personality rather than the consequence of any disease or illness overlying and distorting that personality. 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 make transitory patterns, but the underlying features remain constant."¹ 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.² Although this is so in practice, a particular kind of disturbed behaviour can be exhibited by more than one personality group with different mechanisms pertaining to each.³

PERSONALITY

Personality is what makes one individual different from another.⁴ It is the unique quality of the individual, his feelings and personal goals; the sum of his traits, habits and experiences and the whole system of relatively permanent tendencies, physical and mental, which are distinctive of a given individual.⁵ Alternatively, the ingrained patterns of thought, feeling, and behaviour which characterise an individual's unique lifestyle and mode of adaptation, and which result from constitutional factors, development, and social experience.⁶ These personal characteristics are present since adolescence; stable over time despite fluctuations in mood; manifest in different environments; and recognisable to friends and acquaintances.⁷ Personality has a genetic component and behaviour genetics is concerned with the pathway from genes to behaviour and the lifelong interactions between the genetic constitution of an individual and his environment. However, certain aspects of each individual's personality are generally considered to have been acquired through learning. An underlying biological assumption is that "if what is learnt at any one stage did not have some permanence, we would be endlessly open to change in response to events and circumstances."⁸

¹ A. Sims, *Symptoms in the Mind* (Baillière Tindall, 1988), p. 299.

² *Ibid.*, p. 285.

³ C.P.L. Freeman, "Personality disorders" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p. 592.

⁴ *Ibid.*, p. 588.

⁵ K. Schneider, *Clinical Psychopathology* (5th ed., trans. M.W. Hamilton, Grune & Stratton, 1958).

⁶ *Lexicon of Psychiatric and Mental Health Terms* (World Health Organisation, 2nd ed., 1994), p. 75.

⁷ C.P.L. Freeman, "Personality disorders," *supra*, p. 588.

⁸ S. Wolff, "Personality development" in *Companion to psychiatric studies*, *supra*, p. 61.