Report / Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957.

ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY 1954—1957

REPORT

Presented to Parliament by Command of Her Majesty
May 1957

LONDON
HER MAJESTY'S STATIONERY OFFICE
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Cmnd. 169

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NOTE

The estimated gross total expenditure of the Commission is £26,925.

Of this sum £1,725 represents the estimated cost of printing and publishing this report, and £3,025 the cost of printing and publishing the minutes of evidence.

The sum of £817 has been recovered by the sale of minutes of evidence taken before the Commission.

THE ROYAL WARRANTS

ELIZABETH R. } On behalf of
MARGARET. } Her Majesty.

ELIZABETH THE SECOND, by the Grace of God of the United Kingdom of Great Britain and Northern Ireland and of Our other Realms and Territories QUEEN, Head of the Commonwealth, Defender of the Faith, To

Our Right Trusty and Well-beloved Counsellor Eustace Sutherland Campbell, Baron Percy of Newcastle;

Our Trusty and Well-beloved:—

Sir Cecil Oakes, Knight, Commander of Our Most Excellent Order of the British Empire;

Sir Walter Russell Brain, Knight, Doctor of Medicine, President of the Royal College of Physicians;

Thomas Percy Rees, Esquire, Officer of Our Most Excellent Order of the British Empire, Doctor of Medicine, Member of the Royal College of Surgeons, Member of the Royal College of Physicians;

Hester Adrian;

Claude Bartlett, Esquire;

Elizabeth Margaret Braddock;

Harry Braustyn Hylton Hylton-Foster, Esquire, one of Our Counsel learned in the Law;

Richard Meredith Jackson, Esquire, Doctor of Laws;

David Howell Hugh Thomas, Esquire, Member of the Royal College of Surgeons, Licentiate of the Royal College of Physicians;

John Greenwood Wilson, Esquire, Doctor of Medicine, Fellow of the Royal College of Physicians, Member of the Royal College of Surgeons,

Greeting!

WHEREAS We have deemed it expedient that a Commission should forthwith issue to inquire as regards England and Wales into the existing law and administrative machinery governing the certification, detention, care (other than hospital care or treatment under the National Health Service Acts, 1946-52), absence on trial or licence, discharge and supervision of persons who are or are alleged to be suffering from mental illness or mental defect, other than Broadmoor patients; to consider as regards England and Wales the extent to which it is now, or should be made, statutorily possible for such persons to be treated, as voluntary patients, without certification; and to make recommendations:

NOW KNOW YE that We, reposing great trust and confidence in your knowledge and ability, have authorized and appointed, and do by these Presents authorize and appoint you the said Eustace Sutherland Campbell, Baron Percy of Newcastle (Chairman); Sir Cecil Oakes; Sir Walter Russell Brain; Thomas Percy Rees; Hester Adrian; Claude Bartlett; Elizabeth Margaret Braddock; Harry Braustyn Hylton Hylton-Foster; Richard Meredith Jackson; David Howell Hugh Thomas and John Greenwood Wilson to be Our Commissioners for the purposes of the said inquiry:

And for the better effecting the purposes of this Our Commission, We do by these Presents give and grant unto you, or any four or more of you, full power to call before you such persons as you shall judge likely to afford

you any information upon the subject of this Our Commission; to call for information in writing; and also to call for, have access to and examine all such books, documents, registers and records as may afford you the fullest information on the subject and to inquire of and concerning the premises by all other lawful ways and means whatsoever:

And We do by these Presents authorize and empower you, or any of you, to visit and personally inspect such places as you may deem it expedient so to inspect for the more effectual carrying out of the purposes aforesaid:

And We do by these Presents will and ordain that this Our Commission shall continue in full force and virtue, and that you, Our said Commissioners, or any four or more of you may from time to time proceed in the execution thereof, and of every matter and thing therein contained, although the same be not continued from time to time by adjournment:

And We do further ordain that you, or any four or more of you, have liberty to report your proceedings under this Our Commission from time to time if you shall judge it expedient so to do:

And Our further will and pleasure is that you do, with as little delay as possible, report to Us your opinion upon the matters herein submitted for your consideration.

Given at Our Court at Saint James's the Twentieth day of February, 1954; In the Third Year of Our Reign.

By Her Majesty's Command.

David Maxwell Fyfe.

ELIZABETH R.

ELIZABETH THE SECOND, by the Grace of God of the United Kingdom of Great Britain and Northern Ireland and of Our other Realms and Territories QUEEN, Head of the Commonwealth, Defender of the Faith, To Our Trusty and Well-beloved Jocelyn Edward Salis Simon, Esquire, one of Our Counsel learned in the Law,

Greeting!

KNOW YE that We reposing great trust and confidence in your knowledge and ability do by these Presents appoint you the said Jocelyn Edward Salis Simon to be a Member of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, in the room of Our Trusty and Well-beloved Sir Harry Braustyn Hylton Hylton-Foster, Knight, one of Our Counsel learned in the Law.

GIVEN at Our Court at Saint James's the Nineteenth day of November, 1954; In the Third Year of Our Reign.

By Her Majesty's Command.

G. Lloyd-George.

JOCELYN EDWARD SALIS SIMON, ESQUIRE, Q.C.

To be a Member of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency.

NOTE:
The honour of a Baronetcy was conferred on Sir Russell Brain in June, 1954.
The honour of a Knighthood was conferred on Mr. Hylton-Foster in October, 1954.
Dr. Rees was elected a Fellow of the Royal College of Physicians in May, 1956.
Mrs. Adrian became the Lady Adrian in the New Year, 1955.

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ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY 1954–1957

REPORT

TO THE QUEEN'S MOST EXCELLENT MAJESTY

MAY IT PLEASE YOUR MAJESTY,

We were appointed by Royal Warrant "to inquire, as regards England and Wales, into the existing law and administrative machinery governing the certification, detention, care (other than hospital care or treatment under the National Health Service Acts, 1946–52), absence on trial or licence, discharge and supervision of persons who are or are alleged to be suffering from mental illness or mental defect, other than Broadmoor patients; to consider as regards England and Wales, the extent to which it is now, or should be made, statutorily possible for such persons to be treated, as voluntary patients, without certification; and to make recommendations".

WE HUMBLY SUBMIT TO YOUR MAJESTY THE FOLLOWING REPORT

Membership

1. There were two changes in the membership of the Commission during the course of our enquiry. Sir Harry Hylton-Foster, Q.C., M.P., resigned in October, 1954, shortly after his appointment as Solicitor-General. Mr. J. E. S. Simon, Q.C., M.P., was appointed to take his place as a member of the Commission. Mr. Simon resigned shortly after his appointment as Joint Parliamentary Under-Secretary of State for the Home Department in January, 1957, but we had the advantage of his active help as a colleague during almost the whole of the period in which we were formulating our recommendations.

Procedure and Evidence

2. In Appendix I we explain the procedure which we adopted and the sources from which we received evidence and information. We are grateful to all the private individuals, associations, societies, local authorities, hospital authorities and government departments who gave us their views or provided us with information.

3. The minutes of evidence taken in public have been published in daily parts. We have also published an appendix to the minutes of evidence containing some of the written memoranda on which we did not take oral evidence. The oral evidence of four witnesses whom we heard in private and an index to the minutes of evidence are being published at the same time as this report. When we refer to the minutes of evidence in the text of our report, oral evidence is referred to by question numbers (e.g. 3rd Day, Q. 526), written memoranda by page and paragraph numbers (e.g. 8th Day, P. 287, para. 166).

Arrangement of Report

4. The subject into which we were commissioned to enquire is a complicated one. The present law and administrative machinery relating to mental illness and mental deficiency are themselves complex. In order to judge what changes are needed we have also had to view the mental health services in perspective in relation to their own historical background and to

other social services. Although we have concentrated mainly on general principles, in some places we have had to go into detail when describing past and present arrangements and the new arrangements which we recommend for the future. At the beginning of the report is a summary of our main conclusions about the present law and administrative machinery and our main recommendations for the future. Part I of the report contains an introductory survey of the present mental health services which mentions the main problems which we have had to consider and explains our general approach. In Parts II–VII we discuss present and future arrangements in detail under six main headings, (*a*) the need for new legislation, (*b*) the groups of patients which need to be distinguished for legal and administrative purposes, and terminology, (*c*) the procedures which apply to individual patients receiving treatment voluntarily or under compulsory powers, (*d*) the local administration of the mental health services and relations with other social services, (*e*) the powers and duties of the central government, and (*f*) hospitals and homes outside the national health service and other private care. In Part VIII we discuss some of the repercussions of our proposals on parts of the law which are not themselves directly within our terms of reference. At the end of each Part is a list of the recommendations made in that Part.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

General attitude to mental disorder and to certification

(Parts I, II and IV)

(Chapters 1, 2 and 4)

5. Disorders of the mind are illnesses which need medical treatment. Great progress has been made during the present century in developing methods of treatment for many forms of mental disorder.[1] Even when the disorder cannot be completely cured, it is often possible for the patient to live a happy and useful life in spite of some continuing mental weakness. This is now recognised by many of the general public as well as by those who are directly concerned with the care of patients, and most people are coming to regard mental illness and disability in much the same way as physical illness and disability.

6. Some of the laws which still govern the conditions under which mentally disordered patients may receive care[2] in hospital or elsewhere were passed at a time when it was assumed that such patients must be detained under custody while receiving treatment. Although mental hospitals[3] are now allowed to admit voluntary patients, these patients must be well enough to sign an application form expressing a positive wish to receive treatment. All other patients in mental hospitals, and almost all patients in mental deficiency hospitals,[3] are admitted by using procedures which authorise their detention. The main procedures which authorise detention are commonly known as certification. Many people think that only patients who are permanently deranged or dangerous are " bad enough " to be certified, and that certification carries with it some social or moral stigma. But some patients for whom the present law requires these procedures to be used are expected to respond to treatment quickly and perhaps completely, and from the medical point of view there is often no difference between their illness and the illness of voluntary patients. In some cases treatment could quite well be given without powers of detention if the law allowed mental and mental deficiency hospitals (like all other hospitals) to admit patients informally without requiring a written application from the patient. In some cases however the patients' judgment may be affected by their disorder so that they do not appreciate their need for care, and they may be positively unwilling to receive it. Some may be dangerous to themselves or others, or may be incapable of protecting themselves. If proper care is to be provided for such patients, it can only be done by using compulsory powers.

(Chapter 2, paragraphs 135–6, and Chapters 5 and 6)

7. We recommend that the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need

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[1] We use the term " mental disorder " as a general term for all forms of mental ill-health —see paragraph 74.

[2] We use the word " care " to include any form of treatment, training, education, supervision, social support, help and advice.

[3] The term " mental hospital " officially replaced the old term " asylum " in 1930 and is applied to hospitals in the national health service which provide treatment for mental illness and which have been " designated " as mental hospitals under the Lunacy and Mental Treatment Acts. The term used in the Mental Deficiency Acts is " institution for defectives ", but as nearly all such institutions are now hospitals within the national health service we usually refer to them as mental deficiency hospitals. When we wish to refer to all hospitals which specialise in the treatment of mental disorder, including those which have not been " designated ", we use the term " psychiatric hospitals ".

care because of other types of illness, disability or social difficulty. Compulsory powers should be used in future only when they are positively necessary to override the patient's own unwillingness or the unwillingness of his relatives, for the patient's own welfare or for the protection of others.

(Chapter 4, paragraphs 285–6, and Chapter 7, paragraphs 374–7)

8. When compulsion has to be used, there must be special procedures and safeguards. We recommend new procedures for this purpose which would replace the present certification procedures. We hope that the term " certification " and the ideas associated with it will fall completely into disuse and that the public will recognise that these procedures carry no implications about the probable length or cause of the patient's illness or disability.

Groups of mentally disordered patients and terminology

(Parts I, II and III)

(Chapter 1, paragraphs 74–127, and Chapter 3, paragraphs 146–180)

9. Many types and degrees of mental disorder are recognised and classified for medical purposes. For administrative and legal purposes also, patients have been classified in various groups according to the type of care which is provided for them or according to the circumstances in which they may be detained for treatment or received voluntarily. These administrative groups do not necessarily correspond with medical classifications of types of disorder.

10. For many centuries a broad distinction has been drawn between two main groups of patients who are now generally described as " mentally ill " and " mentally defective ". The term " mentally defective " is used of patients whose minds have never fully developed or seem unlikely to do so. The term " mentally ill " is applied to patients whose minds have previously functioned normally but have become disordered, usually in adult life. A person who is mentally defective may also develop a mental illness. Each term covers a wide range of types and degrees of disorder and there is no clear-cut medical distinction between the two ; they are legal and administrative, rather than clinical, terms.

11. The common characteristic of patients who are called " mentally defective " is that their disorder must have arisen before the age of eighteen and must result in incomplete or arrested mental development. Mental defectiveness is defined in this sense in the Mental Deficiency Acts, 1913–1938, which also define four types of defectives, i.e. idiots, imbeciles, feebleminded persons and moral defectives. Some lack of intelligence does not in itself make a person mentally defective. There are many people with a low level of intelligence who manage for themselves without special care. It is only when arrested or incomplete mental development (which may include lack of intelligence but does not necessarily do so) makes a person incapable of managing without special care that he is regarded as mentally defective.

12. Most defectives do not need to be admitted to hospital but live in the general community, many of the feebleminded earning their living in simple forms of employment. Local health authorities may provide supervision, occupation and training for defectives living in the community. Mental deficiency hospitals usually admit all types of defective but not patients suffering from other forms of mental disorder. The procedures for admission to hospitals and other institutions laid down in the Mental Deficiency Acts authorise the patient's detention ; no explicit provision is made for the admission of patients on a voluntary or informal basis. Patients are however in practice now admitted for short periods without any legal formalities.

13. The majority of mentally ill patients also do not need to be admitted to hospital as in-patients. Patients may receive medical treatment from general practitioners or as hospital out-patients and other care from other community health and welfare services. Hospital in-patient treatment is now provided in a few hospitals on a completely informal basis without powers of detention. Hospitals which have been "designated" under the Lunacy and Mental Treatment Acts, 1890–1930, may admit in-patients only through the procedures laid down in these Acts. Any patient who makes a valid written application for treatment for mental illness in such a hospital may be received as a voluntary patient. There are also procedures which may be used, in certain circumstances, for the compulsory admission and detention of patients who are "persons of unsound mind". The term "mental illness" covers a much wider range of forms and degrees of mental disorder than the term "of unsound mind"; the majority of mentally ill patients are not liable to compulsory admission to hospital as persons of unsound mind. "Persons of unsound mind" as well as other mentally ill patients may be admitted as voluntary patients if they can make a valid application, and many can also be suitably treated or cared for outside hospital.

14. The procedures laid down in the Mental Deficiency Acts for the admission of patients to mental deficiency hospitals may be used for defectives only. Designated mental hospitals are forbidden by law to detain any patient who is not "a person of unsound mind", or to admit as a voluntary patient any person who cannot give a valid signature on an application form. Idiots and imbeciles may be admitted to designated mental hospitals as "persons of unsound mind", and feebleminded patients who are able to sign voluntary application forms are sometimes admitted to some mental hospitals as voluntary patients; but since the passing of the first Mental Deficiency Act in 1913, which authorised the provision of separate institutions for defectives and laid down separate procedures for admission, it has become usual for mentally defective patients to be admitted to mental deficiency hospitals only, leaving the mental hospitals for the treatment of mentally ill patients only.

15. There is a group of mental disorders known as psychopathic states which are recognised medically but for which no special provision is made in the law. Many psychopathic patients have seriously aggressive characteristics or show pathological inadequacy in coping with the ordinary problems of life. In some patients the psychopathic behaviour may be associated with a recognised mental illness; in others it may be associated with subnormal intellect and the patient may be considered mentally defective within the meaning of the Mental Deficiency Acts; in other patients the psychopathic behaviour may be the only sign of the patient's mental disorder. There is considerable difference of opinion on the extent to which abnormally aggressive or inadequate behaviour, which is not accompanied by intellectual sub-normality but which is apparent before the age of eighteen, may be taken as evidence of mental defectiveness within the meaning of the Mental Deficiency Acts. Whatever view is taken on this question, there are great similarities from the medical point of view between some patients certified as feebleminded or moral defectives under the Mental Deficiency Acts and some psychopathic patients who are not certifiable as mentally defective nor as of unsound mind under the present law. Psychopathic patients who are regarded as of unsound mind or as mentally defective may in certain circumstances be compulsorily admitted to mental or mental deficiency hospitals for treatment. Those who are not may receive treatment as voluntary patients in mental hospitals or on an informal basis in other

hospitals if they are willing, but they are not liable to compulsory admission or detention ; the only form of legal pressure to accept treatment which may be used is that if they are convicted of a criminal offence submission to medical treatment may be made a condition of probation.

(Chapter 2, paragraphs 142–5, and Chapter 3, paragraphs 181–198)

16. In our view, the administrative distinction between mental illness and mental deficiency has a sound practical basis, but the rigidity with which it has been enforced through two separate legal codes has had some unfortunate results. The grouping of all types of defectives together, legally and administratively, has led to the supposition that they must be a more homogeneous group of patients than they really are. This has led to resentment and misunderstanding on the part of the relatives of feebleminded patients, and to a tendency in many quarters to assert that the higher-grade feebleminded are not mentally defective. The care of feebleminded patients has also been too rigidly separated from the care of the mentally ill and from the forms of treatment which are now being developed for other psychopathic patients. We also consider that there are unnecessary differences between the procedures applied under the present law to mentally ill patients who are admitted to hospital and those applied to mentally defective patients.

17. We recommend that three main groups of patients should be recognised in future for legal and administrative purposes:

(*a*) Mentally ill patients. The term " mental illness " would be used in the same sense as at present, including the mental infirmity of old age. The term " person of unsound mind " would no longer be used.

(*b*) Psychopathic patients, or patients with psychopathic personality. We use the term " psychopathic personality " in a wider sense than that in which it is often used at present and intend it to include any type of aggressive or inadequate personality which does not render the patient severely sub-normal in the sense of group (*c*) below but which is recognised medically as a pathological condition. Our psychopathic group includes all patients at present classified as feebleminded or moral defectives who need care but do not fall into group (*c*), and also some other psychopaths who are pathologically mentally abnormal but are not covered by the present legal definition of mentally defective persons. We use the term " feebleminded psychopath " when referring to psychopaths whose disorder includes a marked limitation of intelligence but still does not bring them into group (*c*).

(*c*) Patients of severely sub-normal personality. This term would be used when the general personality is so severely sub-normal that the patient is incapable of leading an independent life. This group includes all patients at present classified as idiots and imbeciles and some of those now classified as feebleminded. The terms " idiot " and " imbecile " and the terms " mental defectiveness " and " defective " would no longer need to be used.

18. There should be no rigid legal designation of hospitals for any one of these groups of patients only. The extent to which particular hospitals specialise in treating particular types of disorder should be a matter for medical and administrative arrangement, in the psychiatric field as in other branches of medicine. The arrangements should be capable of adaptation as medical developments may require, and there should be no legal barrier preventing the admission of any patient to any hospital which provides the sort of treatment he is thought to need.

19. The law should define the circumstances in which patients in each of these three groups should be liable to compulsory admission to and detention in hospital or to legal control while living in the general community; these would not be the same for all three groups of patients (see paragraphs 24–33). We recommend various procedures appropriate to the varying circumstances in which compulsory powers may need to be used; these form a single set of procedures which do not introduce further distinctions between the three main groups of patients when other circumstances are similar (see paragraphs 34–42). These new procedures should be laid down in a single new Act.

The procedures applied to individual patients

(Parts II, IV, VI and VII)

(i) General

(Chapter 2, paragraphs 128–131 and 137–145)

20. Most of the present procedures are laid down in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. These are now seriously out of date and unnecessarily complicated.

(ii) Care without compulsion

(Chapter 2, paragraphs 132–5, Chapter 5 and Chapter 8, paragraphs 557–561)

21. All forms of hospital and community care should be available in future to patients who are content to receive them without the use of compulsory powers and procedures or formal ascertainment. The administrative methods by which proper standards of care are maintained should not be linked to the procedures prescribed for detained patients and need not be laid down in detail in the law.

22. The law should no longer prevent mentally ill patients from entering hospital without being subject to detention if they cannot make a valid positive application for admission. These patients, like physically ill patients, should be assumed to be content to enter hospital unless they positively object. When patients are admitted without powers of detention there should be no special formalities. They should not be obliged to sign an application for admission, nor to give formal notice of intention to leave. Acceptance of these principles should allow a considerable number of patients who now have to be certified, including many elderly senile patients, to be admitted informally, as to any other hospital or home. Informal admission to designated mental hospitals cannot be introduced without amendment or repeal of the Lunacy Act, 1890.

23. The same principles should be applied to severely sub-normal and psychopathic patients. Most severely sub-normal patients and many psychopathic patients could be admitted informally without powers of detention. We see nothing in the present Mental Deficiency Acts to prevent informal admission to the present mental deficiency hospitals. We recommend that if no legal obstacle is found informal admission should start at once without waiting for new legislation on other matters, and that in suitable cases the powers of detention over patients already in hospital should be brought to an end.

(iii) Circumstances in which compulsion is justifiable

(Chapter 6, paragraphs 312–318 and 359–373)

24. We have reviewed the general circumstances in which it is justifiable to compel mentally disordered patients to accept care, treatment or training against their own wishes or those of their relatives.

(Chapter 6, paragraphs 319–332)

25. As far as mentally ill patients are concerned, we have received many criticisms of the present compulsory ("certification") procedures, and the terminology they use. Although there is some misunderstanding of the purpose the present procedures are meant to serve, it is not disputed that it should be possible to compel mentally ill patients to accept suitable care, if it cannot be provided without compulsion, in circumstances similar to those in which the present law allows "persons of unsound mind" to be "detained for care and treatment".

26. There is also general agreement that compulsory powers should be available to ensure proper care for severely sub-normal patients, if it cannot be provided without such powers.

27. We recommend that, subject to the use of new procedures introducing new safeguards, compulsory admission to hospital or legal control under guardianship while receiving community care should be permitted for mentally ill or severely sub-normal patients when compulsion is necessary for their own welfare or for the protection of others.

(Chapter 3, paragraph 162, and Chapter 6, paragraphs 333–358)

28. There are conflicting views on the circumstances in which psychopathic patients should be subject to compulsion, both as regards those now certifiable under the Mental Deficiency Acts and those not considered certifiable under the present law. Some consider that compulsion is justified in the circumstances covered by the present Mental Deficiency Acts, but only if the patients are intellectually sub-normal as well as temperamentally unstable. Others consider that the present powers should apply to all patients whose personality disorder is known to have arisen before a certain age whether or not it affects the patient's intelligence. Others consider that patients now classified as feebleminded or moral defectives should be subject to compulsion only when their behaviour is anti-social to the extent of offending against the criminal law, and then only for a limited period. Others consider that psychopaths not covered by the present Mental Deficiency Acts should be subject to compulsion in certain circumstances.

29. The definition of mental defectiveness contained in the present Mental Deficiency Acts was intended to include any form of incomplete or arrested development of mind which arises before the age of eighteen, whether or not the patient is sub-normal in intelligence. But this definition, and the statement of the circumstances in which defectives are "subject to be dealt with" under the present Acts, do not provide a satisfactory basis for the use of compulsion in relation to those psychopathic patients to whom the Acts apply, nor do they provide a satisfactory dividing line between those psychopathic patients who should be subject to compulsion and those who should not.

30. The difficulty is that what distinguishes psychopathic patients from ordinary citizens is their general behaviour, not loss of reason or serious lack of intelligence. Most citizens are liable to deprivation of liberty, on grounds of behaviour, only when their behaviour offends the criminal law. If psychopathic patients are subjected to special forms of compulsion on grounds of mental abnormality which is evidenced mainly by their behaviour, this is almost equivalent to the creation of a special quasi-criminal code for them alone. Some aggressive psychopaths who are now certified under the Mental Deficiency Acts may be detained for long periods mainly in order to prevent further acts of violence, and the same would apply to other psychopaths if the special compulsory powers were extended. The criminal law also

provides for preventive detention, but in much more narrowly defined circumstances and for a limited number of years.

31. In our opinion there is not now sufficient justification for special compulsory powers over older feebleminded or other psychopathic patients as wide as those contained in the present Mental Deficiency Acts. There are good arguments for providing training compulsorily when the diagnosis is made while the patient is still young, when training is most likely to be successful. We also think it justifiable to require psychopathic patients to enter hospital for medical observation at any age, for a short period only, at the end of which they must be discharged if they are not then willing to remain for further treatment or training on a voluntary basis. Apart from this, we do not consider that there is sufficient justification for using compulsion, except when they have broken the criminal law. If they break the law, their mental condition can properly be taken into account in determining whether special forms of medical or social care should be provided, compulsorily if necessary, instead of or in addition to normal penal measures.

32. We recommend that psychopathic patients should be liable to compulsory admission to hospital or guardianship if this is necessary for their own welfare or for the protection of others, if under the age of twenty-one at the time of admission; the compulsory powers should lapse when the patient reaches the age of twenty-five if he has not already been discharged, unless his admission followed court proceedings or transfer from prison or approved school or unless he has become liable to compulsion in another category. Psychopathic patients (as well as mentally ill and severely subnormal patients) should be liable to compulsory admission to hospital for medical observation at any age, provided that they are not compulsorily detained for longer than twenty-eight days. Psychopathic patients of any age should also be liable to compulsory admission to hospital or guardianship when convicted of an offence against the criminal law, if the court before whom they are convicted (or the Home Secretary when authorising transfer from prison) is satisfied, after receiving medical advice, that ordinary penal measures alone are insufficient or inappropriate and that the patient requires medical or social care which a particular hospital or local authority is able and willing to provide. These recommendations apply irrespective of the age of onset of the patient's mental disorder or of the level of his intelligence.

(Chapter 3, paragraphs 192–5, and Chapter 6, paragraphs 357–8)

33. We describe the criteria which we expect doctors to use in distinguishing between severely sub-normal and psychopathic patients. We do not think it necessary or desirable that detailed definitions of either term should be written into the law. In our view there should be no more difficulty in interpreting these terms in practice than there has been in interpreting the phrase "of unsound mind" under the Lunacy Acts. The application of compulsory powers to psychopathic patients would be more suitably controlled by the limitations we recommend in regard to age, conviction for a criminal offence, need for medical or social care, training or treatment (other than ordinary penal measures) and acceptance for such care, and by the safeguards in the new procedures which would have to be followed whenever compulsory powers are used, rather than by any attempt to define the nature of the patient's mental disorder or the behaviour which results from it.

(Chapter 6, paragraphs 315–6, 359–364 and 371)

34. Every effort should be made to persuade patients and their relatives to agree to care without compulsion. But if such efforts fail, doctors and

others should not be too hesitant to use the compulsory powers which the law provides, when this seems the only way of giving the patient treatment or training which he badly needs or when such powers are necessary for the protection of others. In particular, the responsible authorities should not be reluctant to bring a criminal charge against psychopathic patients because they consider them mentally abnormal; these patients are responsible citizens in the eyes of the law, and under our proposals this may be the only way to ensure that they receive the medical treatment they need.

(iv) New procedures when compulsory powers are used

(In the following paragraphs, we summarise our chief conclusions and recommendations mainly as they apply to patients admitted to hospitals. The same principles apply to patients placed under guardianship in the community.)

(Chapter 5, paragraph 291, and Chapter 7, paragraphs 378–380)

35. Hospitals should be free to admit any patients for whom they can provide suitable treatment, informally or through compulsory procedures. Even in connection with compulsory powers no formal "designation" of hospitals is necessary.

(Chapter 7, paragraphs 381–3)

36. No hospital should be obliged to admit a patient for whom it cannot provide suitable care, or for whom care could equally well be provided elsewhere, just because that patient is liable to compulsory powers. The new procedures when such powers are used should authorise the hospital authorities to admit and detain the patient, but not order them to do so. The acceptance of the patient as medically suitable for care in the particular hospital should be an essential part of the new procedures, including the procedures used when admission follows court proceedings.

(Chapter 7, paragraphs 384–6)

37. The procedure used for a patient's admission should not result in any distinction of "status". In the hospitals, patients should be classified only according to their mental condition or other medical considerations.

(Chapter 7, paragraph 387)

38. The law should allow patients to be placed in the guardianship of local health authorities, as well as of private individuals. Local health authorities should have a duty to act as guardian when care in the community is needed and cannot otherwise be arranged.

(Chapter 7, paragraphs 388–395)

39. The new procedures must provide safeguards against the use of the compulsory powers in circumstances for which those powers are not intended. At the same time they must be appropriate to the circumstances in which compulsion is properly and justifiably used. The difficulty of reconciling these two requirements may be partly met by arranging for more of the procedures designed as safeguards to be made available for use at the request of those patients who wish to use them, instead of imposing them on all patients alike.

40. It is essential that the working of the new procedures should be in the hands of people who have the sort of knowledge and experience needed to form a sound judgment on the questions at issue. These are (i) the patient's mental condition, (ii) the form of hospital or community care most

suited to his needs, (iii) whether care can be provided without compulsion, and if not whether compulsion is necessary for the patient's own welfare or for the protection of others. No one who is not medically qualified should be required to state an opinion on the patient's state of mind or need for care on his own responsibility, even after considering medical certificates, nor to take action without medical advice.

41. We draw a distinction between the procedures which are appropriate when compulsion is used to override the unwillingness of the patient himself only (we call these the " main procedures "), and those which are appropriate when the unwillingness of the patient's nearest relative is overriden. The latter should be based on the main procedures, but include important additions and modifications. Some additional provisions will be necessary when admission to hospital follows conviction in the courts, and other modifications when the patient is admitted to a hospital or home outside the national health service or to the guardianship of a private individual.

42. Our proposals for new procedures are summarised in tabular form in Appendix III. Their most important features are the following :—

(a) **The main procedures**

(Chapter 7, paragraphs 401–6, 413–4 and 417)

(i) Except in emergency, there should always be two medical recommendations at the time of admission to hospital or guardianship, at least one of which should be given by a doctor experienced in the diagnosis or treatment of mental disorders, and one if possible by a doctor who already knows the patient. It should be permissible (and usual) for one to be given by a doctor on the staff of the receiving hospital (or of the local health authority which is to act as guardian), except for paying patients. There should also be a medical acceptance of the patient as suitable for care in the particular hospital concerned or by the local health authority.

(Chapter 7, paragraphs 407–412 and 415)

(ii) In an emergency, it should be permissible for admission to be arranged with one instead of two medical recommendations, the second being added within seventy-two hours (twenty-eight days in cases of guardianship) if the patient is to be detained longer than that. Compulsory admission should never take place without medical recommendation.

(Chapter 7, paragraphs 416 and 418–9)

(iii) The medical recommendations should contain either a diagnosis of mental illness, psychopathic personality or severely sub-normal personality and a firm recommendation for hospital or community care, or a diagnosis of mental disorder and a recommendation for up to twenty-eight days observation in hospital. In the former case a full explanation should be given of the reason why hospital in-patient care (or guardianship) is recommended rather than other forms of care, and why it is not considered possible to provide it without the use of compulsory powers.

(Chapter 4, paragraphs 264–7, and Chapter 7, paragraphs 401–412, 438–441 and 454)

(iv) Reference to a magistrate at the time of admission when compulsion is used is open to various objections and we do not consider it of much value as a safeguard to the patient. Stronger safeguards would be provided by requiring more than one medical opinion, by

extending the powers of discharge and by providing new opportunities for review by a strong independent body consisting of both medical and non-medical members. We recommend that an application by a relative (or by a mental welfare officer acting in place of a relative) supported by two medical recommendations (or one in an emergency) should authorise the patient's removal to and detention in hospital or control under guardianship, subject to the medical acceptance, powers of discharge, opportunities for review and time-limits on detention which we also recommend. This should apply when the patient's nearest relative does not object to his admission; if he does, one of the procedures mentioned in sub-paragraphs (xii) to (xv) should be used; most of these involve reference to a magistrates court.

(Chapter 7, paragraphs 421–8)

(v) Powers of discharge should be held by each of the following:

(*a*) the patient's nearest relative, subject to a barring certificate which might be given only if the patient is dangerous to himself or others;

(*b*) the medical superintendent or other responsible doctor;

(*c*) any three members of the hospital management committee or board of governors (or of the appropriate committee of the local health authority in cases of guardianship);

(*d*) Mental Health Review Tribunals on specific occasions—see sub-paragraph (vii);

(*e*) the Minister of Health—see sub-paragraph (xi).

The relative and the Minister should not have power to discharge patients admitted only for a period of observation, but relatives should have easy access to the medical superintendent and members of the hospital management committee during that period.

(Chapter 7, paragraphs 429–437)

(vi) The compulsory powers should expire after fixed periods unless renewed. The procedure for renewal should be a recommendation from the medical superintendent (or medical officer of health), with reasons; this should be seen by members of the hospital management committee (or local health authority), who will be able to exercise their power to discharge the patient if they think fit. If they do not, the patient should have access to a Mental Health Review Tribunal (see below).

(Chapter 7, paragraphs 438–454)

(vii) Mental Health Review Tribunals should be set up in order to give patients (and relatives in certain circumstances) opportunities to have an independent investigation into the justification for the use of compulsion, if they so desire. These tribunals should be organised on a regional basis, panels of medical and non-medical members for each region being appointed by the Lord Chancellor in consultation with the Minister of Health. There should be a Chairman in each region who should select members of the panels to form tribunals to consider each case referred for review. The regional Chairman and the chairman of each tribunal should be legally qualified. Patients should have access to such a tribunal (1) at any time within six months after admission if neither the medical superintendent nor the members of the hospital management com-

mittee are willing to use their powers of discharge, and (2) whenever the period of validity of the compulsory powers is extended. The patient's nearest relative should have access to a tribunal if his order for the patient's discharge is overridden by a barring certificate, and once a year if his power of discharge has been withheld under the procedures mentioned in sub-paragraphs (xiv) and (xvi)-(xxi).

(Chapter 7, paragraphs 469–477)

(viii) As the local health authorities under our recommendations (see paragraph 52) would have a duty to provide after-care for patients who have left hospital, it should not be necessary to use licence as a means of providing such care. In many cases, it should be possible to provide suitable after-care without compulsory powers. In those cases in which compulsory powers are still necessary, transfer to guardianship is more suitable than long periods on trial (we prefer the term "trial" to "licence"). Compulsory powers should lapse six months after the patient leaves hospital unless a transfer to guardianship is arranged.

(Chapter 11, paragraphs 747–762)

(ix) Admission and renewal documents should be scrutinised by the hospital and local health authority staff to make sure that they provide valid authority for the use of compulsory powers. The central scrutiny of documents at present carried out by the Board of Control should cease.

(Chapter 7, paragraph 487)

(x) Members of hospital management committees should visit patients regularly, and patients should be able to ask for private interviews.

(Chapter 11, paragraphs 765–784)

(xi) A central authority should have a reserve power of discharge and a duty to visit patients who ask to be visited. The appropriate authority in our view is the Minister of Health.

(b) **Procedures to be used when it is necessary to override the wishes of the patient's nearest relative**

(Chapter 6, paragraphs 328–330, Chapter 7, paragraphs 491–3, and Chapter 10, paragraphs 637–653)

(xii) The obligation imposed on parents by the Education Acts to arrange for their children's education by attendance at school or otherwise should be extended to cover children who require training in a training centre or in hospital in place of education at school, the local health authorities having a duty to provide such training (or to arrange admission to hospital) for those who require it. The procedure in individual cases should be similar to that used when a child is recommended for education in a special school.

(xiii) In some cases it may be appropriate to take action under the Children and Young Persons Acts if a mentally disordered child or young person is in need of care or protection within the meaning of those Acts. A local authority or other person appointed as a "fit person" could then arrange hospital or community care for the patient, informally or by using the main compulsory procedures already described. It should also be possible in appropriate cases for such children to be received into the care of the local authority under the Children Act, 1948, and for the local authority to assume parental rights under their powers under that Act.

(Chapter 7, paragraphs 494–510)

(xiv) In other cases in which the nearest relative unreasonably opposes the provision of hospital or community care for the patient, if it is considered necessary to set the relative's wishes aside for the patient's welfare or for the protection of others, an application should be made to a magistrates court for the relative's power to apply for admission and to order discharge from hospital to be transferred to some other person or to the local health authority (acting through the medical officer of health), or for such a person or local authority to be authorised to act as guardian. The court should be given a medical report and a full explanation of the reasons why the application is considered necessary. The issue before the court would be whether or not the nearest relative is acting unreasonably in opposing the form of care recommended in view of the medical diagnosis and report. The procedure at the court hearing should be similar to that of juvenile courts in " care or protection " cases. If the court decides that the relative's wishes should be set aside, it should authorise (not order) some other person to undertake the appropriate responsibilities. That person could then arrange the patient's admission to hospital, either informally or by using the main compulsory procedures. The nearest relative himself should have a right of appeal to quarter sessions from the decision of the magistrates court. He would be able to apply for the patient's discharge to the medical superintendent or hospital management committee at any time, and should also have the right to ask for a review by a Mental Health Review Tribunal not more often than once a year.

(xv) We also recommend procedures for use in an emergency, or when a period of observation only is recommended.

(c) Procedures in court cases and transfers from prisons or approved schools

(Chapter 7, paragraphs 511–552)

(xvi) In any case in which it is suggested in evidence or appears to the court that a person found to have committed a criminal offence, or a child or young person brought before the court as in need of care or protection or beyond control, is mentally disordered, it should be possible for the court to obtain a medical report. In some cases it will be appropriate to seek a report from the diagnostic clinics mentioned in paragraph 51. The report should be made by two doctors, of similar standing to those who could give recommendations for compulsory admission to hospital or guardianship under the main procedures ; not more than one of the doctors should be a prison doctor. If the doctors consider the person to be mentally disordered the report should include advice, from the medical point of view, on the most suitable way of dealing with him. If care under the health or welfare services is recommended, the report must be accompanied by a statement of acceptance of the patient by the doctor who would be responsible for the treatment or training or community care which is recommended. For some patients penal measures may be more suitable than care within the health or welfare services. A combination of penal and medical measures may be desirable in some cases.

(xvii) If the court is satisfied, after receiving a medical report, that ordinary penal measures alone are insufficient or inappropriate and that the

patient requires hospital or community care which is available for him, such care should be provided with the knowledge of the court but without an "order" by the court. The court should also be required to dispose of the case under its normal powers and procedures, e.g., by absolute or conditional discharge or probation or by a fine. The usual procedures for admission to hospital or community care should then be used, the patient being admitted informally or under powers of control as appropriate. If compulsory detention in hospital or control under guardianship is necessary, the normal application for admission should be accompanied by the court's finding on the case.

(xviii) If a court of quarter sessions or assize is satisfied that there is a real danger of the commission of further and serious offences if the patient is discharged prematurely, it should have power to direct that the patient should not be set at large within a certain period without the consent of the Home Secretary. If during such a period the hospital authorities recommend the patient's discharge but the Home Secretary considers it premature for him to be set at large, other suitable arrangements should be made for the patient's custody. During such a period neither the patient nor his relatives should have direct access to a Mental Health Review Tribunal, but they should be able to apply at any time to the Home Secretary, who should be able to ask a tribunal to enquire into the case and report to him.

(xix) The patient's nearest relative should not have power to order the patient's discharge from hospital if admission follows court proceedings ; he should however be able to apply to the medical superintendent or members of the managing committee at any time, and if discharge is refused he should have access to a Mental Health Review Tribunal not more often than once a year, except when discharge has been made subject to the Home Secretary's consent.

(xx) When an adult psychopathic patient is detained in hospital or under guardianship following court proceedings, the need for the continued use of compulsory powers should be subject to annual review by the medical superintendent and members of the managing committee (or medical officer of health and members of the local health authority). If they recommend continuance there should also be a review by a Mental Health Review Tribunal on each occasion, except during any period in which discharge is subject to the consent of the Home Secretary.

(Chapter 7, paragraphs 553–6)

(xxi) The Home Secretary should be able to authorise the transfer to hospital or guardianship of persons in prisons or other penal institutions or in approved schools who are found to be mentally disordered. The procedure should be analogous to that recommended for use in court cases, i.e., the Home Secretary should authorise, not order, the transfer, and should previously have two medical recommendations and a medical acceptance. As for patients admitted immediately following court proceedings, the nearest relative should not have power to order discharge but the other normal powers of discharge should apply, except that the Home Secretary should be able to stipulate at the time of transfer, in cases in which he thinks it necessary, that discharge or absence on trial or transfer to guardianship should not be authorised without his consent during the remainder of the term of detention or imprisonment to which the patient was previously subject.

(d) Patients in hospitals and homes outside the national health service or in private care

(Chapter 12, paragraphs 824–841)

(xxii) We recommend several modifications of these procedures to apply when patients are received under compulsory powers into hospitals or homes outside the national health service or into the guardianship of private individuals.

(Chapter 12, paragraphs 819–823)

(xxiii) Notification to the local health authority should be required when a mentally ill or severely sub-normal patient or a psychopathic patient under the age of twenty-one is received into the care of a private person who is not a near relative in a place not registered as a nursing home or old persons' or disabled persons' home (see paragraph 55), whether or not the patient is under guardianship. Local health authorities should have power to visit these and other patients in certain circumstances.

(e) Application of new procedures to patients already in hospital or under guardianship

(Chapter 8, and Chapter 12, paragraph 842)

(xxiv) As far as possible, the principles of the new procedures should be applied to patients already in hospital or under guardianship when the new system comes into force, but some special arrangements will be needed.

The administrative organisation of the mental health services

(Parts II, V, VI and VII)

Chapter 2, paragraphs 128–131, and Chapter 9, paragraphs 576–591)

43. After a long period during which mental health services were administered separately from other health and welfare services, a general reorganisation of all such services took place in the years 1944–48. Broadly speaking, the services were re-arranged on a functional basis, instead of according to the category of persons who were to receive them ; the special needs of special groups of patients are now met within the framework of these general functional services, rather than under the authority of separate legislation. As part of this reorganisation, most of those parts of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts which had previously governed the public administration of the mental health services were repealed. Since 1948 the mental and mental deficiency hospitals and local authority community health services for the mentally ill have been provided as an integral part of our general health services under the general powers contained in the National Health Service Acts. Community health services for defectives are provided partly under these general powers and partly as a special duty still remaining under the Mental Deficiency Acts. There are still a few traces of the earlier system in some parts of the present law and administrative practice, which exclude mentally disordered patients from some other general social services, or which require patients to be ascertained or certified as mentally disordered before they may benefit from hospital or community health services.

Chapter 2, paragraphs 132–5, Chapter 9 and Chapter 10)

44. We consider it essential that the services for mentally disordered patients should continue to be an integral part of the general health and

welfare services. Similarly, no one should be excluded from benefiting from any other social service simply because his need arises from some form of mental disorder, if that service can suitably meet some or all of his needs.

45. Before 1948 the local authorities were responsible for all forms of institutional care for mentally disordered patients, as well as community care. Long-term residential care for those who needed it, as well as more active treatment and training, were provided in the mental deficiency institutions, and to a lesser extent in the mental hospitals, which thus fulfilled the functions of residential social welfare institutions as well as of hospitals. No distinction was made between these two functions when these institutions were transferred to the hospital authorities in 1948, and since then the hospitals have continued to provide residential care for defectives who need it on social grounds as well as for those who need specialist medical or nursing services. The hospital authorities rather than the local health authorities are also held responsible for the care of defectives living on licence in the general community after leaving hospital, for as long as the order under which their admission to hospital was originally authorised remains in force ; this sometimes continues for many years after the patient has left hospital. In the mental health field the local authorities thus relinquished to the new hospital authorities in 1948 some functions which properly still belong to them under their general powers as local health authorities or welfare authorities under the National Health Service Acts and National Assistance Act.

46. There is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients or which make it possible to discharge them from hospital sooner than was usual in the past. It is not now generally considered in the best interests of patients who are fit to live in the general community that they should be in large or remote institutions such as the present mental and mental deficiency hospitals. Nor is it a proper function of the hospital authorities to provide residential accommodation for patients who do not require hospital or specialist services, nor to provide other care for patients who have left hospital apart from necessary medical follow-up or out-patient services. The division of functions between the hospitals, local authorities and other official bodies should be broadly the same in relation to mentally disordered patients as in relation to others.

47. The general division of functions between hospitals and local authorities should be:

(i) The hospitals should provide in-patient and out-patient services for patients who need specialist medical treatment or continual nursing attention. This includes the care of helpless patients in the severely sub-normal group who need continual nursing, if proper care cannot be provided at home. It also includes in-patient training designed to promote the mental or physical development of severely sub-normal and psychopathic patients if such training requires individual psychiatric supervision, by which we mean that the patient's individual progress needs to be watched and if possible controlled by a psychiatrist. The aim of treatment or training is to make the patient fit to live in the general community. No patient should be retained as a hospital in-patient when he has reached the stage at which he could return home if he had a reasonably good home to go to. At that stage the provision of residential care becomes the responsibility of the local authority.

(ii) The local authorities should be responsible for preventive services and for all types of community care for patients who do not require in-patient hospital services or who have had a period of treatment or training in hospital and are ready to return to the community. This may involve the provision of day or residential training centres for some severely sub-normal children ; training or occupation centres and social centres for adult severely sub-normal patients, psychopathic patients or patients with residual disability after a mental illness ; residential accommodation in private homes or in homes or hostels provided by voluntary societies or by the local authorities themselves for many types of patients including old people with mild mental infirmity ; and general social help and advice to patients of all types and ages and to their relatives.

(iii) Social work for patients who are not receiving hospital treatment, including patients who have left hospital, is essentially the responsibility of the local authorities, who can also do a great deal in co-operation with the hospital staff for hospital out-patients and even for in-patients. There must be very close co-operation between the medical staff and social workers of the hospitals and local authorities to ensure the best use of the resources of each and maximum continuity in the care of individual patients. Arrangements to ensure such co-operation should be made in each local area. After-care should be provided by the local authorities as long as it is needed, and should not be dependent on the continuation of compulsory powers such as licence or guardianship.

48. This would involve a considerable expansion of residential and non-residential community health and welfare services. In developing these services the local authorities have a major part to play in the prevention and relief of all forms of mental disorder. It is essential that medical officers of health should take a personal interest in this work and have suitably experienced medical officers and social workers on their staff.

(Chapter 10, paragraphs 637–649)

49. Training centres for those severely sub-normal children who are unable to profit by education in ordinary or special schools should continue to be provided by the local health authorities rather than the education authorities. Local education authorities should however have considerable freedom to decide the range of training they provide within the school system, and should be allowed to cater for more children in the lower ranges of ability if they can make suitable arrangements for them. The procedures by which children are referred for training in training centres in place of education at school should be similar to those used when children are recommended for education in special schools ; children should not be declared "ineducable" but should be recommended for training in a training centre, which it would be the duty of the local authority to provide through its health department, or for training in hospital. Medical and dental services should be provided similar to those provided for school children.

(Chapter 10, paragraphs 650–3 and 668–672)

50. There should be close co-operation between the local authorities' children departments and health departments over the care of sub-normal children who cannot suitably live in their own homes. Officers of these departments should also keep in touch with any such children who are admitted to hospital.

(Chapter 10, paragraphs 681–9)

51. New arrangements are needed for the diagnosis and periodical re-assessment of patients who are thought to be severely sub-normal or psychopathic. Diagnostic clinics should be organised on much the same lines as the present child guidance clinics, but should deal with adults as well as children. In some areas it might be suitable to use the child guidance clinics as a nucleus for comprehensive mental diagnostic and consultative clinics for children and adults. There should also be arrangements for regular case-conferences between the medical and other staff of the hospitals and of the health, education, children and welfare departments of the local authorities, to decide on the form of care most suitable for individual patients. This would replace the present arrangements for the "ascertainment" of defectives. The clinics and case-conferences would also be available to prepare advice for the courts when offenders against the criminal law are thought to be suffering from mental disorder.

(Chapter 10, paragraphs 714–5)

52. At present the provision of some community services for defectives and the provision of residential accommodation for the aged and infirm are a positive duty of the local authorities. The provision of other community health and welfare services for mentally disordered patients is permissive only. In order to achieve the necessary expansion of community mental health services throughout the country, their provision for all groups of patients should be made a positive duty. The Minister of Health should use his existing powers to issue a direction to that effect.

(Chapter 10, paragraphs 716–724)

53. The provision of residential hostels and homes and more training, occupational and social centres will involve capital expenditure by the local authorities. Consideration should be given to means by which the expansion of these services can be expedited as far as is consistent with general economic policy, including the possibility of returning to the local authorities some of the smaller buildings now used by the mental deficiency hospitals where these are suitable for use as local authority homes.

(Chapter 11, paragraphs 726–744)

54. The central supervision of all health and welfare services provided by local authorities and hospitals is the function of the Minister of Health. A separate inspectorate such as that now provided by the Board of Control is not necessary. The Minister should have powers of control over the standards of residential homes or hostels provided by local health authorities similar to those which he possesses over old persons' and disabled persons' homes under the National Assistance Act, 1948.

(Chapter 12, paragraphs 792–823)

55. The local authorities should take over from the Minister of Health and justices of the peace responsibility for registering or approving hospitals or homes provided for mentally disordered patients by charitable societies or private individuals, which should become liable to registration under the Public Health Act, 1936, the Public Health (London) Act, 1936, or the National Assistance Act, 1948. It would be necessary to make several amendments to the relevant sections of these Acts. Local authorities should also take over from the Board of Control responsibility for the general oversight of patients in private houses which would not be liable to registration.

(Chapter 11, paragraphs 785–7)

56. The Minister of Health should consider whether the three State institutions should be brought within the national health service administrative system, or whether they should be managed by one or more specially appointed committees. In either case the committee(s) should include members who could visit the hospitals frequently to discharge the functions in relation to patients and relatives which we recommend should be undertaken by other hospital management committees.

(Appendix IV)

57. The Minister of Health should review the arrangements for the central collection of statistics about the mental health services.

Abolition of the Board of Control and of the Visitors appointed by justices

(Chapter 11, paragraphs 788–791)

58. Our recommendations would involve the abolition of the Board of Control, as we recommend other methods as more suitable in present conditions for carrying out all of its present purposes.

(Chapter 7, paragraph 454, and Chapter 12)

59. The functions of the Visitors appointed by justices in connection with the renewal of compulsory powers (under the present Mental Deficiency Acts) would be superseded by those of the Mental Health Review Tribunals. The local health authorities would take over their functions in connection with licensed houses.

Need for new legislation

Chapter 10)

60. Many of our recommendations for the development of community health and welfare services can be undertaken under local authorities' existing powers without new legislation, but there are some points on which amendment or clarification of the present law would be needed.

(Chapter 12)

61. The transfer to local authorities of responsibility for the registration or approval of hospitals and homes outside the national health service and for the general oversight of patients in private care would require new legislation.

(Chapter 2, paragraphs 137–145, and Chapter 13)

62. Our recommendations for new procedures to apply to individual patients and for the abolition of the Board of Control would entail the complete repeal of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts and their replacement by a new Act laying down the circumstances in which compulsion might be used in future and the procedures to be followed. We draw attention to various other statutes which would then need amendment.

PART I

INTRODUCTORY SURVEY OF THE PRESENT MENTAL HEALTH SERVICES

CHAPTER 1

The need for review

63. The proper treatment of people suffering from disorders of the mind, and any restrictions on the liberty of individual citizens which this may involve, are matters of public interest which may at any time become of immediate personal importance to anyone living in this country. Many different sorts of people with different knowledge and experience are involved in operating the laws which govern these matters. These include the patients' relatives as well as doctors, magistrates, public officials and social workers. Ideally, a branch of the law which may affect the liberty of any one of us and in whose operation any one of us may have to take an active part should be as simple and easily intelligible as possible. But our present laws on these subjects are complicated and difficult to understand, and very few people have any general knowledge of what they contain or how they work in practice.

64. Yet the questions with which this branch of the law sets out to deal are simple. What forms of care need to be provided for people who are suffering, temporarily or permanently, from various forms of mental illness or disability? Who should be responsible for administering these services? Are there circumstances in which some patients should be compelled to accept care against their will, or be subject to detention while under care, either for their own welfare or protection or for the protection of other people? If there are, how are we to ensure that powers of compulsion and detention provided for this purpose are not abused?

65. The answers to these questions need to be reviewed from time to time in the light of progress in medical knowledge and methods of treatment, changes in social conditions, movement of public opinion and the success or failure of existing legal and administrative provision. Legislation to deal with these matters in a comprehensive way started in England in the late eighteenth and early nineteenth centuries. During the nineteenth century they were frequently under review by Parliament. Apart from Acts which dealt solely with property or with criminal lunatics, over twenty Acts of Parliament were passed in the eighty-three years from 1808 to 1891 dealing with the care of mentally disordered patients in public or private institutions. During this period there were four consolidations of the law, the last being the Lunacy Act, 1890. In the sixty-five years since 1891 there have been seven Acts dealing with this subject and extensive amendments introduced by other more general Acts, but no complete restatement or consolidation of this branch of the law. Yet during this time there have been great advances in medical understanding and methods of treatment of disorders of the mind. There have been great changes in our general social services, many of which affect the care and treatment of mentally disordered patients. There has also been a change in the general attitude towards using coercion even for a person's own good. Some of these changes have led to amendments to our mental health legislation, but others have been ignored or only partially recognised in this branch of the law.

66. The last complete revision of our mental health laws was the Lunacy Act, 1890. A major addition to the law was made in 1913 by the first Mental Deficiency Act, after the report of the Royal Commission on the Care and Control of the Feeble-minded, 1904–08, which had reviewed these questions in relation to the whole range of mental illness and mental deficiency and had recommended more comprehensive new legislation. An important amendment of the Lunacy Act, 1890, was made by the Mental Treatment Act, 1930, after the report of the Royal Commission on Lunacy and Mental Disorder, 1924-26, which was concerned with mental illness only, but the general simplification of the law which the Royal Commission recommended was not undertaken. Major alterations in the administrative organisation of the mental health services were made by the National Health Service Act, 1946, and other social legislation in the period 1944-48. The present position therefore is that the law is based on Acts which were passed in 1890 and 1913; both these Acts have been extensively amended, but both still embody many general assumptions and attitudes which were current in the late nineteenth and early twentieth centuries but which are not in accordance with present thought. Our present mental health legislation considered as a whole is extremely complicated and also in many respects badly out of date.

The public attitude today and our own general approach

67. The general public now know more about mental illness and are more sympathetic to people suffering from it than ever before. An increasing number of people have friends or relatives who have been patients in mental hospitals, most of whom have spent a few weeks or perhaps months under treatment and have then come home to resume their normal lives, and first-hand knowledge of the mental hospitals and what they are doing is spreading in this way. Some mental hospitals also have annual "open days" on which members of the public are invited to visit the hospital. Members of the general public also learn about the work of the mental hospitals from time to time through the press, wireless or television. Popular interest in science and medicine certainly extends to psychology and psychiatry, and has led to the publication of excellent popular books on these subjects. Indeed, we believe that most people today would at least pay lip-service to the principle, which has been repeated to us by witness after witness, that the mentally ill are sick people and that the mental hospitals should be thought of primarily as hospitals for the treatment of illness. There is, nevertheless, still a great deal of ignorance and prejudice towards anything "mental" which will not be overcome if it is ignored or discounted. Sensational and unthinking articles sometimes appear in the press and cause a great deal of distress to patients' relatives. But public opinion in general is moving towards a more enlightened attitude, which is fostered and encouraged by the progress which has been made during the last fifty years in the understanding and treatment of mental disorders.

68. But very few people indeed, even among those who have themselves been patients in mental hospitals or have had friends or relatives there, know very much about the procedures and formalities connected with these hospitals. This contrasts with general familiarity with other social services such as schools, general hospitals, employment exchanges, family allowances, pensions and sickness and unemployment benefits. Workers know that they cannot get sickness benefit without a certificate from a doctor and without having enough stamps on their insurance cards. Most people know that if they need to go to hospital this will usually be arranged in the first place by their family doctor. But the procedures which must be followed

when patients are admitted to mental or mental deficiency hospitals are so complicated that even people who have had personal experience of them have only a vague idea of the procedures which they themselves have used and certainly do not know about the whole elaborate system. Those who have never had personal contact with the mental health services are almost completely ignorant of how they work in practice.

69. Because of this, when people hear of these procedures having been used in a particular case they often think that the law is being misapplied. For instance, people with a friend or relative who has been a patient in a mental hospital and who has come out well or much better than when he went in do not think of him as "a person of unsound mind", or as the sort of person who ought to have been "certified". Others are very indignant when they hear of people who have become mentally disordered in their old age being "certified". Even people who accept the idea that mental illness is susceptible to medical treatment like other illnesses frequently think that, in contrast to this, "certification" carries the implication of permanent mental derangement or life-long or hereditary mental instability. As a result, they tend to draw a distinction between people who are temporarily ill or whose mental illness is known to be due to physical causes or who have no mental illness until late in life and other people, usually unknown to them, whom they describe as "really mental" and for whom they consider "certification" to be appropriate. Few people realise that "certification" is simply a procedure for admission to hospital which has to be applied under the present law to many patients who are expected to recover quite quickly after proper treatment, and that for many old people it is the only method of admission to the hospitals which provide the expert medical and nursing care which they require.

70. Most people know even less about mental deficiency. In the first place, few people know what the distinction between mental deficiency and mental illness is. They may know families with a child who is obviously abnormal, and they may include such children in their idea of the "really mental" people. On the other hand, increasing popular interest in the nature of mental disorders and a growing public sympathy with handicapped children, particularly the physically handicapped, are bringing some people, rather slowly perhaps, to a more understanding attitude towards children who are born mentally handicapped or deformed. In either case, when people think of mental defectives they tend to think of children or adults with severe mental defect, who are usually also abnormal in appearance. They dislike the (mistaken) idea that old people, or people who recover from short-lived mental illnesses, are through certification identified with defectives of this sort. They also see no connection between these more severely handicapped defectives and some young people they may read about in the newspapers who look perfectly normal and can do a normal job but are nevertheless also "certified" as "mental defectives". Popular scientific books and press articles or wireless programmes do not tell them much about these high-grade defectives or the reasons why the present Mental Deficiency Acts apply to them.

71. A good deal of publicity is given to discussion of the mental condition of people who have committed serious crimes, particularly crimes of violence. When such a crime is committed by a patient from a mental or mental deficiency hospital, or by a person who has some time previously been a patient, the fact may be reported in the press. Quite apart from this, the mental state of other offenders is often a subject of evidence at their trial, and there is considerable public interest in scientific discussion of the interrelation between abnormal mental conditions and crimes of

violence or criminal behaviour of any sort. Many people probably include in their idea of people who are "really mental" and ought to be locked up the type of person who appears to have no control over violent impulses or no appreciation of the moral or social implications of such behaviour. The word "psychopath" is finding its way into our common vocabulary in this connection. Many people seem to assume that when a criminal is found to be mentally abnormal in this way he can be certified and sent to Broadmoor or some similar place. They do not realise that many criminals who have committed violent or sexual crimes, and whose mental condition is generally agreed to be abnormal, cannot under the present law be certified as of unsound mind, and that comparatively few can be certified as mentally defective. Some people who do appreciate this think it wrong that such people should be treated as fully responsible for their actions and sentenced to imprisonment. Others think it wrong that they should be released after a comparatively short time when their mental abnormality and their violent propensities are unchanged. Many people find it difficult to understand why a person who has become mentally confused in old age and needs to be taken care of, but is no danger to other people, should be certified, while this cannot be done to people whose mental abnormality is known to make them potentially dangerous criminals.

72. So there is a good deal of rather confused thinking about mental disorder and little real knowledge of the procedures which the law lays down for use in the mental health services. If these were more widely known and understood, there would, we feel sure, be public criticism of a different kind. The idea of a sinister class of person who is "really mental", who needs to be certified and locked up, would probably fade. People would find that, although those who administer the mental health services look on their work as a social service comparable with other branches of medicine or of social welfare, the administrative procedures which the law requires them to use reflect an attitude towards the patients these services are designed to help which is quite different from the attitude which underlies our other social services today. They would ask why this is so, why some of the procedures are necessary at all, why others are so complicated, what purpose they are meant to serve, whether in fact they do serve that purpose, and whether it is a purpose which most people today would still think right.

73. That is the spirit in which we ourselves have approached these subjects. In this report we describe as simply as we can what the present law is and the ways in which we think it should be altered, bringing out the main principles from the mass of detailed rules and regulations in which they are embodied. In the rest of this chapter we explain briefly what is meant by mental illness and mental deficiency and the forms of care which are now thought appropriate for mental patients. This general outline of the present mental health services is supplemented by the statistics contained in Appendix IV. In Parts II to VIII of our report we discuss the legal and administrative aspects of the subject in more detail and make recommendations for many changes.

Mental disorder, mental illness and mental deficiency

74. It is inconvenient that there is at present no single expression in common use which covers all forms of mental ill-health. "Mental illness" would seem the obvious term to use, but in practice this is usually applied to a group of mental disorders which includes neither mental deficiency nor the still rather obscure forms of mental abnormality which are sometimes called "psychopathic states". The Royal Commission on the Care and

Control of the Feeble-minded, which reported in 1908, used the term "mental defect" to include the whole range of mental ill-health, but the term "mental defect" or "mental deficiency" is now almost always used in the narrower sense given to it in the Mental Deficiency Acts which were passed after that Commission reported. In this report when we want one expression to refer to the whole range of abnormal conditions of the mind we use the term "mental disorder". We prefer this term to either "mental abnormality" or "mental disability", as either of these other terms might seem to imply, erroneously, that all through his life everyone is either normal or abnormal, either fully capable or disabled, whereas in fact many forms of mental disorder last only a short time. We also prefer the term "mental disorder" to the term "mental unfitness" which we considered as an alternative. We realise that the term "mental disorder" is sometimes used at present as a synonym for mental illness, but in that limited sense it is much less commonly used than the term "mental illness" and it is not so used, as far as we are aware, in any statute. We do not consider that using the term "mental disorder" in this comprehensive sense should lead to misunderstanding or confusion, and we prefer it to any alternative that we have been able to think of.

75. Long before the days of modern psychiatry and psychology, when only the extreme forms of mental disorder were recognised as such, a distinction was drawn between people who had been seriously abnormal all their lives, and those who became irrational, for long or short periods, after growing up and being fully rational. It was seen that children who were born mentally and physically deformed usually remained helpless all their lives, whereas people who lost their reason for the first time in adult life sometimes recovered it, and there were obvious differences between the behaviour of "fools" and "madmen", or, as they were called in the law, "idiots" and "lunatics" (or "persons of unsound mind"). Much more is now known about the development and working of the mind, many more varieties and degrees of disorder are recognised, and many different methods of treating them have been evolved. But a broad distinction is still drawn in medical, legal and administrative practice between two main groups of patients, the mentally ill and the mentally defective. The term "mentally defective" is used of patients whose minds have never fully developed or (if they are children) seem unlikely to do so. The term "mentally ill" is applied to patients whose minds have previously functioned normally and have become affected by some disorder, usually in adult life. A person who is mentally defective may develop a mental illness in addition.

76. Our present mental health legislation consists of two separate series of Acts of Parliament, the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts. The Lunacy and Mental Treatments Acts apply to the mentally ill. The nineteenth century Lunacy Acts, which preceded the present Lunacy and Mental Treatment Acts, applied to all the forms of mental disorder which the law then recognised, including some forms of mental defectiveness. The Lunacy Act, 1890, which, much amended, remains in force as the principal Act of the present Lunacy and Mental Treatment Acts, still applies to "idiots" as well as "persons of unsound mind", but since the first Mental Deficiency Act was passed in 1913 few defectives have been certified under the Lunacy Act. The Mental Deficiency Acts apply to mentally defective patients only. They contain a legal definition of mental defectiveness and of four classes of defectives, who are called idiots (the most severely handicapped), imbeciles, feebleminded persons and moral defectives. We describe these four classes of defectives in more detail in Chapter 3.

77. The basis for this distinction between the mentally ill and the mentally defective is practical rather than scientific. Broadly speaking, people who develop a mental illness in adult life and people who have been mentally retarded since birth or childhood need and receive different forms of care and treatment. On the other hand, the term "mental defectiveness" as well as the term "mental illness" covers a wide range of mental conditions, and there is a body of opinion which considers that it would be more suitable to treat some forms of mental deficiency in the same hospitals as the milder forms of mental illness than to accommodate all types of mentally defective patients together in one hospital. It is also a fact that some diseases which affect the brain, at whatever age they occur, result in a mental condition similar to that of a person whose mind has never fully developed, and general degeneration of the mental faculties in adult life sometimes has a similar result.

78. One of the questions on which we received a great deal of evidence, and on which opinions differ widely, is whether the term "mentally defective" should be confined to people who are sub-normal[1] in intelligence, or whether it should also be applied, as it sometimes is at present, to some whose intelligence is normal,[1] being near or even above average,[1] but who show serious lack of maturity in other aspects of their personality. This question is closely related to the problems arising from forms of mental disorder resulting in abnormal and anti-social behaviour which are often referred to as psychopathic. We discuss these questions in Chapter 3.

79. Although there is a great deal which is still not fully understood about the causes and characteristics of mental disorders, a wide variety of forms of disorder are now recognised and many illnesses which, if untreated, might become severe and perhaps incurable can often be recognised at an early stage and successfully treated. Much can also be done towards the cure or improvement of conditions which, not many years ago, were considered incurable, and towards the social rehabilitation of those who in the past would have been considered incapable of living outside an institution. During the present century many new methods of care and treatment have been developed and applied both to mental illness and to mental deficiency. But this is only a beginning; though treatment for mental illness is far more successful than it was even twenty years ago, its development is still at an early stage and much remains to be discovered. It is not necessary for us to describe the various forms of mental disorder in detail, but we should like to emphasise the following general points.

80. Mental illnesses, even of the same type, may vary in their severity. One person may overcome a mild depression without serious interruption of his normal life; another may be more deeply affected and find himself unable to carry on with his usual duties; another may sink into a mood of profound depression and despair with feelings of unworthiness and suicidal tendencies. The first may pass unnoticed by his neighbours; they may describe the second as having a "nervous breakdown", and the third as "really mental". But all three are suffering from the same type of illness in varying degrees of severity. There is no good reason for sympa-

[1] In common speech a distinction is not always drawn between the use of the words "normal" and "average". We differentiate between them. Qualities such as height or intelligence vary from one individual to another. The variation is distributed over a wide range on each side of the "mean" or "average". Small deviations from the mean are common and large deviations are rare. We use the term "average" in relation to intelligence to indicate an intelligence quotient of approximately 100. We apply the word "normal" to the range on each side of the "average" in which the great majority of individuals are found.

thising with one and regarding another as a person to be shunned and avoided.

81. Some forms of mental illness are known to have organic, social or psychological causes; the causes of others are not yet known. Some of those which can be attributed to a known cause may involve disturbances of behaviour or mental deterioration no less severe than those which occur in illnesses whose causes are still unknown. Some of the illnesses whose cause is unknown may be equally, or even more, susceptible to treatment than some of those whose cause is known.

82. The degree of disturbance of a patient's behaviour is no guide to the prospects of recovery. A person whose behaviour is so peculiar or violent or who has become so irrational that anyone would call him "quite mad" may be suffering from a type of illness for which a psychiatrist may most confidently hope treatment to be successful.

83. Most mental illnesses can occur at any age. An old person may develop one of the forms of mental illness which occur also in younger people, and the illness may respond to treatment in an old person as well as in a young person. The type of mental disturbance or degeneration which is called senile dementia when it occurs in old people may start in early middle age. The type of treatment needed depends on the type of the illness and the severity of its symptoms in any patient, rather than on the patient's age.

84. Some lack of intelligence does not in itself make a person mentally defective. There are many people with a low level of intelligence who manage for themselves without any special form of care. It is only when arrested or incomplete mental development (which may include lack of intelligence) makes a person incapable of managing without special care that he is regarded as mentally defective.

85. The severe forms of mental defect are much rarer than mild forms (see page 310 in Appendix IV). Most patients with mild mental defect (the feebleminded) live and work in the general community, earning their own living and managing their own lives, gaining the special support which they need from relatives and friends or from the services provided by the local health authorities. It is only a minority of feebleminded patients who require training under psychiatric supervision in hospital; the aim of such training is to develop their characters and to teach them how to live and work with other people in spite of their underlying disability; after a period of training many of these patients return to an independent life in the general community.

Present forms of care and treatment and how these services are organised

(i) General

86. Mental disorders are forms of ill-health, and care and treatment are usually based on medical diagnosis and advice. This may be given by a general practitioner, a specialist in psychiatry, or a doctor working in the school health service or for the local health authority. In the past treatment was mainly institutional, but now a great deal of medical treatment and social care is given to mentally ill and mentally defective patients while they continue to live and work in the general community. Care and training are provided for many more defectives (children and adults) through community mental health services than in hospitals (see statistics in Appendix IV). More mentally ill patients now attend psychiatric clinics as out-patients each year than are admitted for in-patient treatment, not to

mention the still larger number of patients with milder forms of illness who are treated by general practitioners. In the past the state's primary duty towards mentally disordered patients was considered to be their compulsory detention for care or custody. This view is now out of date, as in present conditions most patients could be given care or treatment without using compulsory powers. But the idea that treatment involves detention still underlies much of the present law, and for some types of patient the law operates to prevent hospital in-patient treatment except with powers of detention. This is one of the main reasons why the law now needs revision.

87. Social care and treatment are of particular importance in the treatment of all forms of mental disorder. The social environment in which a person lives, the extent to which he has developed an active social life, and the amount of sympathy, understanding and support which he receives from and can give to other people are very important to his mental health. Indeed, mental health in its widest sense embraces the whole field of human relationships and human behaviour, and many forms of mental disorder are evidenced by, and often arise from, disturbance in a person's relationship with other individual human beings or with the society in which he lives. A good social environment will help a person to avoid a serious emotional breakdown; whatever the form of mental disorder and whatever its symptoms, social support may help him to overcome it and reduce the practical difficulties which arise from it. It is, therefore, not only the patient's individual characteristics but also other people's attitudes to him and the material and economic conditions of his life which need to be taken into account in the care and treatment of mental disorder. Much of the preventive work which can be done in the present state of knowledge is in the social field. The provision of social support, under medical direction where necessary, is often enough to enable a person to overcome an illness or to lead a happy and useful life in spite of continuing mental weakness.

88. The care of mentally disordered patients therefore includes social services of various kinds as well as personal medical treatment inside and outside hospital. Special forms of education are also provided for children who are mentally retarded or maladjusted, and special forms of training and occupation for other children and adults. In the following paragraphs we describe present forms of care and treatment under three headings: diagnosis and "ascertainment"; community care; and hospital treatment or training.

(ii) **Diagnosis and "ascertainment"**

89. Most mental illness in adults is first brought to the attention of general practitioners, by the patient himself or by his relatives. If the symptoms are not severe, it may also be treated by the general practitioner. If the general practitioner wishes to refer a patient to a psychiatric specialist, he can arrange, according to the facilities available locally, as for any other type of illness, for the patient to be seen by a specialist at a hospital either as an out-patient or as an in-patient, or if necessary to be visited in his own home.

90. Early mental illness or maladjustment in children may first come to the notice of a general practitioner or of a doctor working at a child welfare clinic or of a school doctor. In most parts of the country there are child guidance clinics for the investigation and treatment of children with behaviour disorders or other difficulties which call for psychiatric investigation; the school health service and the hospital service co-operate in organising and staffing these clinics. There are also a few special hospital units for in-

patient treatment of mental illness in children. A recent development is the recognition of the part which can be played in the promotion of mental health in children by advice given to parents through the general maternity and child welfare services.

91. It is often the general practitioner who sees the first signs of mental deficiency in a child. The severest forms of defect may be apparent from birth, but more often the first sign is general backwardness of development which parents may report to their family doctor or which may be noticed at a child welfare clinic or when the child goes to school. Local health authorities (the county and county borough councils) are responsible for "ascertaining" persons in their area who are mentally defective and who need care or supervision in circumstances which, in the language of the Mental Deficiency Acts, make them "subject to be dealt with". Local education authorities are responsible for informing the local health authorities of any children who are considered incapable because of disability of mind of receiving education at school. When a child is known or thought to be mentally defective, either before school age or after he has started attending school, it is usual for arrangements to be made for him to be examined by a medical officer employed by the local authority, who will recommend whether the child is capable of attending school, or whether he should receive care and training under the community mental health services provided by the local authority itself, or whether he needs care or training in a mental deficiency hospital. Children who are thought to be mentally defective are not usually referred to the child guidance clinics; a few children referred to those clinics may be diagnosed as mentally defective, but the clinics are intended mainly for children who are emotionally maladjusted or suffering from an early mental illness, not for those who are mentally defective.

92. Some children who have remained at school until school-leaving age, including many who have attended special schools, are considered to need further supervision after leaving school because of mental disability. The local education authorities may report them at that stage to the local health authorities and they may then be "ascertained" as mentally defective.

93. Serious behaviour difficulties may arise in childhood, adolescence or adult life from lack of proper emotional development, whether or not accompanied by intellectual subnormality or retardation, and may in some cases lead to a diagnosis of mental defectiveness; we describe these forms of disorder at length in Chapter 3; they raise special difficulties of diagnosis, terminology and treatment.

94. In Chapter 10, paragraphs 681–689, we discuss the administrative arrangements for the diagnosis of all forms of mental defect in children and adults and for the selection of the form of care most suitable for each individual patient.

(iii) **Community care**

95. There are two types of services which may help people suffering from some degree of mental disorder who are living in the general community. The first are general services which are not provided primarily in relation to mental disorder but may help to prevent difficulties which might lead to mental disturbances, or may provide useful social support whether the need for that support arises from mental or other causes. Those with a preventive value include organisations which help people to develop an active social life, such as social clubs, youth organisations, community centres and old people's welfare services, and other services such as the work of marriage guidance councils. Those which provide general social support include the general local health and welfare services, national insurance and national

assistance, and the employment services including those for disabled persons. All these can be used to help people who are incapacitated temporarily or permanently by mental as well as other difficulties, and many who are suffering from mild forms of mental illness or defect do not then need to make use of the more specialised mental health services. These general services can also be used to supplement more specialised forms of care.

96. Secondly, there are various forms of care specially intended to help mentally disordered adults or children or to prevent mental illness. These include special forms of education or training for children, and special forms of training or occupation for adults: advice to the parents of mentally defective children on how to care for them and help them to make the most of their limited abilities: general advice and help to adult defectives including help in finding suitable employment: general advice and help to the mentally ill or infirm and to their relatives: and after-care for patients discharged from hospitals.

97. Voluntary societies have done, and are doing, much valuable pioneer work in the field of community care for mentally ill and mentally defective patients. Local authorities also now have wide powers to provide community care and a duty to provide some specific services, as described in the following paragraphs.

98. Some children who are mentally retarded or maladjusted receive special attention within the educational system. Under the present Education Acts this may be provided in ordinary schools in special classes or by other special arrangements, or the children may attend special schools. A distinction is drawn between children who are "educationally sub-normal" and children who are "maladjusted", though some children may be both. Educationally sub-normal pupils are defined as those who need a specialised form of education "by reason of limited ability or other conditions resulting in educational retardation"; maladjusted pupils are those who "show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational re-adjustment".[2] Children who are considered by the education authorities to be incapable, owing to mental disability, of receiving education at school at all are reported to the local health authorities who become responsible for arranging suitable care or training.

99. Local health authorities have a general duty under the Mental Deficiency Acts to provide suitable training, occupation and general social care in the community for defectives who have been "ascertained" as "subject to be dealt with" under those Acts but who do not need to go into a mental deficiency hospital or other institution. They also have power (but not a duty) under the National Health Service Acts to provide these or other forms of community care for defectives who have not been ascertained. Occupation and training for mentally defective children reported as ineducable who do not go into hospital may be provided at special centres called "occupation centres" or by training at home. Training and occupation are also provided, either at occupation centres or in hospitals, for some adult defectives, including some who as children attended special or ordinary schools, to fit them for normal employment later or as a permanent form of sheltered employment or occupation.

100. Most defectives receiving community care are not under compulsory control. These patients are described as "under voluntary supervision" if they have not been ascertained as "subject to be dealt with", and as "under statutory supervision" if they have been ascertained. Defectives

[2] School Health Service and Handicapped Pupils Regulations, 1953, S.I. 1953 No. 1156.

who have been ascertained may also be placed under guardianship (or sent to an institution). Guardianship gives the guardian legal authority over the defective equivalent to that of a parent over a child under the age of fourteen. The Mental Deficiency Acts do not provide for the local health authority itself to be appointed to act as guardian; the guardian must be an individual person but may be an officer of the local health authority. There are, therefore, three groups of defectives receiving community care from the local health authorities: those under guardianship, those under statutory supervision and those under voluntary supervision. The numbers in each group are shown in Tables 5a and 5b in Appendix IV.

101. Local health authorities also have power (but not a duty) under the National Health Service Acts to provide community care for mentally ill patients and services for the prevention of mental illness. As welfare authorities, the county and county borough councils also have a general duty under the National Assistance Act, 1948, to provide residential accommodation for persons in need of care and attention which is not otherwise available to them, and power to provide other services for handicapped or disabled persons. Adults who are handicapped as the result of mental illness or mental defect may also be eligible for registration as disabled persons under the Disabled Persons (Employment) Act, 1944, and if suitable may receive training, sheltered employment or other assistance under that Act, together with other disabled persons.

102. Some local authorities are more active than others in providing community care. We have received many suggestions for the development of these services. Our attention has also been drawn to problems which arise over the allocation of functions between local authorities and hospitals, and over the extent to which community care for children and adults suffering from various degrees of mental disorder should be provided by local authorities as part of their health services, education services, welfare services or child care services. We discuss these questions in Part V of our report.

(iv) **Hospital treatment or training**

103. Many forms of treatment are now provided for mentally ill patients in hospital. These include various physical methods of treatment (such as electro-convulsive therapy, therapeutic drugs and surgical treatment), various forms of psychotherapy, and the provision of a stable and ordered social environment with suitable daily occupations. Many of these forms of treatment can be given in out-patient clinics, as well as to in-patients.

104. Very few in-patients in mental hospitals are in bed during the day. Most of them are in good physical health. An important aspect of treatment is the provision of suitable occupation and recreation, whether inside or outside the hospital premises. Most mental hospitals have large grounds which provide opportunities for exercise and recreation, and many patients also go outside the hospital grounds to local shops, cinemas and so forth. Some patients go regularly to daily work outside the hospital; others are provided with various forms of occupation in the hospital itself, either helping in one of the hospital's departments such as library, kitchen, laundry or gardens, or undertaking some form of handcraft such as needlework, carpentry, pottery, etc.

105. In-patient treatment for mental illness is provided in hospitals within the national health service, and in a few "registered hospitals" (voluntary hospitals) and "licensed houses" (private nursing homes) outside the national health service. Some national health service hospitals are "designated" by the Minister of Health as "mental hospitals". Designated

mental hospitals, registered hospitals and licensed houses may admit patients only under the procedures laid down in the Lunacy and Mental Treatment Acts as "voluntary", "temporary" or "certified" patients. No one may be admitted as a voluntary patient unless he can give positive expression of his wish to be admitted by a valid signature on an application form. Other patients may be admitted only as temporary or certified patients, and are then subject to detention. Hospitals or nursing homes which have not been designated, registered or licensed may be "approved" by the Minister to receive voluntary or temporary patients only; these patients are subject to the procedures laid down in the Mental Treatment Act. Another form of "designation" allows hospitals in the national health service to receive and detain patients for short periods under the emergency procedures laid down in Sections 20 and 21 of the Lunacy Act, 1890: these are commonly referred to as "Section 20 hospitals" or "observation wards". Designated mental hospitals as well as other hospitals may be designated under Section 20. Other general and special hospitals which provide psychiatric treatment have not been "designated" or "approved"; these admit patients without using the Lunacy and Mental Treatment Acts procedures and have no power to detain patients against their will.

106. Most psychiatric out-patient clinics for mentally ill patients are held at general hospitals, which are usually more easily accessible than mental hospitals. In the last few years a few mental, geriatric and other hospitals have started departments known as "day-hospitals" which provide treatment or occupation during the day for patients who can return home to sleep at night; these are for patients who need a more intensive form of treatment than that normally provided for out-patients attending clinics for an hour or so at a time, but who do not need to be admitted as in-patients. These services are provided under ordinary national health service arrangements and are outside the purview of the Lunacy and Mental Treatment Acts.

107. Appendix IV gives some information about the number of in-patients and out-patients receiving treatment for mental illness, their age, and how long they stay in hospital.

108. In mental deficiency hospitals, some of the most severely disabled patients are physically as well as mentally handicapped and are unable to move without assistance. Even these patients are usually out of bed during the day, and are trained to develop the use of their limbs as far as possible. These severely disabled patients are a small minority. The great majority are physically fit but suffering from a very wide range of forms and degrees of mental disability. For these patients, as for mentally ill patients, a wide range of occupations and recreational facilities are needed. Some patients are capable of only the simplest occupations, but the higher-grade patients can be trained to work in normal employment. The object of training higher-grade patients is to give them a sense of social values and a more stable temperament, so that they may become capable of living and working with other people in a generally acceptable manner. Most mental deficiency hospitals have many types of occupation rooms and workshops, and many patients go to work outside the hospital. Recreations are provided in the hospitals, and patients also sometimes visit local cinemas and shops and have various other outings.

109. Almost all the hospitals in the national health service which provide care or training for defectives have been "directed" by the Minister of Health to be used as "institutions for defectives". These hospitals normally admit patients only under the procedures laid down in the Mental Deficiency

Acts, all of which authorise the patient's detention. Since 1952, these hospitals have also been encouraged to admit patients for short periods without using these procedures; the patients are not then subject to detention. Outside the national health service there are "certified institutions", which admit patients under the Mental Deficiency Act procedures, and "approved homes", which are not allowed to detain patients.

110. Very few mental deficiency hospitals undertake any out-patient work, but a few arrange with local health authorities for children living near the hospital to receive training by attending daily at the hospital instead of attending a local health authority occupation centre.

111. Appendix IV includes some information about the age and length of stay of patients in mental deficiency hospitals. Of the patients admitted in recent years, about two-fifths have been admitted in childhood, about a fifth between the ages of fifteen and twenty and about two-fifths over the age of twenty.

112. The procedures for the admission and discharge of hospital in-patients, the use of compulsory powers in this connection and other procedures laid down under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts have been among the main subjects of our enquiry. We describe the main features of the present procedures briefly in paragraphs 116-127 of this chapter, and discuss them fully in Parts IV, VI and VII of our report.

113. Our terms of reference exclude consideration of the organisation of hospitals and of the treatment provided in them, but we are aware of the difficulties with which many psychiatric hospitals are at present contending in the form of shortage of accommodation, overcrowding, old and unsuitable buildings and staff shortages. It has been suggested to us that, for various historical and other reasons, there are many patients in both mental and mental deficiency hospitals who have either never needed or no longer need the specialist medical and nursing care which it is now their main purpose, as hospitals, to provide. We deal with this question in Part V of our report where we discuss the allocation of functions between the hospitals and the local authorities.

Functions of the Ministry of Health and Board of Control

114. These two central government departments both have responsibilities towards mentally disordered patients. The Minister of Health is given various duties under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts and also has responsibilities in regard to all hospital and community services provided under the National Health Service Acts and National Assistance Act. The duties of the Board of Control are derived almost entirely from the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. The present position is that, broadly speaking, the Minister of Health is responsible for the central supervision of local authority services and of national health service hospitals, and for the registration, licensing, certification or approval of most hospitals, homes and institutions outside the national health service, while the Board of Control is responsible for matters affecting individual patients and the procedures applied to them, especially the procedures which authorise detention. The functions of the Minister and of the Board overlap in various respects, particularly over national health service hospitals and the patients in them. There are differences of opinion on what functions ought to be discharged by central government departments in relation to mentally disordered patients and on whether these duties should be in the hands of two separate authorities as

they are at present. In Part VI of our report we describe the historical background to the present position and discuss arrangements for the future.

Procedures laid down in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts

115. The procedures are set out in more detail in Appendix II, and are discussed in Parts IV, VI and VII of our report.

(i) Lunacy and Mental Treatment Acts

116. Patients may be admitted to designated mental hospitals, registered hospitals, and licensed houses (or received into the care of private individuals as "single patients") as voluntary, temporary or certified patients only.

117. Voluntary patients are required to sign a written application at the time of admission, unless the patient is a child in which case the application is made by his parent or guardian. The patient is not subject to detention but is required to give seventy-two hours notice of intention to leave. A patient may not remain as a voluntary patient for more than twenty-eight days after losing the power to express willingness or unwillingness to remain.

118. A patient who is incapable of expressing willingness or unwillingness may be admitted as a temporary patient and detained for a period of up to six months which may be extended up to twelve months in all. He may not remain as a temporary patient for more than twenty-eight days after regaining power to express willingness or unwillingness.

119. Other patients can be admitted only as certified patients, under various alternative procedures. Certified patients are subject to detention, though the power to detain them expires if not renewed at certain statutory intervals.

120. The procedures laid down for temporary and certified patients are intended partly as safeguards against improper detention. They include orders and certificates before admission, medical reports after admission, powers of discharge, periodic reviews of the necessity for care and detention, inspection of documents, visits to patients and the right of patients to correspond freely with various authorities. Temporary patients are admitted on the application of a relative (or of a local authority officer acting at a relative's request) supported by two medical recommendations; no judicial order is required. The order for the admission of a certified patient, except for short periods in an emergency, must be made by a justice of the peace or other judicial authority, but the nearest relative has power to order the patient's discharge at any time subject only to a barring certificate by the doctor in charge which may be given only if the patient is dangerous. In an emergency, admission may be arranged by a relative or a local authority officer with one medical certificate and no judicial order, but the patient may not be detained under such an order for more than seven days.

121. Sections 20 and 21 of the Lunacy Act, 1890, lay down procedures for the admission of patients in an emergency to hospitals designated for this purpose (see paragraph 105). Under Section 20, admission is ordered by a duly authorised officer without a medical certificate and without a judicial order, though he must report his action to a justice of the peace and the patient may not be detained for more than three days without a medical certificate. If such a certificate is given (under Section 21A of the Act) he may be detained for a further fourteen days. Patients admitted under Section 20 are not "certified patients" in the technical sense, in spite of the fact that if a medical certificate is given to authorise detention beyond three days it "certifies" that the patient is "of unsound mind".

Partly for this reason, the Section 20 procedure, which was originally intended for use in emergencies only, is now often used in order to obtain a short period of observation and treatment in hospital "without certification", during which the patient may recover or become willing to become a voluntary patient.

122. An order for the admission of a certified patient is regarded as mandatory, except in exceptional circumstances, rather than merely as an authority for the hospital to admit and detain the patient.

123. The Lunacy and Mental Treatment Acts and Rules contain detailed regulations for the keeping of clinical and other records, visits to patients by members of the hospital management committee and commissioners of the Board of Control, the supply of information to the Board about the staff of the hospital and about the admission and discharge of patients, and for the inspection of the hospital by commissioners of the Board. These apply to hospitals which have been designated or approved under the Lunacy and Mental Treatment Acts, and to registered hospitals and licensed houses, but not to hospitals which provide psychiatric treatment outside the purview of these Acts.

(ii) **Mental Deficiency Acts**

124. Hospitals which have been directed to be used as institutions for defectives, and certified institutions outside the national health service, do not normally admit patients except under the procedures laid down in the Mental Deficiency Acts. An important exception is the recent practice mentioned in paragraph 109 of admitting patients for short periods without formality; these patients are usually referred to as patients admitted "under Circular 5/52", because it was in a circular with that reference number that the Minister of Health recommended local health authorities and hospitals to arrange these informal, short-term admissions.

125. The procedures laid down in the Mental Deficiency Acts all involve the detention of the patient and require medical certificates or other medical evidence of the patient's mental defectiveness before admission. Certain defectives may be "placed" in hospital (or guardianship) by their parents or guardians. More usually admission is by order of a specially appointed justice of the peace, who may make an order only when it is shown not only that the patient is a defective as defined in the Acts but also that he is "subject to be dealt with" on one of the grounds specified in the Acts. Orders for admission to hospital (or guardianship) may also be made by courts when a defective is convicted of a criminal offence punishable by imprisonment or is found liable to be sent to an approved school. Defectives already in prison after conviction on a criminal charge, or in an approved school, may be transferred to a mental deficiency hospital (or guardianship) by order of the Home Secretary. The need to detain each defective is reviewed at specified intervals, and there are other safeguards including inspection of documents and visits to patients. The procedures differ in detail from those laid down for certified mentally ill patients under the Lunacy Acts. No patient may be finally discharged without the order or consent of the Board of Control, except on the occasion of a special review by Visitors appointed by justices when the patient reaches the age of twenty-one.

126. Defectives may live outside the hospital or institution on licence without a break in the order for their care by the hospital; when on licence they may be recalled to the hospital at any time, and the conditions under which they live and work are controlled by the hospital. It is usual for a defective to have a period on licence before the order is finally discharged.

The order may be renewed while he is living away from the hospital on licence, and sometimes defectives remain on licence for many years.

127. Approved homes (see paragraph 109) are not allowed to receive patients under order and have no power to detain patients. The admission and departure of each defective have to be reported to the Board of Control, who inspect these homes, and there are regulations about medical attendance, the keeping of records etc., but most of the formalities which have to be observed in the hospitals and institutions where the patients are subject to detention do not have to be observed when similar patients are cared for in approved homes.

PART II

THE NEED FOR NEW LEGISLATION AND THE GENERAL FORM IT SHOULD TAKE

CHAPTER 2

The present statutes

128. The special legislation relating to mental disorder enacted between 1774 and 1939 served five main purposes. (i) It authorised the appropriate administrative authorities to regulate the conditions under which mentally disordered patients might be cared for in private establishments. (ii) It laid powers and duties on the appropriate authorities to provide hospitals and institutions and community services for such patients at public expense. (iii) It laid down procedures to be applied to individual patients received for care with or without powers of detention. (iv) It authorised special measures in regard to patients charged with or found to have committed criminal acts who, because of their mental condition, could not appropriately be dealt with under the normal criminal law. (v) It dealt with arrangements for the administration of the property of patients who were incapable of managing their own affairs.

129. In the 1930s the Lunacy and Mental Treatment Acts, 1890–1930, and the Mental Deficiency Acts, 1913–38, authorised county and county borough councils to provide institutional and community services for mentally ill and defective patients outside the poor law, and also contained various provisions about patients accommodated in poor law institutions. These Acts also authorised other public authorities to register or approve and to inspect private homes and charitable hospitals receiving such patients. The same Acts laid down the procedures to be applied to patients cared for in public and in private institutions, and dealt with the arrangements for the administration of patients' property.

130. In the reorganisation and expansion of the health and welfare services which took place under legislation passed in 1944–48 (which we describe more fully in Chapter 9) the poor law was abolished and most of the Acts which authorised the provision of health or welfare services for special groups of patients outside the poor law were also repealed, including most of those sections of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts which had previously authorised the provision of institutional and community services for mentally disordered patients. A series of new Acts was passed which gave general authority for the provision of health and welfare services for all those who need them irrespective of the form of illness or disability from which their need arises. The special needs of special groups are now met by suitable administrative arrangements under these wide general powers. In the hospital field for example, general hospitals, maternity hospitals, hospitals for infectious diseases, mental hospitals, mental deficiency hospitals and other special hospitals are now all provided under the general powers contained in the National Health Service Acts, 1946–52, which make it the duty of the Minister of Health to provide hospital and specialist services "to such extent as he considers necessary to meet all reasonable requirements" and which set up hospital boards and committees to plan and administer the hospital services in their areas. Most services for mentally ill or defective patients living in the general community are also now provided under general powers contained in general health and welfare legislation, including the National Health Service Acts, the National Assistance Act, 1948, the Disabled Persons (Employment) Act, 1944, and the Employment

and Training Act, 1948. Section 30 of the Mental Deficiency Act, 1913, as amended, also remains in force and lays on local health authorities a duty to provide particular community services for defectives in certain circumstances; these are, however, administered as part of the general local health authority services provided under the National Health Service Acts and are governed by schemes approved under those Acts. The Education Acts, 1944–53, contain special provisions for the education of educationally sub-normal and maladjusted children, and also govern the procedures by which children may be reported as being incapable, owing to mental disability, of receiving education at school or as being in need of further supervision after leaving school. The parts of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts which deal with the procedures applied to individual patients, the registration or approval of private establishments and the management of patients' property were not repealed by the legislation of 1944–48, and are still the operative statutes controlling these matters.

131. The Acts which authorise special measures in regard to patients charged with or found to have committed criminal acts are the Criminal Lunatics Acts, 1800 and 1884, the Trial of Lunatics Act, 1883, the Mental Deficiency Acts, 1913–38, the Criminal Justice Act, 1948, the Magistrates' Courts Act, 1952, and the Homicide Act, 1957. Most of the patients dealt with under the first three of these Acts become Broadmoor patients and are outside our terms of reference. It has however been part of our duty to consider those parts of the Mental Deficiency Acts, Criminal Justice Act and Magistrates' Courts Act which relate to patients who are brought before the courts.

The purpose for which special mental health legislation is still needed

132. **We consider it essential that the mental health services should continue to be an integral part of the present national health and welfare services. There is no longer any need for special mental health legislation to provide authority for the provision of public hospital or community services or the registration or approval of private establishments.** Instead, the process of providing all mental health services under powers contained in general legislation should now be completed by bringing private establishments for mentally disordered patients under the same form of public registration as other private hospitals, nursing homes or disabled persons' homes, and by making a few amendments to certain of the existing general Acts to ensure that they contain adequate powers or duties for carrying on or expanding the present mental health services within the framework of the general health, welfare and other social services. We go into this in more detail in Parts V, VI and VII of this report.

133. It was suggested to us that, because all mentally disordered patients are in some degree helpless and may need protection against ill-treatment, special legislation is required to ensure proper standards of care through a special system of inspection of hospitals and other procedures different from those which apply to other ill or disabled people. The need to protect mentally disordered patients from ill-treatment and to encourage proper standards of care was one of the main reasons for special mental health legislation in the past. In the nineteenth and early twentieth centuries a special administrative system had to be created for the mental health services, and (as we describe in more detail in Chapters 4, 9 and 11) the procedures and administrative methods intended to ensure at least minimum standards of care were woven into a single system with the procedures and methods intended as safeguards against improper detention. This was reasonable at a time when almost all mentally disordered patients were

subject to detention while receiving care, and at a time when services for these patients were organised quite separately from services for people suffering from other forms of illness, need or disability. The need to ensure proper standards of care in public and private establishments is as important now as it has ever been. But now that the mental health services are largely integrated administratively into a comprehensive system of health and welfare services, and now that we no longer subscribe to the principle that detention is always a necessary adjunct to treatment, the means by which proper standards of care are to be encouraged, and the need for special legislation for this purpose, have to be reconsidered.

134. The protection and care of patients are the very core of the responsibility of the public authorities responsible for the administration of the health and welfare services, that is to say, the Minister of Health, the hospital authorities and the local health and welfare authorities. **Any special measures needed to maintain standards of care for the mentally ill or disabled beyond those needed to maintain standards of care for the physically ill or disabled should in our view be taken by these authorities as an essential part of their duty to provide proper services; special legislation is not necessary for this purpose.** The distinctive needs of patients suffering from mental disorder should be dealt with as the distinctive needs of all other ill or disabled people are dealt with, by suitable medical and administrative arrangements. The law should not attempt (as special legislation is apt to do) to prescribe in detail what these arrangements should be and thus fix them in a pattern which advances in knowledge and methods of treatment may soon make out of date.

135. The administrative methods by which proper standards of care are to be maintained should not now be linked to the procedures prescribed for detained patients. Helpless patients should receive proper care whether or not they are, for other reasons, subject to powers of detention or control. Compulsory powers should then be used only when they are positively necessary in order to override the wishes of the patient or his relatives for the patient's own welfare or for the protection of others.

136. In our view, as in the view of almost all our witnesses, individual people who need care because of mental disorder should be able to receive it as far as possible with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social or economic difficulty. But mental disorder has special features which sometimes require special measures. Mental disorder makes many patients incapable of protecting themselves or their interests, so that if they are neglected or exploited it may be necessary to have authority to insist on providing them with proper care. In many cases it affects the patient's judgment so that he does not realise that he is ill, and the illness can only be treated against his wishes at the time. In many cases too it affects the patient's behaviour in such a way that it is necessary in the interests of other people or of society in general to insist on removing him for treatment even if he is unwilling. **This makes it necessary to have compulsory powers to override the normal personal rights of individuals in certain circumstances. Special legislation is necessary (*a*) to define the circumstances in which such powers may be used and to provide safeguards against their abuse; (*b*) to protect patients' property when they are incapable of managing their own affairs; and (*c*) in connection with criminal cases. In our view these are the only purposes for which special mental health legislation is still needed.**

Need for repeal of the present Lunacy and Mental Treatment Acts and Mental Deficiency Acts

137. Procedures to regulate the application of compulsory powers to individual patients are still necessary, and must be laid down in special legislation. The present procedures (which we discuss in detail in Parts IV and VI of our report) contain many unsatisfactory features. It would not be possible to remove these simply by amending the present Lunacy and Mental Treatments Acts and Mental Deficiency Acts. Completely new legislation is needed. **The present Acts incorporate some general assumptions and attitudes current in the late nineteenth and early twentieth centuries, many of which are no longer generally accepted.** These underlie not only particular procedures but the arrangement, spirit and language of the Acts as a whole and of the Rules, Regulations and statutory forms. It would not be possible to remove these without repealing the present Acts completely.

138. The attitudes and assumptions which are now out of date include, for example, the assumption that " persons of unsound mind " and " defectives " admitted to " institutions " must be subject to detention, except those patients in mental hospitals who are " suitable " to be voluntary patients. This assumption also lies behind the use of such expressions as " escape ", " recapture " and other similar phrases. There is also a lack of discrimination between the needs of individual patients for particular forms of care. The Acts emphasise the need for doctors to provide grounds for an opinion that a person is " of unsound mind " or " defective ", but do not require them to specify the reasons why the patient requires institutional rather than community care. Under the Mental Deficiency Acts no distinction is made between the circumstances in which a defective may be sent to an institution or placed under guardianship. The procedures applied to mentally ill patients emphasise the importance of the patient's " status ", that is to say, whether he is " certified ", " temporary " or " voluntary ". When a patient's " status " is changed—as when a temporary patient regains volition—he is said to be " discharged " and " re-admitted " even though he does not leave the hospital. There are also still many vestiges in the Lunacy and Mental Treatment Acts and Rules of the distinctions originally drawn between pauper and non-pauper patients. Although the main procedures for admission and discharge now apply equally to paying and non-paying patients, the transfer of a patient from the " health service " to the " private " class must be notified to the Board of Control and other authorities. There are different procedures for moving " private " and " health service " patients from one hospital to another, and the statutory notices of admission and discharge state whether a patient is of the " private ", " health service " or " Broadmoor " class.

139. **Another reason for repeal and partial re-enactment is the great complexity of the present Acts.** The Royal Commission on Lunacy and Mental Disorder, reporting in 1926 on the Lunacy Acts alone, expressed the view that " the existing code . . . is in certain respects too complicated for the comprehension of those who have daily to administer it."[1] Since then it has become much more complicated by amendments and new legislation, and in addition there is the separate mental deficiency code which deals with some of the same principles in a different way. We noticed that some of our witnesses had little knowledge of aspects of the law and of the administration of the mental health services other than those with which they themselves are particularly concerned. Others, in describing the present law to us, sometimes went wrong over details. We do not blame them ; we only hope we have avoided errors ourselves. In this report we deal mainly with general

[1] Cmd. 2700, paragraph 55.

principles and have tried not to become involved more than we must in detail, but if anyone doubts that the present Acts are unnecessarily complicated, especially on comparatively minor matters, let him look at the provisions of the Acts and Rules governing the absence of mentally ill patients from hospital on short leave, on trial, for reasons of health or boarded out. These are described in paragraphs 56 and 57 of the memorandum printed with our first day's evidence and are contained in the following sections of the Lunacy and Mental Treatment Acts and Rules: —

Lunacy Act, 1890:

Section 55 (which contains eight sub-sections), as amended by Lunacy Act, 1891, Section 9, and National Health Service Act, 1946, Section 50 and 9th Schedule;

Section 57 (which contains three sub-sections one of which is now of no effect because the financial provisions to which it refers are obsolete), as amended by National Health Service Act, 1946, Section 50 and 9th Schedule;

Section 63;

Section 275 (5); and

Mental Treatment Rules, 1948:

Rule 4 (which contains six paragraphs).

Or let him look at Appendix II of this report, particularly at the methods of discharge specified in Items 8 and 9. The conditions under which various persons may discharge certified or temporary patients detained under the Lunacy and Mental Treatment Acts are contained in fourteen sections of the Lunacy and Mental Treatment Acts and eight rules of the Mental Treatment Rules. For defectives, on the other hand, there are many fewer methods of discharge. There is no section in the Mental Deficiency Acts dealing solely with discharge, and the method of discharge most commonly used is tucked away in a section of the 1913 Act which deals with the general powers and duties of the Board of Control. We suspect that this is the reason why more than one of our witnesses, though apparently making a general review of the main procedures and safeguards against unnecessary detention, omitted to consider the powers of discharge, which, if adequate, should be one of the most effective of all safeguards.

140. As the result of this complexity, not only is it difficult for magistrates, doctors, social workers and other officials to acquire a sound general knowledge of the law which they have to operate, but also much time is spent in trying to find a way through it, or even round it. It is also only too easy, while concentrating on the detailed provisions of the Acts, to lose sight of their general purpose.

141. The Acts, Regulations and Rules also contain detailed instructions about records, forms of records, notices and plans, the appointment and duties of staff and managing committees, and similar matters which it was not unusual fifty years ago to find laid down by legislation but which are now normally arranged administratively. Many of these are now normal medical, nursing or administrative routine. In so far as it is necessary to ensure uniformity of records and notices, this could now be done without laying down details by statute or statutory instruments which tends to make them unduly rigid and more difficult to alter when changing conditions make them no longer appropriate. Some of the provisions of the present Acts, Regulations and Rules also make distinctions between various categories of patients, and between various types of hospital or institution, the original purpose of which it is very difficult to imagine. There are many which are in any event no longer of any value, and a few

which now even seem obnoxious to the welfare of the patients they are supposed to benefit.

142. **A major reason for the repeal of the present Acts is that the existence of two separate legal codes during the last forty years has, in our view, resulted in a far too rigid legal and administrative distinction between mental illness and mental deficiency, which has been reflected in medical practice also.** This has almost completely separated the treatment of patients classified as feebleminded or moral defectives from the treatment of those classified as mentally ill. Some of our witnesses recommended that the present distinctions should be preserved in any new legislation, so as to help those who are trying to educate the public to appreciate the difference between mental illness and mental deficiency. Many witnesses assumed that there must continue to be a clear-cut distinction between hospitals providing treatment for the mentally ill and hospitals providing treatment for the mentally defective, and that there should be corresponding differences between the procedures laid down by law for admission to and discharge from each type of hospital. We agree that it is important that the services provided should vary according to the varying needs of the patients, and that it is desirable for the public to appreciate the broad distinctions between the main types of mental disorder. But, as we explain in Chapter 3, we consider that three main groups of patients should be recognised in future for legal and administrative purposes, rather than two. In any case there should be free movement of patients to whatever hospital or other place provides the treatment most suited to their individual needs. The rigidity of the present system is particularly serious when one considers the situation of patients who are detained in hospital under compulsory powers. A case came to our notice in which a patient who had been compelled to enter a mental deficiency hospital by use of the compulsory powers provided in the Mental Deficiency Acts could not be transferred to a mental hospital, which was thought likely to be more suitable for him, because he was not considered certifiable as of unsound mind under the Lunacy Acts. Such a situation seems to us to be very wrong. If the medical and social conditions exist which justify the use of compulsory powers, then those powers should be used to ensure the admission of a patient to a hospital which provides the sort of treatment which he needs and not to one which does not

143. We do not consider that the proper way to correct these faults in the present system would be to re-define the categories of patient for whom the law should provide different procedures of admission to differently designated hospitals. **The disadvantages of the present system are likely to be perpetuated under any system based on any rigid designation of hospitals, under which the categories of patient to be received in each type of hospital would be limited by law.** The organisation of the hospital services and the extent to which individual hospitals should specialise in particular types of treatment should be a matter for medical and administrative arrangement. The arrangements should be flexible, so that changes can easily be made as more is learnt about the cause and nature of mental disorders and as methods of treatment are developed. There should be no rigid legal barrier against the admission of any patient to any hospital; the choice of hospital to which a patient should be admitted should be determined only by the type of treatment he is thought to need and its availability in the hospital selected. We do not suggest for one moment that it would be appropriate to treat patients suffering from all forms of mental disorder all in the same hospital. On the contrary, there may be a need for more rather than less specialisation in the type of patients treated in individual hospitals. Our view is merely that there should be a relaxation

of the present rigidity of the separation between services for the mentally ill and services for the mentally defective, which should be governed by medical needs. There is no need for formal "designation" of hospitals. We are confident that this need not hinder the education of the public about the various forms of mental disorder.

144. We also consider that the distinctions drawn in the present law between the procedures applied to individual patients admitted to hospital or guardianship under the Mental Deficiency Acts and those applied to patients admitted to mental hospitals designated under the Lunacy and Mental Treatment Acts are much greater than can be justified by the real differences between these two groups of patients. The safeguards needed when compulsory powers are used depend on similar questions of principle, from whatever form of mental disorder the patient is suffering. **The circumstances in which it may be justifiable to use compulsory powers may differ for patients suffering from different forms of mental disorder, but we see no reason why there should be such great differences in the actual procedures used and other safeguards provided. Our recommendations in Part IV of our report differentiate the circumstances in which compulsory powers may be applied to certain groups of patients, but suggest a set of procedures and other safeguards common to all.**

145. For all these reasons we consider it essential that the Lunacy and Mental Treatment Acts and Mental Deficiency Acts should be repealed. The circumstances in which compulsion may be used in future, and the procedures to be followed, should be laid down in a single new Act, which should be as simple as possible.

RECOMMENDATIONS IN PART II

(1) The public mental health services should continue to be an integral part of the national health and welfare services. The maintenance of proper standards of care for patients is an essential part of the duty of the local and central authorities who provide and supervise these services and should be ensured by administrative and medical arrangements without detailed statutory regulations. (Paragraphs 132–134. See also Parts V and VI.)

(2) Private and charitable hospitals and homes for mentally disordered patients should be registered or approved under the same system as hospitals and homes for other types of patient. (Paragraph 132. See also Part VII.)

(3) Procedures which involve the patient's detention or control should not be used unless the use of compulsion is positively necessary to provide treatment which the patient needs but is unwilling to receive, or to protect him from exploitation or neglect, or for the protection of others. (Paragraphs 135–136. See also Part IV.)

(4) The circumstances in which compulsory powers may be used and the procedures which should be followed should be laid down by law, but the law should not draw rigid distinctions between different groups of patients by the "designation" of hospitals or in other ways. (Paragraphs 136 and 142–144. See also Parts III, IV and V.)

(5) The Lunacy and Mental Treatment Acts and Mental Deficiency Acts should be repealed and replaced by a single new Act to regulate the use of compulsory powers. (Paragraphs 136–145. See also Part IV.)

PART III

DISTINCTIONS BETWEEN VARIOUS GROUPS OF PATIENTS, AND RECOMMENDATIONS FOR NEW TERMINOLOGY

CHAPTER 3

Legal History

146. Very early in English legal history a distinction was drawn between a "lunatic" or "person of unsound mind" ("non compos mentis") on the one hand and an "idiot" or "natural fool" on the other. This distinction is recognised in the Statute de Praerogativa Regis, the date of which is not precisely known but is thought to be early in the fourteenth century. This statute asserted the wardship of lunatics and idiots and of their property to be a prerogative of the Crown.[1] The law distinguished between powers of control over the property of idiots and those over the property of lunatics; the general principle was that the property of a lunatic must be preserved intact and returned to him on recovery, subject only to the maintenance of the lunatic and his family meanwhile out of the estate, whereas the profits of the property of an idiot, beyond what was spent on his maintenance, might be appropriated for the enjoyment of the Crown or of the person entrusted with the custody of the idiot. Since those early days it has been recognised in law that a "person of unsound mind" may recover his sanity or may have lucid intervals, whereas an idiot is presumed to be incurable.

147. During the late eighteenth and nineteenth centuries, a series of Lunacy Acts (which we describe more fully in Chapters 4 and 9) was enacted to provide for the care of "lunatics" in "asylums" and elsewhere. Admission to asylums and other institutions was regulated by the use of procedures which became known as "certification"; these procedures gave authority for the patient's admission and detention for as long as his mental disorder lasted, and could be used only for the categories of persons to whom the Acts applied. These were described in various Acts as "lunatics", "idiots", "insane" and "of insane mind" or "of unsound mind". These terms were used somewhat indiscriminately, in the law and in common speech, as general terms covering all the major forms of mental disorder which seriously affect the intellect or reason.

148. In the second half of the nineteenth century there was a growing consciousness of the special needs of the patients who are now classified as mentally defective, including the feebleminded who are not severely subnormal in intelligence and who were not considered eligible for care under the Lunacy Acts, as well as idiots and imbeciles many of whom were detained at that time in lunatic asylums and workhouses under the authority of those Acts. In 1847 the first "idiot asylum" was opened by a voluntary society. The Idiots Act, 1886, gave authority for the detention of any idiots or imbeciles placed in such asylums by their parents or guardians. In contrast to the Lunacy Acts, which included idiots in their definition of lunatics, the Idiots Act used the words "idiot" and "lunatic" as mutually exclusive terms, stating in its definitions that "idiots or imbeciles do not include lunatics" and "lunatic does not mean or include idiot or imbecile". The Idiots Act was generally interpreted as covering patients

[1] A short account of the history of this royal prerogative and of the early distinction between lunatics and idiots, with quotations from legal authorities, is given in paragraph 765 of the *Report of the Royal Commission on the Care and Control of the Feeble-minded*, 1908, Cd. 4202.

suffering from any form of mental abnormality existing from birth or from an early age, including some who would later have been described as feebleminded. When the term "feebleminded" came into general use towards the end of the century to describe the least severely defective patients, idiot asylums added the term "institution for the feebleminded" to their title. From 1887 onwards voluntary societies opened other homes specifically for the feebleminded. These were not covered by any special legislation and had no power to detain patients.[2] Lunacy Acts passed during this period continued to provide for the care of "idiots" as well as "lunatics" in public lunatic asylums and workhouses. The consolidating Lunacy Act of 1890, which is the principal Act in the present Lunacy and Mental Treatment Acts, applied to all "lunatics" and defined the term "lunatic" as meaning "an idiot or a person of unsound mind".

149. In 1904 the Royal Commission on the Care and Control of the Feeble-minded was appointed to consider the needs of the feebleminded and other mentally disordered persons who were not considered certifiable under the Lunacy Acts, and the need for special forms of treatment for them and for idiots. In their report, published in 1908, this Royal Commission recommended new legislation which would cover all forms of "mental defect", a term which they used in the wide sense in which we use the term "mental disorder". Their report was followed by the enactment of the first Mental Deficiency Act in 1913, which applied to mentally defective patients in the narrower sense in which that term is used today. This Act classified and defined four classes of defectives: "idiots", "imbeciles", "feeble-minded persons" and "moral imbeciles". The Mental Deficiency Act, 1927, replaced the term "moral imbecile" by the term "moral defective" and introduced new definitions of all four classes of defectives, which still remain in force and which we discuss later in this chapter. These Acts authorised the provision of public institutions for the care of mentally defective patients, separate from the lunatic asylums and reserved for patients who are mentally defective within the meaning of these Acts. The Mental Treatment Act, 1930, amended the terminology of the Lunacy Act, 1890, replacing the terms "lunatic" and "asylum" by the terms "person of unsound mind" and "mental hospital". This Act also made it possible for patients suffering from "mental illness" to be admitted to mental hospitals as voluntary patients, whether they are certifiable as "of unsound mind" or not.

150. In its amended form, therefore, the Lunacy Act, 1890, now applies to "persons of unsound mind", and defines the term "person of unsound mind" as meaning "an idiot or a person of unsound mind". Idiots and imbeciles can still be cared for and certified under the Lunacy Acts as well as under the Mental Deficiency Acts, though in practice they are now rarely certified under the Lunacy Acts. Feebleminded persons and moral defectives are certifiable under the Mental Deficiency Acts but (generally speaking) not under the Lunacy Acts, though they (as well as patients suffering from any form of mental illness) may be admitted to mental hospitals as voluntary patients under the Mental Treatment Act, 1930.

151. In the following sections of this chapter we discuss the forms of mental disorder which are covered by these terms, and other forms which are recognised medically but which are not usually held to render the patient certifiable under the Lunacy Acts or Mental Deficiency Acts. **It is**

[2] *Report of the Royal Commission on the Care and Control of the Feeble-minded*, 1908 Cd. 4202, Chapter XXIV, paragraphs 473–4. Chapters XXIV and XXV of this report contain a full account of the work done by the voluntary idiot asylums and homes for the feeble-minded up to that time.

important to bear in mind that when these Acts were passed, it was only patients covered by the terminology used in the Acts who were to be eligible for care in the hospitals or institutions provided under these Acts. Certification was originally necessary to establish the patient's eligibility for these special forms of care at public expense, as well as to authorise his detention while under care. This is no longer the case. All public mental and mental deficiency hospitals are now provided under the National Health Service Acts, which authorise the general provision of " hospital and specialist services " without mentioning, still less attempting to define, the types of mental or physical disorder for which treatment may be provided. Community care for defectives is still provided by local health authorities partly under the authority of the Mental Deficiency Acts, but general authority which would cover almost all these community services is contained in the National Health Service Acts or the National Assistance Act, 1948, without a definition of mental defectiveness being necessary. The limitations still placed on the types of patients who may be admitted to designated mental and mental deficiency hospitals now arise only from the fact that admission is regulated by the procedures laid down in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts, which apply only to patients covered by the terminology used in these Acts. It should be possible in future to provide care without such special procedures for all patients who do not need to be subject to detention in hospital or legal control under guardianship in the community. It is only in connection with the procedures which authorise such detention or control that terms or definitions describing particular groups of patients are now needed in the law.

Meaning of the terms " lunatic ", " idiot ", " insane " and " of unsound mind ", and the terms proposed by the Royal Commission of 1904–08

152. The eighteenth and nineteenth century lunacy legislation did not give any precise definition of the sort of mental condition which was to be regarded as lunacy, idiocy, insanity or unsoundness of mind. It was assumed that these expressions would be understood by the doctors, justices and officials who administered the Acts. And in practice, although their meaning has varied in different contexts and at different periods, their interpretation for the purpose of the Lunacy Acts and Idiots Act did not give rise to serious disagreement either within the medical profession or between doctors, justices and non-medical officials. Great controversy has arisen over the meaning to be attached to the word " insane " in connection with the verdict " guilty but insane " in criminal proceedings. This controversy has not centred round the general meaning of the word " insane ", but around the meaning to be attached to it in that particular context and the criteria for its interpretation which were laid down in the M'Naghten Rules in 1843. This question of the criminal responsibility of the insane is outside our terms of reference. We mention it only in order to point out that the term " insane " in the verdict " guilty but insane " and in the phrase " insane on arraignment " is applied in a narrower sense than that now given in practice by general consent to the phrase " person of unsound mind " as used in the Lunacy and Mental Treatment Acts. Many persons who are certifiable as " of unsound mind " under the Lunacy and Mental Treatment Acts are not insane within the meaning of the M'Naghten Rules. Nor would a mentally ill person, who is " of unsound mind " within the meaning of the Lunacy and Mental Treatment Acts when he is brought to trial, necessarily be found " insane on arraignment ".

153. The term "person of unsound mind" might on the face of it be thought to include persons suffering from any form of mental disorder. In practice, however, during the nineteenth century the terms "lunatic", "idiot" and "person of unsound mind" (or, in common language, the "insane") were generally held to apply to patients suffering from any of the various forms of mental illness or defect which result in defect or loss of reason or intellect, but not to persons suffering from those forms of disorder which are now called feeblemindedness or psychopathic states or forms of mental illness which affect the intellect only slightly or not at all. When recommending that new legal powers were needed in order to enable suitable care to be provided for the feebleminded and moral imbeciles, the Royal Commission of 1904–08 quoted the evidence of one of their witnesses on this point. The witness had been asked to state the reasons why people who "are socially dangerous" and who "have an unimprovable degree of feeble-mindedness" were not certified under the Lunacy Acts. He replied, "I think the reason for non-certification undoubtedly is the prevalent opinion that insanity is necessarily a disorder of intelligence, that it means delusion, or it means intellectual disorder or intellectual defect, and that it is recognised by a comparatively small number of medical men and by a still smaller number of magistrates, that insanity may be manifest in conduct alone, and that a person may be free from delusion and may be intellectually extremely acute and clever, and yet insane, on account of conduct alone."[3]

154. The Royal Commission proposed that care and control should be extended to patients suffering from any recognised form of mental disorder (which they called mental defect), whether or not it affects the intellect. They proposed to distinguish nine classes of mentally defective* persons. These were "persons of unsound mind", the "mentally infirm", "idiots", "imbeciles", the "feeble-minded", "moral imbeciles", and persons who, in addition to being mentally defective*, were inebriates, epileptics, or deaf and dumb or blind.[4] The "feeble-minded" and "moral imbeciles" had not in the past been eligible for care or control as "lunatics", except by stretching the terms used in the Lunacy Acts beyond their generally accepted meaning, because their mental disorder did not result in severe limitation of intellect or loss of reason. Patients who were also inebriates, epileptics, or deaf and dumb or blind had been eligible only if their mental disorder was of a type which made them certifiable as "lunatics"; under the Commission's proposals such persons would also become eligible for care if their mental disorder was akin to that of the feebleminded or moral imbeciles. The Commission's object in defining these nine groups separately was to encourage the provision of separate institutions or other forms of care suited to their special needs. These various services were all to be provided under the same statutory authority which would cover the whole range of mental disorder, the Commission recommending that the existing Lunacy Acts should be amended to permit this to be done.

155. The Commission defined the feebleminded as "persons who may be capable of earning a living under favourable circumstances, but are incapable from mental defect* existing from birth or from an early age (*a*) of competing on equal terms with their normal fellows; or (*b*) of managing themselves and their affairs with ordinary prudence". They assumed that this definition would include "the prodigal" and "the facile", and they commended as an alternative definition: "a feeble-minded person is one who by reason of arrested development or disease of the brain dating

[3] Cd. 4202, para. 562.
* Used in the wide sense in which we use the term "mental disorder".
[4] Ibid., Chapter XXVIII.

from birth or from some age short of maturity has his observing and reasoning faculties partially weakened, so that he is slow or unsteady in his mental operations, and falls short of ordinary standards of prudence, independence and self-control ".

156. They defined " moral imbeciles " as " persons who from an early age display some mental defect* coupled with strong vicious or criminal propensities on which punishment has little or no deterrent effect ". An alternative definition which they commended was " a person who by reason of arrested development or disease of the brain dating from birth or early years displays at an early age vicious or criminal propensities which are of an incorrigible or unusual nature, and are generally associated with some slight limitation of intellect ". But even slight limitation of intellect was not to be an essential criterion ; in 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 defect*".

157. The Commission also discussed whether it would be right to define as a separate class those persons who at that time were sometimes described as " morally insane ", who have characteristics and behaviour similar to those of " moral imbeciles ", but who do not develop these until later than " birth or an early age ". The Commission considered this type of " acquired " mental abnormality to be a form of mental illness which would be properly included in their proposed definition of " unsoundness of mind ", and they stated that they did not consider it scientifically correct to regard persons suffering from this type of disorder as being in a category separate from other " persons of unsound mind ". They proposed that " persons of unsound mind " should be defined as " persons who require care and control owing to disorder[5] of the mind and are consequently incapable of managing themselves or their affairs, and are not included in [any of the other eight classes of mentally defective* persons] ".

158. These recommendations were not accepted in full. The Mental Deficiency Act, 1913, applied only to mental defectives in the present sense of the term, defined under the four classes of idiots, imbeciles, feebleminded persons and moral imbeciles. It did not affect the terminology used in the Lunacy Acts, so that the term " person of unsound mind " continues to be used without more precise definition and has not in practice been extended to cover the " morally insane ". The terminology used in the Mental Deficiency Act, 1913, was altered and re-defined in the Mental Deficiency Act, 1927. The interpretation of the definitions contained in these Acts has given rise to considerable controversy, and is one of the main subjects on which we have received evidence from our witnesses. In the next section of this chapter we discuss this in detail, and also discuss the term " psychopath " which is now commonly used to describe those patients whom the 1904–08 Commission called " moral imbeciles " and " morally insane " as well as persons with other forms of personality disorder including many whom that Commission included in their concept of the feebleminded.

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* Used in the wide sense in which we use the term " mental disorder ".

[5] Used in the sense of an " acquired " disorder not arising at an early age.

Present use of the terms "mental defect" and "psychopathic personality", and the four classes of defectives

(i) The term "mental defect"

159. The present Mental Deficiency Acts apply the term "mentally defective" to four groups of patients. Any patient included in any of these four groups is referred to in the text of the Acts simply as "a defective". The definitions of mental defectiveness and of the four classes of defectives in Section 1 of the Mental Deficiency Act, 1913, in its present amended form, are as follows:—

"1 (1) The following classes of persons who are mentally defective shall be deemed to be defectives within the meaning of this Act:—

(*a*) Idiots, that is to say, persons in whose case there exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers:

(*b*) Imbeciles, that is to say, 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:

(*c*) Feeble-minded persons, that is to say, 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, involves disability of mind of such a nature and extent as to make them, for the purposes of section fifty-seven of the Education Act, 1944, incapable of receiving education at school:

(*d*) Moral defectives, that is to say, 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.

(2) 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."[6]

160. It will be seen that each group of defectives is defined by a description of the patients' mental condition and of the effect which that has on their behaviour, on their ability to protect themselves or on the need for others to be protected from them. That is to say, they are described by a combination of a medical description of their underlying mental disorder and a sociological description of its practical effects. The description of the underlying disorder is in general terms and applies equally to each of the four groups of patients. This is the only attribute which is common to them all and which distinguishes them under present law and practice from persons suffering from other forms of mental disorder. It contains two essential points, that the disorder is one which affects their mental development and that it has existed since before the age of eighteen. The four groups are then differentiated according to the degree of mental defectiveness and the resulting social consequences. These may vary so much that within this comprehensive medical description are included widely differing types of patients needing very different forms of care and treatment.

161. Nevertheless, the Mental Deficiency Acts deal with all defectives on an equal footing (apart from the procedure for "placing"—see paragraph 249), and differentiate their care and treatment sharply both from the care and

[6] Mental Deficiency Act, 1913, Section 1, as amended by Mental Deficiency Act, 1927, Section 1, and Education (Miscellaneous Provisions) Act, 1948, Section 11 and First Schedule.

treatment of people suffering from all other forms of mental disorder on the one hand, and from the care and treatment of normal children, normal sick or needy persons and normal criminals on the other. This has led to the supposition that mental defectives must be a more homogeneous category than they really are. One result of this has been that even those administering the mental health services have in some ways tended not to differentiate sufficiently between the different needs of the different types of defective, particularly in regard to residential and hospital services. In addition, many people working in the mental health services, as well as patients' relatives and others, consider it inappropriate to apply to many of the feebleminded and moral defectives the same general term as is used for idiots and imbeciles. Identifying the term "mental defective" with idiots, imbeciles and feebleminded of low intelligence, they protest that the more intelligent feebleminded and moral defectives are "not mental defectives".

162. We agree that in future there should be more differentiation in terminology and in the services to be provided and in the legal powers of control over these patients. **We have no doubt, however, that those who interpret the present Mental Deficiency Acts as including, among the feebleminded and moral defectives, patients whose intelligence is within the normal[7] range but whose mental development is incomplete or abnormal in other respects, are correctly interpreting the intention behind the present Acts.** It may well be that the law and the terminology should be changed, but if we say that the term "mentally defective" should in future be restricted to persons of low intelligence we still have to decide how to deal with the far more difficult problems which arise in regard to the feebleminded and moral defectives of higher intelligence who are also covered by the present Mental Deficiency Acts.

(ii) **Idiots and imbeciles**

163. The definition of idiots in the present Mental Deficiency Acts applies to patients who are so severely injured or deformed mentally that even when they are fully grown their mentality is like that of a baby or a young child up to about four years old, and they are equally dependent on other people. They are often physically as well as mentally deformed. Usually their mental deficiency is obvious and can be diagnosed at an early age, though diagnosis may be difficult in a child suffering from physical disabilities as well as suspected inherent mental deficiency. Some idiots never learn to walk. Some learn to walk and to develop the use of their hands and rudimentary speech, but the extent to which they can be trained in any form of activity is very slight. They need constant care all their lives. Sometimes they remain at home, receiving care from their parents or relatives, but many of them need to be admitted to mental deficiency hospitals where constant nursing care can be provided. Some of them may be able to profit from habit training and sense training at an occupation centre or in hospital. Numerically they are much the smallest group of defectives (see Appendix IV, page 310).

164. The definition of imbeciles is usually interpreted as applying to patients who even when fully grown have a mentality equivalent to that of a child between three and six or seven years old. Most imbeciles, unless they are also suffering from physical disabilities, can be taught to walk and to wash and dress and feed themselves, and some of them develop quite a high degree of manual dexterity and can occupy themselves happily in simple repetitive tasks. Some of them go to school, but many of them—probably the majority—are found to be incapable of benefiting from education at school, even in a special school; a few of them, however, stay at school

[7] See footnote on page 26.

throughout the normal school life. Those who are excluded from school are usually suitable for training in an occupation centre. When they are grown up, many imbeciles are capable of living in the ordinary world provided that they have good homes and people to look after them. They are, however, by definition never capable of completely looking after themselves. Some of them may be suitable for regular work in sheltered employment or in domestic tasks working at their own tempo ; others can be suitably occupied at occupation centres. Any who are temperamentally unstable in childhood or in later life may need a period of special training under psychiatric supervision. All imbeciles also need to be provided with a home if and when their parents or relatives are unable to provide for them any longer. It is also desirable that some public authority should be responsible for protecting them from neglect or exploitation, both in childhood and in adult life. The likelihood of idiots or imbeciles being neglected or cruelly treated is probably considerably less now than it was even as late as the beginning of the present century, but it is generally agreed that there should be legal and administrative machinery available to protect them against such neglect should it occur.

(iii) **Feebleminded persons, moral defectives and psychopaths**

165. The term "feebleminded" is at present applied to a large group of patients who may differ greatly from each other in intelligence and temperament. At one extreme it is applied to some patients who are seriously sub-normal[8] in all aspects of their personality. The most severely handicapped among the feebleminded need much the same type of help and services as imbeciles, and indeed there has been a general tendency for the classification "feebleminded" to be applied to some patients who more closely fit the general description of imbeciles given in paragraph 164, no doubt partly because this causes less distress to their parents. At the other extreme, the term "feebleminded" is applied to patients whose intelligence is little if at all below average[8] but who are emotionally immature and unstable.

166. When one is considering a person's ability to live an independent and acceptable life in the community, it is not only his intelligence which is important but his personality as a whole and its practical manifestations in his behaviour in life, his powers of judgment, adaptability, prudence or self-control. When the intelligence is very low it can usually be taken as a fairly reliable indication of a person's general personality ; there is a fairly close correlation at very low intelligence levels between intelligence and general mental development. But the higher the intelligence the less reliable a guide it is to a person's general capabilities and character or to his social needs. For this reason it is possible to judge the degree of mental defect of an idiot or an imbecile fairly accurately from his intelligence, but with the feebleminded, moral defectives and psychopaths, the level of intelligence is of much less significance. Although most of those who are at present described as feebleminded are sub-normal or at least below average in intelligence, what distinguishes them and moral defectives and psychopaths most clearly from normal people is their general social behaviour. It is, however, not easy to describe the characteristics of their behaviour in general terms which identify them clearly. It is comparatively easy to describe the type of behaviour which results from the very pronounced defects of personality of idiots and imbeciles, whose general capabilities and behaviour are like those of young children. But it is difficult to describe the characteristics of these other groups of patients in terms which dis-

[8] See footnote on page 26.

tinguish them from the sort of failings which are common to almost all human beings in one degree or another. There is, however, no doubt that there are many persons, at present described as feebleminded, moral defectives or psychopaths, whose intelligence is not seriously impaired but who have pathological defects or abnormalities of personality which result in behaviour which makes it most necessary, in their own interests or in the interests of society as a whole, to provide them with special forms of help or treatment and in certain circumstances to subject them to special forms of control. We are also convinced from the evidence we have received that it is not difficult for doctors to recognise these characteristics in individual patients and to make a diagnosis that is readily acceptable to an intelligent layman on the basis of his own observation of the patient's general behaviour. The difficulty of describing them is a difficulty of language rather than of diagnosis. It is notoriously difficult to describe any medical condition in ordinary language; it is even more difficult to describe or define such conditions in terms suitable to be incorporated in the law, as has been attempted in the Mental Deficiency Acts.

167. Feebleminded patients, moral defectives or psychopaths may be described medically as patients suffering from emotional immaturity or instability; their emotions are warped or blunted, over-inhibited or uncontrolled. This emotional disorder may or may not be combined with some limitation of intelligence or with some more specific form of mental illness.

168. Another way of describing these patients is to give examples of the type of behaviour which may be considered a symptom of their undeveloped or abnormal mental condition. Feebleminded patients and psychopaths have been described as having either predominantly inadequate or predominantly aggressive personalities. An inadequate personality may result in a person having quite abnormal difficulty in applying himself to any job, in controlling his spending, in planning his domestic life and in getting on with other people generally; these difficulties are usually increased when the person is also below average in intelligence. It may be possible to correct such inadequacies to a certain extent in the process of education or by friendly help and supervision after the person leaves school until he is established in adult life, but the basic inadequacy may persist underneath and make the person always liable to break down in the face of the slightest difficulty. Such people may also be in danger of economic or social exploitation by those with whom they live. Women may be in danger of sexual exploitation not of their own seeking, but a much more common difficulty is presented by girls and women who, though sufficiently adapted to the conventions of society in other respects, are sexually promiscuous without realising the consequences to society or to themselves or to the children. Other forms of behaviour which may result from inadequate personalities include persistent drifting from job to job, general inability to take an interest in any form of occupation, pathological lying and swindling, drug addiction and alcoholism. Aggressive tendencies may be manifested in sexual perversion or any form of assault or violence which the person is apparently incapable of controlling and which often appears to have little motivation. There is no absolute distinction between the inadequate and the aggressive groups, and those whose main characteristic is a general inadequacy may be vindictive and bad-tempered and occasionally extremely violent without apparent cause.

169. Descriptions of feebleminded patients and psychopaths given by our witnesses include the following:—Mental defectiveness may be evidenced by "lack of ordinary common sense, ordinary wisdom in one's management of day-to-day plans" (3rd Day, Q. 526). "In practical work in the field one comes across people who on ordinary intelligence tests are apparently just

about on the normal line of intellectual attainment, and yet their behaviour proves that they have not got sufficient ordinary common sense to live properly in the world and are continually committing some act of delinquency . . . We do find the person . . . who is not far below the normal standards of intelligence; he has probably staggered through an ordinary school and yet on coming into adolescence he is found not to have what it takes to live as a normal citizen" (5th Day, Q. 1200). "The undeveloped mind may be manifested chiefly by failure to attain normal control of the emotions or to achieve the qualities needed for normal social behaviour" (8th Day, P. 281, para. 111). Psychopaths are mentally abnormal patients "whose daily behaviour shows a want of social responsibility and of consideration for others, of prudence and foresight and of ability to act in their own best interests. Their persistent anti-social mode of conduct may include inefficiency and lack of interest in any form of occupation; pathological lying, swindling and slandering; alcoholism and drug addiction; sexual offences, and violent actions with little motivation and an entire absence of self-restraint, which may go as far as homicide. Punishment or the threat of punishment influences their behaviour only momentarily, and its more lasting effect is to intensify their vindictiveness and anti-social attitude" (8th Day, P. 287, para. 166). "Practically all the high-grade defectives coming into the institution are people with psychopathic trends of one kind or another, not necessarily the anti-social psychopath, but psychopaths in other ways, unfitted to cope with the demands of ordinary life because of their personality defects" (13th Day, Q. 2591). Psychopaths are "persons who by reason of abnormal personality are so far unable to conform to normal standards of behaviour as to require treatment, care and control, for their own protection or that of the public" (18th Day, P. 686, para. 19). Of psychopathic children at approved schools: "These psychopathic children are completely self-centred (for themselves they are the hub of the universe) and have no regard for the rights or convenience of others. They seek the immediate satisfaction of any desire, they react violently if frustrated, they are without conscience, sense of guilt or insight, and, living as they do in the moment, lack ordinary foresight and judgment and the capacity to learn from experience" (Appendix to minutes of evidence, P. 1327). These descriptions may be compared with the descriptions of the feebleminded and moral imbeciles in the report of the 1904–08 Royal Commission which we quoted in paragraphs 155 and 156, with the present legal definition of the feebleminded and moral defectives which we quoted in paragraph 159, and with the original definition of moral imbeciles in the Mental Deficiency Act, 1913, which was: "Persons 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".[9]

170. In describing these characteristics of the feebleminded, moral defectives and psychopaths, we have not so far distinguished between the three. General descriptions of their underlying mental disorder or of their social characteristics can only be given in terms which apply equally to the feebleminded and to psychopaths, in the widest senses in which these terms are used. The word "psychopath" is used by different psychiatrists and sociologists in different ways. Some recognise either inadequate or aggressive patterns of behaviour as sometimes indicating a psychopathic mental state, while others restrict the term to those whose behaviour is predominantly aggressive. Some apply it to any person who exhibits a "psychopathic" pattern of behaviour, whether or not this is combined with intellectual

[9] Mental Deficiency Act, 1913, Section 1.

deficiency or with some recognised form of specific mental illness; some restrict it to persons showing no sign of any other form of mental disorder. When a wide meaning is given to the term "psychopath" and to the term "feebleminded", many persons could equally well be described by either term, and moral defectives (who represent the aggressive group only) could also be described by either of the other two terms. There are nevertheless some distinctions which are usually drawn in practice. These arise partly from differences in the practical difficulties which result from these emotional disorders according to whether they are or are not combined with some limitation of intelligence, and partly from the patient's age and other circumstances at the time when the patient comes to the notice of official authorities or psychiatrists. Perhaps the easiest way for us to explain these practical distinctions and to complete our description of the feebleminded, moral defectives and psychopaths is to describe how their limitations or disorders of character and behaviour usually come to notice and what can and cannot at present be done about them.

171. Under the educational system a distinction is now drawn between children who are maladjusted and children who are educationally sub-normal, that is to say, broadly speaking, between emotional instability or disturbance on the one hand and intellectual sub-normality on the other, in children of school age, for whom special forms of education may be provided. Special arrangements are also made for delinquent children, children who are beyond the control of their parents or in need of care and protection for other specific reasons; there are various methods of control or training which may be prescribed for such children, one of which is to send them to approved schools; some of these children may be emotionally maladjusted or of sub-normal intelligence or both. Education in a special class or special school or in an approved school may succeed in helping the children to outgrow their difficulties, or, in spite of their limitations, to develop their characters sufficiently to enable them to stand on their own feet in later life as law-abiding citizens. In some cases, however, it becomes clear that the children's intellectual or emotional disorders are too severe to allow them to benefit even from these special forms of education. In such cases, children who have been attending ordinary or special schools within the normal educational system may be declared incapable owing to disability of mind of receiving education at school, thus bringing them within the definition of imbeciles or feebleminded under the Mental Deficiency Acts. We have already mentioned this in relation to idiot and imbecile children of markedly sub-normal intelligence, who constitute the majority of the children who are declared ineducable. Section 57 (4) of the Education Act, 1944, provides, however, that a child may be excluded from school on grounds of mental disability if his mental disability is such that it is inexpedient that he should be educated in association with other children, whether or not his disability also makes him actually incapable of receiving education; in other words, he may be excluded on grounds of behaviour, perhaps combined with an anomaly of physical development, rather than purely on grounds of severe intellectual sub-normality. In theory, this might lead to severely maladjusted children being excluded from school and dealt with as feebleminded, but in practice this does not often happen. Children whose difficulties are recognised during school life as being essentially difficulties of emotional adjustment are not usually reported as ineducable. They are directed, wherever possible, to child guidance clinics or mental hospitals for special psychiatric treatment without being declared ineducable. A Committee on Maladjusted Children which reported to the Minister of Education in 1955 drew attention to the need for further facilities for treatment of this sort. Section 57 (4)

of the Education Act does, however, allow children who on standards of intelligence might be considered educationally sub-normal but not of imbecile grade to be excluded from school if, in addition, they suffer from emotional disorders which make it difficult to manage them even in a special school for the educationally sub-normal. If they are so reported they may then be ascertained as mentally defective, and be provided with training in an occupation centre or recommended for admission to a mental deficiency hospital.

172. Children at approved schools also may be ascertained as mentally defective if they are considered to fall within one of the definitions under the Mental Deficiency Acts. They may then be transferred from the approved school to a mental deficiency hospital by order of the Home Secretary. Any children in approved schools who are found to be seriously sub-normal in intelligence are usually so transferred if and when a vacancy can be found for them. These arrangements are also sometimes used to transfer to mental deficiency hospitals, as feebleminded or moral defectives, children or young persons of slightly below average or even of above average intelligence who have shown persistent abnormalities of behaviour—whether inadequate or aggressive—of the types we have described, which do not respond to the approved school regime and which may be considered evidence of pathologically incomplete or arrested development of personality. Others are sometimes sent for treatment in mental hospitals.

173. There are thus two groups of children who may come to notice as feebleminded or moral defectives during school age, apart from those of severely sub-normal intelligence. Those who come from ordinary or special schools usually have some limitation of intelligence in addition to emotional instability. Those who come from approved schools sometimes have no marked intellectual limitations. Almost all those who come from ordinary or special schools, however, are under age fifteen or sixteen, whereas those transferred from approved schools may be any age up to eighteen and thus include some whose emotional instability has become a serious problem in adolescence rather than in childhood.

174. Many children who have been considered educationally sub-normal while at school, and who have been able to benefit to a certain extent from normal or special education, are still at school-leaving age generally retarded and immature and likely to need more help than other people in order to settle into adult life; some of them may need special help and support throughout their lives. The Education Acts provide for local education authorities to report to local health authorities any children about to leave school who, because of disability of mind, may require supervision after leaving school, and they may then be ascertained as feebleminded (or as imbeciles). Some local authorities make it a practice to report in this way all children who leave special schools for the educationally sub-normal; others only report those whom they consider in immediate need of special help. Probably the majority of the feebleminded are first brought officially to the notice of the local health authorities in this way. The great majority of them are young people with some limitation of intellect and general inadequacy of personality. Some of them in addition are temperamentally unstable or may become so after leaving school, particularly if their home background is unsatisfactory.

175. Mental health social workers employed by local health authorities are able to give general help and advice to these school-leavers and to their parents and, in co-operation with the youth employment officers and the disablement resettlement officers, may help them to find work suited to their abilities and temperament or arrange some form of vocational training or

sheltered employment. As part of their mental health services some local health authorities provide workshops, laundries, sewing rooms, etc. in which feebleminded patients may work either for a period of training or permanently. By accepting such help and guidance, the majority of the feebleminded settle satisfactorily into adult life. If their general social environment is good they may not need further help, though even those who have good homes may need to be provided with a home by public authorities later in life when their parents or relatives cannot look after them any longer, if they cannot manage for themselves. But many of them manage to maintain an independent life and some of them marry. If their own home environment is not good, however, young feebleminded persons with less than average intelligence and a generally weak personality are likely to be easily led into criminal activities or into an otherwise socially unacceptable way of life or to be exploited in one way or another. Many of the feebleminded have very unsatisfactory homes, their parents often also being of low mentality. In many cases it seems probable that the poor home environment may have caused or aggravated the child's emotional and intellectual retardation. In such cases it is often desirable to give the patient a period of training under psychiatric supervision in hospital, so as to give him the opportunity of developing a greater degree of self-reliance in the hope that he will later be able to withstand unfavourable influences. Psychiatric training is usually also desirable for those with aggressive personalities. The length of time needed for such training varies. The aim is to return the patient to the general community as soon as possible, but the time needed for training is usually measured in years rather than in months, and if the patient does not respond, or only responds so long as he remains in the stable environment of the mental deficiency hospital, he is often kept there for many years. Some patients are quite content to accept the hospital regime, but their parents are often opposed to it.

176. It is not usual for local education authorities to invoke these arrangements for reporting children for supervision after leaving school in the case of children who have been considered emotionally maladjusted during their school life. The arrangements are used almost entirely for those who have been considered educationally sub-normal, whether they are merely generally inadequate or whether they are also temperamentally unstable, and whether or not they have attended special schools. It is doubtful whether the arrangements for reporting children to the local health authority for supervision under the Mental Deficiency Acts after leaving school apply, as the law stands at present, to children or young persons leaving approved schools.

177. When the sort of difficulties which we have described come to notice before, at, or soon after school-leaving age, they are generally regarded as signs of " incomplete or arrested development of mind ", justifying a diagnosis of feeblemindedness or moral defectiveness, particularly if the child has been regarded as educationally sub-normal while at school. If they do not come to notice until later on, they are more likely to be dealt with in other ways, and the diagnosis is more likely to be one of psychopathic personality rather than of feeblemindedness or moral defectiveness, though this depends partly on the interpretation which individual doctors put on the legal definition of mental defectiveness. It is laid down by the present definition that mental defectiveness is a disorder of development which must have occurred before the age of eighteen. A diagnosis of feeblemindedness or moral defectiveness cannot, therefore, properly be made unless there was some sign of mental disorder or inadequacy or abnormal aggressiveness in childhood or adolescence. Subject to this, however, the practice of individual members of the medical profession varies greatly in the interpretation they are prepared

to place on the present legal definition. Many doctors, probably the majority, never make a diagnosis of feeblemindedness or moral defectiveness, whether the patient's personality is predominantly aggressive or inadequate, unless the patient shows some limitation of intelligence or has a history of having been regarded as educationally sub-normal or backward in childhood. When they are asked to give an opinion on patients with aggressive or inadequate personalities, who are of average or superior intelligence, they are likely to regard them as inadequate or aggressive psychopaths who are not certifiable under the Mental Deficiency Acts. Other doctors, however, interpret any sign of serious personality disorder which occurred first in childhood or adolescence and has remained uncorrected as evidence of arrested or incomplete emotional development, and if this results in social difficulties sufficient to justify the use of the compulsory powers contained in the Mental Deficiency Acts, they are prepared to make a diagnosis of feeblemindedness or moral defectiveness whether or not the patient's intelligence is below average. Such a diagnosis is however rarely made with adult patients of average or above-average intelligence unless the patient's behaviour is aggressive and seriously anti-social. Often, but not always, the question arises when the person has committed some criminal offence, often of a violent nature ; the order committing him to a mental deficiency hospital may then be made on medical advice either by the court before whom he is charged or, if the court commits him to prison, by the Home Secretary, who has power to transfer defectives from prison to a mental deficiency hospital in the same way as he can transfer children or young persons to such a hospital from an approved school.

178. But even those doctors who do not consider lack of intelligence an essential criterion of feeblemindedness or moral defectiveness cannot under the present legal definition make a diagnosis of either if there is no history of any sort of inadequacy or abnormally aggressive behaviour occurring before the age of eighteen. Most of our witnesses who spoke to us about psychopaths emphasised that psychopathy usually seems to have its origins in the social environment in which the patient grew up, and that perhaps the best hope of treating the patient with any degree of success is to recognise it early. But even if looking back on the patient's history one can see possible causes of the trouble in childhood, it does not necessarily follow that he exhibited any particular abnormality of behaviour before the age of eighteen which could be taken as grounds for an opinion that his disorder falls within the present legal definition of mental defectiveness. In some cases also the psychopathic behaviour seems to be the result of an illness or injury which is known to have occurred after the age of eighteen.

179. Whether the diagnosis is one of feeblemindedness, moral defectiveness or psychopathic personality, if the patient is thought to require medical treatment and if his behaviour is seriously anti-social it is usually thought desirable to provide the treatment in hospital. Methods of treatment are still at an early stage of development and little is yet known about the real nature of the disorders or the type of treatment to which the patients may best respond. Broadly speaking, the tendency has been to give patients who are diagnosed as mentally defective and are admitted to mental deficiency hospitals the same type of occupational training as is provided for the feebleminded of more limited intelligence. Those admitted to mental or neurosis hospitals, where most of the other patients are suffering from mental illnesses uncomplicated by an underlying psychopathic personality, are usually treated by methods similar to those normally applied to the mentally ill rather than the mentally defective. A special unit has been established in recent

years at Belmont Hospital, Sutton, mainly for the treatment of psychopathic patients ; at this unit the emphasis is on re-socialising the patients as members of a community and group techniques are used rather than individual therapy.

180. One of the difficulties has been that it is often not easy to persuade these patients to enter hospital or to remain to complete a course of treatment. Psychopathic patients who are not considered certifiable under the Lunacy Act or under the Mental Deficiency Act, or who are considered to be mentally defective but are not "subject to be dealt with", cannot be compelled to enter or remain in hospital against their will. Except for the few who are willing to enter neurosis or mental hospitals voluntarily there is little possibility of giving them medical treatment except when they have made themselves liable to the sanctions of the criminal law. Their residence in hospital for a period not exceeding one year may be made a condition of probation (under Section 4 of the Criminal Justice Act, 1948—see paragraph 242) ; psychiatric treatment may also be given in prison to persons who exhibit these signs of mental abnormality and have been sentenced to a term of imprisonment by a court. Conviction for a criminal offence also makes them "subject to be dealt with" under the Mental Deficiency Act if they are diagnosed as mentally defective. Patients who are diagnosed as mentally defective and are "subject to be dealt with" on this or any other ground can be admitted to mental deficiency hospitals compulsorily and detained there for as long as is considered necessary. Any who are regarded as "of unsound mind" can be compulsorily admitted to mental hospitals. But although the phrase "person of unsound mind" may be interpreted a little more widely now than at the beginning of this century, it is still more narrowly interpreted than was envisaged by the Royal Commission of 1904–08 when they stated that the "morally insane" would be included in their proposed definition of "person of unsound mind". In suggesting to us that new powers are now needed in order to deal with psychopaths, the Royal Medico-Psychological Association described the present situation in words reminiscent of those used by the witness before the 1904–08 Commission which we quoted in paragraph 153. The Association state in their memorandum of evidence (8th Day, P. 288 paras. 167 and 168, using the term "mental disorder" here as a synonym for mental illness):

> "Logically, it might be contended that all such cases are instances of either mental defect or disorder, according to whether the condition arose during development or was acquired later ; and therefore, if there is severe disturbance of behaviour it should be possible to deal with the patient under the compulsory provisions applicable to mental disorder or mental defect.
>
> Undoubtedly, a number of such cases are so dealt with every year. But the 'intellectual' bias in mental deficiency practice has generally excluded patients with emotional and adaptive defects, even when they were true failures of development ; and in the practice of mental disorder, a similar tradition has identified 'certifiable insanity' too closely with loss of intellect or the presence of delusions. Consequently, psychopathic patients, though their minds are far from sound, are commonly said to be 'not certifiable as of unsound mind'."

Criticisms of the present terminology

181. It is generally agreed that the names of the four classes of defectives defined in the Mental Deficiency Acts are no longer suitable for everyday use. The terms "idiot" and "imbecile" are generally regarded as offensive and in our common speech are often terms of ridicule or abuse. The term "moral defective" is also generally viewed with disfavour. Some people consider it unnecessary, in that moral defectives do not form a completely separate category and under the present legal definitions any moral defective must also be either an imbecile or feebleminded. Others

object to it because it is often misunderstood, many people being accustomed to use the words " moral " and " immoral " with reference to sexual morality only. Others consider it inappropriate because in a more general sense the word " moral " implies standards of judgment quite different from those of medical diagnosis.

182. The term " person of unsound mind " is also criticised, as it gives many people the false impression that it implies a state of permanent mental instability. It was never meant to carry any such implication, and many of the patients to whom it has to be applied under the certification procedures are expected to, and do, recover quickly from their illnesses. The phrase " mentally ill " is now generally used in everyday language as a more appropriate term for patients who are certifiable under the Lunacy and Mental Treatment Acts as well as for others who are not. But the phrase " person of unsound mind " still has to be used in connection with the certification procedures, because it is the phrase used in the Lunacy Acts. This has contributed to the general misunderstanding of the implications of certification, which we discuss in paragraphs 282–286 in Chapter 4.

183. Many people now consider the term " mental defectiveness " unsuitable as a generic term for all disorders affecting the development of the mind. Some of our witnesses suggested that the term " mentally defective " should be restricted in future to patients who are seriously subnormal in intelligence as well as in other ways, and that other terms should be used for feebleminded and psychopathic patients. Others suggested that it should be applied to any patients whose intelligence is clearly below average though not necessarily seriously sub-normal, but not to any whose intelligence is average or above average and whose personality disorder is entirely one of emotional immaturity or instability.

184. We attach considerable importance to finding suitable new terms to replace those contained in the present Mental Deficiency Acts and Lunacy Acts. In the first place, it is important to use terms which will be generally understood and will not give rise to disagreement such as that which has arisen over the meaning of the term " mental defectiveness ". It is equally important to use terms which fit the modern attitude to mental disorder and to those who suffer from it. It is sometimes suggested that it is pointless to change the words used to describe any form of disease or social disability because it is the disease or disability itself which gives rise to fear or shame, and that the new terms soon attract the same odium as the old. It is better, the argument runs, to educate people to adopt a more sympathetic attitude to the disease or disability itself without changing the words. There is some truth in this, but it is also true that when the public attitude has already begun to change the old terms carry part of the odium in themselves and create a new form of fear and misunderstanding of the services and procedures in which they are used. **We consider that the public attitude towards mental disorder has outgrown the terms " idiot ", " imbecile " and " person of unsound mind ", and that new terminology is needed to mark a step forward from ancient prejudices and fears and to be an outward sign of a real advance in public sympathy.**

Recommendations for new administrative grouping and terminology

185. The present division of mentally disordered patients into the two main groups of mentally ill and mentally defective patients is a legal division based on administrative rather than clinical considerations. It is useful to draw a broad distinction between disorders which affect the course or extent of a person's mental development and which are likely to affect his basic personality throughout life, and the mental illnesses which may affect

a normally developed mind and which often last only a short time. There is also a broad practical distinction arising from the fact that mental defectiveness is usually first observed in childhood or early adolescence, which affects the type of provision needed for the patient's care, training and treatment. But this distinction is of only limited validity, even for administrative purposes. Some adult or adolescent patients whose abnormal behaviour is due to a defect in mental development but whose intelligence is not seriously impaired may benefit from treatment not dissimilar from that given, for example, to patients suffering from mild forms of mental illness which as far as can be judged have not developed until well into adult life. Some of the elderly mentally infirm may require much the same sort of care as persons of the same age who have suffered from some degree of mental inadequacy throughout their lives. The high-grade feebleminded and moral defectives in adult life present problems which are almost identical with those presented by psychopaths whose disorder has not been apparent at an earlier age. The community services which are needed to help the feebleminded are not dissimilar from those needed to help the patient recovering from an acute mental illness or left with some residual mental disability after such an illness.

186. In Chapter 2 we criticised the rigidity with which the care of the mentally defective has been separated from the care of the mentally ill under two separate legal codes during the last forty years, and recommended that the system of legal "designation" of hospitals should be discontinued and that the extent to which individual hospitals should specialise in treating particular types of patient should be purely a matter for medical and administrative arrangement. In paragraph 151 of the present chapter we pointed out that no terms or definitions need be included in the law in future except in connection with the use of compulsory powers and procedures. In Part IV of this report we recommend that such powers and procedures should be used in future only when they are positively necessary, and that most patients should receive care, training or treatment without using the procedures which accompany the use of compulsion. All this should lead to a much more flexible administrative system. In the everyday administration of hospital and community services, when referring to particular groups of patients who need particular forms of treatment, it will often be appropriate to use purely medical terms, as is commonly done now to distinguish different groups of mentally ill patients. More general terms will however also still be needed to describe the two or three main groups which need to be differentiated for broad administrative or legal purposes, i.e. because they need different types of services or because there are differing considerations in connection with the use of compulsory powers. But it will only be in connection with the use of compulsion that these terms need be written into the law.

187. We consider that for these broad administrative purposes three rather than two main groups of patients should be recognised. **We do not consider it appropriate to use any single term such as "a defective" as a common epithet for patients whose disorders may vary over so wide a range as those covered by the term "mental defectiveness" at present,** i.e. all types of disorders which affect the development of the mind in its widest sense. There is far more similarity between those among the feebleminded and moral defectives who are not severely sub-normal and psychopathic patients who are at present "not certifiable", than between these feebleminded and moral defectives and idiots and imbeciles. **We consider that in the general administration of hospital and community services, and in connection with**

compulsory powers, the higher-grade feebleminded and moral defectives and other psychopathic patients should be recognised as together constituting one main group of mentally disordered patients, the other two groups being the mentally ill and the severely sub-normal.

188. We describe these three groups more fully in the following paragraphs. We must however emphasise at the outset that each group includes patients suffering from forms of disorder falling into a variety of different medical classifications, which need to be distinguished when the type of care appropriate to each individual patient is being considered. From the medical point of view, also, there is no clear-cut distinction between our three groups, any more than there is between the mentally ill and mentally defective as those terms are used at present. 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. As we have already stated, there should be no rigid legal or administrative barriers to prevent a patient from receiving care with patients in other groups when this is appropriate to his individual needs. We also wish to emphasise that we do not wish any of these terms to be used as a permanent label on any individual for life, in the way that the term "mental defective" has tended to be applied to any patient who has been "ascertained" under the Mental Deficiency Acts. The purpose of diagnosis and classification should only be to indicate suitable forms of care for such period as the patient needs it, not to impose any permanent legal sanctions or civil disabilities.

189. 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 number of patients who need medical and social services in the community or in hospital and 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".

We discuss compulsory powers in Part IV of our report; we consider that the medical and social conditions in which it is justifiable to use such powers can be identified in future without retaining the term "person of unsound mind", which would therefore fall into disuse. The terms "mental illness", "mentally ill" and "mentally infirm" should be the normal legal and administrative terms in future, except when it is appropriate to use more precise medical terms.

190. Our second group comprises those patients suffering from a personality disorder which does not make them severely sub-normal in the sense in which we apply this term to our third group, but which is recognised medically as a form of mental disorder resulting in abnormally aggressive or inadequate social behaviour. For this group we recommend that the terms "psychopathic patients" and "psychopathic personality" should be used. We use the term "psychopathic" in a wider sense than that in which it is usually used at present. We intend it to cover pathologically inadequate as well as aggressive personalities, irrespective of the age of onset of the disorder or of the extent to which it affects the patient's intelligence, provided that the disorder does not render the patient so severely sub-normal that he falls into

our third group. We therefore include in this psychopathic group:—

(*a*) those patients who would be classified as feebleminded persons or moral defectives under the present law and who are not severely sub-normal, and

(*b*) those inadequate or aggressive psychopaths who are not considered certifiable as mentally defective or as "of unsound mind" at present.

We discuss the distinction between this group and the severely sub-normal group in paragraphs 192–195.

191. The third group consists of those patients whose personalities are so seriously sub-normal that they are incapable of living an independent life. This group includes:—

(*a*) all the patients at present described as idiots and imbeciles, and

(*b*) some of those now classified as feebleminded.

We recommend that the terms "severely sub-normal" and "severely sub-normal personality" should be used for this group.

192. In deciding whether a patient is to be regarded as severely sub-normal or psychopathic, it is the patient's whole personality which should be considered, not only or even mainly the level of his intelligence. We mentioned in paragraph 166 that the correlation between intelligence and other personality characteristics or general mental development is usually close when the intelligence is very low, but that the higher the intelligence the less reliable a guide it becomes to the general level of mental development and to a person's ability to live an independent and acceptable life in the community. Intelligence can be measured by various tests which enable one person's intelligence at any period of his life to be roughly compared with that of other people and the result expressed in a numerical formula which is described as the person's "mental age" or "intelligence quotient". Other aspects of the personality—such as powers of judgment, adaptability, emotional stability, prudence or self-control—cannot be exactly measured in this way. It is therefore both tempting and misleading to use the intelligence quotient to indicate the distinction between psychopathic patients and severely sub-normal patients. Even if intelligence were the only consideration, it would be dangerous to rely too far on the intelligence quotient as recorded on any one occasion. At its best an intelligence quotient is only the record of the result of a particular series of tests given on a particular occasion and interpreted by a particular doctor, psychologist or other person. An individual's actual intelligence may improve or deteriorate over a period of time, in childhood or in adult life, and there are other reasons why his performance may vary between one set of tests and another. Intelligence quotients are no longer regarded as infallible nor as having absolute predictive value. But in any case, intelligence is not the only or even the main consideration. The main consideration is the effect of the patient's mental condition on his ability to live as a member of the community. When the intelligence is very low, and there are no other complications such as serious maladjustment, it is a reliable pointer to the patient's general personality. When it is not extremely low but is still well below average, the limitation of intelligence may aggravate difficulties which arise from temperamental instability or emotional immaturity, so that an assessment of the patient's mental condition and its effect on his social capabilities must take both factors into account. In other patients the mental immaturity may not affect the intelligence at all but may be wholly a disorder of emotional development or adaptation, which cannot be translated into any numerical formula but whose nature and effects can be assessed by the exercise of medical judgment.

193. The broad dividing line between the patients whom we call severely sub-normal and those whom we call psychopathic comes in the middle ranges of what is now called feeblemindedness. We would consider a mental age below 7½ to 9, or an intelligence quotient below 50 to 60 on the Stanford-Binet scale, as being a pointer strongly indicative of a personality so seriously sub-normal as to make the patient incapable of living an independent life. But in some cases it may be true to say that patients are seriously sub-normal and are incapable of living an independent life even if their intelligence quotient is, say, 60 or even higher, if they have other serious defects of personality in addition, resulting in a generally sub-normal personality which makes them incapable of managing their own lives or places them in serious danger of being taken advantage of by other people. On the other hand, a person with an intelligence quotient not much over 50 who is temperamentally stable may not be severely sub-normal in this general sense. The diagnosis in each case must be a matter of medical judgment, and we consider that the term " severely sub-normal personality " would be readily understood without more precise definition beyond an indication that it always involves marked limitation of intelligence as well as other personality defects.[10] We doubt if it would be safe to assume that less than about a half to two-thirds of the patients in mental deficiency hospitals who are at present classified as feeble-minded would come into the severely sub-normal group. The proportion among the feebleminded living in the general community and receiving care from the local health authorities is likely to be lower. The rest of the patients classified as feebleminded would be in our psychopathic group.

194. Our psychopathic group can be further sub-divided into two sub-groups of patients who may need rather different forms of care, training or treatment. The common characteristic of the whole group is that the patients are suffering from a personality disorder which does not amount to severe sub-normality but which has sufficiently serious effects on the patient's behaviour to require medical treatment or some special form of social care or training. In the first sub-group one sign of the patient's personality disorder is that the intelligence is well below average ; in the second sub-group the intelligence is near or above average. When a special term is needed to differentiate the first sub-group we use the term " feebleminded psychopath ". We differentiate between these two sub-groups only in connection with the provision of suitable forms of care, as we recommend in Part IV of our report that the whole group should be treated alike as far as compulsory powers are concerned ; any term used for a sub-group therefore need not appear in the law.

195. We have already said that there are no clear-cut medical distinctions between these three groups of patients. On the borderline, there may be little difference between the least seriously disabled patients in the severely sub-normal group and the most severely disabled feebleminded psychopaths. The medical distinction between some forms of psychopathic personality and some forms of mental illness, particularly those types or degrees of illness which would not at present make the patient liable to detention as a " person of unsound mind ", is also not entirely clear. In addition, many patients

[10] We use the term " severely sub-normal " in a much wider sense than that recommended by a Committee of the World Health Organisation whose report on mentally sub-normal children was published in 1954. (*World Health Organisation Technical Report Series*, No. 75, Geneva, 1954.) This Committee recommended the term " mentally sub-normal " for all those whose general mental development, including their intellectual development, is insufficient; they used the term " severe sub-normality " for those in the I.Q. range 0–19, " moderate sub-normality " for those in the I.Q. range 20–49 and " mild sub-normality " for those in the I.Q. range 50–69. We use the term " severely sub-normal " to cover all the patients in this Committee's " severe " and " moderate " groups, and some of those in its " mildly sub-normal " group.

exhibit symptoms both of psychopathic personality and of severe forms of mental illness. The distinctions between patients on the border-lines of the three groups will be important in future, in the new legal and administrative system which we envisage, only when there is a question of using compulsory powers. We discuss in Chapter 6 whether any of our three groups of patients need to be more precisely defined in connection with the use of compulsion. We recommend in that chapter that other safeguards and limitations on the use of compulsion should be introduced, but that no attempt should be made to define in detail the nature of psychopathic or severely sub-normal personality or the behaviour which results from it. In spite of the fact that at some points the three groups may be said to merge into each other, we do not expect doctors to have any more difficulty in applying the terms " psychopathic ", " severely sub-normal " and " mentally ill ", and distinguishing them from each other in connection with the use of compulsory powers, than they have had in applying the term " person of unsound mind " in the past and in distinguishing " persons of unsound mind " from other mentally ill patients. And the very fact that the law would recognise these three groups of mentally disordered patients should help to prevent differences of medical opinion such as have arisen over the extent of the meaning of the term " mental defectiveness ". In choosing the term " psychopathic " to describe our second group of patients, we are conscious that at present the word " psychopath " is used in various different senses, and that it is finding its way into popular language mainly with reference to criminals. But we feel that the use of the term is still sufficiently fluid for doctors and the general public to find no difficulty in accepting it for general use in the broader sense which we have indicated. We feel equally confident that its use is not likely to spread beyond legitimate cases of real mental abnormality when the question at issue is whether the patient should be compelled to enter hospital for medical treatment.

196. No one of our three groups corresponds with the educational terms " educationally sub-normal " or " maladjusted ". Our severely sub-normal group will include some patients who as children are at present considered ineducable, some patients who will have attended special schools for the educationally sub-normal, and some who will have attended ordinary schools. The psychopathic group will include some who are classified as " educationally sub-normal " or " maladjusted " while at school, as well as many whose need for special treatment will not have been apparent during their school life.

197. We considered whether the term " mental defect " or " mentally defective " should be retained to apply to the severely sub-normal group only, but decided that it would cause unnecessary confusion to recommend that a term which is already used in the law in one sense should be used in future legislation in a narrower sense. If this term is to be used in new legislation, it would be necessary to distinguish its new use by a new legal definition. We prefer to recommend terms which in our view will carry a sufficiently clear meaning to the medical profession and to the other persons whose duty it will be to operate the new legislation, without a definition of the type contained in the present Mental Deficiency Acts. **We recommend that the terms " mental defectiveness ", " mental deficiency " and " mentally defective ", which have been the subject of so much argument and misunderstanding, should no longer be used.**

198. In the rest of our report we use the terms " mentally ill ", " psychopathic ", " feebleminded psychopath " and " severely sub-normal ", as far as we can. We always use them when describing the procedures and services which we recommend for the future. But we cannot avoid using the present

legal terms when describing the present procedures and administration of services ; in describing earlier history we must use even older terms.

RECOMMENDATIONS IN PART III

(1) For legal and administrative purposes three main groups of patients should be recognised and the following terminology used:—

Mental disorder (mentally disordered patients) : to be used as a general term covering all forms of mental ill-health or disability.

Mentally ill patients: The term " mental illness " should be used in the same sense as at present, including the mental infirmity of old age. The term " person of unsound mind " should no longer be used.

Psychopathic patients, or patients with psychopathic personality: The term " psychopathic personality " should include any type of aggressive or inadequate personality which does not render the patient severely sub-normal (as below), but which is recognised medically as a pathological condition. Psychopathic patients include any patients at present classified as feebleminded or moral defectives who do not fall into our severely sub-normal group, as well as psychopaths who would not fall within the present legal definition of mentally defective persons. The term **" feebleminded psychopath "** may be applied to psychopaths whose disorder includes a marked limitation of intelligence but still does not bring them into our severely sub-normal group.

Severely sub-normal patients, or patients with severely sub-normal personality : This term should be used when the general personality (covering intelligence and temperament together) is so severely sub-normal that the patient is incapable of leading an independent life. Severely sub-normal patients include those at present classified as idiots and imbeciles and some of those now classified as feebleminded. The terms " idiot " and " imbecile " and the terms " mental defective " and " defective " should no longer be used.

(Paragraphs 185–198.)

PART IV

THE PROCEDURES APPLIED TO INDIVIDUAL PATIENTS

CHAPTER 4

CARE AND COMPULSION: THE PRESENT LAW

Detention and certification

199. In England and Wales in the eighteenth century, only people whose behaviour or sayings were seriously abnormal were recognised as "lunatics" or "idiots", and it was common practice to chain or tie them up or otherwise prevent them from wandering abroad. Many were kept at home, in the houses both of the rich and of the poor. Some were admitted to "private madhouses" run for profit by private individuals. Other patients were admitted to Bethlem or to other voluntary hospitals. Many other mentally disordered people, who had no one to look after them and had been taken up as paupers, vagrants or criminals, were to be found in poorhouses, workhouses, houses of correction and gaols. An Act of 1744 ". . . to make more effectual the laws relating to rogues, vagabonds and other idle and disorderly persons . . ." provided for the apprehension and detention of dangerous lunatics. "Persons, who by lunacy, or otherwise, are furiously mad, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad" might, on the order of two or more justices of the peace, be "apprehended, and kept safely locked up in some secure place . . . or chained . . . for and during such time only as such lunacy or madness shall continue".

200. The conditions under which patients were kept, in private and public institutions alike, and whether or not under medical supervision, were usually very bad. Physical ill-treatment was sometimes deliberate, in an attempt to drive the madness out, sometimes the result of indifference or neglect, and sometimes due to the application of the standards of judgment and treatment which were then considered proper for all who could not or would not work for their living or who broke the law and became subject to its severe penalties. During the latter half of the eighteenth century more humane methods of treatment began to be used by pioneers in the medical profession. Feeling was aroused by reports of the conditions in both public and private institutions, and there was concern at allegations that people who were not insane were being improperly detained in private madhouses. The movement for lunacy reform continued, throughout the nineteenth century and into the twentieth, to have three main aims—(i) to prevent the physical ill-treatment of the mentally disordered; (ii) to ensure that such people were housed under suitable conditions, preferably in institutions specially provided for them; (iii) to ensure that no sane person could be improperly detained as a lunatic. The long series of Acts of Parliament which were passed from 1774 to 1890 tried to achieve these aims through the control and inspection of private institutions by local or central public authorities, through the provision by local authorities of special "asylums" where suitable care would be provided, and through an elaborate system of safeguards against improper detention, one of the chief safeguards being the requirement of medical or other certificates describing the mental condition of any person who was to be admitted and detained.

201. All the early legislation assumed that everyone admitted to private or public institutions would be detained until he recovered from his madness or was discharged to the care and protection of relatives or friends. The early Acts controlling private madhouses, which became known as "licensed houses", assumed that all insane persons admitted would be "confined". The first Act authorising the provision of special public asylums was passed in 1808. These asylums were to house three classes of patients—(i) dangerous lunatics detained under the Act of 1744 which we mentioned in paragraph 199; (ii) criminal lunatics detained "during His Majesty's pleasure" under the first Criminal Lunatics Act, passed in 1800; (iii) pauper lunatics who were to be transferred from poorhouses or "houses of industry". Agreements could also be made whereby persons who were not paupers but whose relatives paid for their maintenance according to their means could also be admitted, so that one asylum might serve both non-pauper and pauper patients. Legal authority for the detention of "dangerous lunatics" and "criminal lunatics" already existed; the Act of 1808 provided authority for the detention of all other lunatics admitted to the new asylums: "all lunatics, insane persons or dangerous idiots so committed to such asylums shall be safely kept and ... no such person shall be suffered to quit the said asylum or to be at large until the visiting justices" (i.e. the managing committee of the asylum—see Chapter 9) "or the greater part of them shall order the discharge of such person and shall signify the same in writing under their hands and seals; and ... if any officer, servant or assistant in such asylum shall notwithstanding, through neglect or connivance, permit such person in any case to escape and be at large without such order as aforesaid, he or she shall for every such offence forfeit and pay a sum not exceeding ten pounds nor less than forty shillings ...". The law still makes any member of the staff of a mental hospital today liable to a fine "not exceeding twenty pounds nor less than two pounds" if he "wilfully permits, or assists, or connives at the escape or attempted escape of a patient . . ."

202. The early Acts required various orders and certificates to be signed before persons might be admitted to be confined or detained in these private or public institutions. The order and medical certificate to be signed before a patient might be admitted to a private licensed house were among the earliest of the many safeguards against the improper detention of sane persons in such houses which were evolved during the eighteenth and nineteenth centuries. Before 1890[1] the documents required were an order or authority from the relative or other person arranging for the patient's admission, and a certificate signed by one or two medical practitioners certifying, among other things, that the patient was insane and was a proper person to be confined. From 1890 onwards the relative or other person could not himself authorise the patient's admission except in a case of urgency, but had to present a petition for an order to be made by a specially appointed justice of the peace.

203. There were rather different reasons for the order and certificate required when patients were to be admitted to public asylums. In the first place, it was necessary to establish that any person who was to be provided with this type of care at public expense was actually in need of it. From that point of view the order and certificate were equivalent to the order for the admission of a pauper to a workhouse, and to the order and medical certificate which were required until as recently as 1948 for the admission

[1] The Lunacy Acts (Amendment) Act, 1889, introduced many important amendments of previous legislation; these came into force in 1890 and were embodied in the consolidating Lunacy Act, 1890, which is the basis of the present law.

of any patient, except in an emergency, to a poor law hospital. Secondly, the cost of maintaining pauper patients in asylums fell wholly or partly on the poor law authorities; as the cost of maintenance in an asylum was likely to be greater than the cost of maintenance in a poorhouse or workhouse, some authority was needed to achieve the transfer of suitable patients to the asylums. The fact that patients in asylums were subject to detention also made it necessary to have specific authority in each case. Under the Act of 1808, the overseers of the poor for parishes within any county for which an asylum had been provided were made responsible for informing the justices of all lunatics and insane persons chargeable to their parish, and the justices were authorised to issue warrants for the conveyance of such persons to the asylums. The justices were clearly the appropriate persons to do this; they were themselves the managers of the asylums (see Chapter 9), they already had authority to order the detention of dangerous lunatics, and at that time they had authority under the general poor law to order poor relief to be given to any person; at the same time as he issued the warrant for the patient's conveyance to the asylum the justice was to make an order on the parish overseer for the payment of the sum necessary for the patient's maintenance in the asylum.

204. Under the Act of 1808 no medical certificate of insanity was required before a pauper could be admitted to an asylum, but by 1819 a certificate was required in a standard form prescribed by law. This had to state that the physician, surgeon or apothecary signing the certificate had, at the direction of the justices, personally examined the patient and that the patient "appears to me to be of insane mind"; no details of the grounds on which this opinion was founded had to be given. During the course of the nineteenth century the forms and procedures were made more elaborate. By 1853 the medical certificates for both non-pauper and pauper patients required the certifying doctor to state that the patient "is a lunatic (or an idiot or a person of unsound mind) and a proper person to be taken charge of and detained under care and treatment", and to give the grounds upon which he had formed this opinion, distinguishing between facts observed by himself and facts communicated by others. This is the form of medical certificate still used today for the admission of certified patients to mental hospitals, except that the term "lunatic" is no longer used. It was never intended that the description of a person as a lunatic or a person of unsound mind in these certificates should imply that he was permanently insane. All the nineteenth century Acts provided for the patient's discharge on recovery, and the medical certificate was intended to relate only to his mental condition at the time of admission.

205. From the very beginning there was a distinction between the forms and procedures for the admission and discharge of paying and pauper patients. At certain periods there were also distinctions between "in-county" and "out-county" paupers, and special procedures for some non-pauper patients admitted to public asylums. Distinctions between the procedures used for paupers, non-paupers admitted on the application of a relative, and non-paupers admitted to public asylums on judicial order having been found not to be under proper care or control, lasted until 1948. The sets of procedures were then reduced to two and each was made available for both paying and non-paying patients. This is the historical reason why the present law provides two main sets of alternative procedures for the admission of certified patients to mental hospitals.

206. The provision of asylums by the justices of the peace proceeded very slowly, even after their permissive powers under the 1808 Act were changed into a positive duty under another important Lunacy Act in

1845. Many mentally disordered people were still housed in workhouses. There was no specific authority to detain them there if they tried to leave, until the Poor Law Amendment Act of 1867, which included a section authorising the detention of any person already in a workhouse who was "suffering from mental disease or from bodily disease of an infectious or contagious character", if the medical officer of the workhouse reported that the patient was not in a proper state to leave the workhouse without danger to himself or others. In the consolidating Lunacy Act of 1890 this was repealed in so far as it applied to mental disease, and other powers to detain mental patients in workhouses were conferred by Section 24 of the 1890 Act; but the phrase "suffering from mental disease" was dropped in favour of the term "lunatic", which was used throughout the 1890 Act and was defined as meaning an idiot or a person of unsound mind.

207. We explained in Chapter 3 what meaning was attached during the nineteenth century to the words "lunatic", "idiot" and "person of unsound mind", as used in the Lunacy Acts. Broadly speaking, these terms covered between them all gross forms of mental abnormality, but not feebleminded-ness or other forms of mental disorder which do not seriously affect the patient's reason or intellect. Many idiots and imbeciles were certified as "idiots" under the Lunacy Acts; they were usually housed in the same lunatic asylums or workhouses as "persons of unsound mind", though a few public authorities provided separate institutions for different types of patients; even when separate institutions were provided, however, the classification of patients did not always correspond in practice to the intention for which the institutions were originally meant to be used.

208. During the latter half of the nineteenth century voluntary societies founded a few "idiot asylums", which admitted the types of patient now known as idiots, imbeciles and feebleminded, and other homes for the feebleminded only (see paragraph 148). Both types of institution had as their main object the provision of suitable education and training for these patients, and a sheltered environment in which they might live and work, if necessary all their lives. The Idiots Act, 1886, gave authority for the detention of any persons placed in idiot asylums by their parents or guardians. There was no power to detain patients in "homes for the feebleminded" either for training or for protective care; but after some ten to twenty years experience the managers of the homes reached the conclusion that, though some of the feebleminded could be cared for on a voluntary basis, there should be some power to detain compulsorily, against their own or their parents' wishes, those who would almost certainly be unable to hold their own in the world if discharged.[2]

209. The main work of the Royal Commission on the Care and Control of the Feeble-minded which was appointed in 1904 was to consider the needs of the feebleminded and other mentally disordered persons who were not considered certifiable under the Lunacy Acts, and the need for special forms of treatment for idiots and imbeciles. There were only a few idiot asylums and homes for the feebleminded, and the enquiries made by the Royal Commission showed that a great many idiots and imbeciles were still being certified under the Lunacy Acts and detained with persons of unsound mind in lunatic asylums or workhouses. Many others, and many feeble-minded persons who were unemployed or unemployable, lived temporarily or permanently in workhouses without being certified or detained. Many feebleminded people were habitual criminals, being continually discharged

[2] *Report of the Royal Commission on the Care and Control of the Feeble-minded*, 1908, Cd. 4202, paragraphs 497, 518, 520.

from prison sentences either to the workhouses or to an unsettled life in common lodging-houses or casual wards. The power to detain people in workhouses under Section 24 of the Lunacy Act, 1890, applied only to "lunatics". The Royal Commission pointed out that the substitution of that word for the phrase "person suffering from mental disease" originally used in the Poor Law Amendment Act, 1867, had restricted the type of mentally disordered persons who might have been detained in workhouses under a broad interpretation of the earlier phrase.[3]

210. The Royal Commission were in no doubt that it was necessary in the interests of the feebleminded that there should be power to detain them in workhouses or in more suitable special institutions, and that other forms of supervision or guardianship involving various degrees of control should also be authorised. They recommended that the Lunacy Acts should be amended so as to provide for the care and control of all the nine groups of "mentally defective"* patients which we mentioned in paragraph 154 in Chapter 3. They envisaged one comprehensive Act under which special care for all these groups could be provided, separated completely from the poor law; supervision or guardianship while living in the general community might be sufficient for some people in some of the groups, but all of them would also be eligible for admission to special institutions, and "the protection of the mentally defective* person, whatever form it takes, should be continued as long as it is necessary for his good". This would involve powers of segregation and detention.[4]

211. Powers of detention in the eyes of most people today are objectionable in principle and are to be used only when it is impossible to manage without them. At the beginning of this century social reformers with the interests of the mentally disordered at heart considered certification a privilege which brought with it the benefits of protective legislation. This is abundantly clear throughout the Report of the Royal Commission on the Care and Control of the Feeble-minded, from which we may quote the following extracts:—

> "Our first principle is that persons who cannot take a part in the struggle of life owing to mental defect*, whether they are described as lunatics or persons of unsound mind, idiots, imbeciles, feeble-minded or otherwise, should be afforded by the State such special protection as may be suited to their needs. Heretofore, lunatics, idiots and imbeciles have received the protection of the law. . . . We propose that this principle of special protection should be extended to all mentally defective* persons. . . . The State should have authority to segregate and to detain mentally defective* persons under proper conditions and limitations, and on their behalf to compel the payment of contributions from relations who are able to pay for their support; or should itself provide such care and accommodation as may be necessary either directly or through the local authority. This, subject to many variations and adjustments, is an extension to the whole class of the mentally defective* of advantages now given to lunatics and idiots only."[5]
>
> ". . . These and other advantages, we hope, may follow from the use of the nomenclature which we recommend, and the methods of certification and provision which depend on it. It can be argued that the Lunacy Act of 1890 covers, or should cover, the whole ground of mental defect* which may be included in the terms "lunatic", "idiot" and "unsound mind", if to the last of these words a very wide meaning indeed be attached. But in fact, except casually and arbitrarily, all mentally defective* persons but "lunatics" and "idiots" have come to be excluded from the operation of the Act. We hope,

[3] Ibid., paragraphs 142–3.
[4] Ibid., paragraph 19 (4).
[5] Ibid., paragraph 19.
* Used in the wide sense in which we use the term "mental disorder"

therefore, that with the aid of a remodelled Statute and by the adoption of the nomenclature which we recommend, many persons who are not "lunatics" or "idiots", and who require very different treatment from either, may receive the protection which they greatly need, but which is altogether denied them at present."[6]

212. The Royal Commission's recommendation that the Lunacy Acts should be extended to cover all forms of mental disorder was not acted on, but the Mental Deficiency Act, 1913, authorised the provision of special forms of care and control for idiots, imbeciles, feebleminded persons and moral imbeciles. Local authorities were made responsible for "ascertaining" all the defectives in their area who were in any of the various forms of social difficulty which make them "subject to be dealt with" under the Act, and for providing suitable "supervision" or, if supervision affords insufficient protection, for arranging admission to an institution certified for this purpose, or to guardianship. All patients admitted to institutions under the procedures laid down in the Act were to be subject to detention. The new mental deficiency services were to be closely controlled by the new central authority, the Board of Control, which was set up under this Act and which replaced the earlier Lunacy Commissioners. No defective admitted under the procedures laid down in the Act was to be discharged from an institution or from guardianship without the Board's order or consent, except on a special review at age twenty-one by Visitors appointed by justices.

213. The Lunacy Acts, 1890–91, and the Mental Deficiency Act, 1913, provided between them comprehensive legal and administrative machinery for the care of defectives who were "subject to be dealt with" and of all mentally ill patients who were "of unsound mind and proper persons to be detained under care and treatment". It was envisaged that care would usually, though not always, be provided in institutions. It was assumed that for care to be effective it must be accompanied by power to detain the patient under care. Persons of unsound mind and mental defectives were regarded as people who were, temporarily or permanently, irresponsible and incapable of protecting themselves. They were to be cared for as children are cared for by a benevolent authority with parental powers of control. But though protective detention was considered very desirable for the mentally disordered, it was still necessary to ensure that it was not abused in the form of improper detention of people who were not mentally disordered. The law retained the elaborate system of medical certificates and judicial orders before admission, and other forms of safeguard after admission, which had been evolved during the nineteenth century. The Mental Deficiency Act, 1913, allowed some defectives to be placed in institutions, under certain circumstances, by their parents or guardians, on the strength of medical certificates, without a judicial order. But apart from this, and apart from the arrangements for voluntary boarders in licensed houses and registered hospitals which we describe later, all the admission procedures laid down in the Lunacy Acts and Mental Deficiency Acts required at least one medical certificate of "unsoundness of mind" or "mental defectiveness" and an order by a justice at the time of admission, except in emergencies.

214. This had two important results. The first was that no patient could be admitted without a firm medical diagnosis of a mental disorder and social conditions serious enough to justify powers of detention. The law envisaged no gradations between "unsoundness of mind" and sanity, and no doubt about the possible causes of retardation of a child's development. A person could not be admitted to an asylum until his unsoundness of mind, as strictly interpreted by medical tradition, was established beyond reasonable doubt

[6] Ibid., paragraph 565.

and often, in those days, beyond hope of cure. A child might not be taken into a mental deficiency institution for a period of prolonged observation before a definite diagnosis was made. An order for a defective's admission to hospital could not be made unless he was "subject to be dealt with" under the circumstances specified in the Mental Deficiency Act. The other important point was the association between admission to mental or mental deficiency hospitals and the justices of the peace. There is little doubt that this has contributed to the popular misunderstanding of the true purpose and implications of the certification procedures, as described later in this chapter. We discuss the part played by the justices in the present procedures more fully in paragraphs 264–269.

215. **Both these features of the admission procedures were corrected to a certain extent, in relation to mentally ill patients, by the Mental Treatment Act, 1930, which made it possible, as we describe later in this chapter, for patients to be admitted to mental hospitals as voluntary or temporary patients without "certification". But these other methods of admission do not apply to mental deficiency hospitals, and in mental hospitals may only be used for patients who are willing to be admitted and are considered capable of understanding the significance of signing an application form, or for patients whose mental confusion is such that they are incapable of expressing willingness or unwillingness to be admitted and for whom such treatment is expected to assist recovery. For all other patients the procedures which have come to be known as "certification", which involve the detention of the patient, provide the only method of admission to designated mental and mental deficiency hospitals, except under emergency or other procedures for short periods only.**

Voluntary treatment and admission to hospital without certification

(i) Mentally ill patients

216. As early as 1853 the law permitted the presence of "voluntary boarders" in licensed houses, under strictly controlled conditions, but not in public lunatic asylums. At first voluntary boarders in licensed houses were restricted to patients who had already been admitted under certificates of insanity, had recovered at least partially, and wished to remain for further treatment. Later, licensed houses were allowed to admit as a voluntary boarder anyone who had been discharged from treatment in an asylum, registered hospital or licensed house not more than five years previously. By 1890 there was no legal prohibition on the admission of voluntary boarders who had not previously been treated for insanity. But even then, although voluntary boarders once admitted were to be visited and seen by the visiting justices and Lunacy Commissioners in the same way as certified patients, and although the law laid down that they must be discharged within twenty-four hours of their giving notice of their intention to leave, so strong was the feeling that certification and detention was the proper course for people who were actually "insane", and so strong was the fear of the improper admission of other persons and the general distrust of licensed houses, that precautions were taken to ensure that no one was admitted as a voluntary boarder unless he was rational enough to take personal responsibility for his own admission. The Act of 1853 had required two members of the Lunacy Commission to satisfy themselves, by personal examination of the patient, of his desire to remain as a voluntary boarder, before they gave consent to his doing so. By 1890 the procedure was that the written consent of two of the Lunacy Commissioners or licensing justices was required before any voluntary boarder might be admitted to a licensed house. This was to be given only on the receipt of a written application from the prospective patient himself. If

the visiting justices or visiting commissioners considered the patient "unsuitable" to be a voluntary boarder when they saw him later, they were to order steps to be taken for his certification and detention if they considered him insane, or for his discharge.

217. Voluntary boarders were also accepted in registered hospitals under conditions laid down in the regulations of each hospital. But voluntary admission to public lunatic asylums or mental hospitals was prohibited by law until the London County Council obtained powers under a private Act in 1915 to establish the Maudsley Hospital for the reception and treatment of "any person suffering from incipient insanity or mental infirmity who is desirous of voluntarily submitting himself to treatment". In 1924 the City of London obtained powers for the admission of voluntary boarders to their mental hospital. In 1926 the Royal Commission on Lunacy and Mental Disorder recommended that facilities for treatment without certification needed extensive development, and that it should be made possible for patients to be received as voluntary boarders in any public mental hospital, registered hospital, licensed house, general hospital, nursing home or in single care. This was primarily intended to make it possible for such hospitals to treat mental illness in its milder forms, or in the early stages when treatment had most hope of success, before the illness had progressed to a stage at which a doctor was prepared to certify that the patient was "of unsound mind". The Mental Treatment Act, 1930, gave effect to the Royal Commission's main recommendations for the admission of voluntary patients and also introduced a new category of "temporary patients". It is this Act which governs the present procedures for the admission of any patients, other than certified patients, to designated mental hospitals to-day.

218. The conditions under which the Mental Treatment Act allows patients to be admitted as voluntary patients are very similar to those under which voluntary boarders had previously been admitted to licensed houses, except that the consent of the central commissioners is not required before admission. Each adult patient has to sign an application form as evidence of his willingness to enter the hospital, and is obliged to give seventy-two hours notice of his intention to leave. If his mental condition becomes such that he is considered no longer capable of expressing willingness or unwillingness to continue to receive treatment he may not remain as a voluntary patient for more than twenty-eight days unless in the meantime he regains his volition and his willingness to remain; he must either become a temporary or certified patient, or leave the hospital. If a voluntary patient has been seen by one of the commissioners of the Board of Control, and the Board consider that the patient's mental state makes him "unfit to remain as a voluntary patient", they may order him to be discharged or steps to be taken for him to be certified or made a temporary patient. **Because no one may be a voluntary patient unless he can give positive evidence of his willingness to be so, some patients who are not considered capable of giving a valid signature on the application form but are not eligible for admission as temporary patients may only be admitted under the certification procedures, even though they are not positively unwilling to be admitted and even if they could in fact be treated and cared for without powers of detention.**

219. The 1924–26 Royal Commission deliberately recommended that voluntary admission should be restricted to patients with "true volition", but at the same time they recommended that other patients with a prospect of recovery should be admitted in the first place under a new procedure for a period of treatment without full certification. This new procedure was to provide authority for the compulsory admission of patients who were unsuitable or unwilling to be received as voluntary patients, and for their detention

in the first place for a period of one month, which might be extended for a further five months. Under this procedure, a relative or friend of the patient or a public official would make an application for the patient's admission, with the support of one medical recommendation for treatment; this application and recommendation would be submitted to a justice, who might make what was to be known as a "provisional treatment order". There would be no "certificate" that the patient was "of unsound mind", only a medical recommendation for treatment; it was intended that this procedure would not be regarded as "certification". A "full certification" procedure was also to be available, for use either as an alternative to the new procedure, or afterwards if the patient did not respond to treatment within the period of "provisional treatment". The Commission thus did not envisage certification as the normal alternative for patients who could not be accepted as voluntary patients, but expected that most of them would be admitted under a "provisional treatment order" in the first place, and that during the period of one to six months many patients would recover and be discharged or become voluntary patients and thus avoid certification.

220. The Commission's recommendations were however not adopted in full. It was evidently felt that the proposed procedure for a provisional treatment order, which would involve a justice's order, would be barely distinguishable from the procedure for "full certification", and the proposal was not proceeded with. The Commission had considered the alternative of admission without a justice's order for all "involuntary" patients who had a prospect of recovery, but had reluctantly rejected it as being too far ahead of public opinion at that time. This alternative was revived, and accepted by Parliament, for the smaller category of "non-volitional" patients only, that is, those incapable of expressing willingness or unwillingness to receive treatment. The Mental Treatment Act allows such patients to be admitted, under certain conditions, as "temporary patients" without certification. The procedure provides for an application for the patient's admission to be made by a relative, friend or public official or other person, supported by two medical recommendations but without a justice's order. The patient must be one who is "suffering from mental illness and is likely to benefit by temporary treatment but is for the time being incapable of expressing himself as willing or unwilling to receive such treatment". The medical recommendations also have to state that admission is "expedient with a view to (the patient's) recovery". Temporary patients may be detained for treatment for up to six months, which may be extended by the Board of Control for up to twelve months in all. If after twelve months the patient needs further treatment but is still unsuitable or unwilling to become a voluntary patient, he may not remain in the hospital unless he is formally "re-admitted" as a certified patient. The Act also lays down that a temporary patient may not remain as such more than twenty-eight days after becoming capable of expressing willingness or unwillingness to remain; unless he again loses volition within the period of twenty-eight days he may remain only if he is accepted as a voluntary or certified patient. The Mental Treatment Act left substantially unchanged the old procedures for the "certification" of patients not eligible for admission as voluntary or temporary patients.

221. Since the passing of the Mental Treatment Act in 1930 an ever increasing number of patients have been admitted as voluntary patients. Seventy-five per cent of all admissions to designated mental hospitals in England and Wales are now voluntary; in some hospitals the rate is over 90 per cent. It has been found possible to admit as voluntary patients many more than those suffering from the milder forms or the early stages of illness; many patients whose illness is such that they could be certified quite properly

as "of unsound mind" have sufficient insight into their condition to wish to receive treatment and are accepted as voluntary patients.

222. Patients who are not positively unwilling to enter hospital may however be considered ineligible for admission as voluntary patients on either of two grounds: (*a*) The doctors may consider that though the patient expresses willingness to enter hospital it is extremely unlikely that he will stay to complete his treatment, and that he can only be satisfactorily treated if the hospital have power to detain him. (This applies mainly to patients who have previously been admitted as voluntary patients and have then refused to accept treatment.) (*b*) The patient may not be considered capable of signing an application form or of understanding its significance.

223. Patients who are not acceptable as voluntary patients on the second of these two grounds are not necessarily eligible for admission as temporary patients. The phrase "incapable of expressing willingness or unwillingness" is one which it is not easy to interpret, and has been restricted in medical practice to patients who are quite disorientated and out of touch with their surroundings. Some patients who are not considered capable of giving a valid expression of willingness by a signature on a voluntary application form are not considered sufficiently incapable of expressing willingness or unwillingness to be accepted as temporary patients; they can therefore only be accepted under the certification procedures. Another restriction on the use of the temporary patient procedure is the stipulation that treatment will assist the patient's recovery. Although some doctors interpret this condition with considerable latitude, it may prevent the temporary admission procedure being used, for instance, for old people whose mental faculties have degenerated in the process of ageing and who are unlikely to recover, even if they fulfil the other conditions for being accepted as temporary patients. Other elderly patients are often incapable of signing a voluntary application form, and for this reason they may have to be certified before they can be admitted to a mental hospital.

224. One of the main reasons for the large number of voluntary admissions to mental hospitals since 1930 has been the dramatic progress which has been made during the present century in the understanding and treatment of mental illness. A new approach to treatment has been made possible through various forms of psychotherapy, by fresh developments in neurology and neuro-surgery, by the use of new drugs and other largely empirical physical forms of treatment, and by progress in the development of social sciences and the study of human behaviour in the community as well as in the individual. At the same time the inter-relation between physical and mental health has become more widely appreciated, and this has helped to break down the previous isolation of psychiatry from other branches of medicine which we mention in Chapter 9. The result of all this has been a revolution in the general attitude towards mental patients and the abandonment, as far as possible, of restrictions on their liberty and freedom of movement while under treatment, as well as greatly improved medical techniques which have made prospects of cure and recovery far better than they were fifty or even twenty years ago. The new techniques have also made it possible to develop out-patient treatment on a large scale. All this has had a great effect on the attitude of the general public and on the willingness of individual patients to enter mental hospitals voluntarily when in-patient treatment is necessary. Nevertheless, nearly 20,000 patients a year are still admitted as certified patients, and about 70 per cent. of the patients in the mental hospitals at present are certified patients (see Table 8 in Appendix IV).

225. **An important recent development has been the provision of psychiatric treatment in hospitals which are not designated or approved for receiving patients under the Lunacy and Mental Treatment Acts, and which are therefore free to give psychiatric treatment without observing the procedures laid down in those Acts.** As it is an offence under the present law to receive "persons of unsound mind" except in the designated hospitals and other places recognised under the Lunacy and Mental Treatment Acts, it has not been thought proper to arrange for the treatment of the more severe forms of mental illness in other hospitals. But beds have been provided for patients suffering from comparatively mild forms of mental illness in general and teaching hospitals and in special neurosis hospitals which are not designated as mental hospitals. In addition, since 1950, some of the buildings which previously formed part of designated mental hospitals (usually separate "villas" in the grounds of the main hospital) have been "de-designated"—a barbarous expression signifying that legally they are no longer designated under the Lunacy and Mental Treatment Acts and are not obliged to observe the procedures laid down in the Acts. Patients enter these emancipated units and the neurosis hospitals just as they would enter any general hospital, without having to sign any application form, without any obligation to give seventy-two hours notice of their wish to leave, and without any notification of their admission or discharge being sent to outside authorities such as the Board of Control or the local health authority. In parts of the country where there are no emancipated units and no neurosis hospitals similar patients are treated in mental hospitals under the procedures laid down under the Lunacy and Mental Treatment Acts and Rules.[7]

226. Another type of hospital for psychiatric patients not designated under the Lunacy and Mental Treatment Acts is usually referred to by the less barbarous but still rather clumsy name "long-stay annexe" or "long-stay psychiatric annexe". Such hospitals receive mostly elderly patients suffering from mental disorder pronounced enough to need nursing attention under psychiatric direction but not requiring the type of active treatment which can only be provided in a fully equipped mental hospital. Some of these patients have already had a course of treatment in a mental hospital, others may have been treated in a general or geriatric hospital or may be admitted straight from home. Some of these "annexes" are administered in association with a mental hospital, some with a geriatric or chronic sick hospital, and some are independent units. Admission is without any legal formality and there is no power to detain patients against their will should they wish to leave. But some of the patients might well be considered incapable of giving a valid signature on an application form, and if there were no facilities available for their treatment except in a designated mental hospital (as is the case in many parts of the country) they could enter only as

[7] At Mapperley Hospital, Nottingham, the number of certified patients has been progressively reduced in recent years until at the end of 1956 none of the patients in the hospital was certified. This hospital of 1,054 beds serves a population of 390,000 in and around Nottingham. 310 of its beds have been "de-designated"; the rest of the hospital (744 beds) is a designated mental hospital and is also designated to receive patients under Sections 20 and 21 of the Lunacy Act, 1890. In recent years all patients have been admitted either as voluntary patients or to beds outside the Lunacy and Mental Treatment Acts or under Sections 20 or 21. Those admitted under Sections 20 or 21 who need to remain longer than the period for which they may be detained under those sections (including any extension under Section 21A) almost always agree to remain as voluntary or "non-statutory" patients, and it is now very rare for any patient to be certified. By a process of constant review it has also been possible to discharge or "re-grade" all the certified patients admitted in earlier years, those who remain in the hospital having become voluntary or "non-statutory" patients. The patients in the hospital on March 1st, 1957, consisted of 303 non-statutory patients, 746 voluntary, 4 detained under Sections 20, 21 or 21A, and 1 certified.

certified patients under powers of detention, or a few as temporary paients.[8]

(ii) Mentally defective patients

227. We mentioned in paragraphs 207–211 that separate institutions for the training of mental defectives were first provided by voluntary organisations, that those registered under the Idiots Act, 1886, had power to detain patients and other homes for the feebleminded had not, and why the Royal Commission of 1904–08 recommended more extensive powers of detention and the provision of special public institutions separate from the lunatic asylums. It is not entirely clear from the Commission's report whether they envisaged any patients being received into public institutions completely informally and without powers of detention, as they had been in the voluntary homes for the feebleminded. **Nor is it certain whether the Mental Deficiency Act, 1913, which followed the Commission's report, was meant to prohibit the admission of patients to the new mental deficiency institutions without powers of detention. All the procedures which it lays down for admission to " institutions ", including those which are now hospitals within the national health service, involve powers of detention. On the other hand, the Act does not specifically prohibit informal admission without power to detain.** Some institutions at one time used to admit patients on an informal basis, but this was discouraged by the Board of Control. Approved homes (see paragraphs 109 and 127) however admit all their patients on an informal basis, as the Act forbids them to admit patients who have been made the subject of an " order ". Since 1952, also, mental deficiency hospitals and certified institutions have been encouraged to accept defectives for temporary care for periods of not more than a few weeks at a time, in order to relieve their families of having to look after them during a holiday or during a period of sickness or other difficulty at home. These patients are admitted without legal formality and without power to detain.[9] Admission and discharge are notified to the Board of Control, but no formal medical certificates are required and there is no judicial order. Apart from this however, there is now no purely voluntary admission to mental deficiency hospitals. Defectives " placed " in hospital at the request of their parents without a judicial order under Section 3 of the 1913 Act are subject to detention, and their parents may not take them away again without the knowledge and consent of the Board of Control; they are subject to the same arrangements for periodic review by Visitors appointed by justices as are patients admitted on a justice's order, and apart from the documents required for their original admission all the provisions of the Acts and Regulations which apply to patients under order apply to them too.

228. **The majority of the defectives who receive care under the present mental deficiency services receive it in the form of supervision from the local health authorities while living in the general community, without compulsory control,** though there is always the possibility in the background of compulsory admission to hospital or guardianship if the social conditions in which the defective lives, or his own behaviour, deteriorate to the extent that it becomes necessary to remove him from his home for his own protection, or

[8] The Minister of Health has also approved arrangements whereby one designated mental hospital (Tooting Bec Hospital) admits informally " persons over the age of 70 years who by reason of infirmity require hospital care and treatment ". These patients are not required to sign any application form and there is no notification to the Board of Control. This is a continuation of special arrangements originally sanctioned in 1924 when the hospital was an asylum for " chronic and harmless lunatics, idiots and imbeciles ", administered by the Metropolitan Asylums Board, and was technically a " workhouse ", not a " lunatic asylum ". The hospital also admits certified, temporary and voluntary patients under the Lunacy and Mental Treatment Acts procedures.

[9] Usually referred to as " Circular 5/52 admissions "; see paragraph 124.

for specialised training, or to provide him with a place to live when his family are unable to look after him any longer.

229. Defectives who have received treatment in hospital may remain subject to compulsory control "on licence" after leaving the hospital, for as long as is considered necessary. In some cases the powers of control are continued only for a few weeks or months, as a period of trial to see how the patient gets on in life in the general community before it is decided whether he is really fit to leave the hospital, and if he adapts himself successfully the order is discharged. But the view has been taken that it is improper, in view of the present arrangement and wording of the Mental Deficiency Acts, for a person who is discharged from an order committing him to hospital care to be placed immediately under "statutory supervision", even if he needs and is willing to accept the help and advice from local authority mental welfare workers which this would make available to him. Some local health authorities provide "voluntary supervision" for defectives discharged from orders, but their duty under the Mental Deficiency Acts (as distinct from their power under the National Health Service Acts) extends only to those who can be placed under "statutory supervision". Many patients have therefore in the past been kept on licence for long periods after leaving hospital in order that they may receive community care which would not otherwise be provided for them. It is also sometimes felt that once a person has been discharged from an order under the Mental Deficiency Acts he should be considered discharged for life, and that a new order for his re-admission to hospital should be made only with great reluctance. Because of this some hospitals do not recommend the discharge of an order if they think there is any likelihood of the patient possibly needing re-admission later; some patients have in the past been kept on licence indefinitely in case they may need re-admission to hospital when their parents with whom they are living die or become unable to provide a suitable home any longer.[10] Patients on licence may be recalled to the hospital at any time on the instructions of the superintendent of the hospital, whether or not their present social circumstances are such that they would be "subject to be dealt with" if they were not already under order. They may also themselves take the initiative and ask to be re-admitted. **Paradoxically, defectives who are already subject to the compulsory control of licence are the only patients who may enter a mental deficiency hospital without further formalities at their own request.**

Present safeguards against the misuse of compulsory powers

(i) General

230. The Lunacy and Mental Treatment Acts, Mental Deficiency Acts and the other Acts mentioned in paragraph 131 in Chapter 2 which allow special compulsory powers to be applied to mentally disordered patients also provide special safeguards against the abuse of these powers. These safeguards consist of the statements in the Acts themselves of the medical and social conditions in which the special powers may be used, and special procedures designed to ensure a certain consensus of opinion that the initial use of those powers and the continued detention of the patient are justified in each

[10] In March, 1956, the Board of Control issued a memorandum reminding the superintendents of institutions and hospital management committees of their duty to keep the cases of all patients on licence under constant review. They stated that they would normally expect that a patient should be discharged after a trial on licence for twelve months at most unless there are overwhelming reasons to the contrary. They asked superintendents and committees to review specially all the circumstances of patients at the end of one year on licence with a view to discharge, if suitable. They also asked for a report on all patients whom it has not been found possible to discharge after a period of eighteen months on licence.

individual case. These safeguards form a system which must be regarded as a whole. It is not possible, for instance, to judge whether the medical and social conditions in which compulsory powers may be used are clearly enough defined without considering also the length of time for which they remain in force and the number and type of people who must agree when they are used in any individual case. The main features of the present system are summarised in tabular form in Appendix II to this report. In the rest of this chapter we describe the present compulsory powers and procedures in more detail, and discuss our witnesses' main criticisms of the present procedures and the present general attitude to "certification" and to the use of compulsory powers.

(ii) Medical and social conditions under which compulsory powers may be used

231. The description in the Lunacy Act, 1890, of the conditions which must exist before a "person of unsound mind" may be compulsorily admitted to hospital or to single care as a certified patient is in very general terms. The patient must be "a person of unsound mind and a proper person to be taken charge of and detained under care and treatment". Some sections of the Act describe in more detail the social conditions under which different admission procedures may be used, but these differentiate only the conditions in which various persons may initiate action. The description of the patient in the medical certificate is the same under all the procedures (except the rarely used inquisition procedure—see paragraph 255). Provided that the various persons who have to take part in the procedures agree that this description applies to the individual patient he may be compulsorily admitted to hospital or to single care without any more precise conditions being satisfied. This very general description has however been strictly limited by medical tradition to patients suffering from certain forms of illness, as we explained in Chapter 3, paragraphs 153–158 and 180.

232. The Mental Treatment Act, 1930, imposes narrower limits on the circumstances in which the "temporary treatment" procedure may be used. The patient must be "suffering from mental illness", "likely to benefit by temporary treatment" and "for the time being incapable of expressing himself as willing or unwilling to receive such treatment". We mentioned in paragraph 223 the limitation placed on the use of this procedure for old people by the wording of the medical recommendation in which the doctor is required to declare that admission is "expedient with a view to (the patient's) recovery". The words "incapable of expressing himself as willing or unwilling" also are not easy to interpret medically. If a patient at first says that he is willing and a few minutes later that he is not, or continually makes conflicting statements without apparently understanding the question at issue, he may properly be considered to be without volition but a doctor may hesitate to declare that he is incapable of expressing himself as willing or unwilling. As a patient in that condition can equally well be certified as "of unsound mind", there is a tendency to use one of the certification procedures rather than the temporary treatment procedure for such patients. The latter procedure has been little used in practice, probably a good deal less frequently than was contemplated when the Mental Treatment Act was passed in 1930.

233. The Mental Deficiency Acts attempt to define in more detail both the medical and social conditions in which compulsory procedures may be used to admit "a defective" to an institution or to put him under guardianship. The definition of mental defectiveness in Section 1 (2) of the

Mental Deficiency Act, 1913, as amended, which we quoted in paragraph 159 in Chapter 3, includes a statement of the character and cause of the mental disorder and the age at which it arose. We described in Chapter 3 the differences of medical opinion which have arisen over the interpretation of this definition. The definitions of the four classes of defectives in Section 1 (1) also include a description of the social effects of the underlying mental disorder in regard to each class of defectives. In addition, Section 2 of the same Act describes further conditions, one of which must be fulfilled before a defective becomes "subject to be dealt with" and liable to compulsory admission to hospital or guardianship (or to be put under "statutory supervision"). Section 2, in its present amended form, is as follows:—

"2 (1) A person who is a defective may be dealt with under this Act by being sent to or placed in an institution for defectives or placed under guardianship—

(*a*) at the instance of his parent or guardian, if he is an idiot or imbecile, or at the instance of his parent if, though not an idiot or imbecile, he is under the age of twenty-one; or

(*b*) if in addition to being a defective he is a person—

(i) who is found neglected, abandoned, or without visible means of support, or cruelly treated, or with respect to whom a representation has been made to the local health authority by his parent or guardian that he is in need of care or training which cannot be provided in his home; or

(ii) who is found guilty of any criminal offence,[11] or who is ordered or found liable to be ordered to be sent to [an approved school];

(iii) who is detained (otherwise than on remand or while awaiting trial or sentence or under civil process) in a prison, remand centre, detention centre or borstal institution, or in a remand home or who is detained in a school approved under Section seventy-nine of the Children and Young Persons Act, 1933, an inebriate reformatory, an institution for persons of unsound mind or a Broadmoor Institution; or

(iv) who is an habitual drunkard within the meaning of the Inebriates Acts, 1879 to 1900; or

(v) who is for the time being the subject of a report in force under the enactments relating to education that he has been found incapable of receiving education at school, or that by reason of a disability of mind he may require supervision after leaving school.

(2) (Repealed)".

234. Section 2(1)(*a*) thus allows idiots or imbeciles of any age and feeble-minded persons or moral defectives under the age of twenty-one to be placed in an institution or guardianship by their parents without further conditions being established, subject to the special procedures which ensure that the diagnosis is confirmed or accepted by various other persons. Apart from this, defectives may not be compulsorily admitted to an institution or guardianship unless one of the conditions listed in Section 2(1)(*b*) is established. Some but not all of these conditions are more specific than the general statements of the social effects of the mental disorder contained in the definitions in Section 1. Section 2(1)(*b*)(v), in relation to children

[11] Although a defective becomes "subject to be dealt with" if he is found guilty of any criminal offence, Section 8 of the Act allows courts to order admission to hospital or guardianship only when the offence is one punishable in the case of an adult with imprisonment (or when a child is found liable to be sent to an approved school).

of school age, adds no condition which is not already contained in the definition of imbecile or feebleminded children in Section 1, except that the procedures for declaring the child ineducable, laid down in the Education Acts, must not only be potentially applicable to the child but must actually have been applied. The general phrases in Section 2(1)(*b*)(i), especially the phrase "neglected" appear sometimes to have been interpreted so widely that they have added little if anything to the general statement of the need for care, supervision or control contained in the definition of feebleminded persons in Section 1; the High Court has however laid down in a recent judgment[12] that the phrase "neglected" should be interpreted more narrowly.

235. So, in spite of the apparent care with which mental defectiveness and the four classes of defectives are defined in Section 1 of the Act, and the circumstances which make a defective "subject to be dealt with" separately set out in Section 2, the medical and social conditions in which the compulsory powers contained in the Mental Deficiency Acts may be used are not as clearly defined as might appear at first sight. There has been much more controversy over the interpretation of these two sections of the Mental Deficiency Act than over the very general description of the circumstances in which mentally ill patients become certifiable under the Lunacy Act.

236. When the compulsory powers under the present Mental Deficiency Acts are used to send a patient to hospital or to put him under guardianship, they are often directed to overcoming the opposition of relatives who may neglect or ill-treat the patient rather than to overriding the wishes of the patient himself. The procedures for admission on a justice's order are also often used when neither the patient himself nor anyone else is opposing his admission to hospital, because no other procedures for admission exist (see paragraph 227). Moreover, only patients who are "subject to be dealt with" can be admitted under order; other patients may need treatment or training, but cannot be admitted at present, even without powers of detention. This seems to be the main reason why there has been a tendency to give a wide interpretation to the words in which the law describes the conditions which make defectives "subject to be dealt with". It has been done so as not to deny hospital care to some patients who clearly need it. But it also involves making them subject to detention.

237. Patients admitted to hospital as certified patients under the Lunacy Act and defectives admitted to institutions or guardianship under the Mental Deficiency Act, under procedures other than emergency procedures, may be detained in hospital or kept under guardianship for up to one year in the first place, subject to the powers of discharge held by various persons (see paragraphs 250–254). The compulsory powers may be extended, under a specified procedure, for further periods. There is no maximum limit on the period of detention or control.

238. There are various circumstances in which mentally disordered adults who are charged with, or have been found by a court to have committed, a criminal offence or children who have been found liable to be sent to an approved school may be treated differently from other offenders or other children in similar circumstances. First, the Criminal Lunatics Act, 1800, and the Trial of Lunatics Act, 1883, contain special provisions for persons who are found "insane on arraignment" and for this reason unfit to plead, and for persons found "guilty but insane" after trial on indictment. Such

[12] *In re Rutty* [1956] 2 Q.B. 109.

persons are dealt with as Broadmoor patients.[13] These arrangements apply only in cases on indictment in higher courts, not in cases taken in magistrates courts. They apply only to persons who are "insane" within the meaning of the M'Naghten rules which, as we mentioned in paragraph 152, do not cover all those who are "of unsound mind" within the generally accepted meaning of the Lunacy Act. The Homicide Act, 1957, has introduced into English law the principle of diminished responsibility, by providing that a person suffering from mental abnormality such as to impair substantially his mental responsibility for the killing of another person shall be liable to conviction for manslaughter instead of conviction for murder. This is intended to cover a considerably wider range of forms of mental disorder than those which come within the M'Naghten rules. It seems probable that these new provisions would be applicable to many types of patients in our psychopathic group including some who are certifiable under the present Mental Deficiency Acts and others who are not.

239. Secondly, Section 30 of the Magistrates' Courts Act, 1952, allows magistrates courts, but not higher courts, to make an order sending an offender to a mental hospital instead of to prison, if the court is satisfied that he has committed an offence punishable with imprisonment and that he is "of unsound mind" and "a proper person to be detained". In other words, the offender must be certifiable on the same medical standards as those used in applying the compulsory powers contained in the Lunacy Act; he would therefore be liable to compulsory admission to hospital under that Act, but when his mental condition and need for treatment come to notice through the commission of a criminal offence, the order for his admission to hospital may be made by the court instead of under the usual certification procedures. This power to order the admission of offenders "of unsound mind" to mental hospitals was first given to magistrates courts by the Criminal Justice Act, 1948. It is, however, parallel to the power which they and higher courts have possessed since 1913 in relation to mental defectives. Section 8 of the Mental Deficiency Act, 1913, allows any court to make an order sending a defective to a mental deficiency institution or guardianship if he is found to have committed an offence punishable with imprisonment, or in the case of a child if he is found liable to be sent to an approved school. Section 8 also allows a court in these circumstances, instead of making the order themselves, to direct the local health authority to present a petition for an ordinary order for the patient's compulsory admission to an institution or guardianship under Section 6 of the Act. Orders made by courts under Section 8 of the Mental Deficiency Act or Section 30 of the Magistrates' Courts Act remain in force for the same length of time, and may be renewed in the same way, as orders for the admission to hospital of patients who have not committed criminal offences; their duration is not related in any way to the term of imprisonment which the court might otherwise have imposed. Neither the Magistrates' Courts Act nor the Mental Deficiency Act obliges courts to use these special powers when offenders or children or young persons are found to be mentally ill or defective; they may deal with them in the ordinary way by a sentence of imprisonment, borstal training or other special forms of detention, or by a fine, or by sending a child or young person to an

[13] The term "Broadmoor patient" is often misunderstood. It covers patients who have been found insane on arraignment, or guilty but insane, and also those who have been removed from prison on the order of the Home Secretary in the circumstances which we mention in paragraph 240. Broadmoor patients may be treated in Broadmoor Institution or in any designated mental hospital, registered hospital or licensed house. All patients in Broadmoor Institution are Broadmoor patients, but not all Broadmoor patients are in Broadmoor Institution.

approved school, or by a probation or supervision order, or by an absolute or conditional discharge. The Mental Deficiency Act does not provide for a patient to be placed under the supervision of the local health authority as an alternative to being sent to an institution or guardianship or to being dealt with under the ordinary criminal law or under the Children and Young Persons Acts.

240. Thirdly, the Home Secretary has power, under Section 2 of the Criminal Lunatics Act, 1884, and under Section 9 of the Mental Deficiency Act, 1913, to order the transfer of mentally disordered persons from prison or approved school to Broadmoor, to mental or mental deficiency hospitals or to guardianship. Those who may be transferred to Broadmoor or other mental hospital on the order of the Home Secretary under the Criminal Lunatics Act include persons who are found to be "insane"[14] while in prison, except under civil process; this includes prisoners awaiting trial, or on remand, as well as those serving a sentence and persons under respited sentence of death. They may have been "insane" when originally admitted to the prison, or they may have become "insane" while in prison. All these, if transferred to Broadmoor or other hospital under Section 2 of the Criminal Lunatics Act, 1884, become "Broadmoor patients". They may be discharged only on the order of the Home Secretary. Those who had previously been sentenced to a term of imprisonment may be discharged by the Home Secretary if he considers them fit for discharge before the end of the term of imprisonment; but if they need to continue their treatment in hospital when the term of imprisonment expires and do not become voluntary or temporary patients, they may remain only if they are again certified as insane under a separate certification procedure (see column 8 of Appendix II to this report); they then cease to be Broadmoor patients and are subject to the normal powers of discharge which apply to all certified patients.

241. Section 9 of the Mental Deficiency Act, 1913, allows the Home Secretary to order the transfer to a mental deficiency institution or to guardianship of defectives who are in prison (except under civil process), approved school, or other place of detention; this does not apply to any who are detained on remand or awaiting trial or sentence. Orders made by the Home Secretary in these circumstances remain in force for the same length of time, and may be renewed in the same way, as orders for the admission to hospital of defectives who have not committed an offence. The defective may be detained in hospital, if his mental condition is considered to make this desirable in his own interests, for a longer period than the period of his original sentence, provided that the order is renewed under the prescribed procedure at the statutory intervals. During the period of the original sentence of imprisonment or approved school training, he may not be sent out of hospital on licence or discharged from the order without the Home Secretary's consent.

242. Lastly, Section 4 of the Criminal Justice Act, 1948, allows any court to make the voluntary acceptance of medical treatment a condition of probation for any offender against the criminal law if the court is satisfied that his "mental condition . . . is such as requires and as may be susceptible to treatment but is not such as to justify his being certified as a person of unsound mind under the Lunacy Act, 1890, or as a defective under the Mental Deficiency Act, 1913". The period of treatment which may be made a condition of probation is limited to a maximum of twelve

[14] The word "insane" in this context is usually interpreted in the same sense as the phrase "person of unsound mind" in the Lunacy Act; it is not restricted to the narrower sense given to it in the M'Naghten rules.

months. The treatment may be in-patient or out-patient hospital treatment, or treatment outside hospital altogether. These provisions were introduced for the first time in 1948 and have been applied since then to many mentally ill and psychopathic patients who are not considered certifiable under the Lunacy Act or Mental Deficiency Act. Many of them have received their treatment as voluntary patients in mental hospitals or in neurosis hospitals. This is the only section of the present law which makes the commission of a criminal offence the occasion for bringing pressure to bear on a mentally disordered patient to accept treatment when his mental condition is not one which the law recognises as justifying his compulsory admission to hospital when he has not committed a criminal offence.

(iii) The present special procedures

243. The safeguards against the abuse of compulsory powers contained in the procedures summarised in Appendix II are (i) the fact that most of the procedures allow only certain specified persons to apply for the compulsory admission of a patient; (ii) the medical certificate(s) and in some cases the judicial order required before a patient may be admitted, and the medical and social conditions which these must establish; (iii) the requirements for medical reports after the patient's admission; (iv) the time limit on the duration of the authority for detention or control unless it is renewed by specific procedures at specified periods; (v) visits by the commissioners of the Board of Control and members of the hospital management committee or Visitors appointed by the justices; (vi) the scrutiny of documents by the Board of Control; and (vii) the methods by which the patient may be discharged. Another point, not mentioned in the Appendix, is that letters addressed by patients to certain official and other persons must be forwarded unopened.

244. The different procedures introduce some or all of these safeguards in different ways. In effect the procedures are designed to ensure that compulsory powers are used only in the limited circumstances allowed by the relevant Acts, and that there is an effective consensus of opinion that each individual patient's admission to hospital or guardianship and continued detention there are justified. The persons who must contribute to that consensus of opinion vary under the various procedures, but may include one or more doctors, a justice of the peace or other judicial authority, Visitors appointed by justices, an officer of the local health authority, the patient's relatives, the managing committee of the hospital and the Board of Control. The consensus of opinion needed at the time of the patient's admission is usually different from that needed for the patient's continued detention thereafter.

245. The procedure most commonly used for the compulsory admission of patients to mental hospitals is that known as the "summary reception order", under Sections 14 and 16 of the Lunacy Act, 1890. The consensus of opinion required before such an order can be made is that of one medical practitioner, a justice of the peace (who must see the patient) and an officer of the local health authority. It is also necessary to have at least the acquiescence of the patient's nearest relative, who has power to order the patient's discharge at any time. As soon as the patient enters hospital he must also be examined by a medical officer on the staff of the hospital. The emergency procedure authorised in Section 20 of the Act initially requires no medical certificate or judicial order but permits the patient's compulsory removal to certain hospitals on the sole authority of a duly authorised officer of the local health authority. This officer is however required to inform a justice, and the patient may not be detained for more than three days unless a medical

certificate is given, which may authorise his detention for a further fourteen days. For the reason mentioned in paragraph 121 in Chapter 1, this procedure is now often used to admit a patient for " observation ", as well as in cases of real emergency.

246. There is another set of compulsory admission procedures which are much less often used and which were originally available only for paying patients. Under these alternative procedures, compulsory admission to a mental hospital is allowed in an emergency, under Section 11 of the Act, for a period not exceeding seven days, on the application of a relative or friend of the patient (if the patient is a paying patient) or of a duly authorised officer of the local health authority (if the patient is not a paying patient), supported in each case by one medical certificate. Admission for a longer period, under Sections 4–8, requires two medical certificates, an application from the patient's relative or other person and an order made by a judicial authority who is usually a specially appointed justice of the peace. Under this procedure the justice need not see the patient, but if he does not the patient may ask to be seen later by another justice.

247. Other procedures for the admission of certified patients to mental hospitals in special circumstances, such as patients wandering at large, or on conviction of a criminal offence in a magistrates court, on discharge from the armed forces, after a period of treatment as a Broadmoor patient, or on transfer from prison not as a Broadmoor patient, are laid down in various Acts and are included in the table in Appendix II. The procedures through which a patient may become a Broadmoor patient are not included in Appendix II, as these are outside our terms of reference.

248. When patients are admitted as " temporary patients ", under the conditions laid down in Section 5 of the Mental Treatment Act, 1930, no judicial order is required. There must be an application made by the patient's nearest relative or by a duly authorised officer on the relative's request or by some other person connected with the patient, supported in each case by two medical recommendations one of which must be given by a doctor specially authorised to make recommendations of this kind.

249. Different procedures are laid down in the Mental Deficiency Acts. Under Section 15 of the 1913 Act, a defective can be taken in an emergency to a " place of safety " by an authorised officer of the local health authority or a police constable, without any medical certificate or judicial order, and may be detained there for an undefined length of time " pending the presentation of a petition " for a judicial order. The normal procedure for the admission of a defective to hospital or guardianship is that laid down in Sections 5–6 of the 1913 Act. An application for a judicial order is made, usually by an authorised officer of the local health authority, with the consent of the defective's parent or guardian (without which an order may not be made unless the judicial authority finds that consent has been unreasonably withheld or that the parent or guardian is abroad or cannot be found), supported by two medical certificates, one of which must be given by a doctor specially authorised to give such certificates. The order is made by a judicial authority who is usually a specially appointed justice of the peace. An alternative procedure under Section 3 of the Act, which in most areas is much less often used, allows the parent or guardian of an idiot or imbecile to " place " him in hospital or under guardianship without a judicial order, and the parent of a feebleminded patient or moral defective under the age of twenty-one to " place " him with a judicial certificate instead of an order; in all these cases there must be two supporting medical certificates, one from a specially approved doctor. When an order is made by a court under Section 8 (1) (*b*) of the Act, the court must be satisfied that the offence which is the subject

of the charge has been committed and that the offender is liable to imprisonment or, in the case of a child, is liable to be sent to an approved school. There must also be medical evidence that the offender is mentally defective, but the number of medical opinions required is not specified and the doctor(s) providing the medical evidence need not be specially approved. The consent of the patient's parent or guardian is not required. When the Home Secretary makes an order, under Section 9 of the Act, for a defective's transfer to hospital or guardianship from prison or from an approved school, he must have two medical certificates; the doctors need not be specially approved; the consent of the parent or guardian is not required.

250. After the patient has been admitted to hospital, single care or guardianship under these procedures, his continued detention or control depends on the views of those persons who have power to discharge him and of the persons they may or must consult before exercising that power. Certified patients in public mental hospitals cannot be detained without the continuing consent or acquiescence of their nearest relative, members of the hospital management committee and the medical superintendent of the hospital in which he is detained, and the Board of Control. The nearest relative may order the discharge of the patient at any time, irrespective of the views of the hospital authorities or of the Board of Control; the only exception to this is that discharge by the relative may be blocked by a barring certificate given by the medical superintendent if he considers the patient dangerous and unfit to be at large, but such a barring certificate (which in practice is very rarely given) may be overruled by any two members of the hospital management committee. Any two members of the hospital management committee on the advice of the medical superintendent, and any three members of the committee without the agreement of the medical superintendent, may also discharge the patient at any time. The Board of Control may discharge the patient at any time if the nearest relative is unable or unwilling to do so, and also in the other specific circumstances mentioned in Appendix II. The order authorising the patient's continued detention lapses at periodic intervals unless the medical superintendent gives a certificate justifying its continuation, and he can at any time advise members of the hospital management committee to discharge the patient. These arrangements now apply to all certified patients in public mental hospitals (except Broadmoor patients), but some of them date only from 1948. Before that date, the relatives of non-paying patients had no power to order discharge on their own authority, and the Board of Control could discharge non-paying certified patients only in the specific circumstances mentioned at Items 8 (*a*) and 9 (*i*), (*j*), (*k*) and (*l*) in Appendix II.

251. There are slightly different methods of discharge for temporary patients in public mental hospitals, and for certified and temporary patients in registered hospitals and licensed houses, as will be seen from Appendix II.

252. For patients in public mental deficiency hospitals, the persons who are concerned in the procedures for discharge are the patient's parents or relatives, the medical superintendent or other medical officer of the hospital, the hospital management committee, Visitors appointed by justices, and the Board of Control. The only persons who have power to discharge the patient at any time, irrespective of the views of the others, are the commissioners of the Board of Control. The medical superintendent and members of the hospital management committee can never themselves authorise the patient's discharge, though they may take the initiative in advising the Board of Control to do so. The parents can only discharge patients who have been placed under Section 3 of the 1913 Act, and then only with the knowledge and acquiescence of the Board of Control who may veto discharge if they

consider that further detention is required in the defective's own interests. Two of the Visitors appointed by justices (who consist of a number of justices, one or more doctors and one or more women) interview patients and consider the need for their continued detention whenever the authority for detention is due to expire, and also when a patient admitted under the age of twenty-one reaches that age. The only occasion on which they have authority to order the patient's discharge is at the age-twenty-one review; on other occasions they only make recommendations to the Board of Control. The commissioners of the Board of Control may discharge patients at any time. (Patients transferred from prison or approved school may not be set at large without the consent of the Home Secretary during the period of the original term of imprisonment or detention.) The Board are advised by the medical superintendent and the Visitors at fixed statutory intervals when the authority for detention is due to expire if not renewed. They also usually consult the hospital management committee and medical superintendent when an application for discharge is received from a patient or his relatives.

253. The arrangements for the discharge of defectives from certified institutions and guardianship are similar to those described in the preceding paragraph, the main difference being that the managers of certified institutions may discharge patients who were "placed" there by their parent or guardian, after giving notice to the parent or guardian and to the Board of Control.

254. It will be noted that it is only at the time of the patient's admission that justices of the peace or other judicial authorities take part in the procedures which apply to mentally ill patients in public hospitals. Once the compulsory admission of the patient has been authorised they can neither order nor prevent his discharge, which becomes a matter for decision by the hospital authorities, relatives and the Board of Control. The Visitors of licensed houses (consisting of a number of justices and one or more doctors) also have certain duties to visit and power to discharge patients in licensed houses outside the metropolitan area, for which the justices are the licensing authority (see paragraphs 578 and 794); these duties and powers are equivalent to some of those which in public mental hospitals are given to members of the hospital management committee and commissioners of the Board of Control. Under the Mental Deficiency Acts, the Visitors appointed by justices also take a continuing part in the review of the need for the detention of defectives in any public or private institution or under guardianship at the statutory intervals at which the authority for detention expires if now renewed.

255. There is also in existence the ancient procedure, now rarely used, by which a person may be found to be of unsound mind "by inquisition". We mentioned in paragraph 146 that in England and Wales, from the early fourteenth century at least, the wardship of "lunatics" and "idiots" and of their property was regarded as a prerogative of the Crown. The usual method of establishing whether a particular person was in fact a "lunatic" or an "idiot" was by the issue of a writ for a judicial inquisition, usually held before a jury. If a verdict was returned that the person was a lunatic or an idiot, he and his property came under the control of the court or officer of state to whom at various periods of history was delegated the exercise of the royal prerogative in these matters. The exercise of the prerogative was annexed to the Court of King's Wards from 1540 to 1660, and at other times was assigned to the Lord Chancellor. The court or official exercising the prerogative could commit the control of the property or person of the lunatic or idiot to some other person who became known as the "committee" of the patient's person or estate. We described in

Chapter 3 how the procedures now known as certification were introduced, from the late eighteenth century onwards, to authorise the detention of patients in institutions, hospitals and private homes. During the nineteenth century new procedures were also introduced for the appointment of guardians or receivers to administer the property of mentally ill and defective persons. But the procedure of legal inquisition for determining the control of the property or of the person of the patient, or both, remains in existence, and is still occasionally used when control of property is involved; for instance, if the patient has property in foreign countries which do not recognise the receivership procedures. An inquisition may now be held without a jury, but the person alleged to be "of unsound mind" may demand one. The question at issue in an inquisition is whether the person is "of unsound mind and incapable of managing himself or his affairs". The exercise of the royal prerogative in relation to the care and commitment of the custody of persons found to be of unsound mind by inquisition and of their estates is now entrusted to the Lord Chancellor and the Judges of the Chancery Division of the High Court; the Court of Protection (the Judge and Master in Lunacy), which is responsible for the administration of the receivership procedures and for the general control of the management of patients' estates for which receivers have been appointed, also deal with the now rare cases of inquisition.[15] The person appointed as "committee of the person" following an inquisition can determine the patient's place of residence and can order his admission to and detention in hospital without using the certification or other admission procedures which are now used for other patients—see column 12 of Appendix II.

(iv) **Criticisms of the present procedures**

(a) **Individual cases**

256. Some of our correspondents sent us information about the experiences of particular individuals who had been certified under the Lunacy Acts. In some cases this information was sent in support of general criticisms of the present procedures or of the way in which they are operated, which we mention in paragraphs 258–286. We also received some sixty letters or statements alleging that individuals who were certified had not been of unsound mind at the time of admission to and detention in hospital. All but a few of these letters were written by the persons concerned themselves, about half of whom had been discharged from hospital before they wrote to us, some of them many years ago. In each case their statement amounted to an allegation that there had been a wrong medical diagnosis, and that the statutory procedures had proved an ineffective safeguard against such an error. In the case of those who had already been discharged from hospital, it would have been impossible for us to judge what the person's mental condition had been while in hospital, and we decided that no useful purpose would be served by our attempting a formal investigation of any of these cases. We did however in each case examine the official records in the possession of the Board of Control, to see whether at least the formalities required by the existing law had been observed. We found no case in which this had not apparently been done, and no case in which the contemporary documents did not, at their face value, contain evidence of mental illness at the relevant time. We also feel bound to state that a considerable number

[15] On 1st January, 1957, there were 37 patients who had been found to be of unsound mind by inquisition. 17 of these were patients resident outside England and Wales who have property in England. Among the 20 resident in England and Wales were 17 cases in which the committee of the estate was also committee of the person, 2 cases in which the committee of the person and the committee of the estate were different individuals, and 1 case in which there was a committee of the estate only.

of the letters in which these allegations were made appeared to contain unmistakable evidence of present mental disorder. Nevertheless, these statements and the perusal of the Board of Control's records on these individual cases gave us an insight into the operation of the present procedures which we found most valuable, in conjunction with the more general criticisms made by other witnesses, in helping us to form an opinion of their effectiveness or ineffectiveness as safeguards against the misuse of compulsory powers.

257. Some individual cases were also quoted to us in support of allegations of abuse of the compulsory powers contained in the present Mental Deficiency Acts. Some of them were brought forward to illustrate views on the interpretation of the definition of mental defectiveness, or on the proper limits of compulsory powers in the future, which we discuss in Chapters 3 and 6. Others were quoted in support of general criticisms of the present procedures which we mention in paragraphs 258–286. Others were intended to illustrate allegations of various forms of abuse, such as disregard of particular provisions of the present law, unnecessary detention of patients because of the value of their labour to the hospital, or unnecessary recall of patients from licence. The accuracy of many of these allegations depended on questions which it would have been impossible for us to determine conclusively, particularly when the real criticisms were not directed against the fact that a patient was detained in hospital or was recalled from licence but against the motives for which it was alleged that this was done. Nevertheless, some of these allegations involved statements of fact about whose accuracy it was possible for us to make some enquiries, and we did this in a number of cases selected at random. As a result of these enquiries we believe that some at least of the allegations were based on inaccurate or incomplete information. This is not to say that we consider the present Acts and their administration to be completely satisfactory. On the contrary, we consider that they contain many faults, and that there is considerable force in many of the general criticisms made by our witnesses. These general criticisms and the allegations in relation to individual cases are also a useful indication of the type of abuse which the public fear and against which there should be safeguards which are both adequate in themselves and such as will be accepted as adequate by the public. We think that the present system does not provide such safeguards. This reason as well as others has weighed with us in deciding to recommend changes in the present law and procedures.

(b) Complexity of the present procedures and lack of discrimination between different patients' needs

258. An obvious criticism of the present procedures is that there are so many of them, with complicated differences between one procedure and another and between the provisions which apply to patients admitted to various types of public or private hospital or institution. Appendix II illustrates this up to a point, but there are many other matters dealt with in the Acts, Rules and Regulations which are not mentioned in that Appendix and which introduce other complications and other distinctions. We mentioned some of these in Chapter 2, paragraphs 139–144.

259. Paradoxically, an equally important and equally valid criticism is that the present procedures do not make enough differentiation between patients who need one form of care and those who need another. The procedures laid down in the Lunacy Acts seem based on the assumption that the proper treatment for any person of unsound mind is to detain him in custodial care, either in an institution or in a private house. Nowadays it is desirable to consider whether a person who is mentally ill or infirm

needs out-patient or in-patient hospital treatment, psychiatric or geriatric treatment or both, residential or non-residential community health or welfare services, and so on. But the forms and procedures laid down by the present law are designed to establish only that the patient is " of unsound mind and a proper person to be taken charge of and detained for care and treatment " ; no distinction is drawn between different forms of care. Moreover, a judicial order for the admission of a patient to a mental hospital is usually considered mandatory, in the sense that the hospitals feel obliged to admit any patient when an order has been made unless there are quite exceptional difficulties in doing so. The relieving officer's order, which was similarly considered mandatory on poor law infirmaries and institutions, was abolished in 1948 with the abolition of the poor law. As a result, at a time of general shortage of accommodation, greater pressure can now be brought to bear on mental hospitals to admit a patient, provided he is " of unsound mind ", than on other hospitals or residential homes. There is some evidence that in some areas at any rate this has contributed to a tendency to use the compulsory powers contained in the Lunacy Acts to admit to mental hospitals patients who, though mentally ill or infirm, are not necessarily in need of the special facilities of a mental hospital. We are thinking here not only of those patients who might be equally well cared for in a geriatric or chronic sick hospital or in an old persons' home, but also of patients whose mental disturbance is clearly part of a terminal illness before death who might be cared for equally well in a general hospital. It may well be that the mental hospital is the best place for some such patients ; but we consider it an abuse of compulsory powers to use them as a form of pressure on one particular type of hospital only to admit patients who could be equally well cared for elsewhere.

260. Similarly, the Mental Deficiency Acts make no distinction between the grounds on which a defective may be put under guardianship and those on which he may be sent to an institution. The medical and social conditions which must be established are identical. A guardianship order can, however, only be made when there is a guardian willing to undertake the considerable legal responsibilities which the Acts lay on him, and to observe the formalities required under the Regulations. The Acts do not provide for a defective to be put under the guardianship of the local authority itself, but only under the guardianship of an individual person (though this may be a local authority officer). It is, therefore, not possible for a local authority to undertake the legal responsibilities and then to board out the defective in a suitable foster home, as can be done under the general child care legislation. This increases the difficulty of finding suitable guardians for patients who are suitable for care in the community, and adds to the number who are sent into mental deficiency hospitals.

(c) The Board of Control's part in the procedures

261. Some of our witnesses criticised the Board of Control on the ground that they exercise their functions in relation to the detention or discharge of individual mentally defective patients in a far from judicial manner, seldom interviewing relatives who ask for a patient's discharge, seldom examining the patients themselves on these occasions, basing their decisions mainly on written reports, and seldom giving reasons for their decisions. Several proposals were made to us for applications for discharge to be considered in future by local or national tribunals before whom the patient would appear in person and before whom also the hospital or other authorities would be required to appear. We give our own views on this in Chapter 7 where we explain our own proposals for new procedures, and in Chapter 11 where we discuss the functions of the central departments. We wish however to state

clearly here that we regard these criticisms not as criticisms of the way in which the Board of Control have performed their functions under the present Acts, but as criticisms of the Acts themselves. The Acts clearly envisage the Board as an administrative rather than a judicial body, in spite of the fact that some of their functions are of a semi-judicial nature.

262. Another general criticism of the present powers of the Board of Control is that it is unsatisfactory that the power to discharge defectives should be concentrated in the hands of a single authority. This is a view put forward by the Board themselves, who recommended to us that powers of discharge should be more widely distributed.

263. The value of the present arrangements under which the Board scrutinise admission documents and other statutory reports and certificates was criticised by some witnesses and defended by others. The Board themselves told us that they feel that the scrutiny of documents in London at a distance from the patient is of little value as a safeguard against wrongful certification, because however convincing the documents are on their face no one who has not seen the patient can guarantee that they correctly describe the individual patient. The Board suggested that it would be better for the documents to be kept at the hospital where the patient is, available for scrutiny by any authorities who have power to discharge the patient. They consider that this would provide both a more effective safeguard and a less wasteful administrative system. Other witnesses consider that the scrutiny in London of every document which is part of the authority for a patient's detention is a valuable safeguard, and in particular that it helps to ensure the maintenance of careful and uniform standards by the doctors who write the certificates; on the other hand, one of these same witnesses told us that the reason why the medical certificates given in support of a diagnosis of mental defectiveness usually record a certain type of information (which has been much criticised—see paragraph 276) is the fact that it is thought that this is the sort of information which the Board of Control expect to see when they scrutinise these certificates (26th Day, Q. 5441–5479) We give our own views on the scrutiny of documents in Chapter 11.

(d) **The justices' part in the procedures, apart from court cases**

264. We received much criticism of the fact that most of the present compulsory admission procedures, except the emergency procedures, require the order of a justice or other judicial authority for the patient's admission to hospital or other form of care. It is often said that this is much resented by patients and their relatives. Many patients and relatives no doubt do not understand or distinguish the different elements in the present procedures, but dislike and resent "certification" as a whole. But all the same we think it is true that the justice is generally considered the central figure in the present procedures, and that the fact that the patient's admission to hospital is "ordered" by an authority whose main function is the punishment of crime has at least contributed to the much-talked-of "stigma" of certification.

265. It was suggested to us by one witness (8th Day, Q. 1638) that the origins of the justice's order were administrative rather than judicial. A strong case can be made out for this view. As we mentioned in paragraph 203 and explain more fully in Chapter 9, the justices had wide administrative functions in the eighteenth and nineteenth centuries when the early lunacy legislation was enacted. The county justices were the forerunners of the present county councils. It was they who were responsible until 1889 for the building and management of lunatic asylums, and they also had administrative powers under the poor law. Under the Lunacy Act, 1828, an order for the admission of a pauper patient from within the area of the county

providing the asylum had to be signed by two of the justices for that county, who also made an order on the parish overseer to pay the cost of the patient's maintenance there, whereas the order for the admission of a non-pauper patient or of a pauper patient from another county needed to be signed only by one member of the managing committee of the asylum (the "Visitors", who may have included persons elected by subscribers as well as justices) and this had to be accompanied by an undertaking for the payment of the cost of the patient's maintenance signed by two responsible people from the area from which the patient came. Under the Lunacy Act, 1845, an order could be made by an officiating clergyman together with the parish overseer or relieving officer, acting in the place of a justice. And until 1890 the order for the admission and detention of a private paying patient was made by a relative or other person, supported by medical certificates, without reference to a justice at all. All these facts suggest that the justice's order, at least before 1890, had a strong administrative flavour. Even in 1890, when a justice's order became obligatory, except in emergencies, for the admission of all private patients (except voluntary boarders) to licensed houses and registered hospitals and of all private as well as pauper patients to county asylums, the justices had not lost all their administrative functions under the Lunacy Acts. It was only in the previous year that county councils began to function as the new administrative authorities for the counties and took over various functions from the justices including the responsibility of providing lunatic asylums. The justices were still responsible for licensing and visiting licensed houses for mental patients outside the metropolitan area. Moreover, in the long enquiries and debates which preceded the Lunacy Acts (Amendment) Act, 1889, the suggestion that a justice's order should be required for the admission of private patients was strongly opposed by many people of experience, including Lord Shaftesbury himself, the father of lunacy reform, though their views were eventually overruled.

266. It is however not possible to distinguish completely the administrative and judicial elements in the functions of justices in the nineteenth century. And whatever the origin of the justice's order in that century, in the twentieth it has certainly come to be regarded as judicial in intent. Considered as judicial procedures, the present arrangements are strongly criticised on other grounds. Some of our witnesses pointed out that a single justice interviewing a patient in his own home or in a hospital, acting on ex parte statements in the form of medical certificates and information supplied by the duly authorised officer, and acting without a judicial colleague and without the Justices' Clerk, has difficulty in acting in a proper judicial manner. Others emphasised the point mentioned in paragraph 264, that the justice's participation in the procedures links certification with the punishment of crime, which is quite contrary to recognition of mental disorder as a form of illness.

267. Other witnesses stressed the fact that the decision whether or not the patient should be compelled to enter hospital or to receive some other form of care turns mainly on the diagnosis of his mental condition and on an assessment of the treatment which he needs, which are medical matters on which it is difficult for a non-medical person to form an independent opinion. These witnesses suggested that the signing of an order by the justice is often a mere formality of little value as a safeguard to the patient. If a check on the opinion of the certifying doctor is needed, they suggested that it would be better to require a second or more authoritative medical opinion instead of the opinion of a justice of the peace.

268. Some witnesses expressed the view that if non-medical as well as medical opinions are to be required on the need for the individual patient

to be compulsorily detained in hospital, in addition to the consent or acquiescence of the patient's relatives, this is adequately provided for when members of the hospital management committee have powers of discharge, as they bring to bear on this question much the same type of experience and general approach as does a magistrate. Others suggested that the justice should remain in the procedures, but should be brought in at a later stage than at present, after the patient has had a period of observation or treatment in hospital, when the doctors can give more considered views and when the proceedings could be more thorough.

269. We also received criticisms of the part played by the justices and other persons who take part as Visitors in the procedure under the Mental Deficiency Acts for the consideration of the need to renew an order which is about to expire. Some witnesses suggested that in many cases at present this too is scarcely more than a formality. The Visitors normally see each patient only for a few minutes at most, and in the view of these witnesses it is almost impossible for them to reach any sound independent opinion about either the patient's mental state or the type of care most suitable for him. Some witnesses proposed that the continuation procedure for patients in mental deficiency hospitals should be the same as for those in mental hospitals, where there are no judicial Visitors taking part. Others suggested that, on the contrary, the present procedure in mental deficiency hospitals should be retained, and that the Visitors should be given greater authority by having power to discharge any patient on any of these occasions instead of only when they interview him at the age of twenty-one.

(e) The doctors' part in the procedures, the powers of duly authorised officers, and the form of medical certificates

270. One of the differences between the various compulsory procedures, which can be understood for historical reasons but which seems inappropriate now, is the difference in the number of doctors whose opinion is required before a patient may be compulsorily admitted to hospital and in the experience or qualifications which they are expected to have. The procedure most commonly used when mentally ill patients are compulsorily admitted to mental hospitals (Sections 14 and 16, Lunacy Act, 1890) requires only one medical certificate, which may be given by any registered medical practitioner, whereas some other procedures under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts require two medical certificates or recommendations and in some cases one of them must be given by a doctor specially approved for the purpose. Under present conditions it would seem reasonable to require that at least a preliminary assessment of the patient's mental condition should be made by a specially experienced medical practitioner before compulsory powers are used, except in an emergency.

271. The most commonly used emergency procedure (Section 20, Lunacy Act, 1890) allows a patient to be compulsorily admitted to hospital on the sole authority of a lay official who may act without or against medical advice. The patient may not, however, be detained in hospital for more than three days without a medical certificate, and within that three days a justice of the peace must be informed about the patient. The reason why these arrangements are laid down by the Act for use in an emergency seems to be that under the normal summary reception order procedure as described in the Act (Sections 14 and 16) the first person to whom the duly authorised officer must apply when he considers that an order should be made is not the doctor but the justice of the peace ; it is the justice who is then required to call for a medical examination of the patient. In an emergency, which might arise at any time of the day or night, the duly authorised officer

might well be unable to find a justice immediately; it seems to be for that reason that the 1890 Act allows him in an emergency to arrange for the patient to be taken at once to hospital and kept there until the justice can be informed and called to see the patient. In practice nowadays this order of events is rarely if ever followed. Usually, it is the doctor who first calls in the duly authorised officer; the latter then arranges for the patient to be seen by a justice after the medical certificate has already been written. Even when the duly authorised officer initiates the action himself, he would normally call in a doctor first and a justice second. Under these conditions, there is less justification for the duly authorised officer having authority to act entirely on his own, even in an emergency. Several of our witnesses recommended that the duly authorised officer should always be required to take medical advice, and some suggested that if he decides to disregard it he should be required to state his reasons in writing.

272. Under the Mental Deficiency Acts, also, authorised officers of local health authorities may take defectives to a "place of safety", in the circumstances covered by Section 15 of the 1913 Act, without consulting a doctor. In practice they act after consultation with a medical officer of the local authority, and in most cases (but not all) the "place of safety" to which the patient is sent is a mental deficiency hospital where the patient comes under medical care.

273. Even when there is no emergency at the time of admission and the full certification procedures or "temporary patient" procedures are used, it is possible for a patient to be compulsorily admitted to a mental or mental deficiency hospital without the doctors at that hospital having seen him or having been consulted about him. In practice, the medical staff of mental hospitals frequently see their patients as out-patients or are consulted about them before admission; they are, however, precluded by the Lunacy Act itself from signing one of the medical certificates in support of the admission order for a certified patient. The Mental Deficiency Acts do not forbid a doctor on the staff of the receiving hospital to sign one of the statutory certificates, except in the case of private institutions, but in some areas at any rate the hospital doctors in fact scarcely ever see their patients before admission. The suggestions which we make in Chapter 10 for new arrangements for medical consultation on the choice of the most appropriate form of care for each patient would help to meet these criticisms, but it may be desirable also to ensure that such consultation takes place before compulsory powers are used by introducing an appropriate declaration into the statutory procedures.

274. We also received many criticisms of the actual form of the medical certificates given under the present Acts. In Chapter 3 we mentioned criticisms of the use of the term "person of unsound mind", and recommended that it should be replaced by the term "mentally ill". There is also the point which we mentioned in paragraph 259, that on most of the statutory forms doctors are asked to report on the patient's mental condition and to substantiate their opinion by recording observed facts on which this opinion is based, but are not required to give an opinion on the particular form of care which the patient needs, still less to give their reasons for recommending one form of care in preference to another.

275. The statutory medical certificates which are used at the time of the admission of patients to mental hospitals have also been criticised on the ground that too much reliance is placed in them on facts observed by the certifying doctor himself at a single examination and too little on the patient's medical history or a general assessment of his mental condition.

It is certainly desirable that every doctor who takes part in these procedures should be personally satisfied that the patient's mental condition is such as to justify the use of the compulsory powers, and that this opinion should relate to the patient's condition at the time when the compulsory powers are used and not to his condition some time previously. This is particularly important when the illness from which he is, or has been, suffering is one which may clear up quickly. But the patient's previous history is frequently a most important aid to diagnosis; if the doctor is to be required to set out in detail the reasons for his opinion, it seems desirable to allow full weight to be given to the patient's medical history.

276. We also received criticisms of the sort of facts which it is customary for doctors to record as evidence of mental defectiveness on the certificates given at the time of admission and when the authority for detention is to be renewed. It has become almost universal practice for such certificates to include a record of a few details of the patient's failure in standard mental tests. These tests consist of a wide variety of questions which are put to the patient to assess his intelligence and social competence. They may justifiably be used as one of the methods by which a doctor judges the extent of the patient's mental development, but a few of the patient's replies or failures recorded on a certificate usually appear inconclusive and frequently quite irrelevant to the question whether or not his mental condition justifies the use of compulsory powers. On the certificates which we have seen by no means all the doctors have added to these details an assessment of the patient's general personality and capabilities and of his need for care or treatment, which are the real points at issue on which the non-medical people who take part in the procedures need to be satisfied. Even when a general assessment of the patient's capabilities is given, the inclusion of answers to particular questions makes the certificate misleading in its general impression. The fact that a person does not know the difference between a King and a President or can name only one of the oceans of the world, which we have seen quoted on several certificates, seems in itself quite irrelevant to the question whether that person is mentally defective to the extent that he is incapable of managing himself or his affairs or that he requires supervision or control for his own protection or for the protection of others (to quote the present legal definitions of imbeciles and feebleminded persons). To mention such things among the grounds for the diagnosis gives the impression that it in fact depends on whether the patient possesses odd pieces of knowledge of that sort. Any ordinary person tends to mistrust the whole diagnosis if facts of that sort appear to play an important part in it. As we mentioned in paragraph 263, one of our medical witnesses attributed the present style of certification to the influence of the central scrutiny of these documents by the Board of Control. We discuss this in Chapter 11.

277. Some of our witnesses also criticised the arrangements by which relatives may obtain an independent medical opinion on the mental condition of patients detained in hospital. The formal procedure provided under Section 49 of the Lunacy Act, 1890, is cumbersome and expensive, and no special procedure is provided under the Mental Deficiency Acts. The hospital authorities usually agree to an outside doctor visiting to examine the patient if the relatives wish, but the relatives have to pay for such examinations whether the formal procedure under Section 49 is used or not. If the patient himself or his relatives ask the Board of Control to consider his fitness for discharge, a medical commissioner may examine him without charge; but the commissioners seldom make special visits for this purpose

and usually rely on the views of the hospital doctors until their next routine visit to the hospital.

278. It was suggested to us by many witnesses that medical superintendents of mental hospitals and perhaps also the doctors in direct charge of the patient's treatment should be able themselves to authorise patients' discharge or absence on trial. At present absence on trial may be authorised only by members of the hospital management committee on the medical superintendent's advice. When the superintendent considers one of his patients fit for discharge he can only recommend this to the relative or members of the hospital management committee or other person who has power to authorise discharge. Some witnesses also suggested to us that medical superintendents and members of the hospital management committees of mental deficiency hospitals should have authority to discharge patients instead of only being able to make recommendations to the Board of Control, though from the evidence of other witnesses it appears that not all medical superintendents or committees wish to undertake this responsibility.

(f) Procedures in court cases

279. Most of the criticisms we received under this heading are mentioned in paragraphs 511–537 in Chapter 7.

(g) Licence of defectives

280. Licence is at present used both as a form of community care and as a form of compulsory control. We discuss its use as a form of community care in Chapter 10. One criticism of its use as a form of compulsory control is that patients may be, and not infrequently are,[16] kept for many years on licence, the order for their detention being renewed at the statutory intervals, and that so long as licence lasts they may be recalled to the hospital at any time without reason given and without passing through any of the procedures which are provided as safeguards on the occasion of first admission to hospital.

281. The other main criticism is directed against one of the conditions laid down in the model form of licence in the Mental Deficiency Regulations. This specifies that while the defective is on licence "special precautions shall be taken to prevent the formation of attachments with members of the opposite sex", and that any sign of such an attachment must be reported at once to the superintendent of the institution. We were told that this condition is sometimes very strictly interpreted, and that the licence-holders sometimes consider that it obliges them to report even casual and completely innocent converse between the patient and members of the opposite sex, and that the patients may then be compelled to return to the hospital. In our view a statutory regulation of this nature is a completely inappropriate method of control over the social behaviour of individual patients. It also seems to us to be unjustified interference in a matter which should be within the medical discretion of the doctor in charge of each individual patient's treatment, which should itself be exercised with proper regard to the freedom of the patient. Patients living in the general community or on trial for discharge must learn to behave reasonably in the company of the opposite sex and should be encouraged to do so. Whether or not a particular "attachment" is undesirable must depend on the circumstances of each case.

[16] See also footnote on page 78.

The present attitude to certification and detention

282. From the evidence we received it is clear that the general attitude to certification and detention today is fundamentally different from the attitude at the beginning of this century and the end of the last, as illustrated by the evidence given to the Royal Commission of 1904–08 and the discussions which preceded the Lunacy Acts (Amendment) Act of 1889. At that time certification of the mentally ill, at any rate in private institutions, was considered necessary largely as a safeguard against the improper detention of sane people. Attention was directed to the protection of the personal liberty of people who were not mentally ill, rather than to any possible ill-effects certification and detention might have on people who were mentally ill or on their families. Certification was not then thought of as damaging to people who really were mentally disordered, but rather as opening the way to protective care. The evidence given to us included allegations (which we discussed in paragraphs 256–257) that some individuals who were not "of unsound mind" or "mentally defective" have been improperly certified and detained, but the great majority of the criticisms of the certification procedures which we received were concerned with the ill-effects which the procedures may have on patients who are known to be mentally disordered or on their relatives. **There is clearly a strong feeling among the general public, as well as among those who are actively concerned in the care of patients, that many patients who are now certified could be given the treatment and care they need without certification in its present form. Almost all the evidence given to us on this aspect of our terms of reference was in favour of reducing the use of compulsory powers to the minimum and of treating mentally disordered patients as far as possible on the same basis as other sick or handicapped persons "without certification".**

283. Although originally designed as a protection for the patient and for other members of the public, the procedures which have come to be known as "certification" are now generally regarded with resentment and dislike. While there has been a general increase in public sympathy towards mentally ill patients and a wider understanding of the fact that mental illnesses are forms of sickness which are usually susceptible to treatment, certification is often felt to imply something quite different. Indeed, certification seems to have attracted to itself the prejudice and misunderstanding which at one time surrounded the whole idea of mental disorder. It is often thought to imply life-long mental instability, or to carry a social stigma both for the patient and for his family which may persist even after the patient leaves hospital, and to cast doubts on his mental or even on his moral reliability throughout his life and perhaps on the mental stability of his children and other near relatives. That these ideas are now usually associated with certification rather than with the mental illness itself is shown by the different way in which many people speak of voluntary as distinct from certified patients. We have direct evidence of this attitude to certification on the part of some patients and their relatives in some of the letters sent to us by present and former patients and other members of the public. Many of those writing about individual patients did not deny that there was mental disturbance at the time when the patient was admitted to hospital, but asserted nevertheless that it was wrong for the patient to be certified. One of our correspondents referred to certification as "a collar mark". Another called it "more of a disaster to the patient than the illness itself". Another, who was treated as a certified patient for four weeks in 1935 after a car accident, wrote in 1954 asking us "to get my name eradicated from your registers so that I no longer bear the stigma of being a certified person". Others recommended that some new procedure should be adopted

for elderly patients so that persons who have "led a blameless life" should not be certified in their old age.

284. We explained earlier in this chapter that the certification procedures were originally intended to provide proof of the need to compel mentally disordered patients to enter and remain in suitable institutions for the duration of their illness only, to establish the patients' eligibility to benefit from a publicly provided service, and to provide safeguards against the improper use of compulsory powers. We should like to assure our correspondents, and any other people who think the same, that no civil disabilities derive from the fact that a person has previously been in a mental hospital as a certified patient. When a certified patient is discharged from hospital, the act of discharge cancels the order for admission in support of which the medical certificates were given, and that order and those certificates no longer have any legal effect whatsoever. If there has also been a receivership order in regard to the patient's property, the receivership order is not cancelled by discharge from hospital, because it is made under other procedures which do not depend on whether the patient is in hospital or not; but it too can be terminated on medical evidence of the patient's recovery from his inability to manage his own affairs. There is no good reason why any social stigma should be attached to any person who is mentally ill, or who has been so for a long or short period in the past, or who suffers from any other form of mental disorder. And there is no good reason for drawing any distinction in this respect between voluntary and certified patients.

285. Nevertheless, this feeling about certification is so strong and so widespread that many of our witnesses urged that the procedure which is used at present for "temporary patients" should be used for all mentally ill patients other than voluntary patients in the first place, "certification" being reserved for those who remain in hospital longer than some limited period of time. **But so long as the law provides compulsory powers for detaining mentally disordered patients for treatment against their own wishes or for subjecting them to other special forms of control, the law must also provide proper safeguards against the abuse of such powers.** These safeguards will almost inevitably involve some formal procedures and written documents, which will be the present-day equivalent of the order and certificates which were considered appropriate in 1890 and 1913. There can be no question of doing without some such procedures and safeguards when a citizen is to be detained, even in a hospital, against his will.

286. **Our approach to the problem of certification has therefore been to consider to what extent special compulsory powers are really necessary in present conditions, and to review the present procedures and safeguards to determine whether they are still effective and appropriate rather than to consider dispensing with them or postponing their application when compulsion is used.** In the first place we have considered whether care might be provided much more frequently in future without powers of detention or control and without using any special procedures. We make recommendations to that effect in Chapter 5. In the second place, we have considered the general principles which may justify special powers of compulsion in relation to mentally disordered patients, and whether the limits within which the present law permits the use of compulsion are too widely or too narrowly defined. Our views on this subject are given in Chapter 6. Thirdly we have considered what procedures should be followed in future when compulsory powers are used. Most of the criticisms of the present procedures mentioned in this chapter seem to us to be valid criticisms. Since these old procedures were first introduced there have been changes in general

social conditions and in medical knowledge and more varied forms of care have become available, which have made the procedures seriously out of date. It is time that they were replaced by a new system which should differentiate between individual patients' needs in the light of contemporary medical and social methods of treatment, but should also be less complicated than the present system and more easily understood by the general public, especially by the patients themselves and their relatives. The new arrangements should not be such as to deny care and treatment to patients who really need it and to whom it can only be made available by the use of compulsory powers, but they should provide a really effective system to ensure that such powers are not misused. Our proposals for new procedures are described in Chapter 7.

CHAPTER 5

RECOMMENDATIONS FOR CARE WITHOUT COMPULSION

General principles

287. Our terms of reference particularly ask us to consider the extent to which it is or should be made possible for mentally disordered patients to be treated as voluntary patients without certification. We described in Chapter 4 the extent to which this is permitted under the present law. The Mental Treatment Act provides for the admission of voluntary patients to mental hospitals, but the requirement that every voluntary patient over the age of sixteen must himself sign an application form precludes the admission as voluntary patients of those who are not considered capable of giving a valid signature, even if they have no positive objection to entering the hospital. The Mental Deficiency Acts make no provision for the admission of patients to mental deficiency institutions without powers of detention. Equally they do not positively prohibit it, but they have been generally interpreted as excluding it, in spite of the fact that a few institutions in the past admitted patients informally, and since 1952 informal admission for short periods has been officially encouraged.

288. In Chapter 2 we stated our view that proper standards of care should now be ensured by means which do not depend on the use of compulsion or on power to detain the patient. We also consider it wrong that treatment without detention should still depend on the patient's ability to make a valid positive application for treatment. Medical and social developments in the last fifty years have brought about a situation in which it is no longer right for the law to assume that mentally disordered patients must be subject to detention while under care in hospital unless they can give positive evidence of their wish to receive such care. In our view the assumption should now be, as it is with all other patients, that they are willing or content to enter hospital unless they or their relatives positively object. Compulsory powers involving power to detain the patient should be used only when they are positively necessary to override the wishes of the patient or his relatives in the circumstances which we discuss in Chapter 6.

289. We consider compulsion and detention quite unnecessary for a large number, probably the great majority, of the patients at present cared for in mental deficiency hospitals, most of whom are childlike and prepared to accept whatever arrangements are made for them. There is no more need to have power to detain these patients in hospital than in their own homes or any other place which they have no wish to leave. We strongly recommend that the principle of treatment without certification should be extended to them. Such a step should help to alter the whole atmosphere of this branch of the mental health services. Many parents of severely sub-normal children at present feel that they lose all their rights as parents when their child is admitted to hospital and automatically becomes subject to compulsory detention there. We have no doubt that the element of coercion also increases the resentment of some feebleminded psychopaths, and of their parents, when they are placed under "statutory supervision" or admitted to mental deficiency hospitals after leaving school, and that this makes it even more difficult than it need be to persuade them to regard these services in the same way as other social services and other types of hospital treatment, as services which are provided for their own benefit. Equally important, if the procedures which authorise detention become the exception rather than the rule, the attitude towards compulsion on the part of those administering the

services should change. These procedures will no longer be a formality which must be gone through before any patient can be given the care he needs. It will be possible to consider the need for care and the justification for compulsion as two quite separate questions in a way which is not possible at present.

290. Admission to hospital without using compulsory powers should also be possible for considerably more mentally ill patients than are at present admitted as voluntary patients. Most "non-volitional" patients of the type who are now admitted as temporary patients could be treated without powers of detention. It should also be possible to admit informally a considerable number of mentally ill and infirm patients who can at present be admitted to designated mental hospitals only as certified patients because they are not considered capable of signing a voluntary application form; these would include a high proportion of elderly patients, of the type for whom "long-stay annexes" are at present provided in some areas.

291. **We therefore recommend that the law and its administration should be altered, in relation to all forms of mental disorder, by abandoning the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it. All hospitals providing psychiatric treatment should be free to admit patients for any length of time without any legal formality and without power to detain.** This should apply to all hospitals inside and outside the national health service and to private nursing homes, including the present registered hospitals, licensed houses and certified institutions.

292. In general, the approach to patients and their relatives when compulsion is unnecessary, and the procedures used to provide patients with the type of care they need, should be as nearly as possible the same as those used in relation to other forms of illness, need or disability. In the following paragraphs we give our views on what should happen at various stages of the patient's care.

Diagnosis and choice of forms of care

293. In paragraphs 681–689 in Chapter 10 of this report we recommend the establishment of diagnostic clinics and case-conferences for the diagnosis and selection of the most suitable form of care for children or adults who are thought to be severely sub-normal or psychopathic. These special diagnostic arrangements should always be used before children are recommended for training in a training centre or hospital in place of education at school (see paragraphs 637–649 in Chapter 10). It might not always be necessary to refer adult psychopaths, particularly those of higher intelligence, to these clinics; direct reference to other hospital out-patient clinics might be more suitable. The diagnosis of mental illnesses in adults should remain largely in the hands of general practitioners with the usual facilities for reference to consultants when desirable. General practitioners and hospital consultants should work in close collaboration with each other. They should also keep in close touch with the local authority's mental health department which should be able to provide social workers and other help, especially for patients who do not need treatment as hospital in-patients.

Community care

294. **All local authority community services should be available to those who can benefit from them without the use of compulsory powers. There should also be no need for formal "ascertainment",** though the local authority will of course need to know which persons in their area are in need of com-

munity care, in order that they may carry out their duty of providing care or after-care to those who need it, as recommended in paragraphs 714–715 in Chapter 10. The new diagnostic arrangements recommended in paragraphs 681–689 would replace the present arrangements for the " ascertainment " of defectives. The whole approach should be a positive one offering help and obtaining the co-operation of the patient and his family.

Hospital out-patient treatment

295. Patients receiving psychiatric treatment as hospital out-patients are already treated on the same footing as other out-patients. This should continue.

Admission and discharge of hospital in-patients

296. Mentally disordered patients should be admitted in the same way as other hospital patients, on medical recommendation by agreement with the hospital medical staff, after using the diagnostic arrangements mentioned in paragraphs 681-689 when appropriate. Emergency admissions should also be possible without legal formality and without power to detain, when appropriate.

297. Some of our witnesses who recommended that mental hospitals should be able to admit some patients without any legal formality thought that it might be necessary to retain in addition a separate procedure like the present procedure for voluntary patients, under which the patient would sign an application form at the time of admission and would be required to give formal notice of his wish to leave. The main argument in favour of requiring some patients to give a certain period of notice of intention to leave the hospital is that if the patient insists on discharging himself prematurely the period of notice gives the hospital authorities time to get in touch with his relatives or, if absolutely necessary, to arrange for his certification so that he can be prevented from leaving. But the same situation may arise in the existing emancipated units,[1] or in long-stay annexes, or in neurosis hospitals or general hospitals in none of which is there a statutory period of notice of intention to leave. These other hospitals succeed in making suitable arrangements in such circumstances and we have no doubt that it could also be done in the present mental hospitals. Although this sort of difficulty might arise more frequently there, their staff are accustomed to handling the many problems to which their patients' mental instability may give rise.

298. The argument in favour of a written application form signed by the patient at the time of admission is that it is held to signify the patient's decision to accept the rules of the hospital, including possibly restriction of freedom of movement within the hospital, censorship of letters, or other aspects of the hospital regime which the patient may find irksome at one time or another. We do not place much importance on a written application form in this connection. Provided that the patient can leave hospital altogether if he insists, we see no reason why he should not be expected to accept the hospital regime which is part of his treatment, including restriction of movement within the hospital premises or grounds if necessary. Some hospitals have gone further than others in dispensing with such restrictions, and in distinguishing those which are necessary because of the individual patient's mental condition from those which are part of an administrative tradition which may have outlived its usefulness. We hope that all hospitals will in future limit such restrictions to those which are necessary on medical

[1] See paragraph 225.

grounds. But it may be an essential part of the treatment of some patients that they should lead a closely regulated life, and some doctors may find it necessary to accommodate some of them for long or short periods in locked wards, whether or not the patients have been content to enter the hospital in the first place. If a patient who has been admitted without the use of compulsory procedures needs, as part of his treatment, to be in a locked ward, we see no reason against this. If he objects—and by no means all patients would object—he must choose between leaving the hospital altogether or accepting the restrictions which the hospital doctors consider necessary in his own interests. In paragraph 302 we discuss the steps which may have to be taken if a patient insists on leaving the hospital when he is quite unfit to do so.

299. As regards the censorship of letters, we recommend that there should be no censorship of out-going letters from patients (whether subject to detention or not) except at the request of individual addressees who ask for letters addressed to themselves to be scrutinised or withheld because they find them distressing. The hospital authorities should have authority to withhold from patients any in-coming letters which it would harm them to receive, but this power should be very sparingly used ; we should expect it to be restricted in practice to those severely sub-normal or psychopathic patients who may need to be protected from malicious or other upsetting correspondence from relatives or others who may have been opposed to their admission to hospital. Whenever a letter is withheld from a patient, it should be returned to the writer.

300. We therefore see no need for the retention of the present voluntary admission procedure. Indeed, we think it would be confusing to retain it in addition to completely informal admission. We recommend that all admissions except under compulsory procedures should be arranged in the same way as admissions to general hospitals, with no application form to be signed by the patient and no statutory requirement for any fixed notice of intention to leave. There need be no statutory notification of the patient's admission to any central or local authority. This should not interfere with the central collection of statistics such as those at present collected by the General Register Office, but it would mean the discontinuance of the notice of admission of each voluntary patient by name which at present has to be sent to the Board of Control and, for patients in provincial licensed houses, to the clerk to the Visitors. We see no reason why the doctor who is going to treat the patient in hospital should not ask the patient at the time of admission for a verbal or even written assurance that he will stay for a certain length of time to complete a course of treatment, if the doctor considers that this will help to strengthen the patient's resolve to overcome his trouble ; such an assurance would however not give the hospital any authority to detain the patient if he later decided to leave before his treatment was complete.

301. The normal method of discharge should be for the hospital doctor who has been in charge of the patient's treatment to tell the patient and his relatives when he considers the patient fit to leave, to inform the patient's general practitioner and to arrange any suitable after-care (with the patient's agreement) in consultation with the general practitioner and the local health authority. If the patient has no home to which he can be discharged and is not well enough to manage for himself, the hospital should get in touch with the local authority's health or welfare department, who, under the arrangements which we recommend in Chapter 10, would have a duty to arrange or provide a suitable home. The patient's discharge need not be reported to any central authority, and should only be notified to the local

health authority when they are going to provide after-care or in cases in which they originally helped to arrange the patient's admission.

302. If a patient expresses a wish to leave the hospital before his doctor considers him fit to do so, he should be seen by the doctor who should try to persuade him to stay to complete his treatment. If he refuses, however, the hospital will have no power to detain him, and he must be allowed to leave, unless the circumstances are such that the doctor considers it necessary to take steps to obtain power to detain him by using one of the emergency or other compulsory procedures which we discuss in Chapter 7. Such procedures could of course not be used except under conditions in which a patient's compulsory admission to hospital would be allowed if he were not already in hospital. It should not be necessary to use compulsory procedures in this way very frequently, but we must recognise the fact that it is sometimes necessary now with voluntary patients, and will probably continue to be necessary from time to time in future. The present practice of different hospitals in these circumstances varies. Some hospitals never arrange for the certification on their own premises of a patient who has been admitted as a voluntary patient; they feel morally bound to allow any voluntary patient to leave the hospital after the expiration of his seventy-two hours notice, and consider that it would undermine the confidence of patients and relatives in the voluntary system if any voluntary patient were ever prevented from doing so. Other hospitals, though disliking the necessity, occasionally arrange for the certification of voluntary patients within the period of the seventy-two hours notice. This is a question on which there is room for real differences of attitude, both among doctors and among patients. We doubt whether, from the patient's point of view, there is any advantage in the expedients adopted in some areas in order to avoid certification of voluntary patients on the hospital's own premises, as, for instance, by arranging for the patient to be taken direct to another hospital where he is certified and then returned to the hospital from which he came. The views of one patient to whom this happened, and who was later discharged, are given in the published minutes of the evidence which we took in private. (Evidence taken in private, Q. 10,001–10,095.) Our recommendations in Chapter 7 for new compulsory procedures include an emergency procedure which may be used when the patient is already in hospital. Whatever the detailed procedures are, however, it will always be distasteful both to the hospital doctors and to the patients to have to use them in these circumstances. We consider it important that when it seems necessary to take steps to detain a patient the doctor should try to explain the situation to the patient, unless the patient's mental condition is such that he is quite incapable of appreciating it, and that such steps should be taken only when it is quite certain that the patient is not otherwise prepared to stay and that his compulsory detention in hospital is entirely necessary.

303. It sometimes happens that a patient's relatives press for the patient's discharge from hospital before the hospital doctors consider him fit to leave. If our recommendations for admission without legal formality are adopted, patients so admitted in future will include, in addition to the present voluntary patients, some who under the present law would be admitted as temporary or certified patients, including some mentally ill or sub-normal patients who, though not objecting to admission to hospital, would not be capable of expressing their own opinion if a relative asked for their discharge. As the hospital would have no power to detain the patient against the patient's own will, it is important to consider how far the wishes of the patient's relative should be treated as the wishes of the patient when the patient is incapable of expressing an opinion of his own.

304. At present, relatives have no power to order the discharge of a voluntary mentally ill patient over the age of sixteen, who has himself applied for admission. The parent or guardian of a voluntary patient under the age of sixteen may remove him on giving seventy-two hours notice. The relative who originally applied for the admission of a temporary patient, or presented a petition for a judicial order (under Sections 4-8 of the Lunacy Act, 1890) for the admission of a certified patient to a mental hospital, may order the discharge of that patient at any time; if such relative is dead or otherwise incapable of acting, the patient's nearest relative may act in his place. The nearest relative of all other certified patients in mental hospitals (except Broadmoor patients) may order the patient's discharge at any time. Even if the hospital doctors consider discharge to be against the patient's best interests, they must discharge the patient on the relative's order, unless they are prepared to certify that the patient is dangerous; even this barring certificate on grounds of danger may be overruled by any two members of the hospital management committee. On the other hand, the relatives of patients who have been admitted to mental deficiency hospitals under order have no power to order the patient's discharge. A parent or guardian who has "placed" a defective in hospital under Section 3 of the Mental Deficiency Act, 1913, may remove him on giving written notice to the Board of Control, if the Board does not veto discharge.

305. In future, when a patient has been admitted without legal formality, if relatives ask for his discharge before the hospital doctors consider him fit to leave, the doctors should explain to the relatives why they consider that the patient needs to remain in hospital. If after this the relatives insist on pressing for discharge, we recommend that the following practice should be adopted:—

(i) If the patient is over the age of sixteen and is capable of expressing his own opinion, he should be asked whether he wishes to stay to complete his treatment. If he does, he should be asked to sign a statement saying that he wishes to stay and that he realises that he is free to leave the hospital when he himself wishes to do so. The relatives' request for the patient's discharge then need not be acceded to. This is one of the very rare occasions on which we recommend that the patient should be asked for a written statement; we consider it desirable in these circumstances as a protection to the hospital against possible allegations that they have detained a patient against his will when they have no authority to do so. The date of signature should be authenticated by or on behalf of the hospital management committee.

(ii) If the patient is under the age of sixteen, or is incapable of expressing his own opinion, and the relative asking for his discharge is his parent or guardian or nearest adult relative, he should be discharged. There can be no question of a barring certificate, even on grounds of danger to the patient or to others, in relation to patients admitted informally, whom the hospital has no authority to detain. We discuss in paragraphs 359-365 and 491-510 other special measures which may be taken if the nearest relative acts quite irresponsibly, either by discharging the patient or by obstructing his admission to hospital when he badly needs treatment for his own welfare or for the protection of others.

(iii) If the patient is under the age of sixteen and if the relative who is pressing for his discharge is not the parent or guardian or nearest adult relative, the parent or guardian or the nearest relative should

be consulted. If he supports the request for discharge, the patient should be discharged. If he wishes the patient to remain in hospital, he should remain.

(iv) If the patient is over the age of sixteen but incapable of expressing his own opinion, and if the relative pressing for his discharge is not the nearest relative, the hospital should ask what provision the relative asking for discharge intends to make for the patient's care after discharge. If it appears that he is not willing or able to make arrangements for the proper care of the patient, the hospital should consult the nearest relative, and if the nearest relative agrees that the patient should stay in hospital, then the view of the nearest relative should prevail and the patient should remain in hospital. The patient would still be free to leave the hospital if he himself wished to do so, and if the nearest relative at any time decided to remove the patient he could do so, even against medical advice. We recommend this exception to the general rule that the patient should be discharged to the care of the relative pressing for his discharge, because it does happen from time to time that relatives who are prejudiced against anything "mental", or do not appreciate the patient's real needs, press for his discharge even if they have no intention of looking after him in any way. We see no reason why a patient should be deprived of treatment which he needs and which he is content to receive, as the result of irresponsible action of this sort on the part of a relative who is not the nearest relative, when the nearest relative wishes the treatment to be continued.

(v) If the relative pressing for discharge is one of several "nearest" relatives equal in kinship to the patient (e.g., two sisters, a sister and a brother, etc.), and the other relative of equal kinship wishes the patient to remain for further treatment, the hospital should use their discretion in deciding whether to discharge the patient or not. We should expect the hospital to discharge if any one of the relatives seemed able to make reasonable arrangements for the patient's care.

Care after leaving hospital

306. **After leaving hospital, community care should be available without powers of compulsory control, whether or not the patient has been subject to detention while in hospital.** Patients who have received hospital treatment on an informal basis, including severely sub-normal and psychopathic patients, will be in the same need of after-care either from the hospital or from the local authority as patients who have been subject to detention while in hospital. Arrangements for trying them out in life outside the hospital and for their after-care should be made with the same freedom from legal formality or sanction as their treatment in hospital. In those cases in which it is still found necessary in future to have legal powers of control over the patient while he is in the hospital, the compulsory powers should be brought to an end as soon as possible after he returns to the general community and after-care should continue without compulsion. In Chapter 10 we recommend that local health authorities should have a duty to provide after-care for all those who need it. There should be no question in future of compulsory powers being prolonged simply to give authority for the provision of after-care or in case the patient may need re-admission to hospital later in life, as licence is sometimes prolonged at present under the Mental Deficiency Acts (see paragraph 229). We discuss in paragraphs 469–477 in Chapter 7 the period for which we consider it would be justifiable in future to prolong such powers. After-care will usually be needed, and should

certainly be available, on an informal basis for much longer than legal power to recall the patient to hospital compulsorily.

Action without new legislation

307. The suggestions made in this chapter need not be written into the new legislation. Most of them simply follow general hospital practice. The suggestion that patients should sign a statement as evidence of their willingness to remain in hospital when relatives press for their discharge, is merely a precaution which we feel hospitals would be wise to take for their own protection, and need not be a statutory requirement. It would not, however, be possible to apply these procedures in "designated" mental hospitals, registered hospitals and licensed houses without amendment or repeal of the Lunacy Act, 1890.

308. **We see no reason why informal admission to the present mental deficiency hospitals need wait on new legislation.** As we understand it, the disfavour with which the Board of Control regarded informal admission to mental deficiency institutions in the past was based on considerations of administrative policy rather than of law. It is apparently accepted that such admission is legally permissible, and since 1952 it has been encouraged for patients who are in hospital only for short periods. The Board of Control and Ministry of Health, in their evidence to us, referred to "the difficulties of treating patients who are not under detention side by side with those who are" (1st Day, P. 18, para. 69). It is not clear precisely what difficulties they had in mind. We have received no evidence of any difficulties arising over the patients admitted informally for short periods, and mental hospitals have been accustomed now for many years to treating voluntary and certified patients side by side in the same wards. It may be that the Board and the Ministry were afraid that the hospitals might lay themselves open to allegations that they were detaining patients without authority to do so if patients admitted informally were treated in locked wards or were confined to the hospital grounds. It will be clear from paragraph 298 that we do not consider this to be a real difficulty. We do not think that hospitals need fear being accused of detaining a patient if they are ready to let him leave the hospital altogether when he or his relatives wish it. It is partly because we think that this principle should be applied in the present mental deficiency hospitals as well as in hospitals treating mentally ill patients, and to the most severely sub-normal patients in particular, that we have described in such detail, in paragraph 305, the circumstances in which the wishes of the relatives should be treated as the wishes of the patient in regard to discharge from hospital.

309. It has also sometimes been held in the past that it is better for patients to be admitted under the formal procedures laid down in the Mental Deficiency Acts because they then obtain the "protection" of the Acts, including formal reviews at statutory intervals of their need to remain in the institution, visits by commissioners of the Board of Control and so forth. The fact that this "protection" involves loss of liberty by the patient and often loss of normal parental rights by even a most devoted parent was apparently considered to be more than offset by the value of such formal procedures as guarantees of proper care. We do not share that view. In present circumstances at any rate, standards of care can and should be safeguarded, when there is no opposition on the part of the patient or his relatives, by methods which do not involve powers of detention.

310. There may also be a feeling that with the present long waiting lists for admission to mental deficiency hospitals any vacancies which occur

should be given to patients who are "subject to be dealt with" under the Acts and thus liable to compulsory admission and detention. Certainly while there are waiting lists there must be a system of priorities, and the most urgent cases will usually be patients who are "subject to be dealt with" in the terms of the present Acts, (though not necessarily so if Section 2 (1) (*b*) of the 1913 Act is strictly interpreted). But we see no reason why patients who are "subject to be dealt with" should not be admitted informally, just as mentally ill patients who are certifiable are admitted to mental hospitals as voluntary patients and to "long-stay annexes" without any formality. Admission without formality need not imply that any patient can jump the queue on the waiting list. It would merely mean that when a bed is offered to the patient who is considered to be in the most urgent need of admission, compulsory admission procedures would be used only if the patient or his relatives object to informal admission.

311. All these considerations, however, are matters of policy, not of law. We have not taken expert legal advice on the legal aspects, but no witnesses have offered us evidence of any positive legal difficulty, and we ourselves see nothing in the Mental Deficiency Acts in their present form to prevent mentally defective patients from being admitted informally, without being subject to detention, to any hospitals provided under the national health service, whether or not these hospitals are also "institutions" within the meaning of the Mental Deficiency Acts. We therefore recommend that the Minister of Health should consider the present legal position, and if no legal obstacle is found should arrange for patients to be admitted informally to mental deficiency hospitals when compulsion is unnecessary, without waiting for new legislation. We see no reason why the same should not apply to the present certified institutions outside the national health service.

CHAPTER 6

FUTURE COMPULSORY POWERS

General considerations

312. There is a fairly wide but circumscribed range of circumstances in which our society recognises a general need to restrict the personal liberty of individual citizens either for the person's own protection or for the protection of other individuals or of society in general. Restriction of liberty is usually accompanied by the provision of special forms of care, treatment, training or occupation for the person who is placed under detention or control. Sometimes need for special forms of treatment or training is itself an essential element in the grounds on which compulsory restriction of liberty is accepted as justified.

313. The criminal law is concerned with anti-social behaviour which is held to justify the restriction of personal liberty primarily for the protection of other individuals or of society in general. Within the criminal law there are provisions to meet the special needs of juveniles and other young offenders, and corrective training or preventive detention may be prescribed for persistent offenders. Outside the criminal law, persons suffering from certain infectious diseases may in certain circumstances be compulsorily removed to and detained in hospital to protect others from infection.[1] Compulsion which may involve some restriction of personal liberty but which is based primarily on the person's own need for protection or for some form of care, treatment or training is also applied to children and to others not capable of looking after their own interests. For example, sick or infirm persons in need of care and attention may be compulsorily removed to hospital or elsewhere under the conditions laid down in Section 47 of the National Assistance Act, 1948.[2] Our child care legislation and Education Acts allow various forms of compulsion to be used in order to provide children with necessary protection from neglect or ill-treatment or with suitable forms of education. This often involves coercion on the parents rather than on the child. It may involve the transfer of parental powers of control from the child's parents to a public authority or other suitable person, or a public authority may in certain circumstances remove a child from the care of a person other than his own parents. Parents may be obliged to allow a public authority to provide suitable education for their child.

314. Some forms of mental disorder have long been accepted as requiring or justifying the restriction of personal liberty in special ways. We described in detail in Chapter 4 the provisions made in the law for this purpose in the past and at present. Several considerations seem relevant to the question whether the law should continue in future to provide forms of control, within stated limits, over people suffering from mental disorder which do not apply to other people:—

(i) When an illness or disability itself affects the patient's power of judgment and appreciation of his own condition, there is a specially strong argument for saying that his own interests demand that the decision whether or not to accept medical examination, care or treatment should not be left entirely to his own distorted or defective judgment. Admission to hospital against the patient's wishes at

[1] Public Health Act, 1936, Sections 169, 170 and 172; Public Health (London) Act, 1936, Sections 201 and 202.

[2] Subject to certain conditions, this allows the compulsory removal to hospital or elsewhere of "persons who (*a*) are suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions, and (*b*) are unable to devote to themselves, and are not receiving from other persons, proper care and attention".

the time may be the only way of providing him with the treatment or training which may restore his health or enable him to take his place as a self-supporting member of the community or to develop his limited capabilities to the greatest possible extent. The better the prospects are of treatment or training being successful, the more important this consideration becomes.

(ii) Some adult mentally disordered patients, especially those who are severely sub-normal, may need the same type of protection as children, in order to prevent their parents or relatives or other persons from neglecting or exploiting them or obstructing the provision of treatment or training which they may badly need and from which they are likely to benefit.

(iii) When mental disorder is known to make a person prone to violence or other forms of seriously anti-social behaviour or to persistent petty crime and he is thought unlikely to respond to ordinary penal measures, special preventive control may be justified. In these and other cases in which an offender against the law is found to be suffering from mental disorder, imprisonment under ordinary conditions or other penal measures may not provide appropriate treatment, and the length of time needed for suitable medical or social treatment or training to have a useful effect may be either longer or shorter than the sentence of imprisonment or length of probation or supervision which courts would normally impose. In cases of severe mental disorder it may be repugnant even to subject the patient to the normal procedures of prosecution and trial.

(iv) The behaviour of a person who is suffering from mental disorder may be so annoying to other people and so persistent that even if it is not criminal the protection of other people from such behaviour may be a factor which, combined with the patient's own need for treatment, may justify the use of special compulsory powers.

(v) Against these considerations, all of which tend to support the case for some special compulsory powers, must be set the individual patient's right to personal liberty. We are not thinking here of the possibility that the liberty of other citizens might be in danger from the wrongful application to them of special compulsory powers which the law intends only for use in case of mental disorder; safeguards against abuse of that sort should be provided by the special procedures which must be used when the compulsory powers are invoked in any individual case. We are thinking rather of the liberty of the mentally disordered person himself. No form of mental disorder should be considered to be, by itself, a sufficient ground for depriving a person of his liberty. It is necessary to balance the possible benefits of treatment or training, the protection of the patient and the protection of other persons, on the one hand, against the patient's loss of liberty on the other. In our view the patient's loss of liberty has been too lightly regarded in the past, particularly in relation to mental defectives. The issue has been obscured by the fact that for these patients the provision of care has not been permitted except after the use of procedures which involve powers of detention. This will not be so under the system which we envisage for the future, in which care will be offered without deprivation of liberty to those who are not unwilling to accept it.

315. **We start our consideration of the need for compulsory powers in present-day conditions by repeating that when a patient is thought to require some form of care, but he or his relatives object, every effort should be made to persuade him or them to agree to care being provided without the use of compulsion.** Such objections are often caused by prejudice based on ignorance, and may be overcome if the patient or his relatives can be persuaded to visit the hospital, training centre, or other place and talk to the doctor, nurses or social workers, and see for themselves what form of treatment or training is proposed, before a final decision is taken. If a patient is willing to attend hospital as an out-patient but not as an in-patient, it may be preferable, even if in-patient treatment is needed, to let him start as an out-patient in the hope that he will agree to in-patient treatment later. We hope that the confidence of the public in the mental health services will grow as they become more widely known and as material standards improve, and that compulsion will become less and less necessary. The development of hospital out-patient services, and of a wider range of community services on the lines we discuss in Chapter 10, should also help to reduce the need to use compulsory powers, as they should make it possible to treat more patients without removing them from their normal surroundings.

316. But, because various forms of mental disorder do affect the patient's own reason and powers of judgment and his power to appreciate the effect on others of his own behaviour, there are likely always to be some who will refuse the offer of treatment or training in any form. **No one disputes that there are some circumstances in which society must in the last resort be able to compel some patients to receive treatment or training in their own interests or for the protection of others, and that some may need to be protected against exploitation or neglect. Indeed, we would go further, and emphasise that when every effort has been made to overcome the unwillingness of the patient or his relatives by persuasion, doctors and others should not be too hesitant to use such compulsory powers as the law may provide, if this seems the only method of giving the patient the treatment or training which he badly needs and which is expected to cure or relieve his illness or to enable him to live a more happy and useful life.**

317. **We consider that the use of special compulsory powers on grounds of the patient's mental disorder is justifiable when :—**

(a) there is reasonable certainty that the patient is suffering from a pathological mental disorder and requires hospital or community care ; and

(b) suitable care cannot be provided without the use of compulsory powers ; and

(c) if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself ; and

(d) there is also either

(i) good prospect of benefit to the patient from the treatment proposed—an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others ;

or (ii) a strong need to protect others from anti-social behaviour by the patient.

318. In paragraphs 319–356 we discuss the extent to which compulsory powers are needed for each of the three groups of patients which we recommended in Chapter 3 should be recognised in future for legal and administrative purposes and the special considerations which apply when the patients' nearest relative is opposed to the provision of hospital or community care which he is thought to need. In Chapter 7 we recommend new procedures to be followed in future when compulsory powers are used, which would require attention to be paid in each individual case to the principles enunciated in this chapter, and which would, in our view, provide more effective safeguards against the misuse of compulsory powers than do the procedures laid down under the present law.

Mentally ill patients

319. Some of our witnesses suggested that the compulsory powers contained in Section 47 of the National Assistance Act, 1948,[3] should be used instead of those contained in the Lunacy and Mental Treatment Acts when it is necessary to effect the compulsory admission to hospitals or welfare homes of elderly senile patients. These witnesses suggested that this section should be suitably amended in order to permit this to be done, and in particular that the phrase "living in insanitary conditions" should be deleted from it. The intention behind this suggestion is to make it possible for old people whose mental powers are failing to be given proper care and protection without "certification", and it must be considered in conjunction with the allegation that many old people are being certified and sent to mental hospitals mainly because there is no other accommodation available.

320. **We have received no evidence to show that old people admitted to mental hospitals are not in fact suffering from mental disturbance or deterioration which makes them "of unsound mind" within the meaning of the present Lunacy and Mental Treatment Acts. Nor do we subscribe to the view that elderly patients should never be sent to mental hospitals.** Old people may develop the same type of mental illnesses as younger people. In others the process of ageing may involve mental deterioration leading to a degree of confusion and disturbed behaviour which calls for expert medical and nursing care. In either case many old people can benefit from the skilled attention which a modern mental hospital can provide, and this should certainly not be denied to them because of their age. It is however wrong that any person who does not in fact need this skilled attention should have to be admitted to a mental hospital, or that any person who is fit enough to leave the hospital should remain there because he has nowhere else to go. There is little doubt that this often happens at present. (See also paragraph 259 in Chapter 4 and paragraphs 596 and 626–631 in Chapter 10.) In future, a wider range of residential and other services should be developed for elderly patients (as recommended in Chapter 10), and alterations should also be made in the procedures for admission to psychiatric hospitals. Our recommendation in paragraphs 381–383 in Chapter 7 that there should be no mandatory order for admission to these hospitals even when compulsory powers are used should help to prevent them being used in future in order to obtain a bed in such a hospital for patients who could be equally well cared for elsewhere. **When treatment in such a hospital is really needed, our general recommendation that all hospitals should be free to admit patients informally should allow many elderly patients who are now certified to be admitted without the use of compulsory powers. When compulsory powers are positively necessary in order to provide suitable care the procedures recommended in Chapter 7 would avoid most of the objectionable features of the present**

[3] See paragraph 313.

certification procedures, and the term "certification" should fall into disuse. We consider these new procedures suitable for mentally disordered patients of all ages. We do not think it is desirable to have special procedures for patients who have passed any particular age or who are suffering from any one form of mental illness or deterioration. We see no reason why the powers contained in Section 47 of the National Assistance Act should not be used in suitable cases to protect senile as well as other patients in the circumstances covered by that section. In other circumstances we consider it more appropriate to use the powers and procedures which apply to other mentally disordered patients, and we see no need to recommend any extension of the ambit of this section of the National Assistance Act.

321. We received some allegations that people who were not "of unsound mind" have been wrongly diagnosed and sent compulsorily to mental hospitals. We regard these as criticisms of the procedures which must be applied when compulsory powers are used rather than as criticisms of the compulsory powers themselves, and we discussed them, as well as the many other criticisms of the present procedures and the way in which they are used, in paragraphs 256–286 in Chapter 4.

322. Apart from the suggestion that different powers should be used for senile patients and criticisms of the present procedures, we received no proposals to curtail the compulsory powers which apply to patients who are properly diagnosed as suffering from those forms of mental illness which make them liable under the present law to compulsory admission to hospital or to control in the community. It is generally agreed that it is right that patients suffering from these forms of mental illness should be subject to special forms of compulsion and control, in the last resort, if proper care cannot otherwise be provided for them. A few witnesses and correspondents expressed the view that the present powers are insufficient or are not used when they should be used. They told us of individual cases in which patients who seemed to need treatment or control were considered by the doctors who examined them to be mentally ill but "not certifiable", or to cases in which patients seem to have been allowed to leave hospital when they were still unstable and in some cases dangerous to others.

323. **Subject to the use of the new procedures recommended in Chapter 7, which would require consideration to be given in each case to the points mentioned in paragraph 317, we do not think it necessary to recommend any change in the circumstances in which compulsory powers may be applied to mentally ill patients. It should be permissible in future for patients to be admitted compulsorily either for a period of not more than twenty-eight days observation and preliminary treatment in hospital or for a longer period of hospital or community care.**

324. We do not think it necessary to define the circumstances in which compulsory powers may be used in more precise terms than those used in the Lunacy Act, 1890. One of the most remarkable features of the administration of this Act has been that the application of the very general phrase "a person of unsound mind and a proper person to be detained for care and treatment" has been confined by medical tradition to much the same medical and social conditions as were considered to be covered by it in the very different general circumstances which obtained when it was first introduced into the law over a hundred years ago. In spite of the vagueness of its terms it has not been extended to other forms of mental illness or disorder which the medical profession and other authorities have come to recognise as requiring treatment in the interests both of the patients and of society as a whole. Because of this, separate new powers were introduced in 1913 to

apply to feebleminded patients and moral defectives, and for the same reason many medical and other witnesses have proposed to us that new powers are now needed to enable care and treatment to be provided for other psychopathic patients. Some of our witnesses proposed that psychopathic patients who are dangerous to others should be subject to compulsory powers as "persons of unsound mind" (leaving most other psychopathic patients to receive treatment on a voluntary basis only), and suggested that this could be done without new legislation because the minds of these dangerous psychopaths are clearly "unsound". Some individual doctors may support this and may be prepared to certify such patients under the present Lunacy Acts, but it is noteworthy that this view was not put to us by any of the medical associations nor by the individual medical witnesses from whom we received evidence, even though most of them did consider that such patients ought to be subject to some form of compulsory control. Most of our medical witnesses recommended new and separate powers to be applied to psychopathic patients; some proposed that the definition of mental defectiveness should be amended so that it would be clear that at least some psychopathic patients could be treated as mental defectives, irrespective of the level of their intelligence; no medical witness suggested to us that dangerous psychopaths should be considered certifiable as "of unsound mind" or "mentally ill". If we were to follow the example of the 1904-08 Royal Commission and to recommend again that the term "person of unsound mind" should be interpreted as including some types of psychopathic patients who are not at present considered certifiable, we have little doubt that the medical profession as a whole would nevertheless find difficulty in accustoming itself to this wider conception of the term, and that many doctors would continue to interpret it in the more limited traditional sense. We do not think it would make any difference from this point of view if the term "mentally ill" were substituted for the term "person of unsound mind". This is one of the reasons (but not the only reason) why we recommend that for administrative purposes the law should recognise psychopathic patients (in the sense in which we use that term, including many now certifiable as feebleminded or moral defectives) as a separate group of mentally disordered patients. Another reason is that we consider that the circumstances in which psychopathic patients may be subject to compulsory powers should be more limited than those which apply to "persons of unsound mind".

325. We also feel certain that if the phrase "a person of unsound mind and a proper person to be detained for care and treatment" is replaced by a phrase which uses the wider term "mentally ill" instead of "person of unsound mind", the medical profession will continue to use much the same criteria as at present in judging the medical and social conditions which justify the application of compulsory powers, i.e. the conditions which in present language make the patient "a proper person to be detained for care and treatment". **We recommend that, subject to the use of the new procedures recommended in Chapter 7, the law should in future allow mentally ill patients to be admitted compulsorily to hospital or to be placed under guardianship in the community "when the use of compulsion is necessary for the patient's own welfare or for the protection of others".** This phrase is intended to cover the same medical and social conditions which are at present held to make a patient "a person of unsound mind and a proper person to be detained for care and treatment". We are quite confident that if this new phrase is adopted compulsory powers will not be extended in practice to mentally ill patients who are not subject to compulsory powers at present.

326. In addition to these general powers which will apply to only a minority of the total number of mentally ill patients, we consider it desirable to retain

powers similar to those contained in Section 4 of the Criminal Justice Act, 1948, to allow the acceptance of medical treatment to be made a condition of probation when patients suffering from milder forms of mental illness are convicted of offences under the criminal law. We mention this again in paragraph 512.

Severely sub-normal patients

327. There is general agreement that compulsory powers should be available for use when necessary to ensure proper care for the patients now classified as idiots or imbeciles. For the great majority of these patients it should be possible in future to provide care without compulsion. The patients themselves will usually accept whatever arrangements are made for them. Their relatives also are usually anxious that proper care should be provided. Some severely sub-normal patients may however themselves be unwilling, and some may have seriously anti-social habits which make it necessary to use compulsion for the protection of others. There are also comparatively rare cases in which the patients may be neglected or exploited by their relatives. Some parents also do not realise or are unwilling to admit the severity of their child's sub-normality and oppose a decision to report him as incapable of receiving education at school or as needing supervision after leaving school.

328. Some of our witnesses suggested that while these patients are children the compulsory powers contained in general child care legislation and in the Education Acts should be used to provide them with proper care and training. and that there is no need for separate powers such as those contained in the present Mental Deficiency Acts. Some witnesses also suggested that similar protection could be given to adult idiots and imbeciles by giving them a legal status equivalent to that of children.

329. **The attitude to the children and to their parents in the services provided for mentally sub-normal children should certainly be more like that in the other child care and education services.** In paragraphs 637-649 and 650–653 in Chapter 10 we discuss the administration of services for mentally disordered children and the extent to which local authorities' children departments and education departments might appropriately participate in them. We recommend in that chapter that the provision of training for children who cannot benefit from the education provided in ordinary or special schools should continue to be the administrative responsibility of the local health authorities rather than of the local education authorities, but that the present procedure for ascertaining children as "ineducable" should be abolished and replaced by a procedure under which they would be "recommended for training" in a training centre or hospital, just as children who need education in a special school are no longer "certified" but "recommended" for special forms of education. Full consideration should be given to the views of the parents themselves, but there should finally be an obligation on parents to allow their children to receive the form of training most suited to their abilities and aptitudes. We suggest that a suitable method of imposing this obligation would be to extend the provisions of Sections 36 and 37 of the Education Act, 1944, to cover training as well as education and to include attendance at a training centre or hospital as an alternative to education at school. It should then no longer be necessary to have separate procedures for ascertaining these children as "mentally defective" or for their admission to hospital or guardianship, merely in order to provide suitable training.

330. The compulsory powers provided for the care or protection of children and young persons under the Children and Young Persons Acts, under the child life protection provisions of the Public Health Acts and Adoption Act, 1950, and under the Children Act, 1948, can be used only under

specified conditions which take no account of the question whether the child or young person is mentally sub-normal.[4] We do not consider these conditions wide enough to cover all the circumstances in which it may be justifiable to provide care or protection for a mentally sub-normal or abnormal child or young person. Because of his mental condition a mentally disordered child may need more protection against neglect or exploitation than a normal child. While, therefore, we consider that use should be made of the compulsory powers contained in the general child care legislation when this is appropriate, we recommend that special compulsory powers which take the child's mental condition into account should also be available. There should be similar special powers to ensure the provision of care for severely sub-normal adolescents and adults. **We recommend that these special powers and the circumstances in which they may be used should be the same as those which we proposed in paragraphs 323 and 325 in relation to mentally ill patients, i.e. compulsory admission to hospital for up to twenty-eight days observation or to hospital or guardianship for a longer period of care should be allowed when the use of compulsion for this purpose is necessary for the patient's own welfare or for the protection of others. A list of detailed circumstances in which compulsion may be used, such as that contained in Section 2 of the Mental Deficiency Act, 1913, would no longer be necessary, and the expression " subject to be dealt with " should no longer be used.** We discuss in paragraphs 359–365 the general considerations which should govern the use of such powers against the wishes of the patients' relatives.

331. Although there is general agreement that compulsory powers should be available when necessary to protect the patients now classified as idiots and imbeciles, we received conflicting views about those who are at present classified as feebleminded. The disagreement centres, however, mainly round those whose intelligence is not seriously impaired. We do not think that it would be disputed that the classification " feebleminded " is applied at present to some patients who are so seriously sub-normal that they are incapable of living an independent life and who should be grouped, as far as compulsory powers are concerned, with those now classified as imbeciles. There are however differences of opinion on where the dividing line should be drawn between imbeciles and those of the feebleminded who should be subject to the same compulsory powers on the one hand, and on the other the rest of the feebleminded and moral defectives in respect of whom it may be right for compulsory powers to be more limited. A few of our witnesses suggested substantial curtailment of the present compulsory powers in regard to all those now classified as feebleminded. A much larger number of witnesses suggested that the compulsory powers which apply to idiots and imbeciles should also apply to all feebleminded patients whose mental disorder clearly affects their intelligence as well as other aspects of their personality ; most of these witnesses considered that this group of patients should not include any with an intelligence quotient higher than about 70 to 75. Other witnesses suggested that intelligence should not be a determining factor at any level. In paragraphs 192–195 in Chapter 3 we described where we consider this dividing line should be drawn. We include in the severely sub-normal group a smaller proportion of the patients now classified as feebleminded than would those of our witnesses who referred to an intelligence quotient of 70 to 75. We must emphasise, however, that this recommendation is linked with our recommendations later in this chapter for certain compulsory powers

[4] The child life protection provisions of these Acts do not at present apply to mentally defective children (see Chapter 12), but such children are not excluded by law from the purview of the rest of the child care legislation except in the circumstances mentioned in Section 8 of the Children Act, 1948—see paragraph 653 in Chapter 10.

to apply also to the patients in our psychopathic group. For those feebleminded patients and moral defectives who fall into the psychopathic group as described in Chapter 3, we do not think it necessary to retain compulsory powers as wide as those which may occasionally be needed for the severely sub-normal. But we do think it necessary that those patients should be liable to compulsory care in circumstances no more narrowly restricted than those recommended later in this chapter. And we think it wrong that such compulsory powers should be limited to those patients only, when the considerations which justify them apply with at least equal force to other psychopathic patients also. Our recommendations for the recognition of the three groups of patients described in Chapter 3 and for the compulsory powers which should apply to each are interrelated and must be regarded as a whole. If compulsory powers in regard to psychopathic patients are to be more narrowly restricted than we recommend, it would be necessary to re-consider the dividing line between the severely sub-normal and psychopathic groups and probably to include in the former a higher proportion of the patients at present classified as feebleminded or moral defectives.

332. We discuss in paragraph 358 whether any definition of the severely sub-normal group of patients should be written into the law in connection with the use of these compulsory powers.

Psychopathic patients

333. The patients to whom we apply the term "psychopathic" include some whom all doctors agree are at present liable to the compulsory powers contained in the Mental Deficiency Acts, some over whose certifiability under those Acts there are differences of medical opinion, and others whom all doctors agree to be not certifiable under the Mental Deficiency Acts as they stand at present. Some patients at present certified as feebleminded or moral defectives may be suffering from severe forms of mental disorder which would at present also render them liable to certification under the Lunacy Act, 1890; under our proposals these patients would be liable to compulsory admission to hospital or guardianship as mentally ill patients in the circumstances discussed in paragraphs 319–325. Under the present heading of psychopathic patients, we are discussing compulsory powers only in relation to patients who are not at present considered certifiable under the Lunacy Act and would thus not be liable to compulsion under our proposals as mentally ill patients, and whose mental disorder also does not bring them into our "severely sub-normal" group, and who are recognised as suffering from the forms of personality disorder described in Chapter 3 as "psychopathic".

334. The question of compulsory powers in relation to the patients included in our psychopathic group gives rise to difficulties of two kinds. In the first place there are differences of opinion on whether special compulsory powers are justified at all in relation to these patients, and if so whether they should apply equally to all such patients or only to some of them. Secondly, those who consider that such powers are justified in certain circumstances have difficulty in describing those circumstances in medical or sociological terms which seem to identify them satisfactorily and further disagreement arises over the language used to describe them.

335. Most of our witnesses explained their views on these questions by telling us whether, and why, they consider that the compulsory powers contained in the present Mental Deficiency Acts in relation to feebleminded persons and moral defectives are satisfactory or whether they should be curtailed, clarified or extended. Some witnesses also made separate suggestions for new compulsory powers over psychopaths who are at present considered

liable to compulsion neither under the Mental Deficiency Acts nor under the Lunacy and Mental Treatment Acts. Many of our witnesses assumed that one set of legal definitions or descriptions should regulate both the use of compulsory powers and the groups into which patients should be classified for treatment. In commenting on the present legal definitions of mental defectiveness and of the various classes of defectives they did not always distinguish these two different purposes for which the present definitions are used. We explained in Chapters 2 and 3 why we consider that groups of patients need be named or defined in the law in future only in connection with compulsory powers. Our views as set out in the following paragraphs relate only to the medical and social conditions in which compulsory powers may be justified. We believe that care should be provided in much wider circumstances for those who are not unwilling to accept it. There should not be any rigid definition of the type of patients whom particular hospitals may admit for treatment or training. The classification of patients for various forms of hospital or community care should be determined solely by their medical and social needs, and should not depend on whether or not compulsory powers have been used, or were available for use, for any particular patient.

336. All the general considerations on the use of compulsion which we listed in paragraph 314 were mentioned to us by one witness or another as applying to psychopathic patients. Some witnesses rejected all those which support the use of special compulsory powers except when the patient has committed an offence against the criminal law, and considered that even then they should be used only for certain types of patients and with a definite limit to the period of compulsory control. A larger group of witnesses proposed that the compulsory powers contained in the present Mental Deficiency Acts should be continued but should apply only to patients with a definite impairment of intelligence. But several of the witnesses who suggested this were clearly thinking mainly of the classification of patients for treatment; they either contemplated the more intelligent patients receiving treatment and being liable to compulsion under some other classification, or expressed no views on what should be done for them. Another group of witnesses supported the application of the present powers to all patients whose disorder can be shown to have arisen during the course of childhood or adolescence, irrespective of the level of their intelligence; that is to say, they supported the limitation contained in the present definition of mental defectiveness that the mental disorder must have existed since before the age of eighteen (some witnesses suggested that the age of twenty-one would be more appropriate), but did not wish any limitation of intelligence to be considered an essential criterion. Some witnesses also recommended the introduction of new powers wider than those contained in Section 4 of the Criminal Justice Act, 1948, to apply to psychopaths who are outside even the widest interpretation of the present definition of mental defectiveness.

337. Those witnesses who recommended that there should be special compulsory powers over some or all of the patients in our psychopathic group stressed, as we ourselves have stressed, that what distinguishes these patients from ordinary people is their general behaviour due to an abnormal mental condition, and they tried to identify the people to whom these special compulsory powers should apply by describing both their underlying mental condition and the behaviour which results from it. Many witnesses described this behaviour in very general phrases. Some suggested that the phrase "resulting in social inefficiency" or "social inadequacy" should be added to the present definition of mental defectiveness, and drew our attention in this connection to Section 19 of the Mental Health Act (Northern Ireland),

1948. Witnesses who recommended new compulsory powers over psychopaths who do not fall within the present definition of mental defectiveness described their behaviour in various ways, one description being behaviour which "causes danger to the bodily or mental health of others or gives rise to a reasonable apprehension of such danger" (8th Day, P. 289, para. 176).

338. If one concentrates on the patient's behaviour rather than on the mental condition which lies behind it, one comes very close to making certain forms of behaviour in themselves grounds for segregation from society, which almost amounts to the creation of new criminal offences. We consider that any attempt to define in general terms the sort of behaviour which may justify the use of special compulsory powers is bound to fail, because it seems impossible to find general terms which are not open to a wider interpretation than is intended. An alternative would be to pick out specific forms of behaviour, such as drug addiction, alcoholism or particular forms of sexual perversion, as has been done in some countries. In our own country, the Habitual Drunkards Act, 1879, and the Inebriates Act, 1898, introduced special powers for the detention and treatment of alcoholics in strictly limited circumstances. These Acts are still on the statute book but have fallen into almost complete disuse. Other forms of behaviour (e.g. homosexual offences) have been made criminal offences in this country. There is a growing feeling of doubt whether penal measures provide the most appropriate method of dealing with at any rate some types of sexual offence, and this feeling is strongest in cases where it is agreed that the behaviour is clearly due to an abnormal mental condition[5]. It must be emphasised however that many people who sometimes behave in the same way as psychopathic patients may not themselves have psychopathic personalities. Though psychopathic personality may result in homosexual behaviour, for example, or drug addiction or alcoholism on the part of some patients, by no means all homosexuals or drug addicts or alcoholics would be regarded medically as having a psychopathic personality.

339. It is clear that in so far as it may be right to treat anti-social behaviour as a medical problem and to subject the patient to special compulsory powers on the ground that he is mentally abnormal, the treatment and the use of compulsion must be based on a medical diagnosis of the individual patient's mental condition, not merely on evidence of his behaviour. The difficulty is that with patients in the psychopathic group it is their behaviour which provides the main evidence of their mental condition. We stated in paragraph 166 that we are convinced that it is not difficult for doctors and others to recognise the signs of psychopathic personality in some individual patients even when there is little, if any, impairment of intelligence. The patient's pattern of behaviour over a period of time may be a perfectly valid basis for a medical diagnosis of mental disorder, and may distinguish him from other people who may have performed similar anti-social acts but who are not considered to be suffering from a pathological mental disorder. But if such patients are to be subject to the same sort of compulsory powers as apply to mentally ill and severely sub-normal patients, it would mean—to put the case against such powers in its baldest form—that people who have not broken the criminal law might be subject to compulsory detention in hospital as the result of a diagnosis which is largely based on a record of behaviour which is not criminal and which in other individuals might not be held to indicate psychopathic personality either, and that on the basis of a similar diagnosis a person who has broken

[5] The law relating to homosexual offences and prostitution is at present under review by a Committee appointed by the Home Secretary, with which we have exchanged views on matters of mutual interest.

the criminal law might be detained in hospital for a period which in some cases might exceed even the maximum possible term of imprisonment for the offence which has been the occasion for the application of these compulsory powers.

340. In order to decide whether special compulsory powers are necessary and justifiable in relation to psychopathic patients, in spite of these objections, it may be useful to consider how far the principles we enunciated in paragraph 317 apply to psychopathic patients, and whether they apply to some more clearly than to others.

(*a*) *Reasonably certain diagnosis of mental disorder*

341. In many cases a confident diagnosis of psychopathic personality may be made, whether or not the patient's intelligence is impaired. The diagnosis is more likely to be certain when some limitation of intelligence is present as a pointer to the conclusion that the patient's behaviour is due to a definite mental disorder. With patients whose intelligence is near or above average, a certain diagnosis can often be made on the basis of the patient's general pattern of behaviour, especially if there is a long history of abnormal behaviour dating from an early age ; but there are undoubtedly some cases where the diagnosis is less certain and on which there may be differences of medical opinion ; if such patients are to be subject to compulsory powers, the decision should not depend on the opinion of one doctor alone, and there should be ample facilities for review.

(*b*) *Impossibility of providing care without compulsion*

342. Every effort should be made to persuade psychopathic patients, as well as all other patients, to accept care without compulsion. Some of those now classified as feebleminded and some of those who are not at present certifiable may be willing to do so. But the proportion of the patients needing care who are likely to be unwilling is probably higher in the psychopathic group than in either the mentally ill or the severely sub-normal group. A psychopathic personality does not make it impossible for the patient to manage for himself in the general community (though he may be able to do so only by making undue demands on others or by resorting to some form of crime), and many psychopathic patients do not recognise that they are ill or abnormal and resent attempts to treat them as such. Particularly with feebleminded psychopaths the patient's relatives also are often opposed to the provision of treatment, especially if this deprives them of some benefit from the wages which the patient might otherwise be earning. It is probably when the provision of treatment or training is opposed by the patient or his relatives that it is in fact most needed. With some (though not all) types of psychopathic patients the prospects of treatment or training being successful are small unless the patient's active co-operation can be obtained, but this co-operation may be given once the patient has got used to the hospital environment and has come to trust the medical and nursing staff, even if he was opposed to admission in the first place. This has been the experience of the social rehabilitation unit at Belmont Hospital and of other hospitals.

(*c*) *Patient's lack of appreciation*

343. All psychopathic patients are to some extent lacking in appreciation of their own mental condition or of the social or moral implications of their behaviour. This is true not only of those of low intelligence but also of those of normal intelligence whose emotional immaturity blunts their ability to appreciate the significance of their own actions. This is a typical characteristic of their disorder, though it may be greater in some patients than in others, and though in other respects they may be highly intelligent.

(d) Prospects of cure or improvement

344. Considerably more experience has been gained in treating feebleminded psychopaths than those of higher intelligence because a much larger number of the former are dealt with under the Mental Deficiency Acts. Present methods of treatment in hospital include training under conditions of strict security such as is given in Rampton Hospital, similar forms of training under less restrictive conditions in other mental deficiency hospitals, and physical treatment, psychotherapy and group therapy as practised in mental or neurosis hospitals, including Belmont Hospital where patients are given the maximum possible freedom of expression and of action. It is known that some psychopathic patients respond to each of these methods and that some do not. It is also known that some of them, including some feebleminded psychopaths as well as those of normal intelligence, respond to the punitive and deterrent effect of normal penal processes in much the same way as more normal people, though others do not. A fine or a period of imprisonment or of probation or supervision may be a more appropriate and effective way of treating some psychopaths who have broken the law than treatment or training in hospital. For others it may be desirable to combine the deterrent aspects of imprisonment or detention under conditions of strict security with psychiatric treatment. At present this combination of treatment and detention can be provided for some patients in prison, and it is planned to provide a special psychiatric prison at Grendon Underwood[6] in the near future which is intended for prisoners who need psychiatric treatment and are not certifiable under the Criminal Lunatics Act or Mental Deficiency Act. Treatment in prison can however only be provided within the period of the term of imprisonment for the offence committed, and some psychopathic patients (including some who have broken the criminal law and others who have not) may need a considerably longer period of treatment if they are to obtain any benefit from it. Psychopathic patients who are certified under the Mental Deficiency Act can at present be provided with treatment for as long as is considered necessary in each individual case.

345. In many cases it is not possible at present to cure the underlying mental condition which gives rise to inadequate or aggressive tendencies, but even in such cases treatment or training may enable the patient to regulate his general behaviour so that he can live a normal social life in spite of his underlying disorder. It is generally considered that the prospects of success are greatest when the patient's disorder is recognised early in life and when he receives treatment or training before his inadequate or aggressive behaviour has become ingrained. But for many psychopathic patients, particularly those of normal intelligence, the chances of improvement are at present often uncertain, to say the least. If compulsory powers under which patients may be compelled to enter and remain in hospital can be extended at statutory intervals in the way in which they can be extended at present under the Mental Deficiency Acts, there is a danger that psychopathic patients may be kept in hospital when their detention can no longer be justified by the prospects of benefit from further treatment. The long periods for which some patients are at present detained in mental deficiency hospitals may justifiably be criticised from this point of view. It must however be remembered that at present (as we explain more fully in Part V of our report) these hospitals fulfil to some extent the functions of social welfare homes as well as of hospitals, and have in the past been expected to

[6] This is sometimes referred to as the East-Hubert Institution, because the establishment of such an institution was recommended in a report on the psychological treatment of crime made to the Home Secretary in 1939 by Dr. (later Sir) Norwood East and Dr. W. H. de B. Hubert.

provide a permanent home for many patients whose condition is not susceptible to further improvement. We recommend in Chapter 10 that in future residential homes should be provided for many such patients in which they would be much less cut off from the general community than they are in hospital. We hope most of them would be content to live in such homes without the use of compulsory powers; others might live there under the guardianship of the local health authority. When such homes are available, care must be taken to ensure that patients are not detained in hospital when it is clear that they are not likely to benefit from further treatment or training, unless there are other considerations, such as the protection of the public, which necessitate their continued segregation from the general community. The same applies to patients suffering from chronic forms of mental illness and to severely sub-normal patients who need care but do not necessarily need to be detained in hospital.

(*e*) *Need for protection of the patient*

346. Protection from exploitation may be desirable for some feebleminded psychopaths who are not so seriously sub-normal as to be incapable of leading an independent life but are nevertheless not fully capable of defending their own interests. This consideration applies very little to psychopaths of higher intelligence.

(*f*) *Need for protection of others*

347. The need to protect other people from the anti-social behaviour of psychopathic patients raises some of the greatest difficulties. There are strong arguments both for and against the use of special compulsory powers for this purpose. On the one hand it is pointed out that it is generally accepted that mentally ill patients who are dangerous to others should be detained for as long as seems necessary in each individual case, whether or not they have actually committed a criminal offence, and that some psychopathic patients are certainly no less dangerous to other members of the community than are the comparatively small number of mentally ill patients who may be dangerous. This consideration was urged on us most strongly by those witnesses who recommended the extension of special compulsory powers to psychopaths who are at present not certifiable under the Mental Deficiency Act or Lunacy Act. For example, some witnesses spoke of aggressive psychopaths who are known to be homicidal and yet are not considered certifiable; others referred to the social evils resulting from severe cases of alcoholism, some of which may be psychopathic in origin (24th Day, P. 924, para. 44 and Q. 4822–4830; 26th Day, Q. 5560–5562; 30th Day, Q. 6208). The Association of Chief Police Officers drew our attention to several cases in which patients who had been admitted to hospital after committing crimes of violence or sexual offences again committed crimes of this nature after leaving hospital (31st Day). The Association mentioned these in support of a request for some form of supervision after discharge over patients who have already had some hospital treatment but who are known to have had dangerous tendencies in the past; they suggested that there is already sufficient control over patients discharged from mental deficiency hospitals but not over those discharged from mental hospitals. In looking into the cases they quoted, however, we found that almost as many related to patients previously in mental deficiency hospitals as to patients previously in mental hospitals; most of the former would probably fall into our psychopathic group rather than into the severely sub-normal group. Half of those who had been in mental hospitals had been voluntary patients, but we cannot tell how many would fall into our psychopathic group. There is no doubt that a high proportion of the patients detained in Rampton and Moss Side Hospitals

for defectives of violent or dangerous propensities (including some with intelligence well above average) would be in our psychopathic group; the psychopathic patients in other mental deficiency hospitals also include some who, even though well-behaved while in hospital, might be dangerous if discharged. In considering the protection of the public we must bear in mind not only any criticisms that the present law provides insufficient protection, but also the extent to which public danger might be increased by the abolition or restriction of the compulsory powers at present contained in the Mental Deficiency Acts.

348. On the other hand, against the authorisation of special compulsory powers mainly in order to protect others from anti-social behaviour by the patient, it is argued that, even when there is a sure diagnosis of mental abnormality, this amounts in effect to the creation of a quasi-criminal code which applies only to mentally abnormal patients, and which is based at least as much on an estimate of the patient's probable future behaviour as on his past behaviour. Preventive detention under the ordinary criminal law may only be applied to offenders over a certain age who have a definite criminal record of a certain number of convictions for serious offences; and even preventive detention lasts only for a fixed period, after which the prisoner must be released even if it is almost certain that he will then commit further crimes. If one is to apply preventive control to psychopathic patients under wider conditions than these, one is in effect applying to them preventive detention in hospital in circumstances which would not justify preventive detention in prison under the criminal law. Whether or not special forms of control are justified on these grounds depends on how accurate the diagnosis of the patient's condition and the prognosis of his future behaviour is likely to be, and on the extent to which it is fair to assume that the risks to society from persons suffering from these forms of mental abnormality are greater than the risks which society runs from criminals who are not considered to be mentally abnormal. This question is discussed, in relation to psychopathic criminals who are not certifiable under the present Mental Deficiency Acts in the paper on pages 1320–1327 of the Appendix to our minutes of evidence.[7] This paper shows that a diagnosis of psychopathic personality cannot always be taken to imply a prognosis of further criminal behaviour in the future, and discusses how far the prognosis is affected by whether the patient's behaviour is predominantly inadequate or aggressive, whether his electroencephalogram is normal or abnormal, and whether he is over or under the age of twenty-five. It also compares the criminal record of the group of psychopathic criminals selected for study with that of a control group of non-psychopathic criminals. The former consisted of cases in which psychopathic personality was considered clearly established on severe diagnostic standards, but it is important to bear in mind that one of the diagnostic standards used was that the patients were not certifiable under the Mental Deficiency Acts. We use the term "psychopathic" in a wider sense to include also some types of patients who may at present be detained in mental deficiency hospitals and whose mental characteristics, behaviour and response to treatment it has been possible for doctors to study more closely.

349. We are satisfied that there are some psychopathic patients about whose possession of dangerous tendencies there is no reasonable doubt, and that the protection of other people must be considered a valid basis for the use of special compulsory powers in relation to them. But the use of compulsion on this ground should be subject to stringent safeguards both as regards the

[7] This paper was also published in the *British Journal of Delinquency*, September, 1955 Vol. VI, pp. 126–136.

circumstances in which compulsory powers may be used and the length of time for which they are kept in force.

350. It is possible to make out a case for differentiating in regard to compulsory powers between feebleminded psychopaths and psychopaths whose intelligence is near or above average. In regard to the former, diagnosis would be fairly certain ; some lack of appreciation of their condition could be safely inferred ; some benefit from treatment or training might reasonably be expected ; in some cases protection from exploitation might be required and in some the protection of others would be a valid consideration. In our view, however, it would not be right to make this differentiation. We explained in paragraphs 192–193 that we do not consider that intelligence alone is a sound basis for determining the dividing line, even at a lower level, between those patients we describe as seriously sub-normal and those we describe as feebleminded psychopaths. It is the total personality, the combination of both intelligence and temperament, which is important. The considerations which support the use of compulsory powers over feebleminded psychopaths also apply to many psychopaths of higher intelligence. We consider that it would be placing altogether too much importance on the intelligence of a particular patient, especially at this higher level, if it were made a determining factor in the decision whether or not compulsory powers might be used.

351. We also consider it wrong that the use of compulsory powers should depend on the age at which the mental disorder is known to have first existed. It is true that a long history of abnormal behaviour starting in childhood and continuing into adolescence and adult life may be an important aid to the diagnosis of an adult patient's present mental condition. But the diagnosis may be equally certain when there is no positive evidence that the disorder was present in childhood. In some cases the disorder may be due to an illness or accident which is known to have occurred when the patient was already adult. In others it may be ascribed to a broken home or other environmental conditions which existed during the patient's childhood, but the patient may have shown no positive signs of the effects of these conditions on his personality until adult life. In our view, the use of compulsion must be justified by the medical and social conditions which exist at the time when compulsion is used rather than by those which existed in the past. We see no justification for distinguishing between the compulsory powers which may be applied to two patients of the same age, whose present intellectual and emotional characteristics are similar, who have a similar medical prognosis, and both of whom are exhibiting a similar type of aggressive or inadequate behaviour, but one of whom is known to have shown signs of mental abnormality before the age of eighteen while the abnormality of the other did not arise or was not apparent until after that age. Either they should both be subject to special compulsory powers, or neither of them should be. If the patient's age is to be a limiting factor in the use of compulsory powers, it should be the patient's age at the time when compulsion is used, not the age at which his disorder first arose.

352. If some compulsory powers are to be made available in future in relation to some psychopathic patients who cannot at present be compelled to enter hospital because they are not certifiable under the present law, it is necessary to consider what facilities are available for their treatment. Some of our witnesses who recommended that compulsory powers should be extended to these patients suggested that the powers should remain in abeyance until there are more hospitals providing special forms of treatment for them. These witnesses apparently assumed that such patients

would have to be treated separately from patients classified as mentally defective, even if the definition of mental defectiveness were recognised as covering some patients of normal intelligence. Although we do not agree with this assumption, we do agree that it is quite essential that no patient should be compelled to enter hospital unless the hospital can provide care, training or treatment suited to his needs. One of the most important features of the new procedures which we recommend in Chapter 7 is that, whenever compulsory powers are used, it would have to be clearly established not only that the patient is in need of a particular form of care but also that the hospital or local authority under whose control he is to be put is able and willing to provide that care for him. The doctors taking part in the admission procedures including those on the staff of the receiving hospital, the members of the new Mental Health Review Tribunals which we propose, and all other persons who under our recommendations would have authority to order a patient's discharge, would be required to pay attention to this aspect of the use of compulsion in each case which they have to consider. We think it probable that for some time to come the application of any special compulsory powers to psychopaths of higher intelligence would in practice be limited by the extent to which hospital facilities for treating them can be developed. But some hospitals already specialise in the treatment of such patients, not only Belmont Hospital which we have mentioned but also several mental deficiency hospitals and some mental hospitals and licensed houses, including some which have special units for adolescents or for patients exhibiting particular forms of behaviour such as alcoholism or drug addiction. Provided that the new procedures incorporate the safeguards we propose, we see no reason why such compulsory powers as are to be provided under new legislation should not be used immediately to effect the admission of these as well as other psychopathic patients to any hospital which is prepared to provide suitable treatment for the individual patient.

353. Our review of these considerations leads us to the following general conclusions:—

(i) Any special compulsory powers which are to apply to psychopathic patients should apply irrespective of the age of onset of the patient's mental disorder and irrespective of the level of his intelligence.

(ii) Special compulsory powers over some psychopathic patients are necessary for the protection of the public, and in some cases they are justified by the prospects of improvement in the patient's mental condition or social behaviour if he can be given suitable treatment or training. The circumstances in which the use of compulsion is justifiable are however more limited in relation to psychopathic patients than in relation to mentally ill or severely sub-normal patients, and are also more limited than those in which compulsion may at present be used in respect of psychopathic patients who are certified under the Mental Deficiency Acts.

354. **We consider that there is a strong case for authorising the use of compulsion to ensure training or treatment in hospital or in the community for psychopathic patients in adolescence and early adult life.** In the first place, it is generally agreed that treatment or training is most likely to be successful if it can be given at this stage. Secondly, a society which assumes responsibility for the education of the children of all its citizens, and is prepared to use compulsion if necessary to ensure that children receive education suitable to their abilities and aptitudes, is in our view also justified in using compulsory powers in order to provide special forms of training

for young people who, after the normal period of compulsory education, are still intellectually or emotionally immature and who are thought likely to benefit from such special training. We therefore recommend that, subject to the use of the new procedures recommended in Chapter 7, the law should allow the compulsory admission to hospital or guardianship of any psychopathic patient who, at the time when the compulsory powers are used, has not yet reached the age of twenty-one, if the use of compulsion for this purpose is necessary for his own welfare or for the protection of others, and if he is accepted as medically suitable for the form of hospital or community care proposed. These patients should not be liable to compulsory detention or control beyond the age of twenty-five unless their admission follows court proceedings in the circumstances discussed in paragraphs 511–556 in Chapter 7, or unless by that age it has become necessary to revise the diagnosis as contemplated in paragraph 437.

355. **We also consider it justifiable that psychopathic patients, as well as patients suffering from other forms of mental disorder, should be liable to compulsory admission to hospital at any age for a period not exceeding twenty-eight days for the purpose of medical observation and preliminary treatment, if this is necessary for their own welfare or for the protection of others.** If further hospital or community care is then recommended we hope that at least some patients will be willing to receive it on a voluntary basis, even if they were opposed to admission to hospital in the first instance.

356. **Apart from this, we do not consider that there is sufficient justification for special compulsory powers in relation to adult psychopathic patients except when their conduct is anti-social to the extent of constituting an offence against the criminal law.** When a person has broken the criminal law he has laid himself open to the imposition of control because of behaviour which has been judged by standards which apply to all citizens. It is no longer in question whether or not he should be considered liable to control at all; the question has become whether or not one of a variety of possible forms of control provides a suitable way of treating the individual offender. In deciding this it is relevant to take cognisance of such matters as the offender's past record, estimates of his future behaviour and other factors including his mental condition. We consider it right that special forms of treatment or control should be applied to some psychopathic patients who have been convicted of a criminal offence which may not be applied compulsorily to adult psychopathic patients who have not committed such an offence and which do not apply to offenders who are not mentally disordered. **This does not mean that we consider it right to apply these special measures to all offenders who are psychopathic in the wide sense in which we use that term. It would often be more appropriate to give an ordinary sentence or to use normal methods of probation. Our recommendation is that psychopathic patients should be liable to compulsory admission to hospital or community care on conviction for a criminal offence only if the court is satisfied that normal penal measures alone are insufficient or inappropriate and that the patient requires special medical or social care which a particular hospital or local authority is able and willing to provide. The Home Secretary should also have power to authorise the transfer to hospital or guardianship of offenders or children or young persons who are in prison, borstal or other penal institution or subject to an approved school order, if their mental condition makes this necessary.** Several important questions arise in connection with the application of such special compulsory powers following court proceedings or on transfer from prison or approved school, including the question whether there should be a maximum limit on the duration of these powers in individual cases. Some of these questions

apply to mentally ill and severely sub-normal patients as well as to psychopathic patients. As they involve detailed consideration of the procedures to be used both before and after admission to hospital or community care, our views on them are given in Chapter 7.

357. We have considered whether the law should attempt to define or describe psychopathic personality more precisely as a guide to the doctors who are called on to make the diagnosis. **In our opinion it would do much more harm than good to try to include in the law a definition of psychopathic personality on the analogy of the present legal definition of mental defectiveness.** It is far preferable that, in referring to various forms of mental disorder, the law should use general terms which will convey a sufficiently clear meaning to the medical profession without trying to describe medical conditions in detail in semi-medical language. We discussed the use of the word "psychopathic" from that point of view in paragraph 195, where we expressed the opinion that doctors and the general public would find no difficulty in accepting it for use in the sense which we indicated in paragraphs 190–194. It would in any case be particularly difficult to find a suitable detailed description of psychopathic personality. Such a description would probably have to mention the particular aspects of the personality which may be affected, and possibly also try to give some guide as to the cause of the disorder. But there are too many different types of psychopathic personality, and too little is at present known about their essential nature and causes, for a description of this kind to be easily agreed; and even if one were agreed now, increasing knowledge might soon make it out of date. Lack of knowledge about the nature and causes of particular forms of disorder does not mean that they cannot be recognised and successfully treated in individual patients. There was no difficulty in diagnosing "unsoundness of mind" when even less was known than is known today about the causes and nature of mental illnesses. Many mental and physical illnesses whose cause is unknown can be successfully treated. We do not think that there is any serious danger of the special powers we have been discussing being improperly used for the detention of citizens who are not mentally abnormal if the mental disorder is described in the law simply as "psychopathic personality", and if they may be applied only within the strict limits of age, conviction for a criminal offence, need for something more than normal penal measures and acceptance for treatment, which we have recommended, and subject also to the use of the special procedures which require at least two medical opinions when the powers are first used and which provide various opportunities for review from the medical as well as non-medical points of view. We are convinced that when the point at issue is whether a person should be compelled to enter hospital or be put under legal guardianship against his will, doctors will not make a diagnosis of psychopathic personality until they feel quite certain about it. If there is a difference of medical opinion in an individual case, the procedures which we recommend would introduce far more effective safeguards against the misuse of compulsory powers than would be provided by any detailed definition in the law.

358. The dividing line between psychopathic patients and normal citizens is in our view less likely to give rise to difficulty than the dividing line between psychopathic patients who would only be liable to compulsory powers under the very restricted conditions which we have suggested, and severely sub-normal patients who would be liable to compulsory admission to hospital or guardianship at any age when this can be shown to be necessary for their own welfare or for the protection of others. If any of our three groups of patients is to be more closely defined than we have suggested,

it is the severely sub-normal group for whom this is most likely to be thought necessary. But we ourselves consider that the term "severely sub-normal personality" will itself carry a sufficiently clear meaning to members of the medical profession and to the other persons who would also be involved in the procedures when compulsory powers are used, without being more precisely defined. It implies a severe sub-normality of the personality regarded as a whole. We do not think that there is any danger that that description would be considered appropriate unless the patient was clearly sub-normal in intelligence and childish in temperament. The very fact that psychopathic patients, including feebleminded psychopaths, would be recognised by the law as a separate group, with separate conditions governing the use of compulsory powers, would in our opinion help to ensure that the classification "severely sub-normal personality" is not applied more widely than is intended. There may be differences of opinion over individual patients who are on the borderline between a diagnosis as severely sub-normal and as a feebleminded psychopath; but there are bound to be borderline cases wherever the dividing line is drawn. The most practical and effective way of resolving such differences of opinion is not to try to describe the medical condition in detail, but to rely on the consensus of medical and non-medical opinion when the compulsory powers are applied to any individual patient. The phrases "severely sub-normal personality" and "psychopathic personality" should in our opinion give rise to no more difficulty in their practical application than the phrase "person of unsound mind" does at present.

Relations between hospitals and local authorities and patients' relatives

359. The great majority of the relatives of mentally disordered patients are anxious, willing or content that the patient should receive the care which doctors recommend, though many of them object to some of the present procedures and terminology. The relatives from whom opposition most often comes at present are some of the parents of children who are reported as "ineducable", and some of the parents of patients who have attended ordinary or special schools as children and are later ascertained as feeble-minded or moral defectives under the present Mental Deficiency Acts. Under our terminology some of these patients would be in the severely sub-normal group, some in the psychopathic group, and a few might be regarded as mentally ill.

360. We hope that our recommendations for new terminology, and for the provision of care without "ascertainment" or "certification", normally without any legal formality and without powers of detention, will help doctors and social workers to obtain the co-operation of an increasing proportion of these patients and of their relatives. We consider it most important that every effort should be made to obtain this co-operation, even though it is sometimes difficult when time and staff are limited. Although we do not doubt that doctors, teachers, social workers, and administrative officers already work to this aim, we think that more might be done. The parents of children attending school whom it may be necessary to recommend for transfer to a training centre, or for special community care after leaving school, should be kept as fully informed as possible of the child's progress at school. When it is decided that special forms of care are necessary, the reasons should be explained to the parents and every effort made to obtain their co-operation; when it is necessary to make formal notifications to parents of such a decision, they should usually also be given a personal explanation of why such a notification has to be made and what its effect will be.

361. It should also be remembered that the sense of belonging to a family may be of great importance to the patient. It is not always in his best interests to remove him from a not entirely satisfactory home to even the best-run foster-home or public institution, if he feels strong ties of affection to his own family and home, as many of these patients do. Even if it is at first not possible to obtain the co-operation of the parents or other relatives and compulsory powers have to be used for the patient's own welfare, the patient should not, save in quite exceptional cases, be completely cut off from contact with his relatives, and the efforts to obtain the relatives' co-operation should continue. If a patient is compulsorily admitted to hospital against the wishes of his relatives, the hospital authorities as well as the local health authorities should give them as much information as possible about the purpose of the patient's admission to hospital, the sort of training he will receive there, and how he is progressing. Not only the hospital medical staff, but also members of the hospital management committee (who will have power to discharge the patient) should be readily accessible to relatives who wish to see them, particularly those who are aggrieved by the use of compulsory powers.

362. If a psychopathic patient over the age of sixteen is willing or content to accept care or training in the community or in hospital, in spite of the opposition of his relatives, it may sometimes be possible for this to be provided without the use of any compulsory powers. But the patients who most need further training during adolescence or early adult life are those who are the most immature emotionally, the most lacking in foresight, the most easily influenced by those with whom they live, and the least capable of taking decisions for themselves. So if the relatives cannot be persuaded to agree that the patient should receive the special care which is considered necessary, it will usually be necessary to meet opposition from both the patient and the relatives in the first place, though the patient may soon come to welcome the hospital or community care which is provided. Under our proposals it will not be possible to use compulsory powers to provide training for psychopathic patients after they are twenty-one years old, except for short periods of observation or on occasions when they have been convicted of a criminal offence. It is most important that, if training is needed, it should be provided early in life when the patients are young enough to obtain the most benefit from it. Although it is important to try to obtain the co-operation of the patients and their relatives and thus make the use of compulsion unnecessary, local health authorities must be prepared to use compulsory powers when necessary to provide training for these patients while they are young, when efforts to obtain the relatives' co-operation fail.

363. Even when opposition to the provision of hospital or community care for a severely sub-normal or psychopathic patient comes mainly from the relatives, it may be necessary to place the patient under compulsory control similar to that used when the patient himself is unwilling, which may mean in effect treating an adult patient like a child because he is no more capable than a child of recognising or acting in his own best interests. In some cases, however, it may be possible to provide sufficient protection for the patient by restricting the use of his parents' natural parental powers or of their authority as his "nearest relative", without subjecting the patient to any extra control or deprivation of liberty. This should be done whenever it provides sufficient protection.

364. Although compulsory powers to override the unwillingness of the relatives, rather than or in addition to the unwillingness of the patient himself, will be required mainly in connection with severely sub-normal or psycho-

pathic patients, they should also be available for use in the very rare cases when the nearest relative of a mentally ill patient obstructs the provision of treatment which the patient badly needs. Such cases seldom occur except when the nearest relative himself is of weak mentality or for some other reason is unable to appreciate the patient's mental condition. Such relatives may obstruct access to the patient at home or use their power to discharge the patient from hospital in an irresponsible manner, and it should be possible to protect the patient from such irresponsible action by using compulsory powers.

365. **In Chapter 7 we recommend special procedures for use when it is necessary to set aside the wishes of the patient's nearest relative. These are designed to ensure that such action is not taken (except in emergency or for a short period of observation) unless it is proved to the satisfaction of a magistrates court that the nearest relative is acting unreasonably in opposing the form of care proposed for the patient.** These procedures would be available for use in relation to patients in each of our three groups, subject to the general conditions recommended in this chapter to govern the use of compulsory powers for patients in each group.

The compulsory powers proposed for the future compared with those existing at present

366. We have recommended that compulsory powers should never be used in future if suitable care can be provided without compulsion. This would substantially reduce the number of patients who will be subject to detention while receiving care.

367. Subject to this general principle we have recommended that compulsory powers should be available for use in the following circumstances:—

(*a*) **Mentally ill patients**—Compulsory admission to hospital for up to twenty-eight days observation and preliminary treatment or compulsory admission to hospital or guardianship for a longer period of hospital or community care should be allowed when the use of compulsion is necessary for the patient's own welfare or for the protection of others. This would restrict the use of compulsory powers to roughly the same circumstances in which they may be applied at present to " persons of unsound mind ", subject to the further restriction that such powers should only be used when they are positively necessary to overcome the unwillingness of the patient or of his relatives.

(*b*) **Severely sub-normal patients**—Compulsory admission to hospital or guardianship should be permissible in the same circumstances as those proposed for mentally ill patients.

(*c*) **Psychopathic patients**

(i) Compulsory admission to hospital for up to twenty-eight days observation and preliminary treatment should be allowed for patients of any age for the patient's own welfare or for the protection of others.

(ii) Compulsory admission to hospital or guardianship for a longer period of hospital or community care should be allowed for patients under the age of twenty-one at the time of admission if this is necessary for the patient's own welfare or for the protection of others. The compulsory powers should lapse when the patient reaches the age of twenty-five if he has not already been discharged,

unless admission followed court proceedings or transfer from prison or approved school.

(iii) Compulsory admission to hospital or guardianship should be allowed for patients over the age of twenty-one who are convicted of a criminal offence if the court before whom they are convicted (or the Home Secretary in the case of transfers from prison) is satisfied that ordinary penal measures alone are insufficient or inappropriate.

368. The special procedures which would have to be used whenever these compulsory powers are applied would be designed to ensure that they are used only when care cannot be provided without compulsion and when the patient requires medical or social care which a particular hospital or local authority is able and willing to provide, and that the powers are not kept in force for a longer period than can be justified on the grounds of benefit to the patient or the protection of others. The proposals which we make in Chapter 10 for the allocation of functions between hospitals and local authorities should encourage the further development of community care for those who do not require treatment under close psychiatric supervision in hospital.

369. These proposals would amount to a very considerable curtailment of the compulsory powers which may be applied at present to patients classified as feebleminded persons and moral defectives. Our recommendations may be criticised on the ground that these are the very patients who are most likely to be unwilling to receive treatment without the use of compulsion. Our proposals would not curtail the present compulsory powers in relation to idiots and imbeciles and the severely sub-normal among the feebleminded. But for these severely sub-normal patients compulsory powers would in practice rarely be needed; they would usually be content to accept the care which is offered to them, and their parents and near relatives also in most cases would probably not object to the provision of suitable care, particularly if it can be given on a completely informal basis without "certification". Some of the patients at present classified as feebleminded and moral defectives are suffering from forms of disorder which might also make them liable to certification as "persons of unsound mind" under the Lunacy Acts; these patients would still be subject to compulsory powers under our proposals as mentally ill patients, and could be admitted, compulsorily if necessary, to any hospital providing the type of treatment or training considered appropriate to their needs, or to guardianship. But the great majority of the feebleminded and moral defectives, other than those who are severely sub-normal, would be subject to compulsion only in the restricted circumstances which we have recommended should apply to psychopathic patients. We hope that many of these patients would be content to accept treatment and training without compulsion; if such care can be offered on an informal basis without "certification" both they and their relatives are more likely to be willing to accept it. But it is true that it is from these patients and their relatives that there is at present, and will probably continue to be in the future, most opposition to the provision of hospital and community care, and it is therefore these patients who are most likely to be deprived of opportunities for care or training if the present compulsory powers are curtailed in the way we have recommended. On the other hand, our proposals would extend the use of compulsion, in strictly limited circumstances, to some psychopaths who are not subject to compulsion or pressure at present except under the ordinary criminal law or under the terms of Section 4 of the Criminal Justice Act, 1948.

370. For the reasons we have given, we consider both this curtailment and this extension of the use of special compulsory powers to be justified

and desirable. It is illogical and unnecessary to draw a distinction, in regard to the use of compulsion, between feebleminded psychopaths and those of higher intelligence. **The compulsory powers which apply to those at present certified under the Mental Deficiency Acts are too wide, but the restricted powers which it is justifiable to apply to them are equally necessary for other psychopathic patients.**

371. As a corollary to our recommendation that adult psychopathic patients should be liable to compulsion only after conviction for an offence, we must emphasise that the responsible authorities should not hesitate to bring a charge against a psychopathic patient because his behaviour is obviously wholly or partly due to his abnormal mental condition. Psychopathic patients are responsible citizens in the eyes of the law. Some may respond to ordinary penal measures. For others, under our proposals, conviction in the courts might be the only occasion on which it would be possible to ensure that they receive the medical treatment they need.

372. When discussing the application of compulsory powers to psychopathic and severely sub-normal patients we did not refer specifically to the problems which arise in regard to women and girls of child-bearing age at present classified as feebleminded. Many of these have in the past been admitted to and detained in hospital for fear that, if allowed to remain in the general community, they would be exposed to sexual exploitation or would have children whose upbringing would be beyond their capabilities or to whom it was thought they might transmit their mental defect. Many of those now classified as feebleminded will fall into our category of the severely sub-normal, who are defined as being unable to live in the community without some measure of support. In future, if such support cannot be provided either by their own families or by the local authority (with or without powers of guardianship) some such patients will still need to go into hospital. Some could probably be persuaded to enter hospital without compulsion, though it might be necessary to take power to prevent the relatives from insisting on their discharge, e.g. in the case of a patient from an unsatisfactory or inadequate home who would be likely to be taken advantage of sexually. In a few cases compulsory powers might be necessary to override the patient's own unwillingness.

373. The higher grade patients present a more difficult problem. They need control rather than support, and many are unlikely to be willing to enter hospital without compulsion. We do not think that women or girls in this category should be liable to compulsory admission or detention simply because they might have an illegitimate child or get married if they were free. Complete or abnormal irresponsibility with regard to bearing children might be a factor contributing to a diagnosis of psychopathic personality, and some (but by no means all) prostitutes could be diagnosed as psychopathic; either condition may sometimes be the result of retarded or immature development. We have suggested wide powers to provide training and guidance for adolescent and young adult psychopathic patients under the age of twenty-one, compulsorily if necessary. We hope that this will lead to many more unstable and emotionally immature patients, young men as well as young women, receiving the training they need at an age when they are most likely to benefit from it. We should expect such training, if successful, to establish many of these young people as useful members of the community, capable of holding down a job and of achieving a successful marriage. We do not however consider that these patients, any more than other psychopathic patients, should be detained in hospital beyond the age of twenty-five, unless they have been before the courts and are covered by the arrangements discussed in paragraphs 511-556 in Chapter 7.

CHAPTER 7

FUTURE PROCEDURES WHEN COMPULSORY POWERS ARE USED AND PROCEDURES IN COURT CASES

Disuse of the expression "certification"

374. The word "certification" is not used in the Lunacy Act, 1890, though the Act requires doctors to give certificates of unsoundness of mind. The Mental Treatment Act, 1930, refers to the arrangements for temporary patients as "temporary treatment without certification", and instead of certificates requires medical recommendations in which the doctor makes a declaration as to the mental condition of the patient whom he is recommending for temporary treatment. The Mental Treatment Rules refer to patients as "voluntary", "temporary" or "certified". Patients who have been "dealt with" under the Mental Deficiency Acts are also often referred to as "certified", though the expression is not used in the Acts or Regulations; the expression is sometimes restricted to defectives who have been made the subject of a judicial order for admission to hospital or guardianship; sometimes it is used of any defective who has been "ascertained".

375. We recommend that the procedures to be used in future should not require "certificates" of mental disorder. Instead there should be medical recommendations, similar to those used in the present temporary admission procedures, containing the doctor's opinion that the patient is suffering from a particular form of mental disorder and his recommendation for a particular form of care, or alternatively stating that the patient is suffering from mental disorder (without a more precise diagnosis) and recommending a period of observation.

376. Some of our witnesses who recommended that at the time of admission to hospital there should be medical recommendations instead of certificates, and if possible no judicial order, suggested that if the patient has not been discharged before the end of an initial period of one or two years there should be a special procedure to authorise his continued detention, which would involve medical certificates and a judicial order and would change the patient's status from that of a "temporary patient" to a status equivalent to that of a "certified patient", though possibly with a different name. Certainly, the procedures used at the time of admission, the opportunities for review and discharge and the procedures for renewing the authority for detention must provide sufficient safeguards against the misuse of compulsory powers; but we see no need to introduce the expression "certification" at any stage, nor to change the "status" of the patient. In paragraph 384 we recommend the abolition of all distinctions of "status" based on the method of admission. We should also strongly deprecate a distinction of status based on the length of time a patient has been in hospital. Such a distinction would almost certainly be interpreted by the patients themselves and by the public as implying that all hope of recovery or eventual discharge has been abandoned, and would be in some ways even more objectionable than the present system.

377. **We hope that the new procedures will be recognised by the public for what they are, simply a method of providing a patient with the form of care appropriate to his needs at the time. We trust that the term "certification", and all the mistaken ideas which are associated with it, will fall completely into disuse.**

No " designation " of hospitals

378. We recommended in paragraphs 142–143 in Chapter 2 that there should be no legal distinction between hospitals providing treatment for mental illnesses and those providing treatment for other forms of mental disorder, and that there should be no rigid legal barrier against the admission of any patient to any hospital which can provide suitable treatment for him. It seems probable that treatment for most of the patients suffering from mental disorder who need in-patient treatment will continue to be provided in future in special psychiatric hospitals, but that at the same time some forms of psychiatric treatment will be provided to an increasing extent in general hospitals which also treat other forms of illness. Some areas may also continue to need small psychiatric units mainly for emergency cases, like some of the present Section 20 wards. In paragraph 291 in Chapter 5 we recommended that all psychiatric hospitals should be as free as other hospitals to admit patients without any legal formality and without power to detain. All psychiatric hospitals and all general hospitals in the national health service which provide psychiatric treatment should also be permitted to receive patients under compulsory powers if they are prepared to do so.

379. **The managing committees and staff of hospitals which receive patients under compulsory powers must of course be conversant with the special procedures and safeguards connected with the power to detain patients. This can be ensured in future without formal " designation " or " approval " by the Minister of Health.** There is also no need for legal distinctions between hospitals authorised to receive patients under compulsory powers for short periods or for longer periods, such as exist at present between hospitals designated under Section 20, Lunacy Act, 1890, only, and " designated mental hospitals ". As far as hospitals within the national health service are concerned, all that seems necessary is for the hospital management committees and regional hospital boards in the case of non-teaching hospitals, and boards of governors in the case of teaching hospitals, to decide which hospitals shall receive patients under compulsory powers as well as informally, and for this information to be made available to local health authorities, general practitioners and others with an indication of the types of treatment which each hospital provides. Regional hospital boards would be responsible for ensuring that there are sufficient facilities of this sort in each area.

380. We discuss separately in Chapter 12 the conditions under which charitable and private institutions outside the national health service should be authorised to receive patients under compulsory powers.

No " order " for admission

381. **Whether or not justices of the peace or other judicial authorities take part in the new procedures, the documents required in future when compulsory powers are used to admit a patient to hospital[1] should be regarded as authorising the hospital authorities to admit and detain him, not as ordering them to do so.** The documents should consist of an application for admission, addressed to the hospital authorities, with supporting recommendations. There should also be a statement by one of the medical staff of the hospital that the patient is accepted for treatment. If the application, recommendations and medical acceptance are made in proper form by the proper persons they should constitute authority for the hospital to admit and detain the patient, in place of the present order and certificates.

[1] Similar principles should apply when the patient is placed under guardianship in the community.

382. This should bring several improvements compared with the present position, in which hospitals feel obliged to admit any patient in respect of whom an "order" for admission has been made. In the first place it would add to the general safeguards against the improper use of compulsory powers when there is no mental disorder or when the patient does not need special care. In the second place, even when there is no doubt that the patient is mentally disordered and needs some form of care, this, as well as other steps which we recommend, should help to prevent compulsory procedures being used to force the patient to enter a hospital which does not provide the sort of treatment which he needs. No mentally disordered patient should be simply "put away" against his will in a hospital or other place which does not provide suitable facilities for his care. Thirdly, the hospitals should feel under no stronger obligation to admit patients under compulsory procedures than on a completely informal basis. They should judge the need for admission on medical and social grounds only, and there should be no more likelihood of a bed being found for a patient if compulsory procedures are used than if they are not. Lastly, this should reduce the pressure on psychiatric hospitals to admit patients who would be equally well cared for elsewhere and who do not need the special services provided in these hospitals.

383. We do not wish to encourage psychiatric hospitals to refuse to admit patients because they may be difficult and awkward to treat, nor to turn away any patient who urgently needs treatment which they can provide. Also, in the transitional period while alternative accommodation is being developed in other hospitals or by the local authorities (as recommended in Part V of our report), psychiatric hospitals will have to continue to take in some patients who ideally should be accommodated elsewhere. But the procedures which involve compulsory control over the patient should not be used simply as a form of pressure on a hospital to find a bed for a particular patient.

No distinctions of "status"

384. **After admission to hospital, there should be no distinctions of "status" based on whether a patient was admitted informally or through the use of compulsory powers.** Within the hospital all patients should be treated and classified only according to their mental condition, age, the type of treatment which they require or other medical considerations. They should certainly not be referred to in the new legislation or in statutory documents or in everyday speech by terms denoting status, such as "voluntary patients", "certified patients", "temporary patients" or "placed patients", nor as "informal patients", "detained patients" or "recommended patients". If any distinguishing adjectives are needed, they might be applied to the method of admission (e.g. informal admission or compulsory admission), but not to the patient himself. The patients are simply patients suffering from various forms of disorder. Just as at present many voluntary patients in mental hospitals are certifiable, so under our proposed new system there will be no medical distinction between some patients admitted informally and others admitted under compulsory powers. In their daily life in the hospital there should be no distinctions drawn between them except as individuals or by medical classification. The only other differences are (i) the procedure used for their admission, which by then is a thing of the past; (ii) the procedures by which they may be discharged, which are of importance only when they wish to leave; and (iii) the fact that from time to time there must be special reconsideration of the need to retain patients who were admitted under compulsory powers, but this should take its place only as a special review occurring periodically in the course of frequent medical consideration of each

patient's readiness for discharge. It may be useful for statistics still to be kept of the number of admissions made on an informal basis and of those made through the use of compulsory powers, and of the number of patients admitted under each procedure who are resident in the hospital each year; and of course the hospital staff must keep proper records to ensure that the statutory reviews and other procedures are carried out for patients under powers of detention. But this should not result in the use of distinctive terms denoting "status" in dealing with or referring to patients during their time in hospital.

385. The same principles should apply to patients receiving community care.

386. In Part VIII of our report we discuss briefly the effect of this recommendation on the position of Broadmoor patients and on other parts of the law not themselves within our terms of reference, which at present also differentiate between individual patients on the basis of "status".

Duty of local health authority to act as guardian

387. **Local health authorities, as well as private individuals, should be able to act as the guardian of mentally disordered patients who need community care but for whom it cannot be provided without the use of compulsory powers. Their duty to arrange for the provision of community care (see paragraphs 714-715 in Chapter 10) should include a duty to accept the responsibilities of guardianship whenever guardianship is appropriate and cannot otherwise be arranged.** This would be analogous to their duty to act as a "fit person" under the Children and Young Persons Acts.

Other general considerations

388. **The new procedures must provide safeguards against the use of compulsory powers in circumstances for which these powers are not intended. At the same time, they must be appropriate to the circumstances in which the powers are properly and justifiably used. It is not easy to reconcile these two requirements.** The sort of procedure which seems appropriate as a safeguard when one is thinking of the possibility of a sane person being improperly detained in a mental hospital may be just the sort of procedure which one wants to avoid when dealing with a patient who really is mentally disordered because it will be distasteful and upsetting to him and to his relatives. There is a risk of designing procedures to meet a hypothetical situation which may rarely if ever occur, which will be ill-suited to the circumstances in which they will be most commonly used. **We think that this problem could be approached on rather different lines from those adopted in the past; in particular, more of the procedures designed as safeguards could be available to be used at the request of those who wish to use them, instead of imposing them on all patients alike.**

389. The language in which the procedures are described, and the choice of persons to be responsible for operating them, should be appropriate to the provision of medical treatment, training or social care, albeit compulsorily, rather than merely to the imposition of custody or control. The system should be less complicated than the present system, and more easily understood both by those who operate it and by the general public, including the patients themselves and their relatives. At the same time the procedures should ensure that each patient's individual needs are considered in the light of contemporary medical and social methods of treatment, that the form of care which he is being compelled to accept is the sort of care he really needs, that care could not equally well be provided without using

compulsory powers, and that any other conditions laid down by the law are fulfilled.

390. **It is essential that the working of the new procedures should be in the hands of people who have the sort of knowledge and experience needed to form a sound judgment on the questions at issue.** The main questions which must be considered when compulsory powers are first used are the patient's mental condition, his need for a particular form of care, the possibility of persuading him to accept it without compulsion, and whether the use of compulsion is necessary for his own welfare or for the protection of others. We consider it inappropriate for a person who is not medically qualified to be required to state an opinion on the patient's state of mind and need for care or treatment on his own responsibility even after considering medical certificates, or to take action without medical advice, as the magistrates or other judicial authorities and the Visitors[2] and duly authorised officers are required to do under some of the present procedures. This is not satisfactory from the layman's point of view nor from the doctor's and in our view is of little value as a safeguard to the patient. Medical and non-medical opinions should supplement each other; each person should be expected to contribute to the final decision only what is appropriate to his own knowledge or experience or to his relationship with the patient.

391. We think it right to draw a distinction between the procedures which are appropriate when compulsory powers are used to override the unwillingness of the patient himself only, and those which are appropriate when they are used to override the unwillingness of the patient's relatives. Special procedures will also be needed in some cases when admission to hospital or guardianship follows court proceedings.

392. The procedures which we recommend in paragraphs 396–490 are those which we consider appropriate when compulsory powers are used to override the wishes of the patient when the patient's nearest relative is either willing or acquiescent or when there are no relatives. We call these "the main procedures".

393. In paragraphs 491–510 we recommend procedures which we consider appropriate when compulsion is used to override positive objections from the patient's nearest relative rather than, or in addition to, objections from the patient himself. In paragraphs 511–556 we discuss the powers and procedures in court cases and in cases in which patients are transferred from prison or other penal institution or approved school. These procedures are largely identical with the main procedures but introduce some important additions or modifications, chiefly in the procedure before the patient's admission to hospital or guardianship and in the powers of discharge and arrangements for review.

394. All our recommendations in this chapter are for procedures to be applied to patients receiving community care under the guardianship of a local health authority or hospital care in hospitals within the national health service. In Chapter 12 we recommend modifications which should be made when the patient is to receive care in a hospital outside the national health service or in a private nursing home, or community care under the guardianship of a private individual.

395. The proposed new procedures are summarised in tabular form in Appendix III.

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[2] At least one Visitor in each area must be a medical practitioner, but the Visitors' functions under the Mental Deficiency Acts may be performed by non-medical Visitors alone. We understand that in some areas it is the usual practice for at least one medical Visitor to take part on each occasion, but this is not so in all areas.

Main procedures, when compulsion is used to override the unwillingness of the patient only

(1) Circumstances in which the procedures may be used and the powers of control which they confer

(i) Hospital

396. The need for compulsion to effect a patient's admission to hospital against his own wishes but not against the wishes of his relatives would arise mainly in connection with mentally ill adults. It might also arise in connection with psychopathic patients (including feebleminded psychopaths) between the ages of sixteen and twenty-one, though with these patients there is more likelihood of opposition from the relatives, in which case the procedures recommended in paragraphs 496–510 should be used. The procedure for admission to hospital for observation might also need to be used for psychopathic patients over the age of twenty-one.

397. It should rarely be necessary to use these main compulsory procedures when children or severely sub-normal adults need to go to hospital. Children should usually be admitted to hospital for treatment quite informally, without the use of special compulsory powers, by the exercise of the normal parental authority of the natural parent or of a guardian including any public authority or private person having care of the child under the Children Act or Children and Young Persons Acts or after transfer of authority by use of the special procedures recommended in paragraphs 496–510. Severely sub-normal adults are usually content to accept any arrangements which are made for them, in which case the use of compulsory powers is unnecessary unless there is opposition from the relatives. These main compulsory procedures should, however, be available for use in exceptional cases for children or for severely sub-normal adults, as well as for mentally ill or psychopathic adults or adolescents.

398. The use of the normal or emergency admission procedures would authorise the patient's removal to hospital by a mental welfare officer of the local health authority and his detention in hospital for a period not exceeding the maximum period authorised under each procedure, subject always to the possibility of discharge at any time by any person or group of persons holding the power of discharge.

(ii) Guardianship

399. Community care can be given only if the patient can be persuaded to co-operate with the officers of the local health authority and to accept the help and advice which they have to offer and the arrangements which are made for employment, occupation or training. It should therefore usually be given without using compulsory powers. Sometimes, however, the possession of legal authority may make it possible to obtain a patient's co-operation which would not be given otherwise; in such cases compulsory powers may justifiably be used to place the patient under the legal control of guardianship. With psychopathic patients, particularly feebleminded psychopaths, opposition to the provision of suitable care often comes from the patient's parents or relatives as well as from the patient; when this is so, the procedures recommended in paragraphs 496–510 should be used. But if the parents or relatives of a psychopathic patient under the age of twenty-one agree that community care is necessary, or if the patient has no relatives, and if the patient's own unwillingness to receive training or social help cannot be overcome by persuasion but can be sufficiently reduced by the legal control of guardianship to allow this form of care to have prospects of success, it should be possible to arrange this by using these main procedures. There may also be occasions when it is appropriate for parental

rights over a severely sub-normal child to be transferred to the local authority with the parents' consent, or when the child has no parents. Occasionally it may not be possible to provide suitable care for a severely sub-normal adult without formal powers of control. Powers of guardianship may also sometimes be needed to ensure proper care for people with mild or chronic forms of mental illness or infirmity who do not need to be in hospital; in the great majority of such cases, care could be provided without compulsion; but there may be occasions on which community care under guardianship would be more appropriate than compulsory admission to or continued detention in hospital, especially when facilities for community care are expanded as recommended in Part V of our report. In such cases guardianship would replace the present powers of control over certified patients "in single care" or "boarded out"; it could be used as a method of arranging suitable residential care, in local authority homes or elsewhere, for some elderly people in circumstances not covered by the powers of removal contained in Section 47, National Assistance Act, 1948.

400. When the procedures are used to place a person under guardianship, the local health authority would exercise control equivalent to that of a parent over a child. The patient would usually continue to live in the general community, but the local authority acting through its medical officers and social workers would be able to control his place of residence or employment and his use of his earnings and to ensure that he is provided with training or occupation or other forms of care.

(2) Application for admission on a specific recommendation for hospital care or guardianship, or for admission to hospital for observation

(i) Normal application

401. **We recommend that the application for a patient's compulsory admission to hospital or to the guardianship of a local health authority, including applications for admission to hospital for observation, should be made by a relative of the patient or by a mental welfare officer[3] of the local health authority, with the support (except in emergencies) of two medical recommendations (see paragraphs 413–418), but without reference to a judicial authority (see paragraph 438).**

402. As the person signing the application under this procedure would be the only non-medical person involved before the patient is compulsorily admitted to hospital or guardianship, we do not think that anyone except a relative or public official should be authorised to act in this way. The relative need not, in our opinion, necessarily be the nearest relative (though the nearest relative will usually have power to discharge the patient—see paragraphs 421–428), but we do not consider it appropriate that a friend or neighbour or other private individual who is not related in kinship to the patient should be authorised to make an application in these circumstances.

403. It is necessary to consider the proper powers and duties of mental welfare officers in this connection in relation to the responsibilities both of the patient's relatives and of the doctors. Ideally, in our view, the application should be made by a relative of the patient on medical recommendation, with a mental welfare officer available to explain the procedure and provide

[3] We use the term "mental welfare officer" in place of the present term "duly authorised officer". The present title is not understood by the public and we recommend that it should not be used in future. We do not, however, envisage that every mental welfare officer employed by a local health authority would be permitted to sign these applications. We use the term in the rest of this chapter to refer only to those officers whom the local health authority have authorised to undertake these responsibilities. These might include medical officers as well as social workers.

the application form and to transport the patient to hospital if necessary. But many relatives who accept the need for the patient's compulsory admission to hospital would undoubtedly prefer not to have to sign the application themselves; others would not wish to make the application themselves nor positively to ask the mental welfare officer to do so. In all such cases a mental welfare officer should be able to make the application, provided that the relative knows what is being done and does not object. A mental welfare officer should also be able to make the application on medical recommendation when there is no known relative available, whether or not the patient is to be admitted to a hospital within the national health service and whether as a paying or non-paying patient. If the doctors recommend the patient's admission to hospital or guardianship, and the nearest available relative positively objects, the procedures recommended in paragraphs 496–510 should be used. Under normal conditions these would require an application to a magistrates court for authority to set aside the wishes of the relative, but in an emergency, or when the medical recommendation is for not more than twenty-eight days observation, they would allow a mental welfare officer to arrange admission if necessary even against the wishes of the relatives—see paragraphs 507-510.

404. Neither a relative nor a mental welfare officer would be able to make such an application without the support of medical recommendations, so that if a relative or mental welfare officer were to consider that the patient should be compulsorily admitted to hospital but this were not recommended by doctors, the view of the doctors would prevail. Several witnesses drew our attention to difficulties which may be caused by a difference of opinion in the reverse sense, when doctors recommend the patient's admission and a mental welfare officer who is asked to arrange it hesitates to do so. A doctor with experience in the diagnosis or treatment of mental disorders and a doctor who already knows the patient (whose recommendations would normally be required under our proposals in paragraph 414) are better qualified than anyone to diagnose the patient's mental condition, to assess his need for treatment and to judge the probable effect if treatment is not provided. No responsible relative or mental welfare officer would lightly disregard or dissent from their advice. The patient's relative must however be free to accept or reject the medical advice and to decide for himself whether or not to make the application for admission to hospital, though it may occasionally be necessary to take special steps to override the relative's wishes if his attitude is quite unreasonable in view of the patient's own interests or the need to protect others. And if a mental welfare officer is asked to take the responsibility of signing an application for a patient's compulsory admission to hospital or guardianship, he must in the last resort be free to decline to do so. Difficulties of this sort do not often arise. When they do they can usually be resolved by discussion. If in an exceptional case a mental welfare officer has serious doubts about acting on the medical recommendations, he should in our opinion be required at once to inform the medical officer of health, who would be able to discuss the case fully with the doctors who have made the recommendations, with a view to suitable action being taken.

405. An application for admission to hospital signed by a relative or mental welfare officer, together with the supporting medical recommendations, should provide authority for the patient's removal to hospital. The patient, once admitted, would not be able to discharge himself, but could be kept there until one of the persons having the power of discharge decides to discharge him or until the compulsory powers lapse for any reason.

406. The application for admission to guardianship with supporting recommendations should be delivered to the medical officer of health. The powers of guardianship would come into force when all the documents are complete, including the statement by a member of the local health authority's medical staff that the patient is accepted as suitable for care under the guardianship of the local authority (see paragraph 417).

(ii) **In emergencies**

(a) **Hospital**

407. In emergencies a relative or mental welfare officer should be able to make an application for the patient's compulsory admission to hospital with the support of one medical recommendation instead of two. This should be possible in place of the normal procedure for admission for up to twenty-eight days observation, as well as in place of the normal procedure for admission on a specific recommendation for hospital care. In either case, the compulsory powers should lapse at the end of seventy-two hours after admission unless the second medical recommendation and medical acceptance required under the normal procedure is provided within that period.

408. **In present-day conditions it should be possible to obtain the opinion of one doctor in any emergency, and there is now no need for mental welfare officers to have power to act without medical support.** Relatives and mental welfare officers should be free to decline to act on a medical recommendation in favour of admission (as discussed in paragraph 404), but they should never act without the support of at least one such recommendation.

409. It is important that the emergency procedure should not be used except in real emergencies when action to remove the patient must be taken before there is time to obtain the two medical recommendations required under the normal procedure. The application should contain a statement that because of urgency it has not been practicable to obtain these two recommendations.

410. The patient may be already in hospital (a general hospital or psychiatric or other special hospital) when the emergency arises which makes it necessary to use compulsory powers either to detain him in that hospital or to move him against his wishes to another hospital. In these circumstances it should be possible for his detention for up to seventy-two hours in the hospital in which he is already a patient to be authorised on the strength of a statement of the need for such action signed by a doctor on the staff of the hospital, without an application by a relative or mental welfare officer. The compulsory powers should lapse at the end of seventy-two hours unless within that period a second medical recommendation for up to twenty-eight days observation is added, or an application and second specific medical recommendation for hospital care. If the emergency requires the patient's transfer to another hospital rather than his detention in the same hospital, the relative or a mental welfare officer should be asked to sign an application for his admission to the other hospital with a medical recommendation from the doctor at the first hospital; the completion of these documents would authorise the patient's removal and detention in the other hospital for up to seventy-two hours, as in paragraph 407.

(b) **Guardianship**

411. In an emergency in which a patient urgently needs care but does not need to be in hospital, it should usually be possible to arrange community care without using compulsory powers. But if powers of control are necessary, it should be possible for the local health authority to assume powers of guardianship in an emergency by the use of a simpler procedure than normal.

A mental welfare officer should be able to act in the first place on his own authority with the support of one medical recommendation. In these circumstances the powers of guardianship should be exercisable for a period of up to twenty-eight days. If it is necessary for powers of guardianship to be continued for more than twenty-eight days, it should be possible to extend them by the completion of the normal procedure, i.e. by the addition of a second medical recommendation and a statement of acceptance by a medical officer of the local health authority.

(c) Patients found by the police

412. Under the present law a police constable who has reasonable grounds for believing that a person is of unsound mind or mentally defective may, in certain circumstances, arrange for the patient's admission to a hospital or to a " place of safety " (see columns 1 and 17 in Appendix II). We consider it desirable that the police should be able to take to hospital any person they find in a public place apparently in need of care or control if they have reason to believe that the person is suffering from mental disorder. They should be able to do this for any such person who is content to be taken. If the person is unwilling, the police should have power to compel him to go to hospital only if his behaviour is such that he is liable to arrest under normal police powers; if he is so liable, the police should be able to take him to hospital (if this seems desirable) instead of to a police station. We envisage that the police would normally take the patient to the casualty department of the nearest hospital, or direct to a psychiatric hospital if this is convenient. If the doctor who examines the patient at the hospital considers that the patient is mentally disordered and requires observation or treatment in hospital, it may in some cases be possible to arrange this without using special compulsory powers. If it cannot be arranged without such powers, it should be possible for the patient to be detained in the hospital where he has been examined for up to seventy-two hours, or to be moved to another hospital on the application of a relative or of a mental welfare officer, by using the procedures recommended in paragraph 410. If the patient is thought to require community care rather than hospital care, the doctor who has examined the patient should arrange for a mental welfare officer to be called to take appropriate action.

(3) Medical recommendations for admission, and acceptance by the medical staff of the receiving hospital or local authority

413. Patients should not normally be sent to hospital, except in an emergency, whether or not compulsory powers are used, until one of the hospital medical staff has agreed that the patient needs care, treatment or training which can be provided in that hospital or that he should be admitted for a limited period for observation. In many cases the patient will be seen at an out-patient clinic or will be recommended for admission by one of the case-conferences which we recommend in paragraphs 681–689 in Chapter 10. Sometimes a hospital doctor may agree to admit a patient on information given in a written report or verbal consultation, without having seen the patient himself. When compulsory procedures are used, doctors on the staff of the receiving hospital should not be debarred from giving one of the medical recommendations in support of the application for admission, except for a patient for whose treatment the doctor is to receive a fee. In public hospitals, except for paying patients,[4] we consider that it should

[4] i.e. patients making private arrangements under Section 5 of the National Health Service Act, 1946. We see no objection to a member of the hospital's medical staff signing a recommendation for a patient admitted to a Section 4 " amenity bed ".

be the usual practice for one of the recommendations to be given by a doctor from the receiving hospital. Similarly, when a person is being recommended for community care under powers of guardianship, it would be appropriate for one of the recommendations to be given by a doctor on the staff of the local health authority.

414. **Under the normal procedure as distinct from the emergency procedure, at least one of the two medical recommendations should be given by a doctor specially experienced in the diagnosis or treatment of mental disorders, and the other, if possible, by the patient's general practitioner or another doctor who already knows the patient.** A doctor on the staff of the receiving hospital might qualify under either heading, but it should not be permissible for more than one of the recommendations to be given by members of the receiving hospital's staff.

415. In an emergency, when the application need be supported by only one medical recommendation, this should be given, if possible, by the patient's general practitioner or another doctor who already knows the patient (not excluding a doctor on the staff of the receiving hospital). If no such doctor is available, however, it should be permissible for the recommendation to be given by any registered medical practitioner. The local health authority should arrange for mental welfare officers to have the names of doctors who can be called on in an emergency when the patient's usual doctor is not available or is not known.

416. The medical recommendations given in support of an application for compulsory admission to hospital (except for a limited period for observation), or for admission to guardianship, should include a statement of opinion that the patient is suffering from mental illness or from severely sub-normal personality or psychopathic personality and is in need of hospital care (or community care under guardianship). The grounds on which this opinion is based should be briefly stated. The main aim of the written medical recommendation should be to make the reasons for the recommendation clear to the other people who take part in the procedures, including those who will later have power to discharge the patient. In most cases the main part of the recommendation should consist of a fairly full explanation why hospital care is recommended rather than community care, or vice versa, why it is not considered possible to provide suitable care without the use of compulsory powers, and why the provision of care under compulsory powers is necessary for the patient's own welfare or for the protection of others considered in the light of the principles enunciated in paragraph 317 in Chapter 6. If the patient is considered suitable for some form of care in the community—e.g. in a residential hostel (see Chapter 10)—but this form of care is not available and admission to hospital is considered necessary in preference to leaving the patient uncared for (or if he needs hospital care, and guardianship is recommended until a hospital bed becomes available), this should be stated. In describing the patient's mental condition we do not consider it necessary for the doctor to relate particular symptoms of the patient's disorder if it can be identified by a short diagnostic term. The information recorded in a document of this sort can never cover the whole basis of the diagnosis and it is misleading to quote a few symptoms in isolation. The doctor should keep a full record of the basis of the diagnosis in his clinical notes, on which he can rely if his diagnosis is challenged. In support of a diagnosis of severely sub-normal or psychopathic personality a general description of the patient's capabilities or abnormality should be given ; when the patient's intellectual development is relevant, it would be more suitable to give a description of his general level of intelligence, as illustrated for example by his intelligence

quotient or mental age if this has been tested recently, than to quote his answers to a few test questions.

417. **When one of these two medical recommendations is given by a doctor on the staff of the receiving hospital (or of the local health authority in cases of guardianship) it should include a statement of acceptance of the patient as suitable for care in that hospital or for care under guardianship. Otherwise, a written statement to that effect should be made by a member of the medical staff of the hospital not later than seventy-two hours after the patient's admission to hospital.** If no such statement is made, the compulsory powers should lapse seventy-two hours after admission. A similar statement should be made by a medical officer of the local health authority before the powers of guardianship come into force (see paragraph 406).

418. The medical recommendations for compulsory admission to hospital for a period of observation should include a statement of opinion that the patient is suffering from mental disorder and requires a period of observation in hospital which cannot be given without the use of compulsory powers, and that the use of such powers is necessary for the patient's own welfare or for the protection of others. The grounds on which this opinion is based should be briefly stated; the form should allow any relevant considerations to be recorded.

419. In an emergency when only one medical recommendation is required it should take the same form as one of those described in paragraphs 416 and 418 (i.e. either a recommendation for a particular form of care with supporting reasons or a recommendation for admission for observation) with an additional statement that admission (or power to detain a patient already in hospital) is urgently necessary.

(4) Approval of doctors

420. One of the two medical recommendations for the patient's admission (except in emergency) must be given by a doctor specially experienced in the diagnosis or treatment of mental disorders. It should be the responsibility of the local health authority to approve doctors for this purpose, on the recommendation of the medical officer of health or of the regional hospital board acting through their senior administrative medical officer. We should expect hospital psychiatrists and other specialists with suitable experience, psychiatrists in private practice, medical officers of the local authority's mental health department or school medical service, some general practitioners and suitably qualified and experienced members of the prison medical service to be so approved. We consider it far better that applications for approval should be determined by the local authorities than by a central government department. A central department would have personal knowledge of comparatively few individual doctors; they could confirm the experience of the majority only from reference books or by consulting various local bodies. The medical officer of health is likely to have personal knowledge of most of the experienced doctors working in his area, and can easily obtain information about others from other persons or authorities locally. We should expect most of the applications for the approval of doctors on the staff of hospitals to be put forward through him, but the regional hospital board should also be able to take the initiative in making recommendations direct to the local health authority. Approval given by one local health authority for this purpose should constitute recognition of the doctor's experience for the purpose of recommendations given in any local health authority area.

(5) **Powers of discharge**

(i) **Hospital**

421. Power to discharge the patient from hospital at any time should be held by the patient's nearest relative (with the exceptions mentioned in paragraphs 423–426), by the medical superintendent of the hospital and other members of the medical staff authorised by him to exercise this power (or in hospitals which have no medical superintendent by the doctor in charge of the patient's treatment[5]), by any three members of the hospital management committee or board of governors,[5] and by the Minister of Health[6] with the exception mentioned in paragraph 424. Power to order the patient's discharge on specific occasions would also be given to the Mental Health Review Tribunals whose establishment we recommend in paragraphs 438–454.

422. The normal procedure on discharge should be the same as for patients admitted without the use of compulsory powers, i.e. the medical superintendent should inform the patient's relatives and general practitioner when he considers the patient fit to leave the hospital, should make any necessary arrangements for convalescence or after-care in consultation with the patient, his relatives, his general practitioner and the local health authority, and should then discharge the patient. In some cases a period on trial may be useful (see paragraphs 469–477).

423. If the patient's relatives wish the patient to leave the hospital before this is suggested by the medical staff, they should normally discuss the position with the medical superintendent or a member of his staff. If after such consultation the nearest relative still wishes the patient to leave and the medical staff advise against it, the nearest relative should have authority to order the patient's discharge, subject to the exceptions mentioned in the three following paragraphs.

424. Neither the relative nor the Minister of Health should have power to discharge patients admitted on a recommendation for observation, where the power to detain the patient lapses after twenty-eight days. This would be similar to the present arrangements in relation to patients detained under Sections 20, 21 and 21A of the Lunacy Act, 1890. Both the medical superintendent and members of the hospital management committee should have power to discharge during that period, however, and relatives who wish the patient to leave should have easy access to them to discuss the question. If, after discussion between the relative and the medical superintendent, the nearest relative still wishes the patient to leave the hospital and the medical superintendent thinks that he should remain under observation, the superintendent or the secretary of the hospital management committee should be obliged to inform the nearest relative of the power of discharge held by members of the committee and to give him a list of the members; if the relative wishes it the secretary should also arrange an early meeting between him and members of the committee.

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[5] In the rest of this chapter, for the sake of brevity, our recommendations for the future are described in terms applicable to non-teaching hospitals which have a medical superintendent. References to hospital management committees also apply to boards of governors, and references to medical superintendents apply, in hospitals which have no medical superintendent, to the medical officer in charge of the patient's treatment.

References to medical superintendents are intended to apply also to any other member of the medical staff of his hospital authorised by him to exercise the power or fulfil the function in question. References to the medical officer of health apply to any other doctor similarly authorised by him.

[6] We consider it desirable that some central department or central body of commissioners should have the power to discharge patients who are subject to compulsory powers. In Chapter 11 we give our reasons for recommending that the most suitable person to hold this power is the Minister of Health.

425. If the patient has been admitted on a specific recommendation for hospital care, as distinct from admission for observation, and if the nearest relative orders the patient's discharge, the medical superintendent should be able to issue a barring certificate if he considers that the patient, if discharged, would be dangerous to himself or to others. The nearest relative should then have a right of appeal to a Mental Health Review Tribunal (see paragraphs 438–454). The power of discharge held by members of the hospital management committee and by the Minister of Health should not be subject to a barring certificate.

426. If the patient's nearest relatives are two or more relatives equal in kinship to the patient, and one of them wishes the patient to be discharged and another wishes the patient to remain for further treatment, neither should have absolute authority to override the other. It should be left to the discretion of the hospital authorities whether to discharge the patient or not. We should expect the hospital normally to discharge if any one of the nearest relatives seems able to make reasonable arrangements for the patient's care.

427. The patient would be able to apply for discharge at any time to the medical superintendent, the hospital management committee and the Minister of Health, in addition to any requests he might address to his relatives. He would also have a right to apply to a Mental Health Review Tribunal on the specific occasions mentioned in paragraphs 436, 442 and 468.

(ii) **Guardianship**

428. The arrangements for the discharge of patients from guardianship should be similar, the medical officer of health replacing the medical superintendent, and any three members of the appropriate committee of the local health authority replacing the members of the hospital management committee. The question of a barring certificate should not arise with a patient already living in the community.

(6) **Expiry and renewal of compulsory powers**

429. We recommended in paragraphs 407–410 that compulsory powers used to admit a patient to hospital in an emergency with only one medical recommendation should lapse at the end of seventy-two hours, unless converted by the addition of a second medical recommendation either into power to detain the patient in hospital for up to twenty-eight days observation or into authority for detention in hospital for a longer period, according to the type of medical recommendation given. In paragraph 411 we recommended that powers of guardianship assumed under the emergency procedure should last for up to twenty-eight days, and we described the procedure to be adopted if the powers need to be continued at the end of that period.

430. A patient admitted to hospital for observation may be thought at the end of twenty-eight days to require a longer period of hospital or community care. We hope that many such patients would be content to accept this without any further use of compulsory powers. Otherwise, a fresh application with medical recommendations containing a more precise diagnosis and a recommendation for hospital as distinct from community care, or vice versa, would be necessary if the patient is to be compelled to remain under care. Such an application could be made for mentally ill or severely subnormal patients of any age or for psychopathic patients under the age of twenty-one. Psychopathic patients over the age of twenty-one could not be compelled to remain in hospital or be placed under guardianship unless this is authorised by a court after criminal proceedings in accordance with the procedures described in paragraphs 511–552.

431. An application for compulsory admission to hospital (except under the emergency or observation procedures) with two supporting medical recommendations should authorise the hospital authorities to detain the patient for up to one year, if the compulsory powers are not terminated before the end of that period by the patient's discharge or by his agreement to remain in hospital without further use of compulsion (see paragraphs 455–456). The compulsory powers should, however, lapse seventy-two hours after the patient's admission unless he is accepted as suitable for care in the particular hospital (see paragraph 417). The completion of the procedure for admission to guardianship, including acceptance by a member of the local authority's medical staff, should similarly authorise the exercise of the powers of guardianship by the local authority for up to one year.

432. Most patients admitted to mental hospitals now stay for much less than one year; the statistics in Table 7a in Appendix IV show that only one patient in five of all those admitted in 1952 to the hospitals covered by our questionnaire had not left by the end of one year after admission; two in five of the certified patients remained for over one year. The proportion of patients admitted to mental deficiency hospitals who need to remain longer than one year is very much higher (see Table 11a in Appendix IV).

433. For those patients who need to remain in hospital or under guardianship for more than one year it should be possible for the compulsory powers to be extended if it is still not possible to provide care without them. Before the end of the first year the medical superintendent or medical officer of health should make a special review of the patient's condition and of the care which would be available if he were discharged or if the compulsory powers were not renewed. If the medical superintendent or medical officer of health then considers that the patient should be discharged, he should discharge him. If he considers that the patient should remain under care but that the continuance of compulsory powers is unnecessary, he should terminate the compulsory powers by agreement with the patient or allow them to lapse (see paragraphs 455–457). If he considers that renewal of the compulsory powers is necessary for the patient's welfare or for the protection of others, he should sign a recommendation to that effect, including a statement of his opinion on the patient's mental condition, the reasons for the continuing need for the particular form of care recommended in preference to other forms of care and why it is not possible to provide this without the continued use of compulsory powers. The general considerations mentioned in paragraph 416 apply to these recommendations as well as to those given at the time of admission.

434. For the reasons explained in Chapter 11, we see no advantage in the submission of medical recommendations for scrutiny by a central government department. Each recommendation for the renewal of compulsory powers should however be seen by members of the hospital management committee or of the appropriate committee of the local health authority. If, after discussion with the medical superintendent or medical officer of health if necessary, members of the committee consider that there are not sufficient grounds for the extension of the compulsory powers, they should use their normal power to discharge the patient. The members of the hospital management committee or local health authority would in many cases wish to see the patient on these occasions; they could arrange to see him either in his ward or at a private interview in the hospital, or (with patients on trial or under guardianship) in his home or other suitable place. All patients would have a right to ask for an interview with members of the hospital management committee, or local health authority, at any time (see paragraph 487), and it would of course be open to patients to ask to be seen on these occasions.

But we see no advantage in a formal " parade " of patients when the members of the hospital management committee or local authority do not consider a personal interview necessary and when the patient himself does not wish it.

435. If the members of the hospital management committee or local health authority do not discharge the patient, the medical recommendation would constitute authority for the extension of the compulsory powers for a further period of one year. At the end of the second year, it should be possible for the same procedure to be used to authorise extension for a further period of two years, and thereafter for periods of three years at a time, subject always to the possibility of discharge at any time by any of the persons having power to discharge, and subject also to the lapse of compulsory powers over psychopathic patients when they reach the age of twenty-five if they were admitted under the age of twenty-one without court proceedings (but see paragraph 437). In our view the renewal of the compulsory powers should never be for longer than three years at a time. The renewal of the compulsory powers should in no way affect the patient's " status ".

436. The patient (unless he is under the age of sixteen) should have a right to apply to a Mental Health Review Tribunal after each renewal of the compulsory powers, if the members of the hospital management committee or local health authority do not exercise their power of discharge. This would provide a stronger safeguard for the patient than the interview with the Visitors appointed by justices which takes place under the present Mental Deficiency Acts.

437. If a patient is compulsorily admitted to hospital or guardianship under the age of twenty-one with a diagnosis of psychopathic personality, and if while the compulsory powers are still in force it becomes apparent that he is of severely sub-normal personality or is suffering from a form of mental illness which would justify the use of compulsory powers at any age, it should be possible for a fresh application to be made, with fresh medical recommendations containing a diagnosis of severely sub-normal personality or mental illness and explaining the grounds for it. The compulsory powers would then not lapse automatically on his twenty-fifth birthday if their continuance is then still justified on the grounds which apply to mentally ill or severely sub-normal patients.

(7) Mental Health Review Tribunals

438. We consider that a sufficient consensus of medical and non-medical opinion on the need to compel a patient to accept hospital or community care would normally be provided through the application for the patient's admission made by a relative or a mental welfare officer, the two supporting medical recommendations, the acceptance of the patient as suitable for the form of care recommended, and the continuing power of discharge vested in the nearest relative, the hospital or local authority medical staff, the members of the hospital management committee or local authority, and the Minister of Health. To refer the application and medical recommendations to a justice of the peace before the patient's admission would not in our view provide a significant additional safeguard for the patient, but would be open to the objections which have been made to the participation of the justices in the present procedures which we mentioned in paragraphs 264–267.

439. **But if the patient himself wishes the justification for the use of compulsory powers to be subjected to a review of a more formal nature, we consider that he should have an opportunity to apply to some independent body soon after his compulsory admission to hospital or guardianship.** This need would not be fully met by an application to the hospital management

committee to exercise their power of discharge. We do not doubt that the members of these committees do now, and would in future, consider such requests in as independent and impartial a manner as possible. But it is not possible to make a reasonable decision on these questions without medical knowledge or advice, and the committee would normally rely on the advice of the medical superintendent of the hospital. He or another member of the medical staff would however already have accepted the patient as suitable for treatment and might have made one of the recommendations for the patient's admission, so that an application to the hospital management committee would not entail a completely new assessment of the case. There would be similar objections to relying on the local health authority members' power of discharge in cases of guardianship.

440. Nor do we consider that an application for discharge addressed to the Minister of Health or any other central department would satisfactorily meet the situation. Unless the central department were to send medical officers to see each patient who applies for discharge, they too would have to rely largely on the original medical recommendations and on the opinion of the hospital or local authority medical staff. In our view there would be no point in giving the patient a right to apply for an independent investigation unless it brings about a reconsideration from both the medical and non-medical points of view. It would be possible, though cumbersome and costly, to send medical and non-medical officers of the central department to make a full investigation of each case in which an application is made, but we consider it preferable to have some local body nearer at hand.

441. We have considered the possibility of an application to two or three justices sitting with the Justices' Clerk in attendance (though not in their regular courthouse), after the patient's admission to hospital or guardianship. In such circumstances, they would be able to consider the justification for the use of compulsory powers more thoroughly than is possible under the conditions of urgency which are often present before admission, and the hospital or local authority doctors could give more considered opinions based on a period of closer observation of the patient and his initial response to treatment. But the general objections to the decision being in the hands of justices would apply with equal force whether the decision was taken before or after the patient's admission. Moreover, unless special arrangements were made for obtaining fresh medical opinions, the justices would also have to rely for medical evidence on the original medical recommendations and on the opinions of the hospital or local authority medical staff, and no fresh medical assessment would be introduced.

442. **In our view, the only satisfactory arrangement would be for the justification for the patient's detention in hospital or control under guardianship to be reviewed by some local body which could itself re-assess the case from both medical and non-medical points of view. We therefore recommend that patients should have an opportunity to apply to a tribunal which would consist of medical and non-medical members selected from a panel of suitable persons appointed for each hospital region.** We do not recommend that these tribunals should automatically review every case in which compulsory powers are used, nor that they should have a continuing power of discharge. Our recommendation is that patients (and patients' relatives who have no power to order discharge because the patient has been admitted following court proceedings or under the procedures discussed in paragraphs 496-505 or because a barring certificate has been issued) should have a right to apply to such a tribunal, if they so desire, on specific occasions. One of these occasions should be on application by the patient

within the first six months after compulsory admission to hospital or guardianship, if the hospital or local authority medical staff and members of the hospital management committee or local health authority have already considered and rejected applications for discharge. We mention other occasions in paragraphs 425, 436, 468, 504, 537 and 548.

443. We recommend that the medical and non-medical members on the regional panels from which each review tribunal would be selected should be appointed by the Lord Chancellor after consultation with the Minister of Health. The non-medical members should be people with experience of judicial or administrative processes and knowledge of the social services; they might include some people with legal experience, some justices of the peace, and others with more general experience. The medical members should include psychiatrists and other experienced medical practitioners drawn from the staff of psychiatric, general or teaching hospitals, from private practice or from the staff of local health authorities, and some general practitioners. There should be a Chairman for each region who, with the assistance of a Clerk, would be responsible for selecting members to form a tribunal to consider each individual application. The regional Chairman and the chairman of each individual tribunal should be legally qualified. Each tribunal should include at least one medical member, and might include more than one. It should be borne in mind that if the application is one which turns on the question whether the patient is suffering from mental disorder or not it is in the patient's interest that there should be adequate medical representation on the tribunal to ensure that the tribunal can form a truly independent opinion on the medical as well as the other aspects of his application. Full use should also be made of members with general experience which is neither medical nor legal. A tribunal should not consist of less than three members and might consist of more than three.

444. No member should be selected to serve on a tribunal to hear an application relating to a patient who is in a hospital or under the guardianship of a local authority with which he has any direct connection. It is partly for this reason that we recommend that the panels of members should be compiled on a regional rather than on a more local basis. The regional panels should include enough people drawn from all parts of the region for it to be easy to assemble a tribunal quickly to consider each individual application. It should be possible for the Chairman in one region to ask members on the panel of a neighbouring region to serve on a tribunal the other side of their regional boundary when this is convenient.

445. We should make it clear that these review tribunals would not be acting as an appellate court of law to consider whether the patient's mental condition at the time when the compulsory powers were first used had been accurately diagnosed by the doctors signing the recommendations, or whether there had been sufficient justification for the use of compulsory powers at that time, nor to consider whether there was some technical flaw in the documents purporting to authorise the patient's admission. Some time would inevitably have passed since the patient's admission before an application comes before the review tribunal (applications for discharge must already have been considered by the medical superintendent and members of the hospital management committee), and even in a short time the patient's mental condition may have improved or deteriorated. Any fresh medical assessment must be based on the patient's present condition, though of course with due regard to his medical history. The review tribunal's function would be to consider the patient's mental condition at the time when it considers his application, and to decide whether the type of care which has been provided by the use of compulsory powers is the most appropriate to his

present needs, or whether any alternative form of care might now be more appropriate, or whether he could now be discharged from care altogether. The tribunal should be required to have regard to the general principles governing the application of compulsory powers which we set out in paragraph 317 in Chapter 6.

446. The members of the review tribunals would be expected to make their own investigations, as well as receiving the opinions of the hospital and local authority staff and any opinions which are put to them by or on behalf of the patient or of his relatives or friends. The medical members should have an opportunity of examining the patient personally in private, either together or singly. The tribunal should also be able to make its own enquiries about the care which would be available if the patient were discharged and the prospects of suitable employment for him; for this purpose they should be able to visit the patient's home if they wish, as well as receiving reports from social workers and evidence from the patient, his relatives or friends, prospective employers or others interested in the case.

447. The Clerk in each region would be responsible for organising the tribunals' work, for obtaining any reports they might require and for arranging facilities for them to conduct their own investigations. He should have sufficient experience and knowledge of the health and welfare services to be of real assistance to the tribunals in the conduct of their investigations. The post would probably not be a full-time one; it might suitably be held by a regional officer of a central department or an officer of a regional hospital board whose other duties make him familiar with the various branches of the health and welfare services from which patients should be able to obtain various forms of care or assistance. It would not be appropriate for the post to be held by an officer of a local health authority or of a hospital management committee in whose care a patient might be detained.

448. In some cases the collection of information before the review tribunals take their decision might be entirely by the receipt of written reports or statements and by their own personal investigations. In other cases they might sit together to receive oral statements or to put any questions they wish to the patient or his relatives or friends or to the hospital or local authority staff. If the patient or his relatives or friends so wish, the tribunal should arrange for them and the hospital or local authority staff to be present at the same time for a hearing on more formal lines. Such hearings should normally be held in private. But if the patient or a patient's relative who has referred the case to the tribunal asks that statements made by him or on his behalf and by the hospital or local health authority staff should be made in public, the chairman of the tribunal should have discretion to agree. If after an enquiry held in public the tribunal considers that there should be no public report, it should have discretion to order that the proceedings or specific parts of the proceedings should not be publicly reported, or that the names of the patient or others concerned in the case should not be mentioned. It must be recognised that a large number, possibly the majority, of the applications to the tribunals will come from patients who are clearly mentally disordered, and whose disorder may lead them to desire publicity for accusations against their relatives or those who took part in the procedures for their admission to hospital or members of the hospital staff. The medical reports would have to contain accounts of the patient's mental condition and perhaps also of violent behaviour or domestic troubles or of the unsuitability of his home conditions. It might be most undesirable in the interests of the patient or of his family or of other persons that such proceedings should have unrestricted publicity. The doctors treating the patient and the members of the tribunal must also be able to use dis-

cretion in deciding how much of the medical reports should be made available to the patient himself or stated orally in his presence. On the other hand, there may be cases where it would do no harm for the facts to be made public. Publicity or the possibility of public report is a strong safeguard against abuse of compulsory powers, and when it is not detrimental to the proper interests of the patient or of other people it is to be welcomed. We therefore consider it essential that the chairman of each tribunal should have discretion in determining the conduct of each case and the question of public hearings or public reports.

449. When the tribunal has received all the information which it requires and has discussed the case in private, it should have authority to order the patient's discharge or to recommend his transfer to another hospital or to another form of care or to decide that he should remain in the hospital to which he has already been admitted or remain under guardianship. If it decides that he should remain, this should in no way affect his " status ", nor should it affect the possibility of discharge at any time by any persons holding a continuing power of discharge, nor the period after which the compulsory powers would lapse if not renewed (see paragraphs 431–436); the tribunal would simply decline to intervene.

450. The tribunal should notify its decision to the patient or other person who lodged the application and to the other interested persons. It should record a statement of the reasons for its decision, which should be kept with the documents which originally authorised the patient's detention in hospital or control under guardianship. In cases in which the tribunal declines to intervene, this statement as well as the other documents should be available to be seen on request by members of the hospital management committee or local health authority or by persons acting on behalf of the Minister of Health or by members of another tribunal if they are called on later to consider a request for the patient's discharge. The tribunal should have discretion to determine whether the reasons for its decision should be disclosed to the patient or his relatives.

451. There should be an appeal to the High Court from the decisions of these review tribunals, on points of law only. The procedure should be by case stated. This would mean that if the patient or relative who has made the application to the tribunal considers that the tribunal's decision or conduct of proceedings has been wrong in law, he could ask the tribunal to state a case for the opinion of the High Court on the question of law involved. The tribunal would then be obliged to prepare such a statement, unless it considers that the request is frivolous or does not concern a point of law. If it refuses on one of these grounds, the patient or relative could apply to the High Court for an order requiring the tribunal to state a case. These arrangements should apply only when the patient or relative wishes to challenge the decision of a tribunal on a point of law. He should not be able to use this procedure if he disagrees with the tribunal's decision on other grounds. (These arrangements are quite separate from the special provisions which at present limit the bringing of legal proceedings against persons who have taken part in the compulsory procedures, at present contained in Section 16 of the Mental Treatment Act, 1930, on which we give our views in paragraph 490.) When a case on a point of law is stated for the High Court from other courts the statement is often prepared in practice by the parties to the case rather than by the court itself, though it must be approved by the court. As the proceedings on applications to Mental Health Review Tribunals will usually be informal and neither the patient nor the hospital or local health authority will usually need to be

legally represented, it would be more appropriate, on the very rare occasions on which a point of law arises, for the statement to be prepared by the tribunal itself in consultation with the applicant.

452. Apart from this right of appeal on points of law, there should be no formal further appeal from the review tribunals' decisions. But the fact that the hospital or local authority medical staff, members of the hospital management committee or local authority, and the Minister of Health (as well as the patient's nearest relative) would have a continuing power to discharge the patient, would mean in effect that the patient could again raise the question of discharge at any time with any of them. We discuss the relationship between the review tribunals, the hospital management committees and local health authorities and the central department more fully in Chapter 11.

453. It is difficult to forecast how many applications are likely to be referred to these review tribunals. The number of cases in which compulsory powers would be used at all should, under our general proposals, be much smaller than at present. Even when they are used, many patients settle down once they are admitted to hospital and become content to receive the care, treatment or training provided, and would probably not wish to apply to a tribunal; others recover and are discharged so soon that the question would not arise. But the fact that applications in any one locality might be infrequent, and that any one member on the regional panel might be called on quite rarely to sit on a tribunal, should not result in only a few persons being appointed to the regional panels. Provided that their other experience qualifies them to form a sound judgment on these applications when called on to do so, we see considerable advantage in the members of the tribunals being people who are called on to consider such cases comparatively rarely. It must be recognised that in a great many cases it will be right for the decision to be a rejection of the application for discharge. It is only too easy for anyone who is frequently considering applications which have to be refused to become less alert to recognise the rarer cases where the application should be allowed. It is partly for this reason that we consider that it would be more suitable for these cases to be considered locally by tribunals whose members only occasionally have to act in this way than by commissioners or other officers of a central department who, receiving applications from all over the country, would be frequently considering such applications and frequently rejecting them. It might be desirable for the regional Chairman to sit on individual review tribunals more frequently than other members, particularly while the system is still new, but he would in each case sit with at least two other members. For the same reason, members should be appointed to the regional panels for a limited period, and though re-appointment should be allowed changes should be made from time to time.

454. **In our view these tribunals should provide a much more effective independent opinion than is provided at present either through the requirement for a judicial order before a patient's admission to hospital or guardianship, or through such arrangements as may be made at present for obtaining an independent medical opinion (see paragraph 277), or through the interviews with Visitors appointed by justices in the renewal procedure under the present Mental Deficiency Acts, or through the scrutiny of documents by the Board of Control.** The success of the new system would depend very largely on the experience and calibre of the members of the tribunals, and in particular of the regional Chairmen.

(8) **Termination of compulsory powers by agreement with the patient**

455. At present it is possible for certified or temporary patients in a mental hospital to become voluntary patients. The procedure is that the patient is "discharged", usually by members of the hospital management committee on the advice of the medical superintendent, and the same day signs an application form for "admission" as a voluntary patient; he does not actually leave the hospital. It may be thought that if less importance is to be placed in future on patients' "status" while in hospital there will no longer be any need for arrangements of this sort. It could be argued that if the patient is content to remain where he is, to complete his treatment in a hospital to which he was originally admitted under compulsion, this is a satisfactory state of affairs but one which calls for no formal recognition. There are however two reasons why we think it should be possible to terminate the compulsory powers although the patient is to remain in hospital. The first is that when a patient is getting better it may help to restore his self-confidence to have some formal recognition of the fact that he is staying in hospital by his own choice rather than compulsorily. The second reason is that if a patient needs to remain in hospital for a long time, perhaps for many years, but has recovered sufficiently to appreciate his need for care and is content to remain, compulsory powers are no longer necessary and should not be kept in force; the question of the patient's fitness for discharge or transfer to community care should be under frequent medical consideration, but this should not be linked with the renewal of compulsory powers.

456. We therefore recommend that it should be possible for compulsory powers to be brought to an end by agreement between the doctors and the patient while the patient remains under care. The medical superintendent should sign a statement to be attached to the patient's case papers to the effect that the compulsory powers have been terminated, and the nearest relative should be informed in writing. At the same time, the patient should sign a statement that he wishes to remain in the hospital and that he realises that he is free to leave when he wishes to do so. We think it desirable that the patient should sign such a statement as a protection to the hospital against possible allegations that they have continued to detain a patient without going through the procedures for the renewal of compulsory powers whose period of validity had expired; such allegations might be made either by friends or relatives of the patient or by the patient himself later. For the same reason the date of the statement should be authenticated by or on behalf of the hospital management committee. From this point of view the situation is comparable to that in which a patient admitted without compulsory powers elects to remain in hospital though his relatives are pressing for his discharge (see paragraph 305 (i)). This requirement for a statement signed by the patient would restrict these arrangements to patients who are capable of giving a valid signature, and might make it impossible to use them for some senile patients who, though positively objecting to admission in the first place, later settle down and become content to stay. When people are compulsorily removed to old people's homes or hospital under Section 47 of the National Assistance Act, 1948, the compulsory powers lapse after a certain period unless they are renewed, without the patient signing any sort of statement, but we think that it would be unwise to do without such a statement in the case of patients who have been sufficiently disturbed mentally to require psychiatric treatment in hospital and who have positively objected to admission to hospital in the first place. Our general proposals would allow any patient who is not positively unwilling to enter hospital to be admitted informally without any written application; this

should substantially reduce the number of old people to whom compulsory powers are applied at all. Even when compulsory powers are used, the patient would not be "certified". We think that that is as far as we should go at present.

457. When it is no longer necessary for a local health authority to have powers of guardianship in order to ensure proper care for a patient living in the general community, the medical officer of health should sign a statement to be attached to the patient's case papers. But as the patient is already at large in the general community we do not think there is any need for the patient or his relatives to sign any statement; the powers of guardianship should simply be allowed to lapse.

(9) Transfer from one hospital to another and between hospital and community care, and periods of absence from hospital with medical approval

(i) General

458. Patients who are in hospital under compulsory powers sometimes need to be moved from one hospital to another. Sometimes they are not expected to return to the first hospital, as for instance when a patient is moved to a different part of the country to be nearer his relatives or when a patient who has been a paying patient in one hospital is moved as a non-paying patient to another hospital. Sometimes the patient is sent to another hospital for special treatment with the expectation that he will return to the first hospital, e.g. when he goes for an operation or some other form of treatment which cannot be given in the first hospital. Patients also sometimes go home to their families for a week-end or a longer holiday, or to a holiday home, with the expectation of returning to the hospital afterwards. Sometimes patients are sent to live outside the hospital to see how they get on, before the doctors decide whether they should be discharged or not; if they do not succeed in adapting themselves to life outside, they may need to return to the hospital for further treatment or training. In other cases the doctors may decide that the patient can continue to live outside the hospital if suitable community care is ensured, and, in some cases, if some powers of control are still exercised over the patient. Patients who have been receiving community care under compulsory control also sometimes need to be admitted to hospital.

459. The Lunacy and Mental Treatment Acts and Rules and the Mental Deficiency Acts and Regulations at present provide various arrangements by which patients may be "removed" or "transferred" (to another hospital or to or from single care or guardianship), or may be "permitted to be absent" on short leave, trial, for health, on licence or boarded out, in addition to the ordinary arrangements for discharge. "Variation orders" under the Mental Deficiency Acts (when a patient is transferred from hospital to guardianship or vice versa, or when a new guardian is appointed) may be made only by a judicial authority. The procedures for "removal" or "transfer" allow detained patients to be transferred to another hospital or to single care without a new judicial order, the powers of detention or control and of discharge being transferred at the same time. When patients leave hospital on "leave", "trial" or "licence" or "boarded out" the compulsory powers are not broken or transferred; the medical superintendent has authority to supervise the conditions under which the patient lives or works while away and has power to re-admit or recall him to hospital without going through the procedure for a new admission.

460. Arrangements to serve most of these purposes will also be needed in future, though the procedures should be less complicated and cumbersome than at present. Our recommendations are in paragraphs 462–477.

461. Under some of the present procedures special authority is given to the managers of the hospital to pay for the maintenance of patients while away from hospital. We discuss these in paragraphs 694–701 in Chapter 10. We recommend in that chapter that the power to provide residential care, financial assistance and other services for patients outside hospital should not be linked to compulsory powers of control, and that future arrangements should make it unnecessary for hospital authorities to pay for the maintenance of patients living outside hospital, except perhaps for short periods. It is the powers and duties which hospitals, local authorities and the National Assistance Board possess under the National Health Service Acts and National Assistance Act which should in future determine which administrative authority should provide particular forms of care or financial assistance for individual patients, and in future no other administrative powers should be necessary.

(ii) Transfer from one hospital to another or between hospital and community care, when there is no immediate prospect of return

462. The procedures recommended under this heading should replace the present arrangements for "removal" and "boarding out" under the Lunacy and Mental Treatment Acts and the arrangements for "transfer" or "variation orders" under the Mental Deficiency Acts. Transfer to guardianship or discharge to community care without further compulsory powers should also in most cases replace the long periods of licence by which some patients dealt with under the Mental Deficiency Acts are at present kept under the control of the hospital authorities; we discuss this further in paragraphs 469–476.

(a) Transfer from one hospital to another, or from hospital to guardianship

463. When a patient needs to be transferred permanently from one hospital to another or is ready for discharge from hospital to community care, if the patient is content to accept the arrangements he should be discharged from the hospital in which he is a patient, the compulsory powers thus being terminated. He should then be admitted to the second hospital or provided with community care informally, without being subject to detention in the second hospital or to the control of guardianship.

464. If the patient is unwilling to be moved or to remain in the second hospital or if community care cannot be provided except with powers of guardianship, it should be possible for his compulsory transfer to be authorised, after consultation with his relatives, on the strength of a medical recommendation by the medical superintendent of the hospital in which he has been a patient and a statement of acceptance from a medical officer on the staff of the receiving hospital or local health authority. The medical superintendent's recommendation should include a statement of the patient's mental condition, the reasons why the transfer is desirable and why admission to the second hospital or community care cannot take place without the use of compulsory powers. This recommendation, together with the acceptance by the medical officer of the receiving hospital or local authority, should constitute authority for the patient's transfer and his detention in the second hospital or his control under guardianship. It should also transfer the powers of discharge from the medical staff and members of the hospital management committee of the first hospital to those of the receiving hospital or to the medical officer of health and members of the local health authority. The nearest relative should retain his normal power of discharge. The transfer

should not break the period for which the existing compulsory powers are valid and at the end of which they will expire if not renewed.

465. It should be possible to arrange transfers between hospitals in England and Wales, Scotland and Northern Ireland without (as at present) having to discharge the patient from the existing compulsory powers before crossing the border and then having to go through the procedure for a fresh admission on the other side of the border or of the Irish Sea. In so far as the law in different parts of the United Kingdom may require the participation of different persons in the normal procedures for compulsory admission to hospital, it may be necessary to add an authorisation from one or more such persons before the transfer takes place. It should however be possible to authorise a transfer by any such addition to the existing authority under which the patient is already detained.

(b) **Transfer from guardianship to hospital**

466. If a patient under guardianship of the local health authority needs to be admitted to hospital and if the patient is content, he should be admitted informally, the hospital having no power to detain him. While in hospital he would then remain under the guardianship of the local health authority if the powers of guardianship are kept in force. It should be possible (but not obligatory) for these to be renewed while he is in hospital, under the usual procedure described in paragraphs 433–436; on leaving hospital he would then continue under the guardianship of the local health authority. The nearest relative should retain his normal power to discharge the patient from guardianship (unless admission to guardianship had taken place under the special procedures discussed in paragraphs 496–505, 541–551 or 553–556).

467. If the patient is not content to enter or remain in the hospital, it should be possible for his transfer from guardianship to compulsory hospital care to be authorised by a medical recommendation by the medical officer of health and an acceptance by a member of the medical staff of the receiving hospital. The medical recommendation should contain an opinion on the patient's mental condition and should set out the reasons why hospital care is needed and why this cannot be provided without the use of compulsory powers. This and the acceptance by the hospital should constitute authority for the patient's removal to and detention in hospital. It should also transfer the powers of discharge from the medical officer of health and members of the local health authority to the medical superintendent and members of the hospital management committee. Although the local health authority would relinquish formal control over the patient in these circumstances (because it is necessary for it to be held by the hospital authorities) the local health authority should have a duty to keep in touch with the patient and act towards him as a good parent (see paragraph 672 in Chapter 10). The nearest relative should retain his normal power of discharge (unless admission to guardianship had taken place under the procedures discussed in paragraphs 496–505, 541–551 or 553–556).

468. The patient should have an opportunity to apply to a review tribunal within six months of transfer from guardianship to hospital, if the medical superintendent and members of the hospital management committee have already considered and rejected applications for discharge. A transfer from guardianship to compulsory hospital care should not break the period for which the compulsory powers are valid and at the end of which they will expire if not renewed.

(iii) Patient's absence from hospital when he is expected to return or when it is not certain if he will need to return or not

469. It is generally agreed that it should be possible for patients to be away from hospital for short periods, for a holiday or for a period of treatment in another hospital or for any other reason approved by the medical superintendent, without breaking the existing compulsory powers and without any cumbersome procedure when the patient leaves or returns. It is also generally agreed that the same sort of arrangements should be used when it is not certain whether or not a patient will succeed in life outside the hospital or whether he may need to return for a further period in hospital. There are, however, different opinions on the length of time for which it is justifiable for the hospital to retain compulsory powers, including the right of recall to the hospital, over a patient living in the general community. There is considerable criticism of the very long periods for which some patients have been kept on licence under the Mental Deficiency Acts in the past; periods of two years or more have been common; sometimes it has been more than five, ten or even fifteen years, during which the patient can be recalled on the instructions of the medical superintendent at any time.

470. During the course of our enquiry we asked the medical superintendents of several mental deficiency hospitals for information about the use they make of their power to recall patients from licence. We asked how many patients were sent on residential licence during the years 1949–52 (apart from holidays), how many of these were recalled within various lengths of time after leaving the hospital and for what reasons, and what were the reasons for the recall during 1949–54 of any other patients after over two years on licence. Table 14 in Appendix IV to this report shows the numbers of patients recalled (but not the reasons). The information sent by the medical superintendent of one hospital is printed in full in the Appendix to our minutes of evidence (pages 1367–1383). We found all this information of great interest, but it would be misleading to use it as a basis for a recommendation on the period for which powers of compulsory recall should be retained in future when, if our general proposals are adopted, the whole system will be different.

471. We explained in Chapter 4 (paragraph 229) that for various reasons licence is at present used as a means of ensuring community care for some patients who need some care or supervision after leaving hospital. It is clear that in many of the cases covered by our questionnaire licence would have been terminated sooner if it had been possible for the patient to be transferred to the care of the local health authority under supervision or guardianship. Even under the present law and administrative system we do not think it right that transfer from licence to guardianship should be opposed on the grounds that guardianship is a stricter form of control than licence. The legal power of control over patients on licence under the present Mental Deficiency Acts is much the same as that over patients under guardianship. The strictness of the control depends on the way in which it is exercised either by the medical superintendent and licensee or by the guardian. We consider transfer to guardianship much more suitable than a long period of licence for a patient living in the general community, if it is not possible to terminate the compulsory powers altogether. In paragraph 306 in Chapter 5 we stressed that after-care should be available in future whether the patient is subject to compulsory powers or not. In Chapter 10 we explain the reasons for our view that the care of patients living in the community after a period in hospital is essentially the responsibility of the local health authorities, subject to proper consultation and co-ordination with the medical staff of the hospitals. We recommend in

that chapter that the social and residential care of each patient should become the responsibility of the local health authority when he leaves hospital or as soon as possible thereafter, and we discuss the use of residential hostels in this connection and the stage at which patients should cease to be regarded as hospital in-patients. We also recommend that in future it should be the positive duty of local health authorities to provide after-care for all patients who need it. All this would make it unnecessary in future—and wrong—to keep compulsory powers in force simply in order to enable the hospital to provide after-care. We also see no reason why compulsory powers should not be used more than once for the same patient, if he has been discharged and circumstances arise again later which make this necessary. Compulsory powers should never be kept in force just because it is thought that circumstances may make them necessary again at some future date.

472. It is clear that many of the patients covered by the answers to our questionnaire were recalled to hospital for reasons which would not have led to their admission to a psychiatric hospital, even under present conditions, if they had not already been under order. These reasons include physical illness and accidents such as a broken arm. The reasons for recall in other cases include some which may be valid grounds for admission to such a hospital at present, but which properly call for residential community care rather than hospital care; for example, the illness of those with whom the patient is living or lack of residential accommodation or loss of residential employment. We recommend in Part V of our report that a greater variety of forms of community care should be made available in future and that there should be full consultation between the staff of the hospitals and local health authorities about the form of care most appropriate to each patient's needs. The procedures recommended earlier in this chapter are designed to ensure that this is always fully considered before compulsory powers are used. It would be equally important to ensure that a patient who has received some hospital treatment is not recalled compulsorily unless he is really in need of further psychiatric treatment or training.

473. Under the system which we envisage for the future, many fewer patients will be subject to compulsory powers while in hospital, so that the question whether compulsory powers should be continued when the patient leaves hospital will also arise much less frequently. The patients in regard to whom the question may still be expected to arise are a small proportion of those who have been mentally ill, perhaps some of the severely sub-normal, and a higher proportion of the psychopathic patients. Among psychopathic patients, those who will be subject to compulsory powers will be in two categories only: (*a*) those who have entered hospital following court proceedings or on transfer from prison or approved school; and (*b*) young patients admitted under the age of twenty-one in regard to whom the compulsory powers will lapse at the age of twenty-five whether they are then still in hospital or living in the community.

474. There are two aspects to the question whether it should be permissible, in regard to these patients, for compulsory powers which were first authorised in order to ensure hospital care to be kept in force after the patient leaves hospital. First, there is the question of control over the conditions under which the patient lives while away from hospital. The present arrangements for sending patients on trial, leave or licence allow the medical superintendent to exercise general supervision over these conditions. When it is intended that the patient should return to the hospital after a comparatively short absence, it is right that control should remain in the hands of the medical superintendent while the patient is away. It is also right that the medical superintendent should exercise direct control, or indirect control in consultation with the

local health authority, when one of his patients is being sent out of hospital on trial for discharge from hospital care. In these cases however the aim should be for the local authority to take over effective responsibility for the patient's care at the earliest suitable moment, whether or not compulsory powers are still necessary. If such powers are still necessary, it would be desirable, if control over the conditions under which the patient lives and works were the only consideration, that these powers should be transferred to the local authority when they take over responsibility for the patient's care. And neither the medical superintendent nor the local authority should use these powers to make conditions which cannot be kept, such as forbidding converse with members of the opposite sex. Control over the conditions in which the patient lives and works should be the minimum consistent with the proper care of the individual patient.

475. Secondly, there is the medical superintendent's power to re-admit or recall the patient to hospital without going through the procedure for a fresh compulsory admission or transfer. It should certainly be possible to do this when it has always been intended that the patient should return after a short period of absence. It should also be possible when it fairly soon becomes apparent that a patient who is sent out on trial is not settling down and needs a further period of treatment or training in hospital. But it is wrong that a patient who has lived successfully outside hospital for a considerable period of time should be subject to compulsory re-admission without the use of the usual procedures for admission or transfer and the various safeguards against the arbitrary use of compulsory powers which those procedures contain.

476. In our view the law should allow patients to be sent out of hospital without breaking the compulsory powers held by the hospital authorities, but after a fixed maximum period the powers should lapse unless in the meantime the patient has returned to hospital or has been transferred to another hospital or to guardianship under the procedure described in paragraphs 464–465. This fixed period should be long enough to cover normal absence on holiday or for treatment in another hospital, or a reasonable period of trial for discharge. It should be long enough to make it possible to discharge some patients altogether from compulsory powers by the end of the period rather than having to arrange many transfers to guardianship, though after-care without compulsory powers might continue for a much longer period. **Bearing in mind that it will be the duty of the local authorities to provide after-care for patients who need it whether or not compulsory powers are kept in force, that transfer to guardianship will be possible in those cases in which compulsory powers are still really essential and re-transfer from guardianship to hospital later if necessary, and that if the compulsory powers are terminated the patient can be re-admitted later if necessary by using the procedure for a new admission, we recommend that the powers should lapse when the patient has lived away from the hospital[7] for a period of six months unless a transfer to guardianship is arranged.** Six months will often not be long enough to judge whether the patient can live successfully without further care, but that will not be the question for decision. Community care can continue even if the compulsory powers do not. In almost all cases, the care of the patient should have been taken over by the local authority before the end of the six months period. The question will be for the medical officer of health (in consultation with the medical superintendent) to decide whether community care should continue without powers of guardianship or whether a transfer to guardianship should be

[7] A patient should be regarded as living in the hospital if he is living outside the main hospital premises but is still a hospital in-patient in the sense discussed in paragraph 623 of Chapter 10.

arranged. Transfer to guardianship may be needed more often for psychopathic patients over the age of twenty-one than for other patients, as if the compulsory powers lapse and it becomes apparent later that a further period of training in hospital is required re-admission would be possible only with the patient's consent, unless the question arises in connection with criminal proceedings. The powers of guardianship should however not be prolonged even in these cases without good reason, but should be kept under review and terminated when the progress of the patient warrants it.

477. We therefore recommend the following arrangements:—

(*a*) A patient who has been subject to compulsory powers in hospital after admission under the "main procedures"[8] should be able to leave the hospital at any time and for any purpose with the approval of the medical superintendent without the compulsory powers being terminated or transferred. It should not be necessary for the medical superintendent to obtain the concurrence of members of the hospital management committee. The medical superintendent should be able to make any conditions he considers necessary as to the patient's care and his place of residence or employment while absent from hospital. These conditions should not be laid down centrally by regulations, but should be decided in the light of the needs of each individual patient. The medical superintendent should have power to re-admit or recall the patient to hospital at any time within a period of six months after leaving the hospital, without going through the procedure for a new compulsory admission. It should be possible for the compulsory powers to be renewed by the normal renewal procedure if otherwise due to expire during the six months period. If the patient does not return to hospital within six months, the compulsory powers (even if recently renewed) should lapse unless transfer to another hospital or guardianship is arranged by the procedures described in paragraphs 464–465.

(*b*) When these arrangements are used to send a patient out of hospital on trial for discharge, his day-to-day care should be taken over by the local health authority as soon as convenient, usually well before the end of the six months period. At any time within that period the compulsory powers may be terminated by discharge from hospital care, or may be transferred into guardianship by the procedure described in paragraph 464. If the patient is transferred to guardianship and later needs to be re-admitted to hospital, this should be possible under the arrangements described in paragraphs 466–468. If he is not transferred to guardianship and the compulsory powers lapse and later he needs to be re-admitted to hospital, an informal admission without the use of compulsory powers would be possible at any time; if the patient is unwilling to return without the use of compulsion, one of the ordinary procedures for a new compulsory admission could be used, subject to the general conditions governing the use of these procedures.

(*c*) These arrangements could also be used to send a patient to another hospital for a period of special treatment. (i) If the patient is content to go to the second hospital and remain there as long as is considered necessary, this should be authorised by the medical superintendent without any formal procedure. The power to discharge the patient altogether from hospital care would remain with the medical

[8] For modifications in the case of some patients admitted following court proceedings or on transfer from prison or approved school see paragraphs 520 (ii) (*b*) and 554.

superintendent and members of the hospital management committee of the first hospital, and with the nearest relative. When the patient is ready to leave the other hospital, it would be for the medical superintendent of the first hospital to decide whether he should be discharged completely or return to the first hospital. (ii) If the patient is not content to go to the second hospital or to remain there for treatment, it would be necessary to obtain authority for his removal by using the procedure for a transfer recommended in paragraphs 464–465; if necessary, the same transfer procedure should be used to effect his return to the first hospital later.

(10) Absence without medical approval

478. The Lunacy and Mental Treatment Acts allow certified or temporary patients who have "escaped" to be "recaptured" and taken back to the hospital within fourteen days, whether they have left the hospital without permission or have refused to return at the end of a period of trial (in the latter case the power to recall a certified patient lapses if a medical certificate is sent to the hospital certifying that the patient's detention as a person of unsound mind is no longer necessary). The Mental Deficiency Acts place no time limit on the power to "apprehend" a defective who is absent from an institution or from his guardian with or without leave or licence, and this power is considered to last for the remainder of the current period of validity of the order for the patient's detention in the institution or under guardianship, which in some cases may be up to five years.

479. We recommend that in future patients who leave hospital without the medical superintendent's approval, or who leave with his approval but do not return when recalled, should be liable to compulsory re-admission on the medical superintendent's instructions within a period of twenty-eight days from leaving or failing to return. If the failure to return takes place less than twenty-eight days before the end of the six months period mentioned in paragraph 476, the compulsory powers should not lapse at the end of the six months period. The compulsory powers should however lapse in all cases (subject to the modifications for certain patients mentioned in paragraphs 481 and 550) after the patient has been absent without approval for more than twenty-eight days. If after that the patient gets into difficulties sufficient to justify a fresh admission the normal admission procedures should be used.

480. Similar arrangements should apply when a patient under guardianship or on trial leaves the place where he has been told to live and fails to return.

481. If a psychopathic patient over the age of twenty-one is absent without approval and is not found before the compulsory powers lapse, it will not be possible to re-admit him (unless he is willing to return) unless he is later convicted of a criminal offence. As it might take more than twenty-eight days to find such a patient, we recommend that the powers should not lapse until six months after such a patient leaves or fails to return.

482. New legislation should if possible permit the patient's compulsory recall on the instructions of the medical superintendent or medical officer of health even if the patient has crossed into Scotland or Northern Ireland.

(11) Notification of admission, transfer, discharge and death, and scrutiny of documents

483. The documents authorising compulsory admission or transfer to hospital or guardianship should be carefully inspected by the hospital or local health authority staff when the patient is admitted or transferred. If they do not appear to be complete or in the form required by law,

the hospital or local health authority should not accept them as authorising them to detain the patient or exercise powers of guardianship. If necessary, however, the patient should be cared for on an informal basis, or by the use of emergency procedures, while the documents are being corrected or new documents prepared. In our view, it is not necessary for these documents to be sent to London for scrutiny, nor for the admission and discharge of individual patients by name to be notified to any central department. We discuss this more fully in Chapter 11.

484. The patient's nearest relative or the person with whom he lives or is going to live should normally be consulted and the patient's general practitioner notified before the patient is discharged from hospital. There is no need for any statutory form to be used ; the arrangements should be made by letter or personal interview or by telephone.

485. We do not consider it necessary for the admission or discharge of all patients from hospital to be notified to the local health authority. The arrangements in relation to patients originally admitted under compulsory powers should be the same as those for patients admitted informally (see paragraphs 300–301 in Chapter 5). The local health authority should be notified of the discharge of patients for whom they are to provide aftercare or whose original admission to hospital was arranged by one of their officers, but not of other patients. There is no need for a statutory form of notification ; the method of notification and the information to be given should be agreed between the hospitals and local health authorities locally (see also paragraphs 677–678 in Chapter 10).

486. At present the death of any temporary or certified patient, any patient detained under Sections 20, or 21A of the Lunacy Act, 1890, and any patient in a mental deficiency hospital or certified institution or under guardianship has to be reported to the coroner. We do not consider this necessary. The practice in relation to patients who die in psychiatric hospitals in future should be the same as for patients dying in other hospitals or at home ; there should be an obligation to report the death to the coroner only in circumstances requiring the holding of an inquest or enquiry, i.e. where there are suspicious circumstances or when the death is sudden and the cause unknown.

(12) **Visits to patients by public authorities**

487. Members of hospital management committees should visit the wards regularly and patients should be able to ask for an interview with them at any time. The local health authority should arrange for patients under guardianship to be visited regularly by medical practitioners and social workers. We do not consider it necessary for the frequency of these visits to be laid down by statute, but the Minister of Health may think it desirable to give general advice to hospital management committees and local health authorities about arrangements for patients to be visited and seen and about other opportunities which patients should have for making representations to the authorities responsible for their care. These should also apply to patients who are admitted to care without the use of compulsory powers.

488. Patients in hospital or under guardianship should also be able to ask for an interview with visitors from the central department ; we discuss this in Chapter 11.

(13) **Patients' correspondence**

489. We recommended in paragraph 299 in Chapter 5 that patients' letters to persons outside the hospital should not be censored or stopped, except at the request of the person to whom the letters are addressed, but that

the hospital authorities should have discretion to withhold from patients in-coming letters which it would harm them to receive. These recommendations (including the recommendation that these powers should be very sparingly used) apply to patients detained in hospital (or under guardianship) under compulsory powers as well as to other patients.

(14) Bringing of legal proceedings

490. We recommend that the substance of Section 16 of the Mental Treatment Act, 1930 (which affords protection from legal proceedings for persons who take part in the certification or other procedures unless they have acted in bad faith or without reasonable care), should be re-enacted in the new legislation and should apply to proceedings arising from any action, report or recommendation made in connection with the new compulsory procedures.

Procedures when compulsion is used to override the unwillingness of the patient's relatives, rather than or in addition to the unwillingness of the patient himself

(1) Circumstances in which the procedures may be used

491. In paragraphs 328–330 of Chapter 6 we discussed the extent to which use might be made of powers under the Children and Young Persons Acts, Children Act or Education Acts in order to ensure proper care when the patient is a child.

492. The arrangements which we recommend[9] should be made under the Education Acts when a child is recommended for training in place of education at school should in themselves normally provide sufficient compulsory powers and sufficient opportunity for the consideration of representations by the parents, whether the training is to be given at a day or residential training centre or in a psychiatric hospital as a day-patient or in-patient. The use of these procedures would introduce no stricter form of control over these children than over normal children who are obliged to attend an appropriate school.

493. If a child or young person who has been dealt with under the Children and Young Persons Acts needs psychiatric treatment or training in hospital, the local authority or other person appointed to act as a "fit person", or the headmaster or headmistress of an approved school if an approved school order has been made, would have sufficient authority to arrange for the patient's admission to a suitable hospital. This should normally be arranged without the use of further compulsory powers, quite informally; if in an exceptional case it is thought necessary to have specific power to detain the patient in hospital, it should be possible for the main procedures recommended in paragraphs 401–490 to be used. The person who applies for admission should also hold the power of discharge normally held by the nearest relative (see paragraphs 305 and 421–425). The authority to act in place of the nearest relative would however lapse when the validity of the fit person order or approved school order expires. If it is necessary to detain the patient at the end of that period against the wishes of the nearest relative, the procedures recommended in paragraphs 496–510 should be used. Alternatively, a transfer from an approved school might be arranged under the procedure described in paragraphs 553–556; the compulsory powers over a psychopathic patient would then not lapse automatically at age twenty-five as they would otherwise do.

[9] See paragraph 329 in Chapter 6, and paragraphs 640–642 in Chapter 10.

494. We recommended in Chapter 6 that other powers should also be available in order to ensure proper care for mentally disordered children and adults when this is necessary for their own welfare or for the protection of others, and in paragraphs 359–365 of that chapter we discussed the considerations which apply when the patient's relatives object to his receiving such care. It is only in the circumstances covered by our recommendations in that section of Chapter 6 that the procedures recommended in paragraphs 496–510 should be used.

495. We also wish to make it clear that these procedures should be used only when the relatives would otherwise positively obstruct the provision of proper care. If the patient has no relatives, care should be provided without the use of compulsion if the patient is content to receive it. If a patient without relatives is himself unwilling, the main procedures for admission described in paragraphs 401–419 should be used, a mental welfare officer making the application for admission in the absence of relatives. If the patient has relatives but they are indifferent, the same should apply, the mental welfare officer acting instead of the relatives. The positive consent of a relative is not required under our proposals for the provision of care without the use of compulsion, nor for the patient's compulsory admission to hospital or guardianship under the main compulsory procedures. But the nearest relative would have power to insist on the discharge of a patient admitted without compulsion if the patient is a child or incapable of expressing his own opinion, and to discharge any patient admitted under the main procedures (except during a limited period of observation or in the rare event of the issue of a barring certificate). If the nearest relative positively obstructs the provision of care (by dissuading the patient from accepting it, or by objecting to others making an application for the patient's compulsory admission, or by using his power of discharge) and if it is considered that in doing so the relative is acting unreasonably, it should be possible to use the procedures discussed in the following paragraphs.

(2) Admission procedure, powers of discharge and arrangements for review, except in emergency or when admission is for short period of observation

496. **Although we do not consider it necessary or appropriate for a justice of the peace or other judicial authority to take part in the procedures when compulsion is used to override the unwillingness of a mentally disordered patient only, there are different considerations when it is proposed to use compulsion to override the wishes of a relative who positively objects to the provision of the form of care which is recommended for the patient.** In these circumstances the questions which have to be considered by those who invoke compulsory powers are not only the patient's mental condition and his need for care, but also whether the nearest relative should be prevented from exercising power or authority to which his relationship to the patient would otherwise entitle him. **The fitness of the relative to play his normal part in the procedures is at issue, as well as the needs of the patient. This is a question which we consider should be referred for a judicial decision before compulsory powers are used, except in an emergency or when it is proposed to use the compulsory powers to admit the patient to hospital for a limited period of observation only.**

497. The normal procedure should be for another relative of the patient or a mental welfare officer of the local health authority to make an application to a magistrates court. If the patient is a child or young person the application should be to the juvenile court. The application should explain

why it is considered that the nearest relative is acting unreasonably in opposing the provision of the form of care recommended for the patient.

498. The application should be accompanied by a medical report from two doctors containing an opinion on the patient's mental condition and explaining why hospital or community care is considered necessary and why it cannot be provided without using compulsion to overcome the unwillingness of the patient's nearest relative or of both the relative and the patient. The report should be made by doctors who would be able to give the medical recommendations in support of an application for admission under the main procedures as described in paragraphs 413–414, and it should include or be accompanied by a statement that the patient has been accepted for the hospital or community care recommended.

499. The court should not be expected to make its own assessment of the patient's mental condition but should normally accept the diagnosis contained in the medical report unless this is challenged by the nearest relative. The issue before the court would be whether or not the nearest relative is acting unreasonably in opposing the form of care recommended. The doctors should be available to give any further information the court might require in this connection. In reaching its decision the court should be required to have regard to the welfare of the patient.

500. The patient should not necessarily be required to attend in court. He and the nearest relative should however have a right to ask that he should be present, and the court should agree to this unless they decide on medical advice that it would be detrimental to the patient. Whatever the age of the patient, there should be the same restrictions on the admission of the public to the court and on the reporting of proceedings as apply in juvenile courts. In general the procedure should be similar to that adopted by juvenile courts when a child is brought before them as being in need of care or protection, and the court should have a similar discretion to see the patient and the relative separately from each other.

501. If the court decides that the nearest relative is acting unreasonably and that his wishes should be set aside, it should adopt one of two courses according to whether hospital or community care is recommended for the patient. If hospital care is recommended, the court should authorise another relative, or some other suitable private person, or the medical officer of health,[10] to act instead of the nearest relative in regard to the patient's admission to or discharge from hospital. If the patient is then content to enter hospital, this could then be arranged on an informal basis, as described in Chapter 5; the person to whom the powers of the nearest relative are transferred by the court should be regarded as the nearest relative in relation to the patient's discharge (see paragraph 305). If it is necessary to use compulsory powers to overcome the patient's own unwillingness to enter hospital, the person to whom the powers of the nearest relative are transferred should be able to make an application under the main procedures described in paragraphs 401–409 or could ask a mental welfare officer to do so. The same person would hold the power of discharge normally vested in the nearest relative. In either case the court should give the person a statement authorising him to act as the nearest relative in regard to the patient's admission to and discharge from hospital; this statement should be presented to the hospital at the time of the patient's admission.

[10] In this connection, it should be possible for authority to act instead of the nearest relative to be conferred on the medical officer of health in his official capacity so that it would pass to his successor in office. He should also be able to authorise another officer to exercise this function on his behalf.

502. If the patient is recommended for community care, the court should sign a statement authorising (but not ordering) another relative or other person or the local health authority to undertake the powers and responsibilities of guardianship, and withholding from the nearest relative the power to discharge the patient from such guardianship. The normal procedure for admission to guardianship should then follow and the court's statement should be attached to the normal application and medical recommendations.

503. The nearest relative should have a right of appeal from the decision of the magistrates court to quarter sessions. Notice of the lodging of an appeal should not prevent the patient's admission to hospital or guardianship on the basis of the decision of the magistrates court pending the hearing of the appeal.

504. The nearest relative whose authority has been displaced by the decision of the court should be able to apply to a Mental Health Review Tribunal not more often than once a year if he desires the patient's discharge from hospital or guardianship. The relative should be able to do this even when the patient has been admitted to hospital informally. This would be additional to and quite separate from his right of appeal to quarter sessions against the decision of the magistrates court.

505. If the patient is compulsorily admitted to hospital or guardianship he would be admitted under the main procedures and his right to apply to a review tribunal would be as described in paragraphs 436, 442 and 468. All our other recommendations under the main procedure would apply also.

506. During periods in which the patient has access to a tribunal as often as once a year (e.g. following renewal of compulsory powers at the end of the first or second years after admission) the views of the patient and his nearest relative should be put to the tribunal on the occasion on which an application may be made by the patient. Either the relative or the patient should then be able to take the initiative in referring the case to a tribunal, but a tribunal should not normally be called on to review the case of any patient more often than once a year. An exception would be that if a patient uses his right of access to a tribunal within six months of admission this may be followed by another application by the patient or his relative if the powers are renewed at the end of the first year. Special arrangements may be necessary if a relative with the right to apply annually wishes to apply less than twelve months before compulsory powers which have been renewed for a two-year or three-year period are due to expire if not renewed again ; if the patient agrees, the application might be heard when the relative applies, in lieu of the patient's own right of access at the next statutory review.

(3) Admission to hospital for observation, whether in emergency or not

507. On medical recommendation for a period of observation in hospital not exceeding twenty-eight days, it should be permissible for the main procedures described in paragraphs 401–419 to be used even against the wishes of the patient's nearest relative. The nearest relative would in any case not have power to discharge a patient while in hospital on this type of recommendation for this limited period, though there should be every opportunity for him to make representations to the hospital authorities (see paragraph 424).

(4) Admission in emergency on specific recommendation

508. It should be possible to secure a patient's immediate admission to hospital on a specific recommendation for hospital care, in an emergency, even against the wishes of the nearest relative. This should be done only when the mental welfare officer or another relative considers that the nearest

relative is acting unreasonably to the extent that he is prepared to make application to a magistrates court (as described in paragraph 497) for the nearest relative's wishes to be set aside. In these circumstances it should be possible for the main emergency procedure decribed in paragraph 407 to be used, but the application for admission should be accompanied by a statement that the nearest relative is, in the view of the applicant, acting unreasonably and that an application is also being made to a magistrates court. This would provide authority for the hospital to admit the patient and to detain him even against the wishes of the relative for up to twenty-eight days, provided that a second medical recommendation and the medical acceptance are added within seventy-two hours of admission. If the court has not authorised the transfer of the relative's power of discharge to some other person within twenty-eight days, the relative should assume his normal power of discharge. If during the twenty-eight days and before the application is heard by the court the relative is persuaded to withdraw his objections, we should expect the application to the court to be withdrawn and the patient to remain just as though the relative had raised no objection to the original admission.

509. Subject to similar arrangements for reference to a magistrates court, it should be possible in an emergency even against the wishes of the nearest relative to use the procedure described in paragraph 410 to detain a patient who is already in hospital. But this should be permitted only if the patient was originally admitted informally. This procedure should not be used to block the relative's power to discharge a patient originally admitted under compulsory powers with the relative's consent; if the relative directs the discharge of such a patient it should not be refused unless a barring certificate is justified on grounds of danger; if necessary, however, an application could be made to a magistrates court after the patient's discharge for authority to set aside the relative's wishes and re-admit the patient.

510. With similar modifications, the procedures proposed in paragraph 411 should be available to provide guardianship for up to twenty-eight days in an emergency against the wishes of the nearest relative if he is considered to be acting unreasonably to the extent that an application to a court is considered justified.

Procedures in court cases

(1) General considerations and the powers and procedures of the court

511. In the following paragraphs we discuss the arrangements which should apply in cases dealt with in magistrates courts in which an offender of any age or a child or young person brought before the court as in need of care or protection or beyond control is found to be mentally ill, severely sub-normal or psychopathic; in cases dealt with in higher courts when the accused is considered to be mentally ill, severely sub-normal or psychopathic and is not found insane on arraignment or guilty but insane; and the arrangements for transferring psychopathic or severely sub-normal patients from prison, approved school or other penal institutions to hospital or community care. The arrangements made for persons found "insane on arraignment" or "guilty but insane" and for others who become Broadmoor patients are outside our terms of reference. If our recommendations in regard to other court cases are accepted, however, it will be desirable for consideration to be given to the extent to which similar principles can or should be applied to those now dealt with as Broadmoor patients. The new arrangements we recommend would replace the provisions of Sections 8 and 9 of the Mental Deficiency Act, 1913, and Section 30 of the Magistrates' Courts Act, 1952.

512. Our general recommendations in relation to psychopathic patients would also fundamentally affect the use of Section 4 of the Criminal Justice Act, 1948, as courts would have other powers which would enable them to deal with psychopathic offenders either by probation or in a variety of other ways, without using Section 4. But, as we mentioned in paragraph 326, powers similar to those contained in this section would still be desirable for dealing with offenders suffering from forms of mental illness which would not make them liable to compulsory admission to hospital under our main proposals. We were told of several difficulties which sometimes arise at present when this section is used and the offender undertakes to accept treatment voluntarily as a condition of probation. One difficulty is that the medical advice to the court is not always given by the doctor who is later asked to treat the patient, who sometimes finds the patient unsuitable for treatment after the probation order has already been made. Difficulties may also arise if the court specifies a precise period of treatment, as any precise period may turn out to be too long or too short from the medical point of view. The patient's position under the probation order is not always clear if he leaves hospital prematurely or if he is discharged from hospital before the period of probation has expired. Some hospitals seem to feel that their position is anomalous when the patient is technically a voluntary patient but is there as a condition of probation; it is not always clear whether they have any responsibility for ensuring that the patient does not leave. We were also told that it is not always clear whether responsibility for the care of such patients after they have left hospital lies, or should lie, with the local health authority or with the probation officer. A detailed investigation is at present being made on behalf of the Home Office into the operation of Section 4, and we have seen a report on its first stage. Because this other investigation is in progress we ourselves make no recommendations for amendment of Section 4 itself or of the procedures used under it, but we have borne in mind the difficulties mentioned above, as well as criticisms of Sections 8 and 9 of the Mental Deficiency Act, 1913, when formulating the recommendations contained in the following paragraphs.

513. When one considers the special compulsory powers and procedures which may be used when a patient is admitted to hospital or community care following court proceedings, there are two comparisons to be borne in mind. One is the comparison with the powers and procedures which apply to patients who have not been through the courts. From this point of view the patient's criminal offence may be regarded simply as an action which has revealed the patient's need for treatment, which might equally well have been revealed by other forms of behaviour which would not lead to his being charged in court. The other comparison is with the powers and procedures which apply under the ordinary criminal law to offenders who are not considered mentally disordered. Under the present law, patients dealt with under Section 30 of the Magistrates' Courts Act, 1952, or Sections 8 or 9 of the Mental Deficiency Act, 1913, are in effect treated on the same footing as patients who enter hospital or guardianship under compulsory powers without appearing in court. Section 4 of the Criminal Justice Act, 1948, uses one of the sanctions provided under the normal penal code (a probation order, to which the offender must consent) and otherwise requires the patient to be treated as a purely voluntary patient. Those of our witnesses who criticised these various arrangements based their criticisms mainly on the distinctions which they introduce between the treatment of mentally disordered offenders and that of other offenders who have committed similar offences.

514. Looking at the present arrangements from the latter point of view, it must be borne in mind that a decision to treat a mentally disordered patient who has broken the criminal law differently from other offenders may sometimes appear to him and to the general public to single him out for specially lenient treatment and sometimes to impose specially harsh treatment. The question of an offender's mental condition is sometimes raised on his own behalf when it is hoped that this may lead to some mitigation of sentence or to a probation order with a condition of medical treatment under Section 4 of the Criminal Justice Act (or even to discharge without such an order) instead of imprisonment. A few of our witnesses referred to the possibility of offenders seeking medical treatment "to escape the due process of the law". These witnesses were referring mainly to patients who might enter mental hospitals for comparatively short periods as voluntary patients. A similar attitude is sometimes adopted towards patients who are certifiable under the present Mental Deficiency Acts and who have committed serious offences, the view being taken that they deserve imprisonment as the normal punishment for their offence rather than admission to hospital. But there is a great difference at present between the position of mentally ill or psychopathic patients who enter mental or neurosis hospitals, whether as a condition of probation or not, and that of patients dealt with under the Mental Deficiency Acts. An offender who accepts medical treatment as a condition of probation under Section 4 of the Criminal Justice Act enters hospital as a voluntary patient and may not be detained there; if he leaves hospital prematurely this may be a breach of the probation order, but the longest period for which treatment may be made a condition of probation under this section is twelve months. When a mentally ill patient is sent to a mental hospital as "a person of unsound mind" on the order of a magistrates court under Section 30 of the Magistrates' Courts Act, 1952, he may be detained for a long time, but he may also be discharged at any time by members of the hospital management committee or (unless he is positively dangerous) by his nearest relative. On the other hand, when a patient is admitted to hospital on an order under the Mental Deficiency Act his relatives have no power of discharge. The hospital authorities may release him on licence, but he may be discharged only on the order of the Board of Control (unless he is under the age of twenty-one when admitted, in which case he may be discharged by the Visitors when he reaches that age). Because of the nature of their disorder and the length of time needed for treatment or training to have a chance of success, patients usually stay in mental deficiency hospitals much longer than most patients stay in mental hospitals, and it is usual for patients admitted to a mental deficiency hospital on the order of a court to be detained there for a considerable period. The law allows the patient to be detained indefinitely, provided the order is renewed under the prescribed procedure at statutory intervals. The period of detention in hospital may exceed the term of imprisonment which the offender might otherwise have expected; it sometimes exceeds the maximum possible term of imprisonment for the offence, or it may last literally for life. For that reason as well as for other reasons, the decision of a court to make an order under Section 8 of the Mental Deficiency Act, 1913, or of the Home Secretary to make an order under Section 9 is usually unwelcome to the patient and his relatives.

515. Some of our witnesses criticised Section 8 on the grounds that it permits the imposition of an indeterminate period of detention in hospital following a minor offence for which a normal person would probably be put on probation or given an absolute or conditional discharge, or at most would receive a fine or a limited period of imprisonment. The Home Secre-

tary's powers under Section 9 were similarly criticised because they allow him to order that a defective whom a court has sentenced to a limited term of imprisonment or approved school training shall be transferred to a mental deficiency hospital or guardianship for an indefinite period. The usual answer to these criticisms is that the patient's criminal offence is only one incident which has called attention to his need for medical care, that in many cases he is liable to compulsory admission to hospital on more general grounds quite apart from his offence, and that the period of detention is controlled by the same safeguards which apply to other patients, i.e. by the fact that the compulsory powers expire if not renewed at statutory intervals, and by the powers of discharge.

516. Section 8 was also criticised because it does not mention the possibility that supervision under the care of the local health authority might be the most suitable form of care for some defectives who have come before the courts. It is alleged that courts are sometimes too prone to make an order committing a patient to a mental deficiency hospital when care in the community—either supervision or guardianship—would have been more suitable. Some witnesses suggested that it is not appropriate for a court itself to decide what is the proper form of medical care, and that if a court decides that an offender should be dealt with as a patient rather than under the normal criminal law it should be left to the local health authority to make arrangements for suitable care under the usual procedures which apply to all other patients; this should incidentally also make it clearer to the patient and his relatives that the action which is being taken is not directly linked with the offence which he has committed.

517. Our view on these questions is that even if compulsory powers over patients who have not broken the law were to be as wide in future as those which apply to defectives under the present Mental Deficiency Acts, it would still be desirable to introduce new safeguards to ensure that the power to compel a patient to enter hospital after conviction in the courts is used only when fully justified. But we have recommended that in future adult psychopathic patients who have not broken the criminal law should not be liable to compulsory admission to hospital at all except for short periods of observation. This makes it even more necessary to ensure that the power to apply special forms of treatment or control after the commission of an offence is only used in cases for which normal penal measures alone are clearly inappropriate. It is for this reason that we recommended in Chapter 6 that the special powers should be applicable only if the court is satisfied that normal penal measures alone are insufficient or inappropriate and that the patient requires medical or social care which a particular hospital or local authority is able and willing to provide. Although this consideration is particularly important in relation to adult psychopathic patients, it applies also to younger psychopathic patients and to severely sub-normal and mentally ill patients. These other patients would be liable to compulsory admission to hospital or guardianship, under our proposals, when this is necessary for their own welfare or for the protection of others; neither condition would be fulfilled if it is found that a patient who has committed an offence can be sufficiently and appropriately dealt with without invoking special powers, or if the patient has not been accepted as suitable for hospital or community care. It is equally important to ensure that, when the special powers are quite rightly used to effect admission to hospital or guardianship, they are not kept in force for unreasonably long periods.

518. We must however also give due weight to the point of view that admission to hospital for a short period may be a "soft option" for the offender in some cases, or may give insufficient protection to the public.

We mentioned in paragraph 347 the fear in some quarters that patients may be allowed to leave hospital when they may still be unstable and potentially dangerous. The fact that patients admitted to hospital as a condition of probation under Section 4 of the Criminal Justice Act are voluntary patients and may not be detained was also criticised from this point of view. When patients who could be dealt with under the Mental Deficiency Acts are convicted of serious offences involving personal violence courts sometimes think it preferable to send them to prison so as to ensure that they are detained for a certain period, even when their admission to hospital is recommended on medical grounds. But if such an offender serves a prison sentence he may be deprived of the medical treatment which might improve his condition, and he must be released at the end of his sentence whatever his condition then is. There is a strong case for trying to ensure that patients with dangerous tendencies for whom ordinary penal measures are inappropriate or insufficient (either because the patients are thought likely to respond only to special forms of treatment which are not available in prison or because they may not respond to any form of medical or penal treatment) are not discharged prematurely if they are sent for medical treatment in hospital in place of imprisonment, and for detaining some of them for longer periods than other criminals. Some patients with dangerous tendencies are to be found in each of the three main groups—mentally ill, severely subnormal and psychopathic. Most of those who are mentally ill and are convicted of a criminal offence become Broadmoor patients and are then subject to special conditions in regard to custody and discharge. We consider that there should also be special safeguards for the protection of the public from those whose mental disorder takes the form of a psychopathic or severely sub-normal personality and who are recognised as dangerous to other people. At present any such patients admitted to hospital under the Mental Deficiency Acts may be discharged only by the Board of Control, and if they have been transferred from prison or approved school they may not be set at large except with the Home Secretary's consent during the period of detention originally imposed by the court. If (as we recommend) power to discharge most psychopathic and severely sub-normal patients is to be held in future by the medical staff of the hospitals and members of the hospital management committees we think it desirable that the discharge of patients admitted following court proceedings who are known to be dangerous should be controlled by a central authority who would have special regard to the protection of the public.

519. We therefore recommend that in cases in which the court is satisfied that an offender requires medical care, treatment or training but that there is a real danger of the commission of further serious offences if he is discharged prematurely, it should be possible for quarter sessions or assizes, but not magistrates courts, to name a period within which he should not be set at large without the consent of the Home Secretary. We discuss more fully in paragraphs 522–526 the circumstances in which this might be done. It is necessary to emphasise that dangerous patients form only a small proportion of all the patients in any of our three groups, and that it is not always easy to identify them. The fact that some patients are dangerous does not justify the application to all patients of the sort of compulsory powers and procedures which are necessary for these few patients. Nor should the fact that some dangerous patients may need medical rather than penal treatment be allowed to give all our psychiatric hospitals the character of prisons ; it should be possible to accommodate them in a few special hospitals which have suitable facilities for their treatment and custody, leaving other hospitals free to dispense with restrictive measures to the greatest possible extent.

520. **Courts should therefore have at their disposal the following methods of dealing with offenders and children and young persons who are suffering from mental disorder :—**

(i) By ordinary penal measures and methods of disposal under the criminal law or Children and Young Persons Acts.

(ii) (a) In cases in which the court is satisfied that normal methods of disposal alone are insufficient or inappropriate and that the patient requires special medical or social care which a particular hospital or local authority is able and willing to provide, it should be possible for such hospital or community care to be provided, with or without special compulsory powers as appropriate.

(b) If the court is satisfied, in addition, that there is real danger of the commission of further and serious offences if the patient is discharged prematurely, quarter sessions and assizes, but not magistrates courts, should be able to direct that he should not be set at large without the consent of the Home Secretary within such period as the court thinks fit.

521. **The findings of a court under (ii) (a) or (ii) (b) would result in appropriate action being taken by the health authorities to provide the required treatment or care. In those circumstances the court could discharge the offender, but that should not necessarily follow. The court should use its normal powers of disposing of cases, having regard to the particular circumstances and the special medical or social care that the offender is to receive. We see no objection to a combination of penal and medical measures in these cases, e.g. by imposing a fine even when the patient is to receive hospital treatment or training or community care, or by making the acceptance of treatment, training or community care a condition of a probation or supervision order.** In some cases, no compulsion would be necessary to ensure that the offender accepts the form of care recommended. In others a probation or supervision order would be sufficient. In some cases under (ii) (*a*) and all cases under (ii) (*b*) it would be necessary to authorise the patient's detention in hospital or control under guardianship. Our detailed recommendations on the procedures to be followed are in paragraphs 538–551.

522. The decision whether an offender should be dealt with entirely under the court's normal powers and procedures, or whether he should receive special treatment because of his mental condition, must be taken by the court itself. But before special treatment is authorised it would be essential for courts to have the best possible medical advice, and the arrangements for obtaining it should incorporate adequate safeguards. The arrangements which we envisage are as follows :—

(*a*) In any case in which it appears to a court, or is suggested in evidence, that the person before the court is suffering from some form of mental disorder, the court should be able (as at present) to obtain a medical report on his mental condition with advice on the most suitable form of care or treatment from the medical point of view. This should apply in the case of persons of any age charged with a criminal offence, whether or not the offence carries a sentence of imprisonment, and also when a child or young person is brought before the court as being in need of care and protection or beyond control.

(*b*) In any case in which the court contemplates disposal under methods (ii) (*a*) or (*b*) as described in paragraph 520, it should be obligatory for such a report to be obtained.

(*c*) In the case of criminal charges tried by magistrates courts, the court should call for the report when it is satisfied that the offence has been committed and before deciding how to deal with the offender. In cases heard on indictment in higher courts, it would usually cause great delay if a request for a report could not be made until the accused had been convicted, as this would usually require a remand to the next quarter sessions or assizes which might not be held for several weeks or months. We therefore consider it important that the examining magistrates should make full use of their powers under Section 26 (4) of the Magistrates' Courts Act, 1952, to arrange for a medical report to be obtained during the period when a person committed for trial on bail is awaiting trial in the higher court. Examining magistrates should also be able to direct that such a report should be prepared when the accused is committed for trial in custody. Some magistrates may hesitate to direct that such a report should be prepared, as it may appear to be prejudging a conviction ; in our view, the importance of a proper medical report being available to the higher court at the time of trial outweighs this objection ; the report would of course only be used if the accused is eventually found guilty of the offence.

(*d*) A juvenile court before whom a child or young person is charged with an offence or is brought as being in need of care or protection or beyond control should be able to call for a report at whatever stage of the proceedings seems appropriate. If after receiving this and other reports the court finds that the child or young person has not committed the offence or is not in need of care or protection or beyond control within the strict meaning of the Children and Young Persons Acts but is severely sub-normal, psychopathic or mentally ill and that the provision of proper care is being unreasonably opposed by the parent or other relative, the court should be able to proceed to deal with the case as if an application had been made under the procedures described in paragraphs 496–505. If the court authorises a psychopathic patient's compulsory admission to hospital or guardianship in these circumstances, the admission is not to be considered as following court proceedings and the compulsory powers would lapse automatically when the patient reaches the age of twenty-five if he has not already been discharged. If the charge is proved or the child or young person is found to be in need of care or protection or beyond control, and if compulsory admission to hospital or guardianship is authorised by the court, the admission should be considered as following court proceedings, and the duration of the compulsory powers should be governed by the same principles which are to apply to adult offenders—see paragraphs 523–537.

(*e*) When a medical report is asked for, sufficient time should be allowed for thorough medical examination and observation, with remand as appropriate. If a period of observation as a hospital in-patient is desirable, the patient might enter hospital informally for this purpose, or it might be necessary to compel the patient to enter hospital for not more than twenty-eight days observation using the procedure recommended in paragraphs 401–405.

(*f*) The medical report should be obtained from doctors with experience or knowledge similar to that which would qualify them to give medical recommendations under the main procedures as recom-

mended in paragraph 414, i.e. the patient should be seen by two doctors, one of whom must be approved by a local health authority as experienced in the diagnosis or treatment of mental disorders and one of whom should, if possible, already know the patient. The two doctors should be allowed to make separate reports to the court, or a joint report. In many cases, it would be suitable for the patient to be referred to one of the diagnostic clinics whose establishment we recommend in paragraphs 684–687 in Chapter 10, and for the medical report to be prepared after discussion at one of the case-conferences suggested in paragraph 688. If the court considers it necessary to remand the patient in custody while the report is being obtained, similar enquiries and, if possible, a similar case-conference should be held before a report is made to the court. Not more than one of the doctors signing the medical report should be a prison medical officer.

(*g*) The medical report should include advice, from the medical point of view, on the most suitable way of dealing with the patient. In some cases the recommendation might be that no special arrangements should be made apart from the usual process of the court. In others the doctors might recommend community care under the local authority's mental health or welfare services, or admission to hospital, on an informal basis or with powers of detention. In others they might suggest for the consideration of the court the possibility of a combination of a penal sentence or probation and hospital or community care, e.g. a fine and guardianship, or probation on condition that community or hospital care is accepted. They should also give their opinion on whether there is danger of further and serious offences which the court might consider would require a direction that the patient should not be set at large without the Home Secretary's consent. Special treatment within the prison system, as for instance in the special psychiatric prison mentioned in paragraph 344, should be included among the arrangements which might be considered for recommendation to the court, in so far as it is available. A recommendation for community care under the health or welfare services or admission to hospital should include or be accompanied by a statement from the appropriate officer of the local authority or a member of the medical staff of the particular hospital that he has agreed to accept the patient for the form of care, training or treatment recommended, if the court should so decide. If the reporting doctors consider admission to hospital desirable but there is no suitable vacancy, they should state this and should also make a recommendation for the most suitable alternative form of care (penal or otherwise) which is immediately available.

(*h*) It should be open to the court to reject a recommendation for care under the health or welfare services and to decide instead to use one of the forms of control or punishment provided under the ordinary criminal law. The court should not, however, prescribe a form of care under the health or welfare services which the doctors who have examined the patient do not consider suitable. For example, if the medical report has recommended community care but the court thinks it inappropriate that the offender should remain at large, the court should be able to discuss with the doctors whether admission to hospital might not be preferable to imprisonment, but admission to hospital should not take place without a medical acceptance of the patient by a doctor on the staff of the hospital.

(*i*) The court should then record any decisions relating to mental disorder (paragraphs 520 and 541) and dispose of the case under its normal powers and procedures (paragraph 521).

523. We have considered whether any other general rules should be laid down to govern the circumstances in which these special methods of disposal could be used by the courts. For instance, should they be used only after the commission of particular types of offence or of offences punishable with imprisonment for more than some minimum number of months? Or if such limitations are not necessary when hospital or community care is to be given on an informal basis, are they necessary to restrict the circumstances in which such care may be provided compulsorily with powers of detention or control? And should detention in hospital or control under guardianship have any maximum time limit, to be fixed either by law or by the court?

524. The introduction of such limitations has not been suggested when the offender is mentally ill or severely sub-normal. It is agreed that such patients should be treated as nearly as possible on the same footing as patients who have not been through the courts. Safeguards against the unnecessary use of compulsory powers in the first place and against their continuation for unreasonably long periods would be provided under our proposals by the procedure of the court as discussed in paragraphs 519–522, and by the procedures for the patient's admission to hospital or community care, the periods after which compulsory powers would expire if not renewed, the procedure for renewal and the powers of discharge as recommended in paragraphs 541–551. Are the same safeguards sufficient in the case of psychopathic patients, when added to the special restrictions recommended in Chapter 6, or are still further limitations necessary? We have given long and careful consideration to this question, and have been very conscious of the fact that though the compulsory powers we propose for psychopathic patients are much more restricted than those which apply to many of them at present under the Mental Deficiency Acts they will also apply under our proposals to some patients who at present are subject to compulsion only within the limits of the ordinary criminal law.

525. We have come to the conclusion that limitations of the sort mentioned in paragraph 523 are neither necessary nor desirable, and that it would be more effective to rely on the general restrictions already proposed and on procedures embodying the same sort of safeguards as we propose for other patients, both to ensure that compulsory powers are not used in the first instance unless their use is fully justified, and to ensure that they are not kept in force for unreasonably long periods. Let us recapitulate the safeguards which will apply to psychopathic patients under these proposals when compulsory powers are first used. First, psychopathic patients over the age of twenty-one will not be subject to special compulsory powers unless their behaviour is anti-social to the extent of constituting a criminal offence. When such an offence has been proved, the special powers will not apply unless there is a medical diagnosis of a pathological state, a mental disorder of the type covered by the term "psychopathic". When such a diagnosis has been made, psychopathic offenders will not be liable to hospital or community care against their own wishes unless there is a recommendation from two doctors that such care is necessary and available, and unless the court is also satisfied that ordinary penal measures alone are insufficient or inappropriate. If special treatment is then authorised, it may take the form of community care or treatment in hospital without powers of detention in conditions less restrictive than those which normal penal measures would impose. If it takes the form of control under guardianship or treatment in hospital with powers of detention, the patient will have an offender's usual right of appeal to a higher

court not only against his conviction but also against the method of disposal including the authorisation of detention in hospital or control under guardianship. He will also have a patient's usual right to approach immediately the various authorities who would have power to discharge him from hospital or community care, i.e. the medical superintendent or other doctor in charge of his treatment, the members of the hospital management committee or local health authority, the new Mental Health Review Tribunals and the Minister of Health. If the court decides that, for the protection of the public, the patient should not be set at large for a certain period without the Home Secretary's consent, the patient will not have direct access to a review tribunal or to the Minister of Health during that period but he will be able to apply direct to the Home Secretary who will be able to refer the case to a review tribunal for investigation if this seems desirable. And it will be possible for this restriction on discharge to be imposed only by a court of quarter sessions or assize if it is satisfied that there is real danger of the commission of further and serious offences if the patient is discharged prematurely.

526. **We do not think it desirable to introduce further restrictions on the use of these powers by reference to the type of offence which the patient has committed.** The nature and gravity of the offence will be relevant in many cases to the court's choice of the appropriate method of dealing with the offender, but not in all cases. Some patients who have committed minor offences, particularly young offenders, may be more suitably dealt with by community care from the local health authority or by a period of training in hospital than by ordinary penal measures only. On medical examination, a patient who has committed only a minor offence (such as a minor sexual offence) may be recognised as dangerous; we do not think it should be necessary to wait until such patients have committed a major offence when they can be clearly identified after the commission of a minor one. The same applies to young persons found to be beyond control and to some of those found to be in need of care and protection. The most important considerations in these circumstances are the medical diagnosis and prognosis, in which one individual action by the patient will not be conclusive and may not even be very important. A diagnosis of psychopathic personality is not likely to be made, especially in a patient of normal intelligence, except on the basis of a pattern of abnormal behaviour observed over some considerable period of time. As we mentioned in paragraphs 341, 345 and 348, however, the diagnosis and prognosis may in some cases be difficult. Although we are convinced (as we stated in paragraph 357) that when the point at issue is whether the patient should be compelled to enter hospital against his will no doctor will make such a diagnosis until he feels quite certain about it, the fact that there may in some cases be differences of medical opinion makes it necessary to consider whether special arrangements should be made to ensure that compulsory powers authorised on the strength of such a diagnosis are kept frequently under review. This question is linked with the question whether there should be a maximum time-limit on the duration of special compulsory powers over psychopathic patients, or whether unreasonable prolongation of such powers can be prevented by the same sort of safeguards which will apply to mentally ill and severely sub-normal patients. Several of our witnesses suggested that for psychopathic patients a maximum period should be fixed within the maximum sentence for the offence following which the patient's admission to hospital or guardianship takes place, stressing that the patient is under detention following a criminal offence for which a maximum penalty is fixed by law, within which maximum the court is normally required to name the precise period of detention to which each individual offender is to be subjected. Other witnesses suggested that the court should fix a certain maximum period for each patient's detention

in hospital in the first instance which might be extended later if the patient's condition makes this desirable.

527. It is very important that compulsory powers should not be kept in force for any patient when detention in hospital or control under guardianship can no longer be justified on the grounds set out in paragraph 317. There should therefore be ample opportunities for reviewing the medical diagnosis, the prospect of benefit to the patient from the treatment he is receiving, or (in regard to those detained in hospital) the need to segregate the patient from the community for the protection of the public. This applies to mentally ill and severely sub-normal patients no less than to psychopathic patients. Under the procedures for admission, review and discharge which we recommend for mentally ill and severely sub-normal patients, the compulsory powers will last for up to one year in the first place. Subject to special arrangements for patients whose discharge has been made subject to the Home Secretary's consent, the procedure will then be as follows. If the patient is not discharged before the end of one year, the justification for the continuation of compulsory powers will then have to be the subject of a special review by the medical superintendent of the hospital or other responsible doctor, who will be required to consider whether they are still necessary for the patient's own welfare or for the protection of others. If he does not consider continuation justified on these grounds, he will discharge the patient. If he recommends continuation, his recommendation, explaining his reasons, will be seen by members of the hospital management committee, who will be able to exercise their own power to discharge the patient; they will themselves interview the patient if either he or they themselves so desire. If the members of the committee do not discharge the patient on this occasion, he will be able to ask for a review by a Mental Health Review Tribunal, which will consist of medical and non-medical members with a legally qualified chairman, who will thoroughly review the case from all points of view. The tribunal will see the patient and hear his views and those of his relatives as well as those of the hospital authorities. It will be required to consider the justification for the continuation of compulsory powers in the light of the principles which we enunciated in paragraph 317. If the tribunal considers that, taking into account the diagnosis and prognosis at the time of its review, further compulsory care is no longer justified in the light of these principles, it will order the patient's discharge. If the medical superintendent, the members of the committee, and the tribunal agree that compulsory care is still justified, the superintendent's recommendation will constitute authority for its continuation for one more year, subject to discharge at any time by any of the persons holding a continuing power of discharge, who will include the Minister of Health as well as the hospital or local health authorities. (The patient's nearest relative, who will have power to discharge patients admitted under the main procedures will not, under our proposals in paragraph 548, be able to order the discharge of a patient admitted after court proceedings, though the relative as well as the patient will have access to the Mental Health Review Tribunals on specific occasions.) At the end of the second year, if the patient has not already been discharged, a similar review will take place; then again at the end of the fourth year, and thereafter at three-year intervals for as long as the patient remains in hospital. The longer the period since the patient's admission to hospital, the more stringent would be the standards by which expectation of benefit to the patient or need for protection of the public would have to be judged by the tribunals and others taking part in the review, and by those considering applications for discharge in the intervals between these formal reviews.

528. Quite apart from the fact that these arrangements provide far greater safeguards than do the arrangements made under the present Mental Deficiency Acts, they provide, in our view, the best possible practical system for keeping the justification for the use of compulsory powers under review by people who possess the knowledge and experience needed to form a sound independent opinion on the questions at issue. But we have considered whether yet further safeguards should be introduced for psychopathic patients, because of the difficulty of medical diagnosis and prognosis in some cases, and because comparison with the treatment of ordinary criminals under the ordinary criminal law is perhaps more significant in relation to adult psychopathic patients than in relation to other patients who may be subject to compulsory admission to hospital or guardianship even if the behaviour which reveals their need for care does not constitute a breach of the criminal law.

529. First there is the suggestion that a maximum period of detention in hospital should be fixed for psychopathic patients, after which they should be discharged whatever their mental condition then is. We are satisfied that it would be wrong for any absolute maximum period of detention to be prescribed for patients who are recognised at the time of court proceedings to be dangerous to other people, for whom the special procedure mentioned under (ii) (*b*) of paragraph 520 may be used. The need for the public to be protected from dangerous psychopathic patients for as long as their dangerous tendencies persist is no less great than the public's need to be protected from mentally ill patients who are dangerous. When such a patient enters hospital it is not possible to foretell what his response to treatment may be nor how long he may need to be segregated from the community. The best way to judge this is by periodic reviews such as those mentioned in paragraph 527. We consider it would be equally wrong to restrict the discretion of courts of quarter sessions and assize in naming the period during which the patient may not be set at large without the Home Secretary's consent. We do not consider that the court should be bound to relate this period to the term of imprisonment which might otherwise have been imposed, though in many cases it may think it appropriate to do so. The offence which finally leads to the patient's admission to hospital may be a minor one, but it may well have been preceded by others of a more serious character ; the period during which there should be this special safeguard against premature discharge should not necessarily be limited to the term of imprisonment which might have been imposed for that minor offence. Courts should have full discretion to do what they think fit in view of the patient's criminal and medical record and the medical assessment of his condition. In some cases the court may think it desirable to direct that the patient should not be set at large without the Home Secretary's consent for an indefinite period. But whatever period the court fixes for this special restriction on the power of discharge, we are satisfied that the compulsory powers should continue in force at the end of that period if they are still justified on the criteria enunciated in paragraph 317.

530. A stronger case can be made out for fixing some maximum period of detention for psychopathic patients who are not considered dangerous to this degree at the time when they appear in court. The protection of the public will not be a major consideration in these cases ; the reason for recommending treatment in hospital or community care from the local health or welfare authority, rather than ordinary penal measures, will be mainly that the patient is expected to respond better to one of these special forms of care. He ought to be discharged if he responds well to treatment. But he ought also to be discharged if it becomes clear that he is not likely

to respond to treatment, as this would mean that the main reason for compelling him to accept this treatment is no longer valid; unless his continued segregation from society has become necessary on other grounds, such as the protection of the public, there is no longer sufficient justification for compelling him to remain in hospital or under guardianship. The fact that many psychopathic patients may not respond to treatment, even though it was reasonable at the time of their admission to hope that they might, is an argument in favour of fixing a maximum period during which the chances of response to treatment may be tested, but at the end of which a psychopathic offender should regain his liberty just as other offenders are discharged at the end of their sentence however small their response to the reformative aspects of imprisonment. But for the reasons set out in the following paragraphs we do not consider that this should be done.

531. There are great practical difficulties in each of the various methods by which such a period might be fixed. The court might be required to specify the period for each individual patient, or a maximum period might be fixed by law. In either case the law might or might not require that the period should be related to the maximum possible sentence of imprisonment for the offence which is the occasion for applying the compulsory powers. The most flexible arrangement would be for a period to be specified for each patient individually based on an estimate of how long his treatment may take if he responds well, or how long it will take to tell that he is not likely to derive any substantial benefit from it—though these two periods might be very different from each other. But the doctors will be given a difficult enough task in making their diagnosis and advising the courts on the form of care or punishment to which they think the individual patient is most likely to respond. In most cases we do not think that they would be able at that stage to make any precise estimate of the length of time which treatment might take and we think it would be unreasonable to ask them to try. It would be still less appropriate for the court itself to try to make such an estimate. If the court were to choose a period related to the term of imprisonment which might otherwise have been imposed, it would be to some extent negativing its own decision that normal penal measures are insufficient or inappropriate and that because of this the patient should be given some form of medical treatment under the hospital or community health services. It would not be suitable to impose on this medical treatment the time limit which is considered proper for the duration of penal treatment. Medical treatment might need a longer or a shorter period.

532. If a maximum period had to be fixed at this stage, we are convinced that it would have to be fixed by law. It might then be a single period which would apply in all cases, or it might be identical with the maximum period of imprisonment under the ordinary criminal law for the offence which is the occasion for using these special powers. Either of these methods would lead to serious anomalies and might increase rather than decrease the danger of detaining a patient longer than is justifiable. If a single period were to be chosen which would cover the reasonable requirements of some patients it would appear ludicrously long in the case of others. For instance, it may be possible for the doctors to judge whether or not there are any prospects of benefit from treatment for some patients after observing them for a few weeks. But for other patients, especially feebleminded psychopaths, a period of several years may be needed for treatment to be effective. It might be a long time before the doctors could judge whether the prospect of benefit to such a patient should be abandoned. And if they decide that the patient is still likely to benefit from further treatment, an even longer period may be necessary. A maximum period of three years or five years

would be quite insufficient for many feebleminded psychopaths, especially as this would have to cover any period on trial or under guardianship after leaving hospital which might be necessary for full rehabilitation. But such a period would give an entirely false impression of the length of time for which some other patients might need to remain in hospital. There is always a danger that any maximum period may come to be regarded as the period for which hospitals would be expected to detain the patient, however much it is emphasised that it is to be a maximum, not a minimum, period. If it is argued in reply to this that during this period the safeguards which apply to other patients—procedures for review and powers of discharge—would apply to psychopathic patients as well as to others, there seems no good reason why full reliance should not be placed on these safeguards without fixing such a maximum period.

533. These objections would also apply if the maximum period were not the same for all patients, but were the same as the maximum period of imprisonment for the offence committed. There would also then be the additional objection that the maximum term of imprisonment for some offences is out of all proportion to present estimates of their gravity and far exceeds the length of sentence which any court nowadays would impose. For instance, some forms of larceny carry a maximum sentence of imprisonment for life. If the maximum period of detention in hospital for a psychopathic patient were to be fixed by law as this maximum possible period of imprisonment, it would not in fact bring his treatment into line with that of other offenders, and the distinctions it would draw between one patient and another would be irrelevant both to their mental condition and, in some cases, to the seriousness of their behaviour.

534. Another consideration is that after admission to hospital some psychopathic patients may reveal dangerous tendencies which if apparent at the time they appeared in court would certainly have been accepted as justifying the special restriction on discharge and the accompanying power to detain the patient as long as his dangerous tendencies persist. For the protection of the public these patients may need to be detained for just as long as those whose dangerous tendencies are recognised at the time of the court proceedings.

535. **All these considerations lead us to the conclusion that restrictions imposed at the time of the court proceedings do not provide a suitable method of preventing unreasonable extension of the compulsory powers, and that it is better to rely on procedures for review which will allow the patient's progress under treatment to be taken into account.**

536. The suggestion of some of our witnesses that the court should authorise a limited period in the first place but should be able to extend this if asked to do so amounts in effect to a recommendation that the need to continue the compulsory powers should be reviewed at certain intervals by the court which originally authorised their use. This would, in our opinion, give the courts a function which they cannot properly undertake. Their decision in the first instance is related to the disposal of an offender who has been convicted before them of a certain criminal offence. The question of medical treatment enters into their decision because the offender is considered mentally abnormal, and in that regard the court is required to receive medical advice. The court's authority in relation to the patient derives from the commission of the offence, and its duty is to decide whether ordinary penal measures alone are sufficient and appropriate; if they are not, the court agrees to the provision of medical treatment outside the normal penal system. When the need to continue the use of compulsory powers in order to provide

further treatment is reviewed later in the light of the patient's progress in hospital, the review should be undertaken by persons who can review the need for treatment from all points of view. In the first place this review is the responsibility of the medical staff and the committee managing the hospital or the local health authority, but it should also be possible to have the case reviewed by an independent body. It is to perform this very function that we have recommended the establishment of Mental Health Review Tribunals, which would have a legally qualified chairman and which would include medical as well as non-medical members, and which would be required to have regard to the principles enunciated in paragraph 317. **The Mental Health Review Tribunals are, in our view, the appropriate bodies to conduct the review of the need for the continuance of compulsory powers in the light of the patient's progress, and they should be used to review the detention of psychopathic patients as well as of other patients.**

537. **But because of the special considerations which apply to adult psychopathic patients admitted to hospital or guardianship following court proceedings, we recommend that arrangements should be made to ensure that the case of each such patient is reviewed by a Mental Health Review Tribunal more often than will be usual for other patients.** This could be achieved by a modification of the normal procedure for the expiry and renewal of compulsory powers. If the medical superintendent or other responsible medical officer recommends continuation when the powers would otherwise expire, and the members of the hospital management committee or local health authority after considering his recommendation do not exercise their power to discharge the patient, the recommendation should in all cases be referred to a Mental Health Review Tribunal, instead of leaving the patient to take the initiative in lodging an application. Moreover, such a review should take place every year for adult psychopathic patients, though for other patients after the first two years there would be a two-year interval and thereafter three-year intervals between reviews. Recommendations to this effect are included in paragraphs 545–547.

(2) Procedures to provide patient with hospital or community care

(i) When admission to hospital or community care is arranged informally

538. In many cases it will be possible to provide community or hospital care without compulsory powers, apart from the element of coercion contained in any probation or supervision order made by the court.

539. If a probation order is made in these circumstances the maximum of twelve months treatment which can be made a condition of probation at present under Section 4 of the Criminal Justice Act, 1948, should not apply. It should be possible for the condition that the patient should receive hospital or community care to have effect during the whole period of the probation order. It would be advisable for courts to avoid naming any fixed period for treatment, because of the difficulty of judging in advance how long treatment will take. If a probation order is made with a condition that the patient accepts community care from the local authority, care and supervision should normally be provided by officers of the mental health or welfare department of the local authority. We recommend that Section 3 of the Criminal Justice Act, 1948, should be amended to allow probation orders to be made putting the offender under the supervision of an officer of the local authority instead of a probation officer in these circumstances, just as under the Children and Young Persons Acts a supervision order can place a child or young person under the supervision of any person appointed by the court.

540. If hospital care is recommended and informal admission is considered suitable, if the court thinks fit it should be able to authorise another person to act instead of the nearest relative in regard to the patient's discharge from hospital. This should be possible on the court's own initiative or on application from a relative or mental welfare officer. The arrangements recommended in paragraphs 501–504 should then apply.

(ii) **When the patient is to be subject to detention in hospital or control under guardianship**

541. When it is necessary to authorise the patient's compulsory admission to and detention in hospital or control under guardianship, the court should not make an "order" for the patient's admission. Admission should take place with the knowledge and approval of the court but without an order. The basis is the court's finding that because of the person's mental disorder, normal methods of disposal alone are insufficient or inappropriate, and that he requires some specified medical or social care which a particular hospital or local authority is able and willing to provide. This finding should be entered on the records of the court. Any direction that the patient is not to be set at large within a certain period without the Home Secretary's consent should also be recorded. If such a direction is considered necessary in a case tried in a magistrates court, the magistrates court should record a finding as to the need for compulsory admission to hospital and refer the case to quarter sessions with a request for such a direction to be made, (the patient being admitted to hospital in the meantime). The court records would also show the offence, the conviction and the disposal of the case. Hence a copy of the entry in the record would give an exact and authoritative account of what occurred.

542. An application for admission to hospital or guardianship with two medical recommendations should then be made in accordance with the main procedure for admission on a specific recommendation, as described in paragraphs 401–419. It will already have been ascertained before the medical report is sent to the court that the local authority or hospital concerned is willing to accept the patient, and it should be possible for his admission to be arranged without delay. The application in most cases would probably be made by a mental welfare officer. The medical recommendations would usually be given by the doctors who had sent the medical report to the court; the application and recommendations might be prepared at the same time as the report to the court.

543. A copy of the court's finding as to the need for admission to hospital or guardianship and any direction that the patient shall not be set at large without the Home Secretary's consent should be attached to the application and kept by the hospital or local health authority with the other admission documents. In the case of a psychopathic patient over the age of twenty-one, the court's finding would provide authority for the use of compulsory powers to which the patient would not otherwise be liable; in the case of a psychopathic patient under the age of twenty-one, it would prevent the compulsory powers lapsing automatically when he reaches the age of twenty-five. In the case of psychopathic, severely subnormal or mentally ill patients, it would indicate to the hospital or local health authority that the relative has no power to order the patient's discharge but instead has access to a Mental Health Review Tribunal not more often than once a year (see paragraph 548).

544. It should be permissible for a patient admitted to hospital following court proceedings to be admitted to any suitable hospital which has accepted him for treatment. It will probably be considered desirable for patients

who are considered dangerous to be treated in special hospitals so that other hospitals need not observe too many security restrictions, but there should be no rigid designation of hospitals which would prevent the transfer of patients from one type of hospital to another according to changes in their mental condition and behaviour and the development of special forms of treatment in particular hospitals. The present administrative arrangements whereby patients can be transferred into or out of Rampton and Moss Side Hospitals as their behaviour requires provide a good pattern to follow.

545. For severely sub-normal and mentally ill patients and psychopathic patients admitted under the age of twenty-one who have not yet reached the age of twenty-five, the compulsory powers should expire and be subject to renewal at the same periods as for patients admitted under the main procedures (as described in paragraphs 431–436), subject to the modifications described in paragraphs 547–550.

546. For psychopathic patients admitted over the age of twenty-one and for those admitted under that age who have passed the age of twenty-five, the compulsory powers should expire if not renewed at yearly intervals, except during any period in which discharge is subject to the Home Secretary's consent. The recommendation for renewal should be submitted not only to members of the hospital management committee or local health authority but also in all cases to a Mental Health Review Tribunal.

547. If a court of quarter sessions or assize directs that the patient shall not be set at large within a certain period without the Home Secretary's consent, the medical superintendent and members of the hospital management committee should not have power to order discharge during the period fixed by the court, but they should be able at any time to send a recommendation for discharge to the Home Secretary (as in the case of Broadmoor patients at present). During such a period, the Minister of Health's power of discharge would be merged in that of the Home Secretary. If the medical superintendent recommends a patient's discharge during such a period and the Home Secretary considers it premature for the patient to be set at large, from the point of view of protection of the public, suitable arrangements should be made for the patient's custody either in a special hospital or in a penal institution. At the end of the period named by the court the medical superintendent and members of the hospital management committee of the hospital in which the patient is detained and the Minister of Health should assume their normal powers of discharge.

548. The patient's nearest relative should not have power to order the discharge of any patient admitted following court proceedings, whether or not discharge is subject to the Home Secretary's consent for a certain period. The relative should be able at any time to ask the medical superintendent or members of the hospital management committee (or medical officer of health or members of the local health authority) or Minister of Health to order discharge or (during any period of restriction on discharge fixed by the court) to recommend discharge to the Home Secretary. In addition, he should have direct access to a Mental Health Review Tribunal not more often than once a year, except during any period in which discharge is subject to the Home Secretary's consent; during such a period, neither the patient nor his relative should have the right to demand a review by a review tribunal, but they should be able to apply for discharge direct to the Home Secretary as well as to the other authorities already mentioned, and the Home Secretary should be able to refer the case to a review tribunal for investigation if he thinks fit. As with other patients whose

nearest relative has no power of discharge, tribunals should not be called on to consider the case of any one patient more often than once a year (see paragraph 506).

549. During any period in which the patient may not be set at large without the Home Secretary's consent the need for the continuation of compulsory powers should be reviewed by the medical superintendent and members of the hospital management committee at the same intervals as for other patients, but if as the result of such a review they consider that the continuation of compulsory powers is not necessary, they should send a recommendation to this effect to the Home Secretary instead of themselves discharging the patient or terminating the compulsory powers with his agreement or allowing them to lapse. The compulsory powers should not lapse during such a period for any reason, nor be terminated by agreement with the patient except with the Home Secretary's consent.

550. The power to compel the patient to return to the hospital after being absent without leave should continue until the end of any period during which a court has directed that he shall not be set at large without the Home Secretary's consent. This should apply even if it has not been possible (because of the patient's absence) to conduct the usual periodical review of the need to keep the compulsory powers in force; in such circumstances the powers should not expire when otherwise due to do so.

551. Subject to these modifications, the procedures should be the same as the main procedures described in paragraphs 401–490.

(3) **Right of appeal**

552. In all cases the patient should have a right of appeal to the next higher court against his conviction and against the sentence or other method of disposal of the case under the court's normal powers and against the issue of a direction that discharge shall be subject to the Home Secretary's consent. A successful appeal against conviction should not invalidate the compulsory admission to hospital or guardianship of a mentally ill or severely sub-normal patient or of a psychopathic patient under the age of twenty-one. It should, however, result in the nearest relative assuming the power to order discharge as when patients are admitted without court proceedings, and in the case of a psychopathic patient the compulsory powers should lapse at age twenty-five if he has not by then already been discharged. A successful appeal against conviction would invalidate the use of compulsory powers in relation to a psychopathic patient over the age of twenty-one and should result in his immediate discharge from hospital or community care unless he is then willing to receive it on an informal basis.

Transfer from prison or other penal institution or from approved school

553. Our recommendations under this heading apply mainly to severely sub-normal and psychopathic patients, as most mentally ill patients transferred to hospital from prison become Broadmoor patients and are outside our terms of reference (but see paragraph 878 in Chapter 13). It should be possible to send children or young persons from approved schools to a psychiatric hospital without formality or under the main procedures, the headmaster or headmistress of the approved school having authority to act in place of the nearest relative until the approved school order expires, with the possibility of an application to a magistrates court for some other person to continue to act in place of the nearest relative thereafter (see paragraph 493). But if it is thought probable that the patient may need a long period

of treatment and is unlikely to return to the approved school it should be possible to authorise a transfer as described below; the compulsory powers over the patient would not then lapse at the end of the approved school order nor when a psychopathic patient reaches the age of twenty-five but could continue as long as is found necessary in each individual case. It should be possible for such a transfer to be made either at the time of admission to hospital or after a patient has been admitted informally or under the main procedures if the approved school order has not yet expired.

554. When the Home Secretary authorises the transfer to hospital or guardianship of offenders or children or young persons who are in prison, borstal or other penal institution or subject to an approved school order, (see paragraph 356 in Chapter 6), he should use the same general criteria as those recommended for court cases. He should have power to stipulate that the patient should not be set at large without his consent during the remainder of the term of imprisonment or detention or of the approved school order[11] to which the patient is subject. His powers in this respect should be flexible so that he can adapt them to individual cases in the light of the individual patient's past record. In some cases we would expect no such stipulation to be made; in others reference to the Home Secretary might be required only if the patient is to be completely discharged from control; in other cases it might be required also for a transfer to guardianship or even for a temporary absence from hospital. Any such stipulation should be incorporated in the authority for the transfer.

555. The application for admission to hospital or guardianship should be signed by the prison governor, headmaster of the approved school or other person authorised by the Home Secretary. It should be accompanied by two medical recommendations and a medical acceptance, as in court cases. Not more than one recommendation should be given by a prison medical officer. We should expect the normal practice to be for one of the recommendations to be given by a prison medical officer and the other by a doctor on the staff of the receiving hospital or local health authority who would also give the medical acceptance. The application should also be accompanied by a statement containing the Home Secretary's authority for the particular transfer in question.

556. All other procedures for admission, review and discharge should be the same as for patients admitted to hospital or guardianship immediately following court proceedings. The modifications which are to apply when a court has directed that the patient shall not be set at large without the Home Secretary's consent should apply when the Home Secretary has made a similar stipulation when authorising transfer.

[11] Including the period of supervision following the expiration of an approved school order (Section 74, Children and Young Persons Act, 1933).

CHAPTER 8

TRANSITIONAL ARRANGEMENTS FOR PRESENT PATIENTS

General

557. If the new system recommended in Chapters 5, 6 and 7 is accepted and passed into law, the new procedures would apply when patients are received into hospital or community care after the new legislation comes into force. **The principles of the new system should also be applied as far as possible to patients already under care at that time, who will have been admitted under the procedures contained in the present law. In some cases it would be impossible or inappropriate to apply the new system in full to these patients, and it will be necessary for the new legislation to include some special provisions to meet their special circumstances.** In this chapter we describe what special provisions we think will be necessary, and what other steps should be taken to apply as much as possible of the new system to existing patients.

Before new legislation

558. Most of our recommendations in Part V of our report for the development of various forms of community care can be carried out under existing powers and will not need new legislation. The development of these services can only be gradual, but we hope that a start will be made as soon as possible, without waiting for legislation on our other recommendations. This is not only desirable in itself, but it will also make it easier to deal with some of the patients at present in hospital who will not be liable to be detained there under our proposed new system, but who may need community care if they are unwilling to stay in hospital when the new system comes into force.

559. We also hope that it will be found possible to start receiving patients informally in the present mental deficiency hospitals and certified institutions without new legislation (see paragraphs 308–311). If this can be done, it should also be possible to terminate the compulsory powers over many patients already in these hospitals who can be suitably cared for without such powers. For this purpose, the medical staff should be asked to review the case of every patient, taking into account the attitude of the patient's relatives and the home circumstances as well as the attitude of the patient. In all cases in which they consider compulsory powers can be dispensed with, they should send the Board of Control a recommendation for the discharge of the order. We hope that this will result in the de-certification of most of the severely sub-normal patients and of a considerable number of feebleminded psychopaths, particularly those whose behaviour is inadequate rather than aggressive. We hope that a good many patients and relatives who have been opposed to the patient's detention as a certified defective will agree to the provision of care and training on a voluntary basis. Medical superintendents should not be too cautious in recommending the de-certification of feebleminded patients; they should bear in mind that if afterwards the patient or his relatives insist on his leaving the hospital prematurely the hospital will be free to re-admit the patient without formality if he finds he cannot get on in life outside. In fact in some cases the best way of obtaining the co-operation of the patient and his relatives may be to let the patient leave with a promise of re-admission when he wants to return. If any patients who are discharged get into really serious difficulties later and are unwilling to return they could be re-admitted compulsorily, by a new order under the present law or through the new procedures after the passing of the new legislation.

560. In paragraph 456 we recommended that when patients admitted under the new compulsory procedures later become content to remain and the compulsory powers are terminated without the patient being discharged from hospital the patient should sign a statement of willingness to remain. We do not think this need apply when patients admitted under the present Mental Deficiency Acts are de-certified but remain in hospital, as many of them were not positively unwilling to be admitted in the first place. There would be no objection to patients who can give a valid signature being asked to sign a statement, if this is considered desirable; such a statement would of course not give the hospital power to detain the patient if he later wished to leave. In the case of other patients, it should be sufficient for the Board of Control's authority for the discharge of the order to be put with the case papers and for the patient's nearest relative to be informed; the date of the notification to the relative should be authenticated by or on behalf of the hospital management committee.

561. There should be a similar review of patients in certified institutions and under guardianship. But in view of the fact that community care can already be provided without powers of guardianship, it is unlikely that there will be many cases of guardianship in which the compulsory powers will be considered unnecessary.

After new legislation

562. Other steps to apply the proposed new system to existing patients could not be taken until the new legislation has been passed. The arrangements which we then envisage would be as described in the following paragraphs. For the sake of brevity we describe them as they would apply to patients in national health service hospitals; the same principles should apply to patients in other institutions or under guardianship or in single care (see also Chapter 12).

(i) Patients admitted under the Lunacy and Mental Treatment Acts

563. There should be little difficulty in applying the new procedures to all these patients. Voluntary patients could remain as long as necessary on an informal basis, no longer being under an obligation to give seventy-two hours written notice of intention to leave. Some temporary and certified patients might also suitably remain without powers of detention, particularly those who were not unwilling to enter hospital in the first place but who were considered incapable of signing a voluntary application form; those who are now capable of signing a statement of willingness to remain on an informal basis should be asked to do so; for others, a statement that the compulsory powers have been terminated should be placed with the case papers and the nearest relative should be informed in writing. The date of these documents should be authenticated. In those cases where compulsory powers are still considered necessary for the patient's own welfare or for the protection of others, the new legislation should provide for the new powers of discharge, renewal procedure and all other appropriate parts of the new "main procedures" to apply as from the date when the new legislation comes into force.

(ii) Patients admitted under the Mental Deficiency Acts

564. If all patients at present in hospital or under guardianship are reviewed before the new legislation comes into operation and compulsory powers terminated in all suitable cases, as suggested in paragraphs 559–561, those remaining under order when the new system comes into force should be mainly those who, in the opinion of the medical staff, need to remain under care but will not do so unless they remain subject to compulsory powers.

Any of these who are now classified as idiots or imbeciles and some now classified as feebleminded will fall into our severely sub-normal group and will still be subject to compulsory powers at any age under our proposed new system, if this is necessary for their own welfare or for the protection of others. Among those now classified as feebleminded or moral defectives there may be some who are also certifiable as of unsound mind under the present law and who under our proposals could be compelled to remain in hospital as mentally ill patients (without necessarily being moved to a different hospital) if this is considered necessary for their own welfare or for the protection of others. The rest of those now classified as feebleminded or moral defectives will fall into our psychopathic group.

565. It should be possible to apply most parts of the new procedures, as from the date when the new legislation comes into force, to patients of any age who would be classified in future as severely sub-normal or mentally ill and to patients classified as psychopathic who were admitted following court proceedings or on transfer from prison or approved school. Special consideration must be given, however, to (*a*) the position of adult psychopathic patients whose admission did not follow court proceedings or transfer from prison or approved school, (*b*) the position of patients on licence, and (*c*) the relative's powers of discharge in regard to patients admitted under the present Acts over whom it is necessary to retain compulsory powers.

(a) **Psychopathic patients over the age of twenty-five or admitted over the age of twenty-one, other than those admitted on orders made under Sections 8 or 9 of the 1913 Act**

566. It is fundamental to our proposed new system that in future as many psychopathic patients as possible should receive treatment or training while they are young. For this reason we have proposed that there should be much wider compulsory powers over those whom it is proposed to admit to hospital before they are twenty-one than over older patients. Patients would not be liable to compulsory admission over that age unless they are convicted of a criminal offence and ordinary penal measures are considered insufficient or inappropriate. For patients admitted under that age compulsory powers would lapse at the age of twenty-five unless they had been admitted following court proceedings or on transfer from prison or approved school.

567. When new legislation comes into force a considerable number of the patients in the present mental deficiency hospitals are likely to be psychopathic patients who were not admitted until after the age of twenty-one, or who were admitted under that age but will have passed the age of twenty-five. We hope that many of these patients will be content to remain in hospital without compulsory powers in future. It is however only natural to expect that the fact that they have been compulsorily detained in the past may make some wish to leave just for the sake of leaving, even if they would be far better off in every way if they agreed to stay on a voluntary basis. Among these may be some patients who would be content to live in residential homes outside the hospitals and could quite suitably be discharged to such homes if they existed. The extent to which such homes can be provided in the interval before new legislation comes into force may therefore affect the number who may safely be allowed to leave the hospitals between now and then. In other cases, it may be desirable to let the patient leave, even if he has no really suitable home to go to, as we suggested in paragraph 559 ; some such patients may manage outside better than is expected ; others may wish to come back without compulsion when they learn from experience

that they would be happier in hospital, just as many patients at present return from licence at their own request. But there will be a fairly large number who will not remain unless they are subject to compulsion and whom the medical staff may consider quite unfit to leave, and it will be necessary to decide how the principles of our new system should be applied in order to distinguish those who should continue to be subject to compulsion from those who should not.

568. Some of these patients will not have been admitted to hospital until a fairly late age and will so have missed the opportunity for training while young. Some may have been so long in hospital that they have become completely institutionalised and quite unfit for life outside, and may yet not be willing to remain without compulsion ; not all of these could properly be classified as severely sub-normal, though in their present condition they would in fact be incapable of leading an independent life. Some will have been convicted of criminal offences before admission but will have been admitted under an order made under Section 6 of the 1913 Act, the court having decided to proceed under Section 8(1)(*a*) rather than to make an order under Section 8(1)(*b*). Others of these patients will be known to have committed acts, before or since admission to hospital, which might have been made the subject of a criminal charge but were not because the patient was already under order or was "subject to be dealt with" under the Mental Deficiency Acts on other grounds. Others will not be known to have broken the criminal law. In each of these categories some patients will have been in hospital only a short time, others for many years. We do not think it would be right to say that these patients should simply be sorted into those who had been convicted of a criminal offence before admission and those who had not, and that when the new system comes into force none of the latter should be detained in hospital any longer. If that were done and that only, criteria which we have recommended should apply in future to people who have been living in the ordinary world and are accustomed to its standards would be applied to some patients who have been living for many years in a sheltered and artificial community ; some, but only some, parts of a system which is based on the assumption that most of those who need training will be given it before they are twenty-five would be applied to patients who did not receive training at that age. We wish the general spirit of our new system to be applied to these present patients, but that cannot be done by trying to apply the letter of the new law. We recommend special arrangements on the following lines.

569. The new legislation should allow existing compulsory powers to continue in relation to these psychopathic patients (*a*) if the patient is known to have been admitted following court proceedings and (*b*) if his admission did not follow court proceedings but the medical superintendent[1] considers that he would be dangerous to others or liable to be exposed to danger or serious exploitation from others if discharged, or that he is so institutionalised that he is incapable of living on his own and that there is no suitable institution able to receive him in which he would be willing to remain without compulsion. In deciding whether these conditions apply the medical superintendent should take into account not only the patient's behaviour before admission to hospital but also his behaviour since admission, his present mental condition and prognosis and the circumstances in which he would be placed if discharged. In cases in which the medical superintendent considers that the compulsory powers should continue, he should state the reasons in a special recommendation, which should be considered by members of the hospital management committee and by a Mental Health Review

[1] The circumstances described under (*b*) would not apply to patients under guardianship.

Tribunal following the procedure recommended in paragraph 546 in Chapter 7 for the review of compulsory powers over adult psychopathic patients. In considering these special recommendations the members of the management committees and the review tribunals should have regard not only to the general principles enunciated in paragraph 317 in Chapter 6, but also to the special criteria mentioned at (*a*) and (*b*) at the beginning of the present paragraph.

(b) **Patients on licence**

570. Under our proposed new system, when a patient has been absent from hospital for six months the compulsory powers lapse unless a transfer to another hospital or to guardianship is arranged. When the new legislation comes into force some patients will have already been over six months on licence. The new legislation should allow those living outside hospital to be transferred to the guardianship of the local health authority at the time when the new system comes into force, if compulsory powers are still needed at all.

(c) **Relative's power of discharge**

571. The relatives of most patients detained under the present Mental Deficiency Acts have no power to order the patient's discharge. Under our proposed new system, the nearest relative will have the power of discharge in most cases except when admission follows court proceedings or transfer from prison or approved school, but it will be possible for this power to be withheld on the authority of a magistrates court given at the time of the patient's admission. In applying the new system to existing patients it will be necessary to distinguish those whose relatives should be given the power of discharge when the new system comes into force and those from whose relatives it should continue to be withheld. We are discussing here only those patients over whom compulsory powers are retained after the new legislation comes into force ; the arrangements for the discharge of other patients would be as recommended in paragraphs 301–305 in Chapter 5.

572. It is clear that the power of discharge should be given to the relatives of patients originally admitted under Section 3 of the 1913 Act. Equally clearly, the power of discharge should continue to be withheld from the relatives of patients admitted under Section 6 whose consent was found to be unreasonably withheld when the admission order was made. It should also be withheld from the relatives of patients admitted under Sections 8 or 9 ; the relatives of these patients would not have power to order the patient's discharge under our proposals for the future, but instead would have special access to Mental Health Review Tribunals not more often than once a year except during any period in which discharge is subject to the Home Secretary's consent. The discharge of patients admitted under Section 9 should be subject to such consent after the new legislation comes into force until the end of the term of imprisonment or detention originally imposed, and relatives should not have direct access to review tribunals during that period. For patients admitted on orders made under Section 8, relatives should assume the right of access to the review tribunals as soon as the new legislation comes into operation.

573. It remains to consider what arrangements should be made in regard to patients who were admitted under Section 6 of the 1913 Act and whose parents or guardians gave consent to the making of the original order ; some of these patients will have been admitted following criminal proceedings, the petition for an order having been presented on the direction of a court under Secton 8(i)(*a*). These patients will include some severely

sub-normal patients and a few who may be regarded as mentally ill, but the great majority will be psychopathic, because the majority of the severely sub-normal should be able to receive care in future without the use of compulsory powers. As the majority of the psychopathic patients will be covered by the arrangements recommended in paragraph 569 for special review by the hospital authorities and review tribunals, we think it would be inappropriate for their relatives to have power to order their discharge, and that it would be more suitable to give the nearest relative the right to apply to a review tribunal not more often than once a year.

574. We therefore recommend that, after as many patients as possible have been freed from compulsory powers, the nearest relatives of those who remain subject to such powers should hold the power of discharge if the patient was originally admitted under Section 3 of the 1913 Act. If the patient was admitted under Sections 6 or 8, the relative should not have power to order discharge but instead should have the right to apply to a review tribunal not more often than once a year. If the patient was admitted under Section 9, the relative's right to apply to a review tribunal should apply after the end of the period of imprisonment or approved school order originally imposed on the patient and during that period discharge should continue to be subject to the Home Secretary's consent.

575. The medical superintendent (or medical officer of health in cases of guardianship) and the members of the hospital management committee (or local health authority) and the Minister of Health should have the same powers of discharge as they would have in relation to patients admitted under the new procedures, and patients' relatives would also be able to apply to them at any time to discharge the patient.

RECOMMENDATIONS IN PART IV

(1) Community care and hospital care should be available without formal "ascertainment" or "certification" and without powers of compulsory control to all patients who need care and are not unwilling to receive it, whether or not they can express a positive wish to do so. (Paragraphs 287–294.)

(2) All hospitals should be free to admit patients without legal formality and without power to detain, whether or not they also admit patients who are to be subject to detention. It should be for the hospital boards and committees to decide which hospitals in the national health service are to receive patients with powers of detention; designation by the Minister of Health is not necessary. (Paragraphs 291 and 378–379.)

(3) Patients admitted to hospital without the use of compulsory powers should not be required to sign an application form nor to give a fixed period of notice of intention to leave. They should be free to leave the hospital against medical advice if they wish to do so unless exceptionally the responsible doctor thinks it necessary to use one of the compulsory procedures in order to obtain authority to detain them. In certain circumstances the wishes of the patient's relatives in regard to discharge should be treated as the wishes of the patient. (Paragraphs 296–305.)

(4) Whether or not the patient is subject to detention in hospital, letters written by him should not be censored except at the request of individual addressees, but the hospital authorities should have authority to withhold and return to the sender any incoming letter which it would harm the patient to receive. (Paragraphs 299 and 489.)

(5) Whether or not the patient is subject to detention while in hospital, there need be no statutory notification of his admission or discharge to any central or local authority. Discharge should be notified informally to the patient's relatives and general practitioner, and also to the local health authority if that authority is to provide after-care or helped to arrange the patient's original admission. The obligation to report deaths to the coroner should be limited (as in other hospitals) to circumstances in which an inquest or enquiry appears necessary. (Paragraphs 300–301 and 483–486.)

(6) Community care after leaving hospital should be available to all patients who require it, and should be given without the use or continuation of compulsory powers if possible, whether or not the patient has been subject to detention while in hospital. Patients should be encouraged to accept after-care from the local health authority; arrangements should usually be made before the patient leaves hospital. (Paragraphs 301 and 306. See also Part V.)

(7) Every effort should be made to persuade patients and their relatives to agree to the provision of care without compulsion. If such efforts fail, doctors and others should not be too hesitant to use the compulsory powers which the law provides, when this is necessary for the patient's own welfare or for the protection of others. (Paragraphs 315–316, 359–364 and 371.)

(8) Compulsory powers should be available for use in the following circumstances:—

(i) For mentally ill and severely sub-normal patients: to secure admission to hospital for up to twenty-eight days observation and preliminary treatment or to hospital or guardianship in the community for a longer period of care, if the use of compulsion is necessary for the patient's own welfare or for the protection of others. (Paragraphs 319–332.)

(ii) For psychopathic patients: (*a*) at any age, to secure admission to hospital for up to twenty-eight days observation and preliminary treatment; (*b*) before age 21, to secure admission to hospital or guardianship for a longer period of care, if the use of compulsion is necessary for the patient's own welfare or for the protection of others, the compulsory powers to expire at age 25 if the patient has not already been discharged, unless he is then subject to compulsory powers on other grounds or unless his admission originally followed court proceedings or transfer from a penal institution or approved school; (*c*) over age 21, to secure admission to hospital or guardianship following conviction for a criminal offence or on transfer from a penal institution, if the court or the Home Secretary respectively is satisfied that ordinary penal measures alone are insufficient or inappropriate. (Paragraphs 333–356.)

(9) The special procedures which would have to be followed whenever these compulsory powers are applied should ensure that they are used only when care cannot be provided without compulsion and when the patient requires medical or social care which a particular hospital or local authority is able and willing to provide, and that the powers are not kept in force longer than can be justified on the grounds of benefit to the patient or the protection of others. Our recommendations for new procedures for admission, expiry and renewal of compulsory powers, review, discharge and visits to patients are summarised in Appendix III. (Paragraphs 396–454, 487–488, 491–510 and 541–556.)

(10) These new procedures would replace the present "certification" procedures. The term "certification" should no longer be used. (Paragraphs 282–286 and 374–377.)

(11) The meaning of the terms " mentally ill ", " severely sub-normal " and " psychopathic ", as recommended in Part III, should be sufficiently clear to those who operate the compulsory procedures. Definitions in the law are unnecessary and undesirable even in connection with the use of compulsion. Borderline cases are bound to occur, but the use of compulsion can be more suitably controlled by procedures requiring a certain consensus of medical and non-medical opinion in each case than by any attempt at a legal definition of medical conditions. (Paragraphs 323–325 and 357–358.)

(12) After admission to hospital or community care there should be no distinctions of " status " based on whether patients were admitted informally or by the use of compulsory powers. (Paragraphs 384–386.)

(13) The documents required when compulsory powers are used to admit a patient to hospital or guardianship should be regarded as authority to admit and detain him, not as an order to do so. (Paragraphs 381–383.)

(14) Local health authorities as well as private individuals should be able to act as guardian. Local health authorities should have a duty to do so whenever guardianship is appropriate and cannot otherwise be arranged. (Paragraph 387.)

(15) Mentally disordered children and adults who come before the courts should be dealt with under the Children and Young Persons Acts or under ordinary criminal law unless such measures alone are insufficient or inappropriate. If mental disorder is suggested in evidence or suspected by the court, the court should obtain a full medical report from two doctors, one of whom should be experienced in the treatment or diagnosis of mental disorders, one of whom if possible should already know the patient and not more than one of whom should be a prison doctor. If, after considering such a report, the court decides that hospital or community care from the health or welfare services should be provided in place of or in addition to other measures, and if the patient has been accepted for care by a particular hospital or local authority, such care should be provided with the knowledge of the court but without an order by the court, the patient being admitted informally or under compulsory procedures as appropriate. The court should also dispose of the case under its normal powers and procedures. If the court considers there is a real danger of further and serious offences if the patient is discharged from hospital prematurely, courts of quarter sessions and assize should be able to direct that he should not be set at large within a certain period without the Home Secretary's consent. (Paragraphs 511–537.)

(16) It should be made possible for probation orders to be made putting a mentally disordered offender under the supervision of an officer of the local authority instead of a probation officer when desirable. (Paragraph 539.)

(17) Powers similar to those contained in Section 4 of the Criminal Justice Act, 1948, should be retained for dealing with offenders suffering from forms of mental illness which would not make them liable to compulsion under our main proposals. (Paragraphs 326 and 512.)

(18) The Home Secretary should have power to authorise the transfer of mentally disordered patients to hospital or guardianship from prisons or other penal institutions or from approved schools, and to stipulate that they should not be set at large without his consent during the period of detention originally imposed. (Paragraphs 553–556.)

(19) The justification for patients' compulsory detention in hospital or control under guardianship should be subject to review by Mental Health Review Tribunals on the occasions mentioned in Appendix III. These tribunals should be drawn from panels of medical and non-medical members

appointed in each hospital region by the Lord Chancellor after consultation with the Minister of Health. Each region should have a legally qualified chairman who would select the members to constitute tribunals to consider individual cases. Each tribunal should include both medical and non-medical members, the chairman being legally qualified. The tribunals should be able to make their own investigations as well as receiving the opinions of hospital and local authority staff, the patient and his relatives or friends. The patient or his relative should be able to ask for a public hearing. There should be a right of appeal from the tribunal's decision, on points of law only, to the High Court by case stated. (Paragraphs 438–454.)

(20) If a patient admitted to hospital under compulsory powers later becomes willing to remain to complete his treatment, it should be possible to terminate the compulsory powers if the patient signs an appropriate statement. (Paragraphs 455–457 and 549.)

(21) It should be possible to transfer patients from one hospital to another or between hospital and guardianship, without breaking the compulsory powers, by a new procedure. Transfer between hospitals in England, Wales, Scotland and Northern Ireland should also be permissible. (Paragraphs 463–468.)

(22) It should also be possible for patients to leave hospital with medical approval without the compulsory powers being terminated or transferred. At any time within six months after leaving hospital it should be possible to re-admit or recall the patient without going through the procedure for a fresh admission or to arrange a transfer as recommended above. After six months absence from hospital the compulsory powers should lapse unless a transfer is arranged. Patients who require community care for more than six months after leaving hospital should be transferred to guardianship if community care cannot be provided without compulsory powers. (Paragraphs 469–477.)

(23) Patients who are subject to compulsory powers and who leave hospital without medical approval, or who fail to return when recalled, should be liable to compulsory re-admission within a period of twenty-eight days. Recall should be possible even if the patient has crossed into Scotland or Northern Ireland. The powers should lapse at the end of twenty-eight days. We recommend exceptions for patients whose discharge is subject to the Home Secretary's consent and for all psychopathic patients over the age of twenty-one. (Paragraphs 478–482.)

(24) The substance of Section 16 of the Mental Treatment Act, 1930, should be re-enacted and should apply to proceedings arising from any action, report or recommendation made in connection with the new compulsory procedures. (Paragraph 490.)

(25) We see nothing in the present Mental Deficiency Acts to prevent informal admission to mental deficiency hospitals and certified institutions without powers of detention. Subject to legal advice on this point, informal admission should start as soon as possible, and patients already admitted under the present compulsory procedures should be reviewed with a view to terminating compulsory powers wherever possible. (Paragraphs 308–311 and 559–561.)

(26) Similar action in regard to patients admitted to hospital or single care under the Lunacy and Mental Treatment Acts must await new legislation. All those admitted as voluntary patients and some temporary and certified patients should then be able to remain on an informal basis. (Paragraphs 307 and 563.)

(27) In those cases in which compulsory powers are still considered necessary for patients already admitted to hospital or community care under the Lunacy and Mental Treatment Acts or Mental Deficiency Acts, the appropriate parts of the new procedures should apply as from the date when the new legislation comes into force, subject to the three following recommendations. (Paragraphs 563–565.)

(28) It should be permissible to continue the compulsory powers over adult psychopathic patients already admitted under the Mental Deficiency Acts (*a*) if the patient is known to have been admitted following court proceedings and (*b*) if his admission did not follow court proceedings but if he would be dangerous to others or liable to be exposed to danger or serious exploitation by others if discharged or if he is so institutionalised that he is incapable of living on his own and there is no suitable institution able to receive him in which he is willing to live without compulsion. (Paragraphs 566–569.)

(29) It should be permissible to transfer to guardianship any patients who have been on licence under the Mental Deficiency Acts for over six months when the new legislation comes into force. (Paragraph 570.)

(30) Power of discharge should continue to be withheld from the nearest relatives of patients admitted under Sections 6, 8 or 9 of the Mental Deficiency Act, 1913, who continue to be subject to compulsory powers when the new system is introduced. (Paragraphs 571–575.)

PART V

THE LOCAL ADMINISTRATION OF THE MENTAL HEALTH SERVICES

CHAPTER 9

RELATIONS BETWEEN THE MENTAL HEALTH SERVICES AND OTHER SOCIAL SERVICES

The growth of local and central government and the movement for separate services for mental patients during the nineteenth and early twentieth centuries

576. When a Select Committee of the House of Commons reported in 1763 that there should be legislation to regulate the control of private madhouses, the system of local and central government which we know today did not exist. In the eighteenth century the justices of the peace, the parish officers and vestries and the municipal corporations were responsible locally for keeping law and order and administering Acts of Parliament which affected the lives of ordinary people, including the administration of the poor law. Centrally, there were the King's Ministers, assisted by small staffs, among whom the Lord Chancellor and the Home Secretary had general responsibility for the administration of justice and the keeping of law and order within the United Kingdom. But there was no close association in regard to local administration between the departments of state and the justices and parish officers such as exists today between government departments and local authorities.

577. The history of social reform in the eighteenth, nineteenth and twentieth centuries is also the history of the search for effective forms of local and central government to carry out those reforms and to administer new public services. In the eighteenth and early nineteenth centuries some of the new social legislation piled new administrative responsibilities on existing authorities; other Acts created new local authorities to administer special services and new central authorities to supervise the work done locally. By the end of the nineteenth century there was a series of councils for local areas of different sizes—the counties, boroughs, districts and parishes—each with a variety of functions, as well as other authorities with more limited special functions. The county councils were created by the Local Government Act, 1888, to take over most, but not all, of the administrative as distinct from the judicial functions of the justices of the peace. Since the beginning of the present century, the tendency has been, on the whole, to check the multiplication of special local authorities and to consolidate administration in the hands of county and county borough councils, though this tendency has been recently modified by an increase in the functions of central government departments and by the creation of public boards appointed to organise some public services on a national or regional rather than a local basis.

578. The movement for lunacy reform was one of the earliest of the social movements of the eighteenth and nineteenth centuries to find expression in legislation. During the seventeenth and eighteenth centuries medical science as we think of it today had begun to take shape, and the treatment of mental disorder, for all the crudity and harshness of the methods then adopted, was accepted by medical men as their concern. A few of the new voluntary hospitals which were founded in the eighteenth century had special wards for the insane or were founded for mental patients only,

and some private madhouses were run by doctors. The Act of 1774 for the regulation of madhouses, which followed the report of the Select Committee of 1763, laid down that houses "for the reception of lunaticks" in the cities of London and Westminster and within a radius of seven miles thereof and in the county of Middlesex were to be allowed to operate only under a licence granted by five Fellows of the Royal College of Physicians in London elected by the College as commissioners for this purpose. Private madhouses (or "licensed houses" as they were hereafter called) outside this area were to be licensed by the justices of the peace in quarter sessions. In 1828 responsibility for appointing commissioners for the metropolitan area was removed from the Royal College of Physicians and placed on the Home Secretary. In 1845 Commissioners in Lunacy for the whole of England and Wales were appointed with much wider powers in relation to patients in public as well as private institutions, but they were responsible for the licensing of licensed houses in the metropolitan area only. Outside that area the justices of the peace retained this administrative responsibility, and still retain it today.

579. The first Act authorising the provision of public asylums for lunatics was passed in 1808. Responsibility for such asylums was placed on the county justices of the peace.[1] If the justices considered it expedient that an asylum should be provided in any area they were to appoint a committee of "visiting justices" (or "visitors") to be responsible for the building and management of the asylum. For this purpose they could unite with the "visiting justices" of another county or with the directors of voluntary societies interested in providing accommodation for non-pauper lunatics. As most of the "lunatics" already in public institutions at that time were in poor law institutions (others being in gaols or houses of correction), this was the beginning of the movement to establish mental institutions administratively separate from the poor law. This movement began in the early nineteenth century, but it was not completed until the poor law was finally abolished in 1948. We mentioned in Chapter 4 that many "lunatics" continued to be accommodated in workhouses, and that from 1867 there was power to detain them there. The Mental Deficiency Act, 1913, allowed poor law institutions, if suitable for the reception of defectives, to be approved for this purpose and to be used in the same way as other certified institutions. And from 1808 until the coming into force of the Local Government Act, 1929, the poor law authorities were wholly or partly responsible for the cost of maintaining pauper patients in lunatic asylums. But from the beginning of the nineteenth century until the middle of the twentieth, it was the aim of reformers to dissociate the mental health services from the poor law both administratively and financially.

580. This movement started before, and continued separately from, the similar movement in the field of public health. The first local public health services outside the poor law were concerned with sanitation and infectious diseases. There was no reason for any connection between their administration, which at first was mainly in the hands of the local district authorities, and the management of lunatic asylums, which was the responsibility of the justices of the peace from 1808 to 1889 when it passed to the county and county borough councils. The development of general and special medical services in hospitals in the nineteenth century, other than fever hospitals and sanatoria, was centred in the voluntary hospitals. Few voluntary hospitals accepted mental patients during this period, except those which took mental patients only. Until well into the twentieth century,

[1] Including, under the early Acts, the justices of quarter sessions boroughs and of some other places.

the only hospitals under the administration of public authorities (other than hospitals for infectious diseases and lunatic and imbecile asylums) were the poor law infirmaries which gradually came to provide general hospital facilities for a wide section of the population. The movement for the separation of the public lunatic asylums from the poor law administration did not therefore lead towards a closer link with other health services, but involved separation from them also.

581. Medical knowledge about mental disorder, both in England and in other countries, increased slowly during the nineteenth century. By observation and study of the patients detained in hospitals and asylums the progress and characteristics of different forms of mental illness were recorded and classified, but even by the end of that century little was known about their cause. Less harsh methods of treatment became widely adopted, though progress fluctuated at different periods and in different places. Treatment was still mainly protective and custodial rather than actively curative, though protection and custody are in themselves a valuable form of treatment and help towards recovery. This medical work proceeded almost wholly within the walls of the mental hospitals and asylums, generally speaking in isolation from other branches of medicine. There was, therefore, in the nineteenth and early twentieth centuries no movement in the medical field to oppose the separate administration of the mental health services. On the contrary, separate administration was at that time considered necessary in order that the mentally disordered, especially those who were considered curable, might receive expert medical attention.

582. The Royal Commission on the Care and Control of the Feeble-minded, 1904–08, stressed the desirability of removing mentally disordered patients from poor law and penal institutions and providing them with more suitable forms of care in special institutions or under special community services. Insistence on the need for special services under a separate administration also discouraged close administrative links with the other social services which were developing during the early twentieth century either as further off-shoots from the poor law or as new ventures. The public education services were given authority, in 1899, to provide special education for mentally defective children other than idiots and imbeciles, but apart from this the development of public services for the special care of the mentally defective, from 1913 onwards, involved their separation from new child care and health services as well as from the poor law, the lunatic asylums and the prisons.

583. The strength of the desire to provide mental health services administered separately from other services, and the fact that the movement started so early and continued so long, affected the central as well as the local administrative organisation. The Lunacy Commission which was established in 1845 as a central body to exercise general supervision over the public and private care of lunatics was quite separate from the central Poor Law Commission (which was superseded in 1847 by the Poor Law Board), and had no official connection with the General Board of Health which was created in 1848 (and dissolved in 1858, after being re-constituted in 1854) and which supervised the sanitary services which were developing at that time as the first general public health services outside the poor law.[2] When the Local Government Board was created in 1871, it took over the functions of the Poor Law Board, and was also made responsible

[2] It is however interesting to note that Lord Ashley (later 7th Earl of Shaftesbury), who was chairman of the Commissioners in Lunacy and took a leading part in many branches of social reform, was also chairman of the General Board of Health during the six years 1848–1854.

for public health and general local government matters, but the Lunacy Commission remained separate under the general surveillance of the Home Office and the Lord Chancellor. When the Ministry of Health replaced the Local Government Board in 1919 mental health was coming to be regarded as a branch of general health, and in 1920 the Minister of Health took over various functions under the Lunacy Acts and Mental Deficiency Acts which had previously been performed by the Home Secretary. But the Board of Control, which had replaced the Lunacy Commission in 1913, remained a separate department and the Minister of Health exercised only a loose control over the Board's general policy and financial estimates, for which he was responsible to Parliament.

584. During the late nineteenth century and the first half of the twentieth, health and welfare services for various other groups of people developed inside and outside the poor law, as mental health services had started to do so much earlier. Several of these other services, such as those for the blind and the tuberculous and for mothers and young children, were authorised by special Acts of Parliament. The Local Government Act, 1929, which was an important step in the break-up of the poor law, encouraged county and county borough councils to use these special powers, as far as possible, in preference to general poor law powers which the same Act transferred to them from the Boards of Guardians. During the next few years there was a rapid development of local authority hospital and other health services outside the poor law. General hospitals, community health services, mental hospitals and mental deficiency services were all provided by the same local authorities outside the poor law for the first time since the first lunatic asylums had been established by the county justices at the beginning of the nineteenth century. Medically and administratively, however, there were still few links between local authorities' mental health services and their other hospital and community health services. Centrally, the Board of Control continued to be responsible for the detailed supervision of the mental health services, and worked as a separate department largely isolated from the Ministry of Health.

The reorganisation of the health and welfare services, including mental health services, under the legislation of 1944–48

585. General community health and welfare services and hospital services were further developed during the war of 1939–45, and as part of the post-war reconstruction of social services there was a major reorganisation of all our health and welfare services, including the mental health services, under legislation passed in 1944–48. The poor law ceased to have effect. Most of the Acts under which services for special groups had previously been provided outside the poor law were also repealed. The new legislation authorised the provision of services on a wider basis by various administrative authorities, each of whom became responsible for one or more functional services. Broadly speaking, the administrative divisions which are inevitable in so large a field were drawn according to the type of service provided (e.g. financial assistance, sheltered employment, occupational rehabilitation, residential accommodation, hospital treatment, community health services), rather than according to categories of persons receiving these services (e.g. " poor persons ", " persons of unsound mind ", " blind persons ", " defectives "). This is of course an over-simplified description of a complex system. Under the present pattern of administration, within the general functional divisions special groups of persons are still singled out for special services, as indeed they must be if appropriate services are to be provided, and some types of functional services are only

needed for special groups of persons. But even so most services are provided within a broader legislative and administrative framework than in the past.

586. As part of this reorganisation, an attempt was made to integrate the mental health services administratively, for the first time, with the other special and general health services of the country. The county and county borough mental hospitals and all but four of the registered hospitals, as well as all other types of local authority and voluntary hospitals, were put under the administration of the new hospital boards and committees set up under the National Health Service Act, 1946, which came into operation in July, 1948. These hospitals were however distinguished from other hospitals by being "designated" as "mental hospitals" for the purposes of the Lunacy and Mental Treatment Acts, which continued to regulate the procedures and conditions under which patients might be received with or without powers of detention.[3] All local authority mental deficiency institutions also became administratively part of the new hospital service, and continued to be recognised as "institutions" authorised to receive patients under the procedures laid down in the Mental Deficiency Acts. Public assistance institutions (the former workhouses) were divided between the new hospital service and the new local authority welfare service according to whether the accommodation in them was being used for sick or non-sick persons. Those sections of the institutions transferred as hospitals which were being used to accommodate "persons of unsound mind" detained under Section 24 of the Lunacy Act, 1890, became designated mental hospitals, and those sections accommodating certified mental defectives were authorised to continue to serve this purpose within the hospital service.

587. The section of the Mental Treatment Act, 1930, which gave county and county borough councils power to provide care for mentally ill patients after hospital treatment was repealed, and the same councils, in their capacity as local health authorities, were given wider powers under Section 28 of the National Health Service Act, 1946, to provide for the prevention of illness (of any kind) and the care and after-care of persons suffering from illness or mental defectiveness; it is under the National Health Service Acts that community care for the mentally ill may now be provided by local authorities. Section 30 of the Mental Deficiency Act, 1913, was amended but not repealed; this section still gives local authorities the duty of providing specific community services for mental defectives who are "subject to be dealt with" under the Mental Deficiency Acts. But most, though not quite all, of these services could in fact be provided under the wider powers under Section 28 of the National Health Service Act; these wider powers are used to provide "voluntary supervision" for defectives who have not been ascertained as "subject to be dealt with" under the Mental Deficiency Acts.

588. In 1948 all local authority community health services for the care and after-care of the mentally ill, being provided under the National Health Service Act, were automatically brought under the general supervision of the Minister of Health instead of the Board of Control; the Minister also took over from the Board the supervision of the local authority community services for defectives provided under the Mental Deficiency

[3] The Bethlem Royal Hospital (formerly a registered hospital) and the Maudsley Hospital (formerly administered by the London County Council) were not designated as mental hospitals. Together they were designated as a teaching hospital under Section 11 of the National Health Service Act, 1946, and were approved under the Mental Treatment Act, 1930, to receive voluntary patients under that Act (but not certified or temporary patients). They are also free to admit patients outside the purview of the Lunacy and Mental Treatment Acts.

Acts. The responsibility for providing mental and mental deficiency hospitals, which had previously rested with the county and county borough councils under the general supervision of the Board of Control, became the responsibility of the Minister of Health through the agency of the new hospital management committees, boards of governors and regional hospital boards. Various other functions were also transferred from the Board of Control to the Minister, the intention being as far as possible to give to the Minister responsibility for the supervision of services and to the Board responsibility for the supervision of the procedures related to the admission, detention and discharge of individual patients. We describe and discuss this more fully in Part VI of our report.

589. Under the present system of administration no one administrative authority is responsible for providing the wide range of services which were covered by the poor law. Instead of "poor persons" being provided with financial assistance, residential accommodation, hospital care or other assistance by the poor law authority, now there are various authorities responsible for providing particular forms of service for people whose need for that service may arise from a wide variety of causes. The same system applies to people who were previously singled out as special categories outside the poor law. A man who contracts tuberculosis may now receive special forms of medical advice and treatment from a local health authority or a hospital, sickness benefit under the national insurance scheme, other financial assistance from the National Assistance Board, and, if necessary, sheltered employment later through the services administered under the aegis of the Ministry of Labour and National Service or some of the services for handicapped persons which may be provided by local welfare authorities. It is an inherent danger of this system that one person may have to receive attention from a bewildering number of different authorities and that there may be no single authority seeing all the needs of one individual. It calls for a high degree of co-ordination and consultation between those who operate different branches of our social services and enhances the importance of the work of general practitioners, social workers and others who can take a continuing interest in an individual's progress when he passes from the care of one authority to another. On the other hand, the present system has the advantage of bringing into closer association various branches of medicine or social welfare which were previously separately administered. It has also made most of the social services available or potentially available to a much greater number of people. It has broken away from the idea of dividing people into categories with "labels" which may be regarded as derogatory and as putting them in a class apart from the rest of society. It has also reduced the likelihood of any person being completely dependent on any one administrative authority for all the necessaries of life.

590. The transition from the old system to the new has not yet been completed in relation to mental health, and in some respects people suffering from mental disorder at present have the disadvantages of both systems. The special mental health services were split up in 1948 between the local authorities and the new hospital authorities, and are now administered as part of the general health services, but the "labelling" of individual patients through "ascertainment" and "certification" is still preserved by the procedures laid down in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. Nor was any attempt made in the legislation of 1946–48 to bring the arrangements for the control of private or charitable homes, hospitals or institutions for the mentally ill or defective into line with those for other hospitals or nursing homes outside the national health service, nor

to review the functions of the Board of Control except to the extent we have already mentioned. Neither of these subjects could be completely dealt with without a simultaneous reconsideration of the procedures related to individual patients, the documents, records, and arrangements for inspection and visitation, such as that which it has been our task to undertake. There are also differences in the division of functions between hospitals and local authorities in the mental health field, as compared with their general responsibilities in relation to other patients, which we describe in Chapter 10.

591. There is also still a tendency to exclude persons who have any form of mental disorder from some of the other general functional social services, and to take the line that they should receive any care they need from the special mental health services. This is not true of all the general functional services ; as we explained in Chapter 1, many of the general social services (for example, the employment services for disabled persons) can be, and are, used by people whose need arises from mental disorder. But the treatment of mental patients as a class apart is still preserved in some provisions of the law or by administrative practice. In some cases it is those who operate the more general services who tend to exclude anyone who is in any way mentally disordered ; in others it is those who operate special mental health services who feel they should be responsible for meeting all their patients' needs.

Principles for the future

592. In present-day conditions no one should be excluded from benefiting from any of the general social services simply because his need arises from mental disorder rather than from some other cause. Many mentally disordered patients need special forms of help which can be provided only through the special mental health services, but when a patient's needs can be wholly or partly met by making use of more general services they should be available to him. There has been great expansion and improvement of these services, and a great change in the public attitude towards them, since the days in which poor law relief could be justly criticised as inadequate and inappropriate to the needs of the mentally disordered. Those who are interested in the care of mentally disordered patients should now try to ensure that full advantage is taken of the valuable assistance which the many social welfare services can provide for such patients as well as for others. Many persons now classified as imbeciles and the majority of those now classified as feebleminded are able to live in the general community with relatives or friends and are accustomed to mix and work with other people ; if their relatives or friends die or become unable to give them a home any longer, they need to be provided with a home by some public authority. If they are otherwise suitable to live in a local authority's welfare home, they should be accepted there and not sent to a mental deficiency hospital where they will be largely cut off from the company of anybody but other mentally disordered patients and will be occupying accommodation needed for patients who need psychiatric or nursing attention. Severely disabled young children with both physical and mental defects should not necessarily be excluded from general children's hospitals and sent to mental deficiency hospitals. If they need special attention which cannot be given in a general children's hospital, or if they are old enough to benefit from training under psychiatric supervision, it may be right to send them to a psychiatric hospital ; but if their main need is for general nursing because of their physical disability, as is often the case with very young children with multiple defects, they should not automatically be directed to a hospital whose main function is to provide psychiatric treatment and training which

they do not need. There should be much greater administrative flexibility in deciding what forms of care are really appropriate to each person's individual needs. We discuss some of these questions in more detail in Chapter 10.

593. **The rest of our recommendations in this part of our report deal mainly with the special mental health services which are needed to meet the special needs which cannot be met by more general services, but all our later recommendations should be read against the background of this general recommendation that the existence of some degree of mental disorder should not exclude any person from any form of care or service from which he can suitably benefit.**

594. **It is equally important that there should be interchange of knowledge and experience between those who administer or work in the mental health services and those who administer or work in other branches of the health, social welfare and education services.** The administrative reorganisation of 1948 brought a new division of responsibility between the local authorities and the hospitals, and much attention is being paid to methods of co-ordination between the two, particularly in the mental health field. But that should not make us forget that the mental health services are now part of a comprehensive national health service, which itself is part of a social welfare system covering many inter-related services. We consider it essential that contacts between psychiatric and other general and special interests within the hospital service and within the local authority services should be developed and strengthened. Some of those who work in the mental and mental deficiency hospitals are anxious that the special needs of these hospitals should not be lost sight of in a too closely integrated hospital service. But it is at least arguable that the comparative neglect from which these hospitals have suffered has been due precisely to the special position they have occupied and to their isolation from other hospitals. In our view it is most important, both in the hospital and local authority services, that the needs of the mentally disordered should be seen in future, as they have begun to be seen in the last few years, in relation to other needs, so that their importance will be more clearly and widely appreciated, and so that the resources, knowledge and interest of the health services as a whole can be used in the service of mental health. The mental health services would lose much more than they could gain by a return to isolation and separatism, and it would be most unfortunate if schemes for co-ordination between hospitals and local authorities in regard to mental health were not to be accompanied by correspondingly close contact with other parts of their own services.

CHAPTER 10

THE DIVISION OF FUNCTIONS BETWEEN LOCAL AUTHORITIES, HOSPITALS AND OTHER AUTHORITIES AND THE DEVELOPMENT OF COMMUNITY CARE

The present position

595. In Chapter 1 we gave a short account of the forms of care and treatment which are provided at present for patients suffering from various forms of mental disorder. In Chapter 9 we described the historical background to the present administrative organisation and mentioned that there are some differences in the division of functions between hospitals and local authorities in relation to mental health as compared with their general responsibilities in relation to other branches of the health and welfare services.

596. One aim of the reorganisation of health and welfare services in 1948 was to distinguish between the social welfare functions and hospital functions of the public assistance institutions, which under the new legislation were divided between the new hospital service and the new local authority welfare service. But no similar attempt was made to distinguish between the hospital and social welfare functions of the mental hospitals, the mental deficiency institutions or those parts of the public assistance institutions set aside for patients detained under Section 24 of the Lunacy Act, 1890. All these were transferred into the hospital service, although all of them, particularly the mental deficiency institutions, had always to some extent served both purposes. The mental deficiency institutions had always provided residential care not only for patients needing active training or continual nursing but also for many whose main need was a permanent home with some supervision. Mental hospitals, and even more the parts of the public assistance institutions in which persons were detained under the Lunacy Act, were accustomed to give more or less permanent "asylum" to some patients, especially the elderly, who no longer needed active medical treatment but had no suitable home to which they could be discharged. Before 1948, many other mentally infirm or mentally defective persons were also received into the public assistance institutions without certification. When the public assistance institutions were divided in 1948 between the hospital and welfare services, many of these uncertified persons remained in the welfare accommodation. From 1948 onwards however, partly because of the general shortage of accommodation and partly because of the policy of sorting out the various types of people who had previously been accepted into the public assistance institutions and of providing them with more specialised forms of care, there seems to have been an increasing tendency, in some parts of the country at least, to direct mentally infirm and mentally defective people to the mental and mental deficiency hospitals instead of to social welfare homes, even if they need social rather than specialist medical care. As a result, the extent to which these hospitals are used for social welfare purposes may actually have increased since 1948. The mental hospitals have also continued to be responsible for patients boarded out under Section 57 of the Lunacy Act, 1890, after treatment in hospital, although little use is made of this section at present.

597. Community care for defectives (other than the provision of residential accommodation) has in general remained a local authority responsibility since 1948. But the hospitals have been held responsible for the care of any patient living in the community on licence after a period in hospital, so

long as the legal authority under which he was originally committed to the care of the hospital is kept in force, which may be for many years after he actually leaves the hospital. At the same time, because of shortage of accommodation and staff, the hospitals have been unable to admit all those who need psychiatric or nursing care; many of these patients have had to remain at home, receiving only such forms of community care as the local authorities have been able to provide, and creating great difficulties both for their families and for the local authorities.

598. Before 1948 general social care for mentally ill patients, in so far as it was provided at all, was mainly for hospital patients and patients discharged from hospital, and was undertaken either by voluntary organisations or by local authority staff working from the hospitals. In general this work has been carried on and developed by the hospitals since 1948 when the hospitals and their staff were transferred to the new hospital boards and committees. But local health authorities have a general responsibility under Section 28 of the National Health Service Act, 1946, for providing care and after-care for patients living in the community, and since 1948 some authorities have appointed staff in their mental health departments to undertake social work for patients who have not been referred to hospital for treatment or are attending only as out-patients or who have been discharged from hospital. In some areas the local authority staff and the hospital staff co-operate very closely and have worked out arrangements by which they pool their resources or divide their activities on agreed lines. Elsewhere they work more in isolation from each other. In some areas almost all the social work which is done is undertaken by the hospitals for their own patients and discharged patients; in others very little social work is undertaken specifically for the mentally ill, apart from the work of arranging the admission to hospital of certified patients which all local authorities undertake.

599. It is thus apparent that the local authorities, who before 1948 were responsible for all forms of institutional and community care for mentally ill or defective patients, relinquished to the new hospital authorities in 1948 partial responsibility for some services which still properly belonged to them under their general powers under the National Health Service Act and National Assistance Act. This was partly, though not entirely, due to the fact that in the past the power to provide some forms of community care (such as the care of patients on licence or boarded out) was closely linked with the powers of control authorised in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts for patients admitted to hospitals or other institutions. Although the power to provide care is now mainly derived from more general powers under the National Health Service Acts and National Assistance Act, the practical division of functions between hospitals and local authorities in the mental health field in 1948 was made to fit in with those powers of control, even when this conflicted to some extent with the authorities' general functions under the new legislation.

600. Difficulties arising from this confusion of responsibilities have been aggravated by a general shortage of beds in mental, mental deficiency, geriatric and chronic hospitals and in old people's homes, and of places in occupation or training centres. Considerable progress has been made since 1948 in opening new beds and centres in spite of restrictions on capital development, but the provision of more accommodation by hospital and local authorities will not of itself produce a satisfactory service unless the responsibilities which each type of authority is to undertake are clarified.

General principles for the future

601. **The recommendations of our witnesses were generally in favour of a shift of emphasis from hospital care to community care. In relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past.** It is not now generally considered in the best interests of patients who are fit to live in the general community that they should live for long periods in large or remote institutions, such as the present mental and mental deficiency hospitals, in which they are inevitably largely cut off from the normal world and from mixing with other people. For those who cannot live with their own relatives it is considered more appropriate to provide residential homes in towns and villages, with as many as possible of the residents working in normal employment and the others having suitable occupation either in the homes or hostels themselves or in some form of sheltered employment or occupation centre. The extent to which patients with long-term disabilities could live in future in less isolated residential homes must depend partly on the willingness of the general public to tolerate in their midst some people with mild abnormalities of behaviour or appearance. We believe that the increasing public sympathy towards mentally disordered patients will result in a higher degree of tolerance in this regard. But even without this, many of the patients now in hospital should be immediately acceptable as members of the general community, where they would already be if they had families or friends with whom to live.

602. In our view, the division of functions between the local authorities, the hospitals and other official bodies should be broadly the same in relation to mental disorder as in relation to other forms of illness or disability. The local authorities should resume those responsibilities for mentally disordered patients which are appropriate to their general powers under the National Health Service Acts and National Assistance Act. Broadly speaking this would mean that the main functions of the hospitals should be to provide specialist medical treatment and training and nursing and ancillary specialist services; they should not be expected to provide long-term residential care for persons who do not need these services, nor after-care for patients after discharge from hospital apart from any necessary medical follow-up or out-patient services. Subject to proper co-ordination between the local authorities and the hospitals, the local authorities should be responsible for community health or welfare services for people who are not hospital in-patients.

603. We do not wish to lay down too rigid a classification of functions, and we realise that the application of the principles we recommend will have to be gradual in many areas. With these reservations, we consider it possible to distinguish the proper functions of the hospitals from those of the local authorities broadly as follows:—

(i) **The hospitals should provide in-patient and out-patient services for patients who need specialist medical treatment or training or continual nursing attention. The aim of hospital treatment or training is to make the patient fit to return to life in the general community. Patients should not be retained as hospital in-patients when they have reached the stage at which they could return home if they had reasonably good homes to go to. At that stage the provision of residential care becomes the responsibility of the local authority.**

Specialist medical treatment for psychopathic[1] and severely subnormal[1] patients includes in-patient training designed to promote

[1] We use these terms in the sense indicated in Chapter 3.

any aspect of their mental or physical development, varying from habit training for severely sub-normal children to character training for psychopathic adolescents and adults, if such training requires individual psychiatric supervision. By "requiring individual psychiatric supervision" we mean that the patient's individual progress needs to be watched, and if possible controlled, by a psychiatrist. Local authorities should be able to employ a psychiatrist in general charge of their community mental health services, or otherwise obtain psychiatric advice on the planning of those services, including training or occupation centres, sheltered workshops and residential homes. But psychiatrists employed by or advising a local authority would not be responsible in that capacity for the medical treatment of individual patients.

The hospitals (psychiatric hospitals or other hospitals) should undertake the care of patients who need continual individual nursing attention because of serious mental or physical disability (if proper care cannot be provided at home), even if the patients do not need to be under individual psychiatric supervision. But local authorities should not be debarred from employing nurses in residential homes, if this is desirable for the proper care of patients who do not need individual psychiatric supervision nor continual individual nursing attention.

(ii) **The local authorities (or other public authorities such as those administering the employment services) should be responsible for preventive services and for all types of community care for patients who do not require in-patient hospital treatment or training or who have had a period of treatment or training in hospital and are ready to return to the community.** Apart from or in addition to residential accommodation, the form of help needed varies greatly according to the type or degree of the patient's mental disorder. Some severely sub-normal children need special training in place of education in school. Industrial rehabilitation may be needed by patients recovering from mental illness who are expected to become fully fit for normal employment. Vocational training leading to normal employment may be needed by some feebleminded psychopathic patients after leaving school. Other feebleminded psychopaths and the more intelligent among the severely sub-normal and some patients left with long-term disability after mental illness may need long-term sheltered employment of an industrial type. Those more severely disabled by mental illness, the majority of severely sub-normal adults and some old people will more suitably be catered for by centres which provide simple occupations or handcrafts and social contacts. General social help and advice in their own homes may be needed by all these types of patients, and also by many who work in open industry but whose mental disability makes it abnormally difficult for them to cope with the normal problems of living.

(iii) **Social work for patients who are not receiving hospital treatment, including patients who have left hospital, is essentially the responsibility of the local authorities. They can also do a great deal in co-operation with the hospital staff for hospital out-patients and even for in-patients.** There must be very close co-operation between the medical staff and social workers of the hospitals and local authorities to ensure that the best use is made of the resources of each and maximum continuity in the care of individual patients.

Arrangements to ensure such co-operation should be made in each local area. After-care should be provided by the local authorities as long as it is needed, and should not be dependent on the continuation of compulsory powers such as licence or guardianship.

604. In the rest of this chapter we discuss the application of these principles in more detail and discuss the directions in which present services need to be extended.

605. It has not been within our terms of reference to enquire into the administration of hospital services. Our recommendations in this chapter cover only the general division of functions between the hospitals and the local authorities, methods of co-ordination between them, the development of community services, and the legal powers which should be used by the local authorities for this purpose. As the background to these recommendations it is necessary to bear in mind the great variety of specialist medical services which are provided in the hospitals now, or are likely to be developed in the forseeable future, for the diagnosis and treatment of the many different forms of mental disorder in patients of all ages, including in-patient and out-patient treatment, day-hospitals, diagnostic clinics and domiciliary visits. This is a time of new ideas and new methods in hospital treatment as well as in community care. We hope that the proposals in Parts II and IV of our report for doing away with the "designation" of hospitals and for new procedures for the admission of patients will remove some obstacles to the development of hospital services, particularly for psychopathic patients, both feebleminded psychopaths and those of normal intelligence.

606. Services for severely sub-normal and feebleminded patients living in the general community have always been an important part of the mental deficiency services. Even though almost all residential care is at present provided in the hospitals, the number of defectives living outside hospital and receiving "voluntary" or "statutory" supervision from local health authorities or under guardianship is considerably greater than the number of patients in mental deficiency hospitals (see Appendix IV, Table 10a). There is no essential difference between the type of care given as "statutory supervision" under the Mental Deficiency Acts and that given as "voluntary supervision" under the National Health Service Acts, and in future no such nominal distinction should be necessary. We agree with the suggestion made by some of our witnesses that these services should not in future be given the formal name "supervision", which suggests enforcement of control, and that it is preferable to use the general term "community care", which we use to cover all forms of care (including residential care) which it is appropriate for local health or welfare authorities to provide.

607. Community services for mentally ill patients are a more recent development. Social work for mentally ill patients started for patients who were or had been receiving hospital treatment, and, as we mentioned in paragraph 598, since 1948 has continued to be carried on mainly from the hospitals. Apart from statutory duties in connection with the admission of patients to hospital the local authorities are only gradually building up again teams of social workers to deal with the problems of people whose lives are affected to some extent by some form of mental illness but who can live in the general community.

608. Our proposals would involve a considerable expansion in the community services to be provided by the local health or welfare authorities for all groups of patients. In paragraphs 716–724 we discuss briefly the general implications of such expansion in regard to staff and finance and

ways in which it might be expedited as far as general economic considerations permit.

609. **We have felt it right to assume that a fair share of our national resources will be allocated in future to the mental health services both by the central government and by local authorities, and that it is recognised that in many areas these services have a considerable amount of lee-way to make up compared with some other parts of the country's health and welfare services.** It may be inevitable that financial considerations will limit the speed at which the necessary improvement of the mental health services can take place, but we trust that even in present conditions this will be given a high priority.

610. There is another important financial point which has been very much in our minds while considering the proper functions of the local authorities on the one hand and of the hospitals on the other. Although many county and county borough councils are anxious to expand their services on the lines we recommend, there is a real danger that others may be reluctant to acknowledge their full responsibilities, particularly in regard to functions which since 1948 have been wholly or partly discharged by the hospitals, because of the fact that services provided by the hospitals are financed entirely from the exchequer whereas at present half the cost of the local authorities' health services and almost the entire cost of their welfare services have to be met from rates raised by the local authorities themselves. It would be very wrong if this fact were allowed to impede the proper development by local authorities of the community services which are now considered necessary for various groups of patients. **Whether the money for services which are agreed to be necessary is raised through rates or taxes makes no essential difference to the general public from whom both rates and taxes are raised, and neither the county and county borough councils nor the central departments should allow themselves to be influenced by this consideration.**

611. Hospital and community services for disabled persons, including those handicapped by mental disorder, have recently been reviewed by the Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons which was set up in March, 1953, under the Chairmanship of Lord Piercy. This Committee's report was published in November, 1956.[2] In paragraphs 288–297 of its report the Committee discussed the special problems of the rehabilitation and resettlement of the mentally disabled and classified the mentally disabled who need rehabilitation into four groups described as follows:—

"(*a*) Patients who have recovered from psychosis or neurosis and high-grade mentally defective patients who have been socially trained and are employable. This group needs help—possibly including some vocational training—in getting employment, and may need help at home.

(*b*) Convalescent patients, whose recovery is not as complete as that of those in the first group, and who need expert rehabilitation preparatory to help in getting work.

(*c*) Neurotic or mildly psychotic patients and medium-grade mental defectives or other defectives with residual instability, who are employable but need to live under psychiatric supervision and care." (In a later paragraph this group is described as " not fit for discharge from hospital care ".)

"(*d*) Deteriorated mental patients, and low-grade defectives, who must remain as in-patients of mental or mental deficiency hospitals but some of whom are capable of training and occupation in hospital workshops."

[2] Cmd. 9883.

612. In our view this classification does not give sufficient recognition to the existence of a group of patients who may or may not have required hospital treatment or training but who are not capable of normal employment, and therefore do not fall into groups (*a*) or (*b*), but who do not need to live under direct personal psychiatric supervision, and therefore do not fall into group (*c*), though their life and work should be under the sort of general medical oversight which could be given by the doctors (including psychiatrists) working in or advising a local authority's health department. In our view this is a large and important group, whose needs we frequently mention in the rest of this chapter. Apart from this we are generally in agreement with the views of this Committee. In later sections of this chapter we mention some of its recommendations on the administration of services for the disabled generally.

Residential accommodation

(i) General

613. Many witnesses suggested to us that local authorities should provide residential hostels for patients who need to be provided with a home and some help and advice but do not need psychiatric training or nursing care in hospital. Hostels or residential homes were suggested for young people leaving special schools for the educationally sub-normal, adult feeble-minded psychopaths who need fairly close supervision but do not need hospital training or who could be discharged after a period of training if they had a suitable home in which to live, severely sub-normal patients of any age whose relatives can no longer provide them with a home, elderly mentally ill or infirm patients, and patients recovering from mental illness or left with residual mental disability after such an illness.

614. Although we received conflicting evidence from the representatives of the local authorities themselves on the question whether they should provide residential homes (see paragraphs 619–622), we have no doubt that the local authorities should be responsible for providing residential as well as non-residential community care for patients handicapped by mental disability. Their responsibilities can be distinguished from those of the hospitals according to the general principles set out in paragraph 603. In deciding whether an individual patient should receive hospital or community care the consideration should be whether or not he requires in-patient treatment or training with individual psychiatric supervision or continual nursing attention. We discuss later the criteria by which this should be judged in regard to particular groups of patients.

615. It should be possible for local authorities to provide residential community care in various ways. They should be able to provide residential homes themselves. They should also be able to " board out " some patients with private individuals who are able to give the sort of care and attention which the patient needs, or to place patients in homes run by voluntary societies or private persons subject to their general approval and supervision. Some patients who are in employment might be found suitable lodgings and receive general help and advice from visiting social workers.

616. Residential homes provided by the local authorities themselves should not be large institutions. Twenty to thirty residents might be a usual size, with a maximum not much over fifty. They should not be in isolated places, but in or near enough to towns or villages for the residents to participate in the life of the general community as far as they are able. It would not be suitable for the local authorities to accommodate in one house all the different types of patients who might need residential care. For instance, young persons who have just left school and who are being helped to learn

to hold their own in the world and to become self-supporting citizens should not be placed in the same home as severely sub-normal children or adults. In some of the smaller local authority areas there might not be a sufficient number suitable to live together to make an economic unit. Various arrangements could be made to overcome this difficulty. One home might take residents from more than one local authority area. Or patients who are still hospital in-patients but who can suitably live in a hostel (see paragraph 623) might live in the same hostel or home as patients receiving residential community care from the local authority, with suitable financial arrangements. Some psychopathic patients whose intelligence is not seriously sub-normal might live in the same home or hostel as patients of a similar age left with residual mental disability after an acute mental illness. Many older persons whose mental disability is only slight could suitably live in ordinary old people's homes. There is also room for experiment in the extent to which residential accommodation might be combined with occupation or training centres which would also be attended by patients living with their own families.

617. The extent to which homes can be found with private families or individuals may be affected by our proposal in Chapter 7 that the local authority itself as well as individual persons should be able to act as guardian to patients who need this form of control; this would allow local authorities to arrange for suitable patients to be boarded in private houses without the foster-parent or other person having to assume the full responsibilities of a legal guardian.

618. Whatever form of accommodation is favoured in any particular locality, we are convinced that the aim should be a deliberate re-orientation, away from institutional care in its present form and towards residential homes in the community. It will however be essential for the medical and other staff of the local authorities and hospitals to co-operate closely in determining the most suitable forms of care for each individual patient. We discuss this in paragraphs 681–689 and 690–693.

(ii) **Hostels and homes for severely sub-normal and psychopathic patients**

619. We consider that residential homes or hostels should be provided by the local authorities for severely sub-normal and psychopathic patients. In our view many of the patients at present in mental deficiency hospitals would be more suitably accommodated in such homes.

620. The Association of Municipal Corporations and the London County Council told us that they agree in principle that local authorities should provide hostels or homes for patients who can suitably live in the general community. The London County Council have already opened a hostel for girls who have left special schools and need help in the transition to adult life and employment, and a few other local health authorities have opened or are planning other types of hostel. The Association of Municipal Corporations told us that they felt sure that many more local health authorities would wish to provide hostels if they were sure that their powers under Section 28 of the National Health Service Act, 1946, were sufficiently wide to allow them to do so. The County Councils Association, on the other hand, suggested that the provision of residential accommodation should be the sole responsibility of the hospital authorities, because of the difficulties which would otherwise arise in deciding whether individual patients were suitable for admission to a local authority home or to a hospital.

621. The County Councils Association also questioned whether there are in fact substantial numbers of patients at present accommodated in mental deficiency hospitals who could suitably live in homes of this sort. After

giving oral evidence to us, they asked a few representative county councils how many persons from their areas, including educationally sub-normal children reported as being likely to require supervision after leaving school, had been admitted to these hospitals or recommended for such admission during the last five years owing to the lack of a suitable home, in circumstances where the provision of hostel accommodation would have enabled them to live in the general community and either to attend occupation centres or to obtain suitable employment nearby. The replies received from eighteen county councils showed a very great difference in the estimates made by individual councils, even when differences in the size of the population which they serve are taken into account (Appendix to minutes of evidence, P. 1357–1363). Although it is clear that the estimates were also affected by the extent to which individual authorities found it possible to place patients in private homes or in residential employment, the variation in the numbers they suggest might have been suitable for hostels is so great that we can only assume that they were using very different standards in assessing the use which might be made of hostels of this sort. One authority serving a population of over 1,000,000 stated that during the period in question only six patients were placed in private homes under supervision, yet in their opinion none of those admitted or recommended for admission to hospitals would have been suitable for hostels provided by the local authority. On the other hand, one authority serving a population of between 250,000 and 400,000 estimated that 43 patients would have been suitable for hostels, and one serving a population of between 400,000 and 600,000 gave a figure of 57.

622. These estimates relate only to the number of patients who might never have needed to enter hospital if they could have been provided with a home elsewhere ; they do not include any estimate of the numbers who might be suitably discharged from hospital after a period of training if they had suitable homes in which to live. It is also relevant to note the number of patients who are at present admitted to mental deficiency hospitals in middle or later life. Out of 2,838 patients of all ages admitted during 1954, 471 (roughly one in six) were over age thirty-five on admission ; of these about half (about one in twelve of the total) were over age 45, including 72 (one in thirty-nine of the total) over age 55. Not all of these would necessarily have been suitable for local authority residential homes. But although the numbers who may need to be admitted to such homes in any one year may not be large, most of those admitted in middle or later life would probably need to remain for the rest of their lives, so that for even a small number of admissions a year a substantial amount of accommodation may be required.

623. Some mental deficiency hospitals find that it helps patients who are likely to become fit for discharge to have a period of several weeks or months living in a house which provides living conditions more like those which they will meet after discharge than exist in a large hospital ward, and that patients acquire self-reliance by progressing by stages from close supervision in the main hospital to the full independence of life in the outside world. A hostel run by hospital staff but physically separate from the main hospital buildings provides a useful stage in the patient's progress, and many such hostels are now provided within the hospital service. Some of our witnesses were uncertain which type of authority should be responsible for running hostels of this sort if the local authorities become responsible for providing residential care for patients who can live in the general community. Our view is that it will still be proper for the hospitals to provide hostels for this purpose. The stage at which a patient should be discharged from hospital care to community care after a period of training in hospital should be deter-

mined according to the principles set out in paragraph 603. When a patient who has needed hospital training first goes to work outside the hospital by day the hospital medical staff will usually wish to observe his behaviour at work and outside working hours fairly closely for a period before they decide whether he has acquired sufficient stability to have a good prospect of being able to live under normal conditions. Up to the stage at which a patient would be considered ready to return to live at home if he had a reasonably good home, he should in our view be considered a hospital in-patient, whether he is living in a hospital ward or in a separate house or hostel. Some of the large hospitals may need to have hostels of their own to accommodate patients who are at this stage; in other areas it may be more convenient to arrange for the patients to live in homes or hostels provided by the local authority in which other persons also live and who have never needed to go into hospital or who have already been discharged from hospital care. There should be flexibility and variety in the arrangements to suit local conditions. But when any patient reaches the stage at which he would go back to live at home, if his home provided a reasonably stable environment for him, he should no longer be regarded as a hospital in-patient. If at that stage he has no suitable home in which to live, it should be the duty of the local authority to provide one, either by arranging for him to live in a private home, or in residential employment, or in suitable lodgings, or in a home provided by the local authority itself. The hospital medical staff may wish to receive follow-up reports, or to see him from time to time as an out-patient, and the hospital should be ready to re-admit him for further training if he gets into difficulties again, but at this stage, in our view, as far as the provision of residential accommodation is concerned, he passes from hospital in-patient care to community care. We discuss in paragraphs 673–676 the question of the stage at which the local authority's social workers should become responsible for giving the patient general help and advice and help in arranging employment; this need not necessarily coincide with the stage at which he ceases to be a hospital in-patient.

624. Local authorities should continue to be responsible for arranging short periods of residential care for children or adult patients who normally live at home, in order to give their families a holiday or in time of sickness or other temporary difficulties. It should also be the responsibility of the local authorities rather than of the hospitals to find accommodation for patients who need residential care at least temporarily in an emergency while the most suitable form of more long-term care is being considered. (We suggest that the term " place of safety " should be dropped.) Hospitals should co-operate with the local authorities, but residential homes provided by the local authorities themselves, as well as the hospitals, should be prepared to take patients for temporary care and in emergencies.

625. We discuss separately in paragraphs 650–653 how far local authorities might use their normal child care services to provide residential and social care for mentally sub-normal children. In paragraphs 637–649 and 654–663 we discuss the special needs of children of school age and school-leavers and the question whether residential and other services for them should be provided by the local authorities in their capacity as local health authorities or as local education authorities.

(iii) Residential homes for the elderly mentally infirm

626. We mentioned in paragraphs 319–320 in Chapter 6 the allegation that many old people are at present being certified and sent to mental hospitals because there is no other accommodation available. Several of our witnesses recommended that more accommodation should be provided in local authority

old people's homes for those who are mentally infirm. Some also mentioned to us plans for re-organisation within the hospital service which would, for instance, provide accommodation in psychiatric units forming part of geriatric hospitals, rather than in all-purpose mental hospitals, or which would provide "long-stay annexes"[3] for elderly patients who need special nursing care under psychiatric supervision but do not need to be in a fully equipped mental hospital. We gave our general views on the admission of elderly patients to mental hospitals, and on the procedures to be used, in paragraph 320. As far as the provision of accommodation is concerned, developments within the hospital service itself are outside our terms of reference. Our concern in this connection has been mainly with the division of responsibilities between the hospitals and the local authorities and with the purposes for which accommodation is needed outside the hospital service.

627. The division of responsibility between the local authorities and the hospitals in relation to old people is one which has given rise to a good deal of difficulty since 1948. This was considered by the Committee of Enquiry into the Cost of the National Health Service which reported in January, 1956[4]. The definition of the division of responsibility between hospitals and local authorities which the Committee quote in paragraphs 644–5 of their report, and their comments on it, embody similar principles to those we suggested in paragraph 603, and seem to us appropriate to mentally ill and infirm patients as well as to those who are physically ill or infirm (and of course a great many people fail both mentally and physically as they get old). This definition and the Committee's comments on it are as follows:—

"644. In carrying out the Survey, the Ministry have adopted an interpretation of the statutory responsibility of hospitals and local authorities which seems to us to resolve many of the practical difficulties and doubts which have been referred to in our evidence. Where old people are in need of treatment or care beyond the range of services which can be provided in their own homes, the division of responsibility between the hospital authorities and the welfare authorities has been defined by the Ministry as follows:—

Welfare Authorities

Apart from the active elderly person who is in need of residential care and who is clearly the responsibility of the welfare authority, the latter's responsibility also extends to the following:—

(i) Care of the otherwise active resident in a welfare home during minor illnesses which may well involve a short period in bed.

(ii) Care of the infirm (including the senile) who may need help in dressing, toilet, etc., and may need to live on the ground floor because they cannot manage stairs, and may spend part of the day in bed (or longer periods in bad weather).

(iii) Care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months) and who would, if in their own homes, stay there because they cannot benefit from treatment or nursing care beyond what can be given at home, and whose removal to hospital away from their familiar surroundings and attendants would be felt to be inhumane.

All these are persons for whom any necessary nursing care would be given by relatives, etc., with the help or advice of the home nurse if they were living in their own homes. In welfare homes that care should be given by attendants, assisted or advised by the visiting home nurse in the small welfare home, or by a small staff with nursing qualifications or experience in the larger homes.

[3] See Chapter 4, paragraph 226.
[4] Cmd. 9663.

It is *not* regarded as the responsibility of the welfare authority to give prolonged nursing care to the bedfast (except those in (iii) above), nor as desirable that separate 'infirmary wards' should be created in large homes in which patients from other homes are concentrated.

Hospital Authorities

Apart from the acute sick and others needing active treatment, who are clearly the responsibility of the hospital authority, the latter's responsibility also extends to the following:—

(i) Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years.

(ii) Convalescent care of the elderly sick who have completed active treatment but are not yet ready for discharge to their own homes or to welfare homes.

(iii) Care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home.

It is *not* regarded as the responsibility of the hospital authority to give all medical or nursing care needed by an old person, however minor the illness or however short the stay in bed; nor to admit all those who need nursing care because they are entering on the last stage of their lives.

645. The advantages of this definition of responsibility seem to us to include the following:—

(*a*) It makes clear beyond doubt that there are circumstances in which old people may properly be given nursing care in welfare homes. This will do much to prevent the hardship and suffering caused by the movement of old persons from welfare homes to hospital during minor illness, and when they are entering upon the last stages of their lives.

Some of our witnesses, representing the local authorities, have told us that doubts have been expressed about the power of local authorities to employ nurses in their welfare homes. If these doubts do exist, then it is important that they should be clarified as soon as possible and local authorities informed not only that it is within their power, but also their duty to provide nursing care for old people in such circumstances.

(*b*) It guards against the reappearance of the old 'infirmary wards' in local authority residential accommodation, which all our witnesses have agreed would be an undesirable development in the service.

(*c*) It provides a comprehensive service with no gaps between the hospital and local authority responsibilities."

628. There is at present a clear need for more residential accommodation, of the type which should be provided by the local authorities, for persons suffering from a degree of mental infirmity which is manageable in such a home and which does not require care or treatment under specialist medical supervision. Some would be suitable for general old people's homes, but it might be preferable for others to be in special homes. Many old people could be protected from further mental deterioration if they could be given the security and attention provided in this sort of home early enough, and might then not need to be admitted to hospital. Similar residential care is needed for elderly patients who have been in hospital and have reached the stage at which they would be discharged if they had relatives able to give them a home and a certain amount of supervision. If their relatives are unable to do this, it should be the responsibility of the local authorities to provide accommodation to which patients could be discharged, either in homes owned by the local authorities themselves, or by arrangements with voluntary societies, or in suitable cases by "boarding out" in private homes.

629. If it is doubtful whether an elderly person suffering from some degree of mental infirmity or confusion is suitable for a local authority home, or whether he or she needs hospital treatment, it is probably better that he should go to a psychiatric or a geriatric hospital, at least for a period of observation, provided that this does not result in his having to remain there indefinitely. But there is certainly a need for more homes to which elderly patients can be discharged when they no longer require hospital in-patient treatment.

630. There should of course be arrangements for the mentally infirm living in local authority homes to receive proper medical attention, no less than if they were living with their own families. After discharge from hospital, some may need to be seen from time to time by the hospital specialists, either as out-patients or by domiciliary visits. All of them should also be in the care of a general practitioner. All the resources of the local authority mental health service should also be available to them, as well as general old people's welfare services, just as if they were living with their own families.

631. Local authorities should also be responsible for providing temporary residential care for mentally infirm elderly people who normally live with their relatives, either to enable the relatives to take a holiday or at other times when illness or other difficulty makes it necessary to relieve the relatives temporarily of the responsibility of looking after them.

(iv) **Hostels for younger mentally ill patients**

632. Some of our witnesses also mentioned a need for hostels or after-care homes for younger patients who are recovering from mental illness. In many, perhaps most, cases it is preferable to send the patient straight to his own home on leaving hospital. But this is not always suitable, particularly if the patient lives alone or on leaving hospital has to settle into a new job as well as accustoming himself again to normal social life. Residence in a hostel or home may be needed for longer periods for patients with long-term residual mental disability who cannot benefit from further hospital treatment but can live in the general community if they can be given a suitable home and some supervision. Similar facilities may be needed for people who have not been hospital in-patients but for whom a period in a hostel with friendly supervision might help to prevent a more serious mental breakdown. In fact, hostels or homes may be needed for these patients for much the same reasons as for psychopathic patients.

633. At present some hostels and homes are provided for these purposes in the south of England by the Mental After Care Association, but it is generally agreed that this does not meet the whole need even in that part of the country and that facilities are also needed in the rest of the country.

634. We consider that residential care of this sort should be provided as part of the local authorities' mental health service, whether the local authorities decide to provide hostels or homes themselves or make contractual arrangements with voluntary societies or private nursing homes or board out patients in private houses. We would not wish the hospitals to be precluded from arranging comparatively short periods in convalescent or after-care homes for their patients, but the after-care, including residential after-care, of patients who no longer need hospital in-patient treatment should be primarily a local authority responsibility. This should include the sort of arrangements at present covered by the hospital authorities' responsibilities for "boarded out" patients under Section 57 of the Lunacy Act, 1890. We discuss the question of financial assistance for patients "boarded out" or "on trial" in paragraphs 694–699; in our view the

responsibility should fall in future on the National Assistance Board or on the local authorities, not on the hospitals.

635. Recommendations for residential care would normally be received by the local authority from the patient's general practitioner or from a hospital specialist under whose care the patient has been either as an out-patient or as an in-patient. In the case of patients leaving hospital after in-patient treatment, or attending hospital (including day-hospitals) as out-patients, the arrangements should be made after consultation between the medical officer in charge of the patient's treatment and the social workers of the hospital and local authority, as part of the co-ordinating arrangements which we discuss in paragraphs 690–693.

636. We received little evidence to show what numbers of patients are likely to benefit from this type of residential care, but we expect the amount of accommodation needed for this purpose to be considerably less than that needed for psychopathic patients or for old people.

Training centres for severely sub-normal children

637. Some of our witnesses suggested that occupation or training centres for children should be under the administration of the local education authorities rather than the local health authorities. The main reason for this suggestion is that this would reduce the distress at present caused to parents by the reporting of their children as ineducable, which seems to many parents to carry the implication that their children are considered incapable of developing in any way. Some of our witnesses also suggested that if the occupation or training centres were part of the school system it might be easier than it is at present to arrange for a child to be transferred from a centre to a school if, after attending a centre for a certain period, he seems to be developing sufficiently to be able to benefit from education in a special school. Another point put to us was that if the centres were within the school system children would have the benefit of the school health services, including regular medical inspections and dental treatment, and would also receive school milk and meals.

638. On the other hand, it was pointed out that great care is taken not to exclude from school any child who is thought likely to benefit at all from formal education, including the special forms of education provided in special schools, and that the training of the severely disabled children who are at present excluded is really a matter for special staff working under general medical oversight and cannot be considered as education in any normal sense of that word. The basis of occupation centre training is habit training, teaching the children to keep themselves clean and to feed and dress themselves, sense training to improve alertness, movement and speech, and carefully graduated handwork of all kinds. Occupation centres usually also provide some instruction in reading, writing and arithmetic to those children who are thought to be able to develop even a rudimentary understanding of writing and figures. Most of this is the equivalent of the nursery training of a very young normal child, and when this is the type of training which an older child needs it may more appropriately be considered a health service than an education service.

639. Several of our witnesses who have practical experience and a close understanding of the needs of these children hesitated to express any opinion, or told us that they do not feel that it would make much practical difference whether the centres were under the administrative control of the health department or the education department of the local authorities. Several witnesses, however, pointed out that, although the number of occupation

centres has increased very considerably in the last ten years in spite of financial difficulties, there are still areas where there are no centres or not as many as are needed. This means that children in those areas who have been excluded from the school system are given little or no training of any sort except that which their parents themselves can give.

640. In our view, the most serious criticism of the present arrangements, apart from the need for more centres, is that the present procedures by which these children are excluded from school cause unnecessary distress to parents. The procedures do not help them to appreciate that it does no service to a child to try to give him a form of training which is not suited to his abilities and aptitude, and that it is far better for him that he should go to a school or centre where he will receive the sort of training which may help him to develop to the utmost of his ability. **We do not consider that the proper answer to these criticisms is to recommend the transfer of administrative responsibility for these centres—which we recommend should be called training centres rather than occupation centres—from the local health authorities to the local education authorities. It is more important to revise the procedures and the terminology so that the approach is more positive and less negative.** It should not be necessary to label any child as "ineducable". The approach and procedures should be like those now used when a child is recommended for education in a special school; a child should similarly be recommended for special training in a training centre or hospital.

641. There is no absolute standard which limits the type of education or training which is provided within the education system. Even at present there is considerable variation between the practice of different local education authorities and there is an overlap between the type of children in special schools in some areas and those in occupation centres in other areas. In our view individual local authorities should continue to have considerable freedom to decide the range of training which they provide within the school system. If, with the development of more special schools for the educationally sub-normal, they are able to have a larger number of children in the lower ranges of ability at the special schools and to give them there the particular type of training most suited to their needs, that would be a welcome development. But the main responsibility for providing training centres for the severely sub-normal children at present classified as idiots and imbeciles should continue to be regarded as a health service rather than an education service. **The local health authorities should have a duty to provide appropriate training for any child referred to them for such training on proper medical advice for so long as they and the local education authority in consultation find it desirable. Children who need training under close psychiatric supervision or nursing in hospital should similarly be referred to the hospitals on medical recommendation, without being declared "ineducable".**

642. In deciding which individual children need these special forms of training, the diagnostic arrangements and case-conferences which we recommend in paragraphs 681–689 should be used. Each child's progress should be reviewed through the same arrangements at regular intervals, and the parents should be kept informed. If it is decided to recommend a child for training at a training centre or in hospital, the parents should have an opportunity of making representations just as they can when a child is recommended for education in a special school (and indeed as they can now when a child is reported as ineducable). They should also be under an obligation, when such representations have been considered, to arrange for the child's attendance at the centre or hospital for which he is recommended unless they make satisfactory alternative arrangements. This obliga-

tion might most suitably be introduced by extending Sections 36 and 37 of the Education Act, 1944, to cover training as well as education and to include attendance at a training centre or hospital as an alternative to attendance at school.

643. Children of any age including those under school age should be eligible to attend training centres run by the local health authorities without this prejudicing the question of their attendance at school later.

644. Those responsible for organising the training centres should be able to draw on the knowledge and experience of the education service, as well as on their own knowledge of the special needs of severely sub-normal children, and it should be possible for members of the local authority itself to take a comprehensive view of the whole range of schools, special schools and training centres. Such co-ordination is desirable not only in regard to training but over the whole field of mental health services for children. We do not however wish to suggest the imposition on all local authorities of any single type of statutory committee ; local authorities are well accustomed to the formation of joint committees or sub-committees for the administration of joint services, and we think they can be left free to work out their own methods of co-ordination.

645. Children of school age not attending school should receive health services, such as medical inspection or dental treatment, similar to those provided for school children. Such services are provided for school children not primarily because they are attending school but because they are growing children, and should be provided for all children of that age whether or not they are attending school.

646. Children attending training centres should be provided with free milk and a mid-day meal on the same basis as school children. We understand that milk is in fact already supplied to children attending full-time occupation centres, and that the centres usually also supply a mid-day meal ; this should be a universal practice.

647. It does not seem to us practicable to provide meals for children who are not attending a school or training centre. We understand that at present such children are eligible for " welfare milk " under the welfare foods service, which covers the provision of seven pints of milk a week at a reduced price. This seems to us to be a very reasonable substitute for the provision of $1\frac{2}{3}$ pints of milk a week free of charge and the subsidised mid-day meal provided to children attending schools or training centres. It should be the responsibility of the local health authorities to make sure that parents know that they may apply for welfare milk for children unable to attend a centre.

648. Our other main recommendation in regard to training is of course that sufficient training centres or home training should be provided to meet the needs of all the children who can benefit from it. The number of children attending centres or receiving training at home rose from about 3,000 at the end of 1948 to 8,754 at the end of 1955, but there was then still a known waiting list of 2,973. If in future children are not " reported as incapable of receiving education at school ", but are " recommended for training in a special training centre " or for home training, the duty of the local authorities to provide such training should be even more clearly seen that it is at present. The local authorities, on the other hand, should be relieved of responsibility for those children who are not suitable for training centres and really require training under psychiatric supervision in hospital. We know that these are already the acknowledged aims of the responsible authorities, and that the limiting factors are restrictions on capital development and the recruitment and training of staff.

649. Our attention was drawn to the difficulty of organising training centres in sparsely populated rural areas, where in order to collect a large enough group of children to justify the provision of a centre it would be necessary to bring children from such long distances that to transport them to the centre every day would be bad for the children as well as very expensive. In such areas residential training centres may be needed, or residential homes for boarders near centres which are also attended by day pupils. Some children might be weekly boarders returning home at week-ends; others might stay for the equivalent of a school term. The type of children suitable for training at such centres can be distinguished from those who need to be admitted to hospital if the principles suggested in paragraphs 601–603 are followed. Children suitable for the training centres would be those who do not need constant nursing attention or training under close psychiatric supervision and who would attend a training centre as day pupils if they lived near enough.

Residential and general social care for children and young persons

650. Residential care may be needed for severely sub-normal and psychopathic children and young persons who have no home, or whose home is unsatisfactory or inadequate to their special needs, or when the special care they need cannot be provided in their own home without placing too great a strain on other members of the family. Although some such children are at present taken care of by the local authorities' children committees, the great majority are recommended for admission to mental deficiency hospitals. Some of our witnesses recommended that the local authorities should provide special homes or residential training centres for at least some of these children as part of their community mental health services. Others recommended that all deprived children, even those who are severely sub-normal, should be taken into care under the Children Act or Children and Young Persons Acts.

651. In paragraphs 327–330 we discussed the extent to which the compulsory powers contained in these Acts might be used to protect severely sub-normal children as well as other children, and expressed the view that a mentally sub-normal or abnormal child or young person may need more protection against exploitation or neglect than a normal child, and that while use should be made of the compulsory powers contained in the general child care legislation when this is appropriate, other wider powers which take the child's mental condition into account should also be available. We also consider that most of these children need specialised care of a type which would more suitably be provided through the mental health services than through the child care service, though in this, as in other respects, there should be co-operation and flexibility between the various local authority and hospital services. Neither the law nor administrative practice should rigidly exclude sub-normal children from the child care services if they can suitably mix with other children. For instance, if several children in one family need to be taken into care, and one of them is mentally sub-normal, it may be harmful to all the children to split the family.

652. Generally speaking, we should expect children who are able to attend ordinary or special day schools to be suitable for ordinary children's homes or foster-homes under the child care services. Children with temperamental difficulties may need the special care provided in residential special schools for maladjusted or educationally sub-normal children. It may be possible for children who are unable to benefit even from these special forms of education to be successfully brought up by the local authorities without needing admission to hospital; these children would attend training centres

instead of school, and the home in which they live might be under the supervision of the local authority's mental health department or of the children's department according to the decision of individual authorities. If homes for such children are provided through the children's department, the advice of the mental welfare officers should be available to the foster-parents or house-mothers just as if the children were living with their own parents; if compulsory powers are needed to effect the children's admission, those under the guardianship of the local health authority under the powers discussed in Part IV of this report should be eligible for admission even if the home is administered by the children's department. But although local authorities should be free to undertake the residential care and training of such children, we think it probable that the majority of the severely sub-normal children who require training rather than education and also need residential care will be found to need special care for a period at any rate under psychiatric supervision in hospital.

653. Several witnesses told us that Section 8 of the Children Act, 1948, at present precludes children's officers from keeping in touch with children in mental deficiency hospitals even when the local authority was exercising parental rights over the child before he went into hospital, though that section seems specifically to preserve the parental rights of the local authorities in these circumstances when such rights have previously been assumed under Section 2 of the Act. We discuss the question of outside contacts for hospital patients in paragraphs 668–672, where we recommend that children's officers and foster-parents should be encouraged to continue to take an interest in any child in a mental deficiency hospital who has previously been under their care. When the local authority has been exercising parental rights before the child's admission to hospital, it should have a positive duty to continue to do anything for the child which a good parent would do, without interfering with the work of the hospital. Any legal or administrative provisions which at present prevent this should be removed.

Services for school-leavers

654. Many witnesses drew our attention to the particular problems which attend the transition from school to adult life of children who are to some degree sub-normal but who have attended ordinary or special schools until the normal school-leaving age. There is considerable criticism of the fact that the present arrangements for reporting school-leavers to local health authorities for supervision after leaving school because of their "disability of mind" lead to the label "mental defective" being attached to young people who have not been so called during childhood. On the other hand, there is clearly a need for many of these, the most backward of the children leaving school, to receive special help at this critical stage of their lives. They may need further full-time training or special help in regard to employment, suitable hostel accommodation or lodgings, and general advice from experienced social workers. Some of our witnesses suggested that the local education authorities should provide vocational training centres and social workers to help those who need such help up to the age of eighteen or twenty; this would make possible a further period of full-time educational training after the age at which these young people at present leave ordinary or special schools. Other witnesses suggested that such training should be provided under the Disabled Persons (Employment) Act, 1944.

655. Vocational training may at present be provided under the Disabled Persons (Employment) Act by the Ministry of Labour and National Service for disabled persons who are aged sixteen or over. Training and other services for young people, whether disabled or not, may also be provided

either by the Ministry of Labour or by the local education authorities through the youth employment service under the Employment and Training Act, 1948. Local education authorities can provide full-time education for young persons who remain at school after the school-leaving age of fifteen, and are also responsible under the Education Acts for the provision of any part-time further education provided after leaving school. In addition, there are the local health authorities' powers under Section 28 of the National Health Service Act, 1946, and Section 30 of the Mental Deficiency Act, 1913, under which training and other forms of community care are at present provided for defectives. Local welfare authorities also have power under Section 29 of the National Assistance Act, 1948, to provide various services for disabled persons, which we describe more fully in paragraphs 702–715 where we discuss whether local authorities' health or welfare powers should be used to provide services for mentally handicapped patients.

656. The Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons which we mentioned in paragraphs 611–612, recommended that the minimum age for the provision of vocational training and industrial rehabilitation under the Disabled Persons (Employment) Act should be lowered from sixteen to the school-leaving age, so that such training might be provided for those who leave school at fifteen. The Committee made no explicit recommendation for the extension of the work of local education authorities in connection with training for young disabled persons. With regard to services other than training, the Committee emphasised the need for the youth employment service to pay special attention to the needs of disabled young persons and recommended against the establishment of a resettlement service for children leaving special schools separate from the existing youth employment service. On the other hand the Committee on Maladjusted Children, which reported to the Minister of Education in 1955, recommended that a personal help service should be provided by local education authorities for maladjusted children during school age and for a few years after leaving school, in addition to the existing youth employment service. This Committee also recommended that local education authorities should be able to arrange suitable lodgings or hostel accommodation during the same age-period.

657. We are not inclined to recommend any extension of the functions of local education authorities in relation to young persons who, because of mental backwardness, need services of a special nature after leaving school. Most of the children who leave special schools for the educationally subnormal go direct into normal employment, with help from the youth employment service. If they also need special advice and supervision from other social workers their need is in most cases likely to continue beyond the age of eighteen or even twenty. If they need further full-time training after leaving school, they are even more likely to need general help and supervision for several years at least. In either case, their need for help may recur at any age, and a small extension of the age up to which they are looked after by the local education authorities is not likely to cover the whole period of their lives during which they may need special help.

658. We should perhaps point out here that, though we speak in general terms of the division of responsibility between local education authorities, local health authorities and welfare authorities, in practice they are all the same authorities—county and county borough councils—and that what we are really discussing is which of their various powers under various Acts should be used, and which of the authority's departments should be responsible for organising a particular aspect of the authority's work. All the

different departments should, in any case, work closely together. Some authorities already arrange for their social workers to act for more than one department, so that they can cover the break which might otherwise occur when a child first goes to school and when he leaves, thus passing in or out of the purview of the education department. For instance, some work as health visitors for children under school age and also as school nurses; others work as school visitors for educationally sub-normal children and also as mental health social workers to look after the same children after leaving school.

659. Our view is that any young people leaving school who need a further period of training because of mental backwardness should receive it through the vocational training courses provided by the Ministry of Labour if they are suitable for these courses, and that the others should receive it in centres administered by the local authorities' health or welfare departments or in hospital. The local authorities' health department should also provide social workers to give any of these young people whatever general help and advice they may need in settling into adult life. We see no need for any formal "ascertainment" of these young people. Just as they are introduced to the youth employment officers for special help over employment, so they and their parents should be introduced, before they leave school, to the social workers from the health department who will befriend and advise them for as long as proves necessary. The education and health departments of the local authority and the youth employment officers should work closely together over this (as they do now in most areas). Arrangements by which the same social workers work for both the education and health departments might be more widely adopted, and the proposed personal help service for maladjusted children might well be under the same administrative organisation. The value of the advice which headmasters and headmistresses can give, even after their pupils have left school, should also not be overlooked.

660. In some cases, the home influences to which these school-leavers would be exposed if they lived with their own families would be detrimental to their prospects of settling into a satisfactory adult life; they may have been educated at residential special schools because their homes are unsatisfactory, and to return them to these homes at school-leaving age might be most unfortunate for their further development. There may be others for whom suitable work cannot be found near their own homes and who may need to be in some sort of lodgings when they first take up employment. In either case, it should be possible for the local authorities to arrange suitable places for them to live, in lodgings, or in homes or hostels provided by voluntary societies, or in homes provided by the local authorities themselves, in which there would be a certain amount of friendly supervision. Some young people might need to stay in these hostels or homes only for a year or two, after which they would be able to manage for themselves, but others might need to stay more permanently. This would form part of the residential services which we discussed in paragraphs 613–636.

661. When the need for residential accommodation of this sort arises from unsatisfactory home conditions, it may be necessary for young persons to be placed under the guardianship of the local health authority or of a suitable individual. Guardianship in the community should be more widely used so that the young person is not removed from the general community and the chances of normal employment and sent into a hospital. These young persons should be sent to hospital as in-patients only when it is

felt that their deficiencies of character are such that they really need a period of full-time special training under close psychiatric supervision.

662. All these services should be available to help children leaving approved schools as well as children leaving other schools. We do not feel able to support the suggestion made by the Association of Managers of Approved Schools and the Association of Headmasters, Headmistresses and Matrons of Approved Schools that prolonged after-care for mentally retarded children leaving approved schools should be provided by the approved schools themselves by an extension of the period of licence under the approved school order. We agree that after-care for these young people is most important, but we consider that it should be provided, as it is provided for all those leaving other schools, by the mental health department of the local authority in whose area the young person is living. In any case in which the approved school authorities think such after-care is likely to be needed, one of the local authority's mental welfare officers might be a suitable person to supervise the child or young person on behalf of the approval school while he is on licence before the approved school order expires, thus providing the maximum continuity of individual care. If a longer period of compulsory control is needed for the patient's own welfare or for the protection of others, admission to guardianship would be possible under the procedures recommended in Part IV of our report.

663. The local authorities' mental health services should also be available for the after-care of young people of psychopathic personality who are of normal intelligence, whether they have been at schools within the normal education system or at approved schools. In some cases it may be necessary to use compulsory powers in order to provide these young patients with further care or training either in the community or in hospital.

Industrial training, sheltered employment and occupational and social centres for adults

664. General rehabilitation and resettlement services and sheltered employment may be provided under the aegis of the Ministry of Labour and National Service under the Disabled Persons (Employment) Act, 1944, or the Employment and Training Act, 1948; various services are provided under these Acts by the Ministry itself, local authorities, voluntary organisations and Remploy Ltd. Under Section 29 of the National Assistance Act, 1948, local authorities have power to provide sheltered workshops as part of their welfare services for disabled persons; these come under the general supervision of the Ministry of Health.

665. The Committee on the Rehabilitation, Training and Resettlement of Disabled Persons recommended that sheltered employment for disabled persons who are able to engage in remunerative employment and can be regarded as being covered by Section 15 of the Disabled Persons (Employment) Act should be provided under that Act under the general supervision of the Ministry of Labour, and not under the National Assistance Act under the aegis of the Ministry of Health. The Committee recommended that the powers of local authorities to provide sheltered employment should be transferred from the National Assistance Act to the Disabled Persons (Employment) Act in so far as they relate to such persons; disabled persons whose work can only be of a diversionary character would continue to be catered for under the welfare provisions of the National Assistance Act. The Committee did not make any specific recommendation about the workshops or other forms of sheltered employment or training for adult defectives which are at present provided by local health authorities under their powers

under Section 30 of the Mental Deficiency Act, 1913, and Section 28 of the National Health Service Act, 1948. We presume however that it would have wished the same line of demarcation to apply between sheltered employment under the aegis of the Ministry of Labour and diversionary occupation under the aegis of the Ministry of Health. With regard to mentally handicapped or disabled patients, we see no reason to dissent from this. It would mean that services under the Disabled Persons (Employment) Act should be available for some convalescent patients recovering from mental illness and for some psychopathic patients, including feebleminded psychopaths. It would remain the responsibility of the local authorities either as welfare authorities or as local health authorities to provide occupation centres, workshops or social centres for more severely disabled patients who nevertheless do not need to be in hospital. We presume that this line of demarcation would not prevent workshops provided by the local health or welfare authorities being used, in suitable cases, for the training or rehabilitation of patients who might be expected eventually to become fit for remunerative employment in open or sheltered industry but who might need to start by working at a slower tempo among more permanently disabled patients.

666. At present most local authorities provide few, if any, occupational or social centres for patients suffering from residual mental disability after an acute mental illness. Little experience has so far been gained of the sort of services which will most help these patients. Some pioneer experimental work has been started by a few mental and geriatric hospitals in the form of day-hospitals or social clubs. It seems likely that if more patients are to be discharged from the hospitals in future when they have received all the benefit they can derive from specialist medical and nursing services, there will be an increased need for such occupational and social centres for patients outside the hospitals. Such facilities might also be useful as part of the preventive services for people who have not needed to go into hospital for in-patient treatment, or to help to prevent the relapse of patients who have responded to a first course of treatment. More experimental work in this field is needed. This is a direction in which some local authorities' community mental health services might most usefully be developed and falls clearly within their proper field of activity.

667. Some local health authorities provide occupation or training centres or sheltered workshops and social clubs for adults as part of their mental deficiency services. The people who attend these centres include some who as children have been excluded from school and some who have attended special or ordinary schools. At the end of 1955, 4,317 adults were attending occupation centres and 1,108 were receiving training at home; another 5,763 were on the official waiting lists, a total of some 11,000. If to this number is added those patients of stable temperament who are at present accommodated in mental deficiency hospitals but who might be discharged if they had suitable homes in which to live and some suitable occupation, the number of adults for whom local authorities may in future need to provide occupation centres or workshops may be very considerable, and is almost certainly not less than the number of children for whom a different type of training centre is needed.

Social work and outside contacts for hospital patients

668. Almost all severely sub-normal patients and feebleminded psychopaths and a great many mentally ill patients need and receive medical attention and social help while living at home, before the question of admission to hospital arises. In a great many cases hospital in-patient

treatment is never necessary at all. Most of those who need in-patient treatment at some stage are discharged from hospital later and may again need community care. For many patients therefore their time in hospital, if they go into hospital at all, is only one stage in their treatment and may be the shortest stage. It is necessary to emphasise this because in the past treatment was centred in the hospitals or institutions and community services were subsidiary. For some patients this is still so; community care may not be needed before admission to hospital, or even after discharge, by patients who develop an acute mental illness suddenly, who are admitted to hospital at once as in-patients and recover quickly, or whose families or friends are able and willing to give them the necessary social support before and after their period in hospital. But viewing the mental health services as a whole, hospital in-patient treatment should now be regarded as a stage which is commonly preceded and followed by some form of community care or out-patient treatment. And as the community services and the hospital services are now administered by different authorities it is essential that these authorities and their staff should plan and operate their work in close co-operation so as to ensure the maximum possible continuity of care for individual patients. (We discuss the general question of co-operation in paragraphs 690–693.)

669. When a patient is living with his own family, one of the most important functions of the social worker or mental welfare officer is to advise his family and try to ensure that they understand his needs and difficulties. This is particularly important for feebleminded psychopaths and the less severely handicapped patients in the severely sub-normal group, whose relatives often do not appreciate the patient's special needs; in some cases a poor home environment may have itself contributed to the retardation of the patient's mental development. In some such cases it may be necessary to remove him from the family and to provide training, often in hospital, aimed at making him more self-reliant so that he may eventually be able to return to live either with his own family or in some other home. When this happens the local health authority's work with the family should not necessarily cease. In suitable cases the mental welfare officers should keep in touch with the family and take advantage of any change in circumstances which may make it possible for the patient to return home. This is sometimes done at present, and mental deficiency hospitals usually rely on the local health authorities to provide reports on patients' home circumstances from time to time. We consider that it should be a normal part of the local authorities' community care service to undertake any necessary social work with the family of sub-normal or psychopathic patients, and perhaps of mentally ill patients also, while the patient is in hospital, which may contribute to his welfare when his training in hospital is complete. They should also keep the hospital informed about the home conditions to help them to judge how soon the patient can safely return home. This will involve keeping in touch with the hospital about the patient's own progress there.

670. The Association of Municipal Corporations drew our attention to the fact that before 1948, when local authorities were responsible for institutional as well as community care, members of those authorities used to visit defectives from their area who were in institutions, including those in institutions in other parts of the country too far away from the patient's own relatives to be able to visit easily. The Association suggested that such visits were still desirable and that the power to make them should be restored.

671. We agree that it is most desirable that some link should be maintained between patients in hospitals and the world outside from which they have come and to which many of them will return, and that patients without relatives or whose relatives do not or cannot visit them should be visited from time to time by some other suitable person. Parents and relatives should be encouraged to make visits themselves. Even if the parents were originally opposed to the patient's admission to hospital, they should have every opportunity of seeing the patients and discussing their progress with the hospital staff, and with members of the hospital management committee if they wish. In some places patients' relatives are either organised as Friends of a particular hospital or as an association of parents or relatives living in a particular area, and not only visit their own relatives in hospital but also visit or invite out patients who have no relatives or whose relatives take no interest in them. Such arrangements are of great value and we hope that they will spread in other areas.

672. There will probably still be many patients who are not visited by relative or friends. We think it would be valuable if officers of the local health authorities, who will probably have known the patients before their admission to hospital and may have helped to arrange their admission, were to continue to take a personal interest in these patients while they are in hospital and help to arrange their discharge when they are ready for it. In most cases the most suitable local authority officer to do this would be one of the mental welfare officers of the authority in whose area the patient lived before going into hospital. Sometimes it may be more convenient for visits to be paid by an officer of the authority in whose area the hospital is situated or of another authority from whose area there are other patients in the same hospital. If the patient has been receiving care from the local authority's children's department before admission to hospital, the children's officer or one of her staff might be the most appropriate person to keep in touch with the patient; this should be decided by agreement between the authority's children's department and their mental health department. When a local authority or one of its officers has been given parental rights under a "fit person" order under the Children and Young Persons Acts, or by assuming such rights under Section 2 of the Children Act, 1948, or has been appointed guardian or authorised to act in place of the nearest relative under the new procedures which we recommend in Chapter 7, the authority should have a positive duty to continue to act as a good parent while the child or other person is in hospital. It should be clearly understood that the purpose of visits by local authority officers would be to keep up an outside interest in individual patients, acting in the place of a parent or relative; this should not be allowed to encroach on the hospital's responsibility for the care of the patient while in hospital. The local health authorities' power to make arrangements for the care of persons suffering from mental defectiveness, under Section 28 of the National Health Service Act, 1946, seems to us to be wide enough to cover this work, but if necessary this should be clarified.

Community care after leaving hospital

673. As we mentioned in paragraph 597, mental deficiency hospitals are considered responsible for the care of all patients who have been committed to their care by a judicial order or by being "placed" in hospitals by their parents and who have not been formally discharged, even though the patient is living outside the hospital, possibly far away from the hospital, on licence. In many areas the care of such patients is carried out by local health authority staff on the hospital's behalf, but so long as the order

remains in force (and it may be renewed while the patient is on licence) the patient is regarded under the present Mental Deficiency Acts as still detained in the hospital. In paragraph 229 in Chapter 4 we explained that in the past licence has sometimes been continued for long periods mainly in order to ensure that patients receive after-care which would not otherwise be provided for them.

674. The resettlement of a patient in new surroundings after a period often of some years in hospital is not easily achieved. Several of our witnesses stressed the value of the patient continuing to receive advice and help from the same people whom he has known while in hospital, at any rate for some weeks or months after leaving the hospital. Others pointed out that it may be undesirable for the change from the care of one social worker to another to coincide with the end of the legal sanctions of licence.

675. In our view the after-care of patients after leaving hospital must be considered part of the general community care for which local authorities are responsible. We do not wish the division of functions to be so rigid that hospitals will hesitate to send a patient out until they are sure he is quite ready to cut his links with the hospital. Patients should be sent out on trial as soon as the hospital doctors think there is a reasonable prospect that they may succeed in life outside. But hospitals and local health authorities should work together to this end. The general aim should be for a local authority mental welfare officer to get to know each patient who is leaving hospital and his needs at as early a stage as possible, perhaps even before he ceases to be a hospital in-patient. In many cases the welfare officer will have known the patient before admission, and under our proposals in paragraphs 668–672 may have kept in touch with him and his family while he has been in hospital. In these and in other cases the staff of the local authority may be the most suitably placed to make the initial arrangements for where the patient is to live or work, in consultation with the hospital medical staff, before he actually ceases to be a hospital in-patient, and may help and advise him from then on. The exact arrangements between hospitals and local authorities may vary and should be flexible so that they can be adapted to the needs of individual patients, but (subject to any necessary medical follow-up or out-patient arrangements) the social care of persons who are no longer hospital in-patients is essentially the responsibility of the local authorities, not of the hospitals.

676. It should be the duty of the local authorities to provide after-care for all patients who need it. This should apply to all patients who require such care whether they are subject to compulsory powers or not. The provision of after-care should not be linked with the continuation of compulsory powers; we discussed this aspect of licence in paragraph 306 in Chapter 5 and paragraphs 469–477 in Chapter 7. After-care should be provided without any form of compulsory control wherever possible. If the patient has been subject to compulsory powers while in hospital, and if proper after-care cannot be provided without the continuation of such powers, the patient should be transferred to guardianship not more than six months after leaving hospital, by which time the local authority should have assumed full responsibility for the patient's care; there is no reason why the local authority should not take over responsibility for after-care before the end of the period in which powers of recall are still held by the hospital.

677. It is the local authorities also who should be responsible for any after-care, other than medical treatment, needed by patients who have received hospital treatment for mental illness. Some local authorities who have staff ready to provide after-care for discharged patients told us that mental hospitals rarely refer patients to them or give insufficient information about

patients when they notify their discharge. One local authority suggested that a definite duty should be placed on the medical superintendents of hospitals to consider each patient's need for after-care and, if the patient consents to receive it, to advise whether it should be provided by the hospital or by the local authority, and to notify the local authority accordingly. Another local authority suggested that notices of discharge sent to them by the hospitals should contain fuller information about the patient's illness, prognosis, suitability for employment and suggestions on how after-care could most successfully be provided.

678. We do not think that such matters should be regulated by law, by the imposition of statutory duties or the prescription of statutory forms. In some, but not all, mental hospitals it is the practice for the doctor who has been responsible for the patient's treatment in hospital to send a report, including suggestions for after-care, to the patient's general practitioner. In our view this practice should be adopted in all hospitals. We recommended in paragraph 485 in Chapter 7 that the present requirement for the notification to local health authorities of the discharge of all patients except paying patients should be brought to an end, and that the local authorities should be notified only if the patient needs and is willing to receive after-care or if the local authority originally arranged or helped to arrange the patient's admission. The hospital staff should encourage patients to accept help from the local authority after-care service. Provided the patient agrees, full information should then be given to the local authority. This might be done by a case-conference or by a written report, according to the general arrangements for co-operation between the hospital and local authority staff, which we discuss in paragraphs 690–693.

Care for psychopathic patients

679. We have made few references in the earlier parts of this chapter to psychopathic patients of normal intelligence. Feebleminded psychopaths who are often backward at school and slow or ineffectual in other ways form a large proportion of the patients at present receiving community care from the local health authorities' mental deficiency services. But psychopathic patients of normal intelligence are seldom ascertained as mentally defective unless their conduct is so seriously anti-social that admission to hospital is thought necessary. Special forms of care in the general community are not provided for them at present, though help may be given within the framework of the general social services such as the employment and rehabilitation services, and any who are admitted to hospital under the Mental Deficiency Acts may have a period on licence in the community after hospital treatment before being discharged from order. It may well be, however, that with a general expansion of community mental health services it will be found possible in future to do more for psychopaths of normal intelligence. Some of them may be able to benefit from the occupational training and social centres which are beginning to be developed for mentally ill patients, as mentioned in paragraph 666. Residential and other forms of after-care after leaving hospital may also be as necessary for them as for any other mental patients.

680. In Chapter 6 we stressed the importance of training being provided for as many psychopathic patients as possible early in life when they seem most likely to benefit from it. We recommended that hospitals and local authorities should be free to provide care for psychopathic patients of any age who can be persuaded to accept it without the use of compulsion, and we proposed that these patients should be subject to compulsory care in more limited circumstances than those in which some of them are now

subject to compulsory control under the present Mental Deficiency Acts. Except for short periods of observation, and except when the patient is admitted following court proceedings or on transfer from prison, our proposals would not permit the use of compulsion to admit a patient to hospital or community care after he has passed the age of twenty-one. If these proposals are accepted, and if they are to succeed in their object, local authorities and hospitals must be prepared to develop their services for young psychopathic patients and when necessary to use their powers of compulsion to ensure that the services are used for the patients who can benefit from them most.

Diagnosis and selection of the most suitable form of care for severely sub-normal and psychopathic patients

681. The present arrangements for the diagnosis of mental deficiency and for the choice of the most appropriate form of care for children or adults who are thought to be mentally defective do not seem to us to be entirely satisfactory.

682. Our attention has been drawn to the difficulty of assessing the mental abilities of a child who is blind, deaf or spastic, and to the possibility that retardation due solely to this sort of physical disability may be mistakenly diagnosed as due to mental defect. Quite apart from this, it is often difficult to form a considered opinion of the reasons for a child's backwardness or of the form of treatment or training from which a child or adult can most benefit until the patient has had a prolonged period of observation and testing by an experienced psychiatrist. Yet the procedures laid down in the Mental Deficiency Acts for admission to mental deficiency hospitals require a firm diagnosis of mental defectiveness before admission. Similarly, local health authority services are not usually made available until the patient has been " ascertained " as a defective. A firm diagnosis may therefore have to be made without psychiatric observation and before it is known how the patient will respond to special forms of training or treatment.

683. We have no reason to think that errors of diagnosis are common. We are certain that the teachers, psychologists, social workers and medical officers, who are at present responsible for considering and reporting on children who appear to be incapable of receiving education at school because of mental disability, take great pains to arrive at the right decision and in cases of doubt observe the child's behaviour and performance at school and at home over a long period. But their representatives all emphasised, in their evidence to us, how difficult a decision it sometimes is and how necessary it is to make a re-assessment at intervals later on.

684. Another gap in the present mental deficiency services is that in most areas there are no arrangements, such as exist in the child guidance clinics for maladjusted children, by which psychiatric advice may be given to the parents of children who are living at home, when more expert medical or other advice is needed than can be given by the general practitioner or by a mental welfare officer visiting the home. Doctors working in the local health authorities' mental health departments meet this need up to a point, but there is nothing in this field equivalent to the child guidance clinics, and comparatively few psychiatrists on the staff of mental deficiency hospitals hold out-patient clinics either in their own hospitals or elsewhere.

685. These difficulties should be eased by the alterations in the procedures governing admission to hospitals recommended in Part IV of our report, and by the alterations in the procedures governing the transfer of a child from a school to a training centre recommended in paragraphs 640-642.

But we also consider it most necessary that there should be new administrative arrangements which would bring together the resources of the local authority mental health service, the hospital service, the education and school health services (for children), and (for adults) the local authority's welfare department, for the diagnosis and periodical re-assessment of such patients and for deciding the form of care most suitable for each individual patient.

686. Doctors working in the school health service and in the local authority's mental health department should be able to refer children for investigation by psychiatrists and other specialists before a definite diagnosis is made, particularly in those cases where physical as well as mental disability is either evident or suspected. It should be possible for patients to be referred for examination or observation either as out-patients or as in-patients. Our recommendations in Chapters 5 and 7 would remove the difficulties which now effectively prohibit the admission of patients for prolonged observation as in-patients in mental deficiency hospitals ; psychiatrists from these hospitals should also be available for consultation about children who could be seen in school clinics or at home or as out-patients elsewhere. After a diagnosis has been made, the choice between school, training centre or hospital care for children, and between community care or hospital care for adults, is determined in present circumstances not only by the patient's mental and physical condition but also very largely by the availability of accommodation in hospitals and training centres and by the fact that very little residential care is at present provided except in hospitals. Even in present circumstances there should be more consultation between local authority and hospital staff before the choice is made, particularly when admission to hospital is recommended. This will be even more desirable if a greater variety of forms of care are provided in future on the lines recommended earlier in this chapter.

687. Although we do not wish to make many detailed recommendations about the form of administrative organisation which would best meet these needs, we should give a general indication of what we have in mind. The initiative in organising a suitable diagnostic service should generally lie with the local health authorities, as it would largely replace their present arrangements for the " ascertainment " of mental defectives, but psychiatric specialists should be provided by the hospital boards. In some places it might be appropriate to use existing child guidance clinics as the nucleus of a comprehensive children's mental health clinic which would provide facilities for the investigation and diagnosis of all forms of mental disorder in children, with separate clinics for adults. In other areas, there might be separate clinics for children thought to be severely sub-normal. Investigations which require the services of other specialist staff, such as special types of sight and hearing tests, might be carried out at these clinics if convenient, or the patients might attend elsewhere. The psychiatrist examining a child would also need reports from teachers, psychologists and social workers, and might wish to observe the child over a considerable period (if necessary as a hospital in-patient) before coming to a decision. However the clinics are organised, it would be essential that they should co-ordinate the work in this field not only of the school health service and the hospitals but also of the mental health department of the local health authority, and that they should be adequately staffed with psychiatrists, psychologists and mental health social workers. Clinics undertaking these diagnostic investigations could also suitably function as consultative clinics to give continuing advice to parents and to adult patients, filling the role of hospital out-patient clinics for these forms of mental disorder.

688. In order to ensure proper consultation between the local health authorities, hospitals and local education or welfare authorities on the choice of the form of care most appropriate to each individual patient, we envisage case-conferences attended by an administrative medical officer of the local authority's mental health department, a doctor from the psychiatric hospital serving the area, representatives from the education or welfare departments of the local authority as appropriate, social workers, and if possible also by the patient's general practitioner. They would consider the reports and recommendations received from teachers, psychologists, social workers and any doctors who had examined the patient (at least one of whom we would expect to be present at the conference), the facilities at the disposal of the administrative authorities concerned, and the wishes of the patient and his relatives, and would decide on what form of care should or could be provided for each patient. Administrative as well as clinical considerations enter into this decision and will continue to do so, not only while the present overall shortage of accommodation continues, but also while new forms of residential care are being developed, as we hope they will in future. Case-conferences of this sort are already found to serve a useful purpose in some child guidance clinics, and similar arrangements have recently been introduced in some areas as a means of consultation between the various people who are concerned with problem families. In our view regular arrangements of this sort are essential, if services for severely sub-normal and psychopathic patients are to be properly used and developed. They should ensure that each local authority department, the hospitals and the general practitioners see their work in relation to the work of the others, and should give them an opportunity to work together as a team. Joint consideration of the needs of individual patients should also provide a sound basis for judging the type of services which need to be developed in each locality, and for making recommendations to the appropriate administrative authorities. Patients' needs should be re-assessed from time to time by similar case-conferences in the light of progress reports. The responsibility for organising these case-conferences should rest with the mental health department of the local health authority. It might be convenient to hold them in the same premises as the diagnostic clinics. It should however be possible to start these case-conferences as a piece of consultative machinery between local authority and hospital staff without waiting for the opening of new clinics.

689. These diagnostic clinics and case-conferences could also be used to prepare reports on the mental condition of children, young persons or adults brought before the courts who are thought to be mentally disordered, and to advise on suitable forms of care or control, under the new procedures recommended in Chapter 7, paragraphs 511–552.

Co-ordination between local authorities and hospitals

690. In the preceding sections of this chapter we have often mentioned the need for local authority and hospital staff to work in close contact with each other, so as to ensure continuity in the care of individual patients and to make the best use of the staff and other resources of each branch of our health and welfare services. This is especially important in connection with social work for out-patients and for patients discharged from hospital. We particularly wish to stress the need for hospitals to take full advantage of any services provided by local authorities and of their more intimate knowledge of the area in which the patient lives and the local opportunities for his rehabilitation and resettlement after discharge.

691. In addition to arrangements for the allocation of responsibilities and for day-to-day contacts between medical officers, social workers, and

other staff, we place considerable importance on the members of the hospital and local authorities getting to know each other's services. There is usually some joint membership between local authorities and hospital management committees, but by no means all members serve on more than one authority. It is very useful for members of, for instance, a local authority's welfare committee to be invited to see round the mental hospital serving that area, and for members of the hospital management committee to see old people's welfare services; such visits help them to see where the two authorities' functions touch each other. Such contacts need not be confined to the special mental health services, but can usefully extend to other forms of hospital and local authority activities which contribute towards the prevention or relief of mental disorder.

692. Several of our witnesses suggested specific ways of ensuring co-operation, such as regular meetings between local authority and hospital staff, case-conferences, or the joint employment of social workers. We do not think it would be right to lay down any common pattern. In paragraphs 681–689 we discussed in some detail the new arrangements which we consider necessary for choosing the most suitable form of care for individual severely sub-normal and psychopathic patients, because we consider this to be a major gap in the present services, but even in that connection we do not wish to be too categorical about the administrative methods to be used. Methods of co-operation should be arranged to suit local conditions, such as the staff available, the location of the hospitals and out-patient clinics in relation to the area from which they draw their patients, the number of local health authorities from whose areas patients come to any one hospital, and so on. Different arrangements may be necessary for dealing with different groups of patients, because of differences in the type of community services which they need and in the length of time they usually remain in hospital.

693. Arrangements for close co-operation between the local authorities and the hospitals should be made on the initiative of the authorities in each locality, and should cover the planning of new services as well as co-operation over existing services. The arrangements should be wide enough to include any hospitals providing psychiatric treatment, including neurosis, general and teaching hospitals and out-patient clinics. There is plenty of opportunity for administrative experiments. It is also desirable that schemes of co-ordination which have been found successful in any locality should become widely known. It might be useful if the Ministry of Health were to help to disseminate information about such schemes.

Maintenance grants and cash payments

694. Mental and mental deficiency hospitals sometimes make maintenance grants to patients living in the general community on trial or boarded out or on leave or licence. The Lunacy and Mental Treatment Acts contain specific authority for such grants in respect of patients on trial or boarded out. The Mental Deficiency Acts contain no specific authority in relation to defectives on leave or licence, but it has been assumed that the responsibility of the hospital for the care of its patients, including the power to provide for their maintenance if necessary, continues as long as the legal authority for their detention or control by the hospital. The Mental Deficiency Acts give local health authorities specific authority to contribute to the expenses of defectives under guardianship but not of those under supervision. All these powers are related to the legal powers under which the patients are put into the care of the hospital or guardian, and they are not interpreted as extending to voluntary patients in mental hospitals.

695. The National Assistance Board have general powers to give financial assistance to those in need which now overlap, largely but not completely, these powers of the mental and mental deficiency hospitals and local health authorities. Subject to the provisions of the National Assistance Act and Regulations, it is the Board's duty to give financial assistance to those who "are without resources or whose resources must be supplemented in order to meet their requirements". The Board may not however make grants to any person under the age of sixteen, though a person under that age is counted as a dependent in assessing the needs of his parent. The Board are also precluded from making any payment to any person engaged in remunerative full-time work under a contract of service. They cannot, therefore, assist a mentally disabled person who is employed full-time but who, because of his incapacity to do the same work as a normal person, is not paid the full normal wage for the job. Nor can they make a grant in respect of a mentally sub-normal child below the age of sixteen if the parent is in full-time employment. Local health authorities may at present make grants in these circumstances in respect of a defective who is under guardianship, and guardianship orders are sometimes obtained simply for this reason. This sometimes leads to the extraordinary procedure of a judicial order putting a child under the age of sixteen under the guardianship of his own father simply for this purpose. Adults are also sometimes placed under guardianship so that a grant may be paid.

696. In some areas, hospitals and local health authorities still make grants themselves, even when the recipient would be equally eligible for help from the National Assistance Board. There is also a general administrative arrangement under which the mental and mental deficiency hospitals give pocket-money to some of their in-patients who have no other source of income; claims are not made to the National Assistance Board, who provide pocket-money to patients in all other hospitals in similar circumstances. Some of our witnesses expressed the view that the hospitals or local health authorities are in the best position to judge the right amount of grant for one of their patients or former patients, and that for that reason they should be responsible rather than the National Assistance Board. Other witnesses told us that in many areas the officers of the Board and of the local authorities or hospitals consult together when necessary, the payments being made by the Board (except pocket-money for in-patients).

697. We consider it entirely wrong that compulsory powers which restrict the liberty of an individual patient should ever be obtained or prolonged simply in order that financial assistance may be given to the patient. And whether or not a patient is subject to compulsory powers, the National Assistance Board, rather than the hospital or local health authority, is now the proper authority to make financial grants to mental patients as well as to other persons, in so far as the Board's general powers permit. We recommend that, after consultation with the hospital or local health authority when necessary, the National Assistance Board should normally be responsible for financial grants to hospital in-patients and to patients who have left the hospitals and to those receiving community care from the local authorities, wherever they are living and whether they are on trial or under guardianship or not. In some cases the Board's normal grant would not be sufficient to cover the full cost of the care of a patient who is boarded out in a private home or in a home run by a voluntary society, taking into account the amount of care and attention which is provided in addition to board and lodging. In such cases the local authority should be able to make suitable financial arrangements with the society or individual caring for the patient, but any monetary payments to the patient should be made by the National Assistance

Board. When hospital in-patients leave the hospital for a short period for a holiday or other reason knowing that they will return to the hospital, and when such absence is of therapeutic value to the patient, hospital authorities should not be precluded from giving any necessary financial grant, irrespective of whether the patient has been admitted voluntarily or under compulsory powers; but it is preferable for the National Assistance Board to be responsible even in these circumstances except when the absence is to be for so short a period or is arranged at such short notice that it is not practicable to make an application to the Board.

698. But, as we mentioned in paragraph 695, the National Assistance Board under its present powers may not assist a person who is in full-time employment under a contract of service even if he is paid less than the normal wage because of his disability. The Board may assist people who are prevented by physical or mental illness or disability from working full-time but who work part-time. Patients recovering from tuberculosis, for instance, may be eligible for financial grants while they are only capable of part-time work, and the same applies to other handicapped or convalescent persons. Local authorities also have power under Section 29 of the National Assistance Act, 1948, to give financial grants to certain handicapped persons in certain circumstances, and this power is used to augment the earnings of blind persons working full-time in sheltered employment, such as workshops for the blind, or working at home, who are not eligible for assistance from the National Assistance Board. These augmentation grants are not paid to blind persons employed full-time in open industry, but we understand that blind persons in open industry are usually paid the full rate for their job. The great majority of the mentally disabled who are in employment, including many feebleminded psychopaths, are also paid the full rate for the job, but there are some who are paid less than the full normal wage. In employment where minimum wages are fixed by statutory Wages Boards or Councils—e.g., the catering trade and agriculture—there are statutory arrangements for the payment of lower rates to persons incapable of earning the minimum wage. In other types of employment in which wages are negotiated direct between the employers and the trade unions, lower rates are occasionally paid to severely sub-normal or feebleminded persons, with the knowledge and agreement of the union's representatives. Many such persons are also found work in private domestic employment which does not come under the Catering Wages Act, or in other private employment for which there are no standard rates of pay; the wages agreed between the employer and the hospital or local health authority who make the arrangements may take account of the employee's limited capacities and be less than would be paid to a normal worker.

699. In our view, people who are handicapped by any form of mental disorder, who can work full-time but because of their mental disability cannot do a full normal job and are for that reason paid at a sub-standard rate, should be eligible for help from some public authority. Their need is just as great as that of a person who is earning less than the normal wage for his job because illness or handicap makes him physically incapable of working full-time. In many cases, the most suitable form of help would be for local authorities to provide residential accommodation, either in their own hostels or by arranging suitable lodgings or foster-homes, the worker being required to pay only what is reasonable from his earnings. But this would not help those living with their own families. Though the number of mentally disabled people needing help in such circumstances will probably be small, we think that help should be available when needed. There should certainly be no question of using legal restraints such as guardianship to

make it possible. We consider that the most suitable arrangement would be for local authorities to have power to make grants analogous to the augmentation grants paid to blind workers, but in the case of the mentally handicapped the grants should be available not only to persons working in sheltered employment or at home but also to those working in normal employment at sub-standard rates or at rates specially agreed to suit the worker's limited capacity.

700. In our view there is not such a strong case for financial help for parents who have a mentally sub-normal child living at home but who are not eligible for help from the National Assistance Board. The reasons put forward by some of our witnesses in favour of such help are, first, that local health authorities can already make such payments when the child is under guardianship; secondly, that severely sub-normal children are often destructive and dirty in their habits which may involve their parents in extra expense; and thirdly, that the children need attention in the home all day if they are not attending school or training centre. We know that at present many parents are bearing an almost intolerable burden by having to look after severely sub-normal children who are not receiving proper training. The proper remedy in our view is the provision of adequate training facilities and other services in kind. The problem would not be so serious if all children were able to receive training either at a training centre or in hospital. Local health authorities have powers under the National Health Service Acts to provide home helps, and might perhaps also be able to provide or pay for a laundry service as some authorities do for old people living at home. We consider that these forms of service should be developed. In spite of the difficulties which some parents will inevitably experience until this is done, we do not feel that Parliament should be asked to authorise payments of money to the parents of these children which are not made to the parents of normal children or of children suffering from other forms of illness or handicap.

701. The normal National Assistance Board arrangements, supplemented by the augmentation grants for adult workers recommended in paragraph 699 and by the local authorities' powers to provide residential care when necessary, should replace the local health authorities' present power to make financial grants for defectives under guardianship and the hospitals' power to pay monetary grants for defectives on licence or mentally ill patients on trial or boarded out.

Local authority powers and duties under the National Health Service Acts and National Assistance Act

702. In the preceding sections of this chapter we gave our views on the services which should be provided by the hospital authorities on the one hand and the local authorities on the other. We recommended an expansion of the services which local authorities should provide as part of the community health and welfare services, under their general powers under the National Health Service Acts or National Assistance Act. In paragraphs 703-715 we discuss in more detail the local authorities' powers under these Acts and the extent to which each set of powers might be used to provide services for mentally disordered patients.

703. Section 28 of the National Health Service Act, 1946, gives local health authorities power to "make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons . . .". By direction of the Minister of Health these powers may be made a duty to such extent as he

directs. At present, the only group of persons for whom the provision of services under this section has been made a duty are those suffering from tuberculosis; the provision of other services under this section is at present permissive subject to the approval of schemes by the Minister, though the Minister may modify schemes or direct the submission of new schemes so as to include such services as he considers necessary. Section 28 specifically prohibits the payment of money to persons receiving care, except as remuneration for work done.

704. Section 21 of the National Assistance Act, 1948, lays on local authorities a duty to provide residential accommodation for "persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them". Section 21 (8) states that local authorities are not authorised or required under this section to make any provision authorised or required to be made by them or any other authority under any other powers.

705. Section 29 of the National Assistance Act, 1948, gives local authorities power to "make arrangements for promoting the welfare of . . . persons who are blind, deaf or dumb, and other persons who are substantially and permanently handicapped by illness, injury or congenital deformity or such other disabilities as may be prescribed by the Minister". By direction of the Minister of Health these powers may be made a duty to such extent as he directs. At present the provision of services for the blind, but not for other handicapped persons, has been made a duty by direction of the Minister. The services which a local authority may provide under this section specifically include workshops and hostels, and it is under this section that the augmentation grants which we mentioned in paragraph 698 are made to some blind workers. (We mentioned in paragraph 665 that the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons has recommended that the services provided under this section should be limited to persons who are not capable of remunerative employment.) Section 20 (6) (*b*) states that local authorities are not authorised or required to provide under this section any accommodation or services required to be provided under the National Health Service Act, 1946.

706. Services under these sections of the National Health Service Act and National Assistance Act may be provided through the agency of voluntary organisations.

707. Read in the context of the two Acts, the intention seems to be that Section 28 of the National Health Service Act, 1946, should be used to provide community health services with a distinctly medical flavour, either for the prevention of illness or for the care of persons who are, or have been, suffering from an illness which has required active medical treatment. The powers provided under the National Assistance Act seem to be intended to provide more purely social services for persons suffering from some permanent handicap or chronic disability (including infirmity due to old age) which calls for the provision of special help in the person's every-day life, such as residential care or special forms of occupation and general social help. It will be noted however that services for mental defectives are explicitly mentioned as included in those which may be provided under the National Health Service Acts and are not explicitly mentioned in Sections 21 or 29 of the National Assistance Act.

708. In relation to mental health it seems to us very difficult to draw a distinction between community services needed on medical grounds and those needed on social grounds. All forms of mental disorder directly affect a person's everyday life, and an important element in the medical treat-

ment of such disorders is the attempt to secure the patient's adjustment to his social environment or improvement in the social environment itself. All social work for the mentally disordered has a medical flavour and all medical work for them has social rehabilitation as its aim. It is possible to make a broad distinction between hospital services provided under individual specialist medical supervision and the more general community services which local authorities should provide, but it is difficult in this field to sub-divide local authority services into health services and welfare services. When one is considering community services for mental patients, the powers under Section 28 of the National Health Service Act, 1946, and those under Sections 21 and 29 of the National Assistance Act, 1948, seem to be wide enough for either to be used to provide many of the specific services we have been discussing in this chapter. For this reason we support the recommendation of the Committee on the Cost of the National Health Service[5] that there should be the closest possible integration of these two branches of the local authorities' work. In so far as a distinction between the two can be made in the mental health field, however, our views are as follows.

709. **We consider it essential that the central direction of the community services for mentally disordered patients should be in the hands of the medical officer of health.** He and his staff (medical and administrative staff and social workers) hold a key position. As well as providing general help and advice to individual patients and their relatives, and helping to arrange for them to obtain whatever specific forms of care seem appropriate to their needs, they should take a comprehensive view of all the services which may contribute to the promotion of mental health and the relief of mental disorder. The medical officer of health should stimulate the development of any services which serve this end and are the local authority's responsibility, even if such services are not directly administered by his own department. He and his staff should also work in close co-operation with the general practitioners and the hospitals and be in touch with the staff of other local authority and government departments which provide other general social services, such as the youth employment officers, disablement resettlement officers, children's officers, probation officers, and the staff of the education services, National Assistance Board, etc. They should also be in close touch with voluntary associations and societies. In our view it is essential that this central organising and individual social work should be recognised as part of the responsibility of the medical officer of health. Its vitality and efficacy will depend to a large extent on whether or not he takes an active personal interest in it.

710. **Provided that this organising and individual social work is clearly recognised as a health service, as part of the local health authority's work for the prevention of illness and for care and after-care under Section 28 of the National Health Service Act, 1946, it does not seem to us to be so important to decide whether the more specific forms of care, such as social centres, workshops, occupation centres, training centres and hostels, should be provided under health or welfare powers.** Whichever of these powers are used, these facilities can be invoked to help individual people, just as the more general social services provided by completely separate authorities can be invoked to help mentally disordered people. While these two sets of general powers exist side by side we consider that individual local authorities should be able to use whichever they prefer. Any facilities of this sort specifically intended for mentally disordered persons can legitimately be considered a health service with a medical flavour, and any local authority which wishes to organise such services under the direct administration of

[5] Cmd. 9663, paragraphs 605–606.

its health department should be allowed to do this under the National Health Service Acts. Day or residential training centres for severely sub-normal children we would expect almost invariably to be considered a direct health service rather than a welfare service. Workshops or centres for adults have more affinity to workshops and centres which may be needed for the other groups of handicapped persons mentioned in Section 29 of the National Assistance Act. But few local authorities as yet provide workshops or centres for physically handicapped persons except the blind. While this situation continues many authorities may wish to have their centres for mentally handicapped adults under the direct administration of their mental health department, whereas later on when more provision is made for other handicapped persons they may wish to bring all such services together as general welfare activities. We do not think that any rigid dividing line should be drawn.

711. The situation in regard to residential accommodation is a little different. We consider that local health authorities should be able, as part of their services under the National Health Service Acts, to provide residential training centres for severely sub-normal children, and other accommodation for sub-normal or psychopathic persons of any age or mentally ill adults who require some supervision but who do not require treatment or training in hospital or have already received such training or treatment, in accordance with our recommendation earlier in this chapter. If necessary Section 28 of the National Health Service Act, 1946, should be amended to make it clear that it covers the provision of residential accommodation, directly by the local authority itself or by paying for accommodation in private or charitable homes. On the other hand, this should not lead to the exclusion of all mentally infirm or handicapped persons from accommodation in homes provided under Section 21 of the National Assistance Act, 1948, and Section 21 (8) of that Act may need to be amended. Persons who are suitable for ordinary old people's homes should certainly not be excluded from them. For other elderly people who are mentally infirm and for younger patients the need for residential accommodation will be accompanied by a need for varying degrees of medico-social care for varying lengths of time. So long as adequate services are provided it does not seem to us important which of their available powers are used for this purpose by individual local authorities. Under whichever powers the local authorities provide residential accommodation, however, we consider that any resident who is in paid employment should be expected to contribute a reasonable sum towards the cost of his accommodation, taking into account the amount of his earnings as well as the actual cost of his maintenance.

712. There is also the question of cash grants to patients living at home who are in full-time employment but are receiving a sub-standard wage, which we recommended in paragraph 699. Individuals needing such assistance will probably first come to the notice of the mental welfare officers working in the local authority's mental health department, but we consider that the power to make such payments would most appropriately be introduced by a suitable amendment to Section 29 (6) (*a*) of the National Assistance Act, 1948.

713. We realise that at present the health and welfare services are provided under differing financial arrangements as regards exchequer contributions. The exchequer contributes 50 per cent. of all approved expenditure incurred by the local health authorities. Exchequer contributions towards residential services provided under Section 21 of the National Assistance Act are confined to a smaller contribution towards the capital cost of new accommodation and to weekly payments made by the National Assistance Board

in lieu of payments by residents who cannot meet the normal residential charges from their own resources. There is no exchequer contribution to services provided under Section 29 of the National Assistance Act, apart from services which qualify for a grant from the Ministry of Labour under the Disabled Persons (Employment) Act. The Committee on the Cost of the National Health Service and the Committee on the Rehabilitation of Disabled Persons recommended that all local authority expenditure under Sections 21 and 29 of the National Assistance Act should in future attract an exchequer grant. Since these recommendations were made, the government have announced their intention of replacing the present system of grants towards specific local authority services by a general grant, leaving the local authorities free to determine how much to spend on their various services according to local needs. If the present arrangements were to continue, there would be an obvious financial incentive to local authorities to seek to provide most of their mental health services under the National Health Service Acts. We were not influenced by this consideration when we recommended in paragraph 710 that any services specifically intended for mentally disordered persons can legitimately be considered a health service. But we recognise that there is a case for giving the local authorities some special help towards the development of community mental health services; we discuss this in paragraphs 716-720.

714. There remains the question how far the provision of these services under health or welfare powers should be made a positive duty of the local authorities. The provision of community services, other than residential services, for mental defectives who are "subject to be dealt with" under the present Mental Deficiency Acts is at present a duty under Section 30 of the 1913 Act. The provision of residential accommodation under Section 21 of the National Assistance Act, 1948, for persons in need of care and attention which is not otherwise available to them is also a duty. The power to provide services for the prevention of mental illness and the care and after-care of the mentally ill and defective under Section 28 of the National Health Service Act, 1946, and welfare services for handicapped persons other than the blind under Section 29 of the National Assistance Act, 1948, is at present only permissive.

715. The duty to provide the services covered by Section 30 of the Mental Deficiency Act, 1913, should certainly continue when these services are provided under the more general powers under Section 28 of the National Health Service Act. We think it wrong, even under the present system, that this duty should be confined to patients who are under guardianship or statutory supervision as distinct from voluntary supervision. If our proposals in Part IV of this report are accepted, such a distinction would be impossible in future. **And if the general re-orientation of the mental health services which we have recommended, in the direction of a considerable expansion of local authority community services, is to be achieved, we have no doubt that the provision of community services for all groups of mentally disordered patients should be made a duty.** The provision of the very important community health services for the mentally ill and residential services not covered by Section 21 of the National Assistance Act should not be left as a permissive power. We therefore recommend that the Minister of Health should issue a direction under Section 28 of the National Health Service Act, 1946, making it the duty of the county and county borough councils to ensure the provision of the forms of community care for mentally disordered patients which we have discussed in this chapter, either by providing them under that section or by arranging for their provision under other powers which the councils possess under that Act or other Acts, including the

National Assistance Act and Children Act. If necessary, the wording of Sections 21(8) and 29(6)(b) of the National Assistance Act, 1948, should be amended so as to ensure that the powers conferred by Sections 21 and 29 may be used in this way.

Finance and staff, and ways of expediting the expansion of community services

716. The expansion of community health and welfare services on the scale we have recommended will confront the local authorities with many difficulties, particularly in relation to finance and staff. Even in the most favourable economic circumstances and with a plentiful supply of suitably trained and experienced staff it would take a considerable time to provide residential hostels and homes and training, occupational and social centres, and to expand the work of the local authorities' mental health departments, on the lines we have suggested. We are very conscious of the fact that we are recommending this expansion at a time when public expenditure is subject to strict limitation, especially in regard to capital development, and when it is difficult to find the medical and nursing staff and social workers to staff even the existing community and hospital services.

717. In considering our recommendations, however, it is necessary to bear in mind that the expansion of community services which we have suggested would not consist wholly of extra services, but would be partly due to a re-allocation of functions between the hospitals and the local authorities, the local authorities resuming full responsibility for some community health or welfare services which are at present being partly provided by the hospitals. In view of the present overcrowding and shortage of staff in most mental hospitals, it is unlikely that our recommendations would result in surplus staff or accommodation in these hospitals. But for severely sub-normal and feebleminded patients we have recommended a very substantial shift of responsibility ; if local authorities provide residential homes and hostels for these patients on the scale we envisage it should certainly reduce the pressure for expanding the present mental deficiency hospitals, and in some areas might eventually make it possible to close some of the most obsolete hospital buildings and to release their staff for other parts of the hospital or local authority services.

718. When the local authorities handed over these responsibilities to the hospitals in 1948, together with true hospital functions, they handed over the buildings and staff which they had previously used for the discharge of all these functions together. If they are now to resume responsibility for some of the work which they then relinquished to the hospitals, they have a claim to as much help as can reasonably be given to them in regard to buildings and staff in their task of working these services up again in a new form.

719. Most of the buildings which the local authorities had provided for the residential care of defectives before 1948 were large institutions which accommodated all types of severely sub-normal patients and feebleminded psychopaths. These are not suitable for the sort of residential community care which we have recommended local authorities should provide in future. We are not in favour of any transfer back to the local authorities of buildings which are unsuitable for residential community care, nor do we wish to suggest even temporary arrangements for the joint use of such buildings by the local authorities and the hospitals. But we suggest that the Minister of Health should consider whether he could help to get the local authority residential services started on a more substantial basis than would otherwise

be possible by transferring to them some of the smaller buildings which now belong to the hospital service, and which belonged to the local authorities or to voluntary societies before 1948 or which have been acquired since 1948, and which are suitable in size and situation for use as residential homes or hostels. Such small hospital units do not exist in some parts of the country, and we do not expect many such transfers to be possible. Nor do we wish the hospitals to give up all their small units. The hospitals as well as the local authorities will still need small units for use as hostels under our proposals, as explained in paragraph 623; the provision of small units of this sort has been one of the most progressive developments in the mental deficiency hospitals in recent years. It might help if arrangements were made for the local authorities and the hospitals to share the accommodation in these hostels, at any rate to start with, whether they are transferred to local authority ownership or not. If the Minister's present powers do not permit him to transfer buildings in this way, such power might be taken in new legislation. With the transfer of buildings it would of course be suitable for the hospitals to discharge to the care of the local authorities some patients who are suitable for residential community care in these buildings.

720. The buildings suitable for transfer will fall far short of the amount of accommodation needed for the development of community services on the lines we have suggested. There is a good case for some special financial help from the exchequer towards the capital costs local authorities would incur in providing other accommodation. Expansion of the community mental health services would enable local authorities to resume responsibility for services previously provided by them in buildings which were transferred to the Minister of Health under the National Health Service Act, 1946, and to that extent financial help towards capital costs may be considered to be in lieu of the return of old buildings. It should also relieve the pressure for capital development in the hospital service, particularly in the present mental deficiency hospitals, which if continued would fall entirely on the exchequer. We consider that such special financial help should be payable on expenditure within a limited period only, partly because we look on it in part as replacement of the buildings which the local authorities gave up in 1948 and partly so that it may act as an incentive to local authorities to provide the new buildings as quickly as general economic considerations permit. Before the government statement on local authority finance which was made in February, 1957, we had it in mind to recommend that exchequer grant at a higher rate than the present 50 per cent. (but within the 75 per cent. maximum specified in Section 53 of the National Health Service Act, 1946) might be offered to local health authorities on any approved capital expenditure (but not on maintenance expenditure) incurred on services for mental patients within some fixed period. We envisaged that a period of, say, five years might be fixed in the first place which could be extended if economic considerations severely restricted the amount of capital works which could be approved in the period first fixed. We felt that such an increase in grant should not conflict with general economic policy, as the rate of expansion would still be controlled through the approval of loan sanctions and other methods; the incentive to the local authorities would in effect be towards giving priority to mental health projects within the total limits of capital development permitted. We also hoped that as the special grant would be restricted to capital expenditure only it would be acceptable to the government in spite of the recommendation of the Committee on the Cost of the National Health Service against an increased rate of grant for all local health authority expenditure in general. If the present specific grants for specific services are to be replaced by a general grant, it may be thought

inappropriate to provide financial help for the expansion of local authority mental health services by this particular method. We hope, however, that some means can be found of providing such special assistance. As we mentioned in paragraph 558 in Chapter 8, it is most desirable that a start should be made as soon as possible in the expansion of residential and other community mental health services by the local authorities, and some financial incentive may be necessary for that purpose.

721. The staffing of local authority hostels, homes and centres would also present many difficulties, though in the long run we think that the creation of a more varied range of mental health services might increase the attraction of these services. We have comments to make on three categories of staff: medical staff, social workers, and nurses or nursing assistants.

722. The medical staffing of some local authorities' health departments may need strengthening on the mental health side. The ideal would be for each local health authority to have a psychiatrist (not necessarily whole-time) either on the staff of the medical officer of health or available for regular consultation. The appointment of psychiatrists who would also do part-time clinical work in the hospitals might be desirable. In any case there should be increasingly close links between the medical officers of health on the one hand and on the other the regional psychiatrists and psychiatrists working in the hospitals, and perhaps freer movement of junior medical staff between the local authority and hospital services.

723. The local authorities will also need to employ more social workers if they are to be fully responsible for the after-care of discharged patients and for the social care of patients who have not been hospital in-patients. The Association of Psychiatric Social Workers told us (25th Day, Q. 5138) that in 1955 about 170 of their members were working in hospitals and about 30 for local authorities, apart from those in child guidance clinics. It will hardly be possible for the local authorities effectively to undertake the responsibilities we have recommended if the large majority of the available body of trained psychiatric social workers continue to be employed in the hospitals. In areas in which most of the after-care is at present being done by staff employed by the hospitals, the arrangements for co-operation between the local authorities and the hospital authorities which we discussed in paragraphs 677–678 might suitably result in some of the psychiatric social workers carrying on with the same work in future on behalf of the local authorities. The local authorities will no doubt also need to recruit more mental welfare officers apart from psychiatric social workers. A Committee appointed by the Minister of Health is at present considering the proper field of work and the recruitment and training of social workers at all levels in the local authorities' health and welfare services. This Committee will no doubt take account of the expansion of local authority community mental health services which we have recommended when they are considering the field of work and recruitment and training of mental welfare officers.

724. The recruitment of staff for residential homes and hostels will also not be easy. It will be necessary to have in charge of each hostel a person with some experience of dealing with the type of patients who will reside in it and some understanding of the nature of their disorder. Such people will be hard to come by and few will be found at present apart from those who are or have been employed in hospitals as nurses or nursing assistants or in other capacities. In our opinion it would be quite wrong to suppose that because these hostels or homes are not hospitals nurses should not be

employed.[6] A trained mental or mental deficiency nurse would probably be the ideal person to take charge of such a home, assisted by domestic staff. The care of the residents in these hostels would be rather a different job from that of a nurse working in a hospital under medical direction; in the hostel the nurse would work more on his or her own, and the patients would be more stable, but the nurse would need the same type of skill and experience. This type of work would provide a valuable channel of promotion for some nursing staff, and there should be free movement of staff between these homes and hostels and the hospitals. Any hospitals who transfer buildings to the local authorities, as suggested in paragraph 719, and those who discharge considerable numbers of patients to the care of the local authorities, should also help the local authorities as far as they can by releasing a small number of nursing or other staff who might wish to move to the local authority service with some of the discharged patients.

RECOMMENDATIONS IN PART V

(1) No one should be excluded from benefiting from any of the general social services simply because his need arises from mental disorder rather than from some other cause, if he can suitably benefit from such services. (Paragraphs 592–593.)

(2) Contacts between psychiatric and other interests within the hospital service and within the local authority services should be developed and strengthened. (Paragraph 594.)

(3) The division of functions between the local authorities, the hospitals and other official bodies should be broadly the same in relation to mental disorder as in relation to other forms of illness or disability. Hospitals should provide in-patient and out-patient services for those who need specialist medical treatment or training or continual nursing attention; local authorities should be responsible for preventive services and for health or welfare services (which we call "community care") for people who do not require hospital in-patient treatment or training or who have been in-patients and are ready to return to the community. (Paragraphs 601–610.)

(4) There should be a general re-orientation away from institutional care in its present form and towards community care. This would result in an expansion of local authority services including:—

(*a*) provision of residential accommodation for mentally ill (including elderly mentally infirm), severely sub-normal and psychopathic patients who for various reasons may need residential care but do not need or no longer need hospital in-patient care; (Paragraphs 613–636, 650–652 and 660–663)

(*b*) provision of adequate training facilities either in centres or at home for severely sub-normal children who are unable to benefit from education at school; (Paragraphs 637–649)

(*c*) provision of any necessary further training after leaving school for young people who, on account of their mental condition, cannot be catered for under other general vocational training services, and general social help for these and other school-leavers; (Paragraphs 654–663)

[6] See also the views of the Committee on the Cost of the National Health Service, quoted in paragraph 627 of our report.

(*d*) provision of occupational or training centres, sheltered workshops and social centres for adult severely sub-normal or psychopathic patients or patients with residual disability after mental illness who cannot be catered for under the general rehabilitation services for disabled persons ; (Paragraphs 664–667)

(*e*) general social work to help all types of mentally disordered patients and their relatives, including certain services while patients are also receiving hospital treatment and all forms of community care after patients leave hospital. (Paragraphs 654–663 and 668–678.)

(5) While local authorities should have considerable freedom to decide the range of training to be provided within the school system, responsibility for providing training centres (as they should be called) for severely sub-normal children who cannot benefit from normal or special forms of education in school should continue to be regarded as a health rather than an education service. But the procedures and terminology used should be revised. Children should not be reported as " incapable of receiving education at school " but should be " recommended for training " in a training centre or in hospital for so long as the appropriate authorities in consultation consider it desirable. After full consideration has been given to the views of the parents, attendance at the centre or hospital recommended should be obligatory unless suitable alternative arrangements are made by the parents ; this might be effected by extending the ambit of Sections 36 and 37 of the Education Act, 1944. (Paragraphs 637–644.)

(6) Children of school age not attending school should receive health and welfare services similar or equivalent to those provided for school children. (Paragraphs 645–647.)

(7) Neither the law nor administrative practice should rigidly exclude sub-normal children from the general child care services if they can suitably mix with other children. But most such children need specialised care which it would be more suitable to provide through the mental health services than through the child care service. (Paragraphs 650–653.)

(8) A local authority which has been exercising parental rights or acting as guardian or in place of the nearest relative to a patient in the community should have a duty to continue to act as a good parent while the patient is in hospital. (Paragraphs 653 and 672.)

(9) Local authorities and hospitals should develop their services for young psychopathic patients. (Paragraphs 679–680.)

(10) New administrative arrangements are needed for the diagnosis and periodical re-assessment of severely sub-normal and psychopathic patients, and for consultation between local authority and hospital staff on the choice of the form of care most suitable for individual patients. Reference to hospital specialists for examination as in-patients or out-patients should be possible. Local health authorities, in collaboration with the hospitals, should be responsible for organising diagnostic clinics and case-conferences for these purposes. This should replace the present arrangements for " ascertainment ". (Paragraphs 681–689.)

(11) Arrangements for close co-operation between the staff and members of local authorities and hospital authorities in regard to all mental health services should be made in each local area. The Ministry of Health should help to spread information about schemes which have proved successful. (Paragraphs 690–693.)

(12) The National Assistance Board should be responsible for financial grants to patients in hospital or in the community who need such assistance. Local authorities should be able to make augmentation grants to patients who are in full-time employment but are paid a sub-standard wage because of mental disability. (Paragraphs 697–701.)

(13) The medical officer of health should be responsible for the central direction of local authorities' mental health community services, and should be in charge of the medical and administrative staff and social workers who deal with the needs of individual patients. Local authorities should be free to provide specific services such as residential homes or hostels, training centres and occupational centres under their powers under the National Health Service Acts or National Assistance Act as they think appropriate. (Paragraphs 702–713.)

(14) The provision of community care for all types of mentally disordered patients should be made a positive duty of county and county borough councils. In order to ensure that they have sufficient powers to provide the various services we have recommended, amendments may need to be made to Section 28 of the National Health Service Act, 1946, Sections 21 and 29 of the National Assistance Act, 1948, and Section 8 of the Children Act, 1948, but much can be done under existing powers. (Paragraphs 714–715, 620, 653, 672 and 712.)

(15) If possible some buildings now in the hospital service which would be suitable in size and situation for use as residential homes or hostels, should be transferred to the local authorities, and there also should be some special financial help from the exchequer towards local authorities' capital expenditure incurred during a limited period on services for mentally disordered patients. The hospital authorities should co-operate with local authorities in regard to the recruitment or transfer of staff. (Paragraphs 716–724.)

PART VI

POWERS AND DUTIES OF THE CENTRAL GOVERNMENT

CHAPTER 11

725. In this chapter we discuss the functions of the central government in relation to the general administration of the public mental health services, and in connection with the procedures applied to individual patients. In Part VII we discuss the functions of the central and local authorities in relation to hospitals outside the national health service or nursing or residential homes provided by charitable societies or private persons, and in relation to mentally disordered patients living in other private care.

Supervision of local services and of the general care of patients

(i) The past and the present

726. The closeness of the control exercised by central departments over services administered locally by local authorities, and the methods through which such control has been exercised, have varied a great deal under different Acts and at different periods of our social history. There were considerable variations in the powers and duties given before 1948 under various Acts to the central government departments responsible for the supervision and inspection of the health and welfare services which were administered locally by local authorities. There are also differences in the powers and duties which the central departments exercise under the Acts which have governed the administration of these services since 1948 and which have wholly or partly superseded the earlier legislation. We must describe these differences and the historical reasons for them before making our recommendations for the future in regard to mental health.

727. Immediately before 1948 local authorities were providing mental hospitals and community services for the mentally ill under powers contained in the Lunacy and Mental Treatment Acts; mental deficiency institutions and community services for defectives under the Mental Deficiency Acts; public assistance institutions, including poor law infirmaries, and other forms of relief under the Poor Law Act, 1930; and other general and special hospitals and health services under the Public Health Act, 1936, and Public Health (London) Act, 1936. Under the Poor Law Act the Minister of Health exercised close powers of control and inspection over the residential and other services provided by the local authorities, and the services were regulated in detail by orders made by the Minister. The Public Health Acts gave the Minister of Health no specific power to inspect local authority hospitals but under his general powers under the Local Government Act, 1929, he arranged for his medical and nursing officers to visit the hospitals and give advice on the services provided in them. The arrangements under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts were more complicated and we describe them in greater detail in the two following paragraphs.

728. In the mental health field, from the early nineteenth century and particularly after the establishment of the Lunacy Commission in 1845, central authorities had extensive powers to inspect local authority and private and voluntary hospitals and homes, in addition to, though linked with, specific functions in relation to the admission, detention and discharge of individual patients. They also had general executive powers of control over local authority capital works and finance. These powers were exercised

partly by Ministers and partly by a non-Ministerial board of commissioners (from 1845 to 1913 the Commissioners in Lunacy and since 1913 the Board of Control). The original functions of the commissioners under the Lunacy Acts, apart from functions related to the detention of individual patients, were mainly to visit and inspect institutions provided by local authorities, private persons and charitable bodies. The Chairman of the Commission or Board was not a member of the government and was not directly responsible to Parliament for the work of the Commission or Board.[1] From the outset, various executive functions such as the approval or making of Rules and Regulations and the approval of local authority contracts or plans were the responsibility of Ministers, not of the commissioners. The responsible Ministers were originally the Home Secretary and the Lord Chancellor. Later the Local Government Board also exercised some control over local authority expenditure on mental health services as part of their general responsibilities in relation to local government finance, particularly through the sanctioning of loans. The Mental Deficiency Act, 1913, which transferred to the new Board of Control the functions under the Lunacy Acts previously performed by the Lunacy Commissioners, also gave the Board wide executive functions in relation to the new mental deficiency services, in addition to powers of visitation and inspection, the Home Secretary being responsible only for very general superintendence of the new services and for making Regulations. In 1919, the Minister of Health succeeded to the functions previously performed by the Local Government Board and in 1920 he took over most of the functions previously performed by the Home Secretary under the Lunacy Acts and Mental Deficiency Act. In 1930 some, but not all, of the Minister of Health's executive powers under the Lunacy Acts were transferred to the Board of Control. The position immediately before the re-organisation under the 1944-48 legislation was that the Board of Control was responsible for the day-to-day supervision of all local authority mental health services, for the registration,[2] visitation and inspection of voluntary hospitals and institutions and private nursing and other homes, and for approving the rules of county and county borough mental hospitals and the regulations of registered hospitals. The Minister of Health (under the Mental Deficiency Acts) and the Lord Chancellor (under the Lunacy and Mental Treatment Acts) were responsible for making Regulations or for approving Rules made by the Board. The Minister of Health also had a general oversight over the work of the Board, was responsible to Parliament for estimates and finance, sponsored new legislation, and generally spoke in Parliament on questions of policy affecting the mental health services.

729. These arrangements bore the stamp of their origin in the early nineteenth century when experiments were being made in the constitution of new central departments responsible for the oversight of local authority services. Other bodies of commissioners were later superseded by central departments working directly under a Minister, or under a Board presided over by, or having all its functions exercised by, a Minister who was also a Member of Parliament. It was this system of a central department working under the direct control of a Minister sitting in Parliament which became accepted as the normal pattern for central government departments supervising

[1] Lord Ashley, later 7th Earl of Shaftesbury, was Chairman of the Metropolitan Commissioners in Lunacy from 1829 to 1845 and Chairman of the Commissioners in Lunacy from 1845 to 1885, and was able to speak in the House of Commons and later in the House of Lords on lunacy questions. It was he who, with government support, introduced the two Bills which became the Lunacy Acts of 1845. But he spoke as a private Member.

[2] Except for the licensing of provincial licensed houses. This remained, and still remains, the responsibility of the justices of the peace.

the activities of elected local authorities. One reason why the Board of Control continued until as late as 1947 to exercise executive functions as a separate non-Ministerial department was no doubt the fact that, in addition to these executive functions, it also had semi-administrative semi-judicial functions in relation to the admission, detention and discharge of individual patients. But the continuation of this older form of governmental organisation was also both a sign of, and a continuing factor in, the administrative isolation of the mental health services which we discussed in Chapter 9.

730. In Chapter 9 we described the re-organisation of the health and welfare services under the 1944–48 legislation, which brought the mental health services into the same administrative system as the other health and welfare services and introduced a new division of responsibilities, on a functional basis, between the local health authorities, the welfare authorities and the new hospital authorities. Important changes were also made in the functions of the central departments. But under the new Acts, as under the old, there are differences in the powers and duties given to the central authority (the Minister of Health) in relation to various services.

731. Part III of the National Assistance Act, 1948, preserves a legal foundation for close central control of the local authorities' residential and other welfare services, some of which had previously been subject to detailed central control under the poor law. The Minister has power to make regulations as to the exercise of their functions by local authorities, including regulations as to the conduct of the residential homes which they provide, which may be inspected by the Minister's officers. The Act also requires all local authority welfare services to be described in schemes which must be submitted to the Minister for approval, and requires the local authorities to exercise their functions under the general guidance of the Minister. In addition the Minister has default powers. In practice since 1948 the Minister has not found it necessary to use his formal powers to make regulations as to the conduct of local authority homes, but has relied on less formal methods of consultation and advice, on visits and reports by his officers and on the approval of schemes.

732. The National Health Service Act, 1946, gave the Minister of Health a general duty to secure the effective provision of all the services covered by that Act, including the community services administered by the local health authorities. It also transferred to the Minister the Board of Control's functions under the Mental Deficiency Acts as the central department responsible for the general supervision of the local authority community services for defectives; these services are now governed by schemes approved by the Minister under the National Health Service Acts. In support of his duty to secure the effective provision of services by local health authorities, the Act of 1946 gave the Minister very wide powers in relation to the approval and modification of the schemes under which these authorities are required to exercise their functions, in addition to general default powers. In practice, his duty to supervise these services is exercised through informal consultation and the approval of schemes. His statutory powers under the National Health Service Acts are considerably greater than those which he possessed in relation to the health services for which the local authorities were responsible before 1948, but he has no power to make regulations as to the local health authorities' exercise of their functions, nor to make regulations as to the conduct of, or to inspect, any residential convalescent or other homes.

733. As regards hospital services, the National Health Service Act, 1946, introduced an even closer relationship between the local and central administration. Under this Act the hospital services of the country are now

planned on a national and regional instead of on a local scale, and the former voluntary hospitals and the hospitals previously owned by the local authorities are integrated into a single service financed by the exchequer. The authorities who are responsible for the planning of hospital services over regional areas and for the day-to-day management of the hospitals locally are not elected local authorities nor completely independent boards, but are regional hospital boards and boards of governors appointed by the Minister and hospital management committees appointed by the regional hospital boards. The Minister has an overall duty to provide hospital and specialist services through the agency of these new boards and committees. This has given the Minister of Health much greater authority and responsibility for all hospitals in the national health service (including mental and mental deficiency hospitals) than either he or the Board of Control had before 1948 in relation to the general hospitals, mental hospitals and mental deficiency institutions administered by elected local authorities. It is also a more direct responsibility than that which he has for the community health services provided under the National Health Service Acts by the local health authorities. But although the Minister has been made directly responsible to Parliament for the hospital and specialist services and is given wide powers to make regulations and give directions to the hospital boards and committees, under the administrative structure laid down in the Act the hospitals are not administered by the Minister's own officers but by the boards and committees appointed for this purpose, who appoint their own staff.

734. Although the National Health Service Act, 1946, gave the Minister of Health this direct and comprehensive responsibility for the supervision of the hospital service, no alteration was made in those provisions of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts which make the Board of Control responsible for inspecting hospitals and institutions, including those now owned by the Minister and managed by his agents. There has thus been some inconsistency since 1948 between the position of the Ministry of Health as the government department responsible for the general supervision of all public hospital services, and that of the Board of Control as an inspecting authority in the mental health field. This inconsistency has been partly overcome by making the commissioners and inspectors of the Board also officers of the Ministry, so that they visit and inspect on behalf of both departments simultaneously. The commissioners and inspectors are however still generally regarded, particularly by the staff of the mental and mental deficiency hospitals, as officers of the Board rather than of the Ministry, and the question whether there should be a body of inspectors of hospitals working somehow independently of the Ministry of Health is one on which we received conflicting views from our witnesses.

(ii) Recommendations for the future

735. **It is generally accepted that the proper central department to supervise mental health or welfare services provided by local health or welfare authorities is the department which approves schemes for all local authority services provided under the National Health Service Acts and the National Assistance Act, i.e. the Ministry of Health.** This has been the position since 1948 for all local mental health services provided under the National Health Service Acts and Mental Deficiency Acts and would automatically apply to any new residential or other services provided in future under the National Health Service Acts or National Assistance Act. The form of control which we favour is that which operates under the National Assistance Act, under

which the Minister has formal powers of regulation and inspection but in practice is able to rely mainly on informal methods of consultation and advice. In the mental health field, there should certainly be power for the Minister to make regulations as to the conduct and inspection of residential homes, hostels or residential training centres provided by the local authorities, under whatever Act they are provided. But we see no reason why standards should not be maintained in practice through a system of consultation and advice without detailed regulations actually being made. This has proved possible during the last nine years in regard to old people's homes which before 1948 were subject to rules and statutory orders under the poor law scarcely less formal or detailed than those which have operated up to now in the mental health field.

736. We therefore recommend that the Minister should be given power to make regulations to apply to any convalescent, after-care or other homes or training or occupation centres for mentally disordered patients which may be provided in future by local authorities under the National Health Service Acts, similar to his present power to make regulations under Section 35 of the National Assistance Act, 1948, including regulations as to inspection by the Minister's officers. The inspection of any homes for mentally subnormal children which local authorities might choose to provide under the Children Act rather than under the National Health Service Acts could be carried out under the Home Secretary's powers of inspection under the Children Act; we should expect the Home Office and the Ministry of Health to collaborate in arranging for inspections to be carried out by suitably experienced staff.

737. We now come to the question of the supervision and inspection of mental and mental deficiency hospitals. On this subject we received conflicting recommendations from our witnesses. Some witnesses (including the Ministry of Health and the Board of Control themselves) expressed the view that, now that the Minister of Health is directly responsible to Parliament for all hospital and specialist services within the national health service, he is the central authority responsible for standards of care of patients in psychiatric as well as other hospitals, and that it is neither necessary nor appropriate to place a separate and overlapping responsibility for inspection on some separate central Board. Other witnesses (including the Royal Medico-Psychological Association and the British Medical Association whose representatives included present or former medical superintendents of mental and mental deficiency hospitals) argued that inspectors independent of the Minister, who is ultimately responsible for the administration of the hospital service, would be able to express more independent opinions and would be readier to call attention to defects in the hospitals or to the way in which funds have been allocated. They consider that this would provide a more effective method of ensuring that the claims and needs of mental and mental deficiency hospitals within the national health service are not neglected or pushed aside and that the patients are properly cared for.

738. We have great sympathy with the desire of the medical and other staff of the mental and mental deficiency hospitals, and of their managing committees, to ensure the best possible service for their patients, and with their wish to retain the opportunities they have enjoyed in the past for intimate and friendly consultation with officers of a central department with a wide knowledge of the mental health service in all parts of the country. These are the objects which were clearly in the minds of those among them who urged the retention of the Board of Control more or less in its present form. But we think it is a misconception to suppose that the retention of a body of commissioners working independently of the Ministry

of Health is the best way of achieving any of these objects. Of the two divergent views we have described we are convinced that the one which must be favoured is that put forward by the Board and the Ministry themselves. Constitutional propriety and administrative coherence alike forbid the grant of authority to an independent Board to inspect services for which a Minister of the Crown is himself directly responsible to Parliament. Any Ministry may find it convenient, as a matter of internal organisation, to differentiate its functions of inspection from its functions of administration and to make the two sufficiently independent of each other to ensure that the Minister is fully advised from both these somewhat different points of view. But this differentiation cannot be carried to a point where the inspectorate would report direct to Parliament or public over the Minister's head—and still less could this function be given to one section only of an inspectorate, to inspectors of mental hospitals as distinct from inspectors of other hospitals—without destroying the perspective of policy which it is the very purpose of departmental reports to convey to the Minister and, through him, to Parliament.

739. The force of these considerations is sometimes obscured by the fact that central departments have usually developed their inspectorates as a means of control over elected local authorities who finance the services they administer partly out of their own resources (with the aid of grants from the central government) and are responsible to their own ratepayers as well as being subject to general supervision by the central department in greater or lesser degree. It is sometimes argued that this pattern of responsibilities shared by local and central authorities does not fit the present hospital service, which is wholly financed by the central government and administered by the central government's nominees. A Minister, it is said, cannot inspect himself. But this argument altogether exaggerates the degree to which the Minister of Health, in inspecting hospitals, can be said to be actually inspecting himself. He appoints the members of the regional hospital boards and boards of governors, but not the hospital management committees, nor the staff of any of them. Essentially, under the administrative structure of the Act of 1946, the hospital service is still a locally administered service under the general supervision of a central department and is not directly administered by the central department itself. The main difference between the Minister's position in relation to the hospitals and the position which he and other Ministers occupy in relation to services administered locally by elected local authorities is that there is greater authority behind the advice which he gives to the hospital boards and committees, and that he is in a better position to ensure that any money which can be made available for raising standards is directed to the hospitals where improvements are most needed. He is also under the continual spur of direct and detailed Parliamentary criticism of any services which need improvement.

740. Nor is there any reason to suppose that the recommendations of the Minister's own staff will carry less weight with him or with the hospital boards and committees than those of an independent Board of Control. Experience, indeed, points in the opposite direction. The Royal Commission of 1904–08 and the Royal Commission of 1924–26 both received complaints that the inspection of hospitals by the commissioners (the Lunacy Commissioners in 1904–08, and the commissioners of the Board of Control in 1924–26) was not as effective as it should be because the commissioners had no power to insist on their recommendations being carried out by the local authorities. Both Royal Commissions also commented on difficulties arising from the division of responsibility between the commissioners and the

government departments to whom the Acts gave such formal powers as then existed for controlling local standards, such as the approval of local authority plans or capital expenditure and the power to make or approve hospital regulations and rules. In order to remedy these defects the 1904–08 Royal Commission recommended that the commissioners should work more closely with the Home Office and the Local Government Board in the executive work of examining local authority plans and contracts. The Royal Commission of 1924–26 criticised the fact that the Board of Control's powers under the Lunacy Acts were almost entirely advisory, the executive powers being, at least formally, in the hands of the Minister of Health. This Commission recommended that the Board of Control should be given some of the executive functions of the Minister of Health, and that there should also be additional and closer central powers of control over the local authorities as a means of raising the standards of the mental hospitals. The Mental Treatment Act, 1930, which followed the report of this Commission, transferred to the Board those powers of the Minister which the Commission had recommended should be transferred, but gave no additional powers of control over the local authorities, and the extent to which the local authorities could in practice be persuaded to devote more resources to the improvement of their mental hospitals remained limited. Now that the central department has much greater authority to influence the local administration, and to arrange specific allocations of money for capital improvements or improved standards of maintenance within the funds made available by Parliament for the hospital service as a whole, it would be going against the lessons to be learnt from the history of the mental health services themselves to go back to a situation in which the inspection of hospitals and the executive authority would again be divorced from each other.

741. **For these reasons we are convinced that responsibility for the standard of the services provided in the hospitals must rest squarely on the shoulders of the Minister, and that in this connection a central inspectorate outside the Minister's own department is neither necessary nor desirable.**

742. There remains the question whether we should recommend the continuance of formal visits of inspection to psychiatric hospitals by medical and other members of the staff of the Ministry itself. It is not, we understand, the present practice of the Ministry, nor of the regional hospital boards, to make formal inspections of other hospitals. They obtain their knowledge of the needs and difficulties of particular hospitals in other ways, such as informal visits by medical, nursing and other officers, frequent consultation at all levels both by correspondence and by personal discussions with members and staff of boards and committees, discussion of particular proposals for expansion and development, and, when occasion arises, investigation of complaints received from patients, other members of the public and Members of Parliament. All this already applies to some extent to psychiatric hospitals as well as to other hospitals. We, as a Commission, have no detailed knowledge of how these arrangements compare in effectiveness with the more formal visits carried out by the commissioners and inspectors of the Board of Control, in their dual capacity as officers both of the Board and of the Ministry, though our general experience leads us to think that frequent consultation on specific subjects by officers of special experience is usually more profitable than a more formal general inspection. Our recommendation is that the Minister of Health should consider whether in view of the history and present needs of the psychiatric hospitals, there would be advantage in arranging for regular inspections of these hospitals to be carried out by suitably qualified officers on his staff, in addition to less

formal visits and other methods of consultation. In considering this question he will no doubt take account of the views put to us on behalf of some of the managing committees and staff of these hospitals in favour of the continuance of inspections by persons of high standing from the central department. Whether formal inspections are continued or not, we hope and believe that contacts with the Minister's staff will prove more frequent and effective and no less satisfying to the hospitals than the visits of the commissioners and inspectors of the Board of Control have been in the past.

743. The responsibility of the Minister and of the hospital boards and committees for the standard of care provided in the hospitals includes the investigation of complaints made by or on behalf of patients about any aspect of their care or treatment, including any complaints of ill-treatment by doctors, nurses or other members of the staff or fellow-patients. The investigation of such matters is part of the everyday work of the hospital authorities and the Ministry of Health. When the complaints come from mental patients, there is more difficulty in distinguishing well-founded from imaginary complaints. Hospital authorities and the Minister and his officers need to be careful not to be too ready to accept allegations from patients who may be deluded or malevolent, nor on the other hand to reject complaints simply because they are made by patients whose minds are to some extent disordered. For this reason the hospital management committees of psychiatric hospitals must be specially careful to investigate all complaints impartially. When an investigation from outside the hospital is called for, regional hospital boards and the Minister have a similar responsibility, and when there is prima facie evidence that the complaint may be well-founded they can often investigate it most effectively by appointing one or more persons (not necessarily their own members or officers) to hold an investigation locally on their behalf.

744. In the past it has been one of the functions of the Board of Control to conduct enquiries of this sort. They have special powers and duties under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts in connection with the permission or prohibition of certain forms of physical restraint on patients, the holding of enquiries on oath and the institution of proceedings against members of the staff of hospitals who are accused of maltreating patients. In our view it is preferable that enquiries should be held by or on behalf of those authorities who have power to take disciplinary action should the complaints be substantiated, or to exert other forms of pressure to prevent a recurrence. This is customary in other public services. Enquiries into allegations of malpractices in children's homes, approved schools or prisons, for example, which call for investigation by a central department, would be made at the request of the Home Secretary by persons appointed by him and reporting to him. In relation to hospitals the appropriate central authority is the Minister of Health, and it is no longer necessary for this purpose to retain a separate organisation such as the Board of Control.

Duties in connection with procedures applied to individual patients

(i) General

745. The central departments' functions in connection with the admission, visitation and discharge of individual patients are mainly connected with the procedures which authorise detention, though some apply to voluntary patients also. They are mainly carried out by the Board of Control, though some are governed by Rules or Regulations made or approved by the Minister of Health or Lord Chancellor. The most important of these functions of the Board are the scrutiny of admission documents, their duties in connection

with the continuation of orders, their powers and duties to visit patients in hospital and elsewhere, and their powers of discharge (for details see Appendix II). They also give general advice to hospitals and local authorities on questions arising on any aspects of the present procedures, and deal with a considerable amount of correspondence from patients, discharged patients and patients' relatives. The Lord Chancellor also still has some general powers in regard to " persons of unsound mind ", as well as having general administrative responsibility for the Court of Protection which deals with the management of patients' property and the (now rare) inquisition procedures.

746. Our recommendations in Part IV of our report would reduce the use of compulsory powers and procedures, abolish special procedures when compulsory powers are not used, and simplify the compulsory procedures themselves. An important feature of the new procedures would be that several functions now discharged centrally would be performed locally. Power to discharge detained patients would be held by the medical staff and members of the hospital and local health authorities and in most cases by the patient's nearest relative also, and local Mental Health Review Tribunals would be set up with powers of discharge on specific occasions. It is necessary to consider what powers and responsibilities should be given to a central authority under this system, and what form of central administration would be appropriate. In considering this and comparing possible future arrangements with the present system we must bear in mind that most of the functions of the Board of Control under this heading derive from the functions first given to the Commissioners in Lunacy in the middle of the nineteenth century, which have been only slightly affected by the changes in the relationship between the local and central authorities and the new methods of care and treatment which have developed since then. In the following paragraphs we discuss various functions which are now carried out centrally, and give our views on how and by whom they should be discharged in future.

(ii) **Scrutiny of documents**

747. The documents which are at present sent to the Board of Control include copies of all the statutory admission documents for certified and temporary patients in mental hospitals, registered hospitals, licensed houses and single care and for defectives in mental deficiency hospitals, certified institutions and guardianship, special reports and certificates when an order is to be continued, and notices of transfer, discharge or death. Notices of the admission, departure, discharge or death of voluntary patients and of defectives in approved homes are also sent. We have been told that an average of about 5,000 documents a week are received by the Board, of which about 2,100 a week (about 110,000 a year) are scrutinised by a medical or legal commissioner of the Board and by clerical staff.

748. On the question whether this central scrutiny of documents should continue in future we received conflicting recommendations from our witnesses (see paragraph 263), but the disagreement is only about the best administrative methods of achieving aims on which all are agreed, namely that compulsory powers should not be used except under the conditions allowed by the law and that there should be adequate documentary authority for their use in each individual case.

749. The validity of the documents on the strength of which compulsory powers are used may depend on several questions. One is whether the facts related in them about the patient are true and whether the medical diagnosis and recommendation for a particular form of care accurately describe the individual patient's mental condition and needs. This is partly

a question of fact, partly a question of medical opinion. No routine scrutiny of the documents alone by a person who has not examined the patient can provide any check on their accuracy nor any safeguard against the deliberate submission of false documents or against errors of information or of diagnosis. In so far as the central scrutiny of documents may have come to be regarded as a safeguard for the patient from this point of view, we should make it clear that this is quite illusory. The safeguards against the deliberate falsification of documents or factual and diagnostic errors are the integrity and competence of those who sign the documents, the need for a consensus of several opinions, the provision of opportunities for re-examination by independent persons qualified to judge the questions at issue, and wide powers of discharge. We consider that the new procedures proposed in Chapter 7 would introduce much stronger safeguards of this sort than exist at present.

750. There are however other questions on which the validity of the documents may depend, which can be judged from a scrutiny of the documents themselves. These are whether the facts and opinions recorded in them, if assumed to be accurate, provide proper grounds for the use of compulsory powers within the terms of the law, and whether the documents are complete in the form required by law and contain no technical flaw. At present, if the Board of Control considers that a medical certificate does not contain sufficient evidence of unsoundness of mind or mental defect, or that a medical certificate or other admission document is incomplete or imperfect in any way, and if it is not amended to the Board's satisfaction within a fixed period after the patient's admission, the Board may, if it thinks fit, order the patient's discharge. When the Board considers that any admission document or special report or certificate is defective, it asks for more evidence of unsoundness of mind or mental defect to be added, or for blanks on the forms to be completed, signatures added, dates altered or other technical flaws to be corrected. We were told (1st Day, P. 22, para. 98 and Q. 186) that it is rare for this to result in the discharge of the order; the usual result is the amendment of the document to a form in which it satisfies the Board as providing proper authority for the patient's detention or control. The main effect of this scrutiny therefore is to act as a safeguard for the hospital authorities against detaining a patient without proper documentary authority.

751. **In our view, it should be made clear in future that the primary responsibility for ensuring that there is proper documentary authority for the use of compulsory powers lies with those who use those powers and who would be responsible if they were improperly used,** that is to say, the hospital authorities and local health authorities and their officers and any private individuals who accept the responsibilities of acting as guardian. The admission documents, under our proposals, are to be regarded as authority to admit the patient, not as an order to admit him. The responsibility for deciding to admit and detain the patient will lie with the hospital authority (or the guardian), and it must equally be their responsibility to see that they have adequate authority for doing so. They should not leave this to the judgment of some other body, central or local.

752. The relatives or mental welfare officers who take part in the admission procedures will not be able to judge for themselves whether the medical diagnosis contained in the medical recommendations is correct, nor whether any symptoms recorded in support of the diagnosis do in fact support it. On these questions they should usually accept the opinion of the doctor who has signed the recommendation, but if in exceptional cases they have serious doubts about the validity of the medical recommendations they should

take further medical advice, as discussed in paragraph 404 of Chapter 7. A mental welfare officer should also ask for any clerical error or omission in the medical recommendations to be rectified before he agrees to sign an application for a patient's admission, or to convey the patient to hospital when the application has been signed by a relative.

753. When the patient is admitted to hospital the documents should be scrutinised by the hospital staff to make sure that they contain proper authority for the patient's detention. We should expect the scrutiny for technical flaws or omissions to be done by responsible clerical staff. The documents should also be examined by one of the medical staff who should refer them to the medical superintendent[3] if he has any doubt about their validity on medical grounds. If any admission document contains any technical flaw or omission it should be permissible for it to be amended by the person who signed it, at the request of the hospital authorities, within fourteen[4] days of the patient's admission to hospital. If the medical superintendent considers that either of the medical recommendations does not contain prima facie evidence of mental disorder or of justification for the use of compulsory powers to provide the form of care recommended, he should not accept it as part of the authority for the patient's detention. If he agrees that the patient needs to remain in the hospital and that the use of compulsion is justified, he should not have to discharge the patient but should be able to keep him under the emergency procedures and ask for a new medical recommendation to be provided. If the other medical recommendation and application are in order, they could be used as authority for an emergency admission, the new second medical recommendation being added within seventy-two hours. If they are not, the medical superintendent could himself sign a recommendation under the procedure described in paragraph 410. If two valid medical recommendations are not forthcoming within seventy-two hours of the patient's admission, he should not be compelled to remain ; if he is content to remain without compulsion, he should do so and should sign a statement similar to that recommended in paragraph 456 in Chapter 7.

754. A similar scrutiny should be undertaken by the medical and clerical staff of the local health authority when a patient is recommended for guardianship, and the medical officer of health[3] should similarly be able to ask for a fresh medical recommendation to be provided in place of one with which he is not satisfied ; except in cases of urgency, this should be done before the powers of guardianship take effect.

755. It is clearly desirable that different medical superintendents and medical officers of health should not use widely differing standards in deciding whether medical recommendations can be accepted as valid. This is, in effect, the main argument of those of our witnesses who favour the present system of central scrutiny of documents, which they commended to us as providing " a uniform standard by which the justification for detention can be measured ". (8th Day ; P. 291, para. 2003, 26th Day, P. 1058, para. 212.)

756. In giving our own views on this question, we must again emphasise that the scrutiny of documents is of very limited value as a safeguard against the misuse of compulsory powers. We pointed out in paragraph 749 that it is by itself of no value as a safeguard against genuine errors of diagnosis

[3] To be interpreted as in footnote on page 145.

[4] The present period is fourteen days for documents under the Lunacy and Mental Treatment Acts and twenty-eight days for documents under the Mental Deficiency Acts. Fourteen days should be ample if the scrutiny is done locally instead of centrally and if it is done as soon as possible after the patient's admission.

or deliberate malpractice. It is not of much more value as a means of ensuring uniformity in the criteria used by individual doctors interpreting the general conditions in which the law allows the use of compulsory powers. A scrutinising body can reject documents which do not appear to it to contain clear enough evidence of mental disorder or of the need to use compulsion, and can thus establish standards which that body is prepared to accept. Other doctors, on their own interpretation of the general terms used in the law, may be willing to recommend the use of compulsory powers in only some of the circumstances which the scrutinising body would accept. Unless the standards accepted by the scrutinising body are very restrictive, therefore, there may still be differences of opinion on what the proper criteria should be, even within the limits set by those standards. This is what has happened over the interpretation of the legal definition of mental defectiveness, where the Board of Control and the judicial authorities who have made the admission orders have accepted a very wide interpretation. There has been no similar marked divergence of opinion over the interpretation of the expression "a person of unsound mind and a proper person to be detained for care and treatment", but each certifying doctor must have his own conception of what conditions it covers and of the criteria he should use in individual cases, within the broad limits accepted by medical opinion generally and by the authorities to whom the certificates are submitted. In view of the evidence that the Board of Control's scrutiny rarely results in the discharge of an order as distinct from the amendment of the certificate, and in view of the acknowledged differences of opinion on the definition of mental defectiveness, we doubt if the Board's standards have had any appreciable influence on the criteria used by individual doctors when deciding whether or not a patient is certifiable under the present law.

757. The scrutiny of documents may however have more influence on the type of evidence which doctors select to mention when they write the certificates. It is quite impracticable for any doctor to mention in his written certificate all the grounds for his diagnosis or all the reasons for his recommendation for a particular form of care, and he may select for mention the sort of symptoms or other considerations which he thinks the scrutinising body is likely to accept. As we mentioned in paragraph 263, we were told that the type of information which is now traditionally recorded on certificates of mental defectiveness is that which the Board of Control expects to see before it will accept the certificate, and that doctors have learnt to record information of that sort through having certificates which do not include it returned to them for amendment. If this is so, it seems to us a strong argument against the system of central scrutiny. We consider the present type of certificate most unsatisfactory, and entirely agree with the criticisms mentioned in paragraph 276. We ourselves doubt if it is quite fair to attribute this chiefly to the influence of the Board of Control as exercised through the central scrutiny of documents. Responsibility is shared by the justices who also see and accept the present certificates. To some extent also the faults are due to the wording and design of the statutory forms (though these also are controlled by the central departments, who have power to amend them by laying new Regulations before Parliament). It must also be remembered that though the justices and the Board of Control presumably accept any certificate which seems to them to contain adequate evidence of mental defectiveness this does not necessarily imply that all the certificates they pass are perfect in their eyes. The power of rejection is only a negative form of control. Positive standards can be set only by the certifying doctors themselves. And it must not be thought that even under the present system all certificates follow exactly the same pattern. Most of the certificates we have seen include examples of the patient's

failure to answer verbal tests or questions of general knowledge, as mentioned in paragraph 276, but the other information given in the certificates varies greatly. It is probable that the traditional form of certificate has evolved with the Board's acquiescence rather than at its instigation. We are however willing to believe that the tradition has to some extent been influenced by the certifying doctors' ideas of what the Board of Control expects. We cannot escape the conclusion that undue reliance on central standards, real or imaginary, may have most unfortunate results. It is far better for people to use their own judgment.

758. For the future, the likelihood of major differences of medical opinion, such as have arisen over the meaning of the term "mental defectiveness", should be diminished if the law uses terms which will carry a reasonably clear meaning to the medical profession. We discussed our proposed terminology from this point of view in paragraph 195 in Chapter 3 and paragraphs 324–325 and 357–358 in Chapter 6. We believe that the terms we have proposed would be more uniformly interpreted by the doctors who would be called on to sign recommendations or to accept patients for treatment under the new procedures than are the terms used in the present Mental Deficiency Acts, and no less uniformly than those used in the present Lunacy and Mental Treatment Acts.

759. Next in importance, we place the need for everyone who takes part in the procedures to be satisfied that, as far as he can judge, there is justification for the use of compulsion within the terms of the law. The main value of the doctor's written recommendation is as a guarantee that he has had regard to the general criteria mentioned in the law governing the use of compulsory powers and that he has reasons for considering their use justified in relation to the individual patient which are convincing to the other people taking part in the procedures. As we mentioned in paragraph 416, he should have full clinical notes on which he can rely if his opinion is challenged; in the recommendation itself he should be expected to record only his diagnosis or other general assessment of the patient's mental condition, together with a fairly full explanation of why hospital or community care is recommended and why it cannot be provided without the use of compulsory powers. His main aim should be to make his reasons clear and to satisfy the other people who take part in the procedures. This is far more important than satisfying a single central body. It is the number of different people who must be satisfied which is important. The doctor who writes the recommendation should remember that this includes all the people who have power to discharge the patient, as well as the medical superintendent or medical officer of health who decides whether or not to accept the recommendation in the first place. We do not think it necessary for all admission documents to be submitted to members of the hospital management committee or local health authority as a matter of routine. But they and the Mental Health Review Tribunals and officers of the Ministry of Health should be able to see the admission and continuation documents whenever they are considering an application for discharge, and the documents should be in a form which will make clear to them the reasons why compulsory admission was recommended in the first place and why compulsory powers have later been renewed.

760. Nevertheless, local health authorities and hospitals should be able to look to a central department for advice on the exercise of their responsibility to decide whether medical recommendations and other admission documents can be accepted as valid. The Minister of Health is now the appropriate central authority to advise them on this as on other subjects when advice is needed. The methods by which this advice should be given

should not be laid down by law; the Minister should adopt whatever administrative methods seem appropriate at any time, just as he chooses appropriate methods of advising hospital boards and committees and local health authorities on other aspects of their work including their other legal responsibilities. As regards routine scrutiny for technical flaws and omissions, it may be useful for advice to be circulated on the sort of points the local scrutinising officers should look out for, based on the Board of Control's experience of the sort of flaws which have been found in the past, but with reference of course to the new procedures which, being less complicated, should carry fewer risks of technical errors. The hospital and local authority staff may also sometimes wish to ask for advice either on general principles of acceptance or rejection of recommendations or on individual cases; there may also be occasions when advice from the Ministry is needed to resolve differences of local opinion on general principles. Such advice should normally be given only when asked for. **The present system of submitting all documents for routine central scrutiny is unnecessary and should be abandoned.** The documents should be kept at the hospital (or at the offices of the local health authority when that authority is acting as guardian) and should be made available on request to any public authority having power to discharge the patient.

761. We therefore recommend the following procedures for the scrutiny of documents authorising compulsory powers over patients in national health service hospitals or under the guardianship of local health authorities:—

(*a*) When a mental welfare officer is called on to sign an application for admission or to convey a patient to hospital, he should satisfy himself that the documents are in order. He should be able to ask for technical or clerical errors to be rectified by the person who signed the document. If in exceptional cases he considers that there is insufficient medical evidence that the use of compulsion is justified within the terms of the law, he should at once refer the question to the medical officer of health.

(*b*) Immediately after a patient's compulsory admission to hospital, the admission documents should be scrutinised by medical and clerical officers of the hospital. It should be permissible for any technical or clerical error or omission to be corrected by the person who signed the document, at the request of the responsible officer of the hospital, within fourteen days from the patient's admission, and the patient's detention during that period should not be invalidated. The medical superintendent[5] should be able to ask for a fresh medical recommendation in place of one which does not appear to him to contain sufficient evidence that the use of compulsion is justified within the terms of the law. If necessary, the patient might be detained under emergency procedures while the fresh recommendation is being obtained.

(*c*) When a patient is recommended for admission to guardianship, the admission documents should be scrutinised by medical and clerical officers of the local health authority. It should be permissible for any technical or clerical error or omission to be corrected by the person who signed the document, at the request of the responsible officer of the local health authority. The medical officer of health[5] should be able to ask for a fresh medical recommendation in place of one which does not appear to him to contain sufficient evidence that the use of compulsion is justified within the terms of the law.

[5] To be interpreted as in footnote on page 145.

Except in cases of urgency, such corrections should be made, or fresh recommendations obtained, before the powers of guardianship take effect.

(*d*) The medical recommendations for the renewal of compulsory powers should be seen by members of the hospital management committee or local health authority (see paragraphs 433–435 in Chapter 7).

(*e*) The admission and renewal documents should be kept by the hospital or local health authorities as the case may be, and should be available to be seen by members of hospital management committees, local health authorities, Mental Health Review Tribunals and officers of the Ministry of Health when considering applications for discharge or interviewing individual patients.

(*f*) The Ministry of Health should be prepared to advise hospital and local authorities and their staff on questions arising from the local scrutiny of documents.

(*g*) The routine submission of documents for central scrutiny as under the present law should cease.

762. Similar principles should apply when the patient is in a hospital or home outside the national health service or in private guardianship, with some modifications of detail which we discuss in paragraphs 830–831 and 841 in Chapter 12.

(iii) **Central records**

763. The documents which the Board of Control at present receives for scrutiny are retained by the Board and information derived from these documents is occasionally given to certain other authorised persons on request. For instance, if it appears from the admission documents that a patient possesses property over a certain value, the Board informs the Court of Protection. It also supplies the Court of Protection on request with a "certificate of legal detention" when the Court is considering an application for the appointment of a receiver for a certified or temporary patient or a defective; this certificate in most cases consists of a statement sealed by the Board certifying that the patient has been admitted to a particular hospital or institution as a certified or temporary patient and that no notice of discharge or death has been received. The Board also on request supplies copies of the admission and continuation documents to the solicitors acting in matrimonial cases when a petition for divorce on grounds of insanity is being put forward. The Board is also obliged to supply a copy of the admission documents to discharged patients in certain circumstances.

764. If, as we have recommended, neither the admission nor renewal documents nor notices of admission and discharge are sent in future to the central department, any information of this sort which is needed will be obtainable only direct from the hospital or guardian. In our view this would be more satisfactory than the present system of obtaining it at second hand through the Board of Control. It would be better for any information which can properly be given to be sought from those under whose direct care the patient has been and who hold the originals of the documents authorising the use of compulsory powers. It may however be desirable for the Minister of Health to give general guidance to hospitals and local authorities, and through the local authorities to hospitals and homes outside the national health service and to individual guardians, on the general principles they should adopt when considering requests for information of this sort, which should of course not be disclosed to unauthorised persons.

(iv) **Power of discharge and visits to patients**

765. Our proposals in Chapter 7 would increase the powers of discharge which could be exercised locally. In most cases, we should expect patients to be discharged by the medical staff of the hospital as soon as they are fit to leave; similarly, patients would be discharged from guardianship by the medical staff of the local health authority. Relatives would have power to discharge patients at any time except when this right is withheld on the decision of a court, or when the patient is considered dangerous to himself or to others, or when the patient was originally admitted following court proceedings or on transfer from prison or approved school. The patient and relatives whose power of discharge is withheld would have access to members of the hospital management committee or local health authority who would have power to discharge the patient at any time (or to recommend discharge to the Home Secretary in cases in which his consent is required), and on specific occasions patients and relatives would have access to Mental Health Review Tribunals. In some cases, no doubt, these bodies would decide to discharge the patient; we hope that when they decide not to they would explain their reasons in such a way that the relatives, at least, would accept their decision as reasonable and would not wish to carry the matter further. Indeed, it might be argued that these local powers of discharge are enough, and that if all these persons locally are agreed that the patient should not be discharged there is no need for any further review.

766. In our view, however, these powers of discharge alone would not be quite sufficient. Our proposals in Chapter 7 allow access to the Mental Health Review Tribunals on specific occasions only. Patients would have access to them once in the first six months after admission and after that only at the time of the renewal of compulsory powers; for patients who had already been four years in hospital (other than adult psychopathic patients) this would be only once in three years. Relatives whose power of discharge has been withheld and adult psychopathic patients would have access to a tribunal once a year. We think it right that there should be some public authority, in addition to the hospital authorities and local health authorities themselves, who would have a continuing power to discharge patients at any time. This is particularly important for patients who have no relatives or whose relatives seldom visit them or do not want them to come home. It would in effect provide a continuing opportunity of appeal from the decisions of any medical superintendents and members of hospital management committees who might be unnecessarily cautious in using their own powers of discharge. It is also desirable that patients who are compulsorily detained should have an opportunity, if they wish, of interviews with visitors from outside the hospital, in addition to the opportunity of interviews with members of the hospital management committee.

767. One possible way of arranging this would be to give a continuing power of discharge and visitation to the Mental Health Review Tribunals, as well as the duty to hold full investigations on specific occasions. This would however completely alter the character of the tribunals as we envisage them. They would have to deal with a much greater volume of correspondence from patients and patients' relatives, which would include not only some requests which would require full investigation but also many others from or about patients whose cases the tribunal would already have investigated or whose need to remain in hospital was not in doubt. Many mentally ill patients write frequent letters and should certainly not be deprived of this outlet for their feelings. Any public authority which has a continuing power of discharge must expect to receive such letters and to answer them, using discretion in deciding how often to make fresh enquiries

from the hospital authorities. Moreover, if members of the review tribunals were to be given the duty of visiting patients on request, they would have to be prepared to make frequent visits, many of which would be to patients who were clearly quite properly detained. It would be asking too much to expect busy people of the calibre we hope will be willing occasionally to undertake the sort of investigations we discussed in Chapter 7 to spend much time on this other work. It would probably be necessary to appoint a few salaried members of the regional panels to do this work either full-time or regularly part-time, and they would need some full-time clerical staff. In effect, the tribunals would cease to be solely ad hoc investigating tribunals and would become small permanent public offices, whose members would from time to time conduct full-scale enquiries on applications for discharge but some at least of whom would also have regular administrative duties. They would become part of the everyday administrative machine. They would be, as it were, small regional Boards of Control. We think this would be a mistake. One of the main objects of our proposal to establish these tribunals is to ensure that at certain specific intervals, at the request of the person whose wishes have been overruled, the justification for the use of compulsion should be thoroughly reviewed by an independent body which has not previously had any connection with the case. The special nature of these reviews would be seriously impaired if the complainant had already applied to the same body for discharge, or had been visited by some of its members, and had had his requests rejected, in the intervals between the special reviews. It would also, in our view, affect the general approach of the review tribunals to their work. As we mentioned in paragraph 453, we do not want the members of the tribunals to be people who are continually considering requests for discharge as a matter of day-to-day routine, many of which they must inevitably reject. The duty of holding these special reviews should be separated from the day-to-day administrative responsibilities which a continuing power of discharge and visitation inevitably entail.

768. Another objection to giving these responsibilities to the Mental Health Review Tribunals is that it might create difficulties between them and the hospitals or local health authorities. It is important that the staff and members of these authorities should be recognised, and should recognise themselves, as the authorities primarily responsible locally for the proper care of their patients including questions which arise from the use of compulsion, and for seeing those who wish for personal interviews and for considering applications for discharge. If similar functions are to be given to another public authority as well, as an extra safeguard for the patients, it must be done in such a way as not to detract from this responsibility. We see no objection from this point of view to applications for discharge being referred to local review tribunals on specific occasions at fairly long intervals. But if the tribunals were to hold a continuing power of discharge and visitation, there would, we feel, be a real danger that some hospital or local health authorities might resent this duplication of function and feel that their responsibilities were being undermined, while others might tend to rely too much on the tribunals and pay too little attention to their own responsibilities for these matters. The latter is perhaps the greater danger. These dangers should be less acute if the powers are given to a central rather than another local or regional body, and if it is made clear that they are reserve powers which should not often have to be used if the hospitals and local health authorities are using their own powers in the way they should.

769. In a service such as the national health service which is organised on a national basis, it would be natural to expect that the authority holding

this power to visit and discharge patients who are dissatisfied with the decisions of the responsible authorities locally would be a central authority. There is also the consideration that a central authority holding these powers could review decisions of the review tribunals, as well as decisions of the hospital and local health authorities, by arranging for a fresh enquiry to be held if there seems reason to think that a tribunal has gone wrong on some question of principle or was not in possession of all the relevant facts.

770. For all these reasons, we think it best that a continuing reserve power of discharge and power to visit patients on request should be given not to the Mental Health Review Tribunals but to some central authority which could undertake the administrative work mentioned in paragraph 767 and which could also arrange for a formal enquiry to be held when it appears necessary to do so. In our opinion the proper authority is the Minister of Health.

771. The Ministry of Health and Board of Control themselves recommended to us that the power of discharge should be vested not in the Minister but in independent central commissioners who should be appointed by or on the nomination of the Minister of Health ; such commissioners might also hold appointments on the staff of the Ministry, but they should exercise the power of discharge by independent authority to be conferred on them by statute (1st Day, P. 29, para. 136 ; 23rd Day, Q. 4701–4713). Some other witnesses suggested that central commissioners holding the power of discharge should come under the aegis of the Lord Chancellor and work quite independently of the Ministry of Health (20th Day, Q. 3947–3961 ; 24th Day, P. 930, para. 78, and Q. 4910–13). Our reasons for differing from these recommendations are explained in the following paragraphs.

772. In formulating our own opinion we have taken into account the fact that under the system we recommend for the future there would be the new local Mental Health Review Tribunals which would provide an opportunity for regular reviews locally by people independent of the administrative authorities responsible for the care and detention of the individual patient in each case. This should reduce the volume of work falling on the central authority and would also alter the way in which that work might be handled. In future the central authority should normally receive applications for discharge only when this has already been considered and rejected by the hospital or local health authorities and often by a Mental Health Review Tribunal as well. We envisage that ordinarily the central authority should refuse to consider a case until application has been made to the medical staff and members of the hospital or local authority and to a tribunal when there is a right to go to one. We should then expect the central authority to ask the hospital or guardian for copies of the documents authorising the use of compulsion, for information about applications for discharge already considered locally and the reasons for their rejection, and an up-to-date medical report. If a Mental Health Review Tribunal has recently investigated the case and if there is no suggestion of a material change in the circumstances since that investigation, and if the tribunal's reasons for deciding against discharge appear sound, the central authority should ordinarily not make any further enquiry. Otherwise, we consider it desirable for the patient always to be interviewed personally on the first occasion on which he or his relative applies to the central authority for discharge. If it appears that a tribunal has gone wrong in some matter of principle or has not ascertained all the relevant facts, or if the case has not recently been considered by a review tribunal and there appear to be prima facie grounds for a full enquiry, the central authority should arrange for a fresh enquiry to be held. We should also expect any patient who asks for a visit (as distinct from discharge) to be

visited soon after the first request for such a visit is received. This would often mean making visits to hospitals specially to see such a patient. We do not think it right (as sometimes happens at present) that patients should be told that they will be interviewed on the commissioner's next visit and for this to be left over until the next routine visit to the hospital which may be several months later. The central authority should, however, have more discretion in deciding whether or not to visit a patient the second or subsequent time he asks for a visit or applies for discharge. The central authority would receive a considerable amount of correspondence from patients who are clearly mentally ill and who write frequently, and it should not be required to arrange visits nor to make enquiries from the hospital or guardian every time a patient writes. But whether or not a personal visit is paid, we consider that the actual decision for or against discharge should generally be taken by or on the advice of at least three persons, including at least one medical and one non-medical; the decision should not be taken by or depend on the advice of a single person, whether medical or not.

773. Much of the work falling to the central authority would be of a routine nature, and much of the time of its staff would be spent on visits to patients who would be found to be quite properly detained. If this were to be made a full-time job it would not be likely to attract medical or non-medical officers of the requisite calibre, certainly not people of the experience and standing who would be needed on the rare occasions when a full enquiry is to be held which might reverse the decision of a Mental Health Review Tribunal. In order to add interest to the work it would be desirable for most if not all of those undertaking it to spend only part of their time on this work and to have other duties also.

774. Whether the power of discharge is given to the Minister of Health (as we recommend) or to commissioners acting in an independent capacity, the day-to-day work of visiting patients and determining applications for discharge which do not appear to call for a full enquiry would need to be carried out by medical and non-medical officers employed regularly on this work for part of their time, with a secretariat to deal with correspondence. Enough officers should be appointed to this work to enable them to visit patients in any part of the country soon after the application for a visit or for discharge is received, to consider and determine the majority of the requests for discharge and to have time for other employment as well. It would clearly be convenient if they could have other regular part-time work in a department where they would all work together, and where the secretariat could also be located.

775. Arrangements would also have to be made to deal with requests for discharge which appear to need a full investigation. If the power of discharge were to be held by independent commissioners, there would have to be some senior commissioners of high standing (both medical and non-medical) to conduct such investigations. It would be convenient for at least one medical and one non-medical senior commissioner to be regular part-time commissioners with other part-time work in the same department as the junior commissioners and the secretariat so that they would be available for easy consultation. Other senior commissioners might be persons who are not full-time civil servants, who could be called on to investigate individual cases when required, such as medical or non-medical members or staff of hospital boards or committees or doctors in private practice or persons engaged in other forms of public service. If the power of discharge were to be given to independent commissioners, we would consider it desirable that enough people not on the staff of any government department

should be appointed as senior commissioners to enable an enquiry to be conducted entirely by such commissioners if this appeared desirable in any individual case. If the power of discharge were held by a Minister, however, a wider variety of methods of investigation would be available. Often the most suitable course might be for the Minister to refer the case to a Mental Health Review Tribunal for investigation or re-investigation. Alternatively, he could appoint one or more persons of suitable qualifications and standing to investigate and report to him; such persons might be experts in some branch of medicine or have high legal or other qualifications. Occasionally a public enquiry might be desirable to deal adequately with the case or allay any public suspicion or uneasiness. Power to refer a case to a Mental Health Review Tribunal would have to be conferred on the Minister by the legislation establishing those tribunals; power to arrange other forms of enquiry is a power incidental to the position of any Minister.

776. We do not consider that it would be appropriate for the power of discharge to be given to the Lord Chancellor or to commissioners working part-time in one of the departments for which he is responsible. In our view the Lord Chancellor should no longer be expected, or indeed empowered, to exercise administrative responsibility for the care or control of mental patients as distinct from the care and control of their property. In practice he has already relinquished almost all his active concern with these matters, apart from his general responsibility for the Court of Protection. We mentioned in paragraph 255 that he, together with the Judges of the Chancery Division, is entrusted with the care and commitment of the custody of persons found to be of unsound mind by inquisition and of their estates. It was suggested to us by several witnesses that this ancient procedure, which is now very seldom used, should be abolished. We certainly think the inquisition inappropriate in the twentieth century as a method of obtaining authority to compel a patient to accept care or treatment, and our recommendations in Chapter 7 imply its abandonment for this purpose. We were glad to learn from the Master in Lunacy (29th Day, P. 1193, para. 18, Q. 5907–5910 and 5996–7) that he agreed that it could well be abolished altogether, provided that appropriate consequential amendments are made to those parts of the law which form the basis of the jurisdiction of the Court of Protection and of receivers in receivership cases, and provided that the position of committees in existing inquisition cases is preserved. The Lord Chancellor at present also has some statutory powers under the Lunacy and Mental Treatment Acts in regard to the care and visitation of persons of unsound mind. Many of these are now seldom exercised. Most of them would clearly be inappropriate to the Lord Chancellor under the general system of local and central administration which we recommend in Chapters 10 and 12 and in the earlier part of the present chapter, except in so far as powers of visitation are needed in connection with the control of patients' property. The legal and medical Visitors whom the Lord Chancellor appoints under Section 163 of the Lunacy Act, 1890, are in fact chiefly occupied in visiting persons whose property has been, or is proposed to be, put under the control of the Court of Protection, and in making reports to that Court on any questions on which the Court requires information for the proper exercise of its duties in relation to patients' financial affairs. We have not regarded it as within our terms of reference to enquire in detail into the parts of the law and administration which deal with the protection and control of patients' property. In general, however, it seems to us right that these matters should be dealt with separately from the administration of the health and welfare services provided (or to be provided under our proposals) under the National Health Service Acts and National Assistance

Act, and we assume that they will continue to be dealt with by the Court of Protection, with the Lord Chancellor as the responsible Minister. Under our proposals this would be the Lord Chancellor's only remaining active responsibility in the field of mental health (apart from the appointment of the members of the regional panels for Mental Health Review Tribunals.)

777. The suggestion that commissioners holding the power of discharge might be attached to one of the Lord Chancellor's departments becomes in effect therefore a suggestion that they should be attached to the Court of Protection, or should undertake work for the Court for part of their time. We think that this is inappropriate in principle and also that it would not provide a satisfactory practical solution. We consider it important that the question whether a person needs treatment in hospital, and whether the use of compulsion for that purpose is necessary, should be kept quite separate from the question whether he is mentally capable of managing his own financial affairs. (We mention this also in Chapter 13.) The fact that these two questions are in most cases determined quite separately under the present system is often not appreciated even by patients and their relatives. We think this distinction should be emphasised. To attach commissioners holding the power of discharge to the Court of Protection would undoubtedly blur it. Moreover, if independent commissioners are to have other part-time work of a more varied and constructive character which would make their job more attractive, it must be work suited to the type of knowledge and experience which will be needed for the work of a commissioner. The type of people who would be qualified to undertake the work of a commissioner would be doctors, experienced social workers and other persons with special knowledge of the health and welfare services. Suitable employment for such persons would be available in the Ministry of Health, but is not likely to be found in connection with the work of the Court of Protection. Even if their work were to be combined with that of the Lord Chancellor's Visitors (if there were no other objections to such a course), this would not provide work for the number of medical officers who would be required to act as junior commissioners, nor for any commissioners without medical or legal qualifications though persons with other forms of experience in the health or welfare services would make very valuable junior commissioners and should certainly be included among their number if such commissioners are to be appointed at all.

778. If there are to be independent commissioners who would also have other work in some government department, by far the most suitable department would be the Ministry of Health (as that Ministry and the Board of Control themselves suggested to us). The work which the exercise of the power of discharge would entail would be closely related to the work which arises from the Minister's general responsibilities for supervising the hospitals and the local health and welfare services. The use of compulsory powers is one aspect, though a peculiar one, of the services provided for the care of the patient, for which the Minister has general executive responsibility. The staff of the Ministry must in any event include psychiatrists and other medical officers, nursing officers, welfare officers and other specialist staff, as well as administrative and executive staff, many of whom must have the same qualifications as would be needed for the work of a commissioner and whose work in the Ministry would be likely to add variety and interest to the job.

779. We think it would be possible to operate a system by which commissioners holding a continuing power of discharge in their own right and the duty to visit patients in connection with this power would hold dual

appointments as commissioners and as officers of the Ministry of Health, with a few other senior commissioners who would not hold such dual appointments. Under such a system the commissioners would act as individuals, taking personal decisions on individual cases referred to them. They would have no corporate functions, and would not be responsible for the formulation of policy or for giving advice to hospitals or local authorities or for the management of any hospitals. There would therefore be no need for them to be constituted as a corporate Board. Commissioners acting in a dual capacity under this system should not have any difficulty in distinguishing between their work as officers of the Ministry and their independent responsibilities as commissioners. We accept the evidence of the Chairman of the Board of Control that he and the other senior commissioners have had no difficulty in the last few years in acting quite independently when considering applications for discharge (23rd Day, Q. 4700).

780. Nevertheless, we see important objections to such a system. In the first place, it seems to us an unnecessarily cumbersome piece of administrative machinery, bearing in mind that the number of cases referred to the central authority should be much smaller than at present. Secondly, it would allow less flexibility in dealing with cases which call for a full enquiry, as we pointed out in paragraph 775. Further, it does not seem to us appropriate that a discretionary power such as the power of discharge should be held by commissioners of this sort acting in their own right. There is no inherent objection to powers being conferred on civil servants in their own right, but this is appropriate only when strict principles can be laid down to which their decisions must be subject, as is the case for example with district auditors and special commissioners of income tax. No precise criteria can be laid down to govern the use of this power of discharge, and occasionally (though only occasionally) its exercise would involve an enquiry which would in effect amount to the consideration of an appeal from the decision of a Mental Health Review Tribunal. The exercise of a discretionary judgment of this nature is, in our opinion, proper only to a higher court or tribunal or to a Minister of the Crown. A continuing power to discharge patients, with the routine administrative work which it would involve, could not appropriately be given to a court of law. Nor do we wish to propose a central appellate tribunal similar in composition to the local review tribunals. It is not necessary to provide for a regular right of appeal from the decisions of the local review tribunals (except on points of law, on which we have proposed a right of appeal to the High Court), as the review tribunals themselves would be reviewing decisions originally taken by others; only occasionally would it be desirable to review a case already fully investigated by a review tribunal. The main work falling on the central authority holding the power of discharge would, as we have already pointed out, consist of dealing with correspondence and visits to patients about whose need to remain in hospital there is no reasonable doubt. But this routine work would have to be combined with the power to exercise discretionary judgment in regard to applications for discharge which, occasionally, might require the holding of a formal enquiry at a high level. The proper authority to exercise such a power seems to us to be a Minister of the Crown.

781. We do not consider that objection can properly be taken to vesting the power of discharge in a Minister on the ground that this would give a member of the executive control over the liberty of individual citizens. The power of discharge would give the Minister power only to release people from detention and control. In no circumstances would he be able to order

a patient's detention. Nor would the Minister be the main discharging authority, as the Board of Control is under the present Mental Deficiency Acts. He would be able to order discharge, but not to prevent discharge by others. The patient could be discharged at any time by the medical staff or members of the hospital or local health authorities, and in most cases by his nearest relative also, irrespective of the views of the Minister. The Mental Health Review Tribunals would also be able to discharge the patient the next time his case came before them, even if discharge had been refused by the Minister.

782. We have also considered the possible objection that if the Minister held the power of discharge he might be subjected to undesirable political pressure on individual cases. Even at present, although he himself has no power to order discharge, the Minister of Health may be asked questions in Parliament about the discharge or licence of individual patients, and he receives and answers many letters from Members of Parliament on this subject. At present he normally confines his replies to reporting the facts of the case and the decisions taken by the hospital management committee or Board of Control, which he has no authority to overrule. If he himself held the power of discharge he might be exposed to slightly stronger pressure. It must be remembered however that many Ministers have powers and duties of a quasi-judicial nature, and it does not appear that their liability to be questioned in Parliament is in any way an embarrassment. The Home Secretary's responsibility for prisons, borstals and approved schools includes certain powers in relation to the discharge or release on licence of individual persons, and at present he alone holds the power to discharge Broadmoor patients. It appears to be accepted that the merits of a particular case are not a proper subject for detailed public discussion. On requests for discharge the Minister would still need to take medical and other advice, and we feel confident that he would not be subjected to unreasonable pressure after taking a decision in the light of such advice, or that if he were he would be able to withstand it by relying on that advice.

783. The fact that the Minister of Health has executive responsibility for the health services does not disqualify him from exercising the power of discharge ; on the contrary, it makes him the appropriate Minister to do so. As we pointed out in paragraph 778, the work arising from the power of discharge would be closely related to the Ministry's other responsibilities. Before 1948 the Board of Control exercised executive functions as well as its present duties in regard to individual patients. The power to visit patients and the reserve power of discharge, as well as all other functions in regard to the mental health services which need to be discharged centrally, should now also be held by the present central executive authority, the Minister of Health. This would provide the most coherent administrative system, and would also accord with the principle which we have emphasised in other connections, that there should be as few distinctions as possible between mental health services and other parts of the national health service.

784. **We therefore recommend that a continuing power to discharge patients from compulsory powers (except during periods when discharge is subject to the Home Secretary's consent as proposed in Chapters 6 and 7) should be held by the Minister of Health.** The procedures to be used in considering applications for discharge should not be laid down by law, but the Minister should be given power to refer cases to the new Mental Health Review Tribunals when he considers necessary. We should expect the work of visitation and the consideration of applications for discharge which do not call for a formal enquiry to be undertaken by medical and non-medical officers of the Minister's staff of no less seniority and experience than those

who would have been suitable for appointment as junior commissioners under the alternative system discussed in paragraphs 774–779.

State Institutions

785. Before 1948, Rampton Hospital and Moss Side Hospital for defectives of violent or dangerous propensities were owned and managed by the Board of Control. Broadmoor Institution was owned by the Home Secretary and managed on his behalf by a council of supervision. In 1948 and 1949 the ownership of these three hospitals was transferred to the Minister of Health. But, unlike other hospitals owned by the Minister, their management is not in the hands of hospital management committees appointed by regional hospital boards nor are they directly managed by the Ministry itself. They are managed on behalf of the Minister by the Board of Control. The admission and discharge of individual patients at Rampton and Moss Side are controlled by the Board of Control, and of patients at Broadmoor by the Home Secretary.

786. It is perhaps barely within our terms of reference to recommend whether these hospitals should continue to be managed by a centrally appointed committee or not. All questions affecting Broadmoor patients are clearly outside our terms of reference. As regards Rampton and Moss Side, however, we feel it right to point out that the new compulsory procedures recommended in Chapter 7 will lay on the managing committees of individual hospitals powers and responsibilities in relation to the detention, visitation and discharge of patients quite separate from those of the central authority. We have also stressed the importance of members of managing committees being freely accessible to patients and their relatives, especially when the relative's own power of discharge has been withheld. The patients in Rampton and Moss Side Hospitals probably present more difficult problems than those at any other hospitals in the country. This makes it all the more important for members of the managing committee, as well as the medical superintendents, to be personally accessible to patients and their relatives who have grievances. If at all possible they should be given a personal hearing, and in reply personal explanations are preferable to formal official letters. It seems clear that this will require fairly frequent attendance by members of the managing committee at the hospitals themselves, so that they can see visiting relatives who wish to see them as well as being easily accessible to the patients. This seems to imply that, whether the committee is centrally or locally appointed in future, some at least of its members should be people living within a reasonable distance of the hospital who would have sufficient time to give to this important aspect of the committee's work. In any event, no managing committee should be wholly identical with the persons advising the Minister on applications for discharge or authorised to exercise the power of discharge in their own right. Whatever arrangements are made for the exercise of the central power of discharge, all applications should be considered by persons unconnected with the hospital in which the individual patient is detained who should be able if necessary to reverse the decision of the managing committee of the hospital.

787. We therefore recommend that the Minister of Health should consider whether it would now be suitable for these hospitals to be brought within the normal national health service administrative system, or whether they should be directly administered by one or more specially appointed committees. If he decides on the latter, the members of the committee(s) should include some local members, and no member should be called on to decide or advise on applications for discharge addressed to the central department by patients in these particular hospitals.

788. **The proposals made in this chapter and in Chapter 12 would involve the abolition of the Board of Control.** There are always regrets when changing conditions make it necessary to wind up or reduce the functions of an organisation which has served its purpose well and earned the respect and affection of those who have been closely connected with it. These regrets should however be mixed with satisfaction when the reason for the change is to carry on the objects of the earlier organisation by new methods which are thought likely to be more effective in changed conditions. The objects of our mental health legislation and of those who have operated the mental health services have not changed during the last hundred and fifty years. These objects have always been and still are to provide the best available care and treatment for mentally disordered patients, to protect the general public, and to guard against abuse of the compulsory powers which may be needed for either purpose. But during this long period advances in medical knowledge, new methods of treatment and the development of new organs of government and new social services have naturally demanded changes in the medical and administrative methods by which these objects are pursued.

789. Radical changes were made in both the local and the central administrative organisation of the mental health services in 1947–48 when these services took their place as an integral part of the general health services of the country. It was then that the Board of Control handed on to the Ministry of Health its functions as the central department responsible for the general supervision of the mental health services as distinct from the procedures applied to individual patients. Continuity in administration was well preserved by the arrangements by which the people who had previously exercised these responsibilities as members or staff of the Board continued to carry them out as officers of the Ministry, and at the same time continued in their former capacities to carry out the functions still vested in the Board. So smooth was this transition that we doubt if it is fully realised even now by some of those working in the mental and mental deficiency hospitals how much of the day-to-day work of the people whom they know as senior commissioners of the Board has in fact been performed since 1947–48 in their capacity as officers of the Ministry and will remain unaffected by our proposals.

790. Our main task has been to review the parts of the law which give the Board of Control functions concerned with the liberty of the subject and the procedures applied to individual patients, which were substantially unaffected by the 1944–48 legislation and which date from an earlier period. In Part IV of this report we recommended changes of procedure and administrative method which we think desirable in order to bring these aspects of the law up to date. We hope we have made it clear that in our opinion the chief safeguard against the abuse of compulsory powers is not to allow their use at all except when they are really necessary, and to make all forms of treatment available without the use of compulsion. The present general attitude to mental disorder and present-day methods of treatment make this possible over a wide field. Even if in other respects the present procedures when compulsion is used were to remain unchanged, this change alone would substantially reduce the amount of work falling on the Board of Control, especially in relation to the patients now classified as mentally defective. Our other general recommendation which most affects the functions of the central departments is that the misuse of compulsory powers is now more likely to be prevented by increased opportunities for review and discharge locally, with reserve powers at the centre, rather than by concentrating control in the

central department. This also is a reflection of the great changes which have taken place since the days when the Commissioners in Lunacy were first appointed over a hundred years ago. We also consider it more appropriate now that a reserve power of discharge and visitation should be held by a Minister of the Crown than by a non-Ministerial Board of public servants.

791. Those who have taken part in the work of the Board of Control may well look back with pride to the part which the Board has played since 1913 in the development and improvement of our mental health services during a difficult period. We hope that they, and all who know what valuable work they have done, will welcome our recommendations for a different future organisation, which should make it possible to pursue the same general aims by methods more suited to the conditions of our time.

RECOMMENDATIONS IN PART VI AND APPENDIX IV

(1) Mental health and welfare services provided by local authorities should continue to be supervised by the Minister of Health. The Minister should be given power to make regulations as to the conduct and inspection of homes or centres for mentally disordered patients provided under the National Health Service Acts. (Paragraphs 735–736.)

(2) The Minister has general responsibility for the services provided in psychiatric hospitals (including the investigation of complaints) and it is neither necessary nor desirable to have a separate inspectorate outside the Minister's own department such as is at present provided by the Board of Control. The Minister should consider whether there would be any advantage in arranging regular inspections of these hospitals by suitably qualified officers on his staff in addition to less formal visits and consultation on the lines already adopted in other hospitals. (Paragraphs 737–744.)

(3) Responsibility for ensuring that there is proper documentary authority for the use of compulsory powers must lie with those who use the powers, i.e. hospital and local health authorities and their officers and private individuals acting as guardians. The routine submission of documents for central scrutiny should cease and the procedures for local scrutiny and custody of documents described in paragraph 761 should be adopted. (Paragraphs 747–761.)

(4) Subject to general guidance on principles from the Ministry of Health, information about patients in response to requests from authorised persons should be supplied direct by the hospital or local authorities or guardians. (Paragraphs 763–764.)

(5) The proper central authority to hold a continuing power to discharge patients who are subject to compulsory powers is the Minister of Health (except when discharge is subject to the Home Secretary's consent). The Minister should have power to refer cases for investigation by Mental Health Review Tribunals as well as to arrange investigations by other methods. (Paragraphs 765–784.)

(6) The judicial inquisition as to lunacy should be abolished. (Paragraph 776. See also Part VIII.)

(7) The Minister of Health should consider whether the three state institutions should now be brought within the normal national health service

administrative system or whether they should be directly administered by one or more specially appointed committees. The managing committee(s) should in any case include some local members; no member of the committee(s) should be called on to decide or advise on applications for discharge addressed to the central department by patients in these hospitals. (Paragraphs 785–787.)

(8) These recommendations would result in the winding-up of the Board of Control as all its present duties and purposes would be carried out by other means which we consider more suitable in present conditions. (Paragraphs 788–791.)

(9) The Minister of Health should review the arrangements for the central collection of statistics about the mental health services. (Appendix IV, paragraph (vii).)

PART VII

HOSPITALS AND HOMES OUTSIDE THE NATIONAL HEALTH SERVICE AND OTHER PRIVATE CARE

CHAPTER 12

Registration, approval and inspection by public authorities

(i) Present arrangements

792. Homes and hospitals for mentally disordered patients outside the national health service are at present excluded from the general system of registration and inspection which applies to other voluntary hospitals, nursing homes and disabled persons' and old persons' homes. Children to whom the Mental Deficiency Acts apply are excepted from the general arrangements for child life protection which might otherwise apply to them if living with persons other than their parents or guardians. When these other general systems were first introduced, arrangements for the registration and inspection of hospitals and homes for the mentally ill and defective were already in existence under special mental health legislation. Some of these special arrangements had their origins in the earliest provisions of the eighteenth and nineteenth century lunacy legislation, while others were introduced during the present century under the Mental Deficiency Act, 1913, and Mental Treatment Act, 1930. They vary in detail according to the administrative system in force at the time when each of the operative Acts was passed (see Chapter 9), though some functions previously exercised by the Board of Control were transferred to the Minister of Health under the National Health Service Act, 1946. The result is that the arrangements as they stand at present are complicated and are also quite different from those which apply to other voluntary hospitals and private nursing or residential homes and to other children. They are described in the following paragraphs.

Registered hospitals

793. These are voluntary hospitals for the mentally ill outside the national health service, not run for profit but recognised as charities. They are registered under the Lunacy Acts and may receive voluntary, temporary or certified patients only under the procedures laid down in the Lunacy and Mental Treatment Acts. The registering authority is now the Minister of Health and the hospitals are inspected by the Board of Control. Registration does not require renewal, but it is a condition of registration that the hospital regulations are approved by the registering authority, who is empowered to discontinue the registration if the regulations are not properly carried out. There are at present[1] four registered hospitals, all of which were registered in or before 1860; they vary in size from about 170 to 550 beds and at present accommodate about 1,280 patients. They provide a full range of treatment for mentally ill patients and are comparable to the designated mental hospitals in the national health service.

Licensed houses

794. These are the equivalent of private nursing homes, and most of them provide active medical treatment. They may receive certified, temporary or voluntary patients only under the procedures laid down in the Lunacy and Mental Treatment Acts. They vary in size and some of them are quite

[1] The numbers of hospitals and homes quoted in this chapter are correct for January 1st, 1957. We have not taken account of changes which may have occurred since that date.

small. Licensed houses in the metropolitan area, of which there are at present nine with about 220 patients in all, are licensed by the Minister of Health and inspected by the Board of Control. Licensed houses outside the metropolitan area, of which there are at present fourteen with about 630 patients, are licensed by the justices of the peace for the quarter sessions borough or county and are inspected both by the Board of Control and by visitors appointed by the justices. The licences remain in force for not more than thirteen months at a time, but may be renewed if the Minister of Health or the justices respectively are satisfied that the house has been "in all respects well-conducted". On the recommendation of the justices or of the Board of Control the Lord Chancellor may revoke or prohibit the renewal of the licence of a house licensed by the justices; similarly, the Minister of Health, on the recommendation of the Board of Control, may revoke a licence granted by himself. Since 1890 the opening of new licensed houses and the enlargement of existing ones have been prohibited by Section 207 of the Lunacy Act, 1890. It is, however, possible for the managers of a licensed house to apply to the Minister of Health for approval to provide a nursing home to receive voluntary and temporary patients only (see paragraph 795); such a home may be provided in the same grounds as an existing licensed house but it is technically a separate establishment and the patients are not interchangeable.

Other hospitals or homes receiving mentally ill patients

795. Hospitals or nursing homes may be approved by the Minister of Health for the reception of voluntary or temporary patients under the Mental Treatment Act. The approval need not be for a fixed period but in practice is given for a year at a time; it may be revoked by the Minister at any time. Hospitals or nursing homes so approved are inspected by the Board of Control. There are at present twelve nursing homes so approved. They may receive patients under the procedures laid down in the Mental Treatment Act for voluntary and temporary patients, but are not precluded from receiving other patients who are not technically "of unsound mind" on an informal basis without observing these procedures. Similarly, there is nothing to prevent other hospitals or homes which have not sought approval from the Minister from providing psychiatric treatment or nursing or residential care for persons who are mentally ill or infirm but who are not "of unsound mind", without using the procedures for voluntary patients laid down in the Mental Treatment Act and without being inspected by the Board of Control; such hospitals or homes would, however, be subject to registration by the local authority either as nursing homes under the Public Health Act, 1936, or Public Health (London) Act, 1936, or as old persons' or disabled persons' homes under the National Assistance Act, 1948.

Other mentally ill patients in private care

796. The Lunacy and Mental Treatment Acts allow "persons of unsound mind" to be taken into the care of, or reside with, private individuals as certified, temporary or voluntary patients in certain specific circumstances. These include certified or temporary patients who have been in a hospital or licensed house and who have left it either to be "boarded out" in the care of relatives or friends or "on leave" or "on trial"; these patients remain under the general supervision of the hospital and may be recalled to the hospital if necessary. "Persons of unsound mind" may also live as certified, temporary or voluntary patients as "single patients" in the care of private individuals.

797. Any person who wishes to receive a "single" voluntary patient must be approved by the Minister of Health; the approval is not limited

to a particular patient and need not be for a fixed period, but in practice is given for a year at a time; it may be revoked by the Minister at any time; the patient is visited by the Board of Control. A person who wishes to receive a "single" temporary patient must obtain the consent of the Board of Control (not the Minister of Health) on each occasion; the patient is visited by the Board of Control. A person who wishes to receive one certified patient in single care does not have to obtain the prior consent of the Minister of Health or of the Board of Control, but a person wishing to receive more than one such patient must obtain the approval of the Board of Control; all certified patients are subject to visitation by the Board. It is rare for approval to be given for one person to take charge of more than two "single" patients.

798. On December 31st, 1956, there were 44 certified patients and 4 voluntary patients in single care. The majority of these were patients who had previously been in hospital; only a few had gone direct into single care. A few nursing homes which are approved to receive voluntary or temporary patients (see paragraph 795) also receive one or two certified patients who are technically "single patients" in the care of the person in charge.

799. Except for patients who are boarded out or on leave or trial or in single care, and except for certified, temporary or voluntary patients in licensed houses or approved nursing homes or patients who have been the subject of a judicial inquisition, it is an offence under Section 315 of the Lunacy Act, 1890, for a private individual for payment to take charge of, receive to board and lodge, or detain a person of unsound mind or person alleged to be of unsound mind. Subject to the same exceptions, it is also an offence for private individuals to receive or detain two or more "persons of unsound mind" even without payment. Subject to the same exceptions, Section 206 of the same Act applies to any person of unsound mind or person alleged to be of unsound mind, who is detained or treated as such in a private family or charitable establishment without payment; there is no obligation on any person taking care of a "person of unsound mind" in these circumstances to inform the Board of Control that he has done so, but if any case comes to the Board's knowledge they have authority under Section 206 to require the person in charge of the patient to send them medical reports and any other particulars the Board think fit; they may act in regard to the patient as though he were a "single patient", except that they may not order his discharge from the place where he is being treated or detained, but on their information the Lord Chancellor may do so. It appears that Section 206 could apply to a mentally ill person living with his own family, as well as to a person detained or treated alone without payment in any other place, whereas Section 315 seems to refer only to the reception of such persons into places other than their own homes either for payment or in the company of at least one other "person of unsound mind".

Certified institutions

800. These are mental deficiency institutions outside the national health service which receive patients under the same arrangements as national health service mental deficiency hospitals; that is to say, although the Mental Deficiency Acts do not specifically prohibit the admission of uncertified patients, in practice patients are normally only admitted under the procedures laid down in the Acts which involve certification and detention (except for short periods under Circular 5/52). These institutions are certified by the Minister of Health and inspected by the Board of Control. The certificates

need not be for a fixed period but in practice they are given for periods varying from one to ten years. The Mental Deficiency Regulations contain detailed regulations as to the conduct of certified institutions. The certificate may be revoked by the Minister "if dissatisfied with the condition or management" of the institution. There are at present twenty-one certified institutions, accommodating some 1,450 patients. Almost all of them are run by religious bodies and were disclaimed by the Minister of Health from transfer to the national health service in 1948. A few of them are part of convents which also receive other persons who are not certified as mentally defective. Almost all the accommodation in them has been put at the disposal of the regional hospital boards who select the patients and pay for their maintenance under contract with the managers of the institutions. Many of the patients in these institutions are, however, severely sub-normal or feebleminded psychopathic patients of stable temperament, for whom it would be the responsibility of the local authorities rather than of the hospitals to provide residential care in future if our proposals in Chapter 10 are accepted.

Certified houses

801. The Mental Deficiency Acts allow defectives to be received into "certified houses", which are the equivalent of licensed houses under the Lunacy Acts, that is to say, establishments owned and managed by private individuals and authorised to receive patients under detention. The Minister of Health is responsible for certifying certified houses and they are subject to inspection by the Board of Control. There are at present no certified houses in existence.

Approved homes

802. These are homes for defectives which are not authorised to receive any patient who has been made the subject of an "order"; they may not even receive patients who are under guardianship or on licence. Most of them are run by private individuals, though a few are owned and managed by voluntary societies. They are approved by the Minister of Health and subject to inspection by the Board of Control. The approvals need not be for a fixed period, but in practice they are usually given for a year at a time. They may be revoked by the Minister if he is "dissatisfied with the condition or management" of the home. There are at present thirty-eight approved homes, accommodating some 900 patients. Most of them are small, the majority providing a home for less than twenty-five patients and only three taking over fifty.

Other defectives in private care

803. The Mental Deficiency Acts allow defectives to be put under the guardianship of private individuals in certain circumstances, either by their parents or by a judicial order. Local health authorities must obtain the consent of the Board of Control before recommending to a judicial authority the appointment of any person as guardian who already has charge of three defectives or has a person under his care under the Lunacy and Mental Treatment Acts; when the arrangements for guardianship are not made through the local health authority, any person wishing to receive more than one defective must obtain the consent of the Board of Control. Defectives under guardianship are visited by the Board. The local health authorities also arrange visits to those for whom they are responsible (i.e. when the petition for guardianship was presented by one of their officers or when they are contributing towards the cost of the patient's maintenance). There are some 2,650 patients under guardianship at present. Defectives may

also live with private individuals on leave or licence from a mental deficiency hospital or certified institution or on leave or licence from a guardian.

804. Apart from these arrangements for defectives on leave or licence or under guardianship, any one who undertakes the care and control of a defective (in any of the four classes defined in the Acts), or receives a person under his care as a defective elsewhere than in an institution, certified house or approved home, is obliged by Section 51 of the Mental Deficiency Act, 1913, to notify both the local health authority and the Board of Control, and may not receive more than one defective without the Board's consent. In practice, if a private individual wishes to receive more than a small group of defectives, he is advised to apply for approval from the Minister of Health to open an approved home. Section 51 is held to apply not only when defectives are placed in private care or in private schools by their parents, but also when they are admitted to a " place of safety " or to temporary care at the instigation of the local health authority or when mentally defective children are boarded out by local authorities' children committees. It applies irrespective of the patient's age and whether or not the person receiving the patient does so for reward or through a third party ; in these respects it has a wider ambit than the general child life protection legislation. All defectives notified under Section 51 are liable to be visited by the Board of Control. There are at present some 430 defectives so notified to the Board of Control living in private care either singly or in small groups. Section 51 is not held to apply to defectives living with their own parents or with near relatives.

Visits and powers of entry

805. Authority to visit or order visits to people believed to be of unsound mind or defective is contained in various sections of the Lunacy Act, 1890, and the Mental Deficiency Act, 1913 ; the Acts provide penalties for the obstruction of persons authorised to make such visits. When there is reasonable cause to believe that a defective is neglected or cruelly treated, Section 15 of the Mental Deficiency Act, 1913, allows a justice to issue a warrant for a search to be made by a police constable accompanied by a medical practitioner ; such a search warrant confers powers of entry, by force if necessary, to any place specified in the warrant. The Lunacy Acts contain no specific authority for forcible entry to obtain access to a person of unsound mind.

(ii) **Recommendations for the future**

806. The importance of maintaining proper standards of care by methods of control which do not depend on the use of compulsory or other procedures for the admission of individual patients is just as great in private or charitable as in public hospitals or homes, and it is essential that the arrangements for their registration and inspection by public authorities should be really effective.

807. The present arrangements described above seem to us to be unnecessarily complicated. We also see no reason in principle why the registration and inspection of hospitals, nursing homes and residential homes for mentally disordered patients should be the responsibility of different administrative authorities from those responsible for the registration and inspection of hospitals or homes for other sick, infirm or disabled persons and for children's homes and child life protection. In particular, the licensing of provincial licensed houses by justices of the peace is an anachronism.

808. On the other hand, the arrangements for the registration and inspection of other hospitals, nursing homes and residential homes and for child

life protection are themselves somewhat complicated and are made under pre-war as well as post-war legislation. Although the registering authority in each case is the county or county borough council,[2] who also have powers of inspection, there are differences between the arrangements under the Public Health Act, 1936, and Public Health (London) Act, 1936, which apply to nursing homes and voluntary hospitals, those under the National Assistance Act, 1948, which apply to old persons' and disabled persons' homes, and those under the two Public Health Acts, the Children Act, 1948, and Adoption Act, 1950, which apply to child life protection generally and children's homes. There are considerable differences in the reasons for which the registering authority may refuse to register or may withdraw registration from a private home, in the powers given to the appropriate Minister to make regulations for the conduct of such homes, and in the powers of inspection given to the appropriate central department in addition to those given to the local authority. We mention the most important of these differences in the following paragraphs in which we make recommendations for the future control of hospitals and homes receiving patients or residents suffering from mental disorder.

809. Under the National Assistance Act, 1948, county and county borough councils are responsible for the registration and inspection of old persons' or disabled persons' homes (other than nursing homes). The Minister of Health has power to make regulations as to the conduct of such homes and to arrange inspections. We consider that this system would be suitable for application to residential homes for persons suffering from any form of mental disorder who need the sort of care which local health or welfare authorities would have general responsibility for providing under our proposals in Chapter 10, and who do not need active specialist medical treatment or continual nursing care. These arrangements would be much more suitable than the present arrangements in the mental health field under which the Minister of Health and Board of Control are responsible for registration and visitation. If a woman living in Yorkshire or in Devon, for example, wishes to care for a number of severely sub-normal children in her house, the sort of questions which need to be considered before approval is given are whether the house can accommodate that number of children under suitable conditions, whether the person has sufficient knowledge of the special care which such children need and whether she has a suitable staff. Such questions can be more effectively considered by a local authority near at hand than by the staff of a government department in London. The local authorities have medical officers and social workers well qualified to inspect such homes and to give any advice which may be needed. If these homes were brought within the ambit of the National Assistance Act, the Minister of Health would be able to arrange for inspection by his own officers if circumstances arose which made this desirable, and he would also have power to make regulations as to the conduct of the homes. In practice, however, we should expect control to be left largely in the hands of the local authorities.

810. We therefore recommend that private or charitable residential homes for persons suffering from any form of mental disorder which provide the sort of care and supervision which we have recommended in Chapter 10 should in future be considered a local authority rather than a hospital function, should be made subject to registration by local authorities as disabled persons' or old persons' homes under Part IV of the National Assistance Act, 1948.

[2] Except that under the Children Act, 1948, the registering authority for voluntary children's homes (i.e., those wholly or partly supported by voluntary contributions or endowments) is the Home Secretary.

811. We also consider that private nursing homes and voluntary hospitals providing medical or nursing treatment should be registered by some local or regional authority rather than by a central government department. We are doubtful, however, whether the arrangements for the registration and inspection of nursing homes and hospitals under the two Public Health Acts of 1936, as they stand at present, would be entirely suitable to ensure the maintenance of standards of care and treatment in establishments such as the present registered hospitals or licensed houses or nursing homes approved under the Mental Treatment Act, many of whose patients are suffering from serious forms of acute mental illness which require specialist medical or nursing treatment. One difficulty is that the local authorities, who were themselves responsible for providing hospitals when the 1936 Acts were passed, no longer do so and no longer necessarily have among their own staff medical or nursing officers conversant with the most recent developments in the treatment of mental illnesses and the organisation of mental hospitals. This difficulty might be overcome by arranging for suitably experienced officers to be made available by the hospital authorities or the Ministry of Health to undertake the work of inspection on behalf of the local authority. But it seems that unless the Acts are amended such arrangements could only be made informally and with the good-will of the hospitals or nursing homes which are to be inspected, as the relevant sections appear to confer a statutory power of inspection only on officers of the registering authority itself.

812. There are other ways also in which the powers of the registering authorities under the Public Health Acts are narrower than those under other Acts. The reasons for which a local authority may refuse to register, or may withdraw registration from, a nursing home under the Public Health Acts are expressed in slightly more restrictive language than those for which the local authority may refuse to register a disabled persons' or old persons' home under the National Assistance Act, and contrast with the present arrangements under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts under which the Minister of Health has very wide discretion in approving or revoking the approval of a hospital, nursing home, licensed house, certified institution or approved home. Moreover, the Public Health Acts give the local authority power to make bye-laws only in regard to the keeping of records and notices of death, whereas the National Assistance Act gives the Minister of Health power to make regulations as to the general conduct of disabled persons' or old persons' homes.

813. The power to inspect records raises another small but important point. In giving officers of the registering authority power to inspect nursing homes and their records, the Public Health Acts expressly withhold authority to inspect the medical record of any individual patient. The Mental Treatment Rules give both the Minister of Health and the Board of Control authority to call for copies of the records relating to any patient in any hospital or home authorised to receive patients under the Lunacy and Mental Treatment Acts. It is a very common manifestation of mental illness for a patient to make complaints about his treatment and accusations against doctors, nurses or other persons which often have no foundation in fact but which, if taken at their face value or if investigated and substantiated, would provide grounds for very serious criticism of the standards of the hospital or nursing home and might make it necessary for the registering authority to consider withdrawing the registration. It is therefore desirable in the interests both of the patients and of the owners and staff of the homes or hospitals that the registering authority should be able to investigate such complaints fully, and for this purpose it may be necessary

to have access to the clinical records of the patient's condition and treatment at the time to which the complaints refer. If, therefore, hospitals and nursing homes for the mentally ill are to be registered in future under the same arrangements as other hospitals and homes, it would in our view be necessary to modify the relevant sections of the Public Health Acts so as to allow the inspection of clinical records, in confidence, by the medical officer of health or other medical practitioner acting on behalf of the local authority, for the purpose of investigating a complaint made by the patient himself or by another person making representations on his behalf.

814. It could be argued that the regional hospital boards rather than the county and county borough councils would now be the most appropriate public authority to be responsible for registering and inspecting private nursing homes and voluntary hospitals for mental patients. We do not, however, make a recommendation in this sense, for two reasons. The main reason is that we consider that these homes and hospitals should be registered by the same authorities as other types of nursing home, both as a matter of principle and because some nursing homes may wish to take both psychiatric and other types of patients. A second reason is that there seems to us to be some advantage in having one single authority responsible for registering nursing homes and disabled persons', old persons' or children's homes, so that a private individual or voluntary society need not be referred from one public authority to another but can apply to one local authority and have the application considered for registration under whichever Act seems most appropriate in view of the type of services provided.

815. We see no objection in principle to patients being received under compulsory powers in hospitals or nursing homes outside the national health service, provided that the registering authority is satisfied that the hospital or home provides suitable facilities for the care of the patients, and provided that there are sufficient safeguards against the abuse of compulsory powers. We see no need to draw a distinction in this respect between hospitals or other institutions provided by charitable or non-profit making organisations and those owned privately. In our view the present licensed houses as well as the present registered hospitals perform a useful function in providing treatment outside the national health service for some patients suffering from severe forms of mental illness which may sometimes require the use of compulsory powers. Our recommendations in Chapter 5 should make it possible for many more patients in future to be treated without the use of compulsory powers at all, and the type of private homes which might most usefully be increased in future would be nursing or residential homes or hostels for patients who can be cared for without the use of compulsion. But provided that the general supervision of private nursing homes is adequate we see no reason to continue the restriction on the opening or enlargement of establishments similar to the present licensed houses in which some patients might be subject to compulsory powers. The procedures applied to individual patients who are subject to such powers should however be modified to include extra safeguards when the patient is admitted to a hospital or home which is not owned by a public authority; our proposals for such modifications are in paragraphs 824–831.

816. We therefore recommend that voluntary hospitals and private nursing homes for persons suffering from any form of mental disorder (other than the residential homes which we have recommended should be registered under the National Assistance Acts) should be registered by county and county borough councils under the Public Health Acts of 1936. In the amending legislation which will be required the Acts should be amended to allow inspection by persons other than the council's own officers; arrangements

should then be made for inspections to be carried out by suitably experienced medical, nursing or other officers made available by the hospital authorities or Ministry of Health. The Acts should also be amended to allow the inspection of the medical record of any patient suffering from mental disorder in connection with the investigation of a complaint about the treatment of that patient, and to allow the inspection of the documents which authorise any patient's detention under compulsory powers. Amending legislation should also give the Minister of Health power to authorise visits of inspection and to make regulations as to the conduct of nursing homes or voluntary hospitals receiving mentally disordered patients; although the effective sanction would be the power of the registering authority to withdraw registration, the Minister should have the same powers as he has in relation to disabled and old persons' homes, particularly in view of the fact that some of the patients in these hospitals and nursing homes might be detained against their will.

817. The registering authority should keep a separate section of its register of nursing homes and hospitals for those homes and hospitals authorised to receive patients under compulsory powers. Homes and hospitals registered in this section would of course also be free to receive patients without such powers. We also recommend that the power of the registering authority to exempt from registration and inspection any hospital or institution not carried on for profit should not be used to exempt any hospital, nursing home or other institution receiving patients suffering from mental disorder.

818. **These arrangements for registration under the National Assistance Act or Public Health Acts would replace the present arrangements for the registration or approval of registered hospitals and licensed houses under the Lunacy Act, 1890, and of other hospitals or homes under the Mental Treatment Act, 1930, and of certified institutions, certified houses or approved homes under the Mental Deficiency Acts.**

819. These arrangements would also apply to some of the places in which "single patients" or groups of patients on licence or under guardianship are received at present, which would fall within the definitions of nursing homes or old persons' or disabled persons' homes. They would not however cover mentally disordered patients who might be taken to live in private houses or other places not falling within these definitions. In order to protect such patients from exploitation or neglect, it is desirable that there should be some public control over the conditions under which they live. We agree with the view put to us by the Board of Control and Ministry of Health that it is no longer necessary or desirable that this control should be exercised by a central government department. County and county borough councils are fully capable of exercising such supervision as is necessary either as part of their child life protection service or as part of their community mental health services. Under our general proposals in Chapter 6, the power to protect patients from exploitation or neglect by providing community or hospital care compulsorily (except for a short period for observation) would apply only to mentally ill and severely sub-normal patients of any age and psychopathic patients under the age of twenty-one. The arrangements recommended in the following paragraphs should also be restricted to the same groups of patients.

820. We recommend that notification to the local authority should be required when such a patient is received into the care of any private person other than a near relative in a place which is not required to be registered as a nursing home or as a disabled or old persons' home, whether or not he is received for payment and whether or not with powers of guardianship.

When the reception of such a patient is notified, the local authority should have powers of visitation and inspection as though the home were registered as a disabled or old persons' home. If it is then or later considered necessary for the patient's own welfare or for the protection of others that he should be compulsorily admitted to hospital or taken into the guardianship of the local authority, this would be possible on the application of a mental welfare officer, under the procedures described in Chapter 7.

821. Local authorities should also have power to arrange visits to any place in which they have reason to believe such a patient is living, whether or not they have been notified as described in paragraph 820. This would give them power to visit patients living with near relatives as well as patients in other private homes. If it is considered necessary for the patient's own welfare or for the protection of others, an application for such a patient's compulsory admission to hospital or to the guardianship of the local health authority could then be made.

822. We consider that arrangements similar to those contained in Section 15 (2) of the Mental Deficiency Act, 1913, should continue in future to permit access on a magistrate's warrant, by force if necessary, to any person who is thought to be suffering from any form of mental disorder and is thought to be liable to compulsory admission or recall to hospital or guardianship, if there is reasonable cause to believe that he is neglected or cruelly treated.

823. Except when patients are under guardianship, notification, visitation and inspection should be entirely in the hands of the local authorities and it should not be necessary for visits to be paid by the officers of any central department.

Procedures to be used when patients are admitted compulsorily

(i) Hospitals or nursing homes outside the national health service

824. The procedures described in Chapter 7 should be used when patients are received compulsorily in these hospitals and homes, subject to the additions and modifications set out in paragraphs 825–831. These additions and modifications should apply when the hospital or home is one managed by a charitable or non-profit making organisation as well as when it is a home run for profit. We consider this necessary because the managers of any institution wholly or partly dependent on patients' fees may appear to have some incentive to keep its beds full.

(a) Admission procedure

825. No owner or manager of such a hospital or home and no medical or other member of the staff should be able to make an application for a patient's compulsory admission, nor to sign either of the medical recommendations in support of such an application. Except in emergency there should in each case be two medical recommendations from outside doctors in addition to a medical acceptance by a doctor on the staff of the receiving hospital or home. When the emergency procedures are used, the one medical recommendation should be given by a doctor not connected with the hospital or home.

(b) Powers of discharge and visits

826. Three members of the managing committee or governing body (where there is one) should have the same powers of discharge and duty to visit patients which are recommended in Chapter 7 for members of hospital management committees. In addition, similar powers of discharge, and authority to visit, should be held by members of the registering authority.

i.e. the local authority or its appropriate committee. Regional hospital boards should also, as now, have power to discharge any patient maintained in such a hospital or home at the board's expense, and to visit such patients. Patients should be able to ask for an interview at any time with a member of the registering authority, or with the medical officer of health or other medical practitioner acting on his behalf. The other powers of discharge recommended in Chapter 7 should also apply. Officers of the Ministry of Health should have power to visit at any time, but would normally do so only at the request of the patient or his relatives or of the registering authority.

827. When considering applications for discharge from patients in hospitals or nursing homes outside the national health service, all the authorities concerned should give particular consideration to the question whether compulsory in-patient treatment or residential care is really necessary, or whether out-patient treatment or care at home, which the patient might be more willing to accept, might be sufficient.

(c) **Expiry and renewal of compulsory powers**

828. In hospitals or homes which have a managing committee, the procedure for the renewal of compulsory powers when otherwise due to expire should be the same as in national health service hospitals, i.e. the medical recommendation for renewal should be seen by at least three members of the committee, and if they decide not to discharge the patient he should be informed of his right to apply to a Mental Health Review Tribunal (or in the case of adult psychopathic patients there should be automatic reference to a review tribunal). Where there is no managing committee, the medical recommendation for renewal should be placed with the admission documents and the patient should be informed in writing of his right to apply for discharge to the registering authority ; such an application should be made and considered before the patient may apply to a review tribunal.

(d) **Transfer to another hospital or to guardianship**

829. The medical superintendent (or doctor in charge of the patient's treatment) should be able himself to sign a recommendation for transfer under the procedure described in paragraph 464. In addition, the medical officer of health of the registering authority, after consultation with three members of the local authority or its appropriate committee and with the consent of the patient's nearest relative or other person authorised to exercise the nearest relative's power of discharge, should be able to sign a recommendation for transfer to another hospital in place of the medical superintendent. This should apply whether or not the medical superintendent has issued a barring certificate against a relative's order for the patient's discharge. Similar action should be possible in order to effect a patient's transfer to guardianship. This would replace the present powers of the Board of Control or its commissioners to order the removal of patients from one institution to another.

(e) **Scrutiny of documents**

830. The managers of these hospitals and homes should in their own interests arrange for the documents to be examined by their staff as soon as the patient is admitted. The appropriate person at each hospital or home should be able to ask for the correction of technical or clerical errors or omissions, as proposed in Chapter 11 for national health service hospitals. The medical superintendent or other medical officer authorised by him, or if there is no medical superintendent the doctor in charge of the patient's treatment, should also be able to ask for a fresh medical recommendation

in place of one which does not seem to him to contain sufficient evidence that the use of compulsion is justified. Any general guidance issued by the Ministry of Health to national health service hospitals (see paragraph 760) should be made available to other hospitals and homes through the registering authority.

831. Persons visiting the hospital or home on behalf of the registering authority or Ministry of Health should be authorised to inspect any of the documents which purport to provide authority for any patient's detention and to interview the patient, whether or not a complaint or application for discharge has been received.

(ii) Private guardianship

832. Compulsory control over patients receiving community care should not often be necessary. When it is necessary, we should expect the local health authority to act as guardian in most cases in future. It would be possible for patients under the guardianship of the local health authority to live in their own home or in any other private house or in a home or hostel provided by a voluntary organisation, as well as in local authority homes or hostels, provided that the local authority is satisfied with the standard of care provided. There may, however, be some cases in which it would be suitable for powers of guardianship to be undertaken by a private individual and procedures for this purpose should be provided in any new legislation. We mentioned in paragraph 502 that magistrates courts should be able to authorise a relative other than the nearest relative, or some other individual, to undertake the powers and responsibilities of guardianship against the wishes of the patient's nearest relative in certain circumstances. Private guardianship might also occasionally be arranged at the instance of the nearest relative or when there are no known relatives, or when the patient is found by a court to have committed a criminal offence or to be in need of care or protection or beyond control. A person appointed guardian would exercise control over the patient equivalent to that of a parent over a child, but would not control his property unless he had also been appointed as receiver by the Court of Protection.

833. The procedures for patients under private guardianship should be the same as for patients admitted to the guardianship of the local health authority, with the following additions and modifications.

(a) **Approval of guardians**

834. Any person wishing to become the guardian of a patient should notify the local health authority. This should apply even when an application is made to a magistrates court under the procedures recommended in paragraphs 496–502, so that the local health authority's views on the suitability of the applicant may be available to the court. No person should be allowed to act as guardian unless he has been authorised to do so by a court (under the procedures described in paragraphs 496–502 or following court proceedings as discussed in paragraphs 511–551) or by the local health authority (when there have not been court proceedings and there is no opposition from the patient's nearest relative).

(b) **Admission procedure**

835. An application for the patient's admission to guardianship with two supporting medical recommendations should be made in the form recommended in Chapter 7, but neither the application nor recommendation should be by the proposed guardian himself. Instead of a medical acceptance, there should be a statement by the proposed guardian accepting the responsibilities of guardianship. The guardian should have a duty to notify the

local health authority on the day on which he accepts and assumes these responsibilities, and the local health authority should have a duty to arrange a visit to the patient not less than one month after receiving the notification.

(c) **Visits**

836. The local authority would have power to visit under the general powers recommended in paragraphs 820–821. They should arrange visits no less frequently than to patients under their own guardianship (see paragraph 487). The guardian should be responsible for ensuring regular visits by a medical practitioner. Officers of the Ministry of Health should have power to visit at any time, but would normally do so only at the request of the patient or his relative or of the local health authority.

(d) **Powers of discharge**

837. Any three members of the local health authority or its appropriate committee, after consultation with the medical officer of health, should have power to discharge patients from private guardianship. The power of discharge should also be held by the guardian and the patient's nearest relative (unless this power had been withheld at the time of admission under the procedures recommended in paragraphs 491–510, 541–551 or 553–556), and by the Minister of Health and (on specific occasions) by the Mental Health Review Tribunals.

(e) **Expiry and renewal of compulsory powers**

838. The powers of guardianship should be valid for the same periods as if the patient were under the guardianship of the local health authority. The medical recommendation for renewal should be made by the patient's usual medical attendant, and should be kept by the guardian with the original admission documents. The patient should be informed in writing of his right to apply for discharge to the local health authority and following that to a review tribunal, as in the case of patients in registered nursing homes without a managing committee (see paragraph 828).

(f) **Transfer to hospital with the guardian's agreement**

839. If the patient needs to enter hospital and is content to do so and the guardian agrees, the arrangements should be as described in paragraph 466 for other patients under guardianship. If power to detain him in hospital is necessary, the procedure described in paragraph 467 should be followed, the medical recommendation being given by the patient's usual medical attendant and the guardian holding the power of discharge usually held by the patient's nearest relative.

(g) **Admission to hospital against the wishes of the guardian, or transfer to the guardianship of the local health authority**

840. If the patient's admission to hospital is thought necessary, but the guardian is unwilling, a mental welfare officer should be able to apply to a magistrates court for the wishes of the guardian to be set aside, using the procedures described in paragraphs 496–510. A mental welfare officer should also be able to apply to a magistrates court, under the same procedures, asking the court to authorise the local authority itself to take over the guardianship of the patient, if the guardian is using his authority unreasonably against the best interests of the patient and if it would not be sufficient protection simply to discharge the patient from guardianship.

(h) **Scrutiny of admission and renewal documents**

841. When a patient is admitted to private guardianship there must be a notification to the local health authority who must arrange a visit within

one month (see paragraph 835). This will provide an opportunity for officers of the local authority to see the patient and inspect the documents at the same time. The documents should also be available for inspection at other visits, and in connection with applications for discharge addressed to the local health authority, Minister of Health or Mental Health Review Tribunal.

(iii) **Transitional arrangements for present patients**

842. Arrangements similar to those recommended in Chapter 8 should be made for patients in hospitals and homes outside the national health service and for single patients and patients under guardianship at the time when new legislation comes into force.

RECOMMENDATIONS IN PART VII

(1) Private or charitable residential homes for persons suffering from mental disorder which provide residential community care as distinct from hospital services should be subject to registration under Part IV of the National Assistance Act, 1948. (Paragraphs 806–810.)

(2) Private or charitable nursing homes or hospitals for mentally disordered patients (including the present registered hospitals and licensed houses) should be subject to registration under Part VI of the Public Health Act, 1936, and Part XI of the Public Health (London) Act, 1936, with the following modifications:—

(i) It should be possible for inspection to be carried out by persons acting on behalf of the registering authority whether or not they are officers of that authority. Suitably experienced officers of the hospital authorities or of the Ministry of Health should assist the local authorities by making such inspections on their behalf.

(ii) The medical record of any patient should be available for inspection by medical officers during the investigation of a complaint about the patient's treatment.

(iii) The power of the registering authority to exempt from registration and inspection hospitals and homes not carried on for profit should not be used in relation to hospitals or homes receiving mentally disordered patients.

(iv) The Minister of Health should have power to authorise visits of inspection and to make regulations as to the conduct of these hospitals and homes. (Paragraphs 811–818.)

(3) Subject to the arrangements recommended for registration and inspection, it is not necessary to continue the ban on the opening or enlargement of private nursing homes similar to the present licensed houses. (Paragraph 815.)

(4) Homes and hospitals authorised to receive patients under compulsory powers should be registered in a separate section of the local authority's register. (Paragraph 817.)

(5) When patients are admitted to these hospitals and homes under compulsory powers, the procedures recommended in Chapter 7 should apply, subject to the additions and modifications recommended in paragraphs 825–831.

(6) Notification to the local health authority should be required when a mentally ill patient or severely sub-normal patient of any age or a phychopathic patient under the age of twenty-one is received into the care of a private person other than a near relative in a place not registered as a nursing home or as a disabled or old persons' home, whether or not the patient is received for payment and whether or not under guardianship. The local authority should then have powers of visitation and inspection as though the place was registered as a disabled persons' home. (Paragraphs 819–820.)

(7) Local health authorities should have power to arrange visits to any place in which they have reason to believe such a patient is living, whether notified or not and whether living with a near relative or not. If there is reasonable cause to believe that such a patient is neglected or cruelly treated, it should be possible to obtain a magistrate's warrant to permit entry by force if necessary. (Paragraphs 821–822.)

(8) When patients are placed under the guardianship of a private individual, the procedures recommended in Chapter 7 should apply, subject to the additions and modifications recommended in paragraphs 835–841.

(9) Transitional arrangements should be made for present patients similar to those recommended in Chapter 8. (Paragraph 842.)

PART VIII

MISCELLANEOUS

CHAPTER 13

843. In this chapter we mention various parts of the law to which our attention has been drawn, which deal with subjects which are not themselves within our terms of reference, but which would need consideration if the recommendations made in the other parts of our report are accepted. This would be necessary because these other parts of the law depend on terminology or classifications which we have recommended should be abolished, or on references to the Lunacy and Mental Treatment Acts or Mental Deficiency Acts which we have recommended should be repealed, or because they would be affected by our recommendations in other ways. We have not attempted to make this chapter exhaustive, and are aware that there are also some other Acts or Regulations which would need similar consequential amendments.

Civil rights, liabilities and disabilities

(i) General principles

844. In some respects the civil rights and liabilities of persons suffering from mental disorder differ from those of other citizens. In so far as these are governed by the principles of common law, they depend broadly speaking on whether the patient is capable of appreciating the nature and effect of the act in question, e.g. the signing of a document. If the validity of such an act is challenged on grounds of mental incapacity, evidence is required as to the person's mental capacity in relation to the particular act in question. Evidence that the person was a voluntary or certified patient in a mental hospital at the time is not in itself conclusive. It is recognised in common law that unsoundness of mind does not necessarily affect all the faculties and is not necessarily completely disabling; a patient who is properly detained in hospital as a person of unsound mind may nevertheless be deemed capable of certain acts, e.g. executing a will. It is also recognised that a person of unsound mind may recover, or may have lucid intervals. The same general principle that mental capacity must be judged in relation to the particular act in each individual case also applies to defectives, though there is an assumption in common law that idiots are incapable of certain acts, e.g. of exercising a vote, and an idiot is presumed to be incurable.

845. In so far as the civil liabilities or disabilities of mentally disordered persons are governed by statute law, they are determined by the words of the statutes and the interpretation placed on them by the courts. Some such statutes adopt terminology or classifications derived from the present Lunacy and Mental Treatment Acts or Mental Deficiency Acts and apply the particular disability or liability to all patients covered by that terminology or classification without further enquiry in each individual case into the patient's fitness to perform the act or undertake the responsibility in question. For example, men who are the subject of an order under the Mental Deficiency Acts or under statutory supervision (as well as certain other mental patients) are without further question exempt from liability to be called up for service under the National Service Act, 1948. If our recommendations for new terminology and procedures are adopted, it will be necessary to amend the wording of any statutes which at present depend on the classifications contained in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. Most of these classifications cover groups of patients suffering from

a wide variety of types or degrees of disorder, and their use as the basis for determining civil rights and liabilities has led to some odd anomalies under the present law. The terminology and procedures we have proposed for the future would be even less suitable for some of these purposes. In general, we consider that each such statute should include a description of the type or degree of mental disorder which is significant for its own purposes; only rarely is this likely to correspond exactly with the whole of one of our three main groups of mentally disordered patients; even more rarely would the procedure used to admit the patient to hospital or community care be a relevant criterion for these other purposes. In paragraphs 846–881 we discuss in more detail some of these present statutory provisions and other related matters to which witnesses have drawn our attention.

(ii) **Patients' property**

846. In paragraph 776 we recommended the abolition of the inquisition procedure and mentioned that this would involve consequential amendments of those parts of the law which form the basis of jurisdiction in receivership cases. If the Lunacy Act, 1890, is completely repealed, as we have recommended, it would in any case be necessary to re-state and re-enact these parts of the law, which are at present contained in Part IV and some other sections of that Act and amending Acts. Section 116 of the 1890 Act contains a list of the categories of patients to whom the provisions of Part IV of the Act apply as regards the management and administration of their property, and Section 64 of the Mental Deficiency Act, 1913, applies these provisions to defectives. These sections seem to assume incapacity to manage their affairs on the part of certified and temporary patients under the Lunacy and Mental Treatments Acts and defectives in institutions or under guardianship, without further enquiry into their mental condition, whereas for other patients (voluntary patients in mental hospitals or elsewhere, and any other persons not in institutions and not under guardianship or in single care) the Court of Protection have no jurisdiction unless the Judge or Master in Lunacy is satisfied of the patient's incapacity by specific evidence in each case. We were however told (29th Day, Q. 5911–5921) that in practice the Court of Protection require specific medical evidence of such incapacity in all cases when an application for the appointment of a receiver is being considered, even for certified and temporary patients. Once it has been decided that a receiver is to be appointed, the receivership arrangements are not affected by a patient's change of "status" or discharge from or entry into hospital; the question of his capacity to manage his own affairs is thereafter dealt with quite separately from the question whether he needs treatment in hospital or not, or whether he is still a certified patient or not; separate medical evidence of his recovered capacity to manage his affairs is required before the receivership is terminated.

847. Receivers are not appointed for all the patients receiving treatment in mental hospitals. At 31st December, 1955, the total number of receiverships in force, for patients of all types including those not in hospital and some defectives, was 23,588, whereas there were over 150,000 patients in hospital under the Lunacy and Mental Treatment Acts alone, of whom over 110,000 were certified patients.

848. Before 1948 the Lunacy Act, 1890, required the managing committee of each mental hospital to make rules for the government of the hospital and to submit them for approval by the Board of Control. These usually contained rules about the signing of documents by patients, irrespective of whether their affairs were in the hands of a receiver. Each hospital

had its own rules, but it was common for them to lay down that patients should not be allowed to sign any documents affecting their property or income except a will or codicil; this prohibition usually did not apply to voluntary patients whom the medical superintendent considered capable of managing their own affairs but it usually applied to all certified patients. Since 1948 hospitals have not been required by law to have rules, but no doubt the established practice in regard to the signing of documents continues in most hospitals. If, in spite of such a rule, a certified patient whose affairs are not in the hands of a receiver signs such a document while in hospital, and if its validity is challenged in the courts on the ground of his mental incapacity, the issue would presumably be judged by the general principles which we mentioned in paragraph 844, and the fact that he was a certified patient at the time would not necessarily be taken as conclusive evidence of incapacity. For patients in mental deficiency institutions or under guardianship, the Mental Deficiency Regulations lay down that no patient shall be allowed to sign any legal document without the knowledge of the superintendent or guardian. The consent of the superintendent or guardian is not required however, and the purpose of the regulation seems to be to ensure that if the document is later challenged evidence will be available as to the patient's state of mind at the time.

849. We do not think it right that it should be assumed in law or in administrative practice that mentally disordered patients who are admitted to hospital under compulsory powers are necessarily incapable of managing their financial affairs. Some types of mental illness which would justify a patient's compulsory admission to hospital as a person of unsound mind under the present law, and as a mentally ill patient under our new proposals, would not necessarily affect his powers of judgment in relation to his financial affairs. It must always be a distressing experience for a patient to be compelled to enter hospital against his will; if at the same time he is automatically deprived of all control over his finances, this can hardly fail to add to his distress and resentment and to the difficulties which face his family, whereas if he can still sign cheques, or authorise another person to carry on his business until he returns, this extra distress may be avoided. One of our witnesses (25th Day, Q. 5222–5223) mentioned as typical a case in which a certified patient was discharged a fortnight after admission in order to deal with the essential business of his small-holding, in spite of the fact that his hospital treatment was not finished; apparently, no one else had authority to sign the necessary papers, and as a certified patient he could not sign them while in hospital. This seems ridiculous. If such a patient is capable of signing the papers outside hospital he would presumably have been equally capable of signing them if they had been sent to him while he continued his treatment in hospital. As things stand at present, the hospital medical staff are asked to use discrimination in deciding whether voluntary patients are capable of managing their own affairs or not, and according to the evidence of the Master in Lunacy (29th Day, Q. 5921) this does not give rise to any difficulty. In our view they should be allowed to use the same discrimination in regard to the signing of documents by patients who have been admitted under compulsory powers, when no receiver has been appointed, and should be able to advise bank managers and solicitors accordingly.

850. We think it important that the law and administrative arrangements dealing with patients' property should not be in any way dependent on whether the patient is in hospital or not or whether a hospital patient has been admitted with or without compulsion. It should be possible for new legislation about patients' property to define the jurisdiction of the

Court of Protection without reference to the procedures used for the patient's admission to hospital. For this purpose a general phrase might be found similar to that contained in the latter part of Section 116 (1) (*d*) of the 1890 Act, which would cover all persons who through mental disorder are incapable of managing their own affairs, without further particularisation. We also hope that it will be possible to discontinue the use of the word Lunacy in the title of the authorities administering this branch of the law as well as in all other connections.

851. Our proposal in paragraph 849 might go some way to meet a difficulty to which many witnesses drew our attention, namely that it often takes a considerable time for the Court of Protection to authorise someone to handle a patient's affairs, and that until this is done no one has authority to carry on the patient's essential business or in some cases to pay his rent to preserve his tenancy or alternatively to terminate a tenancy to prevent the accumulation of debt. These witnesses suggested that a simple and rapid interim procedure is needed which would authorise someone to act on the patient's behalf and which could be brought into action within a few days of his admission. When the Master in Lunacy gave evidence to us we discussed with him at some length (29th Day, P. 1192, paras. 8–17, and Q. 5922–5992) both the present arrangements and the sort of new arrangements which might be made to meet this difficulty. He told us that in many cases in which the estate is not large enough to justify the appointment of a receiver the patient's relatives do in fact manage to carry on with the help of banks and solicitors, and that the Court of Protection give informal advice in a great many such cases. In the case of larger estates, the Court can appoint an interim receiver very quickly if necessary. We were told by other witnesses (12th Day, Q. 2282–2287) that if the patient's relatives have no other resources the National Assistance Board can sometimes arrange for the payment of rent, and that some local authorities would regard the protection of a tenancy as part of their responsibility for the temporary protection of a patient's property while he is in hospital, in spite of the fact that their duty under Section 48 of the National Assistance Act, 1948, is to protect movable property only. Nevertheless, many of our witnesses mentioned these financial problems as among the main difficulties which arise when a patient is admitted to hospital, and urged that some new arrangements were much needed; some suggested that the duty of local authorities to protect property should be extended to property other than movable property. From this evidence it seems that the difficulties probably arise chiefly in connection with small properties which the Court of Protection might not think required the appointment of a receiver and about which they are not at present consulted.

852. What new arrangements would be suitable to meet these difficulties must depend partly on the volume of work which would be involved. The witnesses who drew our attention to the problem did not give an estimate of the number of cases in which action would be needed. Most of them also made only general suggestions about what local authorities would be expected to do if they were given new responsibilities of this sort; it would obviously make a lot of difference whether they were to be concerned only with patients who had no relatives who could act, or whether they were also expected to help or even to oppose relatives who wished to act themselves. The Master in Lunacy evidently expected that a lot of work might be involved in advising all relatives concerned with small properties, and told us that the Court of Protection could not undertake this with their present staff. He was generally in favour of giving local authorities a duty to take action when no other satisfactory arrangements had been made, subject to the knowledge

and general approval of the Court of Protection. On the evidence before us we do not feel able to assess the extent of these difficulties, nor how far they would be relieved by our recommendation in paragraph 849 that patients admitted to hospital against their will should not be prevented from continuing to handle their own affairs, or at least from authorising someone else to act for them temporarily, if they are capable of doing so. We think further enquiries are needed before practical proposals can be made. We recommend that the Minister of Health should ask hospital and local authorities for more detailed information about the extent of the problem, and should then discuss with them and with the Court of Protection, in consultation with the Lord Chancellor, what new arrangements would be suitable and practicable; new legislation might be required.

(iii) **Marriage and divorce**

853. The Royal Commission on Marriage and Divorce, which reported in 1955, conducted a general review of the law on these subjects including the special provisions which affect persons suffering from mental disorder. They recommended some changes in these parts of the law. They also pointed out that the terminology used in some parts of the present law and in some of their own recommendations might need to be reviewed in the light of our recommendations. In the following paragraphs we explain what amendments we think would be necessary to take account of our proposals in Parts III and IV of our report; these of course refer to England and Wales only.

(a) **Persons found to be of unsound mind by inquisition**

854. Under the Marriage of Lunatics Act, 1811, a marriage is void ab initio if either party is a person of unsound mind so found by inquisition, even if the marriage takes place in a lucid interval. The Royal Commission made no recommendation on this matter. If the inquisition is abolished, as we have recommended, this would become obsolete and the Act might well be repealed.

(b) **Use of terms "insanity", "person of unsound mind" or "mental illness"**

855. Under common law a marriage is void ab initio if either party at the time of the marriage is suffering from insanity to such an extent as to be incapable of understanding the nature of the ceremony or as to have insane delusions on the subject.

856. Section 8(1)(*b*) of the Matrimonial Causes Act, 1950, makes a marriage voidable if either party to the marriage was at the time of the marriage of unsound mind, provided that the Court is satisfied that the petitioner was at the time of the marriage ignorant of the facts alleged, that proceedings are instituted within a year of the date of the marriage, and that marital intercourse with the consent of the petitioner has not taken place since the discovery by the petitioner of the existence of grounds for the decree. The Royal Commission recommended that this provision should be redrafted so as to make it clear that it applies only when a person has gone through a ceremony of marriage with a full understanding of the nature of the ceremony and of what it imports, but was nevertheless of unsound mind at the time. This would provide a clearer distinction between marriages which are voidable on these grounds and those which are void ab initio on the grounds mentioned in paragraph 855.

857. A marriage is also voidable under Section 8(1)(*b*) of the 1950 Act if either party to the marriage was at the time of the marriage subject to recurrent fits of insanity or epilepsy, provided that the court is satisfied on

the same three points mentioned in paragraph 856. The Royal Commission recommended that the wording should be altered to "subject to recurrent attacks of insanity or epilepsy".

858. Under Section 1(1)(*d*) of the 1950 Act a petition for divorce may be presented on the ground that the respondent "is incurably of unsound mind and has been continuously under care and treatment for a period of at least five years immediately preceding the presentation of a petition". Section 1(2) defines the meaning of "under care and treatment" in this context. The Royal Commission recommended a new definition of the phrase "continuously under care and treatment", which we mention in paragraph 862, but recommended that this ground of divorce should remain unaltered in other respects.

859. These sections of the Matrimonial Causes Act use the terms "insanity" and "of unsound mind". We have considered whether we should recommend that these terms should be altered when the term "person of unsound mind" ceases to be used as part of the basis for compulsory admission to hospital. We do not consider that it would be appropriate to replace them by the terms "mental illness" and "mentally ill" without further qualification. Many patients who are mentally ill are not certifiable as of unsound mind under the present law. (Such patients would still not be subject to compulsory admission to hospital under our new proposals because of the limiting effect of the requirement that the use of compulsion must be necessary for the patient's own welfare or for the protection of others, which would be equivalent to the present requirement that compulsion may be used only when the patient is of unsound mind and a proper person to be detained for care and treatment.) If the term "mental illness" or "mentally ill" were to be substituted for the terms "insanity" or "of unsound mind" in Section 8(1)(*b*) of the Matrimonial Causes Act without further qualification, it might be held that these grounds for nullity had been extended to milder forms of mental illness, which is not intended. "Insanity" and "of unsound mind" have a recognised meaning in the context of the Matrimonial Causes Act which does not depend on the terminology used in other Acts, and we recognise that there is a case for retaining these terms in Sections 1 and 8 of this Act.

(c) **Use of term "mental defective"**

860. Under Section 8(1)(*b*) of the 1950 Act, a marriage is also voidable if either party was at the time of the marriage a mental defective within the meaning of the Mental Deficiency Acts, 1913–38, provided that the court is satisfied on the three points which we mentioned in paragraph 856. The Royal Commission discussed whether, as this section stands at present, it applies to all persons who are mentally defective within the meaning of Section 1 of the Mental Deficiency Act, 1913 (as amended by later Acts), or only to those who have been certified or ascertained as subject to be dealt with under the Mental Deficiency Acts. They recommended that it should be made clear that it applies to all persons who are defective within the meaning of Section 1. They pointed out however that the definition of mental deficiency and the classification of mental defectives contained in this section were being reviewed by us at the time when they reported and that our recommendations might lead to alterations in this part of the law. In order to make their intentions clear they stated that the degree of mental defectiveness which in their opinion justifies annulment of a marriage is that which makes the spouse unfitted for marriage and the procreation of children.

861. This part of Section 8(1)(*b*) of the Matrimonial Causes Act will certainly have to be amended if the Mental Deficiency Acts are repealed.

It would not be easy to replace this reference to mental defectives simply by a reference to one or more of the three groups of mentally disordered patients which we have recommended should be recognised in future for the purposes of providing hospital or community care. The possibility of substituting a new phrase which would embody the criterion suggested by the Royal Commission will have to be considered when new legislation is being prepared.

(d) **Meaning of the phrase "under care and treatment" when divorce is sought on grounds of insanity**

862. As already mentioned, Section 1(1)(*d*) of the Matrimonial Causes Act, 1950, allows a petition for divorce to be presented on the ground that the respondent is incurably of unsound mind and has been continuously under care and treatment for a period of at least five years. Section 1(2) describes what is to be recognised as "care and treatment" for this purpose by reference to the authority for the patient's detention or treatment as laid down in the Lunacy and Mental Treatment Acts and certain other Acts. It includes any period of detention in pursuance of an order under the Lunacy and Mental Treatment Acts (thus covering any period of treatment as a certified patient and certain periods of treatment as a temporary patient), and any period of treatment as a voluntary patient immediately following treatment under order. Other periods as a voluntary patient are not included, nor are periods of treatment in hospitals to which the Lunacy and Mental Treatment Acts do not apply. The Royal Commission recommended that Section 1(2) should be amended so that care and treatment in any hospital or other institution provided or approved by the appropriate authority for the treatment of mental illness should be deemed to be care and treatment for the purpose of divorce proceedings. If the Lunacy and Mental Treatment Acts remain unamended, the Royal Commission's proposal would recognise for this purpose treatment as a voluntary, temporary or certified patient under the Lunacy and Mental Treatment Acts, and also treatment outside these Acts in publicly owned or approved hospitals or homes. The Royal Commission also made suggestions about the interpretation of the word "continuously" in Section 1(1).

863. If the Lunacy and Mental Treatment Acts are repealed, as we have proposed, Section 1(2) of the Matrimonial Causes Act would have to be amended. If the reference to detention in pursuance of an order under the Lunacy and Mental Treatment Acts were replaced by a reference to detention in hospital under our new compulsory procedures, the scope of the definition of "care and treatment" would be made narrower, as we expect more patients to enter hospital without using compulsory procedures in future. If the Royal Commission's wording is adopted, the scope of the definition would be wider than at present (as they intended). We see no difficulty, from the point of view of our own recommendations, in the new wording proposed by the Royal Commission, except that it is not quite clear whether it would cover a period of residence in, for example, an after-care home which might not provide "treatment" in a strict sense but which might care for patients who are still "of unsound mind" and are unfit to return to their own homes but are not expected to benefit from further treatment in hospital. We suggest that "care" should always be mentioned as well as "treatment" in this context.

(e) **Divorce of defectives of dangerous or violent propensities**

864. The Royal Commission recommended that a new ground for divorce should be introduced, which should allow either spouse to apply for the dissolution of the marriage on the ground that the other spouse is a mental

defective who, by reason of his or her dangerous or violent propensities, has been detained in an institution for mental defectives for a continuous period of at least five years immediately preceding the application, and whose recovery from such violent or dangerous propensities is highly improbable.

865. This recommendation could not be adopted as it stands if our general proposals are accepted, as it uses the terms "mental defective" and "institution for defectives" which derive their meaning from the present Mental Deficiency Acts. As this proposed ground of divorce is not part of the present law, and as it is not yet known whether legislation is likely to be introduced to bring it into force, we do not think it necessary for us to suggest how it might apply under our proposed new system.

(iv) **Liability for national service**

866. The First Schedule to the National Service Act, 1948, contains a list of persons who are not liable to be called up for service under the Act. The list includes all temporary and certified patients under the Lunacy and Mental Treatment Acts, Broadmoor patients and defectives in hospitals, certified institutions or approved homes or under guardianship or statutory supervision or notified under Section 51 of the Mental Deficiency Act, 1913. The only men automatically relieved of liability for service because of physical illness or disability are those registered as blind persons.

867. Men suffering from mental disorder who are not included in the list in the First Schedule (e.g. patients receiving psychiatric treatment as out-patients, or as in-patients outside the Lunacy and Mental Treatment Acts, or as voluntary patients under these Acts, defectives under voluntary supervision and mentally disordered patients who are not receiving any form of hospital or community care), and men suffering from physical illness or disability other than blindness, are not exempted from liability for service; their fitness is assessed as described in paragraph 869.

868. If a man who has previously belonged to one of the categories listed in the First Schedule ceases to belong to such a category while he is still of call-up age (e.g. on discharge from hospital), he becomes liable for registration and call-up in the normal way. He is then treated in the same way as all other men who are liable for service; his medical fitness for service is investigated as described in the following paragraph.

869. Every man who is liable for service is asked at his medical examination to declare whether he has ever suffered from various specified illnesses, one of which is mental illness, and the effect of any such illness on his fitness for service is taken into account by the medical board which determines his medical category of fitness for service. If the man is in hospital when due for registration or for examination by a medical board, a medical report would normally be obtained from the hospital, and the medical board would consider whether the man should be found unfit for service because of the nature of his illness or whether consideration of the case should be deferred in expectation of recovery.

870. The First Schedule to the National Service Act, 1948, would have to be amended if the Lunacy and Mental Treatment Acts and Mental Deficiency Acts are repealed as we have proposed.

871. We presume that the reason why the Act at present relieves certain groups of patients of liability for service without investigation of their individual fitness is that it is administratively convenient to exclude automatically any group of men who are almost certain to be unfit or unavailable for service. But as far as their mental condition and prospects of recovery

or present fitness are concerned, it is not always relevant to distinguish, even under the present system, between voluntary and certified patients in mental hospitals. The exemption of certified patients in hospital, in any case, only lasts until they are discharged. Nor do we consider it appropriate to distinguish between defectives under voluntary supervision and those under statutory supervision. Different local authorities adopt different principles in deciding which school-leavers should be reported under Section 57 (5) of the Education Act, 1944. Some report all children leaving special schools for the educationally sub-normal, who are then placed under the " statutory " supervision of the mental health department. Other local authorities report only some of these school-leavers for statutory supervision, and provide " voluntary " supervision for others ; the decision is likely to depend quite as much on the child's home circumstances as on his own capabilities. Many defectives under statutory supervision are capable of normal employment in open industry. One local authority has told us that one of the things they bear in mind in deciding whether a boy should be placed under statutory or voluntary supervision is his suitability for national service and his keenness to undertake it ; even so defectives under statutory supervision occasionally enter the armed forces as volunteers, passing a medical board in the usual way ; when that happens they are usually considered for discharge from supervision. A considerable number of defectives under voluntary supervision are called up and complete their national service in the usual way. The local authority mentioned above (a very large county borough) had forty-three defectives under voluntary supervision serving in the forces in 1954, of whom one was a corporal and one a lance-corporal, as well as four who were on the authority's books as under statutory supervision.

872. Under our proposed new system the distinction between voluntary and statutory supervision would disappear, and so would the category of " defectives ". It would also be even less relevant than it is at present to distinguish for the purpose of liability for national service between patients who have been admitted to hospital informally and those who have been admitted under compulsory powers. Severely sub-normal patients would almost certainly be unfit for service whether or not they were receiving hospital or community care, and it might be practicable for such patients to be automatically exempted from liability for service ; administrative arrangements could no doubt be made for local health authorities and hospitals to inform the Ministry of Labour and National Service of all such patients of call-up age under their care. Our psychopathic group of patients would include some men who would almost certainly be fit for service as well as some who would not. The fitness of men who develop a mental illness at this age would depend partly on the nature and length of their illness. For mentally ill and psychopathic patients individual assessment would probably be the only practical course. If it were thought desirable, the responsible hospital or local authority medical officers might be asked to send in reports on such patients whom they consider unfit for service because of their mental condition, in order to assist the medical board in determining their category of fitness for service.

Sexual offences against mentally disordered persons

873. The Sexual Offences Act, 1956, consolidated the existing statute law on sexual offences, including the provisions of Section 5 of the Criminal Law Amendment Act, 1885, and Section 56 of the Mental Deficiency Act, 1913, which related to sexual offences against female defectives ; these provisions are now re-enacted in the Sexual Offences Act, 1956, and the relevant sections of the earlier Acts have been repealed. Section 7 of the 1956 Act uses the

terms " idiot " and " imbecile ", and several sections use the term " defective ". Section 8 (1) mentions particular forms of hospital or community care with specific reference to the Mental Deficiency Act, 1913.

874. The 1956 Act contains a definition of " defective " very similar to the definitions contained in the Mental Deficiency Acts, but so worded as to cover in one definition all the four classes of defectives as defined in the Mental Deficiency Acts. The definition in this Act stands on its own without explicit reference to the Mental Deficiency Acts, so that it would not be invalidated if the Mental Deficiency Acts were repealed. It may be thought anomalous for the term " defective " to be retained in this Act with its present meaning if it is abolished for other purposes; there is however no need for it to be affected by changes made elsewhere, if it is considered suitable for the purposes of this Act.

875. Section 7 of the 1956 Act makes it an offence for a man to have unlawful sexual intercourse with a woman whom he knows to be an idiot or imbecile. Section 8 makes it an offence for a man to have unlawful sexual intercourse with any woman who is under care or treatment in an institution, certified house or approved home within the meaning of the Mental Deficiency Act, 1913, or placed out on licence therefrom or under guardianship under that Act, unless he does not know and has no reason to suspect her to be a defective. Section 8, and perhaps also Section 7, would need amendment if the Mental Deficiency Acts are repealed. We do not think that it should be difficult to find new ways of describing those patients who need the protection given by these sections.

876. Section 324 of the Lunacy Act, 1890, and Rule 15 of the Mental Treatment Rules make it an offence for any member of the staff of a hospital or home or the attendant of a single patient to have sexual intercourse with a woman who is a certified, temporary or voluntary patient under the Lunacy and Mental Treatment Acts. This applies only to intercourse between a patient who has been admitted to hospital or other care under the Lunacy and Mental Treatment Acts procedures and a member of the staff of the hospital or other place where they are receiving care or treatment. It does not apply to patients receiving psychiatric treatment in other hospitals. It was not incorporated into the Sexual Offences Act, 1956. When the Lunacy and Mental Treatment Acts are repealed it will be necessary to consider how the substance of this section might be re-enacted.

Broadmoor Institution and Broadmoor patients

877. The law and administrative machinery relating to Broadmoor patients are outside our terms of reference. But some of the recommendations we have made in relation to other patients would make it necessary for some of the arrangements which at present apply to Broadmoor Institution and Broadmoor patients to be reconsidered by the responsible authorities. We mentioned some in paragraphs 386, 511 and 785–787 and recapitulate them here together with some other points mentioned by our witnesses which seem to deserve consideration.

878. In paragraph 511 we suggested that consideration should be given to the extent to which the principles underlying our proposed new procedures could be applied to persons now dealt with as Broadmoor patients. We hope that the procedures we recommend in paragraphs 553–556 for severely sub-normal and psychopathic patients who are transferred from prison to hospital could be extended also to mentally ill patients. We also hope that at least parts of the procedures recommended in paragraphs 520–521 and 538–552 could be applied when a trial on indictment results in a verdict

of " guilty but insane ". Whether this can be done or not, we hope that the term " Broadmoor patient " can be dropped, particularly in relation to patients in hospitals other than Broadmoor itself, as its retention would be anomalous if other distinctions of " status " or " class " are discontinued as we recommended in paragraph 384.

879. Some of our witnesses suggested that it should be possible for patients in other hospitals who are not " Broadmoor patients " to be transferred to Broadmoor Institution, if they are homicidal and need close control and supervision. We did not ask for other views on this question, as it did not appear to be within our terms of reference, but on the face of it it seems reasonable that there should be facilities for transferring patients from other hospitals to Broadmoor, if their mental condition or behaviour makes this desirable, just as they can be transferred from Broadmoor to other hospitals, and just as patients can be transferred between Rampton and Moss Side hospitals and other mental deficiency hospitals. We hope this will be considered whether or not alterations are made in the admission procedures for " Broadmoor patients " (see paragraph 878) and whatever arrangements are made for the future management of Broadmoor Institution (see paragraphs 785–787).

The Yarmouth Naval Hospital Act, 1931

880. Under this Act special procedures are laid down for the admission, detention and discharge of patients in the Yarmouth Naval Hospital. Persons who may be admitted as patients include officers of the Royal Navy or Royal Marines whether they are on the active list or not, and certain other categories of persons who are serving or have previously served in the Royal Navy, Royal Marines, Royal Fleet Reserve, Royal Navy Reserve or Royal Naval Volunteer Reserve, and also other war pensioners already detained elsewhere under the Lunacy and Mental Treatment Acts (except voluntary and temporary patients). The procedures for the compulsory admission, detention, visitation and discharge of patients in this hospital (other than voluntary patients) differ in many ways from those which apply to certified and temporary patients under the Lunacy and Mental Treatment Acts. We understand that the future of this hospital is at present under consideration, and that changes are contemplated which, if approved, would involve the abolition of these special procedures. It seems to us desirable that the procedures and safeguards which we have recommended for patients in other hospitals should also apply to patients in this hospital.

Patients who enter mental hospitals on discharge from the armed forces

881. In column 9 of Appendix II to this report, we mention the special procedures which may be used in certain circumstances for admitting patients to mental hospitals on discharge from the armed forces. The main difference between these procedures and the summary reception order procedure under Sections 14-16 of the Lunacy Act, 1890, is that the patient's compulsory admission is authorised by the appropriate service authorities, and neither duly authorised officer nor magistrate is called in. These procedures do not apply at all to commissioned officers, and may only be applied to other ranks in limited circumstances (see Appendix II, item 1, column 9). We understand that they are not often used. We hope that it will not be necessary to retain special procedures for this group of patients in future, and that the procedures recommended in Part IV of our report will be used for all such patients who need hospital or community care.

RECOMMENDATIONS IN PART VIII

(1) Acts and Regulations which affect the civil rights, liabilities or disabilities of mentally disordered patients should include a description of the type or degree of disorder which is significant for their own purposes. Only rarely will groups of patients who need to be identified for these purposes correspond with the whole of any of the three groups of mentally ill, psychopathic or severely sub-normal patients, and even more rarely will it be right to identify them by reference to the procedures used for their admission to hospital or community care. (Paragraphs 844–845.)

(2) The law relating to patients' property, marriage and divorce, liability for national service, and sexual offences (and other Acts and Regulations) will need amendment if the Lunacy and Mental Treatment Acts and Mental Deficiency Acts are repealed, and are discussed in the light of recommendation (1) in paragraphs 846–876.

(3) The Minister of Health should make enquiries about the difficulties alleged to arise in connection with patients' property at the time of admission to hospital and should consult other appropriate authorities about action to overcome them. (Paragraphs 851–852.)

(4) Consideration should be given to the extent to which the general principles recommended for other patients and other hospitals might also be applied to Broadmoor patients and Broadmoor Institution. (Paragraphs 877–879.)

(5) The principles which apply to other patients should also apply to patients in Yarmouth Naval Hospital. (Paragraph 880.)

(6) Consideration should be given to the abolition of the special procedures which may at present be applied to mentally ill patients who enter mental hospitals on discharge from the armed forces. (Paragraph 881.)

A summary of the main conclusions and recommendations in the report as a whole appears at the beginning of the report.

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882. It is customary to conclude a report such as ours with an expression of thanks to the Secretary of the Commission or Committee concerned, and there may be some danger lest such tributes may come to be regarded as merely conventional. For this reason, we should like to underline the quite special debt that we owe to Miss H. M. Hedley, not only for the drafting of our report and for her untiring devotion to a very arduous task, but also for the constant assistance she has given to us in our deliberations. Our conclusions are, of course, our own and we are glad to be able to present them unanimously; but Miss Hedley's clarity of judgment and her wide knowledge of the whole field covered by our enquiries have protected us against the temptation, to which we might otherwise have been exposed, of purchasing unanimity at the price of precision. We hope we have not slurred difficult issues and, if we have avoided this fault, it is largely because Miss Hedley has consistently set before us the most exacting questions and has put our answers in the least ambiguous language.

883. We are also much indebted to Mr. F. R. Howes, Mr. J. Seaward, Miss E. N. Gearing, Mr. L. W. Godfrey, Mr. R. P. Roberts, Miss V. E. Atkinson, Mr. J. H. Causeway and Miss K. Collins, who in their several capacities worked very well indeed for us during the various periods in which they served as members of our staff. Their steady and competent work has greatly assisted the smooth conduct of our business.

ALL OF WHICH WE HUMBLY SUBMIT FOR YOUR MAJESTY'S GRACIOUS CONSIDERATION.

PERCY OF NEWCASTLE (*Chairman*).
CECIL OAKES.
W. RUSSELL BRAIN.
T. PERCY REES.
HESTER A. ADRIAN.
C. BARTLETT.
ELIZABETH M. BRADDOCK.
R. M. JACKSON.
D. H. H. THOMAS.
J. GREENWOOD WILSON.

H. M. HEDLEY (*Secretary*).

7th May, 1957.

APPENDIX I

PROCEDURE AND SOURCES OF EVIDENCE AND INFORMATION

(i) We held our first meeting in private on 25th February, 1954, to consider our procedure. We issued a notice in the press on March 14th, 1954, announcing that we were ready to receive evidence, and asked persons wishing to submit evidence to us to send a memorandum in writing. We also addressed invitations to a number of associations and societies who appeared likely to have special knowledge of subjects within our terms of reference. We later fixed March 1st, 1955, as the closing date for the submission of written memoranda of evidence.

(ii) We received memoranda of evidence from 68 associations, societies, local authorities, hospital authorities and government departments, and memoranda or letters on subjects within our terms of reference from nearly 250 individual persons, including many engaged in or associated with mental health work, patients in mental and mental deficiency hospitals, former patients, patients' relatives and others. Many of these offered to give oral evidence in support of their written memoranda. It was not practicable for us to invite all those who offered to give oral evidence; we selected those from whom it seemed to us desirable to obtain further amplification of the views set out in their written memoranda or letters. We took oral evidence from 42 associations, societies and public authorities and 11 individual persons. Lists of those who gave oral evidence, and of some of the others who sent written memoranda or letters, are given at the end of this Appendix. In the second list we have not included the names of any present or former patients or other persons who wrote about the personal experiences of individual patients; we found their letters of great interest and assistance, but as we know that many would prefer their names not to be mentioned, we have omitted the names of all.

(iii) Our oral evidence was taken in public, except that we heard in private four witnesses who were either former mental hospital patients or wished to speak about the experiences of individual patients. The minutes of evidence taken in public were published in daily parts; the evidence taken in private is being published simultaneously with this report. An appendix to the minutes of evidence has also been published, containing memoranda supplied in response to requests made by us in the course of oral evidence, and some other memoranda from persons or associations from whom we did not take oral evidence. An index to the minutes of evidence, including the appendix, is also being published.

(iv) We received letters from over 60 present patients or other persons asking us to arrange for individual patients to be discharged from hospital or transferred to a different hospital. We had to inform these correspondents that we had no power to arrange such discharge or transfer.

(v) We are grateful to the Board of Control for allowing us access to their files, and to other public authorities who supplied us with information on request. All the statistics quoted in this report were supplied by the Ministry of Health or the General Register Office, except where otherwise indicated; we are much indebted to them for helping us in this way.

(vi) We have studied the reports of the two Royal Commissions which enquired into various aspects of our mental health legislation and administration earlier in this century (the Royal Commission on the Care and Control of the Feeble-minded, 1904-08, and the Royal Commission on Lunacy and Mental Disorder, 1924-26), and the reports of other Commissions and Committees which appeared relevant to our enquiry.

(vii) We did not as a Commission make any formal visits to hospitals or local authority establishments, but we all made informal visits, singly or in small groups, to hospitals or local authority centres; at Rampton Hospital, Retford, and Belmont Hospital, Sutton, several of us met groups of psychopathic patients. We wish to express our gratitude to all the members and staff of the hospital

and local authorities who arranged this for us. We were also very glad to have an opportunity of meeting Dr. R. L. Langdon-Down, M.B., M.R.C.P., who had been a witness before the Royal Commissions of 1904-08 and 1924-26 and who when we met him was in his 89th year ; we were sorry to learn of his death a few months later.

(viii) Our terms of reference were restricted to the law and administration in England and Wales. We have, however, acquainted ourselves with the main provisions of the present law relating to mental disorder in Scotland, Northern Ireland and Eire, and have also been much helped by the information contained in the survey of legislation in many countries published in 1955 by the World Health Organisation under the title " Hospitalization of Mental Patients ".[1] We have also seen the draft Act on the Hospitalization of the Mentally Ill which was prepared in the Federal Security Agency of the United States of America, as revised in 1952. We have read the White Paper containing proposals for amending the law relating to mental illness and mental deficiency in Scotland, which was published in December, 1955.[2]

(ix) We were glad to have the opportunity of meeting Dr. A. Querido, Professor of Social Medicine, Amsterdam University, and Director of the Public Health Department, City of Amsterdam, when he was on a visit to London in February, 1955. He told us about proposals for new legislation in Holland which had been prepared by a Royal Commission of which he was a member. We were also much interested to receive a communication from Dr. H. O. Wildenskov, Medical Superintendent of Kellers Institution, Brejning, Denmark.

(x) We held meetings on 44 whole days and 13 half days, of which 20 whole days and 12 half days were occupied in taking oral evidence.

1. List of Witnesses who gave oral evidence

Name of organisation, department or individual witness	Reference to Minutes of Evidence
Miss A.	Evidence taken in private
Association of Chief Police Officers of England and Wales	31st Day
Association of Headmasters, Headmistresses and Matrons of Approved Schools	11th Day
Association of Hospital Management Committees ...	20th Day
Association of Managers of Schools Approved by the Secretary of State	11th Day
Association of Municipal Corporations	4th Day and Appendix
Association of Psychiatric Social Workers	25th Day
Mr. B.	Evidence taken in private
Board of Control	1st and 23rd Days
British Medical Association	26th Day and Appendix
British Psychological Society	17th Day and Appendix
Mr. C.	Evidence taken in private
Confederation of Health Service Employees	18th Day
County Councils Association	14th Day and Appendix
Court of Protection	29th Day
Miss D.	Evidence taken in private
Dr. E. W. Dunkley	29th Day
Fountain Hospital Management Committee	14th Day
Friends of Menston Hospital	25th Day

[1] Reprinted from *International Digest of Health Legislation*, 1955, 6, 1–100.
[2] Cmd. 9623.

Name of organisation, department or individual witness	Reference to Minutes of Evidence
Dr. W. A. Heaton-Ward	30th Day
Institute for the Study and Treatment of Delinquency...	19th Day
Institute of Hospital Administrators	19th Day
Dr. Maxwell Jones, C.B.E.	30th Day
Lt.-Col. W. O. H. Joynson, J.P.	6th Day
Justices' Clerks' Society	5th Day
Justices for the County of Devon	7th Day
Liverpool City Council	24th Day and Appendix
London County Council	16th Day and Appendix
Dr. J. F. MacMahon	30th Day
Magistrates' Association	9th Day
Medical Practitioners' Union	27th Day
Mental After Care Association	2nd Day
Ministry of Health	1st and 23rd Days
National Association of Local Government Health and Welfare Officers	12th Day
National Association for Mental Health	12th and 28th Days
National Association of Parents of Backward Children	4th Day
National Association of Probation Officers	19th Day
National Council for Civil Liberties	22nd and 27th Days
National Institute for the Deaf	10th Day
National Spastics Society	10th Day
National Union of Teachers	28th Day
Sir William Nottidge, J.P., D.L.	6th Day
Dr. A. A. W. Petrie, C.B.E., F.R.C.P., F.R.C.S.Ed. ...	29th Day
Royal College of Physicians	13th Day
Royal Medico-Psychological Association	8th Day
Royal National Institute for the Blind	10th Day
Royal Western Counties Hospital Management Committee	15th Day
Socialist Medical Association	18th Day
Society of Chief Administrative Mental Health Officers	3rd Day
Society of Labour Lawyers	21st Day
Society of Medical Officers of Health	17th Day
Society of Mental Welfare Officers	5th Day
South West Metropolitan Regional Hospital Board ...	24th Day

2. **Written Statements and Correspondence**

Others who assisted the Commission by sending written memoranda or letters included the following:—

Mr. F. R. Ablett.
Dr. W. P. Alexander, Mr. R. Beloe, Mr. B. S. Braithwaite and Dr. E. Thomas.
Anglesey County Council.
*Dr. R. A. J. Asher, F.R.C.P.
Mr. P. Benenson.

* Memorandum printed in Appendix to Minutes of Evidence.

Birmingham (Mental A) Hospital Management Committee.
Birmingham Regional Hospital Board.
Dr. H. Bourne.
Buckingham Rural District Council.
Cassel Hospital Management Committee.
District Manager, Christian Science Committees on Publication for Great Britain and Ireland.
Dorset County Council (Children's Committee).
Duxford (Hants) Magistrates.
Mr. R. Trevor Evans.
Mrs. E. Frampton and Dr. R. W. L. Ward.
Dr. I. Frost.
Miss N. Fuller.
Dr. L. Gellner.
*Dr. T. C. N. Gibbens, M.B.E., Dr. D. A. Pond and Dr. D. Stafford-Clark.
*Home Office.
Institute of Almoners.
Institute of Social Psychiatry.
Inter-Regional Committee of Four Regional Associations of the Blind for England and Wales.
Dr. O. Vaughan Jones, F.R.C.S.Ed., F.R.C.O.G.
Dr. A. D. Leigh, F.R.C.P.
*National Corporation for the Care of Old People.
National Council of Women of Great Britain.
National Federation of Old Age Pensions Association (Langdon Hills and District Branch).
National Old People's Welfare Committee.
*National Society of Children's Nurseries.
Dr. H. J. O'Loughlin.
Mr. F. Openshaw.
*Professor L. S. Penrose, F.R.S.
Messrs. Pollard, Stallabrass and George Martin.
Mr. L. V. Priestley.
Probate and Divorce Bar Association.
Mr. R. L. Reddish.
Retreat Hospital, York, Committee of Management.
Mr. D. Rhydderch, J.P.
Dr. B. W. Richards.
Mr. W. Robertson.
St. Lawrence's Hospital Parents and Relatives Association.
Mr. A. Skeffington, M.P.
Mr. W. H. Snowdon.
Society of Registered Male Nurses (Chief Male Nurses' Association).
South Western Regional Hospital Board.
Dr. E. S. Stern.
Mrs. M. Townsend.
Miss D. M. Watkins.
*Dr. C. A. H. Watts.
Dr. D. White.
Rev. G. Wilde.
Women Public Health Officers' Association.
Women's Group on Public Welfare.

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* Memorandum printed in Appendix to Minutes of Evidence.

APPENDIX II. SUMMARY OF PROCEDURES APPLIED TO PATIENTS ADMITTED TO HOSPITALS, INSTITUTIONS, SINGLE CARE OR GUARDIANSHIP UNDER THE PRESENT LAW

(This Table is intended to show in summary form the main procedures laid down under the Lunacy and Mental Treatment Acts, Mental Deficiency Acts and other relevant Acts for the admission, detention, visitation and discharge of patients, and the main differences between the procedures which apply to different categories of patients. Some details have been over-simplified for the sake of brevity. Where there is doubt about the interpretation of the Acts we have followed what appeared to us to be the most authoritative opinion.)

		SUMMARY OF PROCEDURES BEFORE AND AFTER ADMISSION OF PATIENTS (OTHER THAN PERSONALLY PATIENTS) TO MENTAL HOSPITALS, REGISTERED HOSPITALS, LICENSED HOUSES, SINGLE CARE OR OTHER APPROVED HOSPITALS OR HOMES											SUMMARY OF PROCEDURES BEFORE AND AFTER ADMISSION OF PATIENTS TO MENTAL DEFICIENCY INSTITUTIONS OR GUARDIANSHIP				
		Patient admitted under Sections 25 or 25, Lunacy Act, 1890, to a hospital vested in the Minister or approved for this purpose (not necessarily a mental hospital)		Patient admitted by urgency order (Section 11, Lunacy Act, 1890)	Patient admitted by reception order on petition (Sections 4–8, Lunacy Act, 1890)	Patient admitted by summary reception order		Patient admitted on order under Section 20, Magistrates' Courts Act, 1952	Patient admitted by order under Section 1, Criminal Lunacies Act, 1884	Patient admitted on order under Section 16, Army Act, 1955, Section 16, Air Force Act, 1955, Section 5, Mental Deficiency Act, 1958	Temporary patient admitted under Section 5, Mental Treatment Act, 1930	Voluntary patient admitted under Section 1, Mental Treatment Act, 1930	Patient admitted under Section 12, Lunacy Act, 1890, after in-patient proceedings	Patient admitted under Section 1, Mental Deficiency Act, 1913	Patient admitted by order under Section 6, Mental Deficiency Act, 1913	Patient admitted by order under Section 9, Mental Deficiency Act, 1913	Patient admitted by order under Section 9, Mental Deficiency Act, 1913	Patient admitted to "place of safety" (in institution or guardianship) under Section 11, Mental Deficiency Act, 1913
		Section 25, Lunacy Act, 1890 (Column 1)	Section 25, Lunacy Act, 1890 (Column 2)	(Column 3)	(Column 4)	Sections 16 and 18, Lunacy Act, 1890 (Column 5)	Sections 17 and 18, Lunacy Act, 1890 (Column 6)	(Column 7)	(Column 8)	(Column 9)	(Column 10)	(Column 11)	(Column 12)	(Column 13)	(Column 14)	(Column 15)	(Column 16)	(Column 17)
Admission	Item 1. Persons for whom application for admission may be made and who may be detained	Any person for whom a duly authorised officer of a mental hospital may make application under Section 25, Lunacy Act, 1890, (see Column 2)	Section 25 (1): Any person of unsound mind for whom a justice of the peace, on information on oath, is satisfied that it is necessary for the person's welfare or the public safety that he should forthwith be placed under care and control. Section 25 (2): Any person for whom a summary reception order has been made, to provide for detention until he can be removed to the place named in the order.	Any person of unsound mind who is a proper person to be detained under care and treatment.	Any person of unsound mind who is a proper person to be taken charge of and detained under care and treatment, and who is not under proper care and control. Any person who wilfully and without lawful authority detains or ill-treats any person of unsound mind who is under care and treatment.	Any person of unsound mind who is wandering at large and is a proper person to be detained under care and treatment.	Any person charged before a magistrates' court who appears to be suffering from mental disorder and is a proper person to be detained under care and treatment.	Any person charged before a court of assize or quarter sessions or before a court of summary jurisdiction with an indictable offence, if the court is satisfied that he did the act or made the omission charged but is insane or was insane at the time of the commission of the offence, and that it is expedient for the protection of the public that a hospital order should be made.	(a) Any patient already in hospital who is a "Broadmoor patient"; or (b) any prisoner certified insane under Section 2 of the Act by two members of the visiting committee of a prison or a Prison Commissioner or one of them (after consulting two medical practitioners), who is about to be absolutely discharged or whose term of imprisonment is about to expire, and who is unfit to be at large.	Any man or woman, other than a commissioned officer, who is about to be discharged from H.M. Forces and in respect of a dangerous person of unsound mind; or (b) a person of unsound mind requiring treatment as a mental hospital and having no relative (being no relative willing to take charge of him, or no relative whom it would be reasonable to allow to do so), and who is unfit to be at large.	Any person who is mentally ill and is likely to benefit by temporary treatment and is incapable of expressing himself as willing or unwilling to receive treatment.	Any person who makes written application for treatment for mental illness on, if under age, his parent or guardian makes application.	Any person found by inquisition to be of unsound mind and incapable of managing himself and his affairs.	Idiot or imbecile of any age. Feeble-minded person or moral defective under age 21.	Any defective who is subject to be dealt with under Section 2 of 1913 Act.	Any defective who has been restricted by a court of a criminal offence punishable with imprisonment (Section 9, 1913 Act), but from whom it is fairly to be sent to an approved school.	Any defective who is declared in a prison, approved school or other institution under conditions specified in Section 9.	Any defective who is declared by a court to be a defective and ordered to be detained in a place of safety.	Any person whom a duly authorised officer or constable has reasonable cause to believe to be a defective who is neglected, ill-treated, or without visible means of support or ordinarily treated.
	Item 2. Medical certificates or evidence or other certificates required.			One medical certificate, as to patient's mental condition and expediency of immediate care.	Two medical certificates, one by patient's usual medical attendant where practicable or statement why not practicable.	One medical certificate.		Evidence from two medical practitioners.	Any medical or other evidence which the justice may deem sufficient. (The patient will already have been certified—see Item 1.)	One medical certificate.	Recommendation signed by two medical practitioners, one of whom is the patient's usual medical attendant, or by a doctor approved for this purpose by Minister of Health.	None if over age 16. If under 16, recommendation signed by two doctors, one of whom is patient's usual medical attendant or by a doctor approved for this purpose by local health authority or Minister of Health.	Copy of the order appointing the committee of the person or such an order has been made.	(a) Two medical certificates, one by a doctor approved for the purpose by local health authority or Minister of Health. (b) If patient is not idiot or imbecile, declaration by parent/guardian and one other person who may be sent of the grounds giving medical certificate.	(a) Two medical certificates, one by a doctor approved for the purpose by local health authority or Minister of Health, or a certificate that medical examination was impracticable. (b) If patient is not idiot or imbecile, declaration by parent/guardian and one other person who may be sent of the grounds giving medical certificate.	Medical evidence that person is a defective before the court.	Certificate of two medical practitioners.	
	Item 3. (a) Persons authorised to apply for judicial order. (b) Judicial orders made by:	(a) As in column 7 and 8. (b) As in columns 7 and 8.		(a) Husband or wife or relative of patient (preferably one with whom patient has resided), wife or relative of patient, manager to be stated. (b) "Judicial authority" (a justice specially appointed (Section 10, Lunacy Act, 1890) or any justice, except the applicant, empowered by the said act see the patient, but if he has not the power he may act in his own later by another judicial authority.	(a) Duly authorised officer of local health authority. (b) Any justice having jurisdiction in the place where the patient is. The justice must see the patient.	(a) Duly authorised officer of local health authority or any constable.	(a) Magistrates court before whom the patient is charged.	(a) Superintendent of hospital, or governor of prison where patient is. (b) Any justice who has jurisdiction where patient is or who is a member of the visiting committee of prison where patient is.					(a) If no committee of the person has been appointed, the Master in Lunacy.	(a) None. (But see Item 2 (b) above.) (b) "Judicial authority"—see Item 3 (b), column 3.	(a) Judicial or board of definition duly authorised officer of local health authority. An order may not be made without written consent of the parent or guardian, unless the person is unreasonably withheld or access parent or guardian is unreasonable. (b) "Judicial authority"—see Item 3 (b), column 3.	(a) Any court of competent jurisdiction.			
	Item 4. Whom an judicial order is required, person who authorises or orders patient's admission.	Duly authorised officer of local health authority or any constable.		For private patient, husband or wife or relative or other person connected with patient. If order for private patient is not signed by husband, wife or relative, reason to be stated. For other patients, duly authorised officer of local health authority.						Army Council, Air Council or Admiralty respectively, or any officer deputed by them.	Husband or wife or relative of patient if possible, or in their request duly authorised officer of local health authority, or other person connected with patient.	Patient himself if over age 16. Parent or guardian if patient is under age 16.	The committee of the person. See also Item 5 (b) above.	Parent or guardian of idiot or imbecile. Parent of feeble-minded person or moral defective.			Secretary of State (Home Secretary).	Duly authorised officer of local health authority, or any constable.	
Examination or Consultation Powers	Item 5. Medical reports or impressions on an after admission.	Medical officer to answer patient's physical condition on admission and record it in register.		(a) Statement on patient's physical condition on admission to be given to person bringing patient to a hospital stated in the Minister. (This does not apply to patients admitted to private hospitals or homes or to single care.) (b) Medical statement to be sent to Board of Control between second and seventh day after admission. (c) Patients admitted by order on petition: report on mental and physical condition to be sent to Board of Control one month after admission. A copy to be sent to clerk of the Visitors in regard to patients in houses licensed by justices. (d) Extract to be made in patient's clinical record as prescribed in Rules 41 and 49 of Mental Treatment Rules, 1948, or like patients in single cases in the medical journal as required by Rule 57. See also Item 7 below.									As at (a) in columns 3—10.	Medical statement to be sent to Board of Control between second and seventh day after admission. (Other medical reports to be sent to Lord Chancellor's Visitors, or single by committee of person and medical attendant whether patient is in hospital or single care at and, under Master of Patients' Estates Rules.)	(a) Medical statement to be sent to Board of Control within 7 days after admission. (b) Extract to be made in patient's record at intervals prescribed in Regulation 38 of Mental Deficiency Regulations, 1948. (This does not apply to patients under guardianship.) (c) Patients under guardianship: extract to be made in Guardianship Book at intervals prescribed in Regulation 78 of Mental Deficiency Regulations, 1948. See also Item 7 below.			
	Item 6. Period for which person may be detained, if not discharged in interim, at end of which certificate or order for further detention is required.	1 days, which may be extended for up to another 14 days.	14 days, which may be extended for up to another 14 days.	7 days or, if a petition for a reception order is pending, until the petition is finally disposed of.	1 year, and thereafter may be continued for periods of 1 year, 1 years and successive periods of 5 years.						Up to 6 months, which may be extended for further periods not exceeding another 6 months in all.	Patient may leave at any time on giving 72 hours notice, in order age 16 on such notice being given by parent or guardian.	Indefinitely. (The report of committee of patient if not renewed at 3-yearly intervals, but the order for transfer into hospital or other form of care, or for any person to have the charge of unconfirmed is in force.)		1 year, and thereafter if continued by Board of Control for 1 year and successive periods of 5 years. NOTE: If defective has been dealt with under Section 9, and the order under the Mental Deficiency Acts expires or is discharged before the end of the term of imprisonment, detention in approved school etc., the defective is to be sent back to prison, approved school etc., unless the Secretary of State (Home Secretary) agrees to his being set at large.		Pending presentation of petition for Section 4 order.	
	Item 7. Continuation procedure.	Certificate by medical officer of hospital that patient is of unsound mind and that it is expedient for his welfare that he should be detained for a further period not exceeding 14 days.		Authority for detention ceases in force for further period if special report on patient's mental and bodily condition with a certificate that he is still of unsound mind and a proper person to be detained under care and treatment is sent to Board of Control by the medical officer or medical attendant when period of detention is due to expire.							Board of Control may extend time for not exceeding 1 month at a time on the petition of the person entitled to make application for the patient's admission accompanied by a statement as to patient's mental and bodily condition by medical officer or medical attendant.				Board of Control may continue order when due to expire after considering:— (a) special report by the Visitors appointed by patient on patient's mental condition and means of care and supervision which would be available if he were discharged, stating their opinion whether he is still a proper person to be detained under the order; (b) special report by medical officer or medical practitioner on patient's mental and bodily condition and certificate that he is a proper person to be detained in his own interest; and (c) report of any medical practitioner who at request of parent or his relative or friend has examined patient and means of care and supervision which would be available if he were discharged.			
Discharge	Item 8. Rejection or lapsing of authority for patient to remain (apart from lapsing at end considered in Items 6 and 7).				(a) Board of Control may order discharge if an incorrect or defective medical certificate is not amended to their satisfaction within 14 days after patient's admission. (b) Authority for detention lapses if the patient escapes and is not recaptured within 14 days. (c) Authority for detention lapses if the patient is not visited by a Visitor within 3 months of a medical certificate that detention is no longer necessary is sent to the hospital management committee or the manager of the registered hospital or licensed house. (This does not apply to temporary patients.) (d) Temporary patient may not be detained as such for more than 28 days after becoming capable of expressing himself as willing or unwilling to receive treatment.							Patient may not be retained as a voluntary patient more than 28 days after being patient to be discharged. He can withdraw his notice four days.				Board of Control may refuse discharge if any incorrect or imperfect order or any document upon which the order was founded is not amended to their satisfaction within 28 days after patient's admission.		
	Item 9. Persons having powers of discharge.			(a) Patients admitted by order on petition: the person on whose petition the order was made, or if he is dead or incapable the person who made the last payment on account of patient, or the appropriate relative, or any one. (b) Patients admitted otherwise than by order on petition: the appropriate relative, or (private patients only) the person who made last payment on account of patient, or (temporary patients only) the person either that duly authorised officer) who applied for the patient's admission, or any one. (c) If no person is qualified or able or willing to act under (a) or (b), the Board of Control, at any time. (d) Patients maintained in registered hospital or other private hospital by regional hospital board: regional hospital board at any time. Note.—Discharge under (a), (b), (c) or (d) may be prevented by a barring certificate signed by the medical officer stating that the patient is dangerous and unfit to be at large, but the barring certificate may be overruled by two members of the hospital management committee or by the Minister, or by two members of the Board of Control visiting a registered hospital, licensed house, other hospital or home or patient in single care, or by Visitors of a licensed house. The following methods of discharge are not subject to a barring certificate. (e) Patients in a hospital vested in the Minister: three members of the hospital management committee or two members on the advice in writing of the medical officer, at any time; or two members, if they think fit, on application of a relative or friend of patient who undertakes to take care of him. (f) Patients in registered hospitals, licensed houses or other private hospitals or homes, or in single care, must be discharged within 7 days of recovery. (g) Patients in registered hospitals, licensed houses or other private hospitals or homes, or in single care, may be discharged by the managing committee to carry out visit following month-end report. (See Item 10 (f) below.) (h) Patients in houses licensed by justices: the Visitors after two visits at an interval of not less than 7 days by same two Visitors, one medical, if they consider patient is detained without sufficient cause. The Board of Control or Commissioners have power to discharge in the following specific circumstances:— (i) Patients in registered hospitals, licensed houses or single care: two Commissioners, one medical and one legal, within 7 days of a visit, if they consider patient is detained without sufficient cause. (This does not apply to temporary patients, but see (m) below.) (j) Patients admitted by order on petition: Board of Control in any case in which they, after considering a report made to them by the Visitor(s) or Commissioner(s) who visit the patient following the receipt of a month-end report (see Item 10 (f) below), determine that the patient ought to be discharged. (k) Patients in registered hospitals, licensed houses or single care: Board of Control or two Commissioners if in their opinion the special report (of a special report and certificate) does not justify the accompanying certificate. (See Item 7, columns 4–8.) (l) Any patient: Board of Control on report by two medical practitioners who have examined the patient under Section 40 of the Lunacy Act, 1890. (m) Temporary patients: Board of Control at any time.		(a) Patient himself, if over age 16, on giving 48 hours notice in writing. (b) Board of Control if they consider patient's mental state renders him unfit to remain as a voluntary patient.	Committee of the person or, if there is no committee, the Master in Lunacy. (This includes discharge from hospital or single care—there is a separate procedure for discharge of order of committee.)	(a) Patients admitted under Section 5: parent or guardian on giving notice to Board of Control, unless Board determine otherwise. (b) Patients admitted otherwise than by order on petition: person who made last payment in respect of patient's interest. (c) Patients admitted to certified institutions under Section 5: the managers on giving a month's notice to the parent or guardian and to the Board of Control. (d) The Visitors appointed by justices must interview every patient when by attains age 21, and on every occasion before which the Board of Control may consider the question of discharge or transfer. (e) At least two members of the management committee of a hospital vested in the Minister must visit each patient detained in the hospital at least once every six months. (f) Patients under guardianship arranged by local health authority: the Visitors appointed by justices must arrange for visits to be paid at least once a year by a medical practitioner with experience in mental deficiency, and at least twice a year by officers of the local health authority or other approved persons. (g) One or more Visitors appointed by justices must visit every patient under guardianship if requested to do so by Board of Control. (h) Members or officers of regional hospital board may at any time visit patients maintained by board in certified institutions.		
	Item 10. Visits by public authorities.	One or more Commissioners of Board of Control to visit as directed by the Board. Hospitals inspected under Section 26 are, in practice, visited once a year by one Commissioner.		(a) One or more Commissioners of the Board of Control may visit any mental hospital, registered hospital, licensed house, any hospital or home receiving voluntary or temporary patients, and patients in single care, at any time. (b) Single care must be visited once every month by medical officer appointed by hospital management committee, and one or more Commissioners every hospital or home receiving voluntary or temporary patients and all patients in single care at least once a year, and one visit must be without notice. (c) The frequency of visits by Commissioners of the Board to licensed houses is laid down in Section 191 (2) and (3) of the Lunacy Act, 1890, but the Lord Chancellor has directed under Section 191 (7) (b) that licenses licensed by the Minister need not be visited more than twice a year. All patients must be seen on each occasion of visit. Note.—The Board has given a timetable under Section 15 of the Mental Treatment Act, 1930, that visits under (b) or (c) above which are required to be paid by two Commissioners may be paid by one Commissioner. In practice visits are made to most mental hospitals by two Commissioners. (d) Visitors appointed by the justices may visit licensed houses licensed by justices at any time. Such houses must be visited four times a year by at least two Visitors, one a medical practitioner, and twice a year by at least one Visitor. All patients must be seen on each visit. (e) Patients admitted to registered hospitals, licensed houses or other private hospitals or homes, or in single care, must be visited by two members of the hospital management committee or by two members of the Board of Control at least once every two months. (f) Patients admitted by order on petition: must be visited following month-end report by one or more Commissioners of the Board of Control, or by the medical Visitor of licensed houses, or by one or more members of the hospital management committee of a hospital vested in the Minister or of the managing committee of a registered hospital. (g) Temporary patients: patients in hospitals vested in the Minister must be visited within one month of admission by two members of hospital management committee; patients in other hospitals or homes or in single care must be similarly visited by two of the Visitors of licensed houses for the district (or, if no metropolitan area, by the Board of Control. (h) The Lord Chancellor or a Secretary of State may order the Board of Control or any other person to visit and examine any person of unsound mind.									As in column 3—11. (In addition, any patient in hospital may:— (a) Have his conduct by Lord Chancellor's Visitors as directed by Rules in Lunacy or by order of the Judge in Lunacy and in any case by Lord Chancellor. (b) If in a private house, must be visited by Lord Chancellor's Visitors four times in each of first two years after admission. (c) May be visited by Board of Control at request of person on behalf by the Lord Chancellor.)		(a) One or more Commissioners or Inspectors of Board of Control may visit at any time, and must visit twice a year, one visit a year being paid to institutions by a Commissioner or district from an inspector. (b) The Visitors appointed by justices must interview every patient when by attains age 21, and on every occasion before which the Board of Control may consider the question of discharge or transfer. (c) At least two members of the management committee of a hospital vested in the Minister must visit each patient detained in the hospital at least once every six months. (d) Patients under guardianship arranged by local health authority: the Visitors appointed by justices must arrange for visits to be paid at least once a year by a medical practitioner with experience in mental deficiency, and at least twice a year by officers of the local health authority or other approved persons. (e) One or more Visitors appointed by justices must visit every patient under guardianship if requested to do so by Board of Control. (f) Members or officers of regional hospital board may at any time visit patients maintained by board in certified institutions.		Patients in mental deficiency hospitals and certified institutions are visited as in (a) and (c) in previous column.
	Item 11. Documents to be sent to Board of Control, Visitors or public authorities.	Notice of death on account of the doctor, within 2 days.		(a) Notice of admission and copy of statement or other order or application for admission, with copies of supporting documents, to be sent to Board of Control, and (for patients in houses licensed by justices) to the clerk of the hospital management committee or clerk of the Visitors. (Copies of admission documents not to be sent in case of temporary patients.) (b) Notice of discharge or delivery of transfer to or from private or health service class, to Board of Control, and (for health service patients) to local health authority, and (for temporary patients) to the clerk of the Hospital Management Committee or clerk of the Visitors, within 2 days. (c) Notice of death, to the coroner of the district, the Board of Control, the registrar of deaths, the local health authority (health service patients), the clerk of the Visitors (patients in houses licensed by justices), the clerk of the hospital management committee (temporary patients in hospitals vested in the Minister), and in single care), and the clerk of the hospital management committee (temporary patients in hospitals vested in the Minister), within 2 days. See also Items 5 and 7 above.		(a) Notice of admission and, if patient is under age 16, copy of statement of fitness to be sent to Board of Control, and, for patients in houses licensed by justices, to clerk of Visitors, within 2 days. (b) Notice of departure, or transfer to or from private or health service class, to Board of Control, and (for health service patients) to local health authority, within 2 days. (c) Notice of death to Board of Control, and (for houses licensed by justices) to clerk of Visitors, within 2 days.	(a) Notice of discharge or removal to be sent to Board of Control, to the local health authority (for health service patients), clerk of the Visitors (patients in houses licensed by justices), and to Master in Lunacy, within 2 days. See also Item 5 above.	(a) Notice of admission, together with copy of order and/or other admission documents, to be sent to Board of Control within 7 days of admission. (b) Particulars of transfer, discharge, escape or exception to be sent to Board of Control, to the local health authority (for health service patients only), and the regional hospital board (patients maintained by them in certified institutions), within 7 days. (c) Patients under guardianship: notice of change of address, transfer, discharge, escape or exception to be sent to Board of Control and, where appropriate, to local health authority. (d) Notice of death of any patient to the coroner of the district, the Board of Control, the registrar of deaths, the local health authority (health service patients only), and the regional hospital board (patients maintained by them in certified institutions), within 2 days. See also Items 5 and 7 above.		Board of Control notified of admission and discharge or death.

APPENDIX IV

STATISTICS

INTRODUCTION

(i) The purpose of this Appendix is to supplement the survey of the present mental health services given in Chapter 1 of our report and to illustrate particular points mentioned in other chapters. The statistics have been obtained from the Ministry of Health or the General Register Office except where otherwise stated. All the figures relate to England and Wales. The comments are our own.

(ii) Because the various sets of available statistics do not give strictly comparable information (see paragraph (iv) below), most of the tables in this appendix contain round figures only. We use exact figures when they are available for the whole of any one table.

(iii) In each table we have given the most recent figures available. Those obtained from the Ministry of Health are for the year 1955. Those which come from the General Register Office are for earlier years; some are derived from a special enquiry made in 1954 which is not made annually; others come from statistics which have not yet been fully analysed for 1955.

(iv) The Ministry of Health and the General Register Office at present collect and publish three main sets of statistics relating to mentally disordered patients:—

(*a*) Statistics relating to all patients dealt with under the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. These statistics started under the Commissioners in Lunacy, were continued by the Board of Control and are now collected and published by the Ministry of Health. Some go back as far as 1845. They cover patients in hospitals and homes both inside and outside the national health service, and defectives receiving community care. They are based on the procedures and classifications laid down in the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. They do not cover patients receiving hospital treatment as in-patients outside the purview of these Acts, or out-patients, or mentally ill patients receiving community care from the local health authorities.

Although these statistics are now collected by the Ministry of Health, we refer to them as "Board of Control statistics" in order to distinguish them from those described under (*c*) below.

(*b*) Statistics collected by the General Register Office under a scheme which started in 1949. These relate only to voluntary, temporary and certified patients in designated mental hospitals within the national health service, and patients other than short-stay patients in mental deficiency hospitals in the national health service and in Rampton and Moss Side Hospitals. They exclude all patients in hospitals or homes outside the national health service, all out-patients, and in-patients receiving psychiatric treatment in national health service hospitals outside the purview of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts. They also exclude all patients detained under Sections 20, 21 and 21A of the Lunacy Act, 1890, whether in designated mental hospitals or other hospitals. They exclude all patients in the Bethlem Royal Hospital and the Maudsley Hospital, whether admitted as voluntary patients under the Mental Treatment Act or outside the purview of the Lunacy and Mental Treatment Acts. They exclude patients admitted to mental deficiency hospitals for short periods under Ministry of Health Circular 5/52. They exclude Broadmoor patients in Broadmoor Institution but include Broadmoor patients in designated mental hospitals. They contain no information about patients receiving community care.

In relation to the patients whom they do cover, however, these statistics are very full and detailed, containing much more information than that now included in the Board of Control statistics, though some of this information was collected by the Board of Control before 1949. They also include a considerable amount of medical information, e.g. in regard to diagnoses, which is not obtainable from the present Board of Control or Ministry of Health statistics.

(*c*) The hospital statistics which have been collected since 1949 by the Ministry of Health from all national health service hospitals include statistics from psychiatric hospitals in the same form as from all other hospitals. These statistics cover patients receiving psychiatric treatment outside the purview of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts, as well as patients to whom the procedures laid down in those Acts have been applied. They cover out-patient services and domiciliary specialist services as well as in-patient services. They do not cover Rampton or Moss Side Hospitals or Broadmoor Institution or any other hospitals or homes outside the national health service (apart from war pensioner and Polish hospitals).

These Ministry of Health statistics are the only ones which cover out-patients and mentally ill in-patients receiving treatment outside the purview of the Lunacy and Mental Treatment Acts; the latter now constitute a considerable proportion of the total receiving in-patient psychiatric treatment each year. But these statistics record fewer details than do the Board of Control and General Register Office statistics. For instance, the Ministry of Health statistics give no information about the age or length of stay of hospital in-patients, as the General Register Office statistics do. They do not record the number of patients admitted to hospital each year, as the Board of Control and General Register Office statistics do. In most hospitals the number of patients admitted in any year is roughly equivalent to the number of vacancies created by the discharge or death of other patients. The Ministry of Health statistics record the annual number of discharges and deaths and therefore give a rough indication of the number of patients admitted outside the Lunacy and Mental Treatment Acts. These statistics do not however record deaths separately from discharges, nor do they distinguish between patients transferred direct to another hospital and patients discharged home. For patients received under the Acts, the Board of Control and General Register Office statistics record deaths separately from discharges and distinguish between direct admissions or discharges and transfers; the General Register Office statistics further distinguish between first admissions and re-admissions.

The Ministry of Health also collect some statistics about local health authority services, welfare services and general practitioner services. Most of these do not distinguish services provided for mentally disordered persons from similar services provided for persons suffering from other types of illness or disability.

(v) Because the information recorded in each of these three sets of statistics is different, and because each set of statistics excludes some mentally disordered patients included in one or both of the others, it has been difficult for us to compile a comprehensive statistical picture of the present mental health services as a whole. In some tables in this appendix we have had to leave gaps. In most tables we have had to use round figures. Some tables relate to certain groups of hospitals or patients only. We have not been able to include as much information about community health services as their importance demands; they are however more fully described in Chapters 1 and 10 of our report.

(vi) We meet other difficulties when we wish to compare the present with the past. Although the Board of Control statistics go back many years, the statistics for one period are not always truly comparable with those for another. For example, pre-1948 and post-1948 statistics for mentally ill patients are not exactly comparable. Before 1948, statistics were obtained from the county and county borough mental hospitals similar to those obtained since 1948 from the designated mental hospitals. But before 1948 many fewer statistics were obtained about patients detained under the Lunacy Acts in public assistance institutions; the Board of Control statistics contain no record of the number of admissions to the mental wards of these institutions each year, nor of discharges or deaths, nor of the age of patients admitted or patients resident, though they do record the total number of patients resident at the beginning of each year. During the 1920's and 1930's about 10 per cent. of the accommodation for patients dealt with under the Lunacy and Mental Treatment Acts was in the mental wards of these institutions. It may reasonably be assumed that the patients in these wards included a high proportion of elderly patients. These parts of the public

assistance institutions became designated mental hospitals in 1948, and the patients in them are included in the post-1948 statistics. To compare pre-1948 statistics which do not include these patients with post-1948 statistics which do, may give a misleading picture, particularly when the number of patients in different age groups is being considered. This discrepancy cannot be eliminated by comparing the pre-1948 statistics for the former county and county borough mental hospitals with post-1948 statistics for the same hospitals only, omitting the former public assistance institutions altogether; in some areas the "up-grading" of former public assistance institutions since 1948, the allocation of catchment areas, and other causes have resulted in patients who would formerly have been admitted to public assistance institutions being sent to former county and county borough mental hospitals and a greater variety of patients being treated in the former public assistance institutions. The picture is further complicated by the increase in out-patient treatment in recent years, and the increasing extent to which in-patient treatment is being provided outside the purview of the Lunacy and Mental Treatment Acts. Some patients who in earlier years would probably have been admitted to mental hospitals as in-patients under the Lunacy and Mental Treatment Acts now receive treatment in these other ways, but the full statistics collected about in-patients in designated mental hospitals are not obtained about them.

(vii) We recommend that the Minister of Health should review these arrangements and introduce a system under which whatever special mental health statistics are considered necessary, either from the administrative or medical point of view, would be collected for all mentally disordered patients, instead of being limited by the "designation" of hospitals or the use of particular admission procedures. If the proposals in our report are accepted such distinctions will mean even less in future than they do now.

INCIDENCE OF MENTAL DISORDER AND COMPARISON WITH OTHER DISEASES AND DISABILITIES

General incidence

Various estimates have been made of the incidence of mental illness, or of particular types of mental illness, on the basis of the investigation of a particular area or of some group of people who may be regarded as a typical or random sample of the population. Each investigator has first had to decide what forms or degrees of illness are to be the subject of his survey, and by what criteria he will define them. One investigator has rarely adopted exactly the same criteria as any other, and while each investigation brings out points of interest it is difficult to judge how far one supports another or to draw any general conclusions from them. It has, for example, been estimated that about 10 per cent. of the patients seen by general practitioners are suffering from psychoneurosis, mostly of a mild character.[1] Other general practitioners, each adopting his own criteria of the type of illness of which his survey takes cognisance, have estimated the proportion of neurotic patients in their practices at figures varying from 2 per cent. to 70 per cent.[2] A survey of a sample of adult male and female workers in engineering factories in war-time showed that 10 per cent. of the workers had suffered from "definite and disabling neurotic illness", and a further 20 per cent. from "minor forms of neurosis", during the course of six months; "neurotic illness" caused between a quarter and a third of all absence from work due to illness, in the group of workers studied.[3]

Estimates of the incidence of mental deficiency in the general population of England and Wales were made after a detailed investigation of six areas undertaken in 1925-1927.[4] It was then estimated that of every 10,000 of the

[1] Fry, J. (1954), *Medical World*, 80, 6, discussing his experience in his own practice and estimates made by other medical practitioners.

[2] Paulett, J. D. (1956), *Lancet*, ii, 37.

[3] Fraser, R. (1947), *Medical Research Council, Industrial Health Research Board Report* No. 90.

[4] H.M.S.O. 1929: *Report of the Mental Deficiency Committee*, Part IV.

population about 80 were mentally defective in the sense that at some period of their lives they would require the type of care which should be provided under the Mental Deficiency Acts. It was estimated that among each 80 defectives, 4 were idiots, 16 imbeciles and 60 feebleminded. Any estimate of the number of persons who may require care from the special mental health services is affected by the extent to which general social conditions, such as full employment and general social welfare services, make it possible for persons suffering from mild degrees of mental disability to manage in the general population without special care, and by the degree of administrative separation or integration of mental health services and other social services which is thought desirable at any period. An estimate made in 1929 might not be equally applicable in 1956. These considerations are much less likely to affect the estimate of the incidence of severe forms of mental sub-normality.

Likelihood of admission to hospital

More precise statistics are available about the number of mentally disordered patients who receive psychiatric treatment in hospital. From these figures various other estimates and comparisons can be made. The General Register Office have compiled tables showing the expectancy of admission to mental and mental deficiency hospitals at various ages based on the number of first admissions to designated mental and mental deficiency hospitals in the national health service and general death rates at various ages in 1954. They have made similar estimates of the expectancy at various ages of notification as a case of pulmonary tuberculosis, based on notification and death rates in England and Wales in 1954. It must be emphasised that any such estimates must be based on the conditions obtaining at the time when they are made; these conditions may later undergo fundamental changes.

Table 1

Admissions to mental and mental deficiency hospitals per 100,000 population in 1954

(Designated mental and mental deficiency hospitals in the national health service, and Rampton and Moss Side Hospitals)

	Mental Hospitals		Mental Deficiency Hospitals	
	First admissions	Second or subsequent admissions	First admissions	Second or subsequent admissions
Men admitted per 100,000 male population (all ages)	86	54	7	0·8
Women admitted per 100,000 female population (all ages)	108	74	5	0·7

Table 2

Expectancy at birth of admission to a mental or mental deficiency hospital (as in Table 1) or of notification as case of pulmonary tuberculosis sometime during life

	Expectancy of admission to mental hospital per 1,000 births of each sex	Expectancy of admission to mental deficiency hospital per 1,000 births of each sex	Expectancy of notification for pulmonary tuberculosis per 1,000 births of each sex
Men	51	4	62
Women ...	69	3	47

Proportion of health services devoted to mental health

It is also possible to make some comparisons between the number of patients receiving care or treatment for mental disorder and the number of patients receiving care from the health services because of other diseases or disabilities.

(a) Hospital in-patients

Table 3

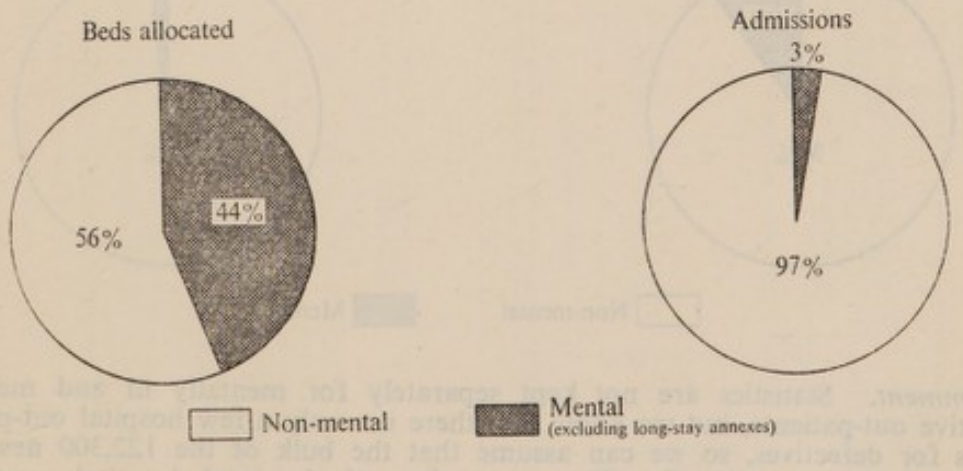
Hospital in-patient services in 1955

(National health service hospitals, State Institutions and War Pensioner and Polish hospitals directly administered by the Ministry of Health)

	Allocation of beds at 31st December, 1955	Turnover of patients: *Admissions (including transfers) in 1955	
		Number of admissions	Number per 100 beds
Mental illness:			
Under Lunacy and Mental Treatment Acts and Broadmoor patients ...	153,500	97,400	63
Outside these Acts	4,000	14,800	370
Mental deficiency	58,400	5,400†	9
Diseases of the chest	29,300	66,400	227
Chronic sick:			
Psychiatric long-stay annexes	1,500	107,600	199
Other chronic sick	52,700		
All others	186,900	3,368,700	1,802
Total	486,300	3,660,300	

* The figures given in this column are in fact the numbers of discharges and deaths: see paragraph (iv) (*c*) on page 308.

† This figure includes 1,900 short-stay admissions under Ministry of Health Circular 5/52; if these were omitted the number of admissions per 100 mental deficiency beds would be 6.



Comment. Patients suffering from mental disorder (i.e. mental illness or mental deficiency) constituted 3 per cent. of all in-patient admissions in 1955. To care for these patients and those admitted in previous years who are still in hospital requires 44 per cent. of the total beds in the hospital service. The annual turnover of beds

in psychiatric hospitals (except those treating patients outside the Lunacy and Mental Treatment Acts) is far smaller than in other hospitals, even than in those treating chronic sick (mainly elderly) patients and those treating diseases of the chest (mainly pulmonary tuberculosis). This is due to the long periods for which some mentally disordered patients remain in hospital. But only a small proportion of those now admitted to mental hospitals each year become long-stay patients (see Table 7a). The annual turnover of beds in mental hospitals has increased greatly in recent years (see Table 9b).

In both mental and mental deficiency hospitals the number of long-stay patients is affected by the fact that both types of hospital are at present to some extent fulfilling the function of social welfare institutions as well as of hospitals (see paragraphs 595-599 of our report).

(b) **Hospital out-patients**

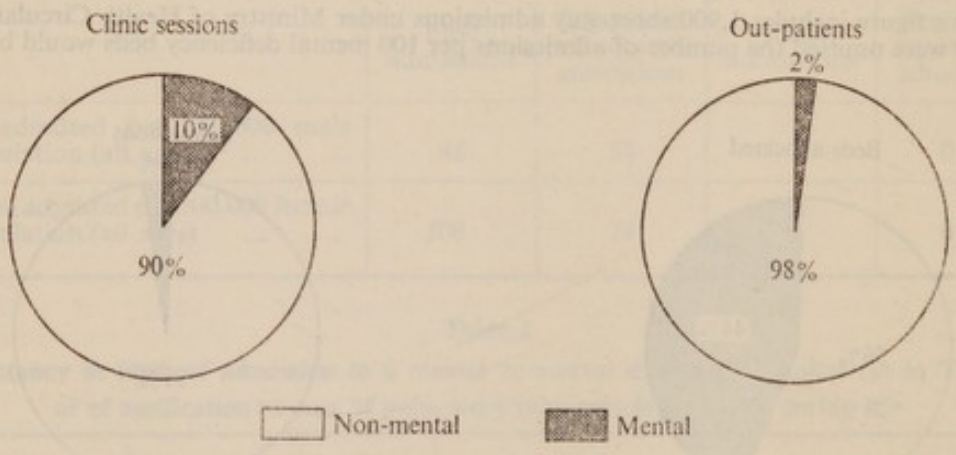
Table 4

Hospital out-patient services in 1955

(Same hospitals as for Table 3)

	Clinic sessions held in 1955	Number of out-patients attending for diagnosis or starting courses of treatment in 1955
Mental illness and deficiency, excluding child guidance	90,100	122,300
Child guidance	30,200*	13,600*
All other specialties (excluding casualty department work) ...	1,045,200	6,711,100
Total	1,165,500	6,847,000

* There are in addition child guidance clinics administered by local education authorities about which we have not been able to obtain comparable statistics.



Comment. Statistics are not kept separately for mentally ill and mentally defective out-patients, but we know that there are only a few hospital out-patient clinics for defectives, so we can assume that the bulk of the 122,300 new out-patients were mentally ill. The proportion of the total hospital work for out-patients (as measured by clinic sessions) allocated to mental disorder is far smaller than the proportion of the total work for in-patients (as measured by the number of in-patient beds—Table 3), but the number of psychiatric clinic sessions and out-patients has increased regularly in recent years—see Table 9a.

(c) **Community care**

It is not possible to make useful statistical comparisons between the work of local authorities in the mental health field and the rest of their health and welfare services generally. Even if the available statistics about the local authority mental health services were more comprehensive or more detailed than they are (see paragraphs (iv) and (v) on pages 307-308), they could not be directly compared with statistics about other local authority services of a very different character, such as the number of attendances at clinics for expectant mothers or young children.

Comparison may be made between the number of defectives under supervision or guardianship in the community (79,281 at the end of 1955) and the number of persons registered with local authorities as blind or partially sighted (113,118 at the end of 1955).

Table 15 shows how the local authority services for defectives have increased in recent years.

NUMBER OF MENTALLY DISORDERED PATIENTS RECEIVING VARIOUS FORMS OF CARE

Table 5a

Number of persons receiving services at 31st December, 1955

	Receiving treatment from general practitioners	Receiving care or after-care from local health authorities	Registered under Disabled Persons Employment Act	Boarded out by hospitals or in single care	In residential accommodation provided by welfare authorities or voluntary societies	Hospital out-patients	In-patients in	
							National health service hospitals and Broadmoor	Registered hospitals, licensed houses and approved nursing homes
Persons suffering from some form or degree of mental illness or infirmity.	Not known	Not known	28,275*	100	Not known	Not known	153,100 plus 1,500 in long-stay annexes and unknown number in other chronic sick hospitals	2,350

	Under voluntary supervision	Under statutory supervision	Under guardianship	Registered under Disabled Persons Employment Act	In residential accommodation provided by welfare authorities or voluntary societies (other than approved homes)	On licence from hospitals (other than short-term licence)	In-patients (excluding those on long licence) in	
							National health service hospitals and Rampton and Moss Side	Certified institutions and approved homes
Persons suffering from some form or degree of mental deficiency	16,900	59,600	2,800	6,352*	Not known	4,750	54,550 plus small number under Circular 5/52	2,250

* April, 1956 (exact) figures obtained from Ministry of Labour and National Service.

Comment. In this table we have included boxes for the main forms of care available for mentally disordered persons, even though the numbers receiving some forms of care are not known. We have done this as a reminder of the variety of services which are or might be made available to them. We do not mean to imply that statistics ought to be kept of all these patients separately from other patients benefiting from the same general services.

Some patients may be receiving more than one of these services at the same time. For instance, patients receiving treatment from general practitioners or as hospital out-patients may also be receiving care or after-care from the local health authority; patients boarded out by hospitals, in single care or in residential accommodation may be receiving medical treatment from general practitioners or as hospital out-patients; defectives registered as disabled persons may also be under the supervision of the local health authority; and so on.

Table 5b

Patients received during 1955

	For care or after-care from local health authorities	Boarded out or admitted or transferred to single care	Hospital out-patients	In-patients admitted to national health service hospitals and Broadmoor, excluding transfers	Admitted to registered hospitals, licensed houses and approved nursing homes
Persons suffering from mental illness or infirmity	Not known. About 90,000 patients were discharged from hospitals during 1955 but probably only a small proportion were referred to local authorities for after-care	80	Child guidance 13,600 Others, mostly adults 122,300*	102,800 plus unknown number to long-stay annexes and other chronic sick hospitals	2,750

	For supervision		For guardianship	Sent on licence from hospitals (other than short-term licence)	Admitted to national health service hospitals and Rampton and Moss Side, excluding transfers but including Circular 5/52 and " place of safety " admissions	Admitted to certified institutions and approved homes
	Voluntary	Statutory				
Persons suffering from mental deficiency	1,100	5,800	60	2,450	4,750	400

* Statistics are not kept separately for mentally ill and mentally defective out-patients; see comment on Table 4.

Comment. Some patients may have been admitted to more than one form of care during the year. For example, some out-patients may have been admitted as in-patients later in the same year, or vice versa; some defectives placed under supervision may later in the same year have been admitted to hospital for a short period under Ministry of Health Circular 5/52. Such patients will be counted more than once in this table.

SOME DETAILS ABOUT MENTALLY ILL PATIENTS

Age of patients in designated mental hospitals

Table 6

(Designated mental hospitals in the national health service)

Age group	Patients admitted in 1954 (Age on admission)		Patients resident at 31.12.54 (Age at that date)	
	Number	Percentage of all admissions	Number	Percentage of all residents
Over 75	5,559	7·7%	17,333	11·7%
65—74	8,871	12·4%	28,054	19·0%
55—64	11,310	15·8%	31,738	21·4%
45—54	13,428	18·7%	30,709	20·8%
35—44	12,807	17·9%	21,721	14·7%
25—34	13,763	19·2%	14,748	10·0%
16—24	5,491	7·7%	3,426	2·3%
0—15	470	0·6%	255	0·1%
Not stated	—		96	
Total	71,699	100%	148,080	100%

First admission to a designated mental hospital

Second or subsequent admission

Length of stay of patients in designated mental hospitals

Early in 1955 we wished to know what proportion of the patients now being admitted to mental hospitals stay in hospital for various lengths of time. We therefore sent a questionnaire to ten mental hospitals about the patients whom they had admitted in 1952, asking how many voluntary, temporary and certified patients had been discharged or had died or were still in hospital at certain periods after their admission. This told us the length of stay for periods up to two years, but of course gave no indication of the probable total length of stay of those still in hospital at the end of two years. The hospitals from which we obtained this information were Cane Hill Hospital, Coulsdon ; Fair Mile Hospital, Wallingford ; Goodmayes Hospital, Ilford ; Moorhaven Hospital, Ivybridge ; Prestwich Hospital, near Manchester ; St. George's Hospital, Morpeth ; St. Lawrence's Hospital, Bodmin ; Warlingham Park Hospital, Croydon ; Winterton Hospital, Stockton-on-Tees ; Winwick Hospital, near Warrington. Admissions to these hospitals in 1952 totalled 6,217, just under 10 per cent. of the total admissions to designated mental hospitals in the national health service for that year.

The General Register Office collects statistics about the length of stay of patients who have been discharged or have died each year. From these it is possible to ascertain the length of stay of all patients admitted to designated mental hospitals in the national health service each year who are discharged within twelve months of admission and the number remaining at the end of twelve months, but these statistics do not give as much detail as we obtained by our questionnaire. More detailed information is now becoming available in the General Register Office about patients admitted to designated mental hospitals for the first time in 1954, but it will be some time before these statistics are available for the second year after admission. For these reasons, and because the information obtained by our questionnaire would not otherwise be published, we have used in

Table 7a the information obtained by our questionnaire, in preference to that now obtainable from the General Register Office. Table 7b is based on statistics covering all designated mental hospitals, obtained from the General Register Office.

Table 7a

Length of stay of patients admitted to 10 mental hospitals in 1952

	All ages			Aged 65 or over on admission		
	Voluntary and Temporary	Certified	Total	Voluntary and Temporary	Certified	Total
Admissions to ten mental hospitals in 1952	4,115	2,012	6,127	547	461	1,008
3 months after admission:	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Discharged	63	18	48	40	9	26
Died in hospital ...	3	8	5	13·5	27	20
Still in hospital ...	34	74	47	46·5	64	54
6 months after admission:						
Discharged	78·5	34	63·5	54	15	35·5
Died in hospital ...	4	11·5	6·5	17·5	36	26·5
Still in hospital ...	17·5	54·5	30	28·5	49	38
1 year after admission:						
Discharged	84·5	45	72	59	20	41
Died in hospital ...	5	14	8	22	44	32
Still in hospital ...	10·5	41	20	19	36	27
2 years after admission:						
Discharged	88	50	75	61	22	41·5
Died in hospital ...	5·5	16	9	25·5	52	37·5
Still in hospital ...	6·5	34	16	13·5	26	21

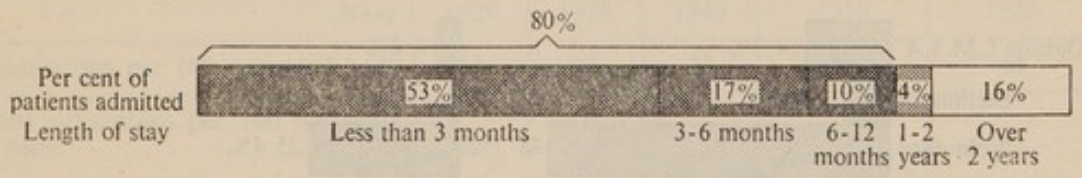
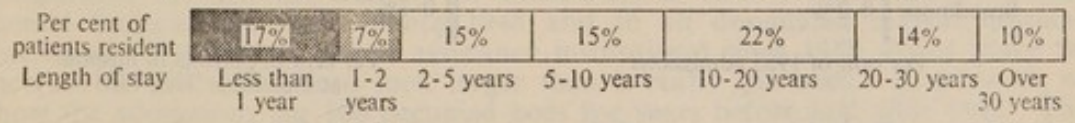


Table 7b

All patients resident in mental hospitals at 31st December, 1954: length of stay at that date

(All designated mental hospitals in the national health service)



Comment on Tables 7a and 7b. Broadly speaking, the patients at present receiving treatment in mental hospitals consist of: (i) patients who stay less than a year, who account for 80 per cent. of the admissions each year but constitute less than 20 per cent. of the patients resident at any one time; over half of these stay less than three months: (ii) long-stay patients, who occupy over 80 per cent. of the total beds; these include some admitted many years ago and the 16–20 per cent. of recent admissions who remain for more than one or two years.

Among recent admissions, a higher proportion of voluntary than of certified patients remain only a short time in hospital, but less than half the certified patients remain longer than one year (see also Table 8). Of patients aged 65 or over when admitted, 20 per cent. die within three months; some of these are

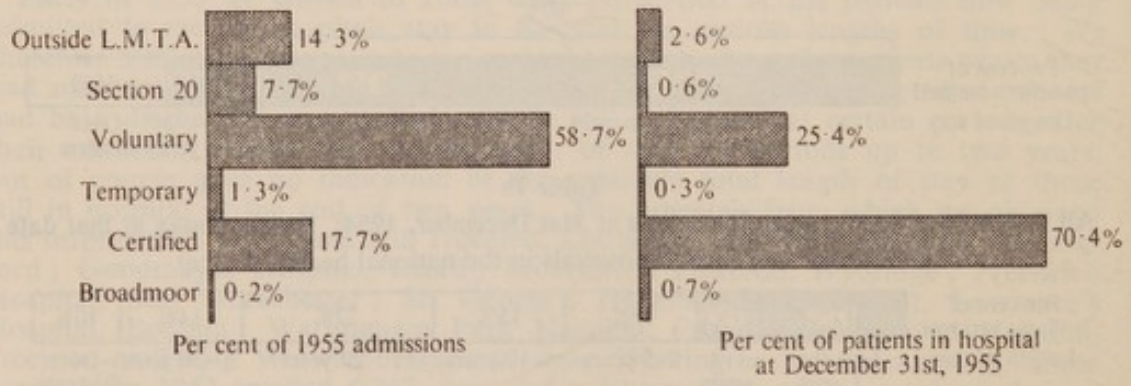
the patients mentioned in paragraph 259 of our report, who are known to be dying when admitted, some of whom might suitably be cared for in other hospitals. 41 per cent. of the patients aged 65 or over when admitted were discharged alive in less than twelve months; only 27 per cent. remain in hospital longer than one year.

" Status " of mentally ill patients in national health service hospitals and Broadmoor, excluding long-stay annexes

Table 8

	Outside Lunacy and Mental Treatment Acts	Sections 20, 21 and 21A, Lunacy Act, 1890	Voluntary	Temporary	Certified	Broadmoor		Totals
						At Broadmoor	Other hospitals	
Patients admitted during 1955 ...	14,750	7,950*	60,350	1,375	18,175	80	110	102,800
All patients in hospital on 31st December, 1955 ...	4,000	850*	38,900	450	107,800	920	180	153,100

* The total number of patients admitted under Sections 20 and 21 of the Lunacy Act, 1890, during 1955 was just over 26,000. At the end of their period of detention under Sections 20, 21 and 21A, over 18,000 remained in the same or some other psychiatric hospital to receive further treatment as voluntary, temporary or certified patients or psychiatric treatment outside the Lunacy and Mental Treatment Acts and are included in the number shown in other columns in this table; another 35 were dealt with under the Mental Deficiency Acts. The 7,950 shown in this table as admitted under Sections 20 and 21 are those whose period of psychiatric treatment did not extend beyond the period of detention under Sections 20, 21 and 21A. The 850 patients in hospital under these sections on 31st December, 1955, include some who would later be discharged to their homes and others who would continue treatment in other categories.



Comment. Over 14 per cent. of the patients admitted for in-patient psychiatric treatment for mental illness in 1955 were received outside the purview of the Lunacy and Mental Treatment Acts. Another 58·7 per cent. were voluntary patients. Voluntary patients constituted 68·5 per cent. of all patients received under the Acts, or 75·4 per cent. if those treated under Sections 20, 21 and 21A only are omitted from the calculation.

Although only 17·7 per cent. of the admissions in 1955 were certified patients (20·6 per cent. of the patients received under the Acts), about 70 per cent. of all the patients in hospital at the end of the year were certified patients. This illustrates again the point mentioned in our comment on Table 7; a high proportion of the total accommodation is occupied by long-stay, mainly certified, patients, whereas a high proportion of the present admissions are short-stay, mainly voluntary, patients.

Development of services over recent years

Table 9a

Number of in-patients, out-patients and patients receiving visits under domiciliary specialist services, 1949-1955

(National health service hospitals and Broadmoor, excluding long-stay annexes)

	In-patient admissions		New out-patients		Patients visited at home by hospital specialist
	Under Lunacy and Mental Treatment Acts	Outside Lunacy and Mental Treatment Acts	Child guidance	Others, mostly adults	
1949	60,900	Not known	3,150	93,800	5,500
1951	68,500	9,500	6,950	106,500	6,550
1953	76,500	11,750	11,900	111,300	8,350
1955	88,050	14,750	13,600	122,300	11,200

Note: A " new " out-patient in these statistics means a patient attending for diagnosis or starting a course of out-patient treatment, whether or not he has had treatment previously as an in-patient or out-patient. Any patient counted among " in-patient admissions ", " new out-patients " or " patients visited at home " may already have been treated as an in-patient or out-patient or have been visited at home in the same or a previous year.

Table 9b

Number of admissions per 100 beds 1929-1955

	County and county borough mental hospitals			All designated mental hospitals in the national health service and Bethlem and Maudsley Hospitals	
Year	1929	1939	1947	1950	1955
Admissions per 100 occupied beds	18	21	31	40	54
First admissions per 100 occupied beds	14	15	21	27	32

Comment. In our general comments in paragraph (vi) on page 308, we mentioned the difficulty of comparing pre-1948 and post-1948 statistics. A simple comparison between the number of admissions to county and county borough mental hospitals in years before 1948 and to all designated mental hospitals (including some former public assistance institutions) since 1948 would make the increase in total admissions look larger than it really has been. In table 9b we show the admissions per 100 occupied beds for years before and after 1948. This is still not an entirely reliable comparison, as the rate of admissions per 100 beds in the public assistance institutions before 1948 may have been different from the rate in the county and county borough mental hospitals, but we consider this comparison less misleading than a simple comparison of total admissions. This comparison illustrates the increased use which is now being made of the available hospital accommodation. A higher admission rate per 100 beds implies a higher discharge rate also. First admissions per 100 beds have not increased to the same extent as total admissions per 100 beds. There is now a higher rate of re-admissions than in 1929. But first admissions alone per 100 beds are more than twice the 1929 figure. All admissions (including re-admissions) per 100 beds are three times as many as in 1929.

SOME DETAILS ABOUT MENTALLY DEFECTIVE PATIENTS

Age of patients

Table 10a

Age of defectives receiving hospital or community care

(Community care from local health authorities. Hospital care in the national health service and Rampton and Moss Side Hospitals, excluding short-stay patients admitted under Circular 5/52)

	Admitted to care during 1954			Receiving care at 31.12.54		
	In community	In hospital	Total	In community	In hospital	Total
Under age 16	4,764	1,221	5,985	17,766	6,982	24,748
Aged 16 and over ...	2,159	1,617	3,776	59,221	51,137	110,358
Total ...	6,923	2,838	9,761	76,987	58,119	135,106

Comment. Although more defectives are ascertained and admitted to community or hospital care under the age of 16 than over that age, the total number aged over 16 receiving care is far greater than the number of children. The majority of those now classified as feebleminded, who form roughly three-quarters of the total number of persons suffering from mental defectiveness (see page 310) attend school until the age of 15 or 16 and are not referred to the mental health services until school-leaving age or later. Defectives of any class may need some help from the mental health services in the community or in hospital at any time in their adult life, many of them for a period far longer than the years of childhood and some of them permanently throughout their lives.

Table 10b

Age of patients in mental deficiency hospitals

(Mental deficiency hospitals in the national health service and Rampton and Moss Side Hospitals, excluding short-stay patients admitted under Circular 5/52)

Age group	Patients admitted in 1954 (Age on admission)		Patients resident at 31.12.54 (Age at that date)	
	Number	Percentage of all admissions	Number	Percentage of all residents
Over 75	9	0·3%	172	0·3%
65—74			1,179	2·0%
55—64	63	2·2%	4,131	7·1%
45—54	170	6·0%	9,352	16·1%
35—44	229	8·1%	11,266	19·4%
25—34	360	12·7%	12,974	22·3%
		(Age 16-19)		
16—24	786	19·1% 27·7%	12,062	20·8%
5—15	953	33·6%	6,589	11·3%
0—4	268	9·4%	393	0·7%
Not stated	—		1	
Total	2,838	100%	58,119	100%

Length of stay of hospital patients

Table 11a

Length of stay of patients admitted to mental deficiency hospitals (excluding transfers) during 1953

(Mental deficiency hospitals in the national health service and Rampton and Moss Side Hospitals)

	Excluding Circular 5/52 admissions	Including Circular 5/52 admissions
	Percentage	Percentage
Discharged within 12 months	2	30
Died in hospital within 12 months ...	4	3
Still in hospital at end of 1 year ...	94	67

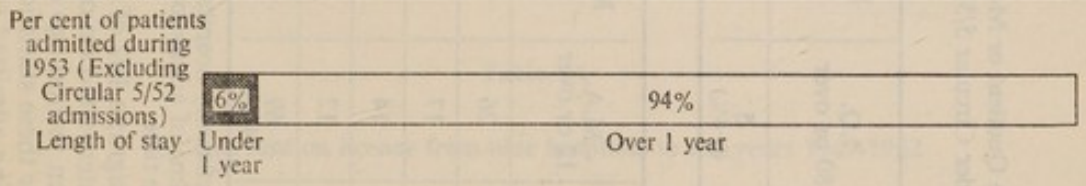
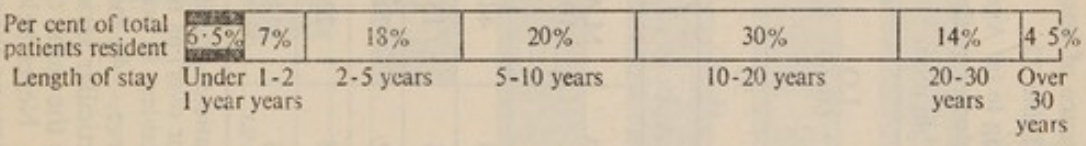


Table 11b

Length of stay as at 31st December, 1954, of patients on books of hospitals at that date (including patients living outside hospital on licence, and excluding patients received under Circular 5/52)

(Same hospitals as for Table 11a)



Legal classification of hospital patients

Table 12

(Same hospitals as for Table 11a, excluding patients admitted under Circular 5/52)

	Idiots	Imbeciles	Feeble-minded	Moral defectives	Total
Patients admitted during 1954 (Classification on admission)	379 (13%)	1,161 (41%)	1,293 (46%)	5	2,838 (100%)
Patients in hospital on 31st December, 1954 (Classification at time of admission)	4,511 (8%)	23,308 (40%)	30,215 (52%)	85	58,119 (100%)

Note: The classification is that recorded at the time of each patient's admission to hospital. Standards of classification may not be uniform. In particular, as mentioned in paragraph 165 of our report, the classification "feebleminded" is sometimes extended to patients who might more properly be classified as imbeciles; the patients admitted in 1954 and classified as feebleminded included some children recorded as having intelligence quotients under 20 and some adults recorded as having a mental age below 5.

Range of intelligence of hospital patients

Table 13

Admissions in the year 1954, grouped according to (a) Age, (b) Intelligence Quotient or Mental Age

(Same hospitals as for Table 12, excluding patients admitted under Circular 5/52)

CHILDREN

	I.Q. not stated or not testable, but patient graded as idiot or imbecile	I.Q. 0–49	I.Q. 50–59	I.Q. 60–69	I.Q. 70–79	I.Q. 80 or over	I.Q. not stated or not testable, but patient graded feebleminded	TOTAL
Aged 0–15	368 (30·1%)	624 (51·1%)	133 (10·9%)	50 (4·1%)	17 (1·4%)	5 (0·4%)	24 (2·0%)	1,221 (100%)

ADULTS

Age	M.A. not stated or not testable, but patient graded as idiot or imbecile	M.A. 0–7	M.A. 8	M.A. 9	M.A. 10	M.A. 11	M.A. 12 or over	M.A. not stated or not testable, but patient graded feebleminded	TOTALS
16–19	26	215	96	74	48	33	26	25	543
20–24	10	112	28	34	15	14	17	13	243
25–34	35	181	41	42	29	5	14	13	360
35 +	45	249	53	46	22	11	12	33	471
Total Adults	116 (7·1%)	757 (46·8%)	218 (13·5%)	196 (12·1%)	114 (7·1%)	63 (3·9%)	69 (4·3%)	84 (5·2%)	1,617 (100%)

Note. The statistics collected by the General Register Office about patients admitted to mental deficiency hospitals include a record of their intelligence quotient (for patients under age 16) or mental age (for patients aged 16 or over) as recorded at the time of admission to hospital. These records are available only for the patients admitted each year, not for the total patients resident in hospital at any one time.

Comment. These statistics can only be used with great reserve. As mentioned in paragraph 192 of our report, the intelligence quotient as recorded at any one time is only the record of the result of a particular series of tests as interpreted on one occasion by one doctor or other person. Also, there are different types of test, not all of which use the same equation between mental age and average intelligence (some take mental age 15 as the average in adults, others take mental age 16). Nevertheless, we consider these statistics to be of some interest as a rough indication of the numbers of patients at various intelligence levels among those at present being admitted to mental deficiency hospitals.

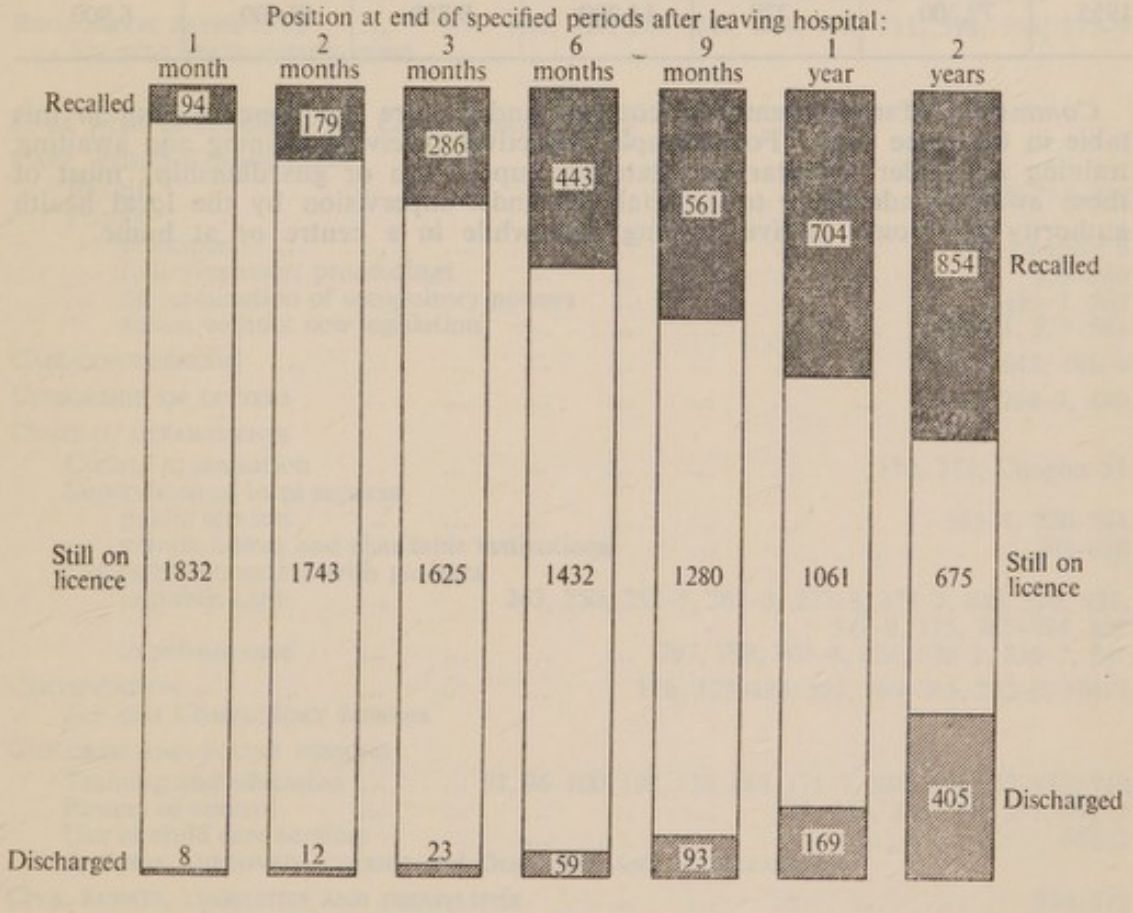
Patients on licence from nine mental deficiency hospitals: numbers recalled or discharged within certain periods

In 1954 we asked nine mental deficiency hospitals for information about the recall and discharge of patients after certain periods on licence. The nine hospitals were Little Plumstead Hall, Norwich ; Cell Barnes Hospital, St. Albans ; Monyhull Hall Hospital, Birmingham ; Brockhall Hospital, Blackburn ; Darenth Park, Dartford ; Royal Western Counties Hospital, Starcross ; Borocourt, Reading ; Prudhoe and Monkton Hospital, Prudhoe-on-Tyne ; St. Lawrence's Hospital, Caterham. The information supplied from Monyhull Hall Hospital is printed in full in the Appendix to our minutes of evidence (pages 1367-1383). The information supplied by all nine hospitals about the length of licence before recall or discharge is summarised below. Patients on holiday or sent on licence to another hospital or to a hostel owned and administered by a hospital are excluded. Our comments on the replies to our enquiry are in paragraphs 470-472 of our report.

Table 14

Patients sent on licence from nine hospitals in the years 1949-1952

Total licences granted in 4 years 1949–1952=1,934



Of the 675 patients still on licence at the end of two years, 97 were later recalled to hospital and 244 discharged, leaving 334 still on licence in January, 1955, when the replies to our questionnaire were sent in.

Table 15

Year	Community care				Hospital care	
	No. of defectives under voluntary or statutory supervision or guardianship	No. of occupation or training centres	No. of defectives receiving training at centres or at home	No. of defectives known to be suitable for but not receiving training	No. of defectives in care of mental deficiency hospitals and certified institutions (including those on licence)	No. of defectives awaiting admission to hospital according to local health authority returns
1939 ...	70,300	178	3,150	Not known	46,700	1,850
1947 ...	71,900	100	3,450	Not known	53,600	3,950
1951 ...	70,200	196	8,650	7,050	56,700	8,050
1955 ...	79,300	279	14,200	8,750	60,600	6,900

Comment. Many patients are counted under more than one heading in this table in the same year. For example, defectives receiving training and awaiting training are under voluntary or statutory supervision or guardianship; most of those awaiting admission to hospital are under supervision by the local health authority and some receive training meanwhile in a centre or at home.

INDEX

(Numbers refer to paragraphs except where otherwise stated)

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