

16. The authorised representative

INTRODUCTION

Legal representation before tribunals is the norm and approximately 90 per cent. of patients in Wales are now legally represented.¹ The other chapters of this book are written in the form of a textbook, seeking to give a balanced and impartial account of the legal and medical considerations relevant to all practitioners. The representative's role is not at all neutral. It is to present a case for discharge in accordance with his client's instructions and this chapter is prepared with that perspective in mind. It is arranged in the following way.

The authorised representative	Legal provisions concerning the authorised representative.	876
Financing representation	Legal aid: the green form and ABWOR schemes.	879
General principles	General principles; formality and manner; the purpose of interviews; taking notes and recording interviews; professional ethics.	884
The client interview:		888
I. Initial steps	The purpose of the first interview; making the arrangements; confirming the appointment; examining the authority for the patient's detention; arriving on the ward; the patients' board; discussing the case with nursing staff; inspecting the case notes; being introduced to the patient; commencing the interview; explaining and exploring alternative remedies; explaining the tribunal proceedings; the client's aims and expectations; completing legal aid forms; the client's account of his financial circumstances.	
2. Preliminary observations	The importance of observing and recording the client's mental state and behaviour: consciousness; responsiveness; level of activity; posture; mannerisms and gestures; appearance; self-care; gait; involuntary movements.	893

¹ *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), p.18.

3. The case history

Basic factual information; identifying the nearest relative; accommodation; education, training and employment; financial circumstances; physical health; drugs and alcohol; forensic history; psychiatric history; the current admission; medication and treatment; after-care and supervision.

899

4. Mental state

Memory; mood and affect; other emotional states; disordered speech and thought; content of thought; perceptual disturbances.

914

After the initial interview

Notifying the tribunal office; commissioning expert reports, disclosing reports; contacting family members and witnesses; comments and observations on the reports; cross-references to the text.

924

The hearing

The client's evidence; questions for the client; the responsible authority's evidence; questions for the responsible medical officer; questions for the social worker; submissions.

931

After the hearing

Provisional decisions and tribunal decisions with recommendations.

943

AUTHORISED REPRESENTATIVES

Section 78 of the Mental Health Act 1983 states that the rules may provide for regulating the circumstances in which, and the persons by whom, applicants and patients may, if not desiring to conduct their own case, be represented in tribunal proceedings.² Rule 10 of the Mental Health Review Tribunal Rules 1983 is concerned with representation. In relation to the proceedings, an authorised representative may take all such steps which his client is required by the rules to take and do all such things as his client is authorised by them to do.³

NOTIFYING THE TRIBUNAL OFFICE

The rules provide that an application shall wherever possible include the name and address of any representative authorised in accordance with rule 10 or, if none has been authorised, state whether the applicant intends to authorise a representative or wishes to conduct his own case.⁴ Insofar as the information is not given in the application, it shall insofar as is practicable be provided by the responsible authority at the request of the tribunal.⁵ Any representative authorised to represent the patient or any other party to the proceedings is required to notify the tribunal of his authorisation and postal address.⁶

² Mental Health Act 1983, ss. 78(2)(f) and 78(3).

³ Mental Health Review Tribunal Rules 1983, r.10(4).

⁴ *Ibid.*, rr.3(2)(e), 30(2)(d).

⁵ *Ibid.*, rr.3(3), 30(3).

⁶ *Ibid.*, r.10(2).

REPRESENTATION : MHRT RULES 1983, r.10

Representation, etc.

10.—(1) Any party may be represented by any person whom he has authorised for that purpose not being a person liable to be detained or subject to guardianship or after-care under supervision under the Act or a person receiving treatment for mental disorder at the same hospital or mental nursing home as the patient.

(2) Any representative authorised in accordance with paragraph (1) shall notify the tribunal of his authorisation and postal address.

(3) As regards the representation of any patient who does not desire to conduct his own case and does not authorise a representative in accordance with paragraph (1) the tribunal may appoint some person to act for him as his authorised representative.

(4) Without prejudice to rule 12(3), the tribunal shall send to an authorised representative copies of all notices and documents which are by these Rules required or authorised to be sent to the person whom he represents and such representative may take all such steps and do all such things relating to the proceedings as the person whom he represents is by these Rules required or authorised to take or do.

(5) Any document required or authorised by these Rules to be sent or given to any person shall, if sent or given to the authorised representative of that person, be deemed to have been sent or given to that person.

(6) Unless the tribunal otherwise directs, a patient or any other party appearing before the tribunal may be accompanied by such other person or persons as he wishes, in addition to any representative he may have authorised.

Mental Health Review Tribunal Rules 1983, as amended by the Mental Health Review Tribunal (Amendment) Rules 1996, r.8.

CHOICE OF AUTHORISED REPRESENTATIVE

A party may not be represented by a person who is liable to be detained or who is subject to guardianship or after-care under supervision under the 1983 Act, or by a person receiving treatment for mental disorder at the same hospital or mental nursing home as the patient. Subject to this limitation, a party may be represented by any person whom he has authorised for the purpose. Apart from solicitors, alternative sources of legal representation include Citizens Advice Bureaux; law centres, hospital advocacy workers; mental health organisations; and the local Community Health Council.

Representative's rights under the rules

The choice of representative can have three important consequences in terms of the representative's rights under the tribunal rules—

1. Where the tribunal is minded not to disclose a document to the patient or a nearest relative applicant, rule 12(3) nevertheless requires it to disclose the document as soon as practicable to that person's authorised representative if he is a solicitor or barrister, a registered medical practitioner or, in the tribunal's opinion, "a suitable person who virtue of his experience or professional qualification" (702).⁷
2. A tribunal may not exclude from a hearing or part of a hearing a representative of the applicant or of the patient to whom documents would be disclosed in accordance with rule 12(3).⁸
3. A tribunal must disclose the full recorded reasons for its decision to a representative of the applicant or of the patient to whom documents would be disclosed in accordance with rule 12(3).⁹

There are therefore potential disadvantages in not authorising a qualified solicitor, barrister or medical practitioner. In practice, many representatives are chosen for the patient by the detaining hospital's Mental Health Act Administrator. However, it is preferable for the appointment to be made by the tribunal in accordance with rule 10 if the patient has no solicitor willing to act.

APPOINTMENT OF REPRESENTATIVE BY THE TRIBUNAL

Rule 10(3) provides that, as regards the representation of any patient who does not desire to conduct his own case and does not authorise a person to represent him, the tribunal may appoint some person to act for him as his authorised representative. A hearing may be adjourned and a representative appointed if it is obvious that the patient is incapable of following the proceedings or presenting a case for discharge but would prefer to be an informal patient. In the case of patients whose cases are referred to a tribunal, they may not wish to be represented anymore than they wish to be present at the hearing. If they will not see a solicitor, or sign legal aid forms, the tribunal occasionally authorises the payment of a solicitor's fees from the tribunal's own budget although there is no authority to do this. The alternatives are for the solicitor to attend at his own expense without instructions, fulfilling the role of an *amicus curiae* and ensuring that the case for detention is properly tested, or holding that the patient's lack of interest is determinative. Although rule 10 permits a tribunal to appoint a representative for a person who does not wish to conduct his own case, and who has not appointed anyone to do so on his behalf, that implies that he has a case which he wishes to present and that he wishes to be represented. While a tribunal may appoint a representative for a patient who wants one, the intention is not that a tribunal may require a person to be represented against his wishes.

THE MENTAL HEALTH REVIEW TRIBUNAL PANEL

The panel is non-exclusive and open to all admitted solicitors, trainee solicitors, solicitors' clerks, and Fellows and Members of the Institute of Legal Executives. Membership is initially for a term of three years. Under the terms of The Law

⁷ Mental Health Review Tribunal Rules 1983, r.12(3).

⁸ *Ibid.*, r.21(4).

⁹ *Ibid.*, r.24(2).

Society's General Regulation, 1987, the Post Qualification Casework Committee deals with applications for panel membership and other related matters. The membership conditions are that the applicant has attended an approved course, an interview, and four tribunal hearings (whether as an observer or representative), of which at least one concerned a patient detained under section 2, one a section 3 patient, and one a restricted patient. The candidate must also agree that references may be sought by the Committee if that is deemed necessary and undertake to both prepare cases and conduct tribunal hearings personally. One-day approved courses deal with relevant aspects of mental health law, tribunal procedure, medical terminology, case studies, reports, evidence, and the role of the authorised representative. Panel interviews last approximately 45 minutes and are partly based on the discussion of case studies. Where the interviewers recommend acceptance, the candidate will normally be accepted. Where deferral or rejection is recommended, the recommendation goes before the Post Qualification Casework Committee. If the committee then decides not to accept the application, the applicant is entitled to appeal against this decision. Deferral involves reinterview after any conditions of deferral have been met, such as attending a further course, observing or conducting further hearings, or undertaking further specified reading. The office may also appoint a "mentor" to help the applicant to attend further hearings and to discuss with him those areas requiring further attention.

DISCLOSURE AND SERVICE OF DOCUMENTS

Rule 10(4) provides that, without prejudice to rule 12(3), the tribunal shall send to an authorised representative copies of all notices and documents which are by the rules required or authorised to be sent to the person whom he represents.

Service of documents

Any document required or authorised by the rules to be sent or given to a person shall, if sent or given to the authorised representative of that person, be deemed to have been sent or given to that person.¹⁰ Documents may be sent by prepaid post or delivered to the last known address of the person to whom the document is directed.¹¹

OTHER FORMS OF SUPPORT

Unless the tribunal otherwise directs, a patient or any other party appearing before the tribunal may be accompanied by such other person or persons as he wishes, in addition to any representative he may have authorised.¹²

FINANCING REPRESENTATION

Patients and nearest relative applicants are entitled to apply for financial help with regard to legal costs and disbursements incurred in providing them with legal advice, assistance and representation. The relevant legislation is set out in Part III of

¹⁰ Mental Health Review Tribunal Rules 1983, r.10(5).

¹¹ *Ibid.*, r.27(6).

¹² *Ibid.*, r.10(6).

the Legal Aid Act 1988 and Part III of the Legal Advice and Assistance Regulations 1989. The Legal Aid Board has the statutory functions of "securing" that advice, assistance and representation are available in accordance with the Legal Aid Act 1988 and of administering that Act. The introduction of a franchise scheme in relation to mental health review tribunal work is presently under consideration. Development work began in April 1997 and application forms were circulated in October 1997.

LEGAL ADVICE AND ASSISTANCE

Patients and nearest relative applicants are entitled to initial advice and assistance under the means-tested "green form" scheme.¹³ The application is made to the solicitor, who completes the form and assesses the client's means.¹⁴ If a patient's means fall outside the prescribed limits, the usual alternatives are for the patient to immediately apply for ABWOR (882) in respect of the initial interview (since this form of legal aid is not means-tested) or for the solicitor to waive his fee for that interview. In exceptional circumstances, where a capable client with substantial savings has chosen to pay private hospital fees of some £350 per day, rather than to be treated under the National Health Service, the solicitor might be disposed to ask for a fee in respect of the first interview, payable at the usual legal aid hourly rates.

Applying for green form advice and assistance

The regulations provide that an application for advice and assistance "shall be made ... to the solicitor from whom the advice and assistance is sought"¹⁵ and "shall be made by the client in person"¹⁶ unless he "cannot for good reason attend on the solicitor ... (in which case) ... he may authorise another person to attend on his behalf."¹⁷ A solicitor may not provide advice and assistance under the scheme until

¹³ The Legal Aid Board's present interpretation of the work covered by the green form scheme is quite restrictive. "Where ABWOR is available for proceedings, the green form should be used to take sufficient instructions in order to make that application. A statement of case is permissible (*sic*) to be drafted under the green form scheme if it is necessary to support the ABWOR application." Once the ABWOR application is pending, the green form should only be used if further work is necessary so that the client's position is not prejudiced. *Letter to the author*, 4 February 1997.

¹⁴ Information in the text about income and capital financial limits under the green form scheme represent the limits currently in force for the year commencing 7 April 1997. The limits are revised annually and revisions may also be made during the financial year.

¹⁵ Legal Advice and Assistance Regulations 1989, reg. 9(1). According to section 43 of the Legal Aid Act 1988, the term "a solicitor" means "a solicitor of the Supreme Court." The Legal Aid Board has not yet objected to the practice of applications being made to an unqualified person, such as a solicitor's clerk who is a member of the tribunal panel. If the practice is ever challenged, whether the statutory intention is that unqualified persons may accept applications must be open to doubt.

¹⁶ Legal Advice and Assistance Regulations 1989, reg. 9(3). This therefore precludes green forms being posted and signed in advance of a hospital appointment.

¹⁷ Legal Advice and Assistance Regulations 1989, reg. 10(1). In *Legal Aid Board costs appeals committee decision LAA 10*, asylum seekers held in detention under the Immigration Act instructed a solicitor's clerk to sign the green form for them. Following the certification of a point of principle by an area committee, the costs appeal committee considered whether this was permissible. It noted that regulation 10 could be used where the client was unable to attend upon the solicitor "for good reason." This included mental patients and persons detained by immigration officers. If good reason could be established, the reason should be recorded and the client could then authorise "another person" to attend on the solicitor on his behalf. That other person had to be in a position to provide the information necessary to complete the green form. If an employee of the solicitor's firm was authorised to be that "other person" a full note of the authorisation/telephone attendance and physical attendance would need to be filed. The extent to which the committee's decision applies in relation to patients detained under the 1983 Act was not made clear but in principle, if there are no friends or relatives who can attend the solicitor's office, it is difficult to draw any distinction between the two types of detainee. *Law Society Gazette*, 94/21, 29 May 1997, p. 34.

the prescribed form has been signed by or on the client's behalf and he has assessed the client's disposable income and disposable capital.¹⁸ Either the client or the person authorised by him shall use a form approved by the Board¹⁹ to "provide the solicitor with the information necessary to enable the solicitor to determine" (a) the client's disposable capital; (b) whether he is receiving income support, income-based job-seeker's allowance, disability working allowance or family credit; (c) if he is not receiving such a benefit, his disposable income.²⁰

Clients directly or indirectly in receipt of income support

If the solicitor is satisfied that the client is "directly or indirectly in receipt of income support," he shall treat that person as if his disposable income and capital do not exceed the level entitling him to free advice and assistance under the scheme.²¹

Assessing and aggregating the client's means

In conducting the means assessment, the solicitor must aggregate the client's disposable income and disposable capital with that of any spouse unless the spouse has a "contrary interest in the matter," they are living "separate and apart," or it would "in all the circumstances... be inequitable or impractical to do so."²² The capital and income of any person the client lives with "in the same household as husband and wife" is similarly to be assessed as if it was the applicant's own capital and income,²³ subject to the same exceptions.²⁴ Having where appropriate aggregated any spouse's or cohabitee's resources, the solicitor must then calculate the client's disposable capital and disposable income by deducting from those gross sums any deductions or allowances permitted under the regulations.²⁵

Capital and disposable capital

"Capital" means "the amount or value of every resource of a capital nature."²⁶ It includes the value of any resources the client has disposed of for the purpose of making himself financially eligible for green form assistance. It excludes the value of the first £100,000 equity of the main or only dwelling in which he resides; a spouse's capital if it would be inequitable or impractical to assess it as his; his household furniture and effects; and the tools and implements of his trade. "Disposable capital" is the client's capital calculated as above, less certain fixed amounts which may be deducted.

¹⁸ Legal Advice and Assistance Regulations 1989, reg. 13(5). Because the solicitor usually has to travel to the hospital to see his client and to complete the application, the Legal Aid Board's interpretation is that the time spent travelling to the hospital, and any initial advice given by letter or telephone, are not chargeable to the legal aid fund. Whether this interpretation is lawful or the regulation is *ultra vires* the Legal Aid Act 1988 in this respect might usefully be judicially reviewed. However, if the procedure outlined in the footnote immediately above extends to persons detained under the 1983 Act, the need for a challenge may now be less pressing. Legal Advice and Assistance Regulations 1989, regs. 9(6) and 10(4).

¹⁹ *Ibid.*, regs. 9(4) and 10(2).

²⁰ *Ibid.*, reg. 13(2) and 13(3).

²¹ *Ibid.*, reg. 13(1); Sched. 2, para. 7(2).

²² *Ibid.*, reg. 13(1); Sched. 2, para. 7(2).

²³ *Ibid.*, reg. 13(1); Sched. 2, para. 7(2).

²⁴ *Ibid.*, Sched. 2 para 7(2)(f).

²⁵ *Ibid.*, Sched. 2, para 4.

²⁶ *Ibid.*, Sched. 2, para 1.

Income and disposable income

"Income" means "the total income from all sources which the person whose disposable income is being assessed has received or may reasonably expect to receive in respect of the seven days up to and including the date of his application."²⁷ As with the capital assessment, it includes income which the client has "directly or indirectly" deprived himself of for the purpose of making himself eligible for green form assistance.²⁸ Unless one of the exemptions applies, to this sum is added the income of any spouse or cohabitee over the same seven day period, the total arrived at representing the client's gross income. "Disposable income" represents the client's gross income less (a) income tax paid or payable on the combined income; (b) national insurance contributions estimated by the solicitor to have been paid in respect of it; (c) an allowance of £27.30 in respect of a spouse or cohabitee who lives with the client, regardless of whether their incomes have been aggregated; (d) any allowances in respect of the maintenance of dependant children or relatives in the same household²⁹; (e) payments of disability living allowance or certain kinds of attendance allowance and any payment from the social fund.

The current financial limits

Green form assistance is not available if the client's disposable capital exceeds £1000 (client with no dependants); £1335 (client with one dependant); £1535 (client with two dependants).³⁰ Provided the client is within the capital limits, he will be entitled to free legal advice and assistance if his disposable income, as defined above, does not exceed £77. If it does exceed that sum, green form assistance is not available. A green form extension must be obtained from the Legal Aid Board before a solicitor's expenditure under the scheme may exceed £88 (£93 in the London area).

Advice and assistance from more than one solicitor

A solicitor may not advise or assist a person under the green form scheme without the prior authority of the Area Director if the person concerned has already received advice under the scheme from another solicitor for the same matter.³¹

THE ABWOR SCHEME

The green form scheme does not extend to representation and the usual practice is to complete an application for assistance by way of representation (ABWOR) at the initial interview. This is then submitted to the Legal Aid Board and granted within one week. In urgent cases, particularly section 2 cases, ABWOR may be granted by telephone. Once granted, the certificate covers all reasonable legal costs and

²⁷ Legal Advice and Assistance Regulations 1989, Sched.2, para 1.

²⁸ *Ibid.*, Sched.2, para 6.

²⁹ £16.90 for each dependant child or dependant relative of the household under 11 years of age; £24.75 for each such person aged 11-15; £29.60 for each such person aged 16 or 17; £37.90 for each such person aged 18 or over. These are the rates for the year commencing 7 April 1997.

³⁰ A further £100 capital allowance should be added for each additional dependant.

³¹ Legal Advice and Assistance Regulations 1989, reg. 16(1). Where a solicitor is told by the client that he has not previously received green form advice from another solicitor, but it transpires that he has, a payment may not be made under the Legal Advice and Assistance Regulations. However, it may be appropriate for an extra-statutory payment to be made. *Legal Aid Board costs appeals committee decision LAA 11*, reported in the *Law Society Gazette* 94/21, 29 May 1997, p.34.

disbursements incurred in the proceedings from that point onwards, although prior authority is required for medical and other expert reports. ABWOR is no longer means-tested.³² A nearest relative applicant may also receive ABWOR, again with-out reference to means.³³ ABWOR is not conditional upon a green form having previously been signed.³⁴

Psychiatric and other expert reports

An application for prior permission must be made to the Area Director of the Legal Aid Board if a solicitor wishes (a) to obtain a report or opinion from an expert; (b) to tender expert evidence; or (c) to perform an act which is either unusual in its nature or involves unusually large expenditure.³⁵ Form ABWOR 6 is the prescribed form. A typical fee for a report from a consultant psychiatrist is £400 (five hours at £80 per hour), plus any fares incurred or a mileage allowance, and in some cases travelling time at £35-40 per hour. Independent social circumstances reports generally cost between £200 and £250.

Legal Aid Board rulings

The Legal Aid Board has issued the following points of principle of general importance:

- There is no authority to pay a solicitor's costs at an enhanced rate³⁶;
- In deciding whether a claim for travel is reasonable, the Board shall consider all the relevant circumstances of the case, including (i) any legitimate expectation of the assisted person of specialist representation, *i.e.* by a mental health review tribunal panel member; (ii) the availability of panel members; and (iii) the undertaking which is required to be given by a panel member to conduct such cases personally³⁷;
- ABWOR for a tribunal does not cover work only carried out for a hospital managers' appeal, including representation on the appeal itself. However, if work is properly carried out in preparation for representation at the tribunal, it should not be disallowed if it incidentally assists at the hospital managers' appeal.³⁸
- Following a deferred conditional discharge decision, the tribunal proceedings are not concluded until either the direction lapses by effluxion of time or the tribunal directs that the patient may be so discharged. The ABWOR approval will therefore continue until the first of these events occurs.³⁹

³² Legal Advice and Assistance Regulations 1989, reg. 5A.

³³ Legal Advice and Assistance (Scope) Regulations 1989, reg. 9(a). Where the nearest relative applies, the patient who is the subject of the proceedings is also entitled to be represented under the ABWOR scheme.

³⁴ Persons with mental health problems are occasionally detained under section 47 of the National Assistance Act 1948. It should be noted that on 7 April 1997 ABWOR was extended to cover proceedings of this type. However, the client's eligibility is subject to the usual means-test and the solicitor's fees are payable at the ordinary ABWOR rate.

³⁵ Legal Advice and Assistance Regulations 1989, reg. 22(7).

³⁶ Legal Aid Board Reference ABWOR 3.

³⁷ Legal Aid Board Reference ABWOR 7.

³⁸ Legal Aid Board Reference ABWOR 9.

³⁹ Legal Aid Board Reference ABWOR 11.

GENERAL PRINCIPLES

Before dealing with the first interview, it is useful to refer to some general principles concerning the preparation and presentation of a client's case.

FORMALITY AND MANNER

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

TAKING INSTRUCTIONS

It is generally possible to take detailed instructions. However, if the client is particularly restless or agitated, he may initially only be able to cope with a short interview. This limitation is quite rare and mainly seen in section 2 cases where there is still evidence of mania. Most often, if any difficulty is encountered, the consequence is merely that a long interview or several interviews is necessary in order to obtain the required information. It is important to persevere and to be thorough because poor preparation produces poor performance.⁴⁰ A detailed interview avoids unpleasant surprises later. By observing and listening to the client and others, the representative can be aware of the strengths and weaknesses of his case, the likely content of the reports and oral evidence, and any inconsistencies between client's account and objectives and what is observed. This enables him to anticipate the likely objections to discharge and to plan questions and submissions which cater for those eventualities. Developing a trust and rapport with the client will later help him to give his evidence in an intelligible and structured way because he will trust the solicitor to make appropriate interventions for him. It also enables the solicitor to explore the possibility of compromise in relation to medication and treatment. Quite often, the patient is more willing to openly discuss the possibility that he has an illness, and needs some medication or treatment, with his solicitor (who is seen as being on his side) than he is with his doctor (who is seen as having deprived him of his liberty, forced injections on him, and to have no interest in or insight into the anxieties and problems which triggered the illness). Most people welcome discussing their beliefs and perceptions in an honest way provided that they do not feel that the only purpose of the discussion is to form a diagnosis and to prescribe compulsory medication. Hence, it is sometimes said that psychiatrists must elicit symptoms whereas other people have no need to.

Taking notes and recording interviews

When time permits, it is useful to maintain a reasonably comprehensive case summary. The form at the end of this chapter can be copied and revised to suit, or simply used as an *aide-memoire* when taking instructions. It will rarely be possible, or appropriate, to attempt to obtain from a single, systematic, interview all of the information necessary to complete the summary. The aim should be to cover the areas in as natural and conversational a way as possible before the hearing, transferring relevant information to the case summary after interviews. The benefit of case summaries is that they minimise the risk of oversights, are appreciated by experts commissioned to prepare reports, and ensure continuity of legal care if a client who is not discharged later reappears to the tribunal.

The use of tape recorders

The occasional practice of tape-recording interviews with clients has little to commend it. It risks undermining the professional relationship by seeming to compromise its confidential basis, inhibits honest and frank discussion of sensitive subjects, and carries the additional risk of the solicitor becoming incorporated into a paranoid construction of events.

⁴⁰ Sometimes referred to as the lesson of the five p's.

PROFESSIONAL ETHICS

The usual rules governing the solicitor-client relationship and the solicitor's duty to the court apply and the following observations are by way of amplification.

Practising the client

The tendency of a few solicitors to practice their clients must be deplored. This form of contempt consists of telling the client the questions invariably asked by tribunals and medical examiners and also the answers to them commonly interpreted as pointers towards discharge. Having been informed by the client that he has no intention of continuing medication if free to refuse it, and that he would immediately leave hospital, the representative emphasises the importance of the client telling the tribunal that he accepts that he has been ill, will take medication for as long as it is prescribed, and remain in hospital for as long as advised. Protestations about future compliance with medication are always unconvincing if at variance with the other facts and merely taint the genuine pointers towards discharge. If not discharged, the approach leaves the client dissatisfied with the outcome, and feeling that he did not have a fair hearing, because he was in effect instructed by his solicitor rather than his case presented on the basis of his instructions to that solicitor.⁴¹ Moreover, if the tribunal members suspect that a particular solicitor favours this approach that must prejudice future applications made by other patients, because it reduces the likelihood of their genuine undertakings being given the weight which they deserve. It brings the profession into disrepute and constitutes a serious breach of the solicitor's overriding duty not to mislead the court. Once trust has been established, if the client's assessment of his situation is clearly implausible and at variance with the facts, the correct approach must be to question his assessment in the same way that a tribunal probes and examines those issues, in the hope that some genuine reassessment emerges prior to the hearing. This is not as unlikely as it sounds. If the client likes his solicitor, trusts him, feels that he understands his resentment, sees him as being on his side, and knows that their conversation is confidential and will not be recorded in the case notes, he will normally welcome discussing his views, and more often than not seriously consider alternative explanations.

The duty of confidentiality

Whether departing from a solicitor's duty of confidentiality may ever be justified is disputed. Because many clients are willing to discuss their mental experiences more freely with their solicitor, partly because of the cloak of privacy, it is often the case that the solicitor is aware of mental phenomena not recorded in the case notes and not aired at the hearing. The general view is that a solicitor remains bound in all situations by the normal duty of confidentiality. If the solicitor knows that the patient is experiencing certain symptoms of mental disorder, he may not positively assert that that is not the case, even if this is the responsible medical officer's evidence. That would amount to misleading the tribunal. Accordingly, the position is analogous to that where a solicitor knows that a defendant in criminal proceedings has previous convictions. He may not describe him as being of good character

⁴¹ The practice usually emerges when a patient not discharged from detention under section 2 then appeals against his subsequent detention under section 3 and, being dissatisfied, instructs a new solicitor to represent him. The Solicitors Complaints Bureau used to be unwilling to investigate the matter on the ground that the only evidence of impropriety was the word of a detained patient. Whether the Office for the Supervision of Solicitors takes a different view has yet to be seen.

simply because the court knows of none. The qualified view is that in wholly exceptional circumstances a solicitor would be justified in disclosing something told to him in confidence. For example, if a tribunal was clearly proceeding on the erroneous basis that there was no immediate significant risk of suicide or homicide. The solicitor's obligations then become similar to those of a medical practitioner as defined in the case of *W. v. Egdeell* (711): onerous but not absolute.

Professional guidance

The *Guide to the Professional Conduct of Solicitors* states that a solicitor is under a duty to keep confidential a client's affairs.⁴² The guide, and the commentaries that form part of it, then set out certain exceptions to this duty but these are mainly statutory.⁴³ The previous edition of the guide included a further exception, which the Law Society still refers to when appropriate. This was that a "solicitor may reveal information which would otherwise be confidential to the extent that he believes necessary to prevent the client from committing a criminal act that the solicitor believes on reasonable grounds is likely to result in serious bodily harm." Suicide is, of course, no longer a crime but, as to this, rule 1(c) of the Solicitors' Practice Rules 1990 provides that a solicitor owes a duty to act in the best interests of the client. As to how to approach any problems in practice, the current view of The Law Society's Mental Health Sub-Committee is set out below.

Advice of the Law Society's Mental Health Sub-committee

- 1 So far as possible, the solicitor should act in accordance with the client's instructions, and the solicitor's own morality or religious beliefs should not affect this.
- 2 The solicitor should, so far as possible, make clear to the client any limits to his duty of confidentiality at the outset, before taking instructions.
- 3 When placed in a situation where the solicitor has concerns as to the client's mental capacity, and where the client may pose a risk to himself or others, the solicitor should seek advice from the Professional Ethics division in relation to the particular circumstances of the case.
- 4 Where the solicitor feels it is essential to disclose information confided in him by the client, the solicitor should advise the client that unless the client agrees to disclosure, the solicitor will cease to act.
- 5 That clients have the right to be heard, and for their views (however bizarre) to be represented.
- 6 Each case must be considered on its own merits having regard for all the facts.

THE USE OF COUNSEL

It is possible for a representative to have two tribunal cases at different hospitals listed for hearing at the same time. This most often occurs in relation to section 2 cases. When deciding whether or not to accept such instructions, all that can be done is to assess the likelihood of conflicting hearings and to advise the client of the possibility. Where two hearings do coincide, it is preferable to arrange an agency with another panel member rather than to use counsel, unless a particular barrister has a proven competency in the field.

⁴² *The Guide to the Professional Conduct of Solicitors* (The Law Society, 6th ed., 1993), para. 16.01.
⁴³ *Ibid.*, para. 16.04.

THE FIRST INTERVIEW — 1. INITIAL STEP

In this case of existing clients, the initial preparation for the first interview involves retrieving old files from storage. Even if they do not relate to previous tribunal applications, they may contain useful biographical details, information about the client's medical and forensic history, and so forth. The steps which can be taken without the client's express consent are, however, limited and most must be held over until he has seen the solicitor and provided him with instructions.

THE PURPOSE OF THE FIRST INTERVIEW

It is important to be clear about the purpose of the first interview. In assessment cases, where time is of the essence, it is necessary to obtain a full history from the initial interview. However, this may be difficult if a recently admitted client remains acutely ill and is, for example, in the manic phase of an illness. In other cases, where reports will be available before any hearing date, and there will be further opportunities to meet the client, more time can be spent simply allowing him to raise and develop his concerns, with the aim of gaining a reasonable understanding of the underlying anxieties and objectives. Where possible, questions should be open-ended, information seeking, and non-judgemental, covering general topics such as schooling, family background, physical health, ward activities, and so forth. It is usually unhelpful to immediately probe, dissect and confront a client's personal beliefs and attitude to treatment. Too challenging an approach leads to resentment and guardedness, and a poor working relationship. Furthermore, because the development of false, irrational, beliefs may for some people be a necessary survival mechanism, a frontal assault on these defensive positions by the forces of logic may also be dangerous for the individual's mental health. In restricted cases, preliminary discussion about the index offence can initially be limited to obtaining factual information about the trial court, the dates of conviction and sentence, the offence charged, the plea, the essence of the prosecution case, the identity of the patient's solicitors in the proceedings, whether an appeal was lodged, and details of other convictions. It is particularly important to be positive and reassuring at the first interview, without making false promises. Some acute wards are very frightening places for those confined in them so the client may be afraid and desperate to be allowed home. A client whose case has been referred to the tribunal, or who has applied unsuccessfully in the past, may also be unduly pessimistic about his chances.

MAKING THE ARRANGEMENTS

Appointments are generally agreed both with the client and the nurse in charge of the ward on which he is detained. It is sensible to verify that the appointment does not interfere with meal-times, other prior appointments, leave arrangements, family visits, and therapeutic activities such as ward rounds and occupational therapy. It is particularly wise to check any weekend leave arrangements if the plan is to see the client during a Monday morning or a Friday afternoon. If an interview early in the day is necessary, perhaps at 8.30am prior to a morning hearing, it is important that the client still has a full breakfast if he is to be at his best. The Legal Aid Board's interpretation of the green form regulations is that a solicitor cannot claim a fee for the time and expense incurred travelling to hospital for the first visit, because no green form signed by the patient yet exists. This restriction should therefore be borne in mind when making the initial appointment. It may be that the hospital can

be visited at either end of the day, on the way to or from the office, or the appointment can be combined with a previously scheduled visit to another client there.

Confirming the appointment

Whatever the arrangements, it is advisable to telephone the ward before departing for the hospital, in order to confirm that the patient is present and that he has not been regraded to informal status. It is not unknown for nurses to forget to enter an appointment in the ward diary or to fail to alert colleagues on another shift of the visit. A final check also ensures that another solicitor has not already visited the patient, because more than one person was making arrangements on his behalf.

EXAMINING THE AUTHORITY FOR THE PATIENT'S DETENTION

It cannot be assumed that there is a valid authority for the patient's detention. Accordingly, the first task on arriving at the hospital is to examine the original application or order, which is usually held by the Mental Health Act Administrator, and to obtain a copy of it. Although it is normal practice to keep copies of statutory documents in the patient's case notes on the ward, their inspection is not a safe substitute for scrutinising the originals. This is because the ward copies are often made at the time of admission and do not show any amendments made during the following fortnight, pursuant to section 15 of the Act (265). Even where the one is a perfect copy of the other, it may be impossible to know from the photocopies whether a particular entry is in different coloured ink and is a subsequent addition. In general terms, the representative will wish to verify that the statutory requirements were complied with, to note the reasons for invoking the compulsory powers, and to check whether the client was an informal in-patient at the time or was subject to some prior authority for his detention. Any periodic renewals of the authority should be similarly scrutinised. If the authority is materially irregular but the rectification period has not yet expired, the client may prefer to let it expire before the point is canvassed on his behalf. Procedural requirements and irregularities were considered in Chapter 4 (253, 271). Possible remedies include an application for habeas corpus (861) or judicial review (857), or submitting that a tribunal may have regard to the irregularity when determining whether to exercise its discretionary power of discharge (574).

ARRIVING ON THE WARD

If the door to an open ward is locked, this is normally because nursing staff shortages preclude continuously observing a patient who has previously absented himself without leave. Careful observation on entering the ward, and during the short walk to the nurses' office, often yields relevant information. It will be apparent whether the ward is an acute facility. Asleep or drowsy patients slumped across communal sofas or chairs indicate the use of relatively high doses of medication, and often also that patients' rooms are locked during the day, in order to encourage participation in ward activities. A disturbed ward atmosphere may reflect a restricted programme of recreational activities or be attributable to the limited availability of non-medical therapies. Occasionally, a neglected patient may be obviously distressed and in need of nursing assistance. These, and similar, general impressions should be noted in case they later assume a relevance in the context of the tribunal proceedings — for example, a plea to the tribunal to exercise its discretionary power of discharge or to recommend that the patient is granted leave or transferred to another hospital.

The patients' board

On entering the ward office, the information on the patients' board should be examined. This usually lists the age, gender, legal status, responsible medical officer and nurse of each patient. It may also specify the date of compulsory applications and orders, which patients are on leave, the level of bed occupancy, whether any seclusion room is in use, and each patient's observation and pass status (e.g. that a patient is subject to continuous observation or that he has escorted ground leave). The information recorded on the board is therefore a useful guide to the nature of the ward, the pressures on staff and ward resources, the use made of compulsory powers, and staff decisions about managing detained patients based on perceptions of their mental states and the associated risks.

DISCUSSING THE CASE WITH NURSING STAFF

The consultant's contact with a patient may be limited to attending the weekly ward round and, consequently, nursing and junior medical staff are often better placed to comment on his mental state. They should be able to summarise the ward activities; the patient's conduct and progress since admission; his treatment plan and compliance with it; relevant developments in terms of leave; the stage which discharge and after-care planning has reached; and any historical trends about response to medication and the acceptance of informal treatment and after-care. It is therefore useful to ascertain the views of nursing staff, the more so if hospital practice is to provide a nursing report for tribunal hearings. It may, however, be more prudent to do this after first meeting the patient and explaining the need to discuss his case with staff. The client will have misgivings about the independence of a solicitor who was chosen for him by an officer of the detaining authority if he is first observed chatting amiably to nurses with whom he is clearly acquainted.

INSPECTING THE CASE NOTES

The majority of consultants have no objection to the patient's solicitor reading the case notes and it may even be ward policy to allow nurses a broad discretion about making them available to representatives. However, if the notes are proffered by a nurse who mistakenly believes that the solicitor is entitled to inspection under the tribunal rules, accepting them without more amounts to taking unfair advantage of that person's inexperience, and so may constitute professional misconduct. If there is any possibility of misunderstanding, the representative should explain the correct position. This is that the rules confer no right of inspection but it would be helpful to see the notes and also save professional time, by avoiding the need to make a statutory application. The nurse can then refer the matter to the charge nurse, or a doctor in the consultant's team, who can decide how to respond to the request.

BEING INTRODUCED TO THE PATIENT

The representative will need to be introduced to his prospective client and require the use of a private room. It may be suggested that a nurse is present during the interview if the client is thought to be unpredictably aggressive but the confidentiality of the solicitor-client relationship precludes this. It is impossible to overemphasise the importance of greeting the client warmly and confidently, approaching him with an outstretched hand. This demonstrates a friendly and receptive approach, a determination not to prejudice the man on the basis of facts or

opinions reported by others, and a lack of any apprehension. In terms of personal safety, such first impressions are important because aggressive or violent conduct, while very rare, is most often triggered by a perception that the prospective victim is at some level a threat, or hostile, or is susceptible to physical intimidation.

COMMENCING THE INTERVIEW

A positive and helpful way of beginning the interview is for the representative to stress that he is legally qualified; independent of the hospital; there to act as the patient's advocate, by helping him to formulate and present a case for discharge; that he therefore wishes to hear how he can help; and that what is discussed is confidential unless the client wishes the point to be advanced on his behalf. Possible alternative remedies and the essential features of tribunal proceedings should then be outlined, the client's broad aims elicited (924), and legal aid forms (and any necessary tribunal application form) completed (879, 619).

Explaining and exploring alternative remedies

It is important not to assume that a tribunal application is the best or only way forward simply because proceedings have been commenced or the visit was arranged in order to complete such an application. The alternative ways of being discharged from liability to detention must be summarised and discussed at the outset, and the client's entitlement to make the tribunal application verified. A note to contact the nearest relative should be made if there is any possibility that he may be willing to complete an order for discharge. In practice, the nearest relative is often unaware that he possesses this power, partly because of ambiguities in the Department of Health's statutory rights leaflets. High Court proceedings or a concurrent appeal to the hospital managers (144) may be appropriate depending upon the facts.

Explaining the tribunal proceedings

The representative should explain that tribunals are independent bodies which exist to ensure that citizens are not detained or liable to compulsory treatment for any longer than is necessary. Legal help is free of charge and this assistance usually includes obtaining necessary expert reports from doctors and other professionals independent of the detaining hospital. In non-restricted cases, it is worth mentioning that a tribunal which does not discharge a patient may still make certain recommendations with a view to facilitating his future discharge (474, 495). If the patient's case has been referred to the tribunal then who has taken this action, and why, should be made clear. The risks of making a tribunal application should also be explained. The general principle in civil cases is that a tribunal can only lead to a relaxation of the current regime. It has no power to further restrict the patient's liberty and there is therefore nothing to be lost. However, if the client is detained for treatment, there is now the possibility if he is not discharged that the tribunal will recommend that a supervision application is made. Different caveats apply to restricted patients. Any previous tribunal decision for the patient's conditional discharge which was deferred will lapse (513) and there is the risk of a return to prison custody if the client is subject to a restriction or limitation direction (386, 556). Similarly, if the client is detained under section 48 and involved in on-going criminal proceedings, there will be a risk of evidence emerging at the hearing which is adverse to the criminal trial or the preferred disposal.

The client's aims and expectations

The client may not have been aware of the range of decisions which a tribunal may make following the hearing. Conversely, if a restricted patient, he may have mistakenly believed that a tribunal has power to order or recommend his transfer to another hospital or that it has a general power to review any compulsory treatment being administered. While the explanation of the tribunal's powers is still fresh in an *unrestricted* client's mind, it is worthwhile obtaining his preliminary thoughts about which of the various alternatives he would regard as an improvement on his current situation: leave of absence at home; a transfer to a different hospital; living in the community under a guardian. Some clients object to being liable to detention, others to being in hospital, others to both. Is therefore useful to establish whether it is more important to be at home, even if on section, or to be off section even if in hospital. Where the client's concerns lie outside the tribunal's remit, for example obtaining a second opinion about medication, the appropriate remedy should be explained and any necessary help offered.

Completing legal aid forms

If the client has not already applied to the tribunal and, having been advised, now wishes to do this, the necessary form or letter of application should be signed. An application for Assistance by way of Representation (ABWOR) and, where necessary, a green form should also be completed. It may sometimes be necessary to telephone the Legal Aid Board from the ward, either to obtain an immediate grant of ABWOR or an extension of the green form limit (880). If the client has significant savings, he should be asked whether his financial affairs are subject to the jurisdiction of the Court of Protection (696) or a power of attorney (698).

The client's account of his financial circumstances, etc.

The way in which the legal aid forms are completed and signed, especially the financial part of the form, may be informative and an early, if unreliable, guide to some of the areas of concern which led to the client's compulsory admission. If the client is unable to sign his name, this may reflect limited intellectual ability, a cognitive deficit, or educational deprivation. A woefully misdirected signature, located some considerable distance from the place indicated, is significant. Marked tremor and a shaky signature may be due to the side-effects of medication or some other condition affecting the client's co-ordination. The client may have an excellent recollection of his personal and financial circumstances, knowing his national insurance number, post code, the precise amount which he receives each week, and so forth. Alternatively, at its worst, there may be a rudimentary or chaotic understanding of his financial position, perhaps in a person who previously managed his own business and who is therefore functioning well below his optimum level. The client may not even have been receiving state benefits prior to admission because of the developing chaos and the absence of anyone to help him overcome such difficulties. The basic information recorded on the form will, of course, tell the solicitor whether the client is married, has children, and whether he has substantial savings (and could afford private medical care). Asking about debts may reveal poverty, substantial credit card bills and excessive spending during a manic phase, and pending litigation in connection with unpaid liabilities such as rent arrears. These stresses may have been instrumental in causing the client to break down or be the consequence of his breakdown. Either way, it is often a case of surveying the wreckage.

FIRST INTERVIEW — 2. PRELIMINARY OBSERVATIONS

The nature of the proceedings means that it is important to be observant and to record any distinctive features which may provide a clue to the client's state of health or be relevant to the conduct and outcome of the case. As with any social situation, quite important information and preliminary impressions are conveyed before any meaningful conversation actually takes place. By the time any interview commences, a legal representative or other observer may already have gathered quite a lot of information relevant to the case—

- In rare cases, the client's consciousness may be obviously impaired (894). This is, however, exceptional and generally only ever seen following a mandatory reference or an application by the nearest relative.
- Where the client's consciousness is not obviously impaired, the first thing to strike the visitor on seeing him may be his level of activity; he is either markedly over-active or under-active (894).
- If the client is sitting or standing relatively still when he is approached, this provides an opportunity to observe his posture, which may be unremarkable or idiosyncratic (895).
- On being introduced to the client, certain aspects of his general appearance may be noticeable. More specifically, certain mannerisms or gestures may be striking or there may be evidence of poor self-care (896).
- On walking with the client to the interview room, and getting settled there, some type of involuntary movement may be conspicuous (898).

Recording and describing what is observed

Observations of these kinds will inevitably lead the representative to make a mental note to ask certain questions, or to explore certain areas, later during the interview or, if more natural, on another occasion. The medical terminology used to describe abnormalities in these different areas of functioning is dealt with later but, where necessary, the main points are briefly summarised in this chapter.

PRELIMINARY OBSERVATIONS

- consciousness • mannerisms and gestures
- responsiveness • appearance
- level of activity • self-care
- posture (the relative position of the parts of the body at rest) • gait (style or manner of walking)

IMPAIRED CONSCIOUSNESS

Consciousness is the awareness of one's own internal thoughts and feelings together with the ability to recognise one's external environment. To be unconscious is to have no subjective experience. Consciousness is a continuum with full alertness and awareness at one end and brain death at the other. **Clouding of consciousness** describes impairment of orientation, perception and attention and it is seen in organic mental disorders. There is difficulty with thinking, attention, perception, memory and usually drowsiness but sometimes excitability.

Full alertness/ awareness	Clouding of Consciousness	Sopor	Coma	Brain death
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Disorientation, attention and concentration

Disorientation is an impaired awareness of oneself in relation to time (the date or time of day), place (where one is) and identity (whether one's own or others), as a result of which speech and behaviour tend to be muddled. To be attentive is to be alert, aware and responsive while to concentrate is to focus and sustain mental activity on a task. Usually, it will quite quickly be obvious whether or not a client is disorientated. If not, it is worthwhile asking the patient the time of day since commonly this is the first element of orientation to suffer in cases of mild impairment of consciousness or of intellectual impairment. The client may also be asked to complete the legal aid form himself, or simply asked for the date. If it is apparent that the patient may not be orientated, he may be asked to give the date, year, time, day of the week, name of the hospital, county the hospital is situated within, and (if applicable) the floor on which the ward is situated.

Causes of disorientation, etc.

Disorientation may be the product of clouding of consciousness, due to a head injury or chronic brain disorder such as dementia, or the result of intoxication. Relatively minor impairment of consciousness may only become apparent, if at all, after the interview's commencement as a result of difficulty obtaining adequate instructions due to impaired concentration or attention. Poor attention and concentration are usually the products of tiredness or disinterest.⁴ However, in some cases, they may be more pervasive, reflecting a general lowering of alertness and awareness or an incapacity to focus and sustain mental activity. This may be because of emotional disturbance, mental impairment, an illness such as schizophrenia or depression, or clouding of consciousness.

⁴ There are many reasons why a client may not adequately answer a series of simple questions clearly aimed at obtaining from him a basic factual account of past events. Most often, the problem is simply a lack of enthusiasm for questions asked on countless previous occasions. In the context of the tribunal proceedings, the professionals involved in making the original application, the doctor who prepares the medical report for the tribunal, the social worker who prepares the social circumstances report, the nurse preparing any nursing report, the medical member of the tribunal, and concerned family members may all have recently spoken with the patient about his circumstances at some length. The solicitor must explain that he may not be able to examine the notes and it is essential that he knows in advance of any relevant information which may be raised at the hearing.

CLIENT UNRESPONSIVE

Stupor denotes awareness accompanied by profound lack of responsiveness. A person may be fully conscious and yet profoundly unresponsive to his immediate environment. While terms such as coma and sopor describe a substantial impairment of consciousness, stupor describes a profound lack of responsiveness to external stimuli and the environment, rather than profound unawareness of it. The two components of stupor are a voluntary absence of any movement (akinesia) and a voluntary absence of any speech (muteness). Where a state of stupor appears to form part of a catatonic schizophrenic illness, it is usually described as catatonic stupor.

SLOWED OR INCREASED ACTIVITY

Retardation is a general slowing down of the conscious patient's mental and bodily functions — a slowing of his thoughts, speech, actions, reactions and movement. Over-activity for substantial periods of time, evidenced by over-talkativeness, restlessness, pacing rapidly up and down, constant talking or loud singing is known as **pressure of activity**. In manic states, such pressure of activity is often accompanied by correspondingly accelerated speech, grandiosity and elation. The term **catatonic agitation** is preferred in the ICD glossary, where it refers to a state in which the psychomotor features of anxiety are associated with catatonic syndromes. Here, the patient's restlessness and activity are associated with his abnormal ideas and perceptions rather than his mood (the degree of elation or depression present).

Catatonic excitement	Normal range of responsiveness	Psychomotor Retardation	Stupor
			Catatonic stupor

Is the client over-active for substantial periods of time, as evidenced by being over-talkative, restless, pacing rapidly up and down, constantly talking or singing loudly?

CLIENT'S POSTURE OR ATTITUDE

A patient's posture may sometimes be described as manneristic or stereotyped. Conventionally, **manneristic postures** differ from **stereotyped postures** in that the former are not rigidly maintained. The term **catatonic posturing** describes the voluntary assumption of an inappropriate or bizarre posture which is usually held for a long period of time. For example, a patient standing with arms out-stretched as if he were Jesus on the cross. The terms **cataplexy**, **catatonic waxy flexibility** and **flexibilitas cerea** are synonymous and they describe a physical state of sudden onset in which the muscles of the face, body and limbs are maintained by increased muscle tone in a semi-rigid position, possibly for several hours and during which time neither expression or bodily position will change.

MANNERISMS, GESTURES, RITUALS, COMPULSIONS

Mannerisms are gestures or expressions peculiar to a person, such as an odd way of walking or eating. They differ from spontaneous, involuntary, movements (dyskinesias, 1065) in that they are voluntary, if idiosyncratic, movements. They differ from stereotyped behaviour in that the latter is carried out in an unvarying, repetitive, manner and is not goal-directed. Stereotyped behaviour, or **stereotypy**, is the constant, almost mechanical, repetition of an action. For example, pacing the same circle each day or repetitive hand movements. A **compulsion** is an irresistible impulse to perform an irrational act which the individual recognises is irrational or senseless and which he attributes to subjective necessity rather than to external influences. Performing the act may afford some relief of tension. Compulsive behaviour may be attributable to obsessional ideas. The terms "**obsession**" and "compulsion" are not synonymous. The former refers to a thought and the latter to an act. A thought may properly be described as obsessional if a person cannot prevent himself from repeatedly, insistently, having that thought albeit that the content of the thought is not delusional in nature. Obsessive thoughts lie behind compulsive acts and stereotyped, manneristic behaviour but they may exist without being externally manifested in the form of an objectively observable repetitive action.

Does the client may exhibit a repetitive pattern of speaking, moving or walking? Does he imitate or copy the movements of another person (echopraxia)? Does he carry out actions in response to an impulse which he has a desire to restrict, or knows is absurd or gratuitous, but nevertheless feels impelled to execute? Does this impulse come from within him or from some body or force outside him? Does he believe that repeatedly carrying out the particular action is in any way strange or odd? Is he obsessed with certain thoughts albeit that the thought itself is not delusional in nature? Is he able to exercise control over those thoughts or do they control him so that he cannot prevent himself from having them?

GENERAL APPEARANCE

The client's physical appearance may give a clue as to why he is in hospital even if he does not raise the matter himself. There may be signs of recent physical injury, possibly sustained during a suicide attempt leading to the client's admission. These injuries may suggest jumping or contact with a motor vehicle. However, superficial, multiple lacerations of the arms and wrists are most often not indicative of attempted suicide but a way of relieving acute tension. Facial cuts and bruises may result from head-banging or other forms of self-abuse, such as punching oneself in the face, or be due to recent falls caused by medication-induced hypotension. "Track-marks" on the arms may indicate the use of injectable street drugs. Other irregularities of appearance which will be readily apparent to any observer are those relating to the client's weight and unusual facial characteristics, e.g. nystagmus, tics, and oedema. As to the possible significance, and therefore the reason for recording, such characteristics, see page 1068. In yet other cases, some part of the client's body is obviously misshapen. This may cruelly be referred to as a physical deformity and sometimes, for that very reason, relevant to the client's mental health, because it grossly undermines his self-confidence and self-esteem.

Are there any signs of physical injury, unusual facial characteristics, disfigurement, or significant weight loss?

Self-care

It may seem that the client has neglected his appearance. For example, he has not washed or shaved or changed his clothes recently, or he is inadequately dressed given the temperature and other conditions on the ward. These signs may be evidence of recent or long-standing difficulties with self-care attributable to an incapacitating mental disorder. If so, the legal relevance of such self-neglect will be two-fold. Firstly, as an indicator that the client suffers from a mental disorder the nature or degree of which is sufficiently severe to affect not only higher human functions but also basic self-care skills. Secondly, a tribunal which is considering whether to discharge at its discretion must often have regard to the likelihood of the patient then being able to care for himself or to obtain the care he needs. In tribunal proceedings, poor self-care is most often seen in cases involving long-stay patients with chronic schizophrenia marked by profound negative symptoms and social withdrawal. However, self-neglect may be a consequence of many other medical conditions: delusional beliefs about washing, often with a religious content (e.g. the client has let his beard grow and cultivated a Jesus-like appearance); depression with retardation or stupor; dementia; mental impairment; and obsessive-compulsive disorders.⁴⁵ There are, however, many reasons why a client's appearance may be poor apart from mental disorder. The sedative effects of medication may be profoundly disabling and render him incapable of attending to even the most basic tasks of daily living. In the case of older people thought to be confused and to have dementia, their appearance may have relatively little to do with their own mental state. The laundry service may be deficient, soiled clothes bundled together without being properly marked, and so gradually lost or returned to owners in a chaotic manner. Other confused patients may have appropriated the client's clothes, believing them and the client's room to be their own. If the client was not admitted from home, his appearance may reflect the admission circumstances and a lack of consideration for his welfare. It may be that, although detained a week ago, he still has only the clothes which he is wearing; no one has gone back to his flat to collect spare clothing, toiletries, and shaving materials. Lastly, the effects of poverty should never be underestimated. It may be that the client cannot afford to spend more on self-care and his mental state, if abnormal at all, has deteriorated because of this rather than vice-versa.

Is there anything to suggest that the client has difficulty caring for himself, whether because of illness, the sedative effects of medication, or some other reason such as mental impairment or advanced age. Does he noticeably neglect his appearance? Does he maintain a reasonable level of hygiene? Is the client in any way concerned about his appearance? What reasons does the client give for his appearance? When absolutely necessary, can the client get up at a required time?

Clothes and artefacts

The other thing which may be immediately striking about the client is his clothes or the artefacts he has with him. It may be clear that some colour or possession has a particular importance for him and this is associated with the cause of his detention.

⁴⁵ For example, the client who spends 20 minutes putting on each sock and shoe, not moving on until he is satisfied that each item has been put on perfectly.

ABNORMAL GAIT AND PROBLEMS CO-ORDINATING MOVEMENTS

If there is nothing distinctive about the client's appearance, posture or his level of activity, it may be that the way he moves is distinctive. Some uncontrollable movement of the body, affecting the face, head, trunk or limbs, is apparent.

INVOLUNTARY MOVEMENTS (1062)

- **Ataxia** An inability to co-ordinate muscles in the execution of voluntary movement. The typical ataxic gait is lurching and unsteady like that of a drunkard, with the feet widely placed and a tendency to reel to one side.
- **Tremor** A rhythmic, repetitive movement of some part of the body which results from the alternating contractions of opposing muscle groups.
- **Dystonia** Dystonia is an abnormal muscular rigidity causing painful and sustained muscle spasms of some part of the body, unusually fixed postures, or strange movement patterns. Dystonic movements usually take the form of a twisting or turning motion of the neck, the trunk, or the proximal parts of the extremities, and they are therefore powerful and deforming, grossly interfering with voluntary movement and perverting posture.
- **Spasms** Spasms are powerful contractions of a muscle or muscles, experienced as pronounced, spasmodic jerks of the muscles. Hiccups, cramp, tics and habit-spasms are types of muscular spasm.
- **Clonus** Muscles usually respond to being stretched by contracting once and then relaxing. Where stretching sets off a rapid series of muscle contractions, this is referred to as clonus (a word meaning "turmoil").
- **Athetosis** Slow, irregular, and continuous twisting of muscles in the distal portions of the arms and legs. These sinuous movements are bilateral (evident on both sides of the body); symmetric (both sides of the body are similarly affected); and most evident at the extremities — with exaggerated writhing motions of the fingers spread in a manner reminiscent of a snake-charmer, alternate flexion and extension of the wrists, and twisting of the muscles in the hands, fingers, feet and toes.
- **Chorea** Chorea is characterised by quick, irregular, spasmodic and jerky involuntary movement of muscles, usually affecting the face, limbs and trunk. The movements resemble voluntary movements but are continuously interrupted prior to being completed. There is a general air of restlessness and, characteristically, impaired ability to maintain a posture. Those parts of the limbs closest to the trunk (the proximal portions) are more affected than those further away (the distal portions). Choreic and athetosis movements may exist in conjunction, when their combined effect is referred to as choreo-athetosis.
- **Tardive dyskinesia** A movement disorder which appears late in treatment, characteristically after long-term treatment with antipsychotic drugs. Involuntary, slow, irregular movements of the tongue, lips, mouth, and trunk, and choreo-athetoid movements of the extremities are common.
- **Akathisia** A restless inability to sit still ("a motor restlessness") and, specifically, a feeling of muscular quivering, often seen as a side-effect of neuroleptic medication or a complication of Parkinson's disease.

Dyskinesia (literally, bad or difficult movement) is a general term used to describe difficult or distorted voluntary movements. It covers various forms of abnormal movement, including tremor, tics, ballismus, chorea, habit-spasm, torticollis, torsion-spasm, athetosis, chorea, dystonia, and myoclonus. Such conditions typically involve uncontrollable movements of the trunk or limbs which cannot be suppressed and impair the execution of voluntary movements. The whole body may be involved or the problem restricted to a particular group of muscles.

- *Is there any evidence of involuntary movements?*
- *Does the problem appear to be one of lack of co-ordination?*
- *Are the movements repetitive?*
- *Do they seem to consist of muscle spasms?*
- *Are the movements bilateral (evident on both sides of the body)?*
- *Are they symmetric (both sides of the body are similarly affected)?*
- *Are they most evident at the extremities (the hands, fingers, feet and toes)?*
- *Is the trunk involved?*

INTERVIEW — 3. TAKING THE CASE HISTORY

Before discussing in detail any alleged abnormal mental phenomena with the client it is best to take a full and systematic case history. This will reveal many of the areas which need to be explored and it ensures that relevant information is not overlooked. It is also less contentious than launching straight into a discussion of the client's beliefs and other experiences. It gives the representative an opportunity to first get to know the client and to form an impression of the most sensitive way of exploring sensitive issues. If it is not possible to take a detailed case history, and this is not likely to be possible within the time available because of the client's level of functioning, access to the case notes should be sought. The references alongside the headings below are references to the relevant part of the case summary form printed as an appendix to this part of the book.

BASIC FACTUAL INFORMATION (1)

In order to save time later, the first task is to obtain basic biographical information and details of relevant addresses and telephone numbers. The representative will wish to know who is the patient's responsible medical officer, who is his social worker and primary nurse, and to verify his legal status. Details will then be required of the patient's nationality and of his family circumstances, including what level of support they do or can offer him. This information will also enable the representative to ascertain whether the nearest relative has been correctly identified.

Family composition and family relationships

The patient's relationship with his family is often quite difficult and there may be little family support to draw upon. Again, it is worthwhile obtaining general back-

ground information about the client's childhood relationships with his parents and siblings and the general atmosphere at home. Also, if relevant, when these relationships began to deteriorate and the reasons for that. Histories of sexual abuse, parental divorce or separation, and general family problems, are disproportionately common amongst people compulsorily admitted to hospital. In the context of schizophrenia, the family environment may contribute both to its development and to the likelihood of relapse (1264). The family history may reveal highly distressing events, such as the death of a relative shortly prior to admission, or a family history of mental ill-health.

What contact does the client have with his parents and siblings? Do they know he is in hospital and, if so, have they visited him? Have they expressed any concern about his health or behaviour during recent months?

Attitude of client's spouse

Not uncommonly, separation or divorce proceedings are ongoing at the time of admission. Apart from the psychological distress, this raises the question of whether the spouse was the nearest relative at the time of the admission and, hence, the issue of the application's legality. At any rate, the spouse may now be disqualified and the person now entitled willing to consider making an order for discharge. The attitude of the patient's spouse may be that the patient cannot return home or that the children have suffered psychologically because of the client's illness. In such cases, the calling in of a social worker, or the spouse's willingness to make the application, may be affected by the fact that committal to hospital is an easier way of ousting the patient from his home than taking proceedings in the county court. However, in terms of section 72, it is not necessary to deprive a person of his liberty to be in the community if there are other ways of protecting family members.

IDENTIFYING THE NEAREST RELATIVE (2)

Having taken the family details, it should be possible to identify the nearest relative and to record the necessary information about him. Before doing so, the representative should verify that no county court order is in force. If the client says that some other person other than his statutory nearest relative is acting in that capacity, the ward staff and hospital Mental Health Act Administrator should be asked if any written authority has been given under regulation 14. As to ascertaining who is the nearest relative, see page 100. If the nearest relative may be willing to order the patient's discharge, he should be contacted forthwith. However, not too much reliance should be placed on the client's assessment of the likelihood of this and he should be warned that most relatives feel bound by the medical advice. It is important not to build up his expectations in any way and to ensure that family relationships are maintained.

Who is the nearest relative? Was the nearest relative correctly identified on the application? If not, what are the legal consequences of this? If the nearest relative was not consulted prior to a section 3 application being made, did either of the exceptions referred to in section 11(4) apply? Is the nearest relative now willing to order the patient's discharge if he has that power?

ACCOMMODATION (3)

The next area to explore is the issue of accommodation. When a person's mental state is deteriorating, it is not uncommon for rent or mortgage instalments to go unpaid, for problems with neighbours to arise, or for a landlord's property to be damaged. It is therefore important to ascertain whether any debts or court proceedings are outstanding which may affect the client's ability to return home following discharge. If the client has no accommodation to go to but is detained for treatment then he will be entitled to after-care upon leaving hospital. The issue of a patient's entitlement to be rehoused has already been dealt with in the context of after-care and the social circumstances report (413, 690, 745). The social worker dealing with the case should be approached about this. In some cases, the local after-care bodies may wish to place the client in supervised accommodation but there be a resistance to this suggestion. If so, guardianship may be being considered.

Does the client have accommodation to go to? Are there any rent arrears and/or possession proceedings pending which need to be sorted out? Is the accommodation currently fit for human habitation?

EDUCATION, TRAINING AND EMPLOYMENT (4)

The client's educational and employment history are important because they help to define how severe are the effects of any illness or disability, point to the likely opportunities for him in the immediate future, and are a good indicator of social and economic deprivation. Not surprisingly, many more poor people suffer mental ill-health, just as they do physical ill-health. While medication offers symptomatic relief, those symptoms were only ever surface phenomena, the superficial manifestations of the mental disorder or conflict. Improving the patient's underlying mental state and self-esteem, as opposed to merely suppressing the worst symptoms, often necessitates improving his social situation and opportunities.

Education

The client's educational history is often a good, if not totally reliable, yardstick against which to assess his current level of mental functioning. It may also yield information about the duration and possible causes of any illness or relapse. Where a dementing process is suspected in an older person, it is the relative decline in which one is particularly interested and which provides the context for interpreting the results of psychometric testing. A disproportionate number of detained patients relative to the population at large will have attended a special school for children with behavioural difficulties. In some cases, a careful history will reveal that the individual first experienced auditory hallucinations or other distressing mental phenomena from a very early age and this information is often not recorded in the case notes or psychiatric report.⁴⁶ For example, the client may say that he had the feeling that graffiti on the blackboard contained some special message for him, or that the violent conduct which led to his being removed from school was a response to voices commanding him to act in that way. He may say that he felt an outsider at school, different from the other children, had few friends or, alternatively, that he

⁴⁶ The received wisdom is that children very rarely have these experiences and hence they are rarely sought or recorded.

enjoyed his schooling, and did well until reaching a certain when his performance and interest declined. All of this information will be relevant in determining the nature of his illness and its effect on his health.

How well, if at all, can the client read and write? Is there any suggestion that his intelligence is significantly below average? When did he leave full-time education and why? If he left school early, did he then manage to obtain work? Did the client ever see an educational psychologist while at school? Was his behaviour at school disturbed and did he attend a special school? Is his current level of intellectual functioning substantially below what one would expect given his education?

Employment history

The benefits of obtaining details of the client's employment history are similar. Quite often, the pattern will be that the client has never been in regular employment since leaving school; has not worked for many years since he was first admitted to hospital; or had a stable employment record over a period of time until perhaps a year prior to his first admission. In the latter case, there is often evidence of a decline in performance and professional relationships leading up to an indefinite period of sick leave, resignation, suspension, or dismissal. Sometimes this is in the context of a feeling that colleagues at work were conspiring against the client. There is still an unfortunate tendency to regard people with schizophrenia as unfit for any sort of employment or training which does not involve mundane tasks such as putting flights on darts or packing boxes. However, it is usually more beneficial not to advise the client to jettison unfulfilled ambitions and opportunities simply because he is or has been ill. Better to emphasise the importance of accepting medical treatment and supervision as ways of achieving stability and maximising the prospect of a return to some activity which interests the client and he finds fulfilling. It is hardly surprising that so many able clients become disabled if they are encouraged all the time not to exercise their abilities. This is nothing more than what used to be called institutionalisation, and the risk of non-compliance with treatment and relapse may well be greater if the message is that insight and treatment involves living the life of an invalid. Even if it does keep the client well, well for what? For most people, treatment is a means to an end and there is little incentive in accepting that one is ill and would benefit from medication if the benefits of doing so are put in these terms. Although one would not think it from listening to medical evidence at tribunals, there are worse things than relapse, one of which is to lapse into invalidity.

- *Viewed historically, does his work record reveal any pattern? How long has he been in each post? Was he dismissed from any jobs? If he is unemployed, for how long? Has he undertaken any employment training courses, other than as a condition attached to receiving benefits? Are there currently any employment opportunities for him?*
- *Has the client's situation at work, school or college been a source of anxiety or worry for him? Has any particular event occurred which has caused him undue distress? Has there been any criticism of his performance? If the client is in work, is his job at risk because of his compulsory admission to hospital? For how long is the job likely to be kept open for him?*

Social and intellectual interest

Apart from being an interesting way of getting to know the client, discussing his social and intellectual interests often provides useful information about his mental health. If a person is inactive on the ward, this may reflect the limited range of available activities; that the prescribed medication affects his concentration and makes him drowsy; that he is depressed and has lost interest in activities which previously gave him pleasure; that his attention and concentration is impaired by auditory hallucinations and other abnormal perceptions; that he is dispirited at being detained; that he is frightened to participate because of the behaviour of other patients; or that his interest in intellectual and social activities has declined over the years, as institutionalisation or the negative symptoms of schizophrenia have set in. A limited range of social activities in the community prior to admission may have similar causes but there are also other possible explanations. A lonely existence may be due to financial or transport problems. If the former, the client's financial position needs to be reassessed and, if the latter, he may be entitled to a bus pass or to reapply for the restoration of a driving licence revoked on medical grounds. If the client's social interests have always been solitary ones, this suggests a natural shyness and introversion, perhaps a sensitivity to criticism, and a tendency to see the world as slightly hostile. On other occasions, it may be more the case that the client had virtually ceased to venture outdoors at all. This may be because of apathy, depression, stupor, agoraphobia, claustrophobia (*sic*), panic attacks, the disabling effects of compulsive dressing rituals, or a preoccupation with inner voices. He may have believed that neighbours or passers-by were surveying him or plotting against him, and have been frightened to go out, or be protecting his home from burglary, in the mistaken belief that there have been intruders. The loss of items misplaced by him in a confused state, or finding household appliances turned on which he did not remember leaving on, may be taken as evidence of this. If the client does go out and regularly visits certain clubs, this raises the possibility of a drug-induced psychosis in a person with no prior history of admissions.

Client's preoccupations

Details of books read in the past establish the likely extent of the client's vocabulary and this may be relevant if it is suspected that a degree of mental impairment is present or that he is now developing dementia. The subject-matter of any books or newspaper articles which he is reading may be illuminating. For example, whether they suggest a morbid interest in violence or pornography or are concerned with mysticism, the occult or political conspiracies. This may lead into a discussion about the role of supernatural forces and political forces in the events which culminated in the client's admission. More generally, the programmes which the client regularly watches again give an idea of his interests and educational background. If the client watches television or listens to the radio, he may be asked if any programmes have been of particular interest or relevance to his situation. It is not uncommon for someone with schizophrenia to believe that the programmes contain special messages or signs for him.

Did the client have an active social life previously or was he shy and reserved, preferring his own company and a more solitary existence? Was he active in any clubs or societies? What pursuits and intellectual activities did the patient previously enjoy? What were his hobbies and leisure interests? What books has he read?

FINANCIAL CIRCUMSTANCES (5)

The question of an in-patient's entitlement to state benefits following discharge from hospital has been dealt with in the context of the social circumstances report (692). Reckless spending leading to substantial financial liabilities at the time of admission is not uncommon during manic phases if the client was previously credit-worthy. This inevitably has serious repercussions for the family's economic welfare if it is now impossible to pay the mortgage, rent or other regular outgoings, and the client cannot return to work. There may well be court proceedings on the horizon, with summonses, or letters before action from credit control agencies, lying unopened at home. Whether it is possible to set some of the contracts aside should be considered although the circumstances which allow this are limited.⁴⁷ However, in all cases it is essential to clarify the client's liabilities and to take any necessary legal steps on his behalf, either by coming to an arrangement for their repayment, by threatening bankruptcy proceedings, or by trying to avoid the contracts. In the case of unpaid rent, any order for possession can usually be suspended on terms. Less often, there is evidence of financial exploitation. The client may have made a significant gift to someone or allowed him control of his bank account. If so, an application for the property's return or a Mareva injunction may be necessary.⁴⁸ If the client's mental state is little changed, the risk of further debts being accumulated remains and, if in remission, the possibility of future similar behaviour must still be borne in mind. An application to the Court of Protection or the execution of an Enduring Power of Attorney may therefore need to be discussed (696, 698).

Where are the client's liabilities? Over what period of time did these arise? How are the debts to be paid? Can any of the liabilities be avoided? Are there any court proceedings pending? Is the client getting all the benefits to which he is entitled? Is it necessary to consider making alternative arrangements for the management of the client's financial affairs?

PHYSICAL HEALTH (6)

It is crucial to obtain details of the client's physical health (1067, 1094, 1294). Physical health problems may, of course, be real or imaginary and the product of a person's mental state rather than its cause. A conversion symptom is a loss or alteration of physical functioning which suggests a physical disorder but is actually a direct expression of a psychological conflict or need. The disturbance is not under

⁴⁷ To have capacity to contract, the patient must be capable of understanding the nature and effect of the contract in question. A contract entered into by a mentally disordered person is enforceable by the other party unless it can be shown that, at the time the contract was entered into, the former was mentally incapable and the other party knew of that incapacity. Where the other party knew that the patient was incapacitated at the time, the contract is not void but merely voidable at the option of the mentally disordered person. The burden of proof as to both issues is on the mentally disordered party and there is a general legal presumption of sanity. Special provisions apply to contracts for "necessaries." Under section 3 of the Sale of Goods Act 1979, an incapacitated person must pay a reasonable price for "necessaries," that is goods suitable to his condition in life and to his actual requirements at the times of sale and delivery.

⁴⁸ The courts will set aside a gift if the patient did not have sufficient capacity to make it or acted under duress. The "degree (of understanding) required varies with the circumstances of the transaction. Thus, at one extreme, if the subject-matter and value of a gift are trivial in relation to the donor's other assets, a low degree of understanding will suffice. At the other, if its effect is to dispose of the donor's only asset of value ... then the degree of understanding required is as high as that required of a will." *Re Beaney (deceased)* [1978] 2 All E.R. 595.

voluntary control and is not explained by any physical disorder. Hypochondriasis denotes an unrealistic belief or fear that one is suffering from a serious illness despite medical reassurance.

Family medical history

The client should be asked about any serious physical health problems from which family members have suffered, in case any of these are of an hereditary nature or have triggered his present distress.

Did the client have any problems with his physical health as a child or during adolescence other than the ordinary childhood illnesses such as measles? Has he ever suffered any head injuries, been unconscious, been hospitalised, or undergone an operation? Did he notice any physical changes during the months preceding admission or during the period preceding his first psychiatric admission? Has he recently been in hospital for the investigation or treatment of a physical condition? When did he last see a General Practitioner? Is there any evidence of malnutrition or weight-loss?

DRUGS AND ALCOHOL (7)

Various conditions attributable to the consumption of alcohol or drugs mimic psychiatric conditions such as schizophrenia or may trigger such a condition in someone already predisposed to it. Some of these drug and alcohol-induced conditions are briefly described in chapter 24 (1302). If the client is dependant on alcohol or has taken illegal drugs, the details must therefore be carefully noted. For the same reasons, a note should also be made of any medication which the patient is or was taking for a physical condition.

Is there any evidence that the client was consuming an excessive amount of alcohol prior to admission or that he was taking prescribed or non-prescribed drugs?

FORENSIC HISTORY (8)

The representative will require details of all previous convictions and periods in custody and will need to know the circumstances of any offences of violence. The forensic history is an important indicator of the likelihood of harm to others associated with mental disorder. If there is no apparent temporal link between a patient's history of offending and his history of mental illness, this may lead to a classification of psychopathic disorder. As to assessing the risk of further violence, see pages 723 and 738. A record of drug-related offending draws attention to the possibility of drug-induced psychosis although, more often, the illegal drugs simply act as a trigger in someone already predisposed to that illness. Two basic points must always be borne in mind when considering the forensic history. Firstly, it cannot be overemphasised that people with mental health problems may be predisposed to crime as much as any other individual from the same background. Psychiatrists have an unfortunate tendency to interpret all violent behaviour as inevitably linked in some way to the client's mental illness, even if the facts clearly suggest it occurred in a setting well known to criminal lawyers. For example, it may naively be assumed

PSYCHIATRIC HISTORY

The solicitor will need details of previous admissions and periods of out-patient treatment and to establish whether the patient ceased treatment during the weeks or months prior to the present admission. If there is no prior history of mental disorder, the immediate biomedical aim will be to explain the present (the pathology) by reference to the past (the aetiology) and so to predict the future (the prognosis). The purpose of taking *any* history is to look for patterns of events which have an explanatory or predictive value. The link may be that the patient relapses when he stops treatment, or that the illness is cyclical in nature (remitting and returning at definable intervals of time), or that particular anniversaries or kinds of event precipitate periods of illness. It may be that all or most of the patient's periods of in-patient treatment are relatively short or relatively prolonged and the tribunal case can be planned with that in mind. In general terms, events in the past reveal the nature of the illness and the patient's response both to it and to treatment. For example, multiple admissions to different hospitals usually suggests an unstable, possibly vagrant, lifestyle marked by poor compliance with after-care programmes. Reasons given for frequent changes of address, and consequential moves between catchment areas, may be essentially paranoid and involve a history of repeated persecution by neighbours. In taking the history, it is important to distinguish between objective facts and their subjective interpretation. Although a single patient may acquire many different diagnoses over time, these are rarely explicable in terms of any corresponding objective changes in his condition. Most often, the different diagnoses reflect only different diagnostic fashions and practices, the fact that different symptoms were (reliably or unreliably) considered to be present or absent and, if present, prominent or not prominent. The client should be asked if he has had routine investigations, such as blood or urine tests. If the diagnosis is doubtful, his stay in hospital has been lengthy, or there have been repeated admissions, more extensive investigations, such as an EEG, will probably have been conducted.

Out-patient treatment

It is helpful to obtain a clear idea of the duration of any periods which the client has spent outside hospital relative to periods spent as an in-patient. As already noted, there may be evidence that the periods outside hospital have become fewer or shorter over time or, conversely, that greater stability has been achieved in recent years. There are many possible explanations for either pattern. For example, it may be that the illness is taking a chronic course and that each successive episode is less complete, with residual symptoms remaining. Greater stability may reflect a change of treatment or the personnel involved in treatment; natural curative processes; maturation and the resolution of underlying personality problems; happier family circumstances characterised by less emotional conflict; a reduction in pressure outside hospital; better compliance with medication; the development of a better understanding of the patient's needs; a wider range of community care facilities; or a reduction in community support. In the last case, the appearance of greater stability is illusory, the product of a failure to identify continuing problems and to intervene.

Is this the client's first admission to hospital? How many times has he previously been in hospital? Has he received out-patient treatment in the past? Is there any pattern to his admissions or periods of remission? Does he have a history of stopping treatment against medical advice following discharge from hospital?

by a psychiatrist unacquainted with the ordinary business of the criminal courts that a known patient who "sorts out" someone who offended his manliness in some trivial way must have been responding to abnormal mental phenomena — the more so if he later suffers a relapse on being confined in prison pending trial and is then observed to be hearing voices and so forth. The psychiatrist may pride himself on eliciting this imaginary connection not obvious to untrained criminal lawyers. Secondly, because diverting people away from the criminal courts is now widely encouraged, the absence of criminal convictions does not necessarily reflect an absence of criminal conduct. Not uncommonly, serious assaults on staff are either dealt with internally or, if reported to the police, not prosecuted. Violent or threatening behaviour may also be viewed as something of a norm on acute admission wards so that assaults by one patient on another do not lead to the involvement of the police unless serious injury results. Even if a client has no convictions, it is therefore important to ask whether he has ever been arrested by the police or placed in seclusion and, if so, the reasons for this.

Restriction order cases

The circumstances of the index offence should be explored, paying particular attention to the considerations considered by the Home Office to be relevant when assessing a patient's suitability to be discharged (766). If the patient's case was disposed of without trial, because he was under a disability, it cannot be assumed that he would have been convicted if tried. It is therefore important to establish what evidence would have been available to the court and to bear in mind that it was never tested by cross-examination. The solicitor will need details of the solicitors who dealt with the criminal proceedings, so that he can obtain their file and check that the Home Secretary's summary is fair and accurate. A note signed by the client authorising the file's release will be necessary. If the trial solicitor's file has been destroyed, copies of the depositions should still be held by the court itself, unless the papers have been sent to the Lord Chancellor's Department or county archives, and the Home Office will itself have a set.

Restriction and limitation direction cases

The representative should explain that the tribunal's powers are very limited and the hearing may result in remission to prison. This may, of course, be what the client wants and in his own interests. There is also a risk that a patient held under section 48 will make admissions during the course of the tribunal proceedings which will prejudice his chances of later being acquitted at the trial of the criminal action. In cases involving patients serving a determinate sentence of imprisonment, knowing their date of release will be important since any restrictions cease to have effect on that day (389).

Does the client have any previous convictions or any criminal proceedings pending? Has he ever had to be physically restrained or placed in seclusion while in hospital? Has any person taken civil proceedings against him for an injunction forbidding him from having contact with them or entering the family home? If he is a restricted patient, what were the circumstances of the index offence?

THE CURRENT ADMISSION (11)

For convenience, the recent history can be dealt with in three stages: events leading up to the admission, the admission itself, and the developments since admission.

Events preceding the admission

Much of the relevant information will already be apparent from the information about the patient's family circumstances, accommodation, employment history, financial position, and medical history. The solicitor needs to know for how long the patient has been ill, what triggered that illness or relapse, whether he unilaterally stopped treatment, and what his attitude was to any suggestions by family members or professionals that he undergo voluntary treatment. If the client unilaterally ceased taking medication, when and why he did so needs to be established. Most often, the reason is that the patient thought that he no longer needed it, did not want to become dependent on it, or the side-effects were intolerable. Depending on the evidence available to him and the degree of suffering, discontinuance may or may not have been a reasonable risk to take at the time. If he had not previously stopped treatment against medical advice or been detained, it may be that he is now aware that the medication was merely suppressing the symptoms and it continues to be necessary. As to possible precipitants, these are listed below. This involves some repetition but it is convenient at this stage to get an overall picture of the problems.

STRESSORS AND TRIGGERS

Conjugal

Is there any matrimonial friction and, if so, did this contribute towards any deterioration of the client's mental health? Does the spouse's behaviour exacerbate his condition? Is there any evidence of domestic violence or pending matrimonial proceedings?

Parental

Has the client's relationship with his parents been problematic? Are his parents over-critical? Has he only recently left home?

Occupational

Have there been any problems at work? Has the client's performance been criticised?

Accommodation

Is the client now living alone and lonely? Has he been homeless or been threatened with homelessness? Has he recently moved from an area where he had strong community ties? Are there any neighbourhood disputes?

Financial

Is the client or his family substantially in debt? If so, have there been any court proceedings?

Forensic

Has the client recently been involved, or is he currently involved, in any criminal proceedings? To what extent did he feel humiliated as a result? Did the involvement reflect a prior decline in his mental health or did it trigger that decline?

Medical

Has the client recently suffered any significant physical injuries or illnesses?

Bereavement

Have any close relatives been very ill or recently died? How long ago was this?

At what point did the client's mental health begin to deteriorate? Had he previously stopped taking medication prescribed to prevent that? Is there any evidence that stressful events of the sort referred to above triggered the present episode of illness, or were any such problems consequences not causes of his illness?

The admission

With compulsory admission, matters usually come to a crisis and some event occurs which persuades family members or professionals that there is no other realistic course of action. This may involve the police and the client's arrest or detention under section 136; an attempt by an informal patient to discharge himself from hospital or to refuse medication; an incident of self-harm or harm to others; serious self-neglect; complaints by neighbours; or extremely bizarre behaviour at home. It is important to identify what occurred immediately prior to the decision to invoke compulsory powers and which caused that decision to be made. If the client is not forthcoming, the grounds recorded on the admission papers can be read to him as an *aide-mémoire*.

Admission initially voluntary or informal

If the admission was originally on a voluntary basis, this demonstrates some appreciation of the need for assessment or treatment. However, such an admission is sometimes more informal than voluntary and it may have been made clear that an application would be made if informal admission was refused. In other cases, the client's willingness to be admitted may have had little to do with any appreciation of the need for treatment. The motivation may be a desire for accommodation and regular meals or a familiar environment. If the original admission was informal or voluntary, the subsequent use of compulsory powers may indicate that the patient's mental state has deteriorated; that it is more serious than was first believed; that some serious incident has since occurred; that different opinions are held about the necessity of a particular kind of treatment, such as antipsychotics, or their administration by injection; that the patient lacks insight into his need for intensive treatment; that his consultant lacks insight into the patient's situation or condition; that the consultant has made no real effort to enlist co-operation or to achieve a compromise: the choice has never been anything but informal or formal treatment on the consultant's terms.

- *What events or concerns gave rise to the admission? Why do the client's doctor or nurses say that admission and compulsion was necessary?*
- *What were the circumstances immediately preceding the decision to invoke compulsory powers which led to that decision being taken? Did those circumstances justify the conclusion that the client was mentally disordered and that his admission was justified or necessary for his own health or safety or to protect others?*
- *Does the client accept that he was mentally unwell at the time of admission and/or that he needed to be in hospital? If the client accepts that at the time of his admission he did require medical help, in what way? Why does he think that he became unwell? How would he describe that illness? What were the symptoms, the exact way in which he was unwell? Did anything happen before he came to hospital which contributed to his becoming ill?*

Matters unhelpful to discharge

As noted, progress is often not uniform and not all developments since admission are helpful. It is crucial that the client is frank with his solicitor about such matters and the importance of this must be emphasised. In section 2 cases the reports are usually only available at the time of the hearing while, in other cases, significant developments may post-date their preparation. The solicitor should therefore stress that he relies on his client to put in context anything which may be construed as adverse, and in sufficient time to enable a response to be prepared. The client needs to be asked whether he has been absent from the hospital without leave, whether he has been restrained or in seclusion, whether it may be said that he has tried to harm himself or others on the ward, whether he has refused medication, and whether there have been any complaints made by other patients or by staff concerning his behaviour. Any allegation of violence or sexual misconduct will inevitably worry the tribunal although, in the former case, it often transpires that the patient was defending himself against attack.

Has the client been restrained or placed in seclusion? Has it been alleged that he has harmed himself or assaulted anyone? Will it be alleged that he has damaged any property on the ward or that he has been physically or verbally threatening? Has anyone complained about his conduct on the ward? Has he refused medication or refused to attend any part of the ward programme? Is it alleged that any untoward incidents have occurred while he has been on leave? Has his leave ever been revoked or cancelled as a result? Has he always returned to the ward from leave at the required time? If not, was he so late returning that he was treated by ward staff as being absent without leave? If so, for how long was he away and did he return of his own volition or was he returned by police or nursing staff? Where was he during his absence? Did he take medication during that period?

MEDICATION AND TREATMENT (12)

In most cases the client will be receiving some form of medication or a physical treatment such as ECT. However, if the reason for his detention is a conduct disorder associated with mental handicap or psychopathic disorder, the role of medication may be limited to dampening down undesired behaviour. Although the sedative effects of antipsychotics are immediate, their antipsychotic effect takes up to three weeks to become evident in cases of schizophrenia and perhaps half of all patients show little or no response. The efficacy of antipsychotic medication in chronic schizophrenia is unclear and some trials have not demonstrated a drug-placebo difference (1254). While the opportunities for improvement were considerably less prior to their development, and death was often nature's remedy, none of the drugs has a curative action, and medication probably only postpones rather than prevents relapse. Although the benefits cannot always be demonstrated, and it is sometimes questionable whether the suffering caused by their administration is less than that being alleviated, tribunals invariably see medication in black and white terms. It is simply a question of whether or not the patient can be relied upon to take medication as prescribed, not whether there are reasonable grounds for not taking the medication in the doses prescribed. In other words, it is not a question of whether the patient has the capacity to come to his own decision in a rational manner but whether or not he will comply.

- *Does he consider that his mental state is now different? If so, in what way? Does he consider that he still needs in-client treatment? If so, for how much longer? Has any one explained why other people consider that he still needs to be in hospital? Do his parents or relatives agree about this?*
- *If the client believes that his admission was unnecessary but has had previous admissions, were all of those admissions also unwarranted? If the client disputes the evidence in the reports, what motive does he ascribe to the reporter for giving that account? Why would the relevant nurse record that he had said or done something if he had not?*
- *Does he consider that he is now functioning at his optimum level? If not, in what respects is he still not entirely back to his normal self?*

Events since admission

Having established the general history and, more particularly, the circumstances preceding and surrounding the use of compulsory powers, the way in which matters have developed since admission should be dealt with. Subsequent events may represent a step backwards from discharge. For example, transfer from an open to a locked ward or to a hospital which has facilities for managing patients whose behaviour is threatening and difficult to control. More often, the patient's situation will have improved so that discharge from hospital or the revocation of compulsory powers are now more realistic options. If the client was admitted to a locked facility, progress typically commences with brief but gradually increasing periods of escorted leave in the hospital grounds; followed by periods of unescorted ground leave and transfer to an open ward; followed by unrestricted ground leave and periods of escorted leave outside hospital; followed by day or weekend leave at home under section 17; followed by unlimited leave at home subject to taking medication, attendance at out-patient clinics, and support from a community psychiatric nurse (CPN); followed by formal discharge from hospital; and, eventually, the discharge or expiration of the application or order authorising his detention. There are, of course, fairly endless variations to this framework but the common theme is a trial period at a lower level of restriction, followed by an indefinite period at that level and, as confidence increases, movement towards the next stage in the discharge and treatment process. Most often, progress is not uniform and, human nature being what it is, some failure to comply fully with leave arrangements is to be expected. A practical approach to minor departures from the regime, such as lateness back from home leave, is normal.

Does the client spend all his time on the ward? If so, is this by choice or because it is a locked ward and part of his management programme? Is he allowed off the ward and, if so, for how long each day? Is this with or without a nursing escort? If without an escort, does he require express permission or does he have a "general pass" to be off the ward? Is he allowed leave only within the confines of the hospital grounds or does he also enjoy town leave? When the client goes into the local town, how does he spend his time? Has the client been granted any day or weekend leave at home? If so, for how long has he had the benefit of this? What, if any, are the conditions imposed on that leave? If the client is currently spending all or most of his time on the ward, what is the more important goal for him? To be at home, even if on section, or to be off section even if in hospital?

Insight into the need for treatment

By medical custom, insight refers to the patient's awareness of the abnormality of his experiences and the fact that his symptoms are evidence of the presence of a mental illness which requires treatment. Only a patient may lack insight if one chooses to define the word in this artificial way. If one prefers the natural meaning of seeing within and understanding — understanding one's own mental processes or those of another, which is the meaning adopted by psychologists — then a doctor may also lack insight. The main content of any medical report consists of the contents of the patient's mind as elicited and interpreted by the contents of the doctor's mind. If the interviewer is uninterested in the patient's problems and the underlying causes, being interested only in obtaining enough information to sustain a diagnosis and to prescribe a form of medication, such a narrow field of view necessarily leads to a narrow understanding of the overall situation. Nevertheless, although any person's insight into their own or someone else's mind can only ever be partial, the patient's lack of insight may often be gross and involve a failure to distinguish subjective from objective experiences. The patient's view not infrequently tends towards one of two poles. Either the admission was necessitated by malign internal forces (ill-health) or it was the product of malign external forces (a failure to understand his situation by others, parental over-anxiety, malice, a conspiracy, and so forth). Although insight is usually beneficial, because it increases the chances of compliance, it is not essential and, indeed, may sometimes be highly undesirable. Many naturally passive, co-operative or compliant individuals take medication without demur, without ever understanding its role, or feeling that it is necessary. Their complete lack of insight is not considered to be a problem. Ultimately, it often suffices that the patient has insight into the legal if not the medical consequences of non-compliance — he has learnt from experience the "lesson of consequences," the fact that exercising his freedom in a certain way leads to his freedom being taken away. Just as the legal consequence of exercising one's freedom to commit murder is life imprisonment, so the patient sees that the consequence of exercising his "freedom" to stop medication is that other people believe that he is again unwell, and he is then admitted to hospital and forced to take that medication.

Whether compromise is possible

If the patient is not willing to bow to these inevitabilities, the sensible course is to see if some compromise concerning medication can be agreed. While a general advantage of injections over oral medicines is certainty about whether the drug has been received, they are unacceptable for many people. Consequently, this clarity consists only of knowing that the drug has not been received. The real choice may be between compromising on oral medication by consent or compulsory treatment by injection. In the absence of any legal framework for indefinite compulsory out-patient treatment, defaulting on injections 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 simply leads to no treatment at all and early relapse. Nevertheless, in practice, it is quite surprising how often the same failed strategy is thoughtlessly followed year after year. The alternatives of compromise or guardianship may not work. However, unless the patient has suddenly gained insight after many years without it, the possibility that informal treatment administered by injection will succeed is nil. The following questions may be asked of the client and care taken not to lead him in relation to his answers—

- *If the client considers that he is now functioning normally, does he still need the medication which is being prescribed for him? What would be the likely effects, if any, of now ceasing medication? Would there be any risk of his health deteriorating?*
- *Has the medication been beneficial in any way?*
- *What is the medication given for? Has its purpose been explained to him? What are its likely effects?*
- *Does the medication have any adverse effects? If so, is the client receiving further medication to control the effects of the other medication? If that is the case, does that medication in turn have adverse effects?*
- *Might the client be prepared to consider taking some alternative medication prescribed by his doctor? Has he previously taken any medication which he considers did help and which he was, and would now be, willing to take?*
- *If the client says that he is now well, and that he has not had any kind of mental health problem, then why would he take the medication at all, particular if it has very unpleasant adverse effects?*
- *Has the client attempted to refuse the medication on the ward? If so, was the team called? If he is given the medication orally does he swallow it or sometimes hold it under his tongue?⁴⁹*
- *If the client considers that he has been ill but is now well, what does he think has brought about that improvement? The client may attribute this to rest and a break from problems at home or work — If so, he should be asked if he thinks that the medication prescribed has helped? Is there any significance in the fact that his voices returned (or whatever) when he ceased medication and then went away when the medication was resumed? If he concedes the point, but states that he no longer needs it because he is now cured, he should be asked to consider whether it may be that the medication which has made him well is keeping him well. The prescription of insulin may be used as an example.*
- *If the section was revoked, and he was free to decide for himself whether or not to take that medication, would he take all of it, part of it or none of it? At the current doses or in smaller dosages?*
- *If the client is willing to continue taking medication on an informal basis, then for how much longer? Who will decide that he no longer requires it — the client or the doctor? What if at the end of the period during which he says he will take it, his doctor strongly advises him to continue? Would he heed that advice or not? Does he have any objection to receiving the medication by injection?*

⁴⁹ Although the patient may tell his solicitor that he is not swallowing the medication, the psychiatric report may nevertheless note the improvement brought about by medication or increasing doses of it.

The ward programme

Details of therapeutic activities can be entered on the case summary form, which includes a table for entering the weekly programme.

Does the client take part in activities such as art therapy, cookery, budgeting, sessions? For how many days or half-days each week? Does he find those activities useful, either as a means of alleviating boredom or as a means of acquiring useful skills? Does he attend a hospital workshop or do gardening, work in the kitchens or hospital stores, or participate in any similar activity? How much is he paid and how does he spend that money? If he was discharged, would he seek similar work outside the hospital? Does the client attend a hospital gymnasium, library, social club, or some such activity?

AFTER-CARE AND SUPERVISION

The representative should establish what kind of after-care the patient has received in the past and what he would be willing to agree to if discharged from hospital. It may be that non-compliance with after-care services was not a factor in the present admission, but there is evidence that the services provided were poorly resourced, poorly planned, or poorly delivered. In restricted cases, it will generally be a condition of discharge that the patient submits to supervision by a social worker and a psychiatrist. This should be explained to him. Chapter 12 summarises the current discharge guidelines and includes an after-care checklist. Chapter 6 explains the statutory duty to provide after-care to patients who have been detained for treatment and the possibility of after-care being provided under statutory supervision. In appropriate cases, where there is little or no evidence of after-care planning, the solicitor may consider commissioning an independent social work report.

What support, if any, would the client be willing to accept when discharged from hospital? Would he be willing to be visited by a community psychiatric nurse, to see a social worker, or to attend out-client appointments at the hospital or a local clinic? Would he be willing to see his General Practitioner periodically if so advised? Does he respect or trust the opinion of any particular professional currently or previously involved in his care? Would he be prepared to accept that person's advice about what medication and other treatment he needs? Would he like an opinion from that professional? Would he be willing to remain in hospital as an informal patient until his doctor is satisfied that appropriate arrangements had been made for his care outside hospital? Has he ever discharged himself against medical advice?

INTERVIEW — 4. MENTAL STATE

When taking the case history, it is sometimes evident that the client has a difficulty remembering events that is more pervasive than the effects of medication or ECT. Alternatively, his answers may lack coherence or demonstrate problems pursuing a chain of thought. More often, the account of the circumstances preceding, surrounding, and following admission is noteworthy because mention is made of

beliefs, perceptions or other mental phenomena which merit further consideration. Any evidence of mental disorder needs to be further discussed and carefully recorded.⁵⁰ This is rarely awkward. The vast majority of clients are only too happy to discuss their mood, feelings and beliefs and surprisingly often indicate that they have not been previously asked any questions about them.

MEMORY

If a person cannot remember information, or accurately remember it, the problem may lie at any one or more of the different stages of the memory process (1070). An inability to give an account of some past experience may be due to failure to register or store the information in the first place (no record was ever made); the loss or degradation of the record (defective retention or an intervening decision to erase it); or an inability to locate the record (the information is available but not accessible, because it was not systematically stored or cannot be systematically searched for). Short-term memory is often tested by giving the patient seven numbers and asking him to repeat them forwards and then backwards; by telling him a name and address and asking him to repeat it verbatim after a single hearing; and by giving him three objects to remember. When the long-term memory is tested, a distinction is usually drawn between "recent" and "remote" memory. Recent memory is tested by asking the patient a question about his activities during the previous 48 hours and then checking the accuracy of his account with a nurse. Remote memory involves remembering events memorised a considerable period ago, such as the client's wedding day or his first day at school. While it is not appropriate to formally test the patient's memory in these ways, the same end can be achieved over the course of an interview by the judicious choice of questions.

MOOD AND AFFECT

A person's affect is how he appears to be emotionally affected by an idea or mental representation. A person whose mood is normal may nevertheless be profoundly affected emotionally by some idea or perception. Affect is often described as being flat (absent or very limited emotional range); blunted (severe lack of normal emotional sensitivity); shallow or restricted (reduced); appropriate, harmonious or congruous; inappropriate or incongruous; or labile (unstable). Mood is the pervasive and sustained emotion which colours an individual's whole personality and perception of events. Consequently, it is sometimes described as sustained affect and mood disorders said to involve a morbid change of affect. Various words are used to describe the features of heightened mood, many of them essentially interchangeable. Elation consists of feelings of euphoria, triumph, immense self-satisfaction or optimism. Euphoria is an exaggerated feeling of physical or emotional well-being seen in organic mental states and in toxic and drug-induced states. Exaltation is an excessively intensified sense of well-being and is seen in manic states. Ecstasy describes a state of elation beyond reason and control or a trance state of overwhelming fervour, for instance religious fervour. Grandiosity, although not usually bracketed with affect, describes feelings of tremendous importance, characterised by an inflated appraisal of one's worth, power, knowledge, importance, or identity and commonly expressed as absurd exaggerations. Extreme grandiosity may attain delusional proportions and is seen in mania and schizophrenia.

⁵⁰ Paragraph 14 of the case summary can be used to record relevant information.

DISORDERED SPEECH OR THOUGHT

If a person's speech is abnormal, this may be because the amount of speech is outside normal bounds; because the production of speech is impaired; because his choice of words is abnormal; because the succession and connection of ideas is illogical; or because its content is abnormal. Having regard to this, abnormalities of speech and thought can be dealt with in the following order: abnormal volume (amount) and rate (tempo) of speech; abnormal delivery of speech (articulation); abnormal choice or use of words (vocabulary); abnormal juxtaposition of words, or the ideas conveyed by them, in phrases and sentences (syntax and the association of ideas); abnormal content of thought (delusions, over-valued ideas, etc.).

The volume (amount) and rate (tempo) of speech

The amount of speech used may be excessive or restricted. Retarded thought (thinking which proceeds slowly towards its goal) is reflected in the individual's speech and, when the amount of speech is very limited, this is sometimes referred to as **poverty of speech**. In extreme cases, the patient is mute, either unable or unwilling to speak. Copious, excessive, production of speech is known as **volubility** or **logorrhoea**. It may be seen in mania or schizophrenic disorders. Where the amount and rate of a patient's speech is increased so that he is difficult to interrupt, this is referred to as **pressure of speech**. In **flight of ideas**, there is a nearly continuous flow of accelerated speech and the patient jumps from one topic to another, his stream of thought directed by chance associations between each fragment of conversation.

The choice of words and vocabulary

The way certain words or phrases are used may sometimes be distinctive. For example, because they are repeated, clearly have a special significance for the individual, or have been invented by him. **Perseveration** denotes the persistent repetition of words, phrases or ideas. Where the patient instead persistently repeats back a syllable, word or phrase spoken by the interviewer, rather than a word or phrase previously spoken by himself, this is known as **echolalia**. **Verbigeration** is the stereotyped and superficially meaningless repetition of words or sentences, which is not an echoing of something said to the patient. Where a patient uses a certain *word or phrase* repeatedly throughout a conversation, such that it is clear that it has a special importance or meaning for him, such phrases are known as **stock phrases**. A **neologism** is a new word invented by the patient.

The structure and form of thought

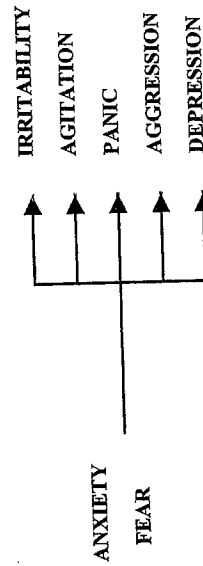
Even though a question is simply expressed and unambiguous, it may be apparent that the client has not understood its meaning or purpose, the information which it was intended to elicit. This may be because the person has interpreted the question too literally and is capable of thinking only in concrete terms — **concrete thinking**. Rational or conceptual thinking involves the use of logic to solve problems. There is sometimes no logical association between the various thoughts expressed in response to a question. The successive thoughts, sentences and topics are not obviously goal-directed or connected in a chain of thought. Marked inability to consciously develop a chain of thought is considered to be indicative of mental

Depression (depressed mood) describes feelings characterised by sadness, apathy, pessimism and a sense of loneliness. It is characteristic of depressive disorders or bipolar disorders. **Lability of mood** denotes a rapidly changing mood. The person affected may laugh one minute and cry the next without there being any corresponding change in external stimuli to account for this. As to assessing the risk of suicide, see page 734.

Does the client display no real emotion? Is there almost complete lack of interest in surroundings and events and a general lack of initiative? Does it seem that he could not "care less" about things generally? Does he laugh or display no concern when recounting how he is about to be killed or undergo some other type of terrifying ordeal? Is his mood elevated? Is he happy, self-confident, infectiously expansive, jocular? Are his plans for the future wholly unrealistic? Is there evidence of depression and suicidal feelings? Does his mood change rapidly, perhaps laughing one minute and then crying the next?

OTHER EMOTIONAL STATES

Anxiety is characterised by an apprehension, tension, or uneasiness that stems from the anticipation of danger. The associated symptoms include tachycardia, palpitations, breathlessness, and light-headedness. **Phobia** denotes a persistent irrational fear of, and desire to avoid, a particular object or situation. Anxiety may be expressed as **irritability**. The depressed patient may become anxious about his inability to respond positively to the problems surrounding him, which makes him anxious and often increasingly irritable. Conversely, sustained, unremitting anxiety and irritability have a depressive effect over a period of time because the individual's performance is constantly undermined and a measure of dejection sets in. In other cases, uncontrollable anxiety or fear surface in the form of motor restlessness (**agitation**) which, as with fits, both reflects and appears to partially alleviate the underlying tension state. A further way of dealing with anxiety or fear is to attempt to suppress it. Anxiety or fear may surface in discrete periods of sudden onset and be accompanied by physical symptoms — **panic attacks**. Fear may lead to **aggression** and **hostility**. In the case of patients who are irrationally fearful, aggression and hostility perform the same function as where there is an objectively real threat to the individual's safety. The individual attempts to reduce fear by eliminating its cause.



Is the client anxious, fearful, irritable, agitated, aggressive or hostile and, if so, why?

disorder and, more particularly, a key feature of schizophrenia. In its best form, conversation is vague and answers to questions "woolly." **Tangentiality** means replying to a question in an oblique or even irrelevant manner. In some cases, there is such a loose connection between the successive thoughts expressed by successive sentences that the goal is never attained — **loosening of associations**. Successive thoughts are either unrelated or only obliquely related but the speaker is unaware that the statements which he is juxtaposing lack any meaningful relationship. When loosening of associations is severe, speech may be incoherent. At its most severe, not only is there no logical association between successive thoughts but a lack of association between successive words, which form a meaningless jumble. This is known as **word salad**. By convention, a distinction is drawn between loosening of associations and **circumstantiality of thought**. In the latter case, the clauses or phrases used by the speaker always maintain a meaningful connection and he remains aware throughout of the original point, goal, or topic. However, although relevant to the subject being discussed and eventually answering the question, the response is indirect and delayed in reaching the point because of unnecessary, tedious details and parenthetical remarks. In **derailment of thought**, there is a sudden deviation in the train of thought, as if a train travelling from one station to another (here from question to answer) had been derailed. In **thought blocking**, the patient's stream of thought, and therefore speech, suddenly stops in mid-flow for no obvious reason. He is either unable to account for the stoppage or attributes it to his thoughts being interfered with by a third party.

THE CONTENT OF THOUGHT — BELIEFS AND IDEAS

Even if the structure and form of a person's thought, and therefore speech, appears normal nevertheless the ideas expressed by him (the content of his thought) may be markedly abnormal. A delusion is a belief which is bizarre, not true to fact; cannot be corrected by an appeal to reason; and is out of harmony with the holder's educational or cultural background. Delusional ideas may form part of a logical fixed system of such beliefs — **systematised delusions**. They are usually categorised according to their content: common delusional themes, such as paranoid and grandiose delusions, are summarised in chapter 18 (1084). Not infrequently, the individual believes that his thoughts are being controlled, infiltrated, poisoned, stolen or made public. **Thought control** describes a belief that one's thoughts are being controlled by some other person, persons, or outside forces. **Thought insertion** is a delusion that thoughts have been, or are being placed, in one's mind by some other person, persons or outside forces — these are often sexual thoughts and the patient knows that they cannot be his because he is not homosexual or has been brought up not to think in such a filthy way. These intrusive thoughts are experienced by the patient as alien. **Thought withdrawal** is when the individual experiences his own thoughts being withdrawn from his mind or otherwise appropriated by an external agency. **Thought broadcasting** is the belief that one's own thoughts are being broadcast to the outside world or otherwise made public knowledge. Apart from the central idea of interference with thought processes, these beliefs have two other aspects in common. Firstly, their nature is essentially paranoid because they are characterised by a belief that the individual is being harmed by some other person or agency. Consequently, there is a significant potential for violence to any individual thought to be involved in causing this harm. Secondly, like all paranoid delusions, the beliefs are characterised by passivity. External agencies have managed to penetrate the patient's mind and the boundaries

between the inner and outer world have been breached. Not only external events but his own inner thoughts are no longer under his own control. Care must be taken to differentiate delusional beliefs from value judgements, over-valued ideas and, more particularly, ideas of reference. An **over-valued idea** is an unreasonable, sustained, idea which is maintained less firmly than a delusional belief. **Ideas of reference** are one kind of over-valued idea. The term denotes an incorrect idea that casual incidents and external events directly refer to oneself which stops short of being a delusion of reference. Apart from delusions, a person's thoughts may be abnormal in a number of other respects. An **obsessional thought** is one which a person cannot prevent himself from repeatedly, insistently, having albeit that the content of the thought is not delusional. A **phobia** is a morbid, persistent and irrational fear of, and desire to avoid, a particular object or situation, associated with extreme anxiety. An **idée fixe** is an unshakeable preconception or conviction.

Persecutory delusions

The client may identify a particular type of person or vehicle as being involved in monitoring or trying to harm him. For instance, grey British Telecom vans, persons of a certain nationality or religion, people who wear spectacles. Alternatively, the conspirators may be identifiable by some sign or gesture they make or an ordinary gesture be interpreted as a hostile, mocking, action. The malign force may be political or religious, e.g. the devil interfering with the client's body and making him impotent or sterile. The patient may be asked if anyone has been bothering him or interfering with his day to day life and, if physical violence has occurred, he should be asked if his victim was involved in some plot against him. The following questions should also be asked of the client unless it is absolutely clear that he does not believe that other people may be trying to harm him in any way—

- *Has the client ever had the feeling that other people were talking about him, or referring to him, when he is in public? Do people laugh at him or demigrate him in some way?*
- *Do other people ever listen to his conversations, monitor his telephone calls, or interfere with his post or the contents of his flat?*
- *Has he ever been followed or spied upon? Are any people conspiring against him? If so, did his current admission form part of that conspiracy? Is his family or anyone at the hospital involved in this conspiracy or presently monitoring his activities? Is he safe in hospital?*
- *Has anyone tried to physically harm him? Has his food, drink or medication ever been tampered with?*
- *Do other people spoil plans he makes and hold him back from achieving the success which is due to him?*
- *Does the client believe that his thoughts, body or actions are influenced or controlled by other persons or forces? Has anyone inserted their thoughts into his mind or stolen his thoughts? Does he believe that other people know what he is thinking or that he can read their thoughts?*

• Does he believe that any recent items on the television or radio, or in a newspaper, referred to him or contained a message for him? Has anything else which he has come across included a coded reference to his situation? For example, the message might be in the form of graffiti, a car number-plate, a logo on a chocolate-wrapper, digits displayed on a liquid-crystal display, or certain colours, a yellow shirt meaning "you are a coward."

• Is the client frightened? If matters do not improve and the threat remains, how will he deal with the threats to his safety? Would violence ever be necessary or justifiable as a form of self-defence? Would the client ever consider ending his life if the suffering became too intense? Have thoughts of suicide or violence ever been inserted in his mind?

Grandiose delusions

Paranoid delusional beliefs are commonly associated with grandiose delusions. An obvious question which arises from a paranoid chain of thought is why the identified third party wants to harm the client? The ascribed motive may be jealousy or the fear of some special talent, knowledge or power which the patient possesses. For example, the client has the ability to heal other patients or to bring peace to the world and political or military forces are trying to stop him. Indeed, he may consider that only he can save the world, that he is the son of God or a prophet, or that but for the plotting he would have achieved great success in his life. In other cases, the patient's grandiosity may reveal itself in beliefs that he has great wealth, is a person of national importance, or is related to the royal family.

Does the client possess any particular powers, information, knowledge or abilities which other people on the ward do not also have? If people are trying to harm him, why is that? Can he control what other people think or do and, if so, can he give an example of this? Do they ever pick up his thoughts and act on them? Does the client have a decreased need for sleep? Does he spend money excessively, running up substantial debts which do not concern him because of grandiose delusions about his wealth or the future success of plans which he has made? Is he careless?

Delusions of guilt and sinfulness

By convention, guilt is self-inflicted, in contrast to shame which primarily depends upon the opinions and views of others. Guilt may commence as low self-esteem and devaluation with the individual attributing exaggerated negative qualities to himself. The patient may chastise himself for having material possessions, poor moral standards, or sexually impure thoughts. Delusions of guilt or sinfulness are commonly associated with depression but may also be found in cases diagnosed as schizophrenia and in certain organic conditions. The patient feels immense guilt for things said or done in the past. He may imagine that he is personally responsible for some imaginary disaster or a real misfortune which logically could not be his fault or of his doing. Examples include a patient who believes he is personally responsible for the suicides of other patients in the hospital (they picked up and acted on his own suicidal thoughts); for an aircraft disaster or earthquake; or for the death or illness of a parent. The risk of suicide is extremely high in such cases. The patient may believe

that only his death can properly atone for these sins, that he is unworthy to live, or that his suffering and guilt is so intense that death would be a release. Great care must be taken to identify the risk of self-harm and details obtained of any suicide attempts (734). It cannot be presumed that because the tablets consumed could not have caused death, or the attempt was discovered shortly after its occurrence, therefore the incident was only a plea for help. The issues of competency and chance need to be considered. A person who intends to kill himself may take too low a dose and learn from that. Likewise, a person who does not intend to kill himself may do so in error if he mistakenly takes too high a dose or he is not discovered, because others tragically depart from their normal timetable. Moreover, some suicide attempts are impulsive so that a lack of planning is not proof of lack of intent. Finally, even if the attempt represented a plea for help it may have been a final desperate plea for a solution and, if help is not given and so the situation then seems totally without hope, the final step before self-destruction.

Does the client feel responsible in any way for the suffering of other people? Has he ever contemplated or planned suicide? Has he ever harmed himself? What does he see as his good points and as being the reasons for wanting to live?

Nihilistic delusions

Nihilistic delusions may accompany delusions of guilt and sinfulness and are seen in cases of very severe depression. However, if the patient says he "feels" dead inside, this may simply be a turn of phrase, descriptive of a general loss of feeling.

Does the client think that his heart or brain no longer exist or that he is dead? Does he believe that his brain, stomach or bowels have rotted or putrefied or are rotting away? Does his skin feel like nothing more than a hollow shell? If his heart has stopped beating or his brain is dead, how is it that he is still able to have this conversation?

Hypochondriacal delusions

If the information previously taken concerning the patient's physical health suggests that his account of being seriously ill may be groundless, the possibility arises that his belief is delusional. It may be that, despite numerous negative investigations and constant medical reassurance that he is in good health, the patient continues to rigidly hold to the idea that he has a fatal disease, claiming that relatives and doctors as not being straight with him.

PERCEPTUAL DISTURBANCES

An hallucination is a sensory perception occurring without external stimulation of the relevant sensory organ. It has the immediate sense of reality of a true perception. Hallucinations are usually categorised according to the sensory modality in which they occur. They may or may not give rise to a delusional interpretation of the hallucinatory experience. The subject of hallucinations is dealt with in greater detail in Chapter 18 (1086).

Auditory hallucinations

An auditory hallucination is a hallucination of sound, most commonly of voices. Auditory hallucinations which consist of voices are often described as being in the first-person ("I am wicked"), in the second-person ("you are wicked"), or in the third-person ("he is wicked"). Unless the possibility of auditory hallucinations can be ruled out, the following questions may be raised—

- *Has the client ever heard any other person's voice speaking to him when he has been alone?*
- *Does he ever "hear" voices which seem to emanate from within himself? If so, do these voices seem to be his own thoughts spoken out aloud or someone else's thoughts?*
- *Does he recognise any of the voices? Are they male or female, a single person's voice or several different voices. If several voices, do they speak separately or concurrently and, if separately, as if holding a conversation? Is that conversation about him?*
- *Do the voices comment on things which he is doing or has done? Are they derogatory, perhaps making sexual remarks, or accusatorial? Does he find the voices frightening or has he become accustomed to them? Are the voices a comfort and do they give him helpful advice?*
- *How old was he when he first heard such voices and have they been continuous since then? How often does he hear the voices and do they tend to occur at particular times of the day or in a particular situation? Do the voices always speak at the same volume, or shout, or does the volume vary? Does the medication he receives make any difference to the frequency of the voices, their content or their volume? Does he draw any conclusions from this?*
- *Do the voices give the client instructions? Has he ever done any act because of advice given to him by the voices? Can he resist any commands given to him? Do the voices ever instruct him to do something which he would generally disapprove of?*
- *Have the voices ever told the client to harm himself or someone else or that someone else is trying to harm him?*

Visual hallucinations

A visual hallucination is an hallucination involving sight. Visual hallucinations may be sub-divided into those which are elementary or simple, such as flashes of light and those which are organised, such as the form of human figures. They must be distinguished from illusions. An illusion is a mental impression of sensory vividness arising out of a misinterpretation of an external stimulus. For example, mistaking a piece of scrunched cotton for a spider or a cat for a rat.

Has the client seen anything which strikes him as strange, unusual or frightening or which other people cannot see? If so, do these experiences occur at a particular time of day or night? What does he see? Do objects ever seem larger or smaller than he later knows they really are?

Other hallucinations

A **gustatory hallucination** is an hallucination of taste, such as a metallic taste, often accompanied by chewing, lip smacking or swallowing movements. Most often, unusual tastes are associated with the medication being prescribed. An **olfactory hallucination** is one involving smell and in cases of temporal lobe epilepsy this may typically be described as similar to burning rubber or burning cabbage. A **somatic hallucination** is an hallucination involving the false perception of a physical experience localised within the body. For example, a perception that electricity is running through the body. A **tactile or haptic hallucination** involves the sense of touch, often something on or under the skin.

Has the client ever experienced any strange smells or tastes the source of which he could not locate? Has he ever felt that other people or some outside force was interfering in any way with his body? Has he ever had the sensation that insects or animals were crawling under or on his skin? Has he ever felt that he might have been interfered with while asleep?

The pattern of any perceptual disturbances

It is obviously important to establish any pattern to the hallucinations and whether they may be due to some condition other than schizophrenia or depression. At its most obvious, the content of auditory hallucinations will be highly relevant. However, the possibility that the experiences have an organic basis or, more specifically, are drug-induced must be borne in mind. Some in-patients trade prescribed medication and there may be access on the ward to street drugs brought in by visitors or patients returning from leave.

Is there any pattern to the client's perceptual disturbances? If he is on depot medication does their frequency increase during the day or two immediately prior to the next injection? Has the patient taken any prescribed or non-prescribed drugs which might account for the phenomena? Does the patient believe that any hallucinations he has experienced have a basis in reality or are part of an illness? For instance, a client who hears God's voice commanding him to do some act may insist that he has actually heard God's voice or, if its intensity varies according to whether or not he is on medication, he may say that it is part of an illness (or, indeed, that the medication robs him of his prophetic powers). Similarly, a visual hallucination of a person may be so vivid that the patient is not willing to concede that he did not really see a living person.

Perceptions of time and space

A number of other unusual perceptions are not classified as hallucinations because they relate to the individual's perception of himself in relation to time, space, and place. For instance, it may seem that half an hour has passed in a matter of seconds.

Alternatively, the client may be aware of beginning to cook a meal one moment and the next moment being aware of the food on the table. In other cases, the client's body or the world may seem unreal or he may have experiences of *déjà-vu*.

Has the client ever been aware of time passing more quickly or slowly than at other times? Does he ever feel that he or the world outside him is unreal?

THE FINAL QUESTIONS

Even if there is good evidence of mental disorder, the final questions must always be, "so what?" and "does it matter?" More particularly, is the client or are other people suffering as a result? Furthermore, would alleviating the symptoms and any gain of insight make life more or less bearable for him as matters presently stand?

AFTER THE INITIAL INTERVIEW

The time available for preparation is necessarily limited in section 2 cases by the tribunal's duty to hear the application within seven days of its receipt. Subject to that constraint, taking a comprehensive statement will usually require more than one interview. Furthermore, once the reports are available, it will be necessary to obtain the client's observations on them and he will need to be seen shortly before the scheduled hearing. This is so that final preparations are made on the basis of his contemporaneous mental state. However many times it is necessary to see the client, and he may request additional visits, the steps listed on the following page should be taken following the initial interview.

THE CASE STRATEGY

Based on the diagnosis, history and the client's instructions, it is important to identify the likely hearing issues at an early stage and to plan the case with them in mind. It should be readily apparent what is likely to be the medical diagnosis. This is reached according to a simple system of pattern recognition (1112) and in most cases involves no real skill, the pattern of symptoms being as obvious to a lawyer, nurse or social worker as it is to a doctor. Similarly, the prognosis is largely based on the history of response to treatment so that anyone aware of that history can make a shrewd guess as to how matters are likely to progress. It is also important not to be bound by very specific instructions in terms of the preferred outcome. Secondary aims can be pencilled in, and additional evidence gathered with them in mind, in case the declared primary aim is unattainable. For example, if a case for discharge is being prepared, the final submission at the eventual hearing may be that (1) there is a duty to discharge because the statutory criteria are satisfied; (2) in the alternative, the tribunal should exercise its discretion in favour of discharge; (3) in the alternative, if the tribunal decides against discharge, it should recommend that the patient be granted leave of absence. The disappointment at not being discharged will be less if the hearing brings about some improvement in the situation. Furthermore, because an unrestricted patient's liability to detention cannot be renewed if he is on leave, its grant advances the date of discharge.

FOLLOWING THE INITIAL INTERVIEW

1. Enter the information from the interview on the case summary form or, if preferred, in the form of a statement.
2. Complete a time record sheet.
3. Notify the tribunal office if this has not already been done, requesting copies of the usual reports when they are available (662). Submit the patient's tribunal application where necessary. *In section 2 cases, the reports will only be available from the tribunal clerk about an hour prior to the hearing. It may, however, be possible to obtain copies from the hospital's Mental Health Act Administrator before then.*
4. Submit the completed ABWOR application to the Legal Aid Board, with any request for authority to obtain expert reports (ABWOR 6) and any written confirmation of an extension to the green form limit. *In section 2 cases, it will be necessary to obtain ABWOR and any necessary authority over the telephone.*
5. Write to the client, explaining his legal position and rights, confirming his instructions and the action taken, and setting out how the solicitor expects the proceedings to progress.
6. Make arrangements to obtain any available information and files likely to be relevant to the proceedings.
7. Contact relatives and other witnesses, where this has been agreed with the client.
8. Contact the responsible medical officer in writing about inspecting the patient's case notes. *Informal access is preferable to making a statutory application if this can be agreed.*
9. Make inquiries of social services about after-care facilities and discharge planning. *The local community care plan and Longman's Social Services Yearbook will include details.*
10. Lodge any other applications or requests to the tribunal, for directions and so forth.
11. Identify the likely hearing issues and the case strategy.
12. Commission any medical report in a section 2 case.

NOTIFYING THE TRIBUNAL OFFICE

Section 2 cases aside, it is generally unwise to notify the tribunal of having been instructed by the patient until after the first interview has taken place. The fact that the hospital have arranged a solicitor for the client does not invariably mean that he wishes to be represented or that some other person has not made alternative arrangements. Furthermore, the solicitor has not yet been instructed. In section 2 cases, it is worthwhile faxing details of dates to avoid to the tribunal office, although it is rare for the tribunal to be able to accommodate the solicitor.

COMMISSIONING EXPERT REPORTS

In section 2 cases, the grant of ABWOR and of the necessary authority for a medical report can be obtained over the telephone. The psychiatrist should be provided with proper, typed instructions and a copy of all relevant documents and case summaries. Poor instructions devalue the usefulness of an expert's report. Even if the expert is thorough, its value in terms of the tribunal, rather than the patient's future management, depends on the expert being given all the relevant facts and clear instructions about the points which his report should address. An ancillary benefit of a medical report is that it allows the advocate to test in advance the submission which he is formulating in his mind. The expert can be asked to address a number of questions, such as "If I were to argue x, is this an inference which is consistent with a body of psychiatric opinion?"⁵¹ However many sub-headings there are, a good report is in five parts, namely (1) Introduction (patient's name, address, ward, consultant, legal status, admission dates, date of examination, date of report, who was consulted, the reports read, the questions which the expert was asked to address etc.); (2) History, facts and symptoms elicited at interview; (3) Analysis; (4) Opinion/conclusions; (5) Recommendations.⁵¹

Independent social work reports

In appropriate cases, where there is little or no evidence of proper after-care planning, or no social worker has been allocated, an application for authority to obtain an independent social circumstances report will be worthwhile. This will be particularly relevant in restricted cases if it may help to reduce the possibility of having to defer any subsequent direction for conditional discharge. A social circumstances report may also be more useful than a medical report if the psychiatric issues are clear cut and the issue is whether alternative arrangements to treatment in hospital can be made for a client who requires intensive support.

Independent psychological report

In cases involving mental handicap or psychopathic disorder, a report from a clinical psychologist can be valuable if it may establish that the patient's IQ is above the conventional cut-off point for mental impairment or suggest that key personality traits are within normal bounds.

⁵¹ Not uncommonly, it will be found with reports prepared by responsible medical officers that any connection between the opinion and conclusions (4), and the reported facts upon which the opinion is notionally founded (2), is not clearly stated or logically defective. A lengthy report may be evidence of thoroughness and conscientiousness but not of understanding. Summarising a long history at length is no substitute for analysing the facts, and the opinion is often utterly silent as to why the facts justify the inferences drawn.

DISCLOSING REPORTS

Where a medical report is unfavourable, it is sometimes difficult to give the client clear-cut advice about its disclosure to the tribunal and the Secretary of State. It is often said that the tribunal will know that the report has been prepared, because the doctor's visit will be recorded in the notes and may even be referred to at the hearing by the responsible medical officer. The tribunal will therefore infer that the report was unfavourable and perhaps think that it was worse than was the case. The answer to that must simply be that one must rely on the president to ensure that the other members confine themselves to the evidence before the tribunal. Moreover, it is certainly not the case that all reports which conclude by recommending discharge are disclosed. There may be one part of the report which expresses a single reservation not expressed in the other reports. The solicitor may be confident that the tribunal will discharge on the evidence already available, the more so having been reassured that discharge is an acceptable risk, and not wish to open up fresh issues. This may particularly be so in a restricted case where the responsible medical officer favours discharge. The greater difficulty is assessing whether to submit a report which is generally unfavourable but not as damning as the only medical evidence currently before the tribunal. The report may undermine the existing medical evidence in several material respects, and even support a lesser application for leave of absence, but the problem remains that there will then be two reports against the main application for discharge. It helps to know which tribunal members have been appointed and what sort of progress is likely to be made questioning the responsible medical officer's opinion. One must also bear in mind the possibility of the patient making some further improvement by the time of the hearing. If discharge on the existing evidence is a possibility, even if unlikely, then it is generally best not to put the report in evidence. The tribunal require seven copies of any report which is tendered in evidence.

Restricted cases

Where a report commissioned on the patient's behalf relates to a restricted patient, it is important to remember to send a copy to the Secretary of State if it is being disclosed. This avoids any possibility of the hearing being adjourned because the Home Secretary has not had an opportunity to see and comment on the report.

OBTAINING FURTHER INFORMATION

In restricted cases, some of the material originally before the court may be available to the patient's solicitor through alternative sources. For instance, from records held at the Crown Court or deposited in the county archives. These are almost always made available for inspection to the solicitor upon written request, together with a written authority for their disclosure from the patient himself. Other relevant files may be held by the solicitors who acted for the patient at his trial or from a firm which acted for him at a previous tribunal. Again, a written request accompanied by the client's authority for disclosure will normally be required.

Long-stay patients

The relevant local NHS trust will be able to provide details of hostels and other community resources managed by the trust or by bodies with which it has contracted. The local social services authority will have published a community care

plan, which includes details of local facilities. They will also have a community care charter, giving the patient a right to a community care assessment within a certain period of time. Details of mental health associations operating in the area may be obtained from the Longman's Social Services Yearbook and from the social services authority itself. Such associations may own or manage suitably staffed hostels or supported housing, or be able to offer some form of day-time support.

CONTACTING FAMILY MEMBERS AND WITNESSES

Initially, there are usually no witnesses who positively support the patient's discharge. However, as his improves, this often changes and the nearest relative may then be willing to make an order for discharge. It is always worthwhile speaking with involved relatives and carers. Firstly, they are likely to attend the tribunal in their own right, so it is important to have advanced warning of what their evidence is likely to be. Secondly, part of the evidence they could give, if asked the relevant question, is likely to be positive. Thirdly, they may have information which contradicts facts in the reports upon which the responsible medical officer's opinion is based. Fourthly, they may disagree with some of the opinions and inferences drawn in the medical report. Fifthly, they may have valuable information concerning the causes of the admission which is important in enlisting the tribunal's sympathy. Sixthly, they may have positive information concerning the prognosis, e.g. the patient's condition has always remitted within three weeks, he is then ready to leave hospital and complies with medication. Lastly, the relative may be able to offer support and supervision, which reassures the tribunal.

COMMENTS AND OBSERVATIONS ON THE REPORTS

It is exceptional for reports to be furnished within the statutory period but this does not make it excusable. Enquiries should be made of the hospital and the tribunal if they have not been received by the time the prescribed period expires. Delay in preparing a medical report often means that the consultant does not envisage that a hearing will eventually be necessary because the patient will be discharged by him before then. Hence he has no intention of writing a report which will not be used. Indeed, the patient may be symptom free and compliant so that little can be written in favour of compulsion. That being so, the consultant is often disposed to discharge the patient if he is forced to explain in writing the current justification for the power of detention. For example, because a direction requiring him to furnish a report within seven days is being sought under rule 13. Once the reports have been received, it will obviously be necessary to obtain the client's detailed instructions on them. Relevant factual information can be added to the case summary but the patient's comments should be set out in a separate statement. Every solicitor has their own methods of working but it can also be useful to highlight or underline in red ink those passages to be put to the patient for comment at the hearing, using blue ink for the lines to be put to the writer of the report.

Content of the medical report

The content of any psychiatric report is the product of two things: the content of the patient's mind interpreted by the content of the doctor's mind. The evidence of mental disorder consists of facts (things actually said to or observed by the writer), inferences from these facts, hearsay (facts communicated to the doctor), inferences from hearsay, assumptions about matters not reported or observed, and

presumptions about what causes and alleviates severe mental distress. Many matters presented as fact are nothing more tangible than suppositions or inferences based on the assumed content of the patient's mind. There is often scope for hearsay gradually to acquire by virtue of frequent repetition the status of hard fact, or for established facts to become distorted.

Submitting observations to the tribunal

Rule 12 allows the representative to submit written observations on the reports. This enables the issues and any matters in dispute to be clarified and itemised in advance of the hearing. Because the responsible authority's statement is necessarily adverse to discharge, the written observations therefore ensure that the members do not come to the hearing aware only of the reasons for detention and perhaps with an unconscious inclination against discharge. Early observations may also allow the medical member to be aware of the issues likely to be canvassed at the hearing and he can then examine the patient with these in mind before forming his preliminary opinion.

CROSS-REFERENCES

The reader is referred to the following parts of the book in relation to matters which may arise during the preparation of the case.

Legal requirements of reports

Prescribed content As to the prescribed content of medical and social circumstances reports and their disclosure to the patient, see **662, 681, 682.**

Inadequate reports As to the tribunal's power to direct that a supplementary medical or social circumstances report be furnished where a report is inadequate, see **783.**

Late reports As to the tribunal's power to direct that a report now due be furnished within a certain period, see **784.**

Discharge powers As to the statutory criteria for discharge, and a tribunal's other powers, see chapters **7-9.**

The medical report

Medical terms As to the meaning of terms used to describe symptoms of mental disorder, see chapter **18** and the index ("*Words and phrases — Medical*").

The diagnosis As to the way in which mental disorders are classified, a diagnosis is made, and the reliability of diagnoses, see chapter **19.** As to the legal meaning of "mental disorder" and its four forms, see chapter **2.**

Medical tests

As to laboratory tests, EEGs, brain scans and chromosomal tests, see Chapter 19.

The treatment

As to a local authority's functions under the National Health Service & Community Care Act 1990, see 154. As to the provision of accommodation, state benefits and of occupational, medical and community services, see 687.

Risk assessment & discharge planning

As to the assessment of risks involved in discharge, in particular the risk of suicide or serious violence towards others, and discharge planning, see chapter 12.

Health Service

As to the organisation of the National Health Service, the role of professionals supplementary to medicine, and the functions of the hospital managers, see chapter 3.

Independent reports

As to the patient's statutory right to have an independent medical examination, see 616, 711.

Community care

The social circumstances report

As to a local authority's functions under the National Health Service & Community Care Act 1990, see 154. As to the provision of accommodation, state benefits and of occupational, medical and community services, see 687.

After-care

As to the duty to provide after-care, and the power to provide it under statutory supervision, see chapter 6.

Local authorities

As to the organisation of social services authorities and the statutory functions of approved social workers, see 151, 160.

Home Secretary

The Secretary of State's statement

As to the Home Secretary's functions, and those of the Aarvold Board, see 162.

Powers

As to the Home Secretary's powers and approach to cases, see 762, 334 et seq.

Procedure

Procedural matters

As to the transfer, joinder, and withdrawal of proceedings, see 638 et seq. As to adjournments, see 817. As to the giving of notice of the hearing, and the venue, see 794.

THE HEARING

The hearing is partly inquisitorial and one conducted by an expert body in a manner which is as informal as possible. The role of advocacy in this context is that of adducing oral evidence and conducting a reasoned examination of the arguments advanced in support of compulsory powers. There are several good books on advocacy which contain guidance on questioning medical witnesses, the best of which is John Munkman's *The technique of advocacy* (Butterworths, 1991), on which the text draws. The most helpful advice for a lawyer undertaking his first hearing is not to be embarrassed by any unexpected turn of events: the tribunal will have seen it all before. If the client's behaviour is affected by the stress, or he finds it impossible to give his evidence in a coherent way, support him and be kindly.

THE CLIENT'S EVIDENCE

It is important to get to the hospital in good time for a meeting with the client. Apart from the fact that a doctor or social worker may bring a supplementary report with him to the hearing, the mental state of some clients is quite variable. If so, the way it was envisaged that the case for discharge would be presented may have to be revised, in the light of the client's current mental state. Arriving early also helps the anxious client and enables the representative to remind him of the procedure and to get him in a positive frame of mind. The patient is taken through his case by the representative, the purpose being to draw out the evidence in a complete and orderly way, subject to relevance and selection. This requires a good proof, preferably one that presents the case in an ordered way. The case summary is useful in this respect because it is structured with the hearing in mind and the order of the client's evidence can often follow that set out in the summary. Thus, the client may first be asked about his family circumstances, accommodation, employment opportunities and so forth. This gives him a chance to relax before moving on to the present admission and subsequent developments and, finally, the more difficult areas of insight, medication and after-care. The occasional judicial president likes to move matters on at a greater speed, not seeing the purpose of dealing with non-contentious matters first, but this is precisely the kind of approach calculated to dissuade patients from ever applying again.⁵² Where possible, the art is to guide without leading and to raise all those points which tend both towards and against discharge. The client should therefore be warned by his representative that he will be asking questions which the client perhaps prefer were not asked and rather not answer. There is, however, no point in hoping that he will not be asked about matters such as whether he accepts that he is ill and needs medication. He will be and he will also be referred to anything which he has previously said or done which is inconsistent with his evidence to the tribunal. The aim must be to admit and avoid, to tone down the damage and to bring out this evidence without emphasis. If the representative asks those stock questions bound to elicit answers unfavourable to discharge, at least he can set them in a sandwich of favourable points. In restricted cases, a demonstration of remorse is often a prerequisite of discharge, so it is important to deal with the client's attitude to his offending. This is something of a public humiliation for him but tribunals rarely interpret silence for the shame it most often is. Some sample questions, the relevance of which obviously has to be determined according to the particular case, are set out on the following page.

⁵² See e.g. S. Dell and A. Grounds, *The discharge and supervision of restricted clients* (Institute of Criminology, 1996), p.69.

THE PATIENT'S EVIDENCE

Accommodation

- Where the client proposes to live
- Type of accommodation
- Basis of the client's occupancy
- Who will be living with him
- Community ties and support
- Details of family members
- Level of family support in hospital
- Family's attitude to the patient returning home
- Divorce/separation issues, if relevant

Employment, education and training

- Employment in the past
- Whether any job is available to the client
- Whether and when he proposes to return to work
- How he will cope with the stress of returning to work
- Any courses or training he proposes to undertake

Financial position

- Debts and savings
- Any pending litigation concerning debts
- How client will cope financially
- Entitlement to state benefits

Physical health

- Any relevant physical health problems

Drugs and alcohol

- Whether client takes illegal drugs
- Attitude to such drugs and their role in his admission
- Whether client accepts that illegal drugs may adversely affect his mental state
- Client's attitude to the risks of combining medication with unprescribed drugs
- Alcohol consumption at the time of admission, if relevant

Forensic history and index offence

Deal with convictions for violence. Take a restricted client through the Secretary of State's account of the index offence, eliciting any mitigating circumstances.

- Does the client regret what he did? If so, why?
- What was the effect on the victim? What does he think the victim's feelings towards him are now? Will the victim have forgotten what happened? If previously an acquaintance, would the victim want to see him again? (psychopathic disorder — issue of empathy)
- Was a restriction order justified? Was it too harsh? If so, what would have been an appropriate punishment?
- Was anyone put at risk by what he did (arson)? What were the possible consequences?
- If he became ill again, might there be a risk that he would do something similar — if not, why not?
- Does he think that he needs supervision on leaving hospital?
- Go through the history of admissions, as briefly as possible
- Does the client accept that any of them were necessary?

Present admission and present mental state

- Go through the relevant passages of the medical and social circumstances reports.
- Mood — ask the client about any symptoms of a mood disorder referred to in the reports
- Thought content — ask the client about any delusional beliefs referred to in the reports
- Perception — ask the client about any hallucinations or illusions referred to in the reports
- Compulsive or ritualistic behaviour — ask the client about any compulsive or ritualistic behaviour referred to in the reports
- Does the client accept that such beliefs or behaviour indicate the presence of a mental illness?
- What events or concerns gave rise to the admission? What were the circumstances immediately preceding the decision to invoke compulsory powers which led to that decision being taken?
- Does the client accept that he was mentally unwell at the time of admission and/or that he needed to be in hospital? If he accepts that he required medical help, in what way? How would he describe that illness? What were the symptoms, the exact way in which he was unwell?
- Did the circumstances also justify the conclusion that his admission was justified or necessary for his own health or safety or to protect others?
- Why does he think that he became unwell? Did anything happen before he came to hospital which contributed to his becoming ill?
- Does he consider that his mental state is now different? If so, in what way? Does he consider that he still needs in-patient treatment? If so, for how much longer?
- Does he consider that he is now functioning at his optimum level? If not, in what respects does he feel that he is still not entirely back to his normal self?

- Might the patient be prepared to consider taking some alternative medication prescribed by his doctor? Has he previously taken any medication which he considers did help and which he was, and would be, willing to take?
- If he considers that he is now functioning normally, does he still need the medication which is being prescribed for him?
- If he says he is now well, and has not had any kind of mental health problem, then why would he take the medication at all, particular if it has very unpleasant adverse effects?
- If he considers that he has been ill but is now well, what does he think has brought about that improvement? *The client may ascribe this to rest and a break from problems at home or work.* If so, he should be asked if he thinks that the medication has helped? Is there any significance in the fact that his voices returned (or whatever) when he ceased medication and then went away when the medication was resumed? *If he concedes the point but states that he no longer needs it because he is now cured, he should be asked to consider whether it may be that the medication which has made him well is keeping him well. The prescription of insulin may be used as an example.*
- If the section was revoked and he was free to decide for himself whether or not to take that medication, would he take all of it, part of it or none of it? At the current doses or in smaller dosages? If all or some, for how much longer? Who would decide when he no longer required it, he or the doctor? What if at the end of the period he says he will take it for, his doctor strongly advises him to continue? Would he heed that advice or not?
- Does he have any objection to receiving the medication by injection?

The ward programme

- What therapeutic activities does the client participate in — art therapy, occupational therapy, self-care skills (laundry, budgeting, etc.) — whilst in hospital

After-care and supervision

- Previous record of compliance with after-care. Has the client ever discharged himself against medical advice?
- Would he be willing to remain in hospital as an informal patient until his doctor is satisfied that appropriate arrangements had been made for his care outside hospital? How long is he willing to remain for?
- What support, if any, would he be willing to accept when discharged from hospital? Would he be willing to be visited by a community psychiatric nurse, to see a social worker, or to attend out-patient appointments at the hospital or a local clinic? Would he be willing to see his General Practitioner periodically if so advised?
- Restricted patients — does the patient understand the likely consequence of not complying with any conditions of discharge (power of recall)?

Final questions

- Final questions to draw together the main points in favour of discharge — Is it therefore the case that ...

- If the patient believes that his admission was unnecessary but has had an obvious admission, were all of those admissions also unwarranted? If the patient disputes the evidence in the reports, what motive does he ascribe to the reporter for giving that account?

Events since the patient's admission

- Deal with anything adverse but also emphasise all those things which commonly justify detention but that which haven't happened in this particular case.

- Does the client spend all his time on the ward. If so, is this by choice or because it is a locked ward and part of his management programme?

- Is he allowed off the ward and, if so, for how long each day? Is this with or without a nursing escort? If without an escort, does he require express permission or does he have a "general pass" to be off the ward?

- Is he allowed leave only within the confines of the hospital grounds or does he also enjoy town leave? When the client goes into the local town, how does he spend his time?

- Has the client been granted any day or weekend leave at home? If so, for how long has he had the benefit of this? What, if any, are the conditions imposed on that leave?

- Is it alleged that any untoward incidents have occurred while he has been on leave?

- Has his leave ever been revoked or cancelled?

- Has he always returned to the ward from leave at the required time? If not, was he so late returning that he was treated by ward staff as being absent without leave? If so, for how long was he away and did he return of his own volition or was he returned by police or nursing staff? Where was he during his absence? Did he take medication during that period?

- If the client is currently spending all or most of his time on the ward, what is the more important goal for him? To be at home, even if on section, or to be off section even if in hospital?

- Has the client been restrained or placed in seclusion?

- Has it been alleged that he has harmed himself or assaulted anyone?

- Has it been alleged that he has damaged any property on the ward or has been physically or verbally threatening?

- Has anyone formally complained about his conduct on the ward?

Current medication and treatment

- What medication or other treatment is being prescribed?

- Has the client consented to receiving the prescribed treatment?

- Has he refused medication or refused to attend any part of the ward programme?

- Has the medication been beneficial in any way?

- What would be the likely effects, if any, of now ceasing medication? Would there be any risk of his health deteriorating?

- What is the medication given for? Has its purpose been explained to him? What are its likely effects? Does the medication have any adverse effects? If so, is the client receiving further medication to control the effects of the other medication? If so, does that medication in turn have adverse effects?

THE RESPONSIBLE AUTHORITY'S EVIDENCE

The aim of questioning the responsible authority's witnesses is to test and probe the accuracy of the evidence, hoping thereby to weaken it, and to elicit further favourable evidence. Thus, Munkman says that the general purpose is like testing the strength of a piece of rope inch-by-inch, strand by strand. Ultimately, however, questioning the facts cannot be expected to shake an account which is substantially true. Questioning is more likely to reveal faulty observation; errors of interpretation; errors of memory; errors of expression, such as exaggeration; and bias in the sense of prejudging some relevant issue. The techniques here are insinuation and probing.

Insinuation and probing

According to Munkman, *Insinuation* involves bringing out new facts and new possibilities, thereby weakening the sting of the version forwarded, and presenting a more favourable view or explanation of the evidence. It may take the form of quietly leading the witness through his evidence, adding facts at one point and modifying details at others. *Probing* involves enquiring thoroughly into the details of the witness's evidence, to discover flaws or to open up a new lead. It may consist of testing whether something stated as a positive fact is in fact that or partly fact and partly the witness's preconceptions or interpretation of the facts. *Bias* is undermined by letting a witness talk and leading him on to show his bias by exaggeration.

RESPONSIBLE MEDICAL OFFICER

The responsible medical officer is questioned first of all by the tribunal's medical member and then by the other tribunal members. It will immediately be apparent whether, based on the reports and the medical member's examination, the tribunal is inclined towards discharge or against discharge. The doctor will either be asked to justify the case for detention or be asked leading questions, along the lines of "do you agree that this is a serious illness?" Consequently, if the responsible medical officer gives his evidence first, before the patient, the extent of the task ahead is made clear. The key is then good preparation and mastering the facts and areas of medical knowledge.

Conclusion must be different if facts different

Any expert's opinion consists of inferences which may or may not be sound, based on facts which may or may not be true. The first approach is to elucidate precisely the facts and inferences upon which the conclusion rests. The facts will often have changed in the patient's favour since the report was written. In general, the first step is to suggest that if the facts are not quite as the expert had been led to believe, or as they had been when his report was written, then the conclusion must be different from that initially given by him. In short, one uses the technique of insinuation to suggest other possibilities. Similarly, if the doctor's conclusion was based on facts which have been disproved then as a matter of logic the inferences to be drawn from the new facts cannot be exactly the same as before.

What conclusion patient's evidence points to if true

Even if the facts remain in dispute, one can put to him the patient's view of events and ask, "if the patient's summary of events were correct, what inferences would you draw; in what way would the view you have forwarded need to be qualified?"

Validity of the inferences given - unchanged facts

A further approach is to challenge the validity of the inferences which have been drawn, assuming the facts are as stated by the doctor. This is again by insinuation. The doctor may be referred to authoritative passages from books on medicine or to the patient's own medical opinion, based on the same evidence. There are few universal truths in psychiatry and research can generally throw up alternative evidence favouring treatment in the community and so forth. Complete mastery of the subject is unnecessary because most cases turn on specific, narrow areas. As long as the advocate can identify the relevant areas in advance, he can research those areas in some detail. Most doctors have inadequate time to prepare their case or allot a low priority to tribunals and do not properly prepare their case. The practitioner will not expect the patient's advocate to have a knowledge of his subject. There is then the possibility of drawing out rash statements, not based on the facts or consistent with research. For example, one consultant tried to shore up his case by saying that his diagnosis was based on the guidelines set out in the DSM-III-R classification, thinking that that would put an end to the discussion. In fact, the fourth revision had been in force for eight months, thereby revealing that he did not know the status of one of the two main international classifications of mental disorders.

The silent evidence

It is easy to forget that what does not exist is a fact — it is evidence. A medical report will necessarily record any symptoms of mental disorder, but it will not specify all of the questions asked and the matters raised which, when dealt with, were indicative of normal mental functioning. That being so, it conceals a great deal of normal mental phenomena and the greater truth is sometimes to be found not in what a report says but in what it does not say. The representative must seek out and draw attention to this silent evidence. The question is what may be inferred from the fact that these signs of mental disorder are absent, and the client has not behaved in manner *x* or *y*. The burden of proof being on the patient, his task is primarily one of establishing that certain things do not exist and hence the tribunal may be satisfied that he is not mentally disordered or his detention is unnecessary. Unless the case is clear cut, it is fundamental to list all the mental phenomena listed in the diagnostic guidelines for the condition and to ask the consultant whether the symptom or sign has been reported or elicited. Similarly, one must establish that the patient has not absented himself without leave, has complied with the ward programme, has not been violent, has not tried to harm himself, and so forth.

Fall-back positions

Just as lawyers who cannot give a court some authority for a proposition commonly resort to the feeble justifications of "inherent jurisdiction," "first principles," or "the common law," so doctors have a similar range of stock answers when nothing more tangible can be had. They may say that their judgment is based on "clinical experience." Experience can consist of nothing more than making the same misjudgement over a number of years and the question remains, "given your (considerable) clinical experience, what signs of mental disorder have you elicited?" Furthermore, "given your clinical experience, if sign *x* was present would not a man of your experience usually be able to elicit it." Likewise, if the doctor resorts to the argument that the patient is concealing symptoms, knowing that this cannot be disproved, the obvious and only question is: "How confident are you in your ability as a

psychiatrist to elicit any signs of mental disorder when you examine a patient?" If, alternatively, it is asserted that the patient remains mentally disordered but the medication is masking his symptoms, it must be pointed out that the doctor cannot know that. A significant number of patients remit naturally: "how can you know that?" The neat answer, "clinical experience," may be followed with, "But that is clinical experience of other patients: what evidence do you have that *this* patient remains mentally disordered?" Then go through one of the two main international classifications and refer to each symptom one by one, asking the doctor if he has any evidence that it is present. Other common devices include meaningless statements such as "he lacks insight into the fact that he is ill and this demonstrates the fact that he remains ill," "his unwillingness to continue with medication indicates that he is still ill," and "I know the patient." Faced with this kind of reasoning, a third approach is that of undermining the doctor's competence to form an opinion. The aim here is to undermine the very foundations of the evidence by showing that he does not know what he is talking about. Many doctors initially only interview their patients for whatever period they deem necessary to reach a diagnosis and to prescribe a course of medication. The patient may then only see his consultant for five minutes each week and not have been interviewed by him for several months. It is often possible to come up a whole range of previous symptoms and facts unknown to the consultant but which he should know if he had properly assessed the patient. Thus, if the doctor is unaware that a young patient saw a child psychiatrist at school, one may innocently ask, "Do you consider that the treatment which x received while at school has any significance in terms of the diagnosis?" or "You must have talked at some length with x about his psychiatric difficulties at school?" Alternatively, one may ask whether the client has ever experienced olfactory hallucinations and, having been told not, invite the client to give an account of the fact that he was experiencing them at the time of his admission. Another option is simply to ask the doctor about the support available from the patient's family. Often, he will not know their names or how many siblings there are at home. Unpleasantness being a last resort, the tactic is best reserved as a response to high-handedness. Sample questions which may be asked of the doctor are listed on the next page.

SOCIAL WORK REPORT

By the time the social worker gives evidence, the tribunal has often come to a view. Consequently, the evidence may consist of little more than the professional adopting his report. The most common defect in the social circumstances report is simply that it does not include the information required by Schedule 1, Part B of the Mental Health Review Tribunal Rules 1983. In this case, the social worker should be taken through the schedule and asked to give the evidence orally. Where there are serious omissions in the provision being made by social services, reference should be made to the authority's statutory duties, which are set out in chapters 3, 11 and 12. Where the after-care planning is inadequate, the social worker should be referred to the relevant guidelines concerning the need to have an after-care plan in place when a tribunal sits. If future discharge or deferred conditional discharge may be necessary, how long it will take to make any necessary arrangements must be established. The issue of transfer into guardianship is occasionally an issue, and worth pursuing. In appropriate cases, the representative will now wish to elicit the opinion that a supervision application is unnecessary. He may also venture to obtain an opinion as to whether the patient should remain liable to detention. However, although approved social workers make the vast majority of applications for detention, they are often reluctant to express any opinion as to this.

THE RESPONSIBLE MEDICAL OFFICER'S EVIDENCE

- Go through relevant passages in medical report.
- Show that the facts have changed since then so the conclusion must also be different.
- Take responsible medical officer through statutory criteria, including (in unrestricted s.3/37 cases) the discretionary discharge matters in s.72(2) and the recommendations referred to in s.72(3) — why would leave of absence be inappropriate?
- What is the diagnosis (*if in doubt or significant to treatment and prognosis*)?
- Expert γ in his book says, "... Are you aware of his findings? Has any relevant research been conducted since then tending to show otherwise?"
- Z has given evidence for the patient that a different approach is appropriate: would you accept that there is no single correct approach? You agree therefore more than one inference can be drawn from these facts?
- What symptoms or signs of mental disorder are currently apparent?
- Is it the case that those symptoms are not sufficient to meet the diagnostic guidelines for ... set out in the ICD-10 classification and the patient is therefore at the very least in remission?
- What is it about the nature or degree of those symptoms which in your view makes them so serious that it is appropriate to deprive this citizen of his liberty?
- What were the circumstances on (date) which dictated that the needs of the situation could not be met except by detaining the patient?
- What progress has been made since then?
- What symptoms present at the time of admission are no longer present?
- Is it the case therefore that not all of the circumstances which in your opinion warranted detention at that time still exist?
- If progress has been made and the patient's mental state is now improved, it must be the case that the risks associated with the patient being at home have also receded?
- Would the patient meet the statutory criteria for being compulsorily admitted to hospital if he was not presently detained?
- Since you have the power to discharge the patient, do you regularly review his case to satisfy yourself that the use of compulsory powers continues to be appropriate? And you weigh up the arguments for and against discharge? [*On the assumption the answer is "yes"*] What are the points for discharge?
- What improvement, and in what areas, would need to be made for you to be satisfied that liability to detention is no longer appropriate?
- Would you accept that the present degree of disorder does not make liability to detention appropriate — your report justifies this on the basis of the history of relapse, that is the nature of the disorder?
- How confident are you in your ability to elicit at examination any symptoms which may be present? (allegation that patient is concealing symptoms)
- Would you agree that the previous admissions have tended to be short-lived; that the patient responds quickly to a resumption of medication?

- Ask questions to highlight the fact that the client has not recently been violent, has not required restraint, has not damaged property, has not absconded.
- Point out that the offence occurred at a time when the illness was undiagnosed and *x* was not receiving any treatment or supervision. Since he has been receiving proper medication, has he ever been violent?
- If he is on a slow-acting injection, does that not mean that you would have plenty of time to readmit him if he defaulted on medication before his condition deteriorated?
- Would you agree that a ward is in many ways a much more provocative and stressful place than being in the community? There is little privacy and a much higher proportion of disturbed people to contend with? If one can cope with such behaviour without reacting violently, that is a very good sign?
- *X* was diagnosed as having a psychopathic disorder mainly because of his immaturity. You say he is now much more mature. Would you agree that maturity is not like mental illness, once you have matured — grown up — you cannot later unmatute?
- Has any information come to light since the last report which increases understanding of the circumstances surrounding the index offence?
- Is the motivation for behaviour that has put others at risk understood?
- Is there any evidence that the patient has an ongoing preoccupation with a particular type of victim or a particular type of violent/sexual/arsonist activity?
- What are the chances of circumstances similar to those surrounding the offence arising again and similar offences occurring?
- In cases of mental illness, what effects have any prescribed drugs had? Do any symptoms remain? Has stability been maintained in differing circumstances? Does the patient have insight into the need for medication?
- In cases of mental impairment, has the patient benefited from training? Is the patient's behaviour more socially acceptable? Is the patient explosive or impulsive?
- In cases of personality disorder, is the patient now more mature, predictable and concerned about others? Is he more tolerant of frustration and stress? Does he now take into account the consequences of his actions? Does he learn from experience?
- Does the patient now have greater insight into his condition? Is he more realistic and reliable?
- Have alcohol or drugs affected the patient in the past? Did either contribute towards his offences?
- Has the patient responded to stressful situations in the hospital in the past and how does he respond now — with physical aggression or verbal aggression?
- If the patient is a sex offender, has he shown in the hospital an undesirable interest in the type of person he has previously been known to favour as his victim? What form has any sexual activity taken? What have been the results of any psychological tests?
- Emphasise the predictability of the offending behaviour and the specificity of the victim. The circumstances in which the patient might be violent are reasonably well established.
- If the patient is on leave, emphasise that he has already had ample opportunity to cause harm.

- Is the patient being treated under the authority of a Form 38 or a Form 39? [See form 38] So it is the case therefore that you have signed a legal certificate to the effect that *x* understands the nature, purpose and likely effects of the treatment you are prescribing for him and he consents to that treatment? [Yes] And you would not sign such a certificate, and not call in the Mental Health Act Commission, unless it was true and the client had given a valid and free consent? So, if the client understands the nature, purpose and likely effects of the treatment and consents to it, he has insight, does he not?
 - What compulsory powers have been necessary — does the patient presently require actual detention? Has it been necessary to restrain him? Has he absented himself and it been necessary to return him? Has it been necessary to administer medication by force? If none of the powers conferred by the application have recently been necessary, what purpose are the compulsory powers serving? How can they be necessary for his health or safety or to protect others? If they have not been necessary, this is surely because the patient has been compliant and co-operative?
 - You would not let a person out of the hospital alone if there was a significant risk that he might harm himself or others? [No] But you let *x* leave the hospital alone? [Yes] So that must mean that you do not consider there is any such risk to himself or others?
 - You have granted *x* leave to be absent from hospital? [Yes] It is correct that under section 17 you have power to impose any conditions on that leave which you consider necessary in the interests of the patient or for the protection of other persons? And you could even require him to be in custody during his absence? You have not imposed any conditions — so that must mean that *x*'s interests and those of other people do not require that he is escorted or subject to conditions when in the community?
 - You have granted *x* extended leave? You can revoke that under section 17, and recall him to hospital, if that is necessary for his health or safety or to protect others? [Yes] But you have not recalled him? [No] So those grounds for again detaining *x* have not existed since then? So at present it is not necessary for his health or safety, or to protect others, that he is in hospital?
- Chronic patient with very limited insight**
- You have been the patient's consultant for *x* years. During that period have you ever reached agreement about whether he has a mental illness and requires medication? If not, what is the likelihood of a change of attitude now? In the absence of any community treatment order, is this not a case where admission can only ever fulfil the limited practical aim of treating an acute phase of illness and that has been done? What do you realistically hope to achieve through a further prolongation of detention? What foreseeable gain justifies such a continued loss of liberty?
 - If the client will always suffer from mental disorder, is he now functioning at his optimum level? If so, and it is not suggested that he needs to remain in hospital for life, what is the discharge plan?
 - Lishman has written that, "it is not infrequently noted that patients lack detailed knowledge of key features of their abnormal beliefs and experiences on recovery from schizophrenia or severe affective disorder." (W.A. Lishman, *Organic Psychiatry, The Psychological Consequences of Cerebral Disorder*, 2nd Ed., Blackwell, 1987, p. 22.) You would agree that he was a very eminent psychiatrist and that is a leading textbook? It is possible therefore to have recovered but for the rational mind to be unable to comprehend that it had acted so irrationally? (allegation of lack of insight)
 - Is it not the case that *x* has been in hospital for [25 years] and is mentally incapable of arranging his own discharge if informal?

POST-HEARING CONSIDERATIONS

In section 2 cases, the decision is sometimes announced by the tribunal after the members have completed their deliberations. Most often, it is communicated in writing although, if the patient is to be discharged, his written copy of the decision is usually sent down to the ward later that same day. The representative will, of course, remain a while with the client, to discuss with him how the hearing went, and to offer support at the beginning of what is an anxious wait for him. He should also escort him back to the ward (whether or not that has been requested). Once the written decision has been received, the representative should speak with the client if he was not discharged and also write to him concerning the reasons and his further rights of appeal. He may wish to apply to the hospital managers for them to exercise their power of discharge if he has not already done so (144).

Provisional decisions

In restriction direction cases, the Secretary of State has 90 days in which to notify the tribunal whether a section 47 patient can be discharged in accordance with its finding (557). In restriction order cases, the patient will need to keep the file open if the tribunal deferred a direction for the patient's conditional discharge. The rules do not provide for the tribunal reconvening if satisfactory arrangements complying with the conditions of discharge cannot be made, although tribunals have been known to reconvene in order to receive an explanation of the problems. At any rate, the solicitor will need to periodically liaise with the hospital concerned if there is any prolonged delay. In appropriate cases, it may eventually be necessary to commence High Court proceedings if the local Health Authority and social services authority is not providing services which the tribunal's direction or the appropriate legislation requires them to provide. There is, of course, nothing to prevent the Home Secretary from granting the patient leave or from transferring the patient to a less secure hospital during the intervening period and, given the discharge direction, he should be encouraged to do so.

Statutory recommendations

If the tribunal made a recommendation under section 72 in respect of an unrestricted patient, the decision should specify the date on which the tribunal will further consider the case in the event its recommendation is not complied with. Again, the file will need to be kept open and in this case the tribunal may reconvene if its recommendation is not complied with (853). As to whether a tribunal which reconvenes can then discharge the patient, see page 476.

SUBMISSIONS

Submissions should be kept brief, so that the determinative points are not lost amongst a welter of secondary considerations. Two to three minutes usually suffices to sum up the points which will be telling, if any are. Where the facts are almost wholly contrary to discharge, the representative has little alternative but to steer well clear of them and to make a technical submission, supported by the odd favourable point of evidence: (1) the patient has told you that he is not mentally ill, and never has been. Accordingly, if you prefer his evidence, you will inevitably discharge and I need not address you further as to that. However, if the tribunal does not accept that evidence, it is nevertheless the case that (2) only ten per cent of in-patients are detained, the threshold for loss of liberty being a high one which few in-patients satisfy; (3) In *Buxton v. Jayne*, Devlin L.J. said that "the unsoundness of mind, whose presence is essential to justify a compulsory order, manifestly means more than mental illness which qualifies a person to be a voluntary patient ... in ordinary language "certifiable" is perhaps more likely to be used to express the same idea." (4) Furthermore, Lord Denning M.R. observed in the case of *Ghani v. Jones* that an Englishman's liberty is not to be denied except on the surest of grounds and that remains the law; (5) taking these points together, it is clear that the circumstances in which liability to detention is appropriate are very few indeed; (6) on the evidence, this is not such an exceptional case that the law can or should sanction deprivation of liberty; (7) in particular, there is no history of violence to others, x's condition has improved since admission, the following symptoms then present are no longer present etc. [whatever can usefully be said]; (8) there are appropriate facilities available in the community and, if necessary, discharge could be postponed for 21 days for arrangements to be made; (9) the responsible medical officer accepted that progress has been made and this would have the incidental benefit of consolidating that progress prior to discharge; (10) in the alternative, a period of trial leave is appropriate, to establish whether further detention for treatment is necessary and appropriate. As to more hopeful cases, the existence of certain facts is generally favourable to discharge: the absence of any positive symptoms of mental disorder; the fact that the illness was sudden in onset and short-lived; the fact that a patient accepts that he is mentally ill and requires treatment, where that is the case; the fact that a client knows the risks associated with stopping medication against medical advice; the fact that the adverse effects of medication are not debilitating; a willingness to remain in hospital informally; a willingness to attend out-patient appointments and to accept supervision; the fact that in-patient treatment is not presently necessary and the client has extended leave to be absent from hospital; a record of compliance with medication; a history of informal admission; relatives who support the need for treatment and will encourage the patient to take medication; the fact that the client has nowhere else to go and will have to remain in hospital for the time being; an absence of any convictions for violence; treatment on an open ward; such a lack of capacity, or such a predominance of negative symptoms, that the patient is incapable of organising his own discharge; a good therapeutic relationship with nursing staff; that this is a first admission and there is no history of chronicity; the fact that the patient's career or employment prospects will be harmed by a prolonged admission; that the patient has been honest about his symptoms; that this is the first time the patient has been sectioned and he now knows that non-compliance has legal consequences and leads to loss of liberty (one is never free from the legal consequences of one's actions and all discharges are conditional in this sense).

MHRT CASE SUMMARY

1. PRELIMINARY DETAILS

Surname		
First names		
Date of Birth		Age
Ward		
Hospital		
Hospital address		
Hospital number		Hospital tel.
RMO		
Social Worker		
Legal status	Informal (voluntary) / Informal (incapacitated) Section 5(2) / 5(4) / 135 / 136 Section 4 / 2 / 3 / 7 / 25A Section 35 / 36 / 38 / 43 / 48 / 48&49 Hospital Order (s.37) / Guardianship Order (s.37) / Restriction Order (ss.37&41) / Limitation direction (s.45A) / Restriction Order (s.46) / Section 47 / Sections 47&49 / Conditionally discharged	
Nationality	British /	Language

FAMILY

Marital status	Married / cohabiting / divorced / separated / single	
Name of spouse / cohabitee		
Father		Age
Mother		Age
Siblings (give age)		
Level of contact with family/carers		
In care or under supervision now or in the past?		Yes / No
Ward of court now or in the past?		Yes / No
Cared for by a guardian now or in the past?		Yes / No
If the answer to any of the above questions is "yes", give details—		

2. STATUTORY NEAREST RELATIVE

Full name	
Relationship	Tel.
Address	
Is the nearest relative likely to be willing to discharge the patient?	
	Yes / No

DETAILS OF ACTING NEAREST RELATIVE (IF RELEVANT)

Court appointee?	Yes / No	Court & date of order
Authorised under reg. 14?	Yes / No	Date of written authority
Name of acting NR		Tel.
Address of acting NR		
Is the acting nearest relative likely to be willing to order discharge?		Yes / No

3. ACCOMMODATION / HOUSING

Client's usual address	(No fixed address)
Type of accommodation	House / flat / maisonette / hostel / group home / hospital ward / residential home / nursing home / other ()
Number of bedrooms	
Other persons in occupation	
Legal basis of client's occupancy	Privately owned (with mortgage) / private landlord / local authority landlord / housing association
Other relevant information	(e.g. rent arrears, disrepair, court proceedings concerning the property or the client's occupancy)

ACCOMMODATION POST-DISCHARGE

Is the above accommodation likely to be available to the client?	Yes / No
Does the client wish to return there?	Yes / No
Is the client willing to consider other types of accommodation?	Yes / No
If yes—	House / flat / maisonette / hostel / group home / hospital ward / residential home / nursing home / other ()
Is the client being assessed for specialist accommodation?	Yes / No
If yes, give details—	

4. EDUCATION, TRAINING AND EMPLOYMENT

DETAILS OF EMPLOYMENT OR TRAINING

Current employment status	Paid employment / working in the home / unemployed / student / full-time / part-time / sick leave
Post held / course being taken	
Name and address of present employers, educational or training institution, or relevant benefits office	

EDUCATION AND TRAINING

Date	Place of study / type of institution	Qualifications
Until		
Until		
Until		
Until		
Give brief details of any difficulties with reading, writing or numeracy, whether innate or otherwise		
Brief details of any history of special schooling, truancy etc.		

EMPLOYMENT SINCE LEAVING FULL-TIME EDUCATION

Approx. dates	Name of employer	Post, trade, etc.
General nature of previous temporary or part-time work undertaken		
Date when last worked		

EMPLOYMENT OR TRAINING POST-DISCHARGE

Is the above employment likely to be still available to the client?	Yes / No / Not applicable
Employment or training which the client wishes to seek post discharge	
Any statutory help to which the client is or may be entitled	
Details of relevant local employment or training projects	

FINANCES AND CAPACITY

SAVINGS

Account	Amount
	£
	£
	£
	£
Total	£

STOCKS, SHARE SAVINGS CERTIFICATES, etc

Type	Number	Unit price	Approx. value
			£
			£
Total			£

CURRENT WELFARE BENEFITS

Income support	Yes / No	£ per week
Other current benefits		£ per week
		£ per week
		£ per week
		£ per week
Total		£

CURRENT EXPENSES

Mortgage / rent	£ wk/mth
	£ wk/mth
	£ wk/mth
	£ wk/mth
Total	£ wk/mth

DEBTS AND LIABILITIES

Summarise general position.

Accommodation arrears	Mortgage arrears	£
	Rent arrears	£
	Catalogue clubs	£
	(a)	£
	(b)	£
	(c)	£
Accounts owing	Credit cards	£
	(a)	£
	(b)	£
	(c)	£
Miscellaneous debts	Other outstanding bills	£
	(a)	£
	(b)	£
	(c)	£
	(d)	£
	Total debts=	£

CAPACITY TO MANAGE PROPERTY AND AFFAIRS

Are the client's property or finances subject to—	An appointmentship	Yes / No
	The Court of Protection	Yes / No
	An Enduring Power of Attorney	Yes / No
Is the client at present incapable by reason of mental disorder of managing her/his property and affairs?		Yes / No / Unclear
Is the client likely to become so incapable in the foreseeable future?		Yes / No / Unclear

6. PHYSICAL HEALTH

Does the client consider her/himself to be in good physical health?	Yes / No
If no, state why, giving date of onset—	
Has the client suffered from any serious illnesses in the past (ignore the usual childhood illnesses)	Yes / No
If yes, give details—	
Has the client suffered any serious physical injuries in the past (e.g. head injuries, road accidents, periods of unconsciousness)	Yes / No

If yes, give details—		Yes / No / Unclear
Has the client or a family member ever suffered from epilepsy?		
If yes, give details—		
Mobility		
Physical signs (tremor, nystagmus, etc.)		

BIOCHEMISTRY

Give details of any abnormal results

7. DRUGS AND ALCOHOL

Does the client consider that s/he is dependent on alcohol or any type of drug?	Yes / No
Has the client tested positive for any non-prescribed drug since admission?	Yes / No
Did the client take any illegal drugs during the month prior to admission?	Yes / No
If yes, give details—	
Give brief details of illegal drug-taking in the past and of any drug dependency	
Give details of alcohol consumption during the month prior to admission	
Give details of any previous treatment for drug or alcohol dependency	

8. FORENSIC HISTORY

PREVIOUS CONVICTIONS (FORM 609)

Details of previous convictions		Yes / No
Has the client ever been remanded in custody or sentenced to imprisonment in connection with a criminal matter?		
If yes, give details		

THE INDEX OFFENCE (SECTIONS 37, 37(1), 45A, 47)

Court	Case no.
Offence(s) and brief details	(1) (2) (3) (4)
Date of offence	
Date of conviction	
Plea tendered	Guilty to Not guilty to Insanity / diminished responsibility /
Date of sentence	
The sentence imposed	
Section 45A, 47, 49 cases only	EDR=
Was the conviction or sentence appealed?	No / against conviction / against sentence

If yes, what was the outcome?	Yes / No
Does the client believe that s/he was wrongfully convicted?	
Name and address of the trial solicitors	

CURRENT CRIMINAL PROCEEDINGS

Court	Case no.
Charges	(1) (2) (3) (4)
Date of committal	
(Estimated) trial date	
Date of conviction / finding	
Date of sentence	
Anticipated pleas	Already pleaded guilty to and awaiting sentence Guilty to Not guilty to Not guilty by reason of insanity Diminished responsibility Unfit to plead.
Name and address of solicitors dealing with the case	

RESTRICTED PATIENTS

Home Office case reference number	
Allocated case worker	
Are any proposals for leave, transfer or discharge under consideration?	Yes / No
<i>If yes, give details.</i>	

9. PSYCHIATRIC HISTORY

Approximately how many previous in-patient admissions		
Summarise briefly any history of admissions		
Give dates of the previous period of in-patient treatment		Yes / No
If a first admission, has the patient received any psychiatric treatment in the past?		
If yes— From General Practitioner Attendance at a mental health community centre As an out-patient As a day-patient From a community psychiatric nurse Other.....		
The treatment offered or provided		

Family psychiatric history

Have any blood-relatives ever received hospital treatment for a psychiatric problem?	Yes / No
If yes, give details—	

10. AUTHORITY FOR THE COMPULSORY POWERS

The admission and authority for the detention, guardianship or supervision			
Date of informal admission	Not applicable /		
Date on which the current period of detention, guardianship or supervision commenced			
Give details of the sections under which the patient has been detained or subject to guardianship since he was last an informal patient	Form	Details	Date
	Application	NR / ASW	Consult NR Not consult
	1st. rec	s.12 / previous acquaintance	Exam Signed
	2nd. rec	s.12 / previous acquaintance	Exam Signed
	Joint med rec	(1) s.12 / previous acquaintance (2) s.12 / previous acquaintance	Exam Signed Exam Signed
Recorded date of compulsory admission (Form 14)			
Are the court order or the application and any subsequent renewal forms valid on their face?			
If no or there are other features of note regarding the statutory documentation, give details here.			
Also give date and details of any recall in restricted case.			

Client's statement, continued...

	Yes / No
Does the client accept that s/he was mentally unwell when admitted?	Yes / No
Does the client accept that s/he needed to be in hospital at the time of admission?	Yes / No
Does the client consider that being in hospital has had any benefits?	Yes / No

II. CIRCUMSTANCES OF THE PRESENT ADMISSION

Events predating the use of compulsory powers

Give details of stressful events predating the use of compulsory powers
(conjugal, parental, occupational, financial, legal, housing, bereavements, illnesses, etc.)

Give details of any cessation of treatment predating the admission
(discontinuance or reduction of medication, etc.)

In cases of relapse, summarise any other common historical trends or factors
(e.g. cyclical illness, anniversary of some previous distressing event, etc.)

Client's account of the events predating the use of compulsory powers

Client's account of the events leading up to the use of compulsory powers
Include client's own assessment of her/his level of functioning prior to admission; performance at home or work, etc.; attitude of family members to the client's interpretation of events. Give details of any incidents of self-harm, damage to property or violence to others

12. CURRENT MEDICATION AND TREATMENT

Medication		Route	Dosage
Prescribed depot (if any)	Name of drug		
Prescribed oral medication (if any)	(1)		
	(2)		
	(3)		
	(4)		
	(5)		
ECT			
When commenced	Type of ECT	Number	Ended on
Is there a Form 38 /39 in existence in relation to the ECT?		Form 38 / Form 39 / Section 62 / Date ...	
Side-effects of treatment			
Is the client bothered by any side-effects of the treatment?	Yes / No		
If yes, give details—			
Consent and compliance with medication			
Is there a Form 38 /39 in existence?	Form 38/ Form 39/ Form not yet due/ Date ...		
Ground upon which Form 39 issued	Incapacity / patient not consenting		
Is the client taking all the prescribed medication?	Yes / No		
If no, give details—			
Are the patient's consultant and the nursing staff aware that the patient is not taking this medication?		Yes / No	
If the client was free to decide, would s/he voluntarily take the prescribed medication / treatment?		Yes / No	

If yes, for how long?	
If the client was discharged from section, for how long would s/he be willing to remain in hospital?	
If the client was free to decide, what kinds of treatment or support would s/he be willing to accept upon leaving hospital?	
Events and progress since admission <i>(seclusion, restraint, self-harm, assaults, absence without leave, leave of absence, transfers)</i>	

Non-pharmacological treatment / weekly programme of activities

	am	pm	evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

MENTAL STATE AND PRESENTATION

General appearance	
Description of general appearance	
Facial expression	sad, serious, happy, smiling, masked, grimacing
Hygiene	clean, body odour, unshaven
Posture	erect, slumped, stooped, tense, relaxed
Dress	appropriate, neat, clean, dirty, bizarre, dishevelled
Signs of anxiety	restless, pacing, gesturing, hyperactive, agitated, wringing hands

Ability to function emotionally, mentally, socially	
MENTAL CLARITY (orientation: time/place/person, confused, clear, impaired, intellectual function, stupor)	
AFFECT (euphoric, cheerful, apathetic, sad, hopeless, dejected, angry, labile, incongruous)	
SPEECH (talkative, silent, rapid, slurred, clear)	
THOUGHT PROCESSES (loosening of associations, circumstantiality of thought, etc.)	

THOUGHT CONTENT (delusion, fearful, morose, flight of ideas, appropriate)	
Delusional (paranoid, grandiose, nihilistic, hypochondriacal, delusions of guilt, etc.)	
Ideas of reference, over-valued ideas, obsessional thoughts, phobias	
PERCEPTION (evidence of hallucinations, illusions)	
Hallucinations (auditory, visual, olfactory, gustatory, tactile, visceral, kinaesthetic)	
COMPULSIVE OR RITUALISTIC BEHAVIOUR	
MANNER (accepting, trusting, co-operative, suspicious, hostile, obstructive, resentful)	
SUICIDAL (thoughts, gestures, intent)	
MEMORY (short-term, long-term, confabulation)	

CONCENTRATION (attention span)	
GENERAL BEHAVIOUR (normal, overactive, retarded, verbally aggressive, physically aggressive: Details)	
NEGATIVE SYMPTOMS	
ABNORMAL PERSONALITY TRAITS	
OTHER FEATURES	
Summary of mental state	

14. DISCUSSIONS WITH THIRD-PARTIES	
Nursing staff	
Date	Nurse
	Details
RMO and other medical staff	
Date	Doctor
	Details
Allocated social workers	
Date	Name
	Details
Family members and other witnesses	
Date	Name
	Details

15. ACTION SHEET	
Details concerning the application or reference	
Application or reference?	
Person making application or reference	
Provision under which made	
Date of the application or reference	
Is the application or reference authorised?	Yes / No

If no, give details—				
Details of MHRT office				
MHRT case reference number				
Representation				
Person referring case to firm	New client direct / existing client / appointed by MHRT /			
Terms	Eligible for Green Form advice and assistance ABWOR Fee agreed of £ Pro bono MHRT undertaking to pay costs Court of Protection authorised			
Statutory reports				
	Due on	Received		
Part A, C, E		Action?		
Medical				
Social				
Home Office				
Independent reports				
	Necessary	Commissioned from	On (date)	Received
Psychiatric	Yes / No			
Neuropsychiatric	Yes / No			
Forensic psychiatric	Yes / No			
Endocrinological	Yes / No			
Other medical—	Yes / No			
Psychological	Yes / No			
Social circumstances	Yes / No			
Assessment of case				
	Points favourable to discharge	Points not favourable to discharge		

Hearing strategy	
Hearing and outcome	
Date(s)	(1) (2)
MHRT members	
Outcome	Application / reference withdrawn on... Client regraded to informal on... Discharged forthwith / on <i>Mandatory discharge / discretionary discharge</i> Not discharged— no recommendation Not discharged— recommendation as follows Absolute discharge (Deferred) Conditional discharge, conditions as follows— (1) (2) (3) (4) (5) Section 74— entitled to be absolutely discharged Section 74— entitled to be conditionally discharged with a direction that patient not be remitted to prison Reclassification— From.... To.....
Client next entitled to apply on—	

APPENDICES TO PART I