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

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

PART II — THE LAW

Detention, guardianship and supervision

2. Legal definitions of mental disorder

INTRODUCTION

"Mental disorder" is defined in section 1 and means "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind."[1] The Act distinguishes four particular "forms" or "classes" of mental disorder: mental illness (**060**), psychopathic disorder (**082**), severe mental impairment (**070**) and mental impairment (**070**).[2] No one may be dealt with under the Act as suffering from mental disorder, or from any form of mental disorder, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.[3]

THE FOUR FORMS OF MENTAL DISORDER

"Mental illness" is not statutorily defined. Unless the context otherwise requires, the other forms of disorder have the meanings given to them in section 1(2) of the Act—

- "Severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly;

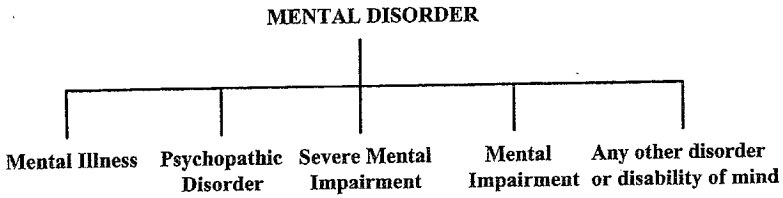
- "Mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly;

- "Psychopathic disorder" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

1 Mental Health Act 1983, s.1(2).
2 *Ibid.*, s.1(2).
3 *Ibid.*, s.1(3).

Significance of the classification

A patient who suffers from one or more of the four specific forms of mental disorder will necessarily come within the general definition of "mental disorder." The converse is not also true. The definition of "mental disorder" includes individuals with a mental handicap not amounting to mental impairment or severe mental impairment and a rather disparate group of people who suffer from some "disorder or disability of mind" not amounting to mental illness or psychopathic disorder.



The need for a true mental disorder

The European Convention on Human Rights permits the "lawful detention... of persons of unsound mind" in accordance with a procedure prescribed by law.[4] A "person of unsound mind" means a person who "by definition ... cannot be held fully responsible for his actions."[5] Lawful detention requires "the existence of a specific condition of mental ill-health."[6] Except in emergency cases, the individual concerned must be reliably shown to be of unsound mind, that is to say, a true mental disorder must be established before a competent authority "on the basis of objective medical expertise."[7] This implies that a finding of mental disorder must be consistent with a recognised diagnostic system, such as the International Classification of Diseases (ICD–10, **1117**). For continued confinement to be lawful the disorder must persist.

Previous legal classifications

The legal classification of mental disorders dates back to medieval times and the present scheme should be considered within its historical context. Several terms now in use have their origins in earlier legislation. Where the statutory terminology has been amended, these changes have been partly substantive and partly euphemistic. The authority for the detention or guardianship of some patients whose cases are reviewed by tribunals dates back to these earlier provisions and will originally have been founded upon the grounds of "subnormality," "mental deficiency," or an obsolete definition of "psychopathic disorder." In practice, care needs to be taken to ensure that such patients are "mentally disordered" as now defined by the law.

4 European Convention on Human Rights, Art. 5(1)(e). The term "person of unsound mind" was also used in the Mental Treatment Act 1930 but replaced by the term "mental illness" in 1959.

5 *X. v. United Kingdom* (1981) 4 E.H.R.R. 181, at para. 82. However, the term is "not one that can be given a definitive interpretation ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness change, in particular so that a greater understanding of the problems of mental patients is becoming more widespread." *Winterwerp v. The Netherlands* (1979) 2 E.H.R.R. 387.

6 *X. v. United Kingdom* (1981) 4 E.H.R.R. 181, at para. 79.

7 *Winterwerp v. The Netherlands* (1979) 2 E.H.R.R. 387.

Admission trends

During the year ending 31 March 1996, 8670 (or 98.2 per cent.) of the 8,826 patients admitted to NHS hospitals for treatment under Part II of the Act were classified as suffering from mental illness. Of the remainder, 85 were classified as mentally impaired (1 per cent.), 55 as having a psychopathic disorder (0.6 per cent.), and 16 as suffering from severe mental impairment (0.2 per cent.). Of those admitted to NHS hospitals under Part III, 1225 were classified as mentally ill (92.3 per cent.), 57 as mentally impaired (4.3 per cent.), 44 as having a psychopathic disorder (3.3 per cent.), and only one patient as suffering from severe mental impairment (0.1 per cent.). Overall, this means that about 14 of every thousand persons compulsorily admitted to hospital suffered from mental impairment, 10 from a psychopathic disorder, and less than two from severe mental impairment.[8]

THE PURPOSE OF CLASSIFICATION

To a significant extent, the statutory terms are terms of art and have no fixed or static meaning. They are "generic terms,"[9] "administrative groupings,"[10] adopted for the purpose of legal categorisation. Their ambit will fluctuate over time as the meaning of "mental illness" and the words used to define the other terms fluctuate in response to changes in medical knowledge and social attitudes. However, legally defining "mental disorder" and sub-dividing disorders into different classes does serve the useful purpose of defining, as far as practicable, the group of citizens to whom the various statutory provisions apply and the circumstances in which resort may be made to compulsory powers.[11] Although the classes are defined in very general terms, and so permit a medical practitioner or a tribunal a broad discretion, the prohibitions in section 1(3), and the fact that the classes exist and are defined at all, demonstrates that the terms are not infinitely elastic or meaningless. While each is capable of sustaining a wide interpretation, each ultimately has a boundary.

THE CONSEQUENCES OF CLASSIFICATION

The way in which a person's mental state is legally classified has important consequences. Provided that the other statutory conditions are satisfied, a person who suffers from "mental disorder" generally may be admitted to hospital for assessment.[12] However, a person must suffer from a condition which falls within one or more of the four specific statutory classes before he can be detained for treatment, received into guardianship, or subjected to statutory supervision following discharge.[13] For some purposes, the statutory procedures further distinguish between what have come to be known as the "major" (mental illness and severe mental impairment) and "minor" (psychopathic disorder and mental impairment) forms of mental disorder.[14]

8 *Statistical Bulletin 1997/4* (Department of Health, 1997).

9 The phrase used in the *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975).

10 The phrase used in the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).

11 See paragraph 60 of the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957): "More general terms will however also be needed to describe the ... main groups which need to be differentiated for broad administrative or legal purposes ...because there are differing considerations in connection with the use of compulsory powers."

12 See Mental Health Act 1983, s.2(2)(a).

13 See *ibid.*, ss.3, 7, 25A, 36, 37, 38, 43, 44, 47 and 48.

14 The terms were coined by Bridge J. in *Re V.E. (Mental Patient)* [1972] 3 W.L.R. 669, at 677–678.

Classification of mental impairment or psychopathic disorder

A person who suffers only from a minor form of mental disorder may not be remanded or removed to hospital for treatment under sections 36 or 48 of the Act. Interim orders apart,[15] no application, order or direction may be made authorising such a person's admission to hospital for treatment unless in-patient treatment is likely to alleviate or prevent a deterioration of his condition.[16] Nor may the authority for an unrestricted patient's detention be renewed for a further period unless it appears that further in-patient treatment is likely to confer such a benefit.[17] A tribunal is not, however, required to discharge a patient who is liable to be detained on account of such a form of mental disorder merely because it is of the opinion that his condition is untreatable in this sense.[18]

Classification of "mental illness" or "severe mental impairment"

Where the conditions specified in the Act are satisfied, a person who suffers from mental illness or severe mental impairment may be detained or received into guardianship under any of the provisions in the Act. It is not a prerequisite of admission or renewal that in-patient treatment is likely to alleviate or prevent a deterioration of his condition.

RECLASSIFICATION

When a person is received into guardianship, admitted to hospital for treatment or placed under statutory supervision, the application, order or direction which authorises that will specify the form or forms of mental disorder from which he has been found to suffer.[19] Sections 16, 20, 21B, 25F and 72 of the Act allow the application, order or direction to be amended if it later appears that the patient is suffering from a form of disorder other than that specified. The reclassification of an unrestricted patient who is detained for treatment may necessitate his immediate discharge.

Reclassification at the time of renewal

A restriction order or restriction direction once made remains in force until discharged. In all other cases, the authority for a patient's detention, guardianship or supervision will lapse unless periodically renewed for periods of six or twelve months at a time in accordance with the provisions of sections 20 or 25G. The authority is renewed upon the medical officer in charge of his treatment furnishing a report stating that in his opinion the statutory conditions for renewal are satisfied. In order to form an opinion as to this, the doctor is required to examine the patient during the final two months of the period of detention, guardianship or supervision which is drawing to a close.[20]

15 See Mental Health Act 1983, s.38.

16 A person who suffers from or is suspected to suffer from such a form of disorder may, irrespective of the condition's treatability, be received into guardianship, detained for assessment under Part II, remanded to hospital for the preparation of a report under section 35, or detained in pursuance of an interim hospital order under section 38.

17 See Mental Health Act 1983, s.20(4).

18 See *R. v. Canons Park Mental Health Review Tribunal, ex p. A* [1994] 3 W.L.R. 630, C.A.

19 There are two exceptions. No form of mental disorder is recorded in the case of a patient who is admitted to hospital under section 5 of the Criminal Procedure (Insanity) Act 1964, nor where a section 2 patient is transferred into guardianship under section 19(1)(a) of the 1983 Act.

20 Mental Health Act 1983, ss.20(3), 20(6).

THE RECLASSIFICATION PROVISIONS

Section	*To whom it applies*	*When it applies*
▪ Section 16	*Unrestricted detained patients and patients subject to guardianship*	Reclassification other than when furnishing a report renewing the authority for the patient's detention or guardianship.
▪ Section 20		Reclassification in the course of furnishing such a renewal report.
▪ Section 21B(8)		Reclassification of a patient who has returned to the place where he is required to be after more than 28 days absence from there without leave.
▪ Section 25F	*Unrestricted patients subject to after-care under supervision*	Reclassification other than when furnishing a report renewing the authority for the patient's supervision.
▪ Section 25G		Reclassification in the course of furnishing such a renewal report.
▪ Section 72(5)	*All unrestricted patients*	Reclassification by a tribunal which does not direct that the patient shall cease to be liable to be detention or subject to guardianship or statutory supervision.

The renewal criteria

In cases involving patients who are detained for treatment, the form or forms of mental disorder which the responsible medical officers finds the patient is suffering from at the time of his examination determine the conditions which must be satisfied before he may complete a report renewing the patient's detention.[21] If the responsible medical officer's opinion is that a patient suffers only from psychopathic disorder or mental impairment, the authority for his detention may only be renewed if it appears that medical treatment in a hospital is likely to alleviate or prevent a deterioration of the patient's condition ("the treatability test").[22] Where, however, his opinion is that the patient suffers from mental illness or severe mental impairment, renewal is permissible on the alternative ground that he would, if discharged, be unlikely to be able to care for himself, to obtain the care which he needs, or to guard himself against serious exploitation ("the vulnerability test"). The grounds for renewing the detention of a patient who suffers from mental illness or severe mental impairment are therefore somewhat broader.

21 Where a patient is subject to guardianship or after-care under supervision, the same renewal criteria apply irrespective of the particular form of mental disorder from which the patient suffers. See *ibid.*, ss.20(7) and 25G(4).

22 Mental Health Act 1983, s.20(4).

Reclassification upon the furnishing of a renewal report

It may be the case that the form of mental disorder specified in a renewal report differs from the form(s) previously specified. Where this happens, the Act provides that the application, order or direction shall have effect as if the form of disorder specified in the renewal report were specified in the original document, and in any such case the medical practitioner need not also furnish a report under section 16 or 25F (see below). No additional right of application to a Mental Health Review Tribunal arises where reclassification is effected through the furnishing of a renewal report, nor need the patient or his nearest relative be informed that reclassification has taken place.

Reclassification other than at the time of renewal

Sections 16 and 25F enable an unrestricted patient's condition to be reclassified by the registered medical practitioner in charge of his treatment at a time other than when furnishing a renewal report.[23] More specifically, if it appears to that doctor that the patient is suffering from a form of disorder other than the form or forms specified in the application, order or direction, he may furnish a report to that effect. Upon doing so, the application, order or direction takes effect as if the form of mental disorder recorded in the report were specified in it. The hospital managers, guardian or responsible after-care bodies, as the case may be, must ensure that the patient and his nearest relative are informed of the report. They may then apply to a tribunal during the following 28 days, unless the report relates to a detained patient and has the effect of terminating the authority for his detention (see below).[24]

Patients who are liable to be detained

If the effect of a report furnished under section 16 is that an unrestricted patient detained for treatment is suffering from psychopathic disorder or mental impairment, but not from mental illness or severe mental impairment, the report must also state the responsible medical officer's opinion as to whether further medical treatment in hospital is likely to alleviate or prevent a deterioration of the patient's condition. Where his opinion is that such treatment is not likely to have that effect, section 16(2) provides that the hospital managers' authority to detain the patient shall cease. In all other cases, the right to apply to a tribunal referred to above arises.

Reclassification under section 72(5)

Section 72(5) provides that a tribunal which does not terminate the authority for an unrestricted patient's detention, guardianship or supervision may direct that the form of disorder from which he is recorded as suffering shall be amended. It has been noted that the form of disorder from which a patient suffers has no legal significance in guardianship and supervision application cases — the grounds for renewal are the

23 In the case of a patient subject to after-care under supervision it is his community responsible medical officer (**148**) who furnishes such a report. Where a patient subject to guardianship has a private guardian it is his nominated medical attendant (**148**). In all other cases, the report is furnished by the patient's responsible medical officer (**147**).

24 There is one exception to this. Where a patient subject to after-care under supervision is reclassified in this way, he may request that the responsible after-care bodies do not inform his nearest relative. See page 452.

same in all cases. In the case of detained patients, the renewal criteria do vary according to the form of disorder from which the patient suffers. Nevertheless, where a tribunal directs reclassification from a major to a minor disorder, or vice-versa, its direction does not thereby determine the renewal criteria to be applied by the patient's responsible medical officer when he examines the patient at the close of that particular period of detention. Those criteria are determined by the form(s) of disorder from which that medical officer, or his successor, finds the patient to be suffering at the time of his examination.[25]

Patients absent without leave for more than 28 days

As to the new provisions concerning the reclassification of unrestricted patients who are returned to the place where they are required to be after more than 28 days absence without leave, see pages 294 and 628. The effect is similar to that just described. If a report furnished under section 21B in respect of a returned patient has the effect of renewing the authority for his detention or guardianship then no additional right to apply to a tribunal arises if it also has the secondary effect of reclassifying him. However, if a report furnished under section 21B merely has the effect of reclassifying him, because it does not also have effect as a renewal report, a right to apply to a tribunal does arise by virtue of the patient's reclassification.

DUAL CLASSIFICATION

A patient may suffer from more than one psychiatric condition at the same time. For example, a person who suffers from a psychopathic disorder or mental impairment may later develop a mental illness. The Act recognises this fact and provides that a person may be legally classified, or reclassified, as suffering from more than one form of mental disorder at the same time.[26]

Whether the classes overlap

The case of *W. v. L.*[27] is sometimes taken as authority for the proposition that a single psychiatric condition may be classified under two legal classes at the same time. The reported facts were that there was a consensus of medical opinion to the effect that the patient suffered from a psychopathic disorder as statutorily defined; he had a persistent disorder which resulted in seriously irresponsible conduct. However, a "distinguished consultant" who later examined him concluded that the conduct which other doctors had previously ascribed to a disordered personality was in fact the result of an organic condition, that is a mental illness. Lord Denning M.R. concluded that there was evidence upon which the county court judge was entitled to

25 See the wording of section 20. Given that the medical officer is not bound by the classification made by the Crown Court or the Court of Appeal in cases where either of those courts makes a hospital or guardianship order, there can be no reason for believing that he is bound by any previous classification made by a tribunal. More generally, see the judgment of Laws J. in *R. v. South Western Hospital Managers, ex p. M.* [1993] Q.B. 683 as to the extent to which directions made by a tribunal are binding.

26 See paragraph 188 of the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957): "From the medical point of view ... there is no clear-cut distinction between our ... groups ... One patient may exhibit symptoms of more than one type of disorder, simultaneously or at different times, and at one time may, for administrative or legal purposes, be regarded as falling into a different group from that in which he has previously been classified."

27 *W. v. L.* [1974] Q.B. 711, 719, C.A.

be satisfied that the patient had a mental illness and "not merely ... a psychopathic disorder" and Lawton L.J. observed that "although the case may fall within the definition of 'psychopathic disorder' ... it also falls within the classification of 'mental illness.'"

Chronic mental illness

The proposition which has been derived from that decision certainly has significant legal and practical consequences. Because mental illness is undefined and psychopathic disorder is so generally defined, the conditions of many mentally ill patients will necessarily be classifiable within both classes unless some account is taken of the historical development of the terms and the clinical and lay associations which they bear — associations which Parliament would have had in mind when it gave the classes their names. Specifically, all patients with a chronic mental illness have a persistent disorder or disability of mind and, consequently, any chronic mental illness which results in abnormally aggressive or seriously irresponsible conduct will constitute a psychopathic disorder. Thus, if section 1(2) is literally interpreted, chronic paranoid schizophrenia will often also come within the definition of a psychopathic disorder as will any chronic mental illness which is severely socially disabling or results in self-injurious conduct.

"Persistent disorder of personality"

Insofar as there is a problem, it stems in part from the fact that the original definition of psychopathic disorder in the 1959 Bill, which referred to a "persistent disorder of personality," was amended during the Parliamentary debates in an attempt to emphasise that something more than a disorder of personality was required; the phrase "a disorder or disability of mind" was therefore substituted for it. However, this evidently had the unintended consequence of leading the doctors in *W. v. L.*, and arguably the court also, to classify as psychopathically disordered a patient whose conduct was not attributable to a persistent disorder of personality. In doing so, the historical distinction between mental illness and psychopathic disorder was eradicated to such an extent that it may reasonably be doubted whether Parliament intended this when it conceived of two broad groups of psychiatric disorders sufficiently distinct to warrant delineation as separate legal classes.

The limitations of W. v. L.

Although some writers have referred to the proposition as if part of the *ratio decidendi*, the point in issue was whether there was evidence of mental illness, which clearly there was. No detailed consideration was therefore given to whether there was evidence of a personality disorder existing independently of the organic illness or the relationship between the two; that issue was academic in terms of the decision which had to be made. The decision is arguably peculiar to a statutory framework which no longer exists following the abolition of the age-limits relating to the civil admissions.

Illnesses, disorders and disabilities

"Mental illness" is undefined except by its own name, which is meant to convey without more a kind of disorder different to "psychopathic disorder" — a term which literally means a disorder of the soul. Mental illness is an "illness," that is

something which affects a person's previous ("premorbid") state of health and well-being. It is literally and specifically "an illness of the mind" and not merely a "disorder or disability of mind." In psychopathic disorder, the patient's mind is persistently disordered or disabled but not through illness. To this extent the concept of personality is incorporated within the definition. Unless one preserves this distinction, "mental illness" becomes synonymous with "disorder or disability of mind" so that as many detained patients are likely to fall within both classes as in either of them.

Summary

The law has historically distinguished between lunacy, idiocy and moral insanity. Although the terminology has changed, the present legal classification is essentially a reworking of the same framework and the distinction is worth preserving. A classification of mental illness only is appropriate where a patient's symptoms, including his conduct, are the manifestations of an illness. Psychopathic disorder will be the appropriate classification where a person's conduct is neither the result of a mind affected by illness nor associated with a significant mental handicap. If there is evidence of a disorder of disability of mind which has persisted prior to the onset of illness then a dual classification is permissible but not otherwise.

WHETHER THE CLASSES ARE COMPREHENSIVE

In the fourth edition of Halsbury's Laws, it was said that in ordinary usage the term "mental illness" in the 1959 Act "apparently covers ... all persons who suffer from mental disorder but are not within the categories of severe subnormality, subnormality or psychopathic disorder as defined."[28] As a statement of the law, this was and is a simplification. Section 1(2) makes it clear that persons who suffer only from a condition of arrested or incomplete development of mind are not to be dealt with under the longer-term powers, from which it may be inferred that it would be unlawful to classify them as mentally ill in an attempt to circumvent the prohibition. The presence of the words "any other disorder or disability of mind" in the general definition of "mental disorder" also indicates that not all mental disorders are reducible to one of its four forms. Although not characterised by mental handicap, these "other disorders or disabilities of mind" do not amount to mental illness or a psychopathic disorder. They are essentially psychiatric conditions which are capable of being sufficiently serious to warrant compulsory assessment and treatment for a limited, defined period but not the use of compulsory powers of a potentially unlimited duration.

Mental disorders requiring the use of long-term powers

A stronger view would therefore be that the four forms of mental disorder are comprehensive insofar as Parliament intended, if the medical opinion is that a patient's mental condition is sufficiently disordered that compulsion under one of the longer-term powers is necessary, that condition will *per se* be classifiable within one of the four statutory classes. Specifically, it may be categorised for legal purposes as a "mental illness" if it does not fall within the statutory definitions of the other three forms. In support of the proposition, it may be contended that the term "mental illness" as used in the Act is a legal rather than a clinical concept. Consequently, its

[28] *Halsbury's Laws of England* (Butterworths, 4th ed., 1980), Vol. 30, p.563.

interpretation is ultimately not restricted by any clinical sense in which it is used. Section 1(3) provides that no person may be legally classified as suffering from mental illness solely on account of the matters set out there. Had Parliament intended that the term's interpretation should be further restricted, those prohibitions would have been specified, either by extending the exceptions in section 1(3) or by defining mental illness.

The need for an illness

The view does not seem wholly satisfactory even when expressed in this way. Although the concept of "mental illness" was conceded to be undefinable, there is ample evidence that Parliament considered that the words sufficiently defined themselves as to warrant their use to denote a class of mental disorders fundamentally different from the others; these conditions were illnesses with all that connotes. The concept of an illness embodied within the term was one well understood by the doctors who would bear the responsibility of recommending the use of compulsory powers of an indefinite duration to prospective applicants. It cannot have been Parliament's intention been that the fourth class was to be seen as nothing more than an infinitely elastic administrative category capable of encompassing all other disorders requiring indefinite treatment. Had that been the case, the longer-term powers would be exercisable in respect of persons suffering from one of the three defined forms of disorder or from *"any other disorder or disability of mind"* of the requisite nature or degree. It is therefore preferable to say that the classes are virtually comprehensive as concerns persons who require indefinite treatment or guardianship because of a mental disorder which is associated with or leads to abnormally aggressive or seriously irresponsible conduct on their part; regard being had to the fact that, where no illness or mental handicap can be discerned which accounts for their behaviour, the disorder or disability of mind causing it must be shown to have existed over a considerable period of time. The classes are not, however, in any way comprehensive as regards mental disorders which do not affect a person's conduct in either of these ways. Such a person may only be placed under a guardian or compelled to accept indefinite treatment if there is medical evidence of an illness, that is some condition affecting the individual's ordinary, pre-existing state of mental health. The formulation is clumsy but attempting to simplify it further risks blurring the basic premise that there are some disorders which warrant the use of compulsory powers of a defined duration but not powers capable of existing indefinitely.

MENTAL ILLNESS

A significant proportion of patients detained on the legal ground of mental illness are diagnosed as suffering from schizophrenia (**1227**) or a mood disorder (**1193**). These conditions are universally accepted as constituting mental illness in law. Although "mental illness" is not statutorily defined, the Act does provide that no person may be dealt with as suffering from mental illness by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Since early on in English legal history a distinction has generally been drawn between lunatics, whose incapacity was or might be temporary and intermittent, and idiots or natural fools, who lacked capacity from birth and who were incurable.[29] The statutes of the eighteenth and nineteenth centuries variously provided for the apprehension or certification of "lunatics," the "insane," and persons "of insane mind" or "of unsound mind."[30] The terminology of the nineteenth-century statutes was, however, inconsistent. Under the Idiots Act 1886 the terms "idiot" and "imbecile" did not include "lunatics" but the Lunacy Acts of 1845 and 1890, and the Lunatic Asylums Act 1853, provided that the term "lunatic" did include "idiots" as well as "persons of unsound mind."

Mental Treatment Act 1930

The Mental Treatment Act 1930 required that the use of the word "lunatic" cease and substituted for it the term "person of unsound mind."[31] In *Buxton v. Jayne*,[32] Devlin L.J. said that the alteration did not suggest an intent to alter the sense of the Lunacy Act 1890, but rather to substitute a word with less disagreeable associations. The 1930 Act also provided for the voluntary or temporary treatment of persons suffering from "mental illness," whether certifiable under the Lunacy Act as being of "unsound mind" or not.[33] "Mental illness" was not defined and nor has it been in subsequent statutes.

Percy Report (1957)[34]

The Percy Commission of 1954–57 reviewed the statutory terminology. It recognised that the division of mental disorders into legal classes was based on administrative rather than clinical considerations.[35] The Commission considered that the public attitude towards mental disorder had outgrown the term "person of unsound mind." It noted that the term "mentally ill" was by then in general usage in respect of persons dealt with under both the 1890 and 1930 Acts.[36] A new terminology was needed to "mark a step forward from ancient prejudices and fears and to be an outward sign of a real advance in public sympathy."[37] Accordingly, the Percy Report recommended the use in any new statute of the phrase "mental illness," which would be used in the same sense as before and therefore include those who became mentally infirm in old age.[38]

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29 See *e.g.* the statutes Praerogativa Regis, Attainder and Forfeiture for Treason (1541), Fines and Recoveries (1580–81); *Beverley's Case* (1603) 4 Co. Rep. 123b; Co. Lit. 247a and 1 Hale P.C. 34; and *ex p. Cranmer* (1806) 12 Ves. 445, *per* Lord Erskine.

30 For a description of the statutes, see chapters 3, 4 and 9 of the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).

31 Mental Treatment Act 1930, s.20(5). The phrase "criminal lunatic" continued, however, until 1948 when it was replaced by the term "Broadmoor patient."

32 *Buxton v. Jayne* [1960] 2 All E.R. 688 at 697, C.A.

33 Mental Treatment Act 1930, ss.1–5.

34 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).

35 *Ibid.*, para. 185.

36 *Ibid.*, para. 182.

37 *Ibid.*, para. 184.

38 *Ibid.*, para. 189.

Mental Health Act 1959

In accordance with the Commission's recommendation, the use of the phrase "mental illness" was adopted in the Mental Health Act 1959 in preference to "person of unsound mind." Its meaning was left undefined,[39] the Ministry of Health's opinion being that its interpretation was matter for clinical judgment.[40] Subsequently, the absence of any statutory definition has occasionally led to problems in practice.[41]

Butler Report (1975)[42]

The Butler Report considered that the expression denoted "a disorder which has not always existed in the patient but has developed as a condition overlying the sufferer's usual personality."[43] No comprehensive short definition was possible, because the term covered a large group of dissimilar disorders.[44] The Committee proposed that a special verdict, "Not guilty on evidence of mental disorder," should be returnable in criminal proceedings where at the time of the act or omission charged a defendant was suffering from "severe mental illness,"[45] which it defined as follows—[46]

> "A mental illness is severe when it has one or more of the following characteristics:—
>
> *a.* lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity;
>
> *b.* lasting alteration of mood of such degree as to give rise to a delusional appraisal of the patient's situation, his past or his future, or that of others, or to lack of any appraisal ;
>
> *c.* delusional beliefs, persecutory, jealous or grandiose;
>
> *d.* abnormal perceptions associated with delusional misinterpretation of events;
>
> *a.* thinking so disordered as to prevent reasonable appraisal of the patient's situation or reasonable communication with others."

A Review of the Mental Health Act 1959 (1978)

In 1975, the Government established an interdepartmental committee to review the Act. The Committee's initial suggestions were set out in a consultative document

39 The Minister of Health referred to the two forms of subnormality and psychopathic disorder as the three "definable forms of mental disorder" (*Hansard*, H.C. Vol. 598, col. 709). In the House of Lords, the Lord Chancellor referred to them by saying that "unlike 'mental illness' these terms are not in general use at present, and we have thought it desirable to define them for the guidance of those applying the compulsory powers" (*Hansard*, H.L. Vol. 216, col. 607).

40 *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (D.H.S.S., 1960), para. 40.

41 "The view seems to have been taken that doctors and others ... would not in practice have much difficulty in fitting any particular case into its appropriate classification. The facts of this case show how difficult the fitting of particular instances into the statutory classification can be," *per* Lawton L.J. in *W. v. L.* [1974] 1 Q.B. 711 at 719, C.A.

42 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975).

43 *Ibid.*, p.5 and glossary, p.xiv.

44 *Ibid.*, para. 5.24.

45 *Ibid.*, paras. 18.20 and 18.30.

46 *Ibid.*, para. 18.35. Appendix 10 to the Report sets out the conditions which the Committee envisaged would constitute severe mental illness.

published in August 1976.[47] , included a definition of "mental illness" which was virtually identical to the definition of "severe mental illness" in the Butler Report, except that the word "lasting" in paragraphs (a) and (b) of the latter was replaced by the words, "more than temporary." However, when the Government set out its proposals for an amending Bill in a White Paper published in September 1978,[48] it proposed that "mental illness" should remain undefined. Although a few suggestions had been made as to how mental illness might be defined, those comments had underlined the difficulties of producing a definition which would be likely to stand the test of time. Nor, it was said, had there been much evidence that the lack of a definition had led to particular problems.[49]

Mental Health (Amendment) Act 1982

The D.H.S.S.'s notes on the 1982 Bill stated that the expression "mental illness" covered "a wide range of illnesses which may require treatment in hospital and for which the term is in general medical use."[50] The lack of a statutory definition had not caused "any" difficulties in practice.

MENTAL HEALTH ACT 1983

The 1983 Act was a consolidating statute and it repeats the position introduced by the Mental Health (Amendment) Act 1982. The Department of Health's view, expressed in its memorandum on the Act, remains that the term's "operational definition and usage is a matter for clinical judgment in each case."[51] The present legal meaning of mental illness differs from that in the 1959 Act in that section 1(3) states that no person shall be dealt with under the Act as suffering from mental illness by reason only of sexual deviancy or dependence on alcohol or drugs. The 1959 Act had provided simply that such a classification could not be made by reason only of promiscuity or other immoral conduct. The meaning of the phrase "sexual deviancy" is considered below (089). Dependence on alcohol or drugs does not preclude the detention of persons who develop organic psychoses, such as Korsakoff's psychosis, as a result of alcohol or drug abuse.[52]

A form of mental disorder

The term "disorder" is used in the International Classification of Diseases "to imply the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions."[53] Mental illness is one form of mental disorder. It is not defined except by its own name, which is meant to convey without more a form of disorder different to psychopathic

47 *A Review of the Mental Health Act 1959* (H.M.S.O., 1976).

48 *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978), p.11.

49 *Ibid.*, para. 1.17.

50 *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S.S., 1982).

51 *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 10.

52 According to the *Memorandum*, ".. there are no grounds for detaining a person in hospital because of alcohol or drug abuse alone, but it is recognized that alcohol or drug abuse may be accompanied by or associated with mental disorder. It is therefore possible to detain a person who is dependent on alcohol or drugs if he or she is suffering from a mental disorder arising from or suspected to arise from alcohol or drug dependence or from the withdrawal of alcohol or a drug, if all the other relevant conditions are met." *Ibid.*, para. 16.

53 *ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (World Health Organisation, 1992), p.5.

disorder and mental impairment. An illness may be seen as the difference between a person's current state of being and functioning and his state of health immediately prior to the onset of a decline in his health, whether subjectively or objectively apparent. Thus, a disease may also be described as an illness but not all illnesses will be diseases, that is attributable to a change in the body's structure. Mental illness is literally and specifically "an illness of the mind" and not simply, as with psychopathic disorder, a "disorder or disability of mind." In psychopathic disorder, the patient's mind is persistently disordered or disabled but not through illness; to this extent the concept of personality is incorporated within its definition. Unless one preserves this distinction, "mental illness" becomes synonymous with "disorder or disability of mind" and as many detained patients are likely to fall within both classes than in either of them.

JUDICIAL GUIDANCE

The courts have historically been reluctant to attempt to define the term "mental illness" and, prior to that, the term "of unsound mind."[54] The only recent judicial guidance is to be found in the case of *W v. L.*

W. v. L.

[1974] Q.B. 711 *C.A. (Lord Denning M.R., Lawton and Orr L.JJ.)*

The facts of the case were that the patient had placed a cat in an oven; cut the throat of another, having first got it to inhale ammonia; hung a dog and a puppy, using wire on one occasion; and used a knife to threaten his spouse, who was seven months pregnant. There was concern for the future safety of the baby. Notwithstanding all this, the patient's wife refused to consent to an application for his admission to hospital for treatment. County court proceedings were commenced to have the patient's wife displaced as the statutory nearest relative, so that an application could then be made. Although medical opinion was united that the patient suffered from a psychopathic disorder, the 1959 Act provided that no application could be made for his detention for treatment if this was the only form of mental disorder from which he suffered. That was the main problem faced by the county court. The county court judge found the patient to be suffering from mental illness and, having done so, held that his wife's refusal to consent to an application was unreasonable.

Court of Appeal

The appeal against the county court's order was unanimously dismissed by the Court of Appeal. Lord Denning M.R.'s reasons for dismissing the appeal were based solely on the fact that the medical evidence before the county court judge "convinced him that this was mental illness. In particular, a "distinguished consultant" had examined the patient during the 28–day observation period. He had concluded that the acts of cruelty occurred in a state of altered consciousness and were the product of an organic condition, rather than a sadistic, disordered, personality. Since the organic illness resulted in behaviour from which others needed to be protected, the admission criteria were satisfied and the consultant had therefore completed the necessary medical recommendation. On his evidence, the husband "was not suffering merely from a psychopathic disorder." Orr L.J. concurred with Lord Denning M.R.

[54] See *e.g. Whysall v. Whysall* [1960] P. 54 at 62–4 and *Buxton v. Jayne* [1960] 2 All E.R. 688 at 697, *per* Lord Devlin : "I am not going to attempt a definition of just what is meant by unsound mind, an expression which the Act itself leaves undefined, nor am I going to search for equivalent language."

Opinion of Lawton L.J.

The third opinion was given by Lawton L.J., who was troubled by the "large gap" in the legislation in respect of adults diagnosed as suffering from psychopathic disorders "of a kind which were likely, if uncontrolled, to cause harm to others." He expressed concern that a doctor anticipating such harm could only wait "in a state of agonised expectation" to see if it materialised. He concluded that this was "a clear case of the law shutting the stable door after the horse has bolted" and the county court judge had been correct to "safeguard this little baby from the possibility of harm." Within this context, His Lordship said that the words "mental illness" are—

> "ordinary words of the English language. They have no particular medical significance. They have no particular legal significance. How should the courts construe them? ... in the way that ordinary sensible people would construe them. That being in my judgment the right test, then I ask myself, what would the ordinary sensible person have said about the patient's condition in this case if he had been informed of his behaviour ...? In my judgment such a person would have said: 'Well, the fellow is obviously mentally ill.'[55] ... If that be right, then, although the case may fall within the definition of 'psychopathic disorder' ... it also falls within the classification of 'mental illness'; ... it is that application of the sensible person's assessment of the condition, plus the medical indication [of an EEG test] which in my judgment brought the case within the classification of mental illness."

Commentary on W. v. L.

Notwithstanding the reference to "a sensible person's assessment" and the results of an EEG test, the above passage has subsequently been sharply criticised by two eminent writers on mental health law, Gostin[56] and Hoggett,[57] and it may conceivably be faulted on a number of other grounds:

- The words "mental illness" are fairly evidently not ordinary words of the English language. Not only Parliament and the courts but also psychiatrists, philosophers and lexicographers have all failed to agree a simple working definition that adequately encompasses such complex phenomena. It is therefore improbable that ordinary people, however sensible, could do so.

[55] The point somewhat ignores the possibility that an ordinary sensible man in *W. v. L.* might have shared the view of the majority of doctors involved in the case and have replied, "Well, the man is obviously a psychopath" since that observation would equally well fit the lay view. The remark attributed to the bystander really says nothing about what constitutes mental illness *per se*. If it has any legal relevance, it is more to do with what constitutes florid mental illness, what used to be called "lunacy" or "unsoundness of mind" (the nature or degree of mental illness required to warrant detention). As Hoggett implies (see Footnote 58), it is an observation about madness.

[56] According to Gostin, "Lord Justice Lawton's view must be unacceptable — mental illness was envisaged as a serious form of mental disorder and it could not be dependant upon any common person's misinformed view of behaviour which is perhaps only eccentric, non-conforming or anti-social. In the absence of any statutory definition of mental illness much will depend on medical opinion, which should be well founded upon behavioural evidence and adequate clinical assessment." L. Gostin, *Mental Health Services — Law and Practice* (Shaw & Sons), para. 9.02.

[57] "It is impossible not to think of this as the 'man must be mad' test. It simply adds fuel to the fire of those who accuse the mental hygiene laws of being a sophisticated machine for the oppression of unusual, eccentric or inconvenient behaviour... It pays scant regard to the painstaking efforts of psychiatrists to distinguish mental health from mental illness by means of carefully described deficiencies, not in behaviour, but in mental functioning." B. Hoggett, *Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), pp.32–33.

- The notion that the words "mental illness" have no particular legal significance is untenable in the context of an Act which provides that different admission, renewal and discharge criteria shall be applied according to the form of disorder from which a patient is found to suffer, and which makes provision for reclassifying patients. Indeed, since the effect of Lawton L.J.'s opinion that the patient was mentally ill had the very significant legal consequence that the patient thereby lost his liberty, the opinion would appear to contradict the proposition used to sustain it.

- If, however, it is correct that the words "mental illness" have no legal significance, their inclusion in the statute would appear to be superfluous.

- The contention that the words have no particular medical significance is difficult to reconcile with a statute which requires that admissions on the ground of mental illness must be founded upon the recommendations of two medical practitioners, one of whom has special experience in the diagnosis or treatment of mental disorder, and both must agree that the patient suffers from mental illness.

- While most people could diagnose mental illness in someone floridly ill, some cases such as that in *W. v. L.* are diagnostically difficult; few ordinary sensible people would be able to recognise an insidious mental illness from the results of a CT scan, EEG or psychometric testing.[58]

- The test would not appear to satisfy the requirement imposed by the European Convention that detention on the ground of unsoundness of mind requires that a "true" mental disorder be established according to objective medical evidence and expertise.

- Insofar as tribunals are concerned, the formulation is really a statement of the lay member's role, which is to provide balance, as a representative of the community outside the legal and medical professions, and to give the responsible lay person's view.[59]

Subsequent case law

The validity of the "Lawton test" was raised as an issue in the case of *ex p. Hayes,* in the context of an appeal against a Mental Health Review Tribunal's finding.

R. v. Mental Health Review Tribunal, ex p. Hayes

9 May 1985 (unreported) *C.A. (Ackner, Griffiths, Browne-Wilkinson L.JJ.)*

The patient was a restricted patient who was not discharged by the tribunal which reviewed his detention. The tribunal's reasons for its decision included the passage, "It was the 'lay' opinion of the tribunal that the patient is 'not totally sane', that is applying the standard test of mental illness he suffers from a disorder." In the Court of Appeal, it was argued that the tribunal was not entitled to rely "wholly" upon what was expressed to be the lay opinion of the tribunal. Ackner L.J. observed that the so-called "lay opinion" was in fact the test mentioned by Lawton L.J. in *W. v. L.* In the event, the point of law being argued was not determined because the court decided, on the facts, that the tribunal had not relied purely on the Lawton test: their decision had gone on to deal with the medical criteria and issues in the manner which the patient's counsel said was the right approach, that is ignoring the lay opinion.

Commentary

Detention on the ground of mental illness requires evidence of the presence of such an illness from two fully registered medical practitioners, one of whom must be approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder. No application, order or direction authorising treatment may be made unless those two doctors agree that the condition constitutes a mental illness. No court may require them to describe as mental illness a condition which they do not regard as constituting such a form of mental disorder. Likewise, the fact that a prospective applicant may think a person is mentally ill is immaterial. When assessing the presence of mental illness and signing medical recommendations, the doctors owe a duty of care to the patient. However, a medical opinion is no more than that. Authority to detain a person requires an application, order or direction. The medical opinion must therefore be satisfactory from the point of view of the person to whom the recommendation is given. It will not be satisfactory, and the grounds for detention will not be made out, if the doctors' opinion is based on an interpretation of the term which is inconsistent with the statutory framework, does not accord with an established body of medical opinion, or is significantly at variance with what ordinary, sensible people understand the term to mean. If this is correct, the reference made by Lawton L.J. to the ordinary, sensible person is an important part of any formal finding that a person is mentally ill. It is, however, arguably the last stage of any such finding. A testing of medical opinion against ordinary standards of commonsense rather than the use of lay opinion to define what constitutes mental illness — if an ordinary, sensible person met the patient in the street would he *also* think that the patient was mentally ill?

OTHER CONTEMPORARY GUIDANCE

Several international bodies have attempted to define the term and definitions are to be found in various foreign statutes. Mental illness is statutorily defined in the Northern Irish but not the Scottish legislation.

United Nations Principles, Guidelines & Guarantees

Mental illness is defined in the United Nations' "*Principles, Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder*"[60] as "any psychiatric or other illness which substantially impairs mental health." The expression "a mentally ill person" is taken to mean, "a person who, because of mental illness, requires care, treatment or control for his own protection, the protection of others or the protection of the community, and for the time being is incapable of managing himself or his affairs."

58 Although most of the doctors who examined the patient in *W. v. L.* were not of the opinion that he was mentally ill, and the case was diagnostically difficult, it is notable that Lawton L.J. said that the fact that he was mentally ill would nevertheless have been "obvious" to an ordinary lay person.

59 *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, May 1995), Appendix 13.

60 *Principles, Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder* (United Nations, 1986).

Mental Health (Northern Ireland) Order 1986

Mental illness is defined in the 1986 Order — the Northern Irish equivalent to the 1983 Act — as meaning "a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons."[61]

THE AMBIT OF THE TERM

The breadth of the term — how many different kinds of disorder or disability of mind the term encompasses when used in a legal context — has already been considered (**059**). The second factor which determines the term's ambit is, for want of a better word, the depth of the term — if a particular condition, such as depression, is potentially classifiable as a mental illness, how serious must that condition be before it constitutes a "mental illness" for the purposes of the Act? Everyone experiences feelings of depression at some time during their lives but, for most people, their depression is mild and ephemeral and not generally regarded as abnormal. For others, the disturbance of mood is more pervasive and seemingly not related to any specific event. Physical symptoms associated with depression may also be apparent, such as poor appetite and weight loss. Although the pattern of symptoms and signs may be regarded by a doctor as "a depressive disorder," the majority of people who are clinically depressed in this sense are able to continue their ordinary daily activities, and their acquaintances may not realise they are clinically depressed or receiving treatment for depression. For the purposes of the Act, are these people to be regarded as mentally ill and also therefore as mentally disordered? The issue is important for patients and tribunals alike. A supervision application may only be made if a detained patient who has leave to be absent from hospital is presently mentally ill. Likewise, a patient's case may only be referred to a tribunal under section 86 if he suffers from mental illness. Furthermore, in guardianship and supervision application cases, a tribunal is only obliged to discharge the patient on medical grounds if satisfied that he is not suffering from mental illness. Providing their decision is not irrational, it would be lawful for a tribunal not to discharge such a patient on this ground if it was not satisfied that he was not mentally ill; even though it was satisfied that any mental illness which might be present was not of a nature or degree warranting supervision or guardianship. That situation could arise where the health of a patient who had previously been moderately or severely depressed was now coping in the community by making occasional visits to his family doctor and obtaining repeat prescriptions, in which case his present level of mentally functioning would, when compared to that of the population at large, be wholly unremarkable.

The nature or degree of mental illness and unsoundness of mind

In *Buxton v. Jayne*,[62] 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." By the time that case was disposed of, the Percy Commission had already recommended that the term "person of unsound mind" be replaced by "mental illness," commenting that:

61 Mental Health (Northern Ireland) Order 1986, Art. 3(1).

62 *Buxton v. Jayne* [1960] 2 All E.R. 688 at 697.

> "Our first administrative group of patients consists of those suffering from mental illness. We use this term in its usual present sense, including those who become mentally infirm in old age. This group includes:—
>
> *a.* a very large group of patients who need medical and social services in the community or in hospital who are not at present subject to compulsory powers, and
>
> *b.* a smaller number who need similar services and who are at present subject to compulsory admission to hospital or community care, in certain circumstances, as "persons of unsound mind."[63]

The Commission went on to say that the medical and social conditions in which it was justifiable to use compulsory powers could be identified in future without retaining the term "person of unsound mind," which would fall into disuse.[64] In essence, this was achieved by requiring that any mental illness present must be of the requisite "nature or degree." The use of these qualifying words was therefore consequential upon the abandonment of the old terms "lunatic," "person of unsound mind" and "certifiable" and the need for some phrase indicating that not everyone suffering from mental illness could be subjected to compulsion. The sense in which the words "mental illness" were used by the Percy Commission was repeated in the D.H.S.S.'s *Memorandum* on the 1959 Act[65]—

> "The term 'mental illness' is not defined. Its interpretation is a matter for medical judgment, but it is expected that when it is qualified by the words 'of a nature or degree which warrants the detention of the patient in hospital for medical treatment' ... it will be taken as equivalent to the phrase 'a person of unsound mind' which has been in use hitherto in connection with compulsory detention ... When it is not qualified by these limiting words, however, the term ... carries its normal (much wider) meaning."

Commentary

Having regard to the above, a person must suffer from a mental illness of the requisite nature or degree before he may be subjected to compulsory powers. However, once compulsory powers have been invoked, because a patient's condition is of this nature or degree, the legal position of a tribunal in relation to a patient subject to supervision in the community — whether under guardianship, conditional discharge, or after-care under supervision — would appear to be as follows. It is not obliged to terminate the use of compulsory powers in relation to a patient whom it considers may still be suffering from mental illness unless it is satisfied that he is entitled to be discharged on one of the other statutory grounds.[66] In this context, these are essentially that guardianship is not necessary for the patient's health or safety or to protect others; that a failure to receive after-care services will not give rise to a substantial risk of serious harm; that it is inappropriate for a conditionally discharged patient to remain subject to restrictions. Whether the patient has recovered or is simply in remission, the nature and severity of his symptoms, the

63 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 189.

64 *Ibid.*, para. 189.

65 *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX*, (D.H.S.S., 1960), para. 40.

66 The statutory criteria for detention or guardianship under Part II and the criteria to be applied when determining whether any patient must be discharged always comprise at least two grounds. The first of them addresses the "diagnostic question" while the criteria which comprise the second ground are directed towards the issue of risk. See p.723.

likelihood of relapse, the likely consequences of relapse, and so forth, will necessarily affect a tribunal's thinking about these other grounds for discharge. Nevertheless, where the degree of compulsion being exercised stops short of deprivation of liberty, and relates instead to some form of control in the community, the unifying thread is that a tribunal's decision does not turn on the nature or degree of any illness which may presently exist. This reflects the fact that, short of actual recovery, continued treatment under supervision in the community may be necessary or appropriate because of the consequences which may follow its discontinuance.

MENTAL IMPAIRMENT AND SEVERE MENTAL IMPAIRMENT

The Mental Health Act 1983 provides that a person may be detained for treatment or received into guardianship on the ground that he is suffering from some kind of mental impairment or severe mental impairment of the requisite nature or degree. These legal classes indicate the presence of a mental handicap associated with some form of conduct disorder.

HISTORICAL DEVELOPMENTS IN TERMINOLOGY

The legal use of the word "idiot" can be traced back to the twelfth century statute Praerogativa Regis. Medieval idiocy examinations involved visual inspection together with questions on orientation, memory, intellect and judgement. "Idiocy" and "simplicity" were distinguished, the former requiring, as with the Court of Protection criteria today, incapacity to manage one's land, goods and general affairs. The terminology of the nineteenth-century statutes was inconsistent. The Lunacy Acts of 1845 and 1890, and the Lunatic Asylums Act 1853, provided that the term "lunatic" included "idiots" as well as "persons of unsound mind." Under the Idiots Act 1886, however, the terms "idiot" and "imbecile" did not include "lunatics." The use of the word "imbeciles" in the 1886 Act marked a change in nomenclature and denoted a degree of mental handicap not amounting to "idiocy."

Radnor Report (1908)[67]

In 1904 the Radnor Commission was appointed to consider the needs of "feeble-minded" and other mentally disordered people who were not considered certifiable under the Lunacy Acts, and the need for special forms of treatment for them and for "idiots." The Commission's report, published in 1908, was followed by the enactment of the Mental Deficiency Act 1913.

Mental Deficiency Acts of 1913 and 1927

The Mental Deficiency Act 1913 distinguished four classes of "mental defectives," namely "idiots," "imbeciles," the "feeble-minded" and "moral defectives."[68] The 1927 Act substituted the term "moral imbecile" for "moral defective" and amended the statutory definitions of all the classes.[69] The classificatory system adopted in the

67 *Report of the Royal Commission on the Care and Control of the Feeble-Minded*, Cd. 4202 (1908).

68 The statutory classification thus closely followed Morel's 1839 classification of such states of mind.

69 Under the 1959 Act, persons previously classified as "moral defectives" or as "moral imbeciles" generally fell within the new class of "psychopathic disorder."

statutes resembles in some respects that in use today. All persons who suffered from an "arrested or incomplete development of mind existing before the age of eighteen" were "mental defectives" but the sub-class within which an individual was placed depended on the degree of mental handicap present and the resulting social consequences. The statutory definitions of the terms "idiot," "imbecile" and "feeble-minded" are set out in table on the following page.

"Idiot"

The term "idiot" was usually interpreted as applying to patients whose mental abilities and living skills never developed beyond those of a baby or a young child of up to about four years of age. Some never learnt to walk, others were able to develop the use of their hands and rudimentary speech but, in all cases, constant care was required throughout life.[70]

"Imbecile"

"Imbecile" generally denoted a patient who when fully grown had a mental age equivalent to that of a child between three and six or seven years old; the majority of individuals so categorised could be taught to walk and to wash and to feed themselves, and some were able to develop a high degree of manual dexterity.[71]

"Feeble-minded"

"Feeble-minded" covered a disparate group of patients. At one extreme were those who needed much the same help as "imbeciles" but who were not so classified in order to avoid distress to their families. At the other extreme were patients whose intelligence was little if at all below average but who were "emotionally unstable." Because of "pathological defects or abnormalities of personality," many people who were feeble-minded behaved in a way which made it necessary in certain circumstances to subject them to special forms of control.[72]

Percy Report (1957)[73]

The Percy Commission considered that patients who suffered from "mental illness" and "severe subnormality" might require in-patient care even though their condition was not responsive to treatment and their prognosis was poor. In contrast, the "higher-grade feebleminded and moral defectives and other psychopathic patients" formed a second distinctive group, detainable if treatable but whose conditions were not of a type which rendered them incapable of independent living or at risk of serious exploitation.[74] The legislation which followed reflected this distinction to the extent that the definitions of mental subnormality and psychopathic disorder in the 1959 Act included a treatability component. The distinction is still drawn in the present Act, but to a lesser extent: see, as can be seen from the conditions which must be satisfied before compulsory admission may take place or a patient's detention may be renewed.

70 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 163.

71 *Ibid.*, para. 164.

72 *Ibid.*, para. 166.

73 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, 1954-1957, Chairman—Lord Percy, Cmnd. 169 (1957).

74 *Ibid.*, para. 187.

LEGAL CLASSIFICATIONS OF MENTAL IMPAIRMENT

Mental Deficiency Act 1927	Mental Health Act 1959	Mental Health Act 1983
"IDIOTS"	"SEVERE SUBNORMALITY"	"SEVERE MENTAL IMPAIRMENT"
"Persons in whose case there exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers" (s.1(1)(a)).	"A state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation or will be so incapable when of age to do so" (s.4(2)).	"A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" (s.1(2)). *If treatment is unlikely to alleviate or prevent a deterioration of the patient's condition, his detention may nonetheless be renewed if he would otherwise be unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation (see s.20).*
"IMBECILES"		
"Persons in whose case there exists mental defectiveness which, though not amounting to idiocy, is yet so pronounced that they are incapable of managing themselves or their affairs or, in the case of children, of being taught to do so" (s.1(1)((b)).		
"FEEBLE-MINDED PERSONS"	"SUBNORMALITY"	"MENTAL IMPAIRMENT"
"Persons in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that they require care, supervision and control for their own protection or for the protection of others or, in the case of children, that they appear to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instruction in ordinary schools" (s.1(1)(c)). *"For the purposes of this section, 'mental defectiveness' means a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury" (s.1(2)).*	"A state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient" (s.4(3))	"A state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" (s.1(2)). *In general, a person who suffers from mental impairment may not be admitted to hospital for treatment unless such treatment is likely to alleviate or prevent a deterioration of his condition (see ss. 3, 37 and 47).*

INTERNATIONAL CLASSIFICATION OF DISEASES (10th REVISION) : MENTAL RETARDATION

Diagnosis	Synonyms	Usual I.Q. range	Intellectual and social functioning
F73 Profound Mental Retardation	*Idiocy, profound mental subnormality*	Under 20	Comprehension and use of language is limited to, at best, understanding basic commands and making simple requests. The most basic and simple visuo-spatial skills of sorting and matching may be acquired, and the affected person may be able with appropriate supervision and guidance to take a small part in domestic and practical tasks. Most are immobile or severely restricted in mobility, incontinent, and capable at most of only very rudimentary forms of nonverbal communication. They possess little or no ability to care for their own basic needs, and require constant help and supervision.
F72 Severe Mental Retardation	*Severe mental subnormality*	20 to 34	The category is broadly similar to that of moderate mental retardation in terms of the clinical picture. Most people in this category suffer from a marked degree of motor impairment.
F71 Moderate Mental Retardation	*Imbecility, moderate mental subnormality.*	35 to 49	Individuals are slow in developing comprehension and use of language, and their eventual achievement in this area is limited. The level of development of language is variable: some of those affected can take part in simple conversations while others never learn to use language, though they may understand simple instructions and learn to use manual signs. Discrepant profiles of abilities are common, with some individuals achieving higher levels in visuo-spatial skills than in tasks dependent on language, while others are markedly clumsy but enjoy social interaction and simple conversation. Achievement of self-care and motor skills is also retarded, and some need supervision throughout life. A proportion learn the basic skills needed for reading, writing, and counting. They are usually able to do simple practical work, if the tasks are carefully structured and skilled supervision is provided. Completely independent living is rarely achieved. The majority show evidence of social development in their ability to establish contact and to communicate with others.
F70 Mild Mental Retardation	*Feeble-mindedness, mild mental subnormality, moron.*	50 to 69	Individuals acquire language with some delay but most achieve the ability to use speech for everyday purposes. Many have particular problems in reading and writing. Most of those in the higher ranges of mild mental retardation are potentially capable of work demanding practical abilities, including unskilled or semi-skilled manual labour. Most achieve full independence in self-care (eating, washing, dressing, bowel and bladder control) and in practical and domestic skills, even if the rate of development is considerably slower than normal. In general, the behavioural, emotional, and social difficulties, and the need for treatment and support arising from them, are more closely akin to those found in people of normal intelligence than to the specific problems of the moderately and severely retarded.

Mental Health Act 1959

The 1959 Act repealed the Mental Deficiency Acts and removed the terms "mental deficiency," "mental defectiveness" and "defective" from the other Acts in which they occurred. Persons suffering from mental impairment were sub-divided into two main classes, the "subnormal" and the "severely subnormal."

"Severe subnormality"

The opinion of the Percy Commission was that all patients previously certified as "idiots" or "imbeciles" would be reclassified as suffering from "severe subnormality,"[75] as would some half to two-thirds of the "feeble-minded" patients then in mental deficiency hospitals.[76] More generally, an I.Q. of below 50 to 60 (equivalent to a child aged 7½ to 9 years) would be a strong pointer towards the existence of "severe subnormality."[77]

"Subnormality"

As to "subnormality," the *Memorandum* on the Act, published by the D.H.S.S., stated that the patients who would in future be classed as subnormal, rather than severely subnormal, "are intellectually dull, but their main problem is one of emotional instability. Many of them need psychiatric treatment as well as training."[78]

MENTAL HEALTH ACT 1983

Section 145(1) provides that, unless the context otherwise requires, "mental impairment" and "severe mental impairment" have the meanings given to them in section 1(2) of the Act—

- "severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly;

- "mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly.

Reasons for the amendments

The terminology and definitions presently in force date back to the Mental Health (Amendment) Act 1982, the present statute being a consolidating Act. The Government's proposals for an amending Act were set out in a White Paper, "*Review*

75 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 191.

76 *Ibid.*, para. 193. Essentially those "imbeciles" who had previously been classified as "feeble-minded" in order to spare their parents distress.

77 *Ibid.*

78 *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (D.H.S.S., 1960), para. 7.

of the Mental Health Act 1959,"[79] which acknowledged that the terms "subnormality" and "severe subnormality" caused "offence and distress."[80] The 1982 Act replaced them with the phrases "mental impairment" and "severe mental impairment" and amended the statutory definitions of the classes—

- No mentally handicapped person could henceforth be classified as mental impaired or severely mentally impaired unless his handicap was associated with abnormally aggressive or seriously irresponsible conduct on his part[81] and both his intelligence *and* social functioning were impaired. Previously, subnormality of intelligence only sufficed.

- The definition of mental impairment was relaxed in that it was no longer a condition of such a classification that the patient's condition required or was susceptible to treatment.[82]

- Under the 1959 Act as drafted, "severely subnormality" had required that a patient's mind was arrested or incompletely developed to such a nature or degree that he was incapable of living an independent life or guarding himself against serious exploitation. This criterion was removed and, under the present classification, severe mental impairment instead requires that a mentally handicapped patient's level of social functioning is severely impaired. The reference to living an independent life was no longer thought appropriate.

"ARRESTED OR INCOMPLETE DEVELOPMENT OF MIND"

The phrase was first used in the 1913 Act — to define "mental defectiveness" — and its use has been continued in subsequent statutes. It indicates a failure to attain developmental milestones because of innate limitations rather than immaturity of personality, lack of education or poor parenting. An organic aetiology is identifiable in a minority of persons who are mildly retarded, in the majority of those moderately or severely retarded, and in almost all cases of profound retardation.[83]

The ICD–10 Classification

The statutory terminology has tended to reflect changes in the terms used in psychiatric classificatory systems and the definition of "mental retardation" in the 10th Revision of the International Classification of Diseases commences with the same words[84]—

79 *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).

80 *Ibid.*, para. 1.21.

81 The change aimed to ensure that mentally handicapped people were not subjected to compulsory powers unless the behaviour associated with their state justified their use. A point repeated in paragraph 10 of the *Memorandum* on the 1983 Act.

82 Although a person suffering from mental impairment cannot be detained for treatment unless such treatment is likely to alleviate or prevent a deterioration of his condition, and treatability became in all cases a precondition of renewal, the definition of medical treatment was broadened to include habilitation and rehabilitation under medical supervision. A further consequence of the amendment was that tribunals are not bound to discharge a person whose condition is untreatable, because that fact does not preclude him from being classified as mentally impaired. Furthermore, the age limits relating to the detention for treatment of persons suffering from subnormality were removed.

83 *ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (World Health Organisation, 1992).

84 *Ibid.*, p.226.

"A condition of arrested or incomplete development of mind, which especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, *i.e.* cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition."

The classification sub-divides conditions of mental retardation into four main categories: mild (F70), moderate (F71), severe (F72) and profound (F73).

Mental infirmity in old age, etc.

Where a mind which has fully developed subsequently becomes impaired, for example through old age or as the result of organic injury resulting from an accident, that condition will not constitute mental impairment. That remains the case however severe the effects on the individual's intellect and social functioning, and however abnormally aggressive or seriously irresponsible the conduct which results.

"IMPAIRMENT"

In its White Paper, "*Review of the Mental Health Act 1959*," the Government proposed substituting for "subnormality" and "severe subnormality" the phrases "mental handicap" and "severe mental handicap." However, the word "impairment" was substituted for "handicap" at the committee stage in the House of Lords because it—

- "distinguishes the small minority of mentally handicapped people who need to be detained in hospital or received into guardianship from the great majority who do not."[85]
- "reflects developments in the understanding of mental handicap and indicates that a person's potential intelligence and social functioning have suffered 'injurious lessening or weakening' [Oxford English Dictionary]; it is preferred to 'subnormal' which compares him to a notional norm."[86]
- "is already in very appropriate usage, as it is used by the World Health Organisation to describe any loss or abnormality of psychological, physical or anatomical structure or function."[87]

Impairment of intelligence

A person may not be classified as suffering from mental impairment unless his intelligence is significantly impaired, nor classified as being severely mentally impaired unless it is severely impaired.

85 *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons, (D.H.S.S., 1982), p.11. A point repeated in paragraph 10 of the Memorandum on the 1983 Act.*

86 *Mental Health (Amendment) Bill: Notes on Clauses, supra,* p.14. According to the White Paper of September 1978, the definition of "subnormality" in the 1959 Act, which referred only to "subnormality of intelligence," was felt not to adequately reflect the behavioural aspects of mental handicap and it was therefore proposed to include in the definition of mental handicap the words "significant impairment of intelligence and social functioning." *Review of the Mental Health Act 1959,* Cmnd. 7320 (1978), para. 1.21.

87 *Hansard,* H.L. Vol. 426, col. 532.

Significant impairment of intelligence

An individual's level of intellectual functioning is normally determined by assessment with a general intelligence test. The ICD–10 classification provides that, if proper standardised tests are used, an I.Q. range of 50 to 69 is indicative of mild retardation. Similarly, the diagnostic criteria for mental retardation in the DSM–IV classification include an I.Q. of 70 or below. As to what constitutes *severe impairment* of intelligence, both classifications distinguish four levels of mental retardation (profound, severe, moderate and mild) and include guidelines as to the I.Q. range which is in general indicative of each class—

GUIDELINE I.Q. LEVELS

	ICD–10	*DSM–IV*	*%. of the mentally retarded population*
Profound	Below 20	Below 20 to 25	1–2%
Severe	20 to 34	20–25 to 35–40	3–4%
Moderate	35 to 49	35–40 to 50–55	10%
Mild	50–69	50–55 to approx. 70	85%

Impairment of social functioning

The inclusion of this criterion in the legal definitions "emphasises the importance of social functioning — this includes the ability to eat, control one's bodily functions, communicate, wash, dress, learn new skills, recognise hazards and display reasonable judgement and foresight. The lack of these abilities is as much a part of mental handicap as low intelligence."[88] A person may not be classified as suffering from mental impairment unless his level of social functioning is significantly impaired nor may he be classified as severely mental impaired unless it is severely impaired. In general, there is a positive association between intelligence, as measured by I.Q. score, and social functioning at lower I.Q. levels but this association declines at the mild and moderate levels of mental retardation.

The ICD–10 and DSM–IV classifications

The ICD–10 and DSM–IV classifications both emphasise that a diagnosis of mental retardation requires not only significantly sub-average intellectual functioning but also significant deficits in social or "adaptive" functioning. A definite diagnosis requires a reduced level of intellectual functioning resulting in diminished ability to adapt to the daily demands of the normal social environment. The table on page 73 summarises the main impairments in social functioning associated with mental retardation. Various methods are commonly used to assess a patient's level of social functioning, based on behaviour observed by professionals and carers and social assessment testing.

88 See Footnote 86.

Inability to care for oneself and the risk of serious exploitation

Both the 1983 Act and the ICD–10 classification recognise that mentally retarded individuals are at greater risk of exploitation and physical or sexual abuse. Under the 1959 Act, a classification of severe subnormality required that the patient's handicap be of such a nature or degree that he was incapable of living an independent life or of guarding himself against serious exploitation. The references in the definition to independent living and serious exploitation were omitted from the definition of severe mental impairment in the present statute. The reason given was that "many mentally handicapped people would be unable to live completely alone without support from family or the social services, but that in itself would not justify the use of compulsory powers."[89] The logic is faulty since that constitutes a reason for retaining rather than discarding the qualification. Removing incapacity to live an independent life, or to guard oneself against serious exploitation, from the definition has the opposite effect to that intended: it allows all people so handicapped to be classified as severely mentally impaired and, since those disabilities are no longer a prerequisite of such a finding, persons with higher social skills also.

ABNORMALLY AGGRESSIVE OR SERIOUSLY IRRESPONSIBLE

The meanings of these words are considered below, in relation to psychopathic disorder (**088**). In this context, it may be noted that the International Classification of Diseases (ICD–10) sub-divides conditions of mental retardation into four main categories (**077**) and provides that clinicians may use a fourth character to specify the extent of any behavioural impairment which is not due to an associated disorder such as epilepsy:

- 0 no, or minimal, impairment of behaviour.
- 1 significant impairment of behaviour requiring attention or treatment.
- 8 other impairments of behaviour.
- 9 is used without mention of impairment of behaviour.

So, for example, a classification of F72.1 denotes a person who suffers from severe mental retardation associated with significant impairment of behaviour requiring attention or treatment.

"AND IS ASSOCIATED WITH"

With psychopathic disorder, the patient's persistent disorder or disability of mind must "result" in abnormally aggressive or seriously irresponsible conduct rather than "be associated" with it. In cases of mental impairment, it suffices that the arrested or incomplete development of mind and the conduct disorder are associated in some way. This is because it may be difficult in practice to establish any clear causal relationship between the two, on account of the fact that both features developed in parallel. However, where a patient's conduct disorder arises from a co-existent mental illness, a classification of mental impairment will not be appropriate.

[89] *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S.S., 1982), p.15.

Mental impairment and mental illness

Mentally impaired individuals can experience the full range of mental disorders and, indeed, the prevalence of other mental disorders is at least three to four times greater than in the general population.[90] However, the diagnosis of other psychiatric conditions in persons with more than mild retardation may be difficult because of limited language development. epilepsy, and neurological and physical disabilities, are common in the moderately and severely retarded. Severe neurological or other physical disabilities affecting mobility are common, as are epilepsy and visual and hearing impairments, in the profoundly retarded.

Mental impairment and psychopathic disorder

The definitions of mental impairment and severe mental impairment to some extent overlap with that of a "psychopathic disorder" in section 1(2). A psychopathic disorder is "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned." Where the I.Q. of a person with a serious conduct disorder is reported as being slightly above or below 70, a tribunal may not be satisfied that the patient is mentally impaired but nevertheless not discharge him on the basis that he has, or may have, a psychopathic disorder of the requisite nature or degree.

SEVERE MENTAL IMPAIRMENT AND MENTAL IMPAIRMENT

A classification of "severe mental impairment" requires that both a patient's intelligence and his social functioning are severely impaired. Likewise, a classification of "mental impairment" requires significant impairment of both intelligence and social functioning.[91] The concepts underlying the legislation have remained more constant than the frequent changes in terminology may initially suggest. In particular, the provisions concerning "idiocy," "imbecility," "severe subnormality" and "severe mental impairment" have all tended to focus not on the condition's treatability but on the individual's vulnerability due to profound retardation — incapacity to live an independent life, severe impairment of social functioning, inability to care for himself or to obtain such care, the risk of serious exploitation. Conversely, the provisions relating to "feeble-mindedness," "subnormality" and "mental impairment" have tended to be directed towards the role of medical treatment, care or training, rather than a need to protectively care for the individual concerned (072).

The importance of the distinction

Whether a person is mentally impaired or severely mentally impaired has important legal consequences. In the case of a person who is severely mentally impaired, it is not a condition of admission that treatment is likely to alleviate or prevent a deterioration of his condition. Similarly, the fact that a patient's condition is unlikely to be treatable in this sense does not preclude a renewal of detention if, in the event of release, he would be unlikely to be able to care for himself, to obtain the care he

[90] *ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (World Health Organisation, 1992).

[91] The current *Memorandum* emphasises that in order for a person to have a mental impairment for the purposes of the 1983 Act, the impairment must be either severe or significant, rather than "slight." *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 12.

needs or to guard himself against serious exploitation (the "vulnerability test").[92] Where a tribunal considers the case of a severely mentally impaired patient who does not satisfy the criteria for being discharged, that tribunal must have regard to the vulnerability test before exercising any discretionary power of discharge.

Admission under Part III

A person suffering from severe mental impairment who is involved in criminal proceedings may be remanded to hospital for treatment by the Crown Court or transferred there for treatment by the Secretary of State. In magistrates courts proceedings, the court may make a hospital or guardianship order without first convicting him of an imprisonable offence provided the court is satisfied he did the act or omission charged. The underlying premise behind these provisions is that a mentally impaired person per se does not suffer from such a serious impairment of intelligence and social functioning as to render him unfit for custody pending trial or unfit for trial.

Sexual offences legislation

It is an offence for a person to have unlawful sexual intercourse with a woman who is "a defective"[93]; to procure a "defective" to have unlawful sexual intercourse in any part of the world;[94] to take such a person out of the "possession" of her parent or guardian with the intention that she shall have unlawful sexual intercourse[95]; to induce or knowingly permit a "defective" to use premises for the purpose of having unlawful sexual intercourse[96]; or to cause or encourage the prostitution of such a person in any part of the world.[97] A "defective," whether male or female, cannot give consent to an act which in the absence of a valid consent constitutes an indecent assault.[98] A man who is suffering from "severe mental handicap" cannot in law consent to a homosexual act in private, whether buggery or an act of gross indecency. The terms "defective" and "severe mental handicap" both mean "a person suffering from a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning." In the context of the 1983 Act, this means that it is a legal presumption that a person who is so handicapped as to be severely mentally impaired is incapable of giving a valid consent to sexual relations. However, persons whose level of intelligence and social functioning is such that they are properly classifiable as "mentally impaired" are presumed to be as capable as any other citizen of consenting or not consenting to sexual relations.

Case law

In *R. v. Hall (John Hamilton)*,[99] the defence argued that no sexual offence had taken place because the victim was not a "defective" within the meaning of the Sexual

92 "Detention will not be renewed unless there is an expectation of further benefit from treatment, except in the case of the mentally ill and severely mentally handicapped. Here the Bill recognises that the health services have a responsibility to care for mentally ill and severely mentally handicapped people whose disorder may make them unable to care for themselves ...": *Reform of Mental Health Legislation*, Cmnd. 8405 (1981), para. 20.

93 Sexual Offences Act 1956, s. 7.

94 *Ibid.*, s.9.

95 *Ibid.*, s.21.

96 *Ibid.*, s.27.

97 *Ibid.*, s.29.

98 *Ibid.*, ss.14 (indecent assault on a woman) and 15 (indecent assault on a man).

99 *R. v. Hall (John Hamilton)* (1988) 86 Cr.App.R. 159.

Offences Act 1956. The young woman's reading comprehension was that of a child aged 7 years and 5 months and her I.Q. of 53 placed her in the bottom one per cent. of the general population. When she gave evidence, both the judge and counsel had difficulty in "getting any sense out of her." The Court of Appeal was dismissive of the defence case, stating that there was "ample" evidence that she was a "defective"; "it is unnecessary to rehearse it."

Pointers towards the severity of mental impairment

Each case must be assessed on its own facts. However, based on the observations made above, the following pointers towards whether a person is mentally impaired or severely mentally impaired may provide a useful starting point.

Pointers towards mental impairment

- An I.Q. above 60 — even if the patient's level of social functioning is severely impaired, his intelligence cannot generally be said to be more than "significantly impaired."
- A capacity to consent to sexual relations and to protect oneself against serious exploitation.
- A general capacity or potential for self-care and independent living.
- A general level of functioning such that if involved in criminal proceedings it would not be inappropriate for the ordinary bail, custody and trial provisions to apply.

Pointers towards severe mental impairment

- An ICD–10 or DSM–IV classification of moderate, severe or profound mental retardation will almost certainly indicate severe mental impairment.
- A lack of capacity for independent living and an inability to obtain necessary care for oneself will also point towards severe impairment.
- An inability to guard oneself against serious exploitation or to give a valid consent to sexual relations.
- A disability so severe that if involved in criminal proceedings it might be inappropriate on medical grounds for the patient to be kept in custody pending trial.

PSYCHOPATHIC DISORDER

Apart from interim orders made under section 38, a person who suffers only from a psychopathic disorder may only be detained for treatment for a potentially indefinite period if treatment is likely to alleviate or prevent a deterioration of his condition. Approximately 25 per cent. of the population of the three special hospitals are legally classified as suffering from a personality disorder as are just under 10 per cent. of all persons detained in regional secure units.[100]

HISTORICAL DEVELOPMENTS IN LEGAL TERMINOLOGY

The way in which medical usage of the term has developed is reviewed in chapter 21 (**1186**).

The Lunacy Acts

Prior to the coming into force of the Mental Deficiency Act 1913, persons who would today be classified as having a psychopathic disorder were not generally certifiable under the Lunacy Act 1890, except by stretching the terms used in the Lunacy Acts beyond their generally accepted meaning. Their mental disorder did not reflect or result in severe limitation of intellect or loss of reason so that they were neither "idiots" nor "lunatics."[101]

The Radnor Commission (1904–08)[102]

In 1904, the Radnor Commission was appointed to consider the needs of "feebleminded" and other mentally disordered people considered to be certifiable under the Lunacy Acts. The Commission's report, published in 1908, was followed by the enactment of the Mental Deficiency Act 1913. The Radnor Report recommended that "moral imbeciles" should be liable to care and control. When determining whether a person could properly be described as a moral imbecile, the Commission suggested that the issue should be "whether the facts interpreted by the evidence of vicious or criminal propensities and incorrigibility proved that the will and judgment were so abnormal as to amount to mental disorder."[103]

"Moral insanity"

The Radnor Report drew a distinction between "moral imbeciles," whose conduct developed in childhood and was attributable to an arrested or incomplete development of mind,[104] and the "morally insane." Although the characteristics and behaviour of the latter were similar to those of a moral imbecile, their disorder developed in adulthood in a personality which had matured normally. The

100 *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder* (Department of Health and the Home Office, 1994), p.11.

101 See the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 154; *Report of the Royal Commission on the Care and Control of the Feeble-Minded*, Cd. 4202 (1908).

102 *Report of the Royal Commission on the Care and Control of the Feeble-Minded*, Cd. 4202 (1908).

103 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 156.

104 Following Pinel, there was a tendency to see moral imbecility as a form of mental deficiency, the result of a degeneration of that part of the brain which dealt with morality and feelings.

Commission considered that the morally insane were persons "of unsound mind" and therefore lunatics certifiable under the 1890 Act. However, in practice, the term "person of unsound mind" was not usually extended to cover the morally insane.

Mental Deficiency Act 1913

In line with the recommendations of the Radnor Report, section 1 of the 1913 Act defined "moral imbeciles" as persons suffering from an arrested or incomplete development of mind existing before the age of eighteen years "who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect."

Mental Deficiency Act 1927

The 1927 Act amended the statutory definitions in section 1. The term "moral imbeciles" was replaced by "moral defectives," defined as "persons in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities and who require care, supervision and control for the protection of others."[105]

Percy Report (1957)

The Percy Commission, whose report was followed by the enactment of the Mental Health Act 1959, suggested the use of the term "psychopathic disorder" as a legal category, which would include both "moral imbeciles" and the "morally insane" and, additionally, many persons then classified as feeble-minded.[106]

The feeble-minded, psychopaths and moral defectives

The Commission viewed "feeble-minded people, psychopaths and moral defectives" as essentially a homogenous group: "When a wide meaning is given to the term "psychopath" and to the term "feeble-minded," many persons could equally well be described by either term, and moral defectives ... could also be described by either of the other terms."[107] In the Commission's view, what distinguished such individuals most clearly from "normal people" was their general social behaviour. Although it was not easy to clearly describe these behavioural characteristics, this difficulty was "a difficulty of language rather than diagnosis." The Commission had no doubt that those who interpreted the Mental Deficiency Acts as including, among the feeble-minded and moral defectives, patients whose intelligence was within the normal range but whose mental development was incomplete, were correctly interpreting the intention behind those Acts.[108] In the event, the Government took the view that the Commission's wide use of the term "psychopathic" involved so great a departure from the sense in which it was normally used by the medical profession and the public as to be liable to lead to confusion.[109] The 1959 Bill therefore sub-divided the category of persons to which the Commission applied the term "psychopathic" into two categories, "subnormal" and "psychopathic."

105 Mental Deficiency Act 1927, s.1(1)(d).

106 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 190.

107 *Ibid.*, para. 170.

108 *Ibid.*, para. 162.

109 See the Lord Chancellor's (Viscount Kilmuir) speech to the House of Lords on 4 June 1959 (*Hansard*, H.L. Vol. 216, col. 670).

Mental Health Act 1959

The Mental Deficiency Acts were repealed by the 1959 Act, section 4(4) of which introduced the legal classification of "psychopathic disorder," defined as "a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to treatment." A number of amendments were made to the definition originally drafted.[110] Most of these were carried over to the 1983 Act and they are therefore considered below in relation to the present statutory definition.

Treatability

An attempt was made during the Committee stage in the House of Lords to remove from the definition the words "and requires," so as to ensure that the category would be confined to persons who "will really benefit from medical treatment."[111] The Government's position was explained by the Lord Chancellor, Viscount Kilmuir, who said that the inclusion of the words allowed action to be taken in a case where the doctor hoped that a patient would respond to treatment.[112]

Age limits

The Act prohibited the reception into guardianship or the detention for treatment under what is now section 3 of any person aged 21 or over on the ground of psychopathic disorder. Furthermore, where a person aged under 21 was received into guardianship, the guardianship application ceased to have effect upon his reaching the age of 25. Similarly, an application for treatment ceased to have effect unless, during the two months preceding the patient's 25th birthday, his patient's responsible medical officer furnished a report stating that he would, if released, be likely to act in a manner dangerous to himself or others.[113] Although an "arrested or incomplete development of mind" did not form part of the statutory definition, the Act still viewed psychopathic disorder as essentially a developmental disorder, although detention or guardianship was not precluded if the disorder resulted in offending later in life and there was some prospect that it might still be treated. The inclusion of the words "whether or not including subnormality of intelligence" also suggested a continuing belief that psychopathic disorder ("moral defectiveness") was sometimes associated with "mental deficiency."

Butler Report (1975)

The Butler Report considered that the terms "psychopathic disorder" and "psychopath" were unsatisfactory from both the medical and legal point of view, but recognised that it was not easy to think of short, more appropriate, alternatives. Although the former was a generic term, adopted for the purpose of legal categorisation and capable of covering a number of specific diagnoses, reliable specific diagnoses had yet to be developed.[114] The class of persons to whom the term related

110 The original definition in the Bill was as follows: "'Psychopathic disorder' means a persistent disorder of personality (whether or not accompanied by sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct in the part of the patient, and requires or is susceptible to medical treatment."

111 *Hansard*, H.L. Vol. 217, cols. 91 and 93.

112 *Ibid.*, col. 98.

113 Parliament debated the sections of the relating to psychopathic disorder at some length.

114 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), paras. 5.2 and 5.13.

did not represent a single c[illegible] identifiable by any medical, biological or psychological criteria.[115] It was not possible to identify "psychopathic disorder" as defined by the Act with a particular sub-category of the International Classification of Diseases, several of which might include patients who showed "abnormally aggressive or seriously irresponsible conduct."[116] It was no longer a useful or meaningful concept and its use as a statutory term should be abandoned and replaced in the Act by the recognised classification of personality disorder, which would not be statutorily defined.[117]

Review of the Mental Health Act 1959 (1978)[118]

In January 1975 the Government announced its intention to review the 1959 Act and an inter-departmental committee of officials was set up to undertake this review. The Committee's initial suggestions were set out in a consultative document published in August 1976. Following the completion of this consultative exercise, the Government's proposals for change were set out in a White Paper, "Review of the Mental Health Act 1959." The Government accepted that "the Act should establish a clear requirement that psychopaths should only be detained under compulsory powers where there is a good prospect of benefit from treatment." However, the Government proposed that the words "and requires or is susceptible to medical treatment" be omitted from the statutory definition of psychopathic disorder since they did not appear appropriate as part of a definition. A "prospect of benefit from treatment" requirement should be incorporated instead into the criteria for compulsory admission and renewal of detention.[119] The White Paper also proposed abolishing the age limits in the 1959 Act.

Reform of Mental Health Legislation (1981)[120]

The object of the White Paper was to explain the changes proposed in the Mental Health (Amendment) Bill which the Government had presented to Parliament.[121] The White Paper indicated that the Government had considered whether psychopathic disorder should be excluded from the Act but had decided against it—

> "The weight of current medical thinking is that most psychopaths are not likely to benefit from treatment in hospital and are for the penal system to deal with when they do commit offences but that there are some persons suffering from psychopathic disorder who can be helped by detention in hospital. For this reason, this category is not excluded from the Act."[122]

Mental Health (Amendment) Act 1982

The 1982 Act implemented the proposals in the Government's White Papers of 1978 and 1981, the effect of which is that the statutory definition of psychopathic disorder is now broader than ever before.

115 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 5.23.

116 *Ibid.*, para. 5.18.

117 *Ibid.*, para. 5.24.

118 *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).

119 *Ibid.*, para. 1.26.

120 *Reform of Mental Health Legislation*, Cmnd. 8405 (1981).

121 *Ibid.*, para. 1.

122 *Ibid.*, para. 12.

The 1983 Act was a consolidating provision and simply repeated the amendments set out in the 1982 Act. Section 1(2) states that "psychopathic disorder" means "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned." No person may be dealt with as suffering from psychopathic disorder "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."[123]

Working Group on Psychopathic Disorder (1986)

In 1986 an interdepartmental D.H.S.S. and Home Office working group identified, without in any way resolving, the inherent problems flowing from the uncertainties about the concept of psychopathic disorder; its diagnosis, treatability, and relationship with offending; the practical difficulties involved in assessing, particularly in an artificial environment, whether the disorder had ameliorated; and what implications (if any) this had for the patient's likely future behaviour upon discharge.

Reed Working Group on Psychopathic Disorder (1994)[124]

In September 1992, the Department of Health and Home Office set up a working group, under the chairmanship of Dr. John Reed, to review the treatment options for people with personality (psychopathic) disorders, their appropriate location, and the arrangements for placing offenders in need of treatment. The subsequent report noted that the term embraced a range of severe personality disorders, the group of people so labelled being extremely heterogeneous. Because the statutory definition rested on behaviour, "it brackets together a wider range of clinical states. It does not help to provide a clear basis for deciding which offenders should be treated as patients and which should be dealt with in the penal system. Comparable problems do not arise over the other categories of mental disorder in the Act where there is much greater professional consensus on both definition and treatment."[125] Following the lead given in the Butler Report, the working group recommended that the term "psychopathic disorder" be replaced in the 1983 Act by "personality disorder," which should not be defined further.[126] A review of the literature on the outcome of treatment, commissioned by the group, concluded that there was insufficient evidence to determine whether or not persons with psychopathic disorder could be successfully treated and no conclusive evidence of the efficacy of long-term hospitalisation.[127]

123 Mental Health Act 1983, s.1(3). Gibbens observed as far ago as 1961 that some psychiatrists had extended the concept beyond a narrow group of dangerously anti-social individuals to include "those with alcoholism and drug addiction, those with sexual and marital disorders and those with employment disorders." T.C.N. Gibbens, "Treatment of Psychopaths" *Journal of Mental Science* (1961) 107, 181.

124 *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder* (Department of Health and the Home Office, 1994).

125 *Ibid.*, p.4.

126 *Ibid.*, pp. 35 and 39.

127 B. Dolan and J. Coid, *Psychopathic and Antisocial Personality Disorders — Treatment and Research Issues* (Gaskell, 1993). Dell had previously found that the main determinant of the length of stay in special hospitals was not what happened to the patient in hospital but the nature of the index offence. Violent assaults, particularly sexual assaults or assaults directed against strangers, were associated with longer periods of detention. In contrast, in those patients suffering from mental illness (mostly schizophrenia), the severity and chronicity of the illness, and not the nature of the offence, were associated with longer detention. S. Dell, *et al.*, "Detention in Broadmoor: factors in length of stay" *British Journal of Psychiatry* (1987) 150, 824–827.

The meaning of the various terms used in the statutory definition of a psychopathic disorder is considered here.

"Persistent"

"Persistent" means "that there must be signs that the disorder has existed over a considerable period of time ... before the diagnosis is made."[128] Its use is intended:

> "to ensure that patients are not classified as psychopathic for the purpose of the compulsory detention ... until the personality disorder ... can be shown to have existed for a considerable period of time. It may be possible to deduce this from the symptoms occurring over such a period, but not all these symptoms amount to abnormally aggressive or seriously irresponsible conduct. There may be a pattern of abnormal behaviour culminating in a seriously aggressive act, such as sexual assault. The earlier signs might have been less serious but quite sufficient to show the doctor that the underlying disorder of personality had been there persistently. That should be sufficient to allow the diagnosis to be made without waiting for serious aggression to be repeated several times before the patient can be sent for treatment."[129]

"Disorder or disability of mind"

As drafted, the 1959 Bill referred to a "persistent disorder of personality" rather than a "persistent disorder or disability of mind." During the Committee stage in the House of Lords, Baroness Wootton of Abinger unsuccessfully moved to replace "persistent disorder of personality" with the words "a mental abnormality," on the ground that "a disorder of personality is often understood to mean something which manifests itself only in behaviour ... We are particularly anxious that persons who are going to be labelled as 'psychopaths' should manifest some abnormality of mind other than their persistently anti-social behaviour."[130] Following discussion of this concern in Committee, the Lord Chancellor introduced an amendment replacing the phrase "persistent disorder of personality" with the words "persistent disorder or disability of mind":

> "Very often the patient's behaviour provides the main symptoms on which the diagnosis is based; but anti-social behaviour of the sort described in the later words of the definition is not in itself enough to establish the diagnosis unless the pattern of behaviour shows other abnormal features which indicate that there is an underlying disorder ... the introduction of the term 'mind' helps to make this clear."[131]

Class of persons embraced by the term

In a statute dealing with mental disorder, the words "disorder or disability of mind" could not be broader and, as the Butler Report noted, the class of persons to whom the term relates do not represent a single class identifiable by any medical, biological or psychological criteria.[132]

128 *Per* the Lord Chancellor (Viscount Kilmuir), *Hansard*, H.L. Vol. 216, col. 756.

129 *Per* the Lord Chancellor (Viscount Kilmuir), *Hansard*, H.L. Vol. 217, col. 97.

130 *Hansard*, H.L. Vol. 217, cols. 91-92.

131 *Per* the Lord Chancellor (Viscount Kilmuir), *Hansard*, H.L. Vol. 217, col. 951.

132 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 5.23.

"Whether or not including significant impairment of intelligence"

The words "whether or not accompanied by (subnormality of intelligence)" in the 1959 Bill were replaced in the 1959 Act by the phrase "whether or not including," which remains part of the statutory definition. The words maintain the historical notion, dating back to 1839, that "mental deficiency" and "psychopathic disorder" are somehow linked. Significant impairment of intelligence does not suffice but equally its presence will not rule out a classification of psychopathic disorder where there is evidence of a disorder or disability of mind which has persisted over time.

"Which results in"

It has been suggested that the concept of psychopathy is logically defective insofar as it infers mental disorder from anti-social behaviour while purporting to explain anti-social behaviour by mental disorder.[133] That would only be so if the words "associated with" or "including" were used. In fact, the reference to a conduct disorder after the words "results in" does not attempt to explain the disorder or disability of mind, rather its consequences. There must first and foremost be a disorder or disability of mind which has persisted over time. However, where that is established, a person is not to be liable to indefinite compulsory treatment or guardianship unless that disorder or disability can be shown to have seriously affected the person's conduct.

"Abnormally aggressive or seriously irresponsible conduct"

The definition requires that the disorder or disability of mind be persistent, rather than the patient's abnormally aggressive or seriously irresponsible behaviour. During the Committee stage in the House of Lords, Baroness Wootton of Abinger unsuccessfully moved to substitute for the words "which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient" the words "which results in *dangerously and* persistently irresponsible conduct."[134]

Non-clinical considerations

In *ex p. Ryan (1991),*[135] Nolan L.J. referred to a medical report prepared for the tribunal, in which the responsible medical officer wrote that whether the patient's sexual assault on a child amounted to seriously irresponsible conduct was "more in the realms of ethics and law than of clinical judgment, and I will not express a personal opinion." His Lordship accepted this, saying—

> "No doubt whether the conduct is the result of the disorder is ... a medical question. Whether it amounts to seriously irresponsible or abnormally aggressive behaviour seems to me ... to raise questions other than of a purely clinical nature."

"Abnormally aggressive"

The "word 'abnormally' emphasises that this is not what one might call ordinary aggression ... There is something peculiar about it: it is a symptom of mental disorder."[136] Various follow-up studies of patients discharged from special hospitals have

133 See the *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 5.20.
134 *Hansard*, H.L. Vol. 217, cols. 91–92.
135 *R. v. Trent Mental Health Review Tribunal, ex p. Ryan* [1992] C.O.D. 157.
136 *Per* the Lord Chancellor (Viscount Kilmuir), *Hansard*, H.L. Vol. 217, col. 97.

shown that those with psychopathic disorders are more likely than most other groups to reoffend.[137] Hostility (negative appraisals of other people) is differentiated from aggression (the behavioural tendency to react with verbal or physical aggression) in Blackburn's psychometric scales of hostility and aggression.

"Seriously irresponsible "

The Butler Committee considered it important to note that the statutory definition of psychopathic disorder included under the criterion of serious irresponsibility persons such as compulsive gamblers.[138] Although it is often said that a single relatively minor offence, such as the theft of an item from a supermarket, constitutes seriously irresponsible conduct this must be doubtful.

Application in a tribunal context

The court's finding that the patient was, at the time of sentence, suffering from a psychopathic disorder is taken as proof that the patient had at that time a psychopathic personality; it then becomes very difficult to establish that that is no longer the case. In a study of forty special hospital tribunal cases involving persons classified as having a psychopathic disorder, Peay found that the principal indication of the disorder was usually the nature, context and repetition of offending behaviour, although psychometric testing and examinations of the patient's early history and school work were sometimes mentioned as serving to confirm (or count against) the diagnosis. A major problem for the patient was overcoming the contention that the only reason why no abnormally aggressive or seriously irresponsible conduct had recently manifested itself was because of his detention in a secure environment.[139]

THE PROHIBITIONS IN SECTION 1(3)

Section 1(3) provides that nothing in the statutory definition of a psychopathic disorder shall be construed as implying that a person may be dealt with under the Act as suffering from such a disorder "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.[140] It is the interpretation of the phrase "sexual deviancy" which has mainly caused problems in practice, particularly in relation to paedophilia.

Sexual Deviancy

The 1959 Act did not expressly preclude the classification of a person as a "psychopath" by reason only of sexual deviancy. In 1975, the Butler Committee observed that it would be wrong to assume that sexual offenders are necessarily mentally disordered on that count alone. The Committee considered that it was necessary "to distinguish, among the generality of those who commit sexual offences, those who do so as a result of sexual deviancy, a condition recognised by

137 M. Norris, *Integration of special hospital patients into the community* (Gower, 1984); D.A. Black, "A 5–year follow-up study of male patients discharged from Broadmoor Hospital" in *Abnormal offenders, delinquency and the criminal justice system* (ed. J. Gunn & D.P. Farrinton, Wiley, 1982); G. Tennent and C. Way, "The English special hospital, a 12–17 year follow-up study: a comparison of violent and non-violent re-offenders and non-offenders" *Medicine Science & the Law* (1984) 24 81–91.
138 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 5.13.
139 J. Peay, *Tribunals on Trial* (Clarendon Press, 1989).
140 See Footnote 125.

the International Classification of Diseases as a mental disorder ..."[141] ...e Mental Health (Amendment) Act 1982 had the effect of taking sexual offenders outside the legal definition of psychopathic disorder unless there was evidence of abnormally aggressive or seriously irresponsible conduct other than sexual deviancy. One effect of the new provisions was that tribunals were required to discharge any patient, restricted or unrestricted, whose detention as a "psychopath" was founded on sexual deviancy alone or who, once that deviancy had been discounted, did not suffer from a psychopathic disorder which was of a nature or degree making detention appropriate. Tribunals have understandably experienced problems implementing the prohibition and a number of tribunal decisions concerning patients admitted to hospital following conviction for a sexual offence have been judicially reviewed.

R. v. Mental Health Review Tribunal, ex p. Clatworthy

[1985] 3 All E.R. 699 — *Q.B.D., Mann J.*

The patient had been convicted in 1967 of the indecent assault of two young girls: he had sat next to them in a cinema and placed his hand underneath the dress of one girl and touched the leg of the other outside her clothing. He had previously been convicted of a number of similar offences and also of attempted buggery. The court imposed a restriction order of five years' duration, at the expiration of which the patient remained detained under a notional hospital order. In 1984, his case was considered by a tribunal. The responsible medical officer's evidence, which was supported by a second consultant psychiatrist, was that the diagnosis of a psychopathic disorder appeared to be based on the applicant's sexual offending. There was no other evidence that he was abnormally aggressive or seriously irresponsible. As his main problem was one of sexual deviance, his condition did not constitute a "mental disorder." Notwithstanding this evidence, the tribunal refused to direct the patient's discharge, stating in their reasons that they were satisfied that he continued to suffer from psychopathic disorder, and saw no change in his condition from the time of his admission in 1967.

Mann J.

Quashing the tribunal's decision,

"It may be at once observed that the effect of sub-s. (3) is apparently to prevent there being a condition of psychopathic disorder when the abnormally aggressive or seriously irresponsible conduct consequent on the persistent disorder or disability of mind is conduct which is a manifestation of sexual deviancy. It may also be observed that it can be contended that sexual deviancy does not mean tendency to deviation but means indulgence in deviation. That contention would achieve support from its context, the context being promiscuity or other immoral conduct and dependence on alcohol or drugs." ...

The grounds for the reasons invite immediately the question: what are the features of psychopathic disorder as defined by the 1983 Act apart from sexual deviancy? The evidence as I read it is that there is no other feature and sexual deviancy is to be discounted under the Act ... It is, I think, appropriate to observe that the definition of psychopathic disorder with which I am now concerned is a definition first introduced into the law by the 1983 Act."

141 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 3.25.

R. ... HRT (Mersey Region) ex p. Davies

CO/1723/85, 21 April 1986. — *Q.B.D., Russell J.*

The patient, who had two previous convictions for indecent assault, was convicted in 1967 of indecently assaulting a young girl whom he enticed to a lonely spot. He was made the subject of a restriction without limit of time. He was granted home leave at the end of December 1982. In March 1983, he approached some young children in the street, mainly girls, and showed them a pornographic magazine. As a result, he was recalled from leave to a special hospital, where he was detained when his case was reviewed by a tribunal in July of that year. Two medical reports before the tribunal concluded that the patient did not suffer from a psychopathic disorder as defined by the Act. The Secretary of State opposed discharge and noted that a medical report from the special hospital had, with reference to the recent incident, described the patient "as a danger to others by reason of his inability to control his deviant sexual impulses and his total lack of insight." The Home Secretary was "conscious also that the incident ... in April 1983 was not thought by those then responsible for his care to be a spontaneous act of foolishness but a serious, sinister, premeditated attempt to lure the girls away." The Home Secretary considered that the patient's rehabilitation should take place with extreme caution and, preferably, via transfer to a local hospital where "his sexual attitudes may be closely monitored." The patient was described as having a bland, superficial attitude to his offences against children.

The tribunal's decision

The tribunal was of the opinion that the tribunal was suffering from a psychopathic disorder and it did not direct the patient's discharge:

> " We are not satisfied that the Applicant could at present overcome the enormous problems with which he will be faced if released into the community without giving way to the uncontrollable impulses which resulted in the offence which occasioned the order in 1967 ... The Applicant's conduct whilst on leave in 1983 which resulted in his return to [the special hospital], and in recent months when he has become sullen and morose and been disruptive is consistent in the view of the Tribunal of one suffering from psychopathic disorder. The incident in March 1983 demonstrates an inability to learn from past events. ... In the light of the Applicant's conduct as recently as March 1983 it is necessary for the protection of other persons that the Applicant should receive medical treatment in Hospital. "

The application for judicial review

The subsequent application for judicial review, which was based on the reasons given for the tribunal's decision, was dismissed. Section 1(3) was not referred to in the judgment and the court decided that the reasons given by the tribunal were adequate, and that there was no unfairness.

R. v. Mersey Mental Health Review Tribunal, ex p. D

The Times, 13 April 1987 — *Q.B.D., Russell L.J. and Otton J.*

Having been found guilty but insane to a charge of murder in 1939, the patient had subsequently been detained in a special hospital and was subject to restrictions. In 1969, he was reported to have engaged in sexual behaviour with men of "infantile mentality," during which he twice placed his hands around the

throat of a fellow patient, in one case rendering his partner unconscious. He had at various times admitted an attraction to young boys, and psychological testing had disclosed "to varying degrees" his "sexual deviation." In March 1984, he was found to have in his possession a photograph of a boy wearing swimming trunks. His case was considered by a tribunal in August 1986. The responsible medical officer, and the psychologist treating him, gave evidence that he no longer suffered from a psychopathic disorder.

The tribunal's decision

The tribunal did not accept this evidence and decided not to discharge. Its reasons included the following passage:

> "We are not persuaded in the light of the history of the applicant and his behaviour between January 1969 and July 1971 when he behaved in a dangerous manner towards young persons and the discovery of a photograph of a young boy in his possession as recently as 1984 that his condition can be described as one suffering only from a *tendency* towards sexual deviation."

The application for judicial review

The patient applied for judicial review of the tribunal's decision, on an unrelated ground. The court observed that his counsel had "realistically" accepted that the tribunal's finding was open to it and did not attack it.

R. v. Mental Health Act Commission, ex p. X

(1988) 9 B.M.L.R. 77 — *Q.B.D., Stuart-Smith L.J., Farquharson J.*

The patient was described as a compulsive paedophile and he had been convicted of 16 offences of indecency or indecent assault on young boys under the age of 16 during the previous decade. He had served custodial sentences on three occasions. One of the arguments advanced before the court was that the treatment which it was proposed to give him — a drug which reduced the testosterone to castration levels — was not treatment for mental disorder but treatment for sexual deviancy, and so did not require authorisation under section 57 of the Act.

Stuart-Smith L.J.

Stuart-Smith L.J. observed that it had become clear during the hearing that responsible medical officer considered that the treatment was for the patient's mental disorder as well as for his sexual deviancy, and the point was therefore not pursued. His Lordship added that "in practice ... it seems likely that the sexual problem will be inextricably linked with the mental disorder, so that the treatment for the one is treatment for the other, as in this case."

R. v. Secretary of State for the Home Department, ex p. K.

[1990] 1 All E.R. 703 — *Q.B.D., McCullough J.*

In January 1971, the patient was convicted of the manslaughter of a neighbour's 12-year-old daughter. Her condition when found indicated that she had been raped, asphyxiated, cut with a sharp instrument and bitten. The patient had previous convictions for rape, indecently assaulting a girl aged seven, and having sexual intercourse with a girl aged between 13 and 16. He had only been out of prison for some six weeks before committing the index offence. The

court was satisfied that he was suffering from a psychopathic disorder and it directed his admission to a special hospital, in pursuance of a hospital order and a restriction order made without limit of time.

The first tribunal

In March 1985, a tribunal reviewed his case. A special hospital consultant gave evidence that in his opinion the patient was not a danger to himself or others and the chief psychologist there said that he was now functioning at a normal level. Given the unanimous medical evidence that the patient was not presently suffering from any form of mental disorder, but taking the view that it was appropriate for him to remain liable to recall, the tribunal conditionally discharged him from hospital.

The Crown Court proceedings

In October 1985, the patient made an unprovoked attack on a girl of 16 whom he saw walking along a road in the afternoon. The next night, he attacked a young woman of 21. After speaking to her, he held her neck in an arm lock and put his hand over her mouth, pulling her into an entry and then pushing her to a crouching position. When interviewed, the patient said only that he did not know why he had done it. A sexual motive for each assault was suspected but could not be proved. Subsequently, the patient pleading guilty in each case to assault occasioning actual bodily harm. He was described in court by his leading counsel as "so disturbed mentally that he cannot control the impulses from which he suffers." However, a special hospital medical report concluded that he had a severe personality disorder, probably with some psycho-sexual involvement, and an alcohol problem. This could not be equated with a psychopathic disorder and, in the doctor's opinion, he was not suffering from a mental disorder as defined by section 1. The judge imposed a sentence of six years imprisonment, describing the patient as "a very dangerous man ... in particular to young girls and young women."

The second tribunal

In 1986, the patient reapplied to the tribunal, once more seeking his absolute discharge from the hospital and restriction orders. The medical evidence before the tribunal was again unanimously of the view that the patient was not suffering from any form of mental disorder. The tribunal accepted this evidence but, as before, also considered it appropriate for him to remain liable to be recalled.

The application for judicial review

The subsequent judicial review proceedings turned on issues unrelated to section 1(3). However, it is noteworthy in this context that, notwithstanding the serious sexual offending, two tribunals were satisfied that the patient's condition and behaviour did not constitute a psychopathic disorder.

R. v. Trent Mental Health Review Tribunal, ex p. Ryan

[1992] C.O.D. 157 — *Q.B.D., Nolan L.J.*

Having been convicted of three serious indecent assaults on young girls in 1972, the patient was subject to a restriction order. In 1986, whilst conditionally discharged from hospital, he was convicted of a further offence of sexual assault on a young girl and sentenced to imprisonment. On completing his sentence he was recalled to hospital. In December 1990, his case was considered by a tribunal. The psychologist's report for the tribunal stated that "one must assume

that his paedophilic interests remain essentially untreated." The patient w[illegible]ot discharged and its reasons included the following passage:

> "The tribunal reminded itself of section (1) subsection (2) ... and concluded that it could not be satisfied that the patient was not suffering from psychopathic disorder. His conduct towards young females has been 'seriously irresponsible' resulting from psychopathic disorder."

Nolan L.J.

Nolan L.J. observed that the tribunal was entitled to say that it was not satisfied "in so far as they went on to conclude that his conduct towards young females had been seriously irresponsible resulting from psychopathic disorder." Neither the tribunal's decision, nor that of the High Court, made reference to sub-section 1(3) or to the judgment in *ex p. Clatworthy*.

Commentary

In some of the summarised cases, reference was made by the tribunals to features other than sexual deviancy that were considered to be indicative of a psychopathic disorder: uncontrollable impulses; lack of insight; lack of remorse; a bland, superficial attitude; sullen, morose and disruptive behaviour; an inability to learn from past events; and so forth. Even when generous account is taken of any other features which might be evidence of a psychopathic disorder, not all of the cases heard after *ex p. Clatworthy* are reconcilable with the approach set out there. An honest assessment of the case law virtually dictates a concession that tribunals have at times been disinclined to apply the prohibition in section 1(3), as interpreted in *ex p. Clatworthy,* and the courts have been reluctant to interfere. In the absence of a provision for transferring such offenders to prison, tribunals have often been faced with the prospect of discharging into the community persons whose tendency to sexually deviant behaviour remains uncurbed. The question arises whether the approach set out in *ex p. Clatworthy* represents an exhaustive statement of the law. Probably the only issue genuinely in doubt is whether the phrase "sexual deviancy" was intended by Parliament to take outside the Act persons whose abnormally aggressive or seriously irresponsible conduct consists only of serious sexual offending. Certainly, a major concern at the time the amendment was made was to put a stop to the practice of dealing with homosexuals, sexually active women, alcoholics and drug users on the basis that their behaviour was a form of mental disorder requiring medical treatment. The reference in section 1(3) to "immoral conduct" would no doubt include prostitution; the reference to "promiscuity" consensual sexual relations with multiple partners; the reference to "sexual deviancy" homosexuality, since, statistically, it represents a deviation from biological and social norms. As to sexual offending, an isolated sexual offence is not always the manifestation of an innate, uncontrollable, impulsive tendency towards sexually deviant behaviour. Any element of impulsivity or lack of control may be the consequence of taking alcohol or drugs. In other cases, the offence may simply be a way of exerting control over a partner or humiliating the victim: first and foremost a serious form of assault, rather than the product of innate sexual tendencies which deviate from the norm.[142] It is possible therefore that the prohibition concerning sexual behaviour

[142] The analysis here ignores the view that all unlawful violence is per se a symptom of mental disorder and, unless an individual's own health or safety is significantly at risk, this should be the main or sole criterion according to which decisions about detention and compulsory treatment are made. Although the view has much to commend it, it is very much a minority view.

which deviates from the norm[illegible]s solely intended to exclude persons who engage in lawful sexual activity, or co[illegible]uct which, although unlawful, is not explicable in terms of an uncontrollable, constitutional, tendency towards that behaviour. This kind of behaviour is quite different from behaviour which arises out of repetitive, obsessional and irresistible thoughts about sexual contact with children and the compulsive acts which result from such obsessions. The inability to mentally control such habitual thoughts and behaviour, despite its criminal nature and the strong social taboos against acting on such thoughts, is arguably a form of obsessional disorder — no less than in a man who cannot resist the thought that the door he has just closed did not make the right sound and that he must keep closing it until it does. It is therefore the obsessive-compulsive aspect of the behaviour which represents the persistent disorder or disability of mind, and brings the person within the Act, rather than the behaviour itself — which may be indulged in by persons without those ingrained traits in their personality. By analogy, if a man rapes a woman in response to some voice telling him to do so, it is not the rape which constitutes mental disorder — other men commit rape for quite different reasons — but the mental thought which gave rise to the act of sexual deviancy. Yet no one would say that the individual is not mentally disordered because the thought manifested itself as a sexually deviant act. If this is correct, there is a clear distinction between sexually deviant behaviour which does not result from a persistent disorder or disability of mind — that is a persistent mental disposition towards such behaviour — and sexually deviant behaviour which results from a persistent disability of mind in the form of a persistent mental disposition towards it. A finding that a person in the first category is mentally disordered would be a finding based on sexual deviant conduct alone, and so unlawful. A finding that a person in the second category is mentally disordered would not, however, be a finding based solely on sexual deviant conduct. It is not a finding based solely on "indulgence in deviation," being founded also on the existence of a persistent disability of mind in the form of an irresistible tendency towards such sexually deviancy. If so, the dicta in *ex p. Clatworthy* may be extended along the following lines:

> "The effect of subsection (2) is to prevent a person from being classified as having a psychopathic disorder unless his aggressive or seriously irresponsible conduct results from a persistent disorder or disability of mind. Furthermore, by subsection (3), he may not be dealt with as suffering from such a disorder by reason *only* of sexual deviancy. Sexual deviancy means indulgence in behaviour which deviates from sexual norms. That conclusion achieves support from its context, the context being promiscuity or other immoral conduct and dependence on alcohol or drugs. The combined effect of the two subsections is therefore that indulgence in conduct which deviates from sexual norms cannot on that ground alone be categorised as seriously irresponsible or abnormally aggressive conduct which is the result of a disorder or disability of mind. One is not entitled to conclude solely from the fact that the individual's behaviour deviates from sexual norms that he therefore has a disordered or disabled mind. If, however, there is evidence that his sexually deviant conduct is the product of a persistent disorder or disability of mind then any finding that such a person is mentally disordered is not one founded *only* on sexual deviancy. It is one founded on sexual deviancy and the existence of a persistent disorder or disability of mind."