

ASSESSMENT OF 'DANGER TO SELF AND OTHERS'

A study of the mental health review tribunal's
interpretation of 'dangerousness'

by

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ASSESSMENT OF 'DANGER TO SELF AND OTHERS'

ABSTRACT

The general research aim was to examine the process by which the mental health review tribunal decided on the 'dangerousness' of the person before them as a basis for their judgement about release or continued detention.

Within the general context of the sociology of law, the research project was concerned with the decision-process as it operated in practice within the established socio-legal framework and its interaction with the concept and causation and social nature of deviance and 'danger'.

It was assumed that the formal-structural approach was insufficient to study and explain the decision-process in practice; so the research incorporated the study of the relationship between socio-demographic facts and the tribunal decisions, a study of the way the facts were perceived by the tribunal members, and consideration of the dilemmas and conflicts experienced in practice and innovatory action arising from anomalies in their rules and powers.

Various methods of data-collection were adopted in respect of the sample of 150 tribunal hearings held at Rampton Hospital:

- a) the systematic observation of the hearing,
- b) the structured interviewing of the legal chairman,
- and c) structured examination of written records for details of the subject.

The findings supported the conclusions that the prescribed rules and powers of the tribunal were insufficient for the task of protecting the individual from unfair detention; and the nature of 'danger' and the social identity of the 'dangerous individual' required a response from the decision-makers beyond objective assessment of observable facts. The decision-process was shown to be a 'human-process' involving emotional and subjective reactions.

A more sufficient model of the decision-process in respect of 'danger to self and others' was developed, designed to take account of external restraints and anomalies in the system, and influences which could not be explained in strictly 'objective' terms.

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CHAPTER ONE

THE CONCEPT AND ASSESSMENT OF 'DANGEROUS' - INTRODUCTION TO THE RESEARCH INTEREST

For some years the researcher worked as a social worker exercising the powers and duties of a mental welfare officer under the Mental Health Act 1959. He was responsible for assessing men and women referred for compulsory psychiatric care and treatment because of the risk to themselves or others. There were various difficulties in seeking to make the predictions about likely future behaviour which were inherent in assessing such risk. Dilemmas arose from the uncertainties about diagnosis and prognosis of mental disorder and about the causation of human behaviour. There were conflicting pressures from the attitudes of the various parties to the situation, such as relatives and the different professionals. Sometimes limited resources were a restraint on the different courses of action which should have been available. The decision to deprive an individual of the freedoms of choice and liberty was a serious step which required careful and responsible justification. Yet too often that decision, although based on clearly prescribed procedures and criteria, had to be made on inadequate information and under various pressures from the social situation within which it was exercised.

When the researcher moved to work in a maximum security hospital, he found further cause for concern about the process by which men and women were compulsorily detained for psychiatric care and treatment. Exploratory studies were undertaken into the social background and life-careers of men and women admitted to Rampton Hospital and the early experiences in the community of patients

discharged from the hospital.⁽¹⁾ These studies were primarily intended to collect information useful to the establishment of a social work service in the hospital and also to aid the understanding of social factors contributing to the admission to special hospitals and successful rehabilitation. But again the findings brought into question the criteria required to assess the 'danger to self and others'. They reflected the influences of uncertainty in the minds of others and the resulting anxiety.

'There was the suggestion that more serious offenders (murder, manslaughter) presented as more mature and stable with a much higher average age, limited previous criminal or psychiatric history, less unemployment etc. It was possible to view the offence as relatively unexpected, and to wonder whether this had been an influential factor in deciding criminal responsibility and legal disposal. In contrast with such serious crimes, many patients were admitted following a relatively minor offence, such as smashing windows and fighting when drunk. Here the decision to detain in special hospital resulted not from concern over the severity of the crime, but apparently from exasperation on the part of medical and legal authorities, in regard to a person who had been extremely disruptive over a long period. This polarisation is perhaps not too surprising, as a minor offender without a previous record would tend to be dealt with fairly routinely by the courts: whereas a serious offence 'out of character' would tend to raise the question of the mental state of the person concerned'. (Hepworth 1976)⁽²⁾

(1) Unpublished internal reports on 'Admission to Rampton' (1975) 'Community discharge follow-up' (1976), D. Hepworth, Social Work Department, Rampton Hospital, England.

(2) D. Hepworth (1976) 'How they came to Rampton' Community Care, England. 13 October, 1976.

It was decided to study more closely the operation of law in relation to mentally abnormal offenders and others detained under mental health legislation in England and Wales. The aim was to find a means of studying through direct observation and systematic research the decision-making process in regard to individuals considered a 'danger to self and others'. As an aid to orientating the research, a review of literature relevant to the concept, causation, and assessment of 'dangerous' behaviour was undertaken.

Provisional Conclusions from review of relevant literature

From the review of literature, the provisional conclusion reached was that the concept of 'danger' in human behaviour involved:

- a) The risk of physical harm from violence,
- b) Impulsive and unpredictable behaviour,
- c) The sense of threat and anxiety experienced by others,
- d) Need to exercise control and restraint on the individual considered to be dangerous.

It appeared that a general consensus view of the causation of 'dangerous' behaviour would take into account:

- a) An inherited component to the individual's personality and characteristic pattern of social responses,
- b) Further developments or distortions by important early inter-personal relationships and subsequent life experiences,
- c) Personality and behavioural defects sometimes aggravated by organic brain damage,
- d) The influence of wider cultural and sub grouping within society upon attitudes and characteristic behaviour,

- e) The more immediate social situation and pressures which can influence the reactions and behaviour of an individual at a particular time.
- f) Antisocial attitudes and uncontrolled impulsive behaviour can sometimes be associated with diagnosable mental disorders.

There appeared to be certain themes which were influential as factors in assessing the degree of risk to others from a particular individual:

- a) The uncertainty about causation and the unexpectedness or perceived abnormality of the behaviour,
- b) The severity of the antisocial behaviour,
- c) The presence of mental disorder, clearly diagnosed or assumed from the behaviour itself,
- d) Intuitive feelings about the individual,
- e) The social background and life career of the individual,
- f) Previous offences or abnormal behaviour,
- g) Circumstances of the antisocial behaviour,
- h) The personality of the individual,
- i) The social control and support available within the living situation.

To find that uncertainty and intuition could be influential factors in the decision making process about the dangerousness of an individual was not considered to be necessarily a cause for great concern. This finding would tend to compliment the provisional conclusions in respect of the concept and causation of dangerous behaviour. There was the strong indication that the threat and anxiety to restrain an individual arose as much from the apparent senselessness, incongruity and unpredictability of his behaviour (in the eyes of the general public or their

representatives) as from any excessive violence. Similarly, it appeared that the understanding of the complexity of factors contributing to the causation of dangerous behaviour involved interpretation, controversy, and uncertainty. The emphasis of G.K.Sturup(1968)⁽³⁾ on intuitive judgement and emotional contact could be a recognition of the need to fill gaps or build bridges between understanding and uncertainty about causation, probability and unpredictability of prognosis, certainties and doubts about the social community response, and the rights of the individual and the general public.

This review of literature having served its purpose as background reading and an aid to orientating the research, the decision making process as prescribed by legislation and formal rules in respect of the restraint of mentally abnormal behaviour was considered. This was with a view to empirical research of the decision making process in practice and the means by which the decision makers dealt with the uncertainties and dilemmas which appeared to be inherent in any consideration of 'dangerous' behaviour.

(3) G.K.Sturup(1968) 'Will this man be dangerous?'
Paper presented at CIBA Symposium on 'Mentally
Abnormal Offender' Churchill and Co(for CIBA Foundation)

CHAPTER TWO

LEGAL RESTRAINT OF THE MENTALLY DISORDERED

This chapter describes the legal context within which decisions are made in respect of the detention, continued restraint, and release of men and women considered mentally disordered. The aim is to make clear the questions which are required to be answered in the process of making decisions in respect of the control or release of any individual.

(a) Compulsory Treatment and Detention in Hospital

It is important to emphasise that the assumption of mental health legislation is that, with very few exceptions, men and women should be offered and receive psychiatric treatment and care because of their mental disorder, with the same legal informality and on the same voluntary basis as they would receive medical treatment or professional help for any other illness or disability. The exceptions, where restraint or compulsion are sanctioned, are not justified by the existence or diagnosis of a mental disorder in itself. The justification for enforcing treatment against the will of the individual is related to the harm which has come or is likely to come to the individual or others as a result of the disorder or as a consequence of not enforcing treatment.

Although other legislation (such as the Criminal Procedure (Insanity) Act (1964)⁽¹⁾) can be used to detain a mentally

(1) Criminal Procedure (Insanity) Act 1964, HMSO

disordered person, this description focuses on the Mental Health Act 1959⁽²⁾ which was designed to repeal previous legislation and bring all mental health legislation for England and Wales into one enactment. For an individual to be required to enter psychiatric hospital or a hospital for the mentally handicapped for observation or longer term treatment, it is initially necessary to answer three questions:

1. Is the individual suffering from "mental disorder of a nature or disability which warrants the detention of the patient in a hospital"?
2. Is informal (voluntary) admission or other means of dealing with the situation not appropriate?
3. Is the detention necessary "in the interests of the persons health or safety or for the protection of other persons"? (Section 26)

The first question has to be answered by two medical practitioners (one in an emergency), and the other questions answered in co-operation with the relatives of the individual and/or the responsible social worker, one of whom is required to make the actual application for admission to hospital. Where the patient is being detained for longer term compulsory treatment under section 26, it is then necessary for the two medical recommendations upon which application is based to specify and give evidence of the particular form of disorder. They are required to classify the disorder in terms of four legal classifications; severe subnormality, subnormality, psychopathic disorder and mental illness. Individuals cannot be compulsorily admitted through the civil proceedings once they have reached the age of 21 years of age if they are considered to be suffering from

(2) Mental Health Act 1959, HMSO.

"psychopathic disorder" or "subnormality" and no other classification.

Within the context of criminal proceedings the criteria for justifying detention are more detailed. Again the Court has to be satisfied on medical evidence of a special medical disorder(one of the four legal classifications). It also has to be decided that:

"The Court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedence of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing with the case is by means of an order". (Section 60).

The offender can be made subject to further special restrictions on discharge if:

"It appears to the Court, having regard to the nature of the offence the antecedence of the offender and the risk of his committing further offences if set at large, it is necessary for the protection of the public so to do". (Section 65)

Individuals can also be transferred from prison to psychiatric hospital care on medical evidence that a specified mental disorder:

"Is of a nature or degree which warrants the detention of the patient in a hospital for medical treatment", the Secretary of State having taken "regard to the public interest and all the circumstances". (Section 72)

For the Department of Health to agree to the admission of someone subject to detention under the Act into one of their special security hospitals, such as Rampton or Broadmoor, they have to be satisfied that the individual:

"In the opinion of the Secretary of State requires treatment under conditions of special security on account of their dangerous, violent or criminal propensities".
(Section 97).

(b) Renewed Detention.

Just as an individual can only be compelled to accept treatment or detained as a last resort where voluntary treatment appears not appropriate, the aim is also to place a time limit on the period of any necessary detention. In the case of an individual detained under a compulsory treatment order(Section 26) a hospital court order(Section 60), or a prison transfer order(Section 72), without the further restriction under Section 65, the order will lapse at the end of specified periods unless the authority to detain is formally renewed by the responsible medical officer. The responsible medical officer is required to justify his opinion:

"That it is necessary in the interests of the patients health or safety or for the protection of other persons that the patient should continue to be liable to be detained".

In respect of patients classified as "psychopathic" or "subnormal", their detention will expire on reaching the age of 25 unless the responsible medical officer has renewed the authority to detain:

"If it appears to him that the patient, if released from hospital, would be likely to act in a manner dangerous to other persons or himself".

Similarly, if the nearest relative has exercised their right to order the discharge of the patient, the responsible medical officer is able to retain the authority to discharge:

"If it is opinion that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself".

Therefore in connection with compulsory admission for treatment, which is normally with the agreement of the nearest relative, the grounds are in connection with "own health or safety or the protection of other persons"; where as continued detention against the wishes of the nearest relative or in connection with psychopathic or subnormal patients achieving the age of 25 needs to be on the more specific grounds of "dangerous to other persons or himself".

In connection with individuals detained under the further Home Office restriction of Section 65, it is necessary for the Secretary of State to be:

"Satisfied that an order restricting the discharge of a patient is no longer required for the protection of the public".

(c) Release From Compulsory Treatment or Detention.

It is fundamental to the intention of mental health

legislation in England and Wales that an individual should become a voluntary patient as soon as possible. More often than not, compulsory admissions to hospital for observation (Section 29, Section 25) are not followed by continued compulsory treatment. It is important to be clear, when studying the decision-making process in regard to compulsory treatment of the mentally disordered, that in deciding to release the person from compulsory treatment the decision-makers are not required to show that they do not need further psychiatric treatment. They are required to decide whether, regardless of the severity of the mental disorder and the need for treatment, it is necessary to enforce treatment or detention to prevent harm to the individual or others.

In respect of individuals detained under Section 26, Section 60, or Section 72, the responsible medical officer has the authority to discharge the detention order as soon as it is his opinion that it is no longer necessary to detain the patient on the grounds of "health or safety protection" or "likely to act in a manner dangerous". In regard to this authority, when a psychopathic or a subnormal patient does reach the age of 25 or where the nearest relative has applied for the discharge of the patient, "own health or safety" is no longer sufficient grounds for detention. The responsible medical officer then has to show that the individual is specifically "dangerous to other persons or himself". Where there is a further restriction of the discharge of an individual under Section 65, only the Home Secretary has the authority to release the individual from hospital when, on advice from the responsible medical officer and others, he is:

"Satisfied that an order restricting the discharge of a patient is no longer required for the protection of the public".

So the above are the questions and criteria to which the decision makers have to apply themselves, when considering the initial detention and renewal or discharge of the detention order. Fundamental to the process is the fact that it is the compulsion that the decision makers are required to justify and not primarily the treatment itself. Although obviously the need for treatment is one of the considerations. The importance of this distinction will become more clear through the closer study of the decision-making process in practice. It has implications for all decision-makers operating within the context of mental health legislation, but none more so than for those within the special hospitals. Special hospitals provide treatment for individuals subject to detention, and are dependent upon the co-operation of the responsible health and community services in the individuals home area when care and treatment would more appropriately be provided on a voluntary basis.

CHAPTER THREE

MENTAL HEALTH REVIEW TRIBUNAL

The aim of reviewing relevant literature was to reach provisional conclusions in regard to the concept, causation, and assessment of 'dangerous' behaviour. This would then be used as one starting point for more direct research into the decision-process in regard to mentally disordered individuals considered a danger to themselves or other people. Following a preliminary study into the social backgrounds of men and women being admitted to special hospitals, an early intention was to focus empirical research onto the decision-process in respect of admission to special hospitals or possibly the decision-making within a special hospital itself in regard to the release of patients. For two main reasons, eventually this empirical research was focussed onto the Mental Health Review Tribunal at Rampton Hospital:

(a) One consideration was that, as a member of the social work department in the hospital, the researcher was too close and involved in the situation to research the decision-making with sufficient objectivity, and

(b) The requirement on the Mental Health Review Tribunal to reach early conclusions within prescribed time-limits was an advantage in studying their decision-process.

Therefore before discussing the research project, it would

be useful to describe the prescribed decision-making process of the Mental Health Review Tribunal. Whilst the decision-making process can be described very appropriately in terms of a formal structural model, it is intended to discuss also other models which are appropriate to any study of the Mental Health Review Tribunal.

Prescribed Officers and other identified roles. (1)

The Mental Health Review Tribunal is a body completely independent of the hospital within which an individual is detained. The Tribunal is required to consider applications for discharge or give advice to the Home Secretary in regard to patients detained under Section 65, of the Mental Health Act 1959. The Tribunal is convened for a particular hearing to consider either an application or reference, and is made up of members from three separate panels appointed by the Lord Chancellor. The 'legal member' and the 'medical member' are each selected from the relevant panel, and there is a separate 'lay member' from a panel which is neither legal nor medical. The 'Chairman of the Tribunal' is a legal member, and he and the Tribunal are assisted by the Tribunal Clerk provided by the Department of Health and Social Security.

The 'patient' is the subject of the application, and the 'nearest relative' is the closest surviving relative as defined in the Mental Health Act. The 'applicant' is the person making the application, and could be either the patient or the nearest relative.

(1) Mental Health Review Tribunal Rules 1960, S.1.1960 No.1139, HMSO

The 'responsible authority' is the managers of the hospital within which the patient is detained, and the 'responsible medical officer' is the psychiatrist in charge of the treatment of the patient. In a sense the application is brought against the responsible authority and medical officer, as there is the clear implication that an application would not be required if the responsible medical officer were already agreeable to discharging the order on his own authority.

The only other role acknowledged in the prescribed legislation and rules is that of the 'representative' of the patient or any other party to the situation.

Prescribed pre-hearing procedures.⁽¹⁾

As indicated previously, periodically the patient and/or nearest relative are entitled to apply to the Mental Health Review Tribunal against the patient's detention by the responsible authority. The prescribed procedures are then as follows:

- (a) The Tribunal Office send a copy of the application to the responsible authority.
- (b) The responsible authority is required to provide a statement for the Mental Health Review Tribunal justifying the patient's continued detention.
- (c) The Tribunal Office provides a copy of the authority's statement to the applicant.

(1) Mental Health Review Tribunal Rules 1960.S.1.1960.No.1139.H.M.S.O.

- (d) The Tribunal Office informs the responsible authority of any response from the applicant to the statement.
- (e) The responsible authority is required to arrange for a report on the home circumstances of the patient for the Tribunal.
- (f) The Tribunal Office informs the nearest relative of the application and the arrangements for the hearing.
- (g) The Chairman of the Tribunal is responsible for the appointment of members from the three panels, with the legal member being the President of the Tribunal.
- (h) Representatives can be authorised by any party.
- (i) The medical member examines the patient and relevant medical records prior to the hearing.
- (j) The Tribunal (all or any members) may interview the patient.
- (k) The Tribunal may interview any witness or require any documents.
- (l) The Tribunal may adjourn for further information before reaching their decision.
- (m) The applicant may withdraw the application at any time.

The above procedures relate to an application from either the patient or nearest relative in respect of someone detained without the further special restrictions on discharge under Section 65. A reference from the Home Secretary follows a

parallel pattern, and it is provided that the patient may request the Home Secretary to refer his case during certain prescribed periods. In practice this has become the predominant initiative for the reference of restricted cases to the Mental Health Review Tribunal.

Prescribed procedures for the hearing and decision (1)

- (n) The Tribunal must include at least one member from each of the three panels, with the President being the legal member.
- (o) The applicant, patient, nearest relative, and/or responsible authority may be represented at the hearing.
- (p) The Tribunal may interview the patient or whoever else they wish.
- (q) The Tribunal may ensure the necessary information is before them; if necessary adjourning for a period for further information to be obtained.
- (r) The decision of the majority is the decision of the Tribunal.
- (s) The recorded decision of the Tribunal in respect of an application should be communicated to the applicant, the patient, and the responsible authority within seven days of the decision being reached, or
The advice of the Mental Health Review Tribunal is forwarded to the Home Secretary and there is no requirement on the Mental Health Review Tribunal to communicate their advice to anyone else.

(1) Mental Health Review Tribunal Rules 1960.S.1.1960.No.1139.H.M.S.O.

Decision of the Tribunal

In regard to applications, the Mental Health Review Tribunal is required to decide whether;

- (a) 'The patient is not then suffering from mental illness, psychopathic disorder, subnormality, or severe subnormality', and
- (b) 'It is not necessary in the interest of the patient's health or safety or for the protection of other persons that the patient should continue to be liable to be detained', or
- (c) 'That the patient, if released, would not be likely to act in a manner dangerous to other persons or himself'. (Section 123)⁽²⁾

It will be seen that the decisions of the Mental Health Review Tribunal are related to the decisions which were required to be made in justifying the initial detention or renewal of a detaining order. An application to the Mental Health Review Tribunal is a form of 'appeal' against the decision to detain or renew the detaining order. It is a means whereby the patient or nearest relative can contest the detention through seeking a second opinion from an independent body.

If the Tribunal decide either that the patient is not suffering from a particular mental disorder or that it is not

(2) Mental Health Act 1959, H.M.S.O.

necessary for a patient to continue to be detained (because of 'health or safety or protection' or 'dangerous to other persons or himself'), it is then the duty of the Tribunal to discharge the order. Apart from the authority to re-classify a patient (if they consider that he is inappropriately diagnosed), their powers are limited to the clear cut decision as to whether the order should be discharged or allowed to continue.

Advice to the Home Secretary

When considering the detention of patients referred to them by the Home Secretary, again their consideration is required to reflect the decisions which justified the person's original detention. In other words, they are required to:

- (a) Question whether the patient is suffering from a specified mental disorder, and
- (b) Question whether the detention and special restriction is still necessary for the protection of the public.

As they are giving advice as opposed to exercising specified powers, there are no limitations on the advice they are able to give. Their considerations would presumably parallel those of the responsible medical officer in respect of the options open. These options would include continued detention, transfer between hospitals, the termination of the special restriction, and absolute or conditional discharge.

Summary

The constitution, procedures and powers of the Mental Health Review Tribunal are formally prescribed by legislation and rules. Therefore the decision-making process of the Tribunal could appropriately be seen in terms of a formal-structural model. Although an appropriate model, further considerations of the Tribunal decision-process in practice will show that a formal-structural model is not of itself an adequate or complete model.

CHAPTER FOUR

THEORETICAL FRAMEWORK AND MODELS APPROPRIATE TO THE STUDY OF THE MENTAL HEALTH REVIEW TRIBUNAL

Sociology is closely related to other social sciences such as social anthropology, psychology, and political science. Although the different disciplines have their own distinct bodies of theory and specialised subject-matter, they share a common interest in the behaviour of man. It is impossible to draw rigid uncrossable boundaries. What distinguishes sociology is its own particular perspective, being concerned with the behaviour of people as members of social groups and social inter-action between individuals. 'The sociologist applies the philosophy and methods of scientific investigation to the behaviour of men and women, as this behaviour influences or is influenced by other men and women'. (MacQueen 1973) (1)

Various specialisations have developed within sociology, some of which over-lap in approach and subject-matter with other social sciences. One example is the Sociology of Law, the division of sociology represented by this research study.

'The emphasis upon rights, obligations and expectations, upon sanctions and predictability within sociology has its counterpart in the sophisticated analyses of these concepts in the tradition of legal scholarship. The same terms are, however, used for different purposes in law and in sociology. Where the lawyer or the legal scholar talks about rights and expectations he does so with normative intentions. The sociologist, on the other hand, uses the same terms without any directly normative purpose, in an attempt to describe, reveal and explain'.

(Aubert 1969) (2)

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- (1) MacQueen D.R. 'Understanding Sociology through Research' Addison-Wesley (Massachusetts 1973) p xi
- (2) Aubert V. 'Sociology of Law' Penquin (1969) p 9

The general academic context is the sociology of law, yet maintaining a clear distinction in relation to the more 'normative' legal scholarship is not without difficulty.

'The sociologist seeking to discover regularities in the process of legal change gets caught between the heavily theoretical bent of modern sociology and the critical, pragmatic themes present in much American legal philosophy and writing on the history of law'.

(Lemert 1970) (3)

Lemert developed his consideration of this issue by emphasising the need for the sociological study of law to concentrate more on the more detailed operation of procedures and agencies established by law.

'An underlying problem may have been that researchers thus far have failed to address themselves fully to problems peculiar to inter-relationships among judicial, administrative, and legislative processes. It is very likely that a generic sociological theory of law, to be profitable, will have to be orientated to the study of procedures, and the formal and informal organisation of administrative agencies and legislatures, as well as courts, rather than to substantive principles of law'.

(Lemert 1970) (3)

Within the general context of the sociology of law, this research project is concerned with the decision-process as it operates in practice within the socio-legal framework established to deal with the restraint and release of mentally disordered men and women considered a danger to themselves or others. The mental health review tribunal has been used to illustrate that the decision-making process is formally prescribed and so could be seen in terms of a formal-structural model. Legislation intended that decisions

(3) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970) p 1 and 2

should be made by the holders of particular offices to whom were assigned the responsibility and authority to make decisions in accord with prescribed procedures. The formal structure was designed to ensure that an individual considered mentally disordered was only deprived of his liberty to refuse treatment through the application of fair and impersonal rules and authority.

The mental health review tribunal can also be used to illustrate that the formal-structural approach is not sufficient or adequate to explain the decision-making process in practice. The tribunal find themselves faced with situations where the rules are inadequate in themselves for the task they are designed to achieve. The rules assume a reasonable certainty and agreement in regard to clinical diagnosis and prognosis, when in fact either or both may be doubtful. The evidence upon which the decisions are required in respect of the likely future behaviour of the individual may be inadequate or indecisive. The tribunal may be restrained in their 'duty to discharge' by treatment or rehabilitative considerations. Whilst there may not be clear evidence to justify compulsory treatment, the need for treatment may be very apparent. The tribunal may consider that the individual's recovery and improved behaviour are dependent on a degree of support from the family and statutory services which could not be assured.

'In recent years it has become sociologically axiomatic to insist that deviant behaviour cannot be studied in isolation from the formal and informal mechanisms which are adopted for controlling it'.

(Bean 1974) (4)

(4) Bean P. 'The social control of drugs' Martin Robertson (London 1974) p 14

'Deviance is established in social roles and is perpetuated by the very forces directed to its elimination or control. This, of course, has to be understood as a process of meaningful social interaction'.

(Lemert 1967) (5)

The inter-relationship between deviant or dangerous behaviour and the social control mechanisms should be recognised as a two-way process. Not only is deviance or dangerousness to some extent established and perpetuated by the attempts of society to apply control; but also the concept and causation and social nature of deviance and 'danger' have dynamic effects on the operation of law and the decision-processes in practice. This too should be understood as a 'process of meaningful social interaction'.

The decision-makers are faced with dilemmas and conflicts which require them to go beyond their formal structure to reach a conclusion. The conflicts and dilemmas are most evident in the situation of the mental health review tribunal considering applications from patients detained within a special hospital. 'The fundamental purpose of a review tribunal is to protect the individual's right not to be unfairly deprived of his liberty' (Wood 1976); (6) and the tribunal is required to reach a conclusion with a prescribed time period. Wood emphasised the 'unique difficulties' under which the tribunals were working. He instanced the difficulties of maintaining the balances between civil liberties and public and personal safety, and between legal, medical and social considerations. He also spoke of the impossibility of divorcing the prescribed 'narrow conceptual framework' from rehabilitative and wider social realities.

(5) Lemert E. 'Human deviance: social problems and social control' Prentice-Hall (New Jersey 1967) p v.

(6) Wood J.C. 'Mental Health Review Tribunals and Social Work' Social Work Today Vol 7 (11 August 1976)

The traditional formal-structural model of sentencing behaviour

In his sociological study of 'rehabilitation and deviance', Bean (1976) ⁽⁷⁾ considered the 'individualised justice' model (punishment and treatment should fit the crime and criminal) and the 'medical' model (diagnosis and appropriate treatment response). He came to the conclusion that he could use these two models 'inter-changeably', as they were each concerned with determining an appropriate response on the basis of facts about the offences or behaviour, the individual and his circumstances.

The traditional model of judicial decision-making assumes that the only significant variables affecting sentencing are those 'facts' visible from the examination of judicial records. This stimulus-response or input-output model of behaviour (Diagram A) would be consistent with a formal-structural approach to the decision-process of the mental health review tribunal. The framework of the prescribed composition and procedures of the tribunal would process the input of 'facts' about the patient and his circumstances and respond with the appropriate decision on the basis of those facts and the prescribed criteria and procedures.

It was decided to incorporate into the research the study of the relationship between various socio-demographic features of the individual with the decisions of the tribunal, as a means of testing the extent to which a straight-forward input-output model was sufficient to explain the decision-process.

(7) Bean P. 'Rehabilitation and Deviance' Routledge and Kegan Paul (London 1976)

DIAGRAM A: Traditional legal model of sentencing behaviour

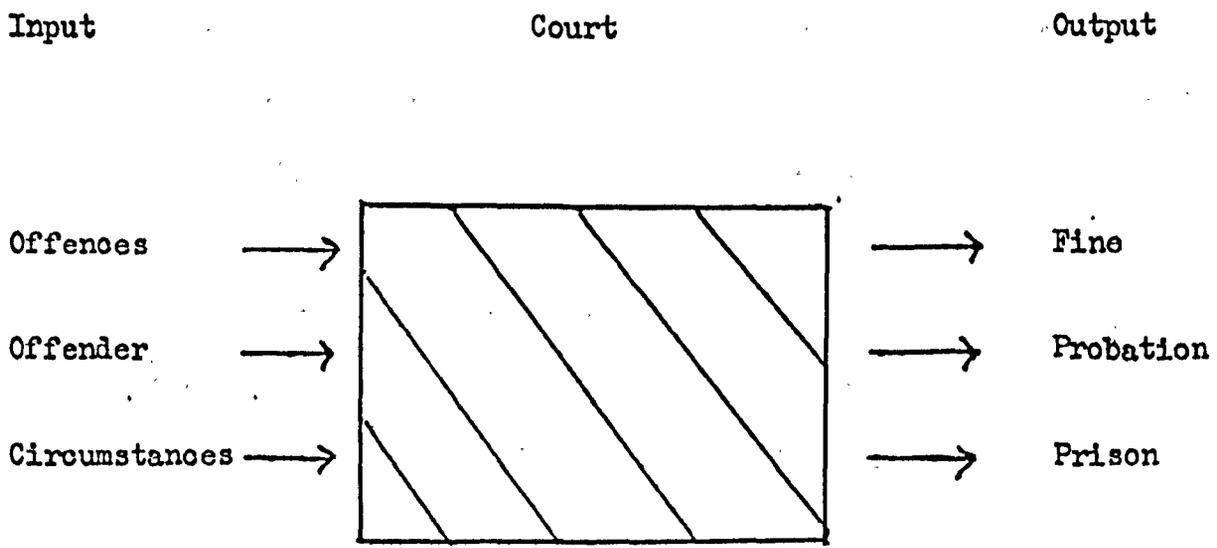
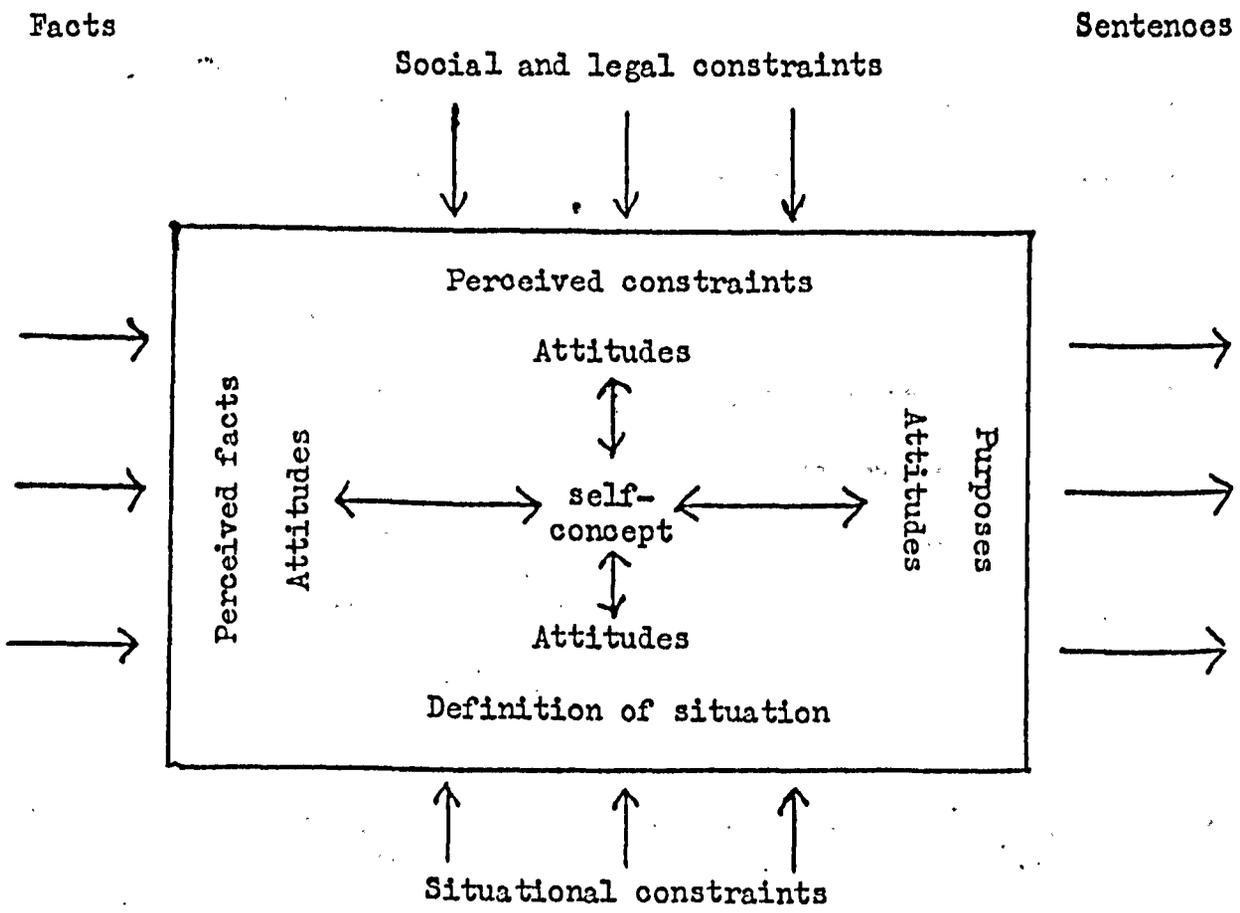


DIAGRAM B: Hogarth's model of 'sentencing as a human process'



(From Hogarth J. 'Sentencing as a human process' Toronto University Toronto 1971, figure 18, p 343)

Sentencing behaviour as a dynamic 'human' process

Bean (1976) ⁽⁷⁾ considered the influence of the problematic nature of law, the administration of justice; and the social pathology model upon judicial response to 'rehabilitation and deviance'. He concluded that it all added up to a 'system of rampant discretions' ⁽⁸⁾ (Matza 1964). In response to the inadequacy of the traditional judicial model, Hogarth (1971) ⁽⁹⁾ developed his model of 'sentencing as a human process' (Diagram B). Sentencing was a dynamic process in which the facts of the cases and the constraints arising out of the law, the social system and other features of the external world were interpreted, assimilated, and made sense of in ways compatible with the attitudes of the magistrates. The results were sentencing decisions which were consistent with the way the decision-makers perceived the situation facing them.

Hogarth studied separately the relationships between externally defined facts and 'facts' as perceived by the judiciary with the judicial decisions. He found that, whereas external facts were often significant variables in the decision-making process (so supporting the traditional model), the 'facts' as perceived by the judiciary were more powerful in the predictive sense. He concluded that 'one can explain more about sentencing by knowing a few things about the judge than by knowing a great deal about the facts of the case'.

(7) Bean P. 'Rehabilitation and Deviance' Routledge and Kegan Paul (London 1976)

(8) Matza D. 'Delinquency and Drift' Wiley (1964)

(9) Hogarth J. 'Sentencing as a Human Process' Toronto University Press (Toronto 1971)

Whilst not attempting any analysis of the attitudes of the members of the mental health review tribunal, it was decided to incorporate into the research a study of the way they perceived the facts of the cases and their situation.

Sociological model to account for the conflicts and anomalies

In addition to the 'facts of the case' and the influence of the perceptions and interpretations of these facts and the situation, there is the need to take account of the dilemmas and conflicts faced by decision-makers such as the tribunal. A theoretical model which would be useful in this respect is the 'socio-legal theory' constructed by Lemert (1970)⁽¹⁰⁾ in response to his study of the process of legal change.

The model developed by Lemert in response to his study of revolutionary changes in the laws regulating the juvenile courts in California has application to the smaller inter-personal social situation of the decision-making of such as the tribunal. His concern paralleled that which has been stated in respect of the tribunal: once the formal structure and systematic development of precedents have played their part in the legal decision-process, how do we account for the 'crises' when prescribed procedures and available facts are insufficient and the response of decision-makers to these conflicts and dilemmas. In considering procedural reform and legal development, Lemert acknowledged the gradual cumulative process with decisions being based upon the prescribed rules and legal precedents. Yet he saw revolution as a feature of legal change, with discreet changes or fairly radical 'new departures'

(10) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970)

in legal practices. He accounted for these changes by paralleling legal revolution with revolution in scientific knowledge or practice.

Lemert applied the theories of Thomas Kuhn (1962) ⁽¹¹⁾ in regard to scientific revolutions. Kuhn argued that the key to scientific revolution was the appearance of new paradigms which offered different perspectives on facts and a change of direction. According to Kuhn, new paradigms appeared because of anomalies, whereby existing paradigms were unable to adequately explain or answer the facts. As these anomalies increased in number, a crisis developed because of doubts and uncertainties; and the new paradigms were seen as the means of reconciling the anomalies with the facts previously explained by the old paradigms. Such changes of direction could lead to conflict, as it was resisted by more traditional scientists. Sometimes the traditional approach was revised to camouflage the revolution and give a greater impression of continuity.

Lemert applied Kuhn's theory of scientific revolution to the process of legal change. He suggested that an accumulation of anomalies in the prescribed legal procedures could lead to an innovatory perspective, resulting in polarisation between the revolutionary view and reactionary resistance. He suggested that these anomalies were usually associated with the inability of the legal process to safeguard rights and interests. They became issues between conflicting interests, and the major aspects of the resulting legal crisis was the concern for fairness, justice and impartiality. In his study of the juvenile criminal law reform in California, he found the main conflict to be between

(11) Kuhn T.S. 'The Structure of Scientific Revolutions'
University of Chicago Press (Chicago 1962)

'parens patriae' (stressing welfare and protection of the individual and others) and 'balanced justice' (stressing impartiality and fairness).

Lemert himself warned of the dangers in transposing theoretical models from one discipline or situation to another. (12) He warned of the temptations to account for too much or to ignore important differences between classes of facts. Yet, the mental health review tribunals were faced with similar conflicts and dilemmas to those Lemert identified in his study of juvenile law reform in California. They were faced with situations where the prescribed procedures were insufficient to safeguard the rights of the parties concerned, where there could be conflict between different interests, and where the tribunal was required to choose between considerations of justice and welfare. Whether the accumulation of anomalies did lead to innovatory perspectives and 'new departures' in practice could only be established by observation and study.

Therefore, it was decided to incorporate into the study of the decision-process of the mental health review tribunal, consideration of the dilemmas and conflicts with which they were faced and the anomalies in their rules and powers which might lead to a crisis in the decision-process and innovatory action. This decision, along with the earlier decisions about the facts of the case and the perception of the facts and their situation by the tribunal members, was considered to complete a more sufficient theoretical framework upon which to base the research aims and methodology (see Part Two).

(12) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970) p 8

PART TWO

RESEARCH PROJECT

CHAPTER FIVE Aims of the research project

CHAPTER SIX General approach to the research
project

CHAPTER SEVEN The research schedule

CHAPTER EIGHT Validity and reliability of
research methods

CHAPTER FIVE

AIMS OF THE RESEARCH PROJECT

The general aim of the research was to examine the process by which the members of the mental health review tribunal reached their conclusions in regard to the 'dangerousness' of the person before them as a basis for the decision or advice about the release or continued detention.

How did the members of the mental health review tribunal impliment their legal responsibility to determine whether the person before them was a sufficient risk to himself or others to justify continued compulsory treatment in hospital?

What factors had the greater influence on their decisions?

How did the tribunal resolve the dilemma between 'parens patriae' and balanced justice, the welfare and protection of the individual and the need for justice to be seen to be done?

How did they deal with a situation where the formally prescribed approach was insufficient to ensure the individual was not unfairly deprived of his liberty?

How did the tribunal decide whether to give the 'benefit of the doubt' to protection or justice, continued detention or release?

The general aim was to examine how the legal requirements to determine whether it was necessary in the interests of the patient's health or safety or the protection of other persons that the patient should continue to be likely to be detained' operated in practice. The empirical research was designed to take into account the various observable features and visible evidence, the way these facts and the situation are perceived by the tribunal members, and their response to dilemmas and conflicts and anomalies.

The specific aims

The specific aims were designed in a form which would enable null hypotheses to be tested through the statistical analysis of appropriate data collected through the observation of the hearings of the tribunal, the interviewing of the chairmen of the tribunal hearings, and the examination of records. The hypotheses were developed into research questions to be incorporated into the various methods of research..

(i) Perceptions of 'dangerous' by the mental health review tribunal.

Neither the legislation such as the Mental Health Act 1959 nor the rules and procedures of the Mental Health Review Tribunal clearly defined or categorised the nature of risk which would justify the continued detention of the applicant or person referred to them. Therefore, in regard to 'danger to self and others', for what were the members of the tribunal looking and how would they describe the risk?

AIM 1: To examine how the members of the tribunal perceive

the nature of the 'dangerousness' or risk associated with the person before them.

Hypotheses (a) There will be no tendency for tribunal members to categorise the nature of risk in particular terms.

(b) There will be no tendency for tribunal members to identify particular categories of potential victims as at most risk.

Research method: Observations of tribunal hearing

Research question: Did the tribunal members refer to the risk associated with the person before them in the following terms:

- | | |
|----------------------------------|--------------------------------|
| Risk of direct physical violence | Psychological harm |
| Indirectly endangering others | Property offences(e.g.larceny) |
| Sexual assault | Other(details) |
| Damage to property | |

Research question: How did the tribunal as a whole appear to view the primary risk?

- | | |
|--------------------------|--------------------|
| Not clear | Damage to property |
| Direct physical violence | Psychological harm |
| Endangering behaviour | Property offences |
| Sexual assault | Other(specify) |

Research question: To whom did the tribunal members refer as potential victims?

- | | |
|---------------------|-------------------------|
| People generally | Elderly |
| Adults own sex | Self |
| Adults opposite sex | Specific other(details) |
| Children | Other(specify) |

Research question: Who appeared to be seen as most at risk?

- | | |
|---------------------|----------|
| Not clear | Children |
| People generally | Elderly |
| Adults own sex | Self |
| Adults opposite sex | Other |

Would you like to make any further comments on how you saw the danger in this case?

(ii) The evidence on which the tribunal based their judgements.

The members of the mental health review tribunal were limited in the extent to which they could directly observe and examine the person before them. Therefore, in seeking to assess the 'danger to self and others', for what evidence were they looking and which factors were most influential?

AIM 2: To examine the nature and relative importance of the evidence upon which tribunal members base their judgement in regard to the dangerousness or risk.

Hypotheses (a) There will be no difference in the extent to which the tribunal members as a whole take account of different categories of evidence.

(b) There will be no difference in respect of legal members.

(c) There will be no difference in respect of medical members.

(d) There will be no difference in respect of lay members.

Research method: Observation of tribunal hearing

Research questions: Was the patient interviewed?

Were any family interviewed?

Was the subject legally represented?

Were any hospital staff interviewed?

Were representatives of any community services interviewed?

Were the usual hospital reports available (hospital statement, ward file, etc)?

Were the home circumstances reports available from the social services?

Were any other reports available?(Details)

What was the length of time of the hearing

Research question: In considering evidence, did the tribunal members show regard for the following:

- Mental disorder
- Immediate offence/behaviour
- Circumstances of immediate offence
- Previous offences/behaviour
- Personality of patient
- Family background
- Previous social/Life-career (school, work, social, etc.)
- Current family circumstances
- Present behaviour/attitudes
- Community support services
- Social adequacy of patient
- Length of stay in Rampton
- Hospital opinion and planning
- Other(details) (school, work, social, etc.)

Research question: Did one factor appear to be more influential with the tribunal as a whole?

- Not clear
- Mental disorder
- Immediate offence/behaviour
- Previous record
- Personality of patient
- Previous life-career
- Community support services
- Length of stay
- Present behaviour/attitudes
- Other(specify)

Research question: Did one factor appear to be more influential with the legal member? (Choice from factors as above questions)

Research question: Did one factor appear to be more influential with the medical member? (Choice from factors as above)

Research question: Did one factor appear to be more influential with the lay member?(choice from factors as above)

Research question: Did they admit to being influenced by uncertainty or benefit of the doubt?

Research question: Did they admit to being influenced by their subjective feelings or intuition about the patient?

Research Method: Interviewing of legal chairman.

Research question: In deciding whether or not this particular patient should continue to be detained in Rampton, which factor appeared to you the most important influence in that decision? (choose from:--)

Mental disorder	Family circumstances
Immediate offence/behaviour	Community support services
Previous record	Length of stay
Personality of patient	Present behaviour/attitude
Previous life-career	Other(specify)

Research question: Which factor would you have said was second in importance as an influence on the decision? (choice as above)

Research question: Was there a further factor which was important in the decision(third in importance)? (choice as above)

Research question: Was there any serious doubt in your mind about whether or not the patient should be released from Rampton?

Research question: Could you say whether you gave any 'benefit of the doubt' in favour or against leaving Rampton?

Research question: Were you at all influenced by your subjective feelings or intuition about the patient?

(iii) Restraints and difficulties in obtaining the evidence.

The members of the mental health review tribunal were very

dependent upon indirect evidence upon which to reach their conclusions. What factors imposed themselves between the tribunal and the evidence they required?

AIM 3: To examine the nature of any restraints or difficulties experienced by the tribunal in obtaining the evidence considered necessary to reach decisions.

Hypotheses (a) Tribunal members did not experience any serious difficulty in obtaining the evidence they required.

(b) Where there is difficulty, it is not due to any particular cause or restraint as against others.

(c) Where there is difficulty, it is not in relation to any particular category of evidence.

(d) 'Benefit of doubt' is not a major factor influencing the decisions of tribunal members generally or specifically.

(e) Intuition and feelings about the patient are not a major factor influencing the decisions of tribunal members.

Research method: Observation of tribunal hearing.

Research questions: Was the patient interviewed?

Was any family interviewed?

Was the subject legally represented?

Were any hospital staff interviewed?

Were representatives of any community services interviewed?

Were the required hospital statements available?

Were the home circumstances reports available from social services?

Were any other reports available?

What was the length of time of the hearing?

Research question: Did the tribunal members refer to difficulties in obtaining evidence required to reach decisions?

Reports not available Family witnesses not available

Available reports Other evidence unavailable
inadequate

Hospital witnesses not
available

Community services
witnesses not available.

Research question: To which category of evidence did the difficulties mainly relate? (categories: mental disorder, etc)

Research question: Did they admit to be influenced by uncertainty or benefit of the doubt?

Research question: Was there any doubt expressed about the legal classification or diagnosis?

Research question: Did they admit to be influenced by their subjective feelings or intuition about the patient?

Research method: Interviewing of legal chairman.

Research question: Did you experience any difficulty in obtaining the evidence you required to reach your decision?

Research question: What was the nature of the difficulty?

No difficulty Hospital witnesses unavailable

Reports unavailable Community witnesses unavailable

Reports inadequate Other witnesses unavailable

Family witnesses Other
unavailable

Research question: Did the difficulty relate to any particular category of evidence or information? (category: mental disorder, etc)

Research question: Was there any serious doubt in your mind about whether or not the patient should be released from Rampton?

Research question: Could you say whether you gave any 'benefit of the doubt' in favour or against leaving Rampton?

Research question: Would you have said that the medical member had any serious doubt about the right course of action?

Research question: Would you have said that the lay member had any serious doubt about the right course of action?

Research question: Was there any doubt expressed about the legal classification or diagnosis?

Research question: Were you at all influenced by your subjective feelings or intuition about the patient?

Supplementary question: Have you any further comments in regard to difficulties in obtaining the necessary information?

(iv) Anomalies and dilemmas arising from their rules and powers.

The prescribed rules and powers implied a clarity of choice between alternatives, objective and available evidence, adequate resources to enable decisions to be effected satisfactorily, and no other serious restraints on reaching conclusions. In practice, with what if any frustrations and complications were the tribunal faced, requiring them to go beyond their rules and procedures?

AIM 4: To examine the nature of any restraints or difficulties experienced by the tribunal arising from anomalies and dilemmas where prescribed procedures and rules are not adequate.

Hypotheses (a) Tribunal members do not experience any serious inadequacy in the prescribed rules and procedures in regard

to the collection of evidence, the deliberations of the tribunal, or the powers of the tribunal.

(b) Tribunal members do not experience any serious dilemmas in regard to the practical choices available to them.

(c) Where they do experience serious dilemmas, they do not arise in regard to any particular aspect of the situation.

Research method: Observation of tribunal hearing.

Research question: Did the tribunal members refer to difficulties arising from inadequacies in the procedures and rules, in regard to:

- i. the obtaining of evidence
- ii. the conduct of the tribunal hearing
- iii. the powers of the tribunal?

Research question: Did the tribunal members refer to difficulties arising because of the need to choose between unsatisfactory alternatives:

- i. dilemmas associated with the need or otherwise for hospital care
- ii. dilemmas associated with the patient's attitude and behaviour
- iii. dilemmas associated with family support and attitudes
- iv. dilemmas associated with community support services
- v. dilemmas associated with public attitudes
- vi. any other dilemmas?

Research method: Interviewing of legal chairman.

Research question: Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the collection of evidence? Could you describe the difficulty?

Research question: Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the conduct of the hearing? Could you describe the difficulty?

Research question: Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the powers of the tribunal in this case? Could you describe the difficulty?

Research question: In reaching your conclusions, did you experience any difficulty which arose from the need to choose between unsatisfactory alternatives?

Research question: Did you face any dilemma which related in any way to the need or otherwise for continued hospital care?

Research question: Did you face any dilemma which related in any way to the behaviour or attitude of the patient himself?

Research question: Did you face any dilemma which related in any way to the support or attitude of the family?

Research question: Did you face any dilemma which related in any way to the provision of community services?

Research question: Did you face any dilemma which related in any way to the question of public attitudes?

Supplementary questions: Have you any further comments in regard to to problems arising from the rules and procedures laid down for tribunals?

Have you any further comments in regard to any dilemmas with which you were faced?

(v) Disagreements between the members: The evidence and 'facts' were open to interpretation and the conclusions were not always self-evident from the procedures and criteria. How do the

members of the tribunal resolve the inevitable differences of emphasis and disagreements in regard to the nature and degree of risk?

AIM 5: To examine the disagreements between the members of the tribunal and the process by which they were resolved.

Hypotheses (a) Tribunal members do not experience any serious disagreement or conflict of opinion among themselves, in regard to any aspect or at any stage of the decision-making process.

(b) Where there is disagreement or conflict, it is not resolved by any particular process.

(c) No one category of member is more influential in reaching a conclusion.

Research method: Observation of tribunal hearing.

Research question: Was there any clear disagreement in regard to the nature of the risk?

Research question: Was there any clear disagreement in regard to potential victims?

Research question: Was there any clear disagreement in regard to the evidence to be taken into account?

Research question: Did there appear to be any conflict of opinion among the tribunal members, in regard to:

- i. the mental state of the patient
- ii. the degree of risk
- iii. the question of release?

Research question: Did one factor appear to be more influential with the legal member? (choice of factors as previously indicated)

Research question: Did one factor appear to be more influential with the medical member? (choice of factors as previously indicated)

Research question: Did one factor appear to be more influential with the lay member? (choice of factors as previously indicated)

Research question: By what process were disagreements mainly resolved?

Agreement through discussion

Giving way to greater knowledge or experience

Majority decision

Adjourning decision

Avoiding decision

Other(specify)

Research method: Interviewing of legal chairman

Research question: Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the degree of risk?

If so, could you give more details of the disagreement?

Research question: Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the nature of the dangerousness or risk?

Research question: Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the potential victims?

Research question: Would you have said that the medical member had any serious doubt about the right course of action?

Research question: Would you have said that the lay member had any serious doubt about the right course of action?

Research question: Was there at any point in the hearing what you would call a serious difference of opinion between the tribunal members in regard to whether or not the patient should leave Rampton?

Research question: How was this disagreement resolved?

- Agreement through discussion
- Greater knowledge or experience prevailing
- Majority decision
- Decision adjourned
- Decision avoided
- Other(specify)

Research question: At any point did the legal member have a greater influence than the other members? In what connection?

Research question: At any point did the medical member have a greater influence than the other members? In what connection?

Research question: At any point did the lay member have a greater influence than the other members? In what connection?

Research question: At any point was it necessary to abide by a majority decision? In what connection?

Supplementary question: Have you any further comments in regard to disagreements and their resolution?

(vi) Tribunal decisions and innovations

The tribunal had the duty to make a decision or give advice in respect of each application or reference. As they could not avoid reaching some clear conclusion, how far did their decisions conform to the prescribed choices and in what if any ways did they vary from those alternatives?

AIM 6: To examine the conclusions reached by the tribunal and the nature of any innovations beyond prescribed choices.

Hypotheses (a) Tribunal members will not tend toward any particular category of decision or advice.

(b) Tribunal hearings will not conclude in other

than decisions or advice to release or not release.

(c) Where there is such innovation, it will not be in response to instances of difficulties in obtaining evidence.

(d) Where there is such innovation, it will not be in response to instances where tribunal members experienced anomalies or dilemmas.

(e) Where there is such innovation, it will not be in response to instances of disagreement between members of the tribunal.

Research method: Observation of tribunal hearing.

Research question: What was the decision of the tribunal?

Not applicable(reference)	No action
Adjourn decision	Reclassification
Discharge order	Other

Research question: What was the advice given by the tribunal?

Not applicable(application)	No action
Adjournment	Transfer to other hospital
Discharge to community	Other

Research question: In regard to any adjournment, what was the reason given or nature of further enquiries?

Not applicable(no adjournment)	Specifically accommodation
Specifically hospital transfer	Other rehabilitative(specify)
To review patient's progress	Other reasons(specify)
Not clear	

Research question: By what process were disagreements mainly resolved?

Research method: Interviewing of legal chairman

Research question: Did you make a definite decision about the application/your advice on this occasion?

Research question: Was your decision or advice in favour of release from Rampton?

Research question: Was your advice or decision in favour of changing the legal classification?

Research question: In your advice to the Home Secretary, did you recommend transfer to a local NHS hospital?

Research question: Did you make any other recommendation to the Home Secretary?

Research question: If you adjourned consideration of the application or reference, what was the purpose in adjourning?

Research question: Did you decide to take any additional action as a tribunal in response to this application or reference?

Research question: Would you like to make any further comments about the evidence you took into account in making your decision?

Research question: How did you overcome the difficulty(in obtaining evidence)?

Research question: Have you any further comments in regard to difficulties in obtaining the necessary information?

Research question: Did you find the need to go beyond the given rules and procedures, and take any unusual course of action in order to overcome this difficulty?

i. in relation to the collection and receiving of evidence?

ii. in relation to the conduct of the hearing?

iii. in relation to the powers of the tribunal in this case?

Research question: Have you any further comments in regard to problems arising from the rules and procedures laid down for tribunals?

Research question: How was this disagreement resolved?

Research question: Have you any further comments in regard to disagreements and their resolution?

Research question: Have you any further comments in regard to this particular hearing?

Research method: Examination of records(where confirmation is necessary)

Research question: What was the decision of the tribunal?

Research question: What was the advice given by the tribunal?

Research question: In regard to any adjournment, what was the reason given or the nature of further enquiries?

(vii) Influence of Socio-demographic facts

The above aims reflected the fact that the decision-making model used in the empirical study of the mental health review tribunal was designed to incorporate the 'perception' of the 'facts' by the tribunal members and the dilemmas and conflicts and anomalies with which they were faced in the process of making decisions. Yet the starting point of the model was a traditional input-output approach to decision-making. Therefore, the aim was also to study the relationship between the tangible 'facts' and the decisions of the tribunal.

AIM 7: To examine basic socio-demographic features of the patient and the tribunal to see if they are related to the decision reached by the tribunal.

Hypotheses (a) There will be no difference in terms of the home area of the patient in regard to the decisions reached by the tribunal.

(b) There will be no difference in terms of the age of the patient in regard to the decisions reached by the tribunal.

(c) There will be no difference in terms of the sex of the patient in regard to the decisions reached by the tribunal.

(d) There will be no difference in terms of the marital status of the patient in regard to the decisions reached by the tribunal.

(e) There will be no difference in terms of the legal classification in regard to the decisions reached by the tribunal.

(f) There will be no difference in terms of the nature of the order in regard to the decisions reached by the tribunal.

(g) There will be no difference in terms of the immediate offences in regard to the decisions reached by the tribunal.

(h) There will be no difference in terms of the victims of offences in regard to the decisions reached by the tribunal.

(i) There will be no difference in terms of the years in Rampton in regard to the decisions reached by the tribunal.

(j) There will be no difference in terms of previous hospital care in regard to the decisions reached by the tribunal.

(k) There will be no difference in terms of previous offences or sentences in regard to decisions reached by the tribunal.

(l) There will be no difference in terms of the previous residential care in regard to decisions reached by the tribunal.

(m) There will be no difference in terms of number of previous hearings in regard to decisions reached by tribunal.

(n) There will be no difference in terms of stage of progress in hospital in regard to decisions reached by the tribunal.

(o) There will be no difference in terms of legal chairman in regard to the decisions reached by the tribunal.

(p) There will be no difference in terms of whether family interviewed in regard to decisions reached by tribunal.

(q) There will be no difference in terms of whether patient legally represented in regard to the decisions reached by the tribunal.

Research method: Examination of records to obtain factual information in regard to patient and tribunal, in order to study the relationship between the above 'facts' and decision and advice of the tribunal.

CHAPTER SIX

GENERAL APPROACH TO THE RESEARCH PROJECT

The focus of empirical study was to be the mental health review tribunal meeting at Rampton Hospital to consider applications for discharge or references for advice from the Home Secretary in regard to people detained within Rampton Hospital. The constitution, procedures and powers of the tribunal at Rampton Hospital were those formally prescribed in legislation and rules, as summarised in Chapter three on the 'Mental Health Review Tribunal'.

In contrast with a special security hospital, in a national health service psychiatric hospital there would be only a small proportion of patients held compulsorily for treatment and therefore eligible to apply or be referred to the tribunal during any period. During a twelve-month period ending December 1977, throughout the whole of the Trent Regional Health Authority with the exception of Rampton Hospital, there were only 33 applications and 13 references heard by the mental health review tribunal. During that same period, the tribunal heard 121 applications and 169 references in respect of men and women detained in Rampton Hospital. As all special hospital patients are detained against their will, during any period there is always a high proportion eligible to be seen by the tribunal. During the years prior to this research and while the project was being designed and negotiated, there were between 300 and 400 hearings of the tribunal at Rampton Hospital during any one year. This was in

relation to a population of patients of 900 to 1,000(The patient population at Rampton has been falling steadily since the early 1970s).

Therefore the mental health review tribunal at Rampton had various advantages as a focus of study:

(a) There was sufficient volume and concentration of applications/ references and tribunal activity at the hospital to provide a very adequate sample of hearings for study within a reasonable time.

(b) As the tribunal met invariably and regularly at the hospital itself, the hearings were easily accessible for study by someone working at the hospital.

(c) The obtaining of the necessary official approval for the research was facilitated by the researcher working at the hospital and employed by the same authority responsible for mental health review tribunals(Department of Health and Social Security)

(d) Whilst the researcher was too close and involved in the hospital situation to research the hospital decision-making with sufficient objectivity, it was inherent in the nature of the mental health review tribunal that it should be entirely separate and independent of the hospital administration and clinical decision-making.

(e) Working in the hospital gave the researcher ready access to the records of patients in regard to socio-demographic details

(f) Working in the hospital facilitated the obtaining of the approval where necessary of various parties such as the consultant psychiatrists and the patients themselves.

During early 1977, the following were approached by the researcher: the Chairman of the Mental Health Review Tribunal in the Trent Regional Health Authority, the Department of Health and Social Security who manage the special hospitals, and the consultant psychiatrists at Rampton Hospital. The research interest and method was outlined; to study the decision-making process of the mental health review tribunal through the observation of hearings, interviewing of members, and the examination of patient records. Ready approval and encouragement was received from members of Mental Health (C Division) of DHSS and the medical staff at the hospital. The Chairman of the Tribunal was very helpful and supportive, making himself available to discuss in more detail the planning and application of the research project. This helped to maximise the research benefit whilst ensuring the minimum interference with their decision-making and the hearings.

General arrangements

The mental health review tribunal were attending at Rampton for between 300 and 400 hearings each twelve month period; including the hearing of applications and references and reconvened hearings where their decision had been adjourned. The pattern of operation was for the tribunal to meet on around three days each week (usually Tuesday, Wednesday, and Friday), considering three applications or references during the course of each day. Tribunal hearings were timed for 11.00a.m., 12.00 mid-day, and 2.00p.m., allowing for at least one hour for each hearing. There was no tendency for either applications

or references to be heard at any particular day or time; it being arbitrary whether any hearing was an application or reference, the arrangement depending on other factors. Hearings were arranged for applications and references chronologically as they were ready. When an application or reference from the Home Secretary was received by the tribunal office, the necessary reports were obtained from the hospital and community services and the medical member requested to examine the patient. When these enquiries were complete and withⁱⁿ the prescribed dead-line for considering the matter, the tribunal office informed all parties concerned of the arrangements for the hearing. One factor which could affect the timing of the hearing on any given day could be the travelling arrangements of people attending the hearing. For instance, the 11.00a.m. hearing time could be avoided for a relative travelling a long distance. Apart from this influence, the date and timing of hearings appeared to be arbitrary. The normal practice was for the same tribunal 'panel', the nominated members of the three panels, and the same tribunal clerk to deal with all applications and references on a particular day. Another regular feature was for the 'Chairman of the Tribunal' to act as president of the hearings on a particular day (Tuesday) during each week.

The tribunal hearings were invariably held in accommodation provided by the hospital administration for the exclusive use by the tribunal for the hearings themselves and as waiting rooms for patients, their relatives, and other parties to the situation.

The above pattern of operation and arrangements for the

hearings were confirmed through observing the hearings and consulting the tribunal staff and the Chairman of the Tribunal. With the advice of the tribunal staff and Chairman, the assumption was made that this pattern of operation and the circumstances of the hearings would continue to apply consistently through the period of study. This assumption was proved correct, with the exception that occasionally the tribunal would meet more or less than the three days during a week in response to a variable volume of applications and references. It was very rare for the tribunal not to hear three applications or references during any one day; the exceptions being when circumstances had required a particular hearing to be cancelled.

It was decided to focus on every tribunal hearing to be held at 12.00 mid-day from a given date until a total of 150 hearings had been studied. The sample of 150 was chosen as large enough to have research credibility and to allow for differentiating between applications and references; and yet attainable within a reasonable period (which was estimated in 1977 to require about 18 months). The aim was to observe the hearing throughout from beginning to conclusion, and then to interview the tribunal president (chairman) as soon after the hearing that day as convenient.

Observing the hearing. An agreement was reached with the Chairman of the Tribunal and through him with the other presidents. The agreement was that, subject to the consent of the patient, the researcher would normally sit in a discreet

position to observe the tribunal hearing, with the understanding that he could be excluded from the whole or part of the hearing at the request of the president without the need for any explanation. This was to avoid any concern that the presence of the researcher could prejudice in any way their deliberations or inhibit any other party. Arising from this understanding and the practice of (either directly or through their legal representative) explaining^{the} presence and gaining the consent of the patient, there were eleven of the 150 hearings which were not fully observed. This arrangement both decreased the sample of hearings fully observed to 139 (although not the number of legal chairmen/presidents interviewed) and introduced possible bias. Seven exclusions concerned two tribunal members (one medical and one lay member) who on principle did not wish the hearings to be observed. With the exception of one case where the patient was known to be excessively suspicious, the reasons for exclusion from the other hearings were not given to the researcher. This 'exclusion' agreement was necessary, as the prime function of the tribunal had to take priority and it was essential that the researcher's presence should not be seen as interfering in any way.

The invariable practice during all the observed hearings was for the researcher to sit in a particular chair in a particular corner to one side of the tribunal and the people they were interviewing. A coded check-off sheet on a clipboard was used to record the structured observation of the hearing (writing up the full standardised observation schedule

at the earliest opportunity the same day to ensure an accurate record). With the exception of perhaps being introduced and the reason for the researcher's presence being generally confirmed by the chairman, at no point during the 139 observed hearings included in the research did the researcher take an active part in the proceedings. In addition to the eleven hearings which were not fully observed (although the chairman interviewed) and the 139 observed hearings, there were two occasions which led to the researcher stepping out of role in order to give advice in a different capacity (each time on the initiative of the members of the tribunal). Both those hearings were excluded from the research sample and replaced by a procedure explained below.

The 12.00 mid-day hearing. The mid-day hearing was selected as the focus of study both for certain practical reasons and with the aim of minimising sampling bias.

Work commitments would not have allowed the researcher to be free to observe and study every hearing for a sufficient period to achieve a credible sample. To have achieved the required sample of 150 by observing every hearing, would have demanded a time-commitment of at least three hours during any day, three days during any week, for at least seventeen weeks. In addition, there would have been the time required for other aspects of the research study; interviewing members and examining records. Therefore it was necessary to select a representative sample.

Another practical consideration was that, as mid-day was the

beginning of the hospital meal-time period, the situation external to the tribunal would be more relaxed. Whilst this would in no way affect the tribunal, the researcher could be more confident of meeting the commitment (in effect in his own time without undue conflict with work commitments).

It was arranged with the tribunal staff and Chairman that, whenever the researcher was prevented from attending a hearing because of other commitments, he would attend the first available replacement hearing regardless of time. Over the fifteen month period of the main study, there were thirteen occasions when it was necessary to attend the first available replacement hearing. As these occasions tended to arise when the researcher was away from the hospital for the whole day, the replacement hearings were more often the following morning at 11.00a.m. (eight occasions) than at 2.00p.m. (five hearings). Two of the latter group were the hearings mentioned above when the researcher was drawn into the hearing in a different role.

The 12.00 mid-day hearing had value also as a means of controlling other variables and minimising bias and error from the influence of these other variables. (a) Focusing on the hearings at a particular time each day minimised the influence of factors which could have varied at different times of the day, but which were extraneous to the aims of the research study. One example was mentioned earlier. In organising the tribunal hearing, the tribunal clerks would tend to avoid the 11.00 a.m. hearing for relatives and others travelling any great distance; whereas the converse did not appear to apply

in that the clerks were not necessarily avoiding the 12.00 mid-day hearing for any known reason. This could have affected indirectly socio-demographic features which were factors in the research, such as geographical home area and attendance of relatives at the hearing. In support of his own independent impressions, the researcher was assured by tribunal staff and members that there was no known bias in the selection of cases for the 12.00 mid-day hearing.

(b) Alternative sampling approaches would have been less satisfactory. To have attempted to study every hearing on a given day each week would have introduced bias. The same tribunal members were involved on any day and therefore would have been less representative of the total group of members of the three panels. As the Chairman of the Tribunal attended on a particular day each week, he would have been regularly included (to the extent of virtually monopolising the interviewing schedules and the hearings being observed) or totally excluded from the study. One hearing a day over an extended period ensured a representative sample of tribunal chairmen and members. Another alternative sampling approach could have been to study a sample frequency of hearings (every third or fourth hearing). In fact the study was tending to sample every third hearing as there were normally three hearings on any day. Every second hearing would have presented problems arising from the volume of research commitments on any one day, similar to those in regard to studying every hearing over a period. A frequency of less than every third hearing would have extended the study by about five months to doubtful advantage. Also there would be practical planning difficulties in regard to a sampling frequency. A minimum of only ten days notice was

required for hearings and therefore the dates and numbers of hearings were not certain well in advance. Attending the mid-day hearing had the convenience of familiarity for the tribunal as well as myself, without involving them in additional work in liaising with me about the hearings to be attended.

(c) From attending the hearings and consulting the tribunal members and staff, the researcher confirmed no known bias in the 12.00 mid-day hearing likely to affect variables and features in the research study (applications or references, male or female, nature of offence, etc.)

(d) The regular attending of the mid-day hearing over a reasonably achievable period of about fifteen to eighteen months would achieve a sufficient sample of the total group and various sub-groups to minimise bias arising from inadequate sampling.

Interviewing the legal chairman. The possibility of interviewing more than just the legal chairman was considered. It was decided the choice should be between the legal chairman or all the members. It was thought a smaller sample of other members for comparison purposes would have limited value, suffering from the same deficiencies as a smaller sample of interviews of legal chairman (i.e. need to avoid bias arising from inadequate sampling). It would have been practically impossible to have interviewed all three members of every hearing.

To have contained three interviews within the time available would have restricted the content and research objectives of the interview schedule. To have attempted to involve other researchers in interviewing all three members of the tribunal consecutively would have presented major planning difficulties and also introduced other variables which would have been difficult to control. To have attempted to interview each of the three members over a longer period after the hearing would have risked serious distortions in their responses due to the passage of time and the intervention of subsequent hearings.

The chosen method was the structured interviewing of the legal chairman of every hearing observed. The aim would be to interview the chairman during the same day as the hearing, either prior to the 2.00p.m. (or next) hearing or where necessary after that hearing. With the very helpful co-operation of the chairmen of the tribunals, this aim was achieved in every case, the interviews usually being during the lunch-time period between the 12.00 mid-day and 2.00p.m. hearings. Such was their willingness to co-operate that it was rarely necessary even to wait until after the 2.00p.m. hearing.

The practice was to meet the chairman in the tribunal room either after the hearing or prior to the next hearing. With only seven exceptions, they were alone. The other members had either left for lunch or the chairman had returned early. On the seven occasions, the chairman invited the other members and/or the tribunal clerk to remain, apparently for reference. As the study sought responses of the chairman, this introduced

some bias but not one considered of sufficiently serious concern to request other people to leave. Apart from the discourtesy, it was decided that the presence of the other parties reflected an interest in the research study which should not be discouraged. The questions from the schedule were voiced to the chairman in a standardised wording and order, and the responses noted onto the spaces provided on the schedule. At the end of each interview, the chairman had opportunity to make any general comments. This provided added interest and information, and also provided the facility to courteously control any tendency to make distracting general comments or stray from the standardised form of the interview schedule.

The pilot study. The research methods and the research schedule were tested through a pilot study of twelve hearings prior to the main research project. The influence of the pilot study on the detailed questions and research items in the observation and interview schedules is discussed in the next chapter on the 'Research schedule'. The pilot study was used also to evaluate the effectiveness of the general methods of approach to the research project. Over a period of about four weeks, the 12.00 mid-day hearings were attended. Eleven hearings were observed by the researcher and the chairman interviewed in respect of twelve hearings. On one occasion, a member of the tribunal objected to the presence of the researcher and only the research interview was completed. On two further occasions, it was necessary for the researcher to attend the earliest available replacement hearing because of a clash with work commitments. During one

hearing, the researcher was required to step out of role and advise the tribunal in a professional capacity. In another instance, he was able to maintain a research detachment during the involvement of a social work colleague in the proceedings.

Whilst initially being rather ill-at-ease in the role of non-participant observer, the researcher was able to use the pilot study to test and establish the feasibility of this role and to settle down to an impersonal standardised observation of the proceedings. The experiences during the pilot study, such as those described above, assisted both in gaining experience in remaining detached and being able to judge when the detachment had been breached. This could have contributed to there being only the two occasions during the main research project when the research role was compromised on the initiative of the tribunal, required those hearings to be excluded from the research sample. Also the pilot study appeared to provide some reassurance to tribunal members that the presence of the researcher was not detrimental to their work and responsibilities. It provided the means of enabling the researcher's presence to begin to be taken for granted. During the main study, the occasions when the researcher was excluded from the tribunal hearing were related mainly to two particular members of the tribunal who appeared to object on principle to the hearings being observed.

The pilot study provided the opportunity to familiarise with the interview situation and establish an adequate standardised

interview presentation. Also the trial confirmed that the period required for a reasonably responsive interview was around fifteen minutes as a norm. This provided for the structured responses to the standardised questions and the opportunity for further comment by the legal chairman. With a few exceptions discussed in the chapter on the 'research schedule', the chairmen found themselves readily able to understand and respond to the questions on the basis of their recent involvement in the tribunal hearing. Greater time beyond the fifteen minute norm arose usually because of the interest of the legal chairmen in extending their comments and discussion at the completion of the interview schedule; rather than due to any difficulty or time required to think out the answers to any questions.

This trial served a purpose which had not been planned. Coinciding with this research project, the tribunal chairmen had been approached about completing an extensive written questionnaire. They appeared to co-operate with this other research but, as that exercise was time-consuming, there was some risk of resistance generalising to this research project. In fact ^{the} pilot study provided tangible evidence that the time involved was limited and helped to ensure the co-operation of chairmen. This has been a general outline of the methods of approach to the research which will be considered in the following chapter concerned more with the specific items within the research schedule which were evaluated through the pilot study before the main study commenced.

CHAPTER SEVEN

THE RESEARCH SCHEDULE

The research schedule was designed to contribute to achieving the aims of the research project through being the means of recording for analysis data obtained through the three methods of research. The schedule was in three sections, one for each research method:

1. Observation of tribunal hearing
2. Details of subject from examination of records, and
3. Interviewing of legal chairman.

The questions within each of the sections were designed to test hypotheses based on the various aims of the research project. In Chapter 5, the hypotheses and research questions are grouped under the seven aims of the research project, to demonstrate how the aims were converted into research questions. In this chapter, the research questions are considered from the view-point of the research methodology.

Section One : Observation of tribunal hearing

There were ninety questions within this section of the schedule, the answers in the majority of instances being codified for analysis. A limited number of questions were for simple reference, such as:

What is the name of the subject?

What is the date of the hearing?

About ten questions were open-ended for comment on particular aspects of the decision-making process being observed:

Further comments on the nature of risk as perceived by the tribunal members.

Further comments on the evidence taken into account by the tribunal members.

Experience during the pilot trial study enabled a few questions which had been left open-ended in the draft schedule to be structured more specifically and codified.

One illustration came within the group of questions concerned with difficulties in obtaining evidence. Experience showed that a question originally worded:

Did their concern relate to particular factors of evidence?

Yes 1 No 0

Specify which.....

could reliably be converted to:

To which category of evidence did the difficulties mainly relate?

- Not clear 0
- Mental disorder 1
- Immediate offences 2
- Previous life-career 3
- Family circumstances 4
- Community support 5
- Present behaviour 6
- Hospital treatment 7
- Other(specify) 8

The trial study showed that some questions included within the draft schedule were unreliable and therefore excluded from the main research project. An example of this was:

Did any one member appear most influential in determining the nature of risk?

The wording of the questions which were included in the research schedule in the main research project are those included within

the grouping 'Observation of tribunal hearing' under the various Aims of Research, in Chapter 5. In addition to the questions detailed, there were for each Aim at least one open-ended question for general comment.

It will be seen that, in some instances, the questions were in a straight-forward yes/no form such as:

Was the patient interviewed? Yes 1 No 0

With some straight forward questions, it was appropriate to include the opportunity for further comment, such as:

Was any family interviewed? Yes 1 No 0

Details _____

Where possible, this straight-forward yes/no approach was used with wider areas of study, such as:

DID THE TRIBUNAL MEMBERS REFER TO THE NATURE OF THE RISK ASSOCIATED WITH THE PERSON BEFORE THEM IN THE FOLLOWING TERMS?

Risk of direct physical violence	Yes	1	No	0
Indirectly endangering others	Yes	1	No	0
Sexual assault	Yes	1	No	0
Damage to property	Yes	1	No	0
Psychological harm	Yes	1	No	0
Property offence(eg larceny)	Yes	1	No	0
Other	Yes	1	No	0
Details				

Experience during the trial pilot study demonstrated that sometimes further factors would be added validly to such areas of questioning. In the pilot draft schedule, the factors in response to the question 'In considering evidence, did the tribunal members show regard for the following.....' did not include 'circumstances of immediate offence', 'social adequacy of patient', 'length of stay in Rampton', and 'hospital opinion and planning'. During the pilot study, these factors were identified and recorded under the category of 'other' to such an extent that it was appropriate to include them as distinct factors for yes/no response.

In contrast, in respect of this same area of questioning concerned with evidence considered, experience during the pilot study showed that 'uncertainty/benefit of doubt' and 'intuition/feelings about the patient' produced more valid and less ambiguous responses if included in the schedule as distinct yes/no questions in their own right:

Did they admit to be influenced by uncertainty Yes 1 No 0
or benefit of the doubt?

Did they admit to be influenced by their
subjective feelings or intuition about the
patient? Yes 1 No 0

It was appropriate to record other observations in the form of choosing between alternatives, such as:

What was the decision of the tribunal? Not applicable 0
No action 1
Adjourn decision 2

Reclassification	3
Discharge order	4
Other	5

The pilot study was particularly helpful in validating alternative factors and also helping to identify valid variables from which to choose (with some questions originally presented in yes/no form with provision for further details). Such an example was mentioned earlier in this chapter: 'To which category of evidence did the difficulties mainly relate?'

Following the pilot study, a number of questions designed to distinguish the individual responses of the legal, medical, and lay members of the tribunal were excluded. Such observations were not reliable, as it was evident that observable behaviour by one member could sometimes be representative of other members who could concur. There could be no necessity for them to repeat the response. Therefore, responses by any member were recorded but, with one exception, attempts to distinguish the responses of different members were excluded from the observation section of the schedule. The one exception was the group of questions concerned with the factors of evidence which appeared more influential with the tribunal as a whole and specific members. The discussion and observable interaction between the members did appear to allow for valid observations of distinct responses.

The 'observation' section of the research schedule used in the main research study included 90 questions with answers coded in 78 columns (card one).

Section Two: Details of subject from examination of records

Socio-demographic details of the patient being seen at each of the 150 tribunal hearings were obtained from official documents contained within the hospital case record on that patient. It was possible to cross-check the information from different independent sources in order to ensure a high level of accuracy. The information was required primarily to achieve Aim 7 of examining basic socio-demographic features of the patient and the tribunal to see if they were related to the decisions reached by the tribunal.

Details were recorded on the following features:

- (1) Regional health authority from which patient originated
- (2) Date of birth and age of patient
- (3) Sex of the subject
- (4) Marital status of the subject
- (5) Legal classification under the Mental Health Act 1959
- (6) Order under which subject detained
- (7) Criminal offences(if any) which led to current detention
- (8) Source of admission if not from court
- (9) Behaviour which led to detention, if not criminal offence
- (10) Victims of offence or misbehaviour
- (11) Number of years in Rampton Hospital
- (12) Number of years in previous hospitals for mentally disordered
- (13) Previous convictions
- (14) Previous sentences
- (15) Whether in residential care as a child

- (16) Whether received residential special schooling, and
- (17) Who made the application or reference to the tribunal?

In addition, subsequent examination of records was used as a means of confirming the decision reached or advice given by the tribunal, particularly where it had not been possible to observe the tribunal hearing.

None of the questions were excluded from this section of the schedule as a result of the pilot study. Some were refined and improved. For instance, the responses to the questions in respect of current and previous offences and previous sentences were originally more open ended; whereas experience showed the reliability of the specified alternative responses included in the schedule for the main study.

"Had the subject been convicted of offences previously?"

Yes	0	No	1
If so, what were they?			
(code to be added later)			

became:

"Of what offences had the subject been previously convicted? (indicate most serious)	No previous convictions	0
Fuller details	Petty theft/larceny only	1
.....	Serious property(robbery)	2
.....	Indecent assault	3
.....	Rape	4
.....	Criminal damage only	5
.....	Arson	6
.....	Violence against person	7
.....	Manslaughter/murder	8
.....	Other(specify)	9

This illustrates how the pilot study also provided the opportunity to improve the wording of questions in order to minimise ambiguity.

Two further questions were added as a result of the pilot study. Originally there was only one question, 'Is the subject known to have been in child care?'. Examination of the records during the pilot study in regard to this question demonstrated the advantage of adding a further supplementary and distinct question: 'Is the subject known to have received residential special schooling?', with the original question being retained but revised to ask about 'residential child care (away from home)?'.

The second question added to this section of the schedule for the main study was transferred from the 'observation of tribunal hearing' section: 'Who made the application or requested the reference to the tribunal?' Often the initiator of the review was not clear from observation, and so it was decided to obtain the information by a different method.

Very early during the main study, before ten hearings had been sampled, a further item of information was made a standardised item on the schedule. The researcher took note of the stage the patient has reached in their progress through the hospital system as some evidence of the opinion of the hospital team about the patient's progress. This involved noting, as a supplementary to the question: 'For how many years has the subject been in Rampton?', whether the patient was on the 'admission', 'secure

block', 'villa', or 'pre-discharge' ward. This provided another feature which could have been relevant influence on the decision or advice of the tribunal.

The 'examination of records' section of the research schedule used in the main research study included 17 questions with answers coded in 17 columns(part of card two).

Section three: Interviewing of legal chairman

There were five main types of question contained within the interview schedule, used as appropriate mainly to contribute to achieving the first six aims of the research:

- (a) Some questions were of a straight-forward yes/no form, often with the opportunity for 'no comment'.

For example:	Was there any doubt expressed about the	No	0
	legal classification of the patient?	Yes	1
		Not clear	2

- (b) Other questions provided for the chairmen to grade their responses:

For example:	Were you at all influenced by your	Definitely	0
	subjective feelings or intuition	Only moderately	1
	about the patient?	Not at all	2
		Could not answer	3
	Did you experience any difficulty	Serious difficulty	
	in obtaining the evidence you	Moderate difficulty	
	required to reach your decision?	Minimal difficulty	
		None at all	

(c) There were questions which required the chairmen to choose from a range of alternative responses. The pilot study demonstrated that this approach was a reliable and valid alternative to simply leaving the questions for open-ended responses. In each case, there was provision for the chairmen to choose their own 'free' response (normally offered as 'Other(specify)'). There are various illustrations of this type of question in the schedule, such as:

'However you rated the danger, in your opinion what is or was the main risk or danger in regard to this particular patient?'

'Who did you see as most likely to be at risk from the person before you?'

(d) There were two types of questions which did allow for open-ended responses. The first of these types were supplementary to any of the above types of questions, providing for further details in regard to a specific aspect or item of study.

For example: 'If so, could you give more details.....
of the disagreement?'

and: 'Could you say any more about this?'

and: 'Could you describe the difficulty?'

Whilst it was unlikely these questions would provide data which could be aggregated and cross-tabulated with other factors, they were designed to draw out further details and comments to

assist and contribute to the analysis of aggregated data.

(e) The further questions were provided at the end of each group of questions concerned with the specific aims of research, allowing the chairmen the opportunity to supplement or elaborate on their responses to that area of questioning.

For example: 'Would you like to make any further comments on how you saw the danger in this case?'

'Would you like to make any further comments about the evidence you took into account in making your decision?'

'Have you any further comments in regard to difficulties in obtaining the necessary information?'

Ambiguities in specific questions

There were a number of instances when the pilot study demonstrated the ambiguity of questions and provided the opportunity to improve the question so as to minimise the ambiguity.

(a) The original question could have been ambiguous in terms of whose view was being solicited from the chairman. For instance, the original question 'What did you see as the main risk?' could have confused the chairman, resulting in either or both an unreliable group of responses (as some chairman simply gave their own view, whilst others might seek to give a consensus view of the tribunal) and/or the distraction of the chairman needing to seek clarification on exactly who was meant by 'you'. This and other similar questions were carefully reworded to make it unambiguously clear that it was the chairman's own view which was being sought. 'In your opinion what is or was the one main risk or danger.....?' Supplementary questions about areas of

disagreement between members were used to gain information in regard to varying views.

(b) Another area of original ambiguity was in regard to what was meant by 'detention'; for example, in the question:

'In deciding whether or not this patient should continue to be detained.....?'

There was sometimes confusion as to whether 'detained'

included a move to another hospital or return to prison.

Therefore in each such question, it was emphasised that

it was 'detention in Rampton' which was being questioned.

For example:

'In deciding whether or not this patient should continue to be detained in Rampton.....?'

'Was there any serious doubt in your mind about whether or not this patient should be released from Rampton?'

'Could you say whether you gave any 'benefit of the doubt' in favour or against leaving Rampton'

One question which was to be crucial in the analysis of data was originally worded:

'Was your decision or advice in favour of release or continued detention?'

In the schedule for the main study, this question was:

'Was your decision or advice in favour of release from Rampton?'

(c) There was sometimes a tendency for chairmen to generalise in their responses to other cases or a general view; therefore some questions were carefully reworded to make it clear they referred to the particular rather than the general. This was emphasised in a number of questions through such wording as 'this particular patient', 'the person before you'

and 'the person you have just seen'.

There had been some tendency in the pilot study for chairmen to generalise in their response to the question:

'Did you experience any difficulty.....in relation to the powers of the tribunal?'

Therefore the question in the schedule for the main study added the emphasis: 'in this case?'

(d) Other examples of ambiguity were where the whole question appeared unclear in meaning to the interviewees, as opposed to the wording being open to different interpretations.

The main example of this difficulty was the question originally worded:

'Were you at all influenced by feelings and intuition about the patient?'

To an extent which surprised the researcher, chairmen were bewildered by this question. Practice showed that the relatively simple rewording to:

'Were you at all influenced by your subjective feelings or intuition about the patient?' resulted in what appeared to be ready and clear understanding and response.

Questions excluded from the interview section of the main study.

The pilot study demonstrated the unreliability of questions concerned with the responses of other members of the tribunal. For example, the question in regard to how the legal chairman viewed the main danger or risk, was originally supplemented with questions in regard to other members:

'Did the medical member appear to take the same view?'

'If no, how did they appear to see the risk of danger?'

Often the chairman was uncertain about the answers to these questions or embarrassed to be asked to respond for another colleague. When they did answer, the researcher was sufficiently doubtful about the reliability to decide to exclude these questions from the study. Such questions were retained only when the chairman appeared to be able to respond reasonably reliably from observation; the questions about whether the other members 'had any serious doubt about the right course of action' and had 'a greater influence than the other members'.

Where these questions were retained the interviewee was allowed the response 'could not say'. Where the question clearly required a judgement rather than a response more from observation, it was excluded.

For example: 'Would you say that any other member was influenced by their feelings or intuition about the patient?'

This question was excluded.

To provide for some further indication of any views contrary to the chairman, rather than asking directly about the views of other members, questions about disagreement were added as supplementary enquiries.

For example: 'Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to.....?'

Questions added to the interview section of the main study.

These have already been indicated. They related mainly to Aim 5 of examining disagreements between the members of the tribunal; and to the extent 'doubt' was a factor influencing the decisions of tribunal members generally or specifically (Aim 3 in regard to difficulties obtaining evidence).

For example: 'Would you have said the medical member had any serious doubt about the right course of action?'

In addition to the above developments to the interview schedule before it was applied in the main study, there were other examples of where the experience of the pilot study suggested means of improving the content and reliability of data collected through this method, through extending the range of alternative responses offered. For example, it was found helpful and valid to extend the responses to the question:

'Did you experience any difficulty in obtaining the evidence you required to reach your decision?' from a straightforward yes/no type response to one which allowed the chairman to grade the difficulty.

The 'interviewing of legal chairman' section of the research schedule used in the main research study included 64 questions with answers coded in 47 columns(part of card two).

Summary

The three sections of the research schedule applied in the

main research study contained a total of 171 research questions, with responses coded in 141 columns (two cards) and 29 questions requiring open-ended responses to supplement the information and analysis.

The questions were grouped in the three sections of the schedule in relation to the seven aims of the research. In regard to the examination of records and interviewing of the chairman, the responses were recorded on the schedule in that same grouping order; whereas observations of the hearing were initially recorded as the observations occurred and subsequently transcribed to the schedule.

The detailed items of the research schedule were thoroughly tested through a pilot study of twelve hearings and necessary revisions made before being applied in the main research project of 150 hearings.

CHAPTER EIGHT

VALIDITY AND RELIABILITY OF RESEARCH METHODS

INTRODUCTION

A starting point for discussing the validity and reliability of the research methods adopted during this particular research project could be the view taken by M.Shipman, 1972,⁽¹⁾ that it was necessary to be cautious about results produced by a researcher working alone.

The dangers associated with research by a single researcher relate to the greater dependency on the integrity of the individual without the controls and safeguards inherent in working as a member of a team or in co-operation with others. Personal bias could become a stronger influence than would be realised in working with other colleagues. Also, there is greater opportunity for the researcher to retrospectively falsify the description of the methodology or even the findings themselves. In the absence of colleagues and external controls, there has to be a greater reliance on the self-discipline of the researcher to maintain a standardisation of approach.

It is necessary to be aware of these dangers and to allow for them in devising or assessing any research project and findings by a single researcher. Yet the 'caution' required in regard to a single researcher could be only a matter of degree different from that appropriate to assessing the credibility of

(1) M.Shipman(1972) 'Limitations of Social Research' Longman(London)

results produced by a research team. If the researcher is actively conscious of the question of his credibility and the need to incorporate safeguards, a single researcher could maintain a consistency and integrity of approach sometimes more difficult to maintain with a group of researchers working together.

In respect of this particular research project, the researcher was aware of the need for caution on his part and by those assessing the credibility of findings. This was reflected in the detail with which the general approach to the research project and the various methods have been described. The detailed descriptions were provided both as evidence of the care taken and to facilitate replication. The same care and concern was shown in the development of the research questions and the design of the research schedule, which have been described in some detail.

The main safeguards in respect of this particular research project were the detailed care taken in devising the empirical approach, the application of various complimentary research methods as collateral and for the purposes of comparison, and the requirement to co-operate with quite a number of different parties to the situation. Although they should not be held accountable to any extent for the methods and findings of the research, various other people were associated with the research in different capacities. These included the tutor and other staff at the University, the tribunal and DHSS officials and hospital staff with whom the research project was negotiated and upon whose continued co-operation the research was dependent, and

the many parties to the hearings of the tribunal. The need for on-going co-operation and liaison with these external influences built into the research a degree of control to support continuity and constancy on the part of the researcher.

Methods of data collection

The following table presents nine possible types of data collection in terms of three sorts of settings and three sorts of acts or responses:

MAIN FORMS OF DATA COLLECTION⁽²⁾

RESPONSES			
STIMULI	NON-VERBAL ACTS	ORAL VERBAL ACTS	WRITTEN VERBAL ACTS
Informal settings (Participant observation)		Conversations, use of informants	Letters, articles, biographies
Formal settings, unstructured	Systematic observation	Interviews, open-ended	Questionnaire, open-ended
Formal settings, structured	Experimental techniques	Interviews, precoded	Questionnaire, structured

(Source: J. Galtung 'Theory and Methods of Social Research' (1967) page 110)

Galtung described research 'settings' in terms of whether stimuli and responses were unsystematic and systematic. The setting was 'informal' when both stimuli (in that stimuli were not kept constant

(2) J.Galtung (1967) 'Theory and Methods of Social Research' Allen and Unwin (in co-operation with Norwegian Universities)

nor presented systematically) and responses (in that responses were not recorded on a predetermined set of response-categories) were unsystematic. In contrast a 'formal structured' setting was where both stimuli and responses were systematic; in that the situation was controlled by the researcher to present stimuli systematically and response categories are kept constant rather than allowing for individual variation.

The settings from which data was collected for this particular research project contained elements of informal and formal, structured and unstructured. The situation of the tribunal hearing was informal and 'natural' in that it was neither shaped or constructed by the researcher. Yet the tribunal system was sufficiently formalised for its own purposes to provide the setting for formal and structured research. The setting was informal when both stimuli and responses were unsystematic and the researcher involved in a form of participant observation; such as when recording open-ended supplementary comments about the situation and aspects of the decision process. Yet, to the extent the activities of the tribunal were organised predictably and their procedures and criteria prescribed, observation could be mainly systematic.

The research methods adopted for this research project could be summarised in terms of Galtung's nine types of data collection.

1. 'Observation of the tribunal hearing' could be defined to include:
 - (a) Systematic observation of primarily verbal acts,

(b) Participant observation(particularly during the pilot study),
and (c) Conversations(only during preparatory involvement).

2. 'Interviewing of the legal chairman' could be defined to
include:

(d) Precoded interviews as the primary method,
and (e) supplemented by open-ended interviews and conversations
(particularly during pilot study).

3. 'Details of subject from examination of records' could be
defined to include:

(f) Examination of written records,
and (g) Questionnaire, structured and completed by the researcher.

Therefore the three methods of research adopted for this
research project incorporated to some extent most of the
types of data collection identified by Galtung, with the
exception of:

(h) Witten questionnaires for respondents(open-ended or
structured),
and (i) Experimental techniques.

Observation of tribunal hearing

Within the 'informal setting' of the tribunal hearing where
the researcher was unable to shape the situation through the control
of variables, a 'participant observation' method of data collection
was being applied. Yet, through the systematic recording of
observations into predetermined sets of prescribed categories,
the researcher was establishing an example of Galtung's 'structured
setting' and limiting 'participant observation' to a secondary method
to supplement 'systematic observation'. This also illustrated that

Galtung's scheme was concerned with generalities and not intended to be applied as inflexible classifications.

In deciding to concentrate on systematic observation of 'verbal acts', it was helpful to consider the relative benefits and disadvantages of participant observation of non-verbal behaviour as well as verbal acts. Participant observation was a means of watching or taking part in behaviour as it happened. This enabled observation of acts which could have been difficult for the participants to explain in words or could have been overlooked altogether. The continuity between different aspects of the situation and the inter-action between the various parties could be more easily acknowledged through participant observation in contrast with less direct or more selective study. It would be argued that observed behaviour is more 'real' and less open to deception than verbal expressions.

It was decided to gain the benefit of direct 'participant' observation without seeking to record in any detail the wider 'non-verbal' behaviour. In fact, non-verbal behaviour could be equally if not more open to the wrong interpretation and could even be deliberately misleading.⁽³⁾ There would be many problems involved in attempting to effectively interpret and systematically record and analyse non-verbal acts such as facial expressions and other physical movements. Not least of the problems would be that of distinguishing the relevant from non-relevant. Also participant observation of wider

(3) Galtung poses and discusses the question 'Can a person lie with acts?' (J.Galtung 1967, page 113)

non-verbal behaviour would have been substantially more expensive in terms of time and recording and storing and analysing data. Therefore, it was decided that, although non-verbal acts and evidence could be as consequential as verbal acts, systematic observation and a degree of more open-ended participant observation would concentrate on verbally expressed responses and evidence. Whilst it was inevitable that to some extent the researcher would be influenced in his observations by the non-verbal behaviour of parties and the tribunal as a whole, he would not normally attempt to monitor and record non-verbal behaviour.

Relative advantages of observation and verbal interviews.

The advantages and disadvantages of 'non-verbal' observation and verbal interviews were considered in prepared the research project. Observation had the advantage of collecting a 'wider' range of data including responses which could be withheld deliberately from an interviewer. The verbal interview approach had the advantage of being more specific in its stimuli and recording of responses and also of minimising the ambiguity more inherent in observed behaviour. Observation was more 'natural' and responses likely to be more 'real'; yet again there would be the problem of interpretation. Although less comprehensive, verbal interviews were likely to be more cost-effective in terms of producing a larger quality of clear data from each 'subject'. The specificity of verbal categories contributed to the reliability of a research method and facilitated replication. The reliability of 'non-verbal' techniques would be more difficult to achieve, although

possible through a sufficiently formal and structured setting and data collection. Verbal interviews provided more opportunity for deception but, in addition to the problem of interpretation, non-verbal information would require translation into 'verbal' for the purposes of analysis and communication.

It was decided to seek to pool the advantages of both approaches of observation and interview. Although observation was used during the preparation and pilot study as a means of exploration upon which to build the methodology of the main research project, the two approaches were mainly collateral and used for replication purposes rather than one being used to build upon the other. It was aimed to gain the advantages of a 'verbal' approach even with the observation, in that the predetermined sets of responses were defined in 'verbal' terms. An example was the observation research question: 'Did the tribunal members refer to the risk associated with the person before them in the following terms:.....?' This could have been seen as a 'non-verbal observation' approach to recording 'verbal' behaviour, in that the observed speakers were not responding to verbal stimuli presented by the researcher. They were participating in the verbal communication inherent in a 'committee' decision-process.

Relative advantages of oral and written verbal responses

In deciding to concentrate on verbal interviews to compliment the 'verbal' data collected through systematic observation, the advantages and disadvantages of interview schedules and written

questionnaires were considered. Although members of the tribunal were likely to have an above average standard of literacy and 'training' in completing forms, written questionnaires could still have resulted in a varied response from respondents. Although written questions could have been seen as a more standardised presentation of stimuli, in fact they would have been inflexible to individual variations in respondents and their circumstances. Sometimes there could have been only a 'face-value' standardisation, in that the same written question could have a different effect on different respondents. An interview could ensure a response and seek to avoid misunderstanding and ambiguity. The interviewer would be able to adjust the timing with which questions were presented to different respondents to ensure a 'standardised' response. The presence of the interviewer could avoid the excessive abuse in terms of varied circumstances and extraneous variables which could apply with written questionnaires. Yet with interviews, the interviewer effect would need to be counter-acted. In this respect, a single researcher had the advantage of the constancy more easily achieved with one researcher and a practiced standardised presentation. Neither method was 'natural', yet interviews could have been experienced as more reminiscent of a normal life activity, conversation.

Although interviews were selected as the preferred method of data collection, the advantages of questionnaires were considered. In contrast with an interview where questions were presented 'in time', a written questionnaire was presented 'in space'. The

respondent, was more able to take account of subsequent questions which could change their frame of reference. Written questionnaires were relatively inexpensive, particularly in terms of time and administration. They could more easily be presented simultaneously (e.g. by post) to all respondents. The respondent knew better what he wanted to answer and was able to record it for himself with the visual check provided by a manual operation.

It was decided to seek to incorporate the advantages of the questionnaire into the interview method through the use of a structured and standardised interview schedule. This would help to counteract the interviewer effect. The presentation of answer alternatives was some substitute for the visual check provided with written questionnaires. Presenting the questions 'in time' and so obtaining a response before the next stimulus was presented was not seen as a disadvantage. Not being able to present the 'questionnaire' to all respondents simultaneously was irrelevant to this research project when the aim was to interview at a standardised time in relation to corresponding hearings (i.e. as soon as possible afterwards).

Advantages and disadvantages of the 'closed question'

It was decided to seek the benefits of systematic and structured responses in respect of all three research methods; observation, interview, and examination of records. In deciding this approach, the disadvantages of the 'closed question' were considered. A 'closed question' was where predetermined alternative responses were presented to the respondent or applied by the

researcher. This was in contrast with an open-ended question which left the respondent or researcher to choose his own frame of reference or record verbatim responses. The advantages were that 'closed questions' facilitated comparability and ensured standardisation; but what were the disadvantages?

Pre-coded categories of responses restricted the freedom of the respondent and discouraged the 'unexpected' response which could have given significant insight. Unstructured interviews could appear more natural and less inhibiting to the respondent. Rather than clarify and standardise responses, inappropriate pre-coded responses could create misunderstanding and ambiguity. Structured responses could sometimes provide a quasi-validity where respondents only appeared to be answering the same question.

In regard to the above dangers, this research project had certain safeguards inherent in the nature of the subject under study. The decision-process about which the tribunal was being observed and questioned was formally prescribed; so that pre-determined categories of responses often reflected prescribed choices. Similarly, other questions related to matters where the alternative responses were sufficiently self-evident (such as the question of evidence taken into account) to validly pre-determine responses. This facilitated the use of what could be called the 'open question, closed answer' approach in regard to many questions. Categories of responses were pre-coded but not presented to the respondent. This provided the advantages of structuring without actually structuring the mind of the respondent.

It was illustrated in the chapter on 'The research schedule' the extent to which the pilot study reinforced the appropriateness and validity of 'closing' many of the questions and answers.

Whilst so much of the subject under study did lend itself to structured questioning, it was attempted also to incorporate some benefits of more 'open' questions and answers. This was achieved mainly in three ways:

- (a) Flexibility was built into most of the predetermined categories of responses by including categories such as 'other' to attract the unexpected response and/or allow a degree of freedom to the respondent,
- (b) Supplementary open-ended questions followed many of the closed questions (for example: 'Could you give more details of the disagreement?' 'Why was that?' and 'Could you describe the difficulty'),
- (c) The opportunity was presented to make 'any further comments' in regard to each area of questioning and about the hearing as a whole.

Reliability and validity

Although the research methodology incorporated a degree of 'participant observation' and 'open-ended questioning', the research project would accommodate replication and comparison. The standardised elements of the various research methods are contained within the research schedule which is printed at the back of this volume. This would facilitate replication, and the quantified findings are available for comparison.

Galtung⁽⁴⁾ suggested that the problem of validity was 'to a considerable extent a philosophical problem, not simply a question of measurement'. Various questions could arise from this view-point in regard to this particular research project. To what extent could we infer from observed 'verbal' expressions the 'true' position of the tribunal and its members in regard to any particular aspect under study? To what extent can we infer from the chairmen's verbal responses what they actually think? To what extent can we infer from what a person says how he would behave? Galtung⁽⁵⁾ summarised his response to the problem of validity in these terms: 'What can be explained and predicted from data collected is the important thing, not how much 'consistency' there is between forms of data-collection with perhaps no theoretical reason for consistency at all between them'. He was questioning the assumption that there should be an unambiguous relationship between thoughts, expressions, and behaviour.

Each method of data collection could be seen to be concerned with its own dimension of evidence in its own right. The 'validity' of observed data would come, not from its evidence of some latent 'truth', but from correlation with other variables and data. There is no absolute answer to the question of whether the verbal responses given by an interviewee truly reflects what is in his mind. While it is desirable to reduce any discrepancy between expressions and thought, for the two to correspond is not necessarily an essential concern to the researcher. This was illustrated with this research project, where the 'committee' decision-

(4) J.Galtung. 1967. page.124

(5) J.Galtung. 1967. page 130

process under study was a verbal process (whilst obviously influenced by latent thought and other processes) and to a large extent the concern was with how the decision-makers justified verbally their decisions. At the same time, aspects of the interview approach helped to militate against any serious discrepancy between expression and thought. The 'master-servant' phenomena was not present in the interview situation, in that there was no reason to suppose that any relative difference in perceived social status would influence the interviewees into giving answers they might consider the researcher would want to hear. The structure and flow of the interview helped to avoid the opportunity for any systematic distortion. But perhaps primarily the protection was in the fact that there appeared to be little if any great reason to deliberately deceive and the research interest was as much if not more with what the tribunal members had to 'say' rather than some deep inner motivations.

The relationship between words and behaviour could illustrate what Galtung meant by referring to the problem of validity as 'philosophical'. How far should there be consistency between words and deeds? How far are verbal and non-verbal data representing different spheres of behaviour and therefore valid in their own right? Perhaps this was less of a problem with this research project which had excluded observation of wider 'non-verbal' behaviour and concentrated on verbally expressed responses and evidence. Also the chairmen were not being asked to speculate in a generalised way on how they would behave in given circumstances; they were being questioned in regard to a specific hearing in which they had just participated. Therefore the chairmen would be less

likely to idealise their likely behaviour nor generalise inappropriately, and the time-dimension would be less of a distortion.

'If a person describes his own behaviour in specific terms, and the reference is to the present, or very recent past or close future, we should have good reasons to expect consistency'
(Galtung 1967)⁽⁶⁾

(6) J.Galtung. 1967. page 128.

PART THREE

RESEARCH FINDINGS

CHAPTER NINE	Sample group of patients
CHAPTER TEN	Perception of 'dangerous' by mental health review tribunal
CHAPTER ELEVEN	The evidence on which the tribunal based their judgements
CHAPTER TWELVE	Restraints and difficulties in obtaining the evidence
CHAPTER THIRTEEN	Anomalies and dilemmas arising from their rules and powers
CHAPTER FOURTEEN	Disagreements between the members
CHAPTER FIFTEEN	Tribunal decisions and innovations
CHAPTER SIXTEEN	Influence of socio-demographic facts
CHAPTER SEVENTEEN	Were the objective 'facts of the case' the only significant variables?

CHAPTER NINE

SAMPLE GROUP OF PATIENTS

This is a description of the patients who were seen by the mental health review tribunal during the 150 hearings which were the subject of this research project. Some of the socio-demographic features of the sample group of patients are compared with those of the population the sample group was designed to represent.

Applications and references to the tribunal

Commencing in September 1977, 150 hearings were observed, selected as described in the chapter 'General approach to the research project'. This obtained a sample group of patients and hearings in respect of 72 applications and 78 references for advice. Table 1 illustrated how the balance of applications and references compared with the total numbers over a longer period.

Table 1 Applications and references

	<u>Total over four years 1976-1979⁽¹⁾</u>		<u>Sample group of patients</u>	
Applications	445	41.9%	72	48.0%
References	617	58.1%	78	52.0%
	1062	100.0%	150	100.0%

$(X_2(1D.F)=1.05 p < 0.50)$

There did not seem to be any significant difference between the

(1) Information obtained from Mental Health Review Tribunal for the Trent Regional Health Authority area(unpublished)

ratio of applications and references in respect of the total and sample groups. This was even more apparent when account was taken of the number of hearings as opposed to the number of applications and references considered during those hearings. One application or reference might involve more than one hearing when the tribunal could decide to adjourn the original hearing for further investigation before reaching a conclusion. During the four year period, a total of 1251 hearings were concerned in considering the 1061 applications and references.

Table 2 Tribunal hearings

	<u>Total over four years 1976-1979⁽²⁾</u>				<u>Sample group of patients</u>			
	<u>Men</u>	<u>Women</u>	<u>Total</u>		<u>Men</u>	<u>Women</u>	<u>Total</u>	
Applications	409	197	606	48.4%	49	23	72	48.0%
References	584	61	645	51.6%	69	9	78	52.0%
	<u>993</u>	<u>258</u>	<u>1251</u>	<u>100.0%</u>	<u>118</u>	<u>32</u>	<u>150</u>	<u>100.0%</u>

It was evident that the sample group of patients and hearings was adequately representative in terms of the balance of applications and references. This applied both in regard to the total groups and when distinguishing between men and women. There was no significant difference in the proportion of women in the total and sample groups (total over four years 20.62%; sample group of patients 21.33%).

(2) Information from DHSS records(unpublished)

Table 2a Total over four years 1976-1979 Sample group of patients

	<u>Women</u>		<u>Women</u>	
Applications	197	76.36%	23	71.87%
References	61	23.64%	9	28.13%
	258	100.00%	32	100.00%

Legal classifications under the Mental Health Act 1959

Table 3 Legal classifications

	<u>Sample group of patients</u>				<u>Total patient population</u> ⁽³⁾			
	<u>Men</u>	<u>Women</u>	<u>Total</u>		<u>Men</u>	<u>Women</u>	<u>Total</u>	
Mental Illness	34	10	44	29.3%	224	49	273	30.9%
Psychopathic Disorder	42	7	49	32.7%	201	34	235	26.6%
Subnormality	28	7	35	23.3%	161	23	184	20.9%
Severe Subnormality	14	8	22	14.7%	88	103	191	21.6%
	118	32	150	100.0%	674	209	883	100.0%

In considering whether there was any significant difference between the legal classifications of the sample group of patients and the total patient population at Rampton, the null hypothesis was not rejected (X_2^2 (3 D.F) = 5.32 $p < 0.20$). At the same time, there could appear to have been some slight tendency, in contrast with the total patient population, for the sample group seen by the tribunal

(3) Patient population in Rampton as at 31.12.78. Information obtained from DHSS records (unpublished)

to include proportionally less patients classified as severely subnormal. This was clearly significant with the women where 49.3% (103 individuals) of the total number of women patients were classified as severe subnormality compared to only 25% (8 individuals) of the women among the sample group. (χ^2 (1D.F) = 5.57p < 0.02) ^(corrected for continuity) It would be reasonable to assume that the reasons why proportionally less of the severely mentally handicapped applied or were referred to the mental health review tribunal included factors related to their limited social ability to take the initiative themselves and greater dependence on others to act for them. Of the 150 hearings, 147 were on the initiative of the patients themselves and only 3 as a result of an application by the nearest relative.

Over a three year period ending 31st December, 1979, 294 men and 92 women left Rampton Hospital, of whom 53 men (18.03%) and 26 women (28.26%) were discharged as a result of applying successfully to the mental health review tribunal.⁽⁴⁾ Therefore, application to the tribunal was one important avenue for leaving custodial psychiatric care which was proportionally less relevant to the more severely mentally handicapped. It will be seen later that proportionally less of the 'severe subnormality' group within the sample of patients were successful in their applications (although the difference was not statistically significant - p < 0.05).

(4) Information obtained from DHSS records (unpublished)

Sex of the patients

Table 4 Sex of the patients

	<u>Sample group of patients</u>		<u>Total patient population</u> (5)	
Men	118	78.67%	674	76.33%
Women	32	21.33%	209	23.67%
	<u>150</u>	<u>100.00%</u>	<u>883</u>	<u>100.00%</u>

$(X_2 (1D.F) = 0.75 \quad p < 0.50$ no significant difference)

Home areas of the patients

Table 5 Regional Health Authorities

	<u>Sample group of patients</u>		<u>Total patient population</u> (5)	
Northern	7	4.6%	53	6.0%
Yorkshire	19	12.7%	76	9.0%
Trent	22	14.7%	131	15.0%
East Anglia	5	3.3%	21	2.0%
North West Thames	5	3.3%	55	6.0%
North East Thames	12	8.0%	73	8.5%
South East Thames	9	6.0%	64	7.0%
South West Thames	4	2.7%	33	4.0%
Wessex	9	6.0%	43	5.0%
Oxford	7	4.6%	43	5.0%
South Western	12	8.0%	72	8.5%
West Midlands	19	12.7%	130	15.0%
Mersey	4	2.7%	11	1.0%
North Western	4	2.7%	34	3.0%
Wales	11	7.3%	43	5.0%
Other	1	0.7%	9	
	<u>150</u>	<u>100.0%</u>	<u>883</u>	<u>100.0%</u>

(Spearman rank order correlation coefficient 0.9110 $p < 0.001$)

Both the sex and home areas of the sample group of patients closely reflect those of the total patient population.

Offender and non-offender status

Whilst all patients in special hospitals were compulsorily detained, not all were offenders. Of the sample group of

(5) Population in Rampton 31.12.78. Information from DHSS records (unpublished)

patients, 27 men and 19 women had been transferred from National Health Service psychiatric hospitals and 2 men and 2 women had been admitted directly from the community. 42 of these patients were non-offenders and detained under civil treatment orders. Table 6 compared the sample group of patients with the total patient population in terms of whether they are offenders or non-offenders, restricted (requiring the consent of the Home Secretary for release) or unrestricted (with the responsible medical officer having the authority to discharge). There appeared to be a slight tendency towards offenders among the women in the sample group (although $p > 0.05$ $X_2(1D.F) = 3.36$) in comparison with the women in the total population of patients. This could be related to the finding that proportionally less of the severely subnormal women appeared to be seeing the tribunal.

Table 6 Nature of detention

	<u>Sample group of patients</u>				<u>Total patient population</u> (6)			
	<u>Men</u>	<u>Women</u>	<u>Total</u>		<u>Men</u>	<u>Women</u>	<u>Total</u>	
Non-offenders (unrestricted)	23	19	42	28.0%	155	156	311	35.2%
Offenders (unrestricted)	26	4	30	20.0%	109	16	125	14.2%
Offenders (restricted)	69	9	78	52.0%	410	37	447	50.6%
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	118	32	150	100.0%	674	209	883	100.0%
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>

$(X_2(2D.F) = 4.41 \quad p < 0.30$ no significant difference)

(6) Population in Rampton 31.12.78. Information from DHSS records (unpublished)

Again the sample group of patients appeared to represent adequately the total group of patients at Rampton Hospital, in that with the possible exception of the slight tendency identified above, the nature of their detention reflected that of the total patient population. This same general finding with the same possible qualification in regard to the more severely mentally handicapped was confirmed in Table 6a which gave more detail of the actual detention orders.

Table 6a Orders under which patients detained

	<u>Sample group of patients</u>		<u>Total patient population</u> (7)	
Section 26 (treatment order)	30	20.0%	220	24.9%
Section 60 (court order)	19	16.4%	94	10.6%
Section 60/65 (restriction)	69	46.0%	357	40.5%
Section 72 (and 72/65) (prison transfer)	16	10.7%	60	6.8%
Other	16	10.7%	152	17.2%
	<hr/>		<hr/>	
	150	100.0%	883	100.0%
	<hr/>		<hr/>	

$(X_2(4D.F) = 8.67 \quad p > 0.05 \text{ no significant difference})$

In Table 6a, there was demonstrated further the possible slight tendency among the sample group of patients toward offenders and against the more mentally handicapped non-offenders. This was

(7) Population in Rampton 31.12.78. Information from DHSS records (unpublished)

shown more clearly in Table 6b which contrasted the offender categories (sections 60, 72, and 65) with Sections 26 and the 'other' category. Within 'other' were mainly those patients detained under the 6th Schedule of the Mental Health Act 1959. These patients were those who were already detained at the time the Mental Health Act was being implemented and their detention was renewed under the special provisions of the 6th Schedule of the Act. As a very general guide-line, they had most in common with patients detained under section 26, in that they were mainly non-offenders and likely to be more socially handicapped. Even though the patients detained under the 6th Schedule at the time of this research project had not necessarily been in Rampton Hospital since 1960 when the Mental Health Act was implemented, they had by definition been in long-term hospital care and therefore were likely to be socially inadequate and more dependent on others to take initiative for them. In addition to their own inadequacies, as long-stay hospital patients they were likely to have lost contact with relatives and friends outside the hospital.

Table 6b Orders under which patients detained.

	<u>Sample group of patients</u>		<u>Total patient population</u>	
Section 60 and 72	104	69.3%	511	57.9%
Section 60/65 and 72/65				
Section 26	46	30.7%	372	42.1%
Other				
	<u>150</u>	<u>100.0%</u>	<u>883</u>	<u>100.0%</u>

(χ^2 (1D.F) = 7.28 $p < 0.01$ highly significant difference)

Comparison with patient populations

It would appear that the sample group of patients was representative of the men and women applying or being referred to the mental health review tribunal considering applications and references at Rampton Hospital. Allied to this, the sample group of hearings at which the applications and references of these patients were considered was representative of the tribunal hearings taking place at Rampton Hospital.

The sample group of patients was representative of the patient population at Rampton Hospital in terms of their sex and home areas, legal classifications, and detention orders. One identified difference (particularly with the women) was that the more severely mentally handicapped non-offenders appeared to be proportionally less represented among the patients being considered by the tribunal. It was suggested that this difference was not a bias in the sample but characteristic of the access to the mental health review tribunal on the part of patients classified 'severe subnormality' or otherwise more severely handicapped.

Other socio-demographic features of the sample group of patients are described below with less comparison with the patient populations and total hearings they represent. The above comparison would appear to support the assumption that these further socio-demographic features and the findings of this research project could be taken as representative of the patients being considered by the tribunal at Rampton Hospital and the decision-making process of the

mental health review tribunal. As already indicated, it could not be assumed that the features of the sample group were necessarily representative of the total patient group in the hospital; in so far as the longer-stay and more socially disabled patients were less likely to be seeing the tribunal.

Age of the patients in the sample group

The ages of the sample group relative to the total patient population could be one of the factors affected by the evidence that longer-stay and more socially handicapped patients were less represented among the patients applying or being referred to the tribunal. The longer-stay patients and those more severely mentally handicapped were likely to be older relative to the categories of patients more adequately represented in the sample group. A high proportion of the 'severely subnormal' patients remaining in special hospitals were admitted before stricter admission criteria had been applied in recent years and often remained because of their need for long-term residential care and the absence of alternative accommodation. In addition to these influences on the ages of the patients in the sample group relative to the total population, another factor would have tended to make the sample group relatively younger. It was in the nature of the rights of patients detained under the Mental Health Act 1959 that they had more frequent access to the mental health review tribunal in the first year or two of the

order detaining them.⁽⁸⁾ This factor could have contributed to a higher proportion of the patients in the sample group being within the first two years of their order and therefore relatively younger than the total group of patients.

Table 7 described the ages of the patient in the sample group. It will be seen that a higher proportion of men and women were in the age range 30 to 39 years, with very few under twenty-one years of age and none of the sample group over sixty years.

Table 7 Age of the patients in the sample group

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Under eighteen years	0	0.0%	1	3.1%	1	0.7%
Eighteen-twenty years	5	4.2%	0	0.0%	5	3.3%
Twentyone-twenty four	26	22.0%	5	15.6%	31	20.7%
Twentyfive-twenty nine	23	19.5%	8	25.0%	31	20.7%
Thirty-thirty nine	36	30.5%	14	43.7%	50	33.3%
Forty-forty nine	17	14.5%	2	6.3%	19	12.6%
Fifty-fifty nine	11	9.3%	2	6.3%	13	8.7%
Sixty and over	0	0.0%	0	0.0%	0	0.0%
	118	100.0%	32	100.0%	150	100.0%

(8) Persons detained under section 26 and 60 (and other unrestricted patients) are entitled to apply to the mental health review tribunal during the first six months of their detention and whenever their order is renewed. Initially orders are renewed after twelve and twenty-four months, and subsequently every two years. Similarly patients detained with the additional restriction under section 65 can request their case be referred to the tribunal after twelve months, twenty-four months, and then every two years. Therefore patients are eligible to see the tribunal with a greater frequency during the first two years of their detention.

Although the difference was not statistically different (perhaps partly because the numbers of older patients were so small), comparison with the limited information available on the ages of the total patient population tended to support the speculation that there would be older patients among the total patient group.

Table 7a

Age of the patients

	<u>Sample group of patients</u>			<u>Total patient population</u> ⁽⁹⁾		
	<u>Men</u>	<u>Women</u>	<u>Total</u>	<u>Men</u>	<u>Women</u>	<u>Total</u>
Sixteen to twenty	5	1	6 4.0%	27	4	31 3.7%
21 to 65 years	113	31	144 96.0%	597	191	788 94.4%
Over sixty-five	0	0	0 0.0%	11	5	16 1.9%
	118	32	150 100.0%	635	200	835 100.0%

$(X_2 (2D.F) = 2.93 p < 0.90$ no significant difference)

The mean average of the sample group of patients was about thirty years for both men and women (estimated from above information as 33.12 years for men and 32.31 years for women). The ages of the men would appear to be more varied than those of the women (standard deviation for the men: 10.44; for the women: 8.69)

Marital status of the patients in the sample group

Table 8 illustrated the extent to which the men and women

(9) Patient population at Rampton Hospital 31.12.79. Information contained in answer to parliamentary question 16.1.80. (Hansard)

appearing before the tribunal (and presumably the total group detained in Rampton) have remained unmarried. There was no significant difference between the extent of marriage experience among the men and women, although the small numbers involved (11 men and six women) could have contributed to this statistical finding (χ^2 (1D.F) = 1.44 $p < 0.30$) (corrected for continuity)

Table 8 Marital status of the patients

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Unmarried	107	90.7%	26	81.3%	133	88.7%
Married	0	9.3%	2	18.7%	2	11.3%
Widowed	0		1			
Legally separated	3		2			
Divorced	8		1			
	118	100.0%	32	100.0%	150	100.0%

Offences and behaviour which led to detention

There was a highly significant difference between the proportions of men and women who had been admitted directly from the courts as opposed to transferred from another hospital or whilst already servicing a prison sentence. 77 men (65.25%) and 9 women (28.13%) had been admitted directly from the courts (χ^2 (1D.F) = 14.04 $p < 0.001$). The difference was even more statistically significant when comparing the numbers of men and women who were offenders. Table 6 described how 95 men (80.50%) and 13 women (40.6%) were offender-patients.

Table 9 described the offences of the 86 men and women admitted directly from the courts. Table 9a described the behaviour which led to the transfer to special hospital from such as hospital or prison of the other 64 patients. The information in regard to

offences and behaviour which led to detention in special hospital was aggregated in Table 9b.

In addition to the 86 patients admitted directly from courts, 46 (19 women) were transferred from national health service hospitals, 14 (2 women) were transferred from prison or borstal, and 4 (2 women) admitted directly from the community.

Table 9 Criminal offences of patients admitted from court

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Manslaughter/murder	13	16.9%	0	0.0%	13	15.1%
Violence	15	19.5%	4	44.4%	19	22.1%
Arson	11	14.3%	0	0.0%	11	12.8%
Indecent assault	23	29.8%	0	0.0%	23	26.8%
Rape	4	5.2%	0	0.0%	4	4.6%
Serious property offence	3	3.9%	0	0.0%	3	3.5%
Petty theft	4	5.2%	0	0.0%	4	4.6%
Criminal damage	1	1.3%	3	33.3%	4	4.6%
Other	3	3.9%	2	22.3%	5	5.9%
	<u>77</u>	<u>100.0%</u>	<u>9</u>	<u>100.0%</u>	<u>86</u>	<u>100.0%</u>

The number of women among the group admitted from court was too small to make generalisations. It was evidence that the predominant offences among the men concerned violence, sexual assault, and arson. Both the offences of the women within the miscellaneous 'other' category concerned child-stealing. The 'other' offences of the men concerned attempted murder, indecent exposure, and child-stealing.

Table 9a Behaviour which led to transfer to special hospital

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Violent behaviour	27	65.0%	21	91.3%	48	75.0%
Sexual assault	7	17.0%	0	0.0%	7	10.9%
Endangering behaviour	2	4.9%	2	8.7%	4	6.2%
Fire-raising	2	4.9%	0	0.0%	2	3.1%
Self injury	1	2.4%	0	0.0%	1	1.6%
Absconding	1	2.4%	0	0.0%	1	1.6%
Other	1	2.4%	0	0.0%	1	1.6%
	41	100.0%	23	100.0%	64	100.0%

'Endangering behaviour' included psychotic threats against children and paranoid threats against members of the family. The miscellaneous 'other' reason for transferring one man was to protect him from other prisoners in respect of his sexual assaults against young boys.

As men and women are admitted or transferred to special hospitals for 'treatment under conditions of special security on account of their dangerous, violent or criminal propensities', (10) it would be expected that 'violence' and other forms of assaults and threats would predominate among the offences and behaviour of a group of special hospital patients. This was confirmed in Table 9b which aggregated this information in regard to the sample group of patients.

Table 9b Offences and behaviour which led to special hospital admission

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Murder/manslaughter	13	11.0%	0	0.0%	13	8.7%
Violence	42	35.6%	25	78.1%	67	44.5%
Sexual assault	34	28.8%	0	0.0%	34	22.7%
Arson	13	11.0%	0	0.0%	13	8.7%
Child-stealing	1	0.8%	2	6.3%	3	2.0%
Property offences	7	6.0%	0	0.0%	7	4.7%
Criminal damage	1	0.8%	3	9.3%	4	2.7%
Other	7	6.0%	2	6.3%	9	6.0%
	118	100.0%	32	100.0%	150	100.0%

(10) Section 97, Mental Health Act 1959.

The highly significant difference between men and women in regard to sexual offences was not unexpected in view of the nature of those offences. In contrast, the absence of offences or misbehaviour among the women in regard to arson did lead the researcher to seek to make a comparison with the total group of patients detained at Rampton Hospital. Table 9c could be used for the purpose of general comparison. It should not be related directly to the previous tables in regard to offences and behaviour (tables 9,9a, 9b) as it did not represent a directly comparable group. Table 9c contained details of the offences of all offenders at Rampton Hospital on 31st December,1978, including those transferred from prison (but no details of non-offenders).

Table 9c Offences of total group of offender patients ⁽¹¹⁾

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Manslaughter/murder	74	14.3%	4	7.5%	78	13.6%
Violence	169	32.7%	17	32.1%	186	32.5%
Sexual assault	121	23.3%	0	0.0%	121	21.2%
Arson	67	12.9%	13	24.5%	80	14.0%
Property offences	88	16.8%	19	35.9%	107	18.7%
	<u>519</u>	<u>100.0%</u>	<u>53</u>	<u>100.0%</u>	<u>572</u>	<u>100.0%</u>

Although the information contained in Table 9c did not concern a group directly comparable with the sample group of patients, certain of the information was useful and interesting. Whilst Table 9c confirmed that sexual offences were a 'male' characteristic, it confirmed also that women had been convicted of arson and property offences. This was despite the sample group of patients not

(11) Offenders among the patient population at Rampton Hospital 31.12.78.
Information from DHSS records (unpublished)

containing any women detained because of convictions or concern about arson. With regard to 'property offences' it appeared that part of the explanation was in the definition of 'property offences' in the information obtained from DHSS records. That category appeared to be a miscellaneous category containing all offences not included in the other categories. Therefore the criminal damage and some other offences or behaviour associated with the women in the sample group were to some extent comparable with 'property offences' in the DHSS information. Therefore it was not unreasonable to assume that property offences (in the sense of larceny, robbery etc) was not an important characteristic of the women detained at Rampton Hospital and being seen by the tribunal.

There was no equivalent explanation in regard to the arson offences. The definition of this offence was unlikely to have varied significantly. Yet almost one quarter (24.5%) of the women offenders in the hospital had been convicted of arson; whereas this concern had not applied to any one of the sample group. Chance was the probable explanation of this apparent contradiction. Although almost 25% of the women offenders had been convicted of arson, the number of individuals was only 13 out of 53 offenders and a total of 209 women patients (6.2% of the women population). A statistical comparison between the women offenders among the total population and those among the sample group would not find a statistically significant difference in respect of arson, despite it not appearing at all among the sample group. A comparison between the arsonists among the total population of offenders (13:40 other offences) and those among the sample group offenders (0:11 offenders) found a probability of greater than 0.05 ($\chi^2_{(1D.F)} = 1.98$ $p < 0.20$ no significant difference) (corrected for continuity)

Previous offences and sentences

Table 10 provided information in regard to the most serious criminal offences of which the sample group of patients were convicted before the offences or behaviour which led to their current detention in a special hospital. It demonstrated some parallels with the previous information in regard to current offences. Women were significantly less likely to have been convicted of offences previously ($X_2(1D.F) = 15.83$ $p < 0.001$ highly significant difference). Sexual offences and violence were pronounced in the criminal records of the men. Property offences such as larceny and robbery were pronounced in the backgrounds of the men (24.6%) in comparison with the women (6.2%).

Table 10

Previous criminal record

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
None	27	22.9%	19	59.4%	46	30.7%
Petty theft	13	11.0%	1	3.1%	14	9.3%
Serious property offences	16	13.6%	1	3.1%	17	11.3%
Indecent assault	29	24.5%	0	0.0%	29	19.3%
Rape	4	3.4%	0	0.0%	4	2.7%
Criminal damage	0	0.0%	3	9.4%	3	2.0%
Arson	8	6.8%	2	6.2%	10	6.7%
Violence	17	14.4%	5	15.7%	22	14.7%
Manslaughter/murder	2	1.7%	0	0.0%	2	1.3%
Child stealing	2	1.7%	1	3.1%	3	2.0%
	118	100.0%	32	100.0%	150	100.0%

Table 10 incorporated one piece of information for each patient; the most serious criminal offence of which he or she had been convicted prior to the offence or behaviour leading to their detention in a special hospital. In contrast, Table 10a included all the different previous sentences of the patients prior to their present

detention. It was clearly evident that the method of disposal preferred by the courts in response to the previous convictions of the women was compulsory treatment in hospital (X_2 (3D.F) = 19.91 $<$ 0.001). Therefore, supplementing the finding that only 13(40.6%) of the women had previously been dealt with by the courts, only 5(15.6%) had previously received any sentence other than a hospital order. In contrast, in respect of the 91 male offenders(77.1%). 64(54.2%) had been sentenced previously to other than hospital orders.

Institutional care

Some of the information contained in Table 10a could be linked with the extent of previous hospital care(Table 11). 100.0% of the women in the sample group had been in hospital care previously and, as illustrated below even when they appeared in court, hospital care was the preferred response of the courts. Significantly less of the men had been in hospital care previously (X_2 (1D.F) = 5.60 $p <$ 0.02) (corrected for continuity). Of the 96 men who had previously been in hospital, 45(46.9%) had been admitted previously from the courts.

Table 10a Previous sentences

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
None	27	22.9%	19	59.4%	46	30.7%
Fines	2	1.7%	0	0.0%	2	1.3%
Probation order	45	38.1%	2	6.3%	47	31.3%
Care order	8	6.8%	1	3.1%	9	6.0%
Borstal/detention centre	16	13.5%	0	0.0%	16	10.7%
Prison	31	26.3%	2	6.3%	33	22.0%
Hospital order	45	38.1%	10	31.3%	55	36.7%
Discharge(court martial)	1	0.8%	0	0.0%	1	0.7%

Table 11 Years of care in previous hospitals

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
None	22	18.6%	0	0.0%	22	14.7%
Less than one year	18	15.3%	4	12.5%	22	14.7%
One to five years	32	27.1%	13	40.6%	45	30.0%
Six to ten years	17	14.4%	4	12.5%	21	14.0%
Eleven to fifteen years	11	9.3%	4	12.5%	15	10.0%
Sixteen to twenty years	11	9.3%	4	12.5%	15	10.0%
21 to 25 years	4	3.5%	1	3.1%	5	3.3%
Over twenty-five years	3	2.5%	2	6.3%	5	3.3%
	118	100.0%	32	100.0%	150	100.0%
Mean average	6.33 years		8.50 years		6.87 years	
Standard deviation	7.13		7.53			

Even though 22 of the men (18.6%) had not been in hospital previously, it would appear that as a group the men as well as the women had spent a substantial time in other hospitals before their admission to Rampton Hospital. Taking into account the length of stay at Rampton Hospital at the time of appearing before the tribunal, it would appear that the men and women in the sample group of patients had spent a total mean average length of stay in hospital care of twelve to thirteen years.

Table 12 Years of care in Rampton Hospital

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Less than one year	4	3.4%	3	9.4%	7	4.7%
Less than two years	16	13.6%	8	25.0%	24	16.0%
Less than three years	16	13.6%	5	15.6%	21	14.0%
Less than four years	13	11.0%	2	6.3%	15	10.0%
Less than five years	14	11.9%	5	15.6%	19	12.6%
Five to nine years	39	33.0%	4	12.5%	43	28.7%
Ten to fourteen years	10	8.5%	3	9.4%	13	8.7%
Fifteen to nineteen years	5	4.2%	0	0.0%	5	3.3%
Twenty to twenty-four years	0	0.0%	1	3.1%	1	0.7%
Over twenty-four years	1	0.8%	1	3.1%	2	1.3%
	118	100.0%	32	100.0%	150	100.0%
Mean average	6.07 years		5.25 years		5.96 years	
Standard deviation	4.05		5.55			

In view of the earlier evidence that proportionally less of the long-stay severely handicapped patients were seeing the tribunal, a comparison was made with the stay of the total patient population at Rampton Hospital.

Table 12a Length of Stay at Rampton Hospital

	<u>Sample group of patients</u>		<u>Total patient population</u> ⁽¹²⁾	
Less than ten years	109	86.0%	577	69.1%
Ten to twenty years	18	12.0%	189	22.6%
Over twenty years	3	2.0%	69	8.3%
	<u>150</u>	<u>100.0%</u>	<u>835</u>	<u>100.0%</u>
Mean average	5.96 years		8.43 years ⁽¹³⁾	

Residential care as a child

Details obtained from the examination of records distinguished between residential child care and residential special schooling (including any period in approved school before the age of eighteen). This information was displayed separately in Tables 13 and 13a. There was no significant difference between the numbers of men and women who had been in residential child care and those who had not been in care. Similarly there appeared to be no clear difference between whether or not they had received residential schooling. For about half the sample group of patients to have been affected in each case did appear to be a large proportion in comparison with the wider population in the country.

(12) Patient population at Rampton Hospital 31.12.79. Information contained in answer to parliamentary question 22.1.80(Hansard)

(13) Mean average length of stay of total patient population estimated from more detailed information contained in above written answer.

Table 13 Residential child care

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Yes	63	53.4%	16	50.0%	79	52.6%
No	54	45.8%	16	50.0%	70	46.7%
Not known	1	0.8%			1	0.0%
	118	100.0%	32	100.0%	150	100.0%

Table 13a Residential schooling

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Yes	61	51.7%	14	43.8%	75	50.0%
No	56	47.5%	18	56.3%	74	49.3%
Not known	1	0.8%			1	0.7%
	118	100.0%	32	100.0%	150	100.0%

This proportion of the sample group to have been in some form of residential care as a child was seen to have been even higher when the information in Tables 13 and 13a was aggregated. When a distinction was made between those who had been in only one of either residential child care or schooling and those who had been in both as a child, it was found that 99 individuals(66.0%) had been in some form of residential care as a child.

Table 13b Residential care as a child

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Child care only	20	16.9%	4	12.5%	24	16.0%
School only	18	15.3%	2	6.2%	20	13.3%
Both child care and residential School.	43	36.4%	12	37.5%	55	36.7%
None	37	31.4%	14	43.8%	51	34.0%
	118	100.0%	32	100.0%	150	100.0%

It was seen from Table 13b that the high proportions of 68.6% of the men and 56.2% of the women had been in some form of residential care as a child. There was no significant difference between men and women (X_2 (1D.F)=1.70 $p < 0.70$).

The above socio-demographic features of the sample group of patients were provided as the initial stage of presenting the findings of the research project. They were a description of the patients which should be taken into account when considering the findings in regard to the decision-process of the mental health review tribunal. Whilst the findings in regard to the operation of the tribunal related to their response to this particular group of patients, the sample group have been seen to be adequately representative of the patients applying and being referred to the tribunal at Rampton Hospital.

**PAGE NUMBERING AS IN THE
ORIGINAL THESIS**

CHAPTER TEN

PERCEPTION OF 'DANGEROUS' BY MENTAL HEALTH REVIEW TRIBUNAL

Introduction

'Violence denotes action; danger denotes a relationship'.
(Sarbin, 1967)⁽¹⁾.

To attribute 'dangerous' to an individual could be a very different concept and process to that of recognising and responding to some form of physical trait or disability. With the latter, the labelling process could be a valid and helpful means of linking the particular disability with an appropriate remedy. Even though the individual as a whole person is obviously affected by the remedy, the response is concerned specifically with the labelled condition and not the individual person as such. At the same time, there can be wider social consequences for the individual even in respect of clearly defined and appropriately labelled conditions, such as 'epilepsy' and 'leprosy'. These wider social consequences for the individual can become more pronounced and complex where the labelling process is an attempt to define any condition or trait which may vary with individual circumstances. It is in respect of such descriptions of human behaviour, such as that of 'dangerous', that it is even more important and yet much more difficult to be clear about the definition of the concept.

The review of relevant literature in regard to the concept

(1) Sarbin T.R. 'The dangerous individual' British Journal of Criminology. Vol.7.(1967) p.285.

of 'dangerous' which preceeded this research did tend to confirm that the concept itself appeared determined often by the perception of the various parties to the situation. The concept of 'dangerous' appeared often a social interactionist phenomenon and not necessarily one which could simply be applied to any individual independent of his social situation. S.K.Weinberg(1968),⁽²⁾ in studying the cultural relativity of normality, concluded that there were great discrepancies in behaviour between the average person in different societies. He saw deviant behaviour as being defined by a particular group and referring to 'the individual's departure from the norms, standardised practices, and approved outlets for his specific role in society'. Deviant behaviour could only be identified and described in terms of the specific group context. He defined deviant behaviour as being functionally inconsistent with a particular society. 'If it challenges, disrupts, or threatens the group, it cannot be used by the society'. Yet, despite his primary conclusions about the relativity of normality and therefore deviant behaviour, Weinberg⁽³⁾ did identify disorders which were recognised cross-culturally. The main kind of deviant behaviour which did receive such common recognition was that 'involving impulsive violence, uncontrollable frenzy, or impulsive attacks on others'. He found that it was a widespread and possibly invariable phenomenon that 'the very presence of such a person constitutes a threat to the society, and society restrains the individual in some way'.

(2) Weinberg.S.K. 'The Sociology of Mental Disorders' Staples Press (London 1968) p.163.

(3) Weinberg.S.K. 'The Sociology of Mental Disorders' Staples Press(London 1968) p.164.

This view of 'dangerous' as primarily concerned with the fear of direct physical violence is confirmed by various 'experts' in the fields of law and psychiatry:

'Where the prospect of violence brings the assumption that it must be avoided, even at the expense of liberty, the prospect of lesser injuries bring solicitude for the liberty of the patient'.

(Goldstein 1968)⁽⁴⁾

'More severe, aggressive or sexual activity involving risk to life and health'.

(Sturupp 1968)⁽⁵⁾

'The propensity to cause serious physical injury or lasting psychological harm'.

(Butler Report 1975)⁽⁶⁾

'An unpredictable and untreatable tendency to inflict or risk serious, irreversible injury to destruction'.

(Scott 1977)⁽⁷⁾

How did the members of the tribunal perceive 'danger'?

A number of research questions were concerned with the 'danger' associated with the patient as perceived by the tribunal members.

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- (4) Goldstein, A.S. 'Mentally Disordered Offender and the Law' Paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint (1968)
 - (5) Sturupp, G.K. 'Will this man be dangerous?' Paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint (1968)
 - (6) Butler Committee Report on 'Mentally Abnormal Offenders' Cmnd. 6244 HMSO (London 1975)
 - (7) Scott P.D. 'Assessing dangerousness in criminals' British Journal of Psychiatry (1977) 131, p.129.

These were included under Aim 1 in the chapter on 'aims of the research project'. The hypothesis that there would be no tendency for tribunal members to categorise the nature of the risk in particular terms was clearly rejected. The responses to the observation and interview research questions demonstrated a significant tendency to categorise the 'danger' in terms of 'direct physical violence'.

Observation Findings

Table 1 Did the tribunal members refer to the risk associated with the person before them in the following terms:

	<u>Yes</u>	<u>No</u>	<u>Total hearings</u>	
Direct physical violence	103	36	139	74.1%
Endangering behaviour (mainly arson)	33	106	139	23.7%
Sexual assault	51	88	139	36.7%
Damage to property	42	97	139	30.2%
Psychological harm	6	133	139	4.3%
Property offence(larceny etc)	48	91	139	34.5%
Other	7	132	139	5.0%

Table 2 How did the tribunal as a whole appear to view the primary risk?

Not clear	19	13.7%
Direct physical violence	65	46.8%
Endangering behaviour	6	4.3%
Sexual assault	37	26.6%
Damage to property	2	1.4%
Psychological harm	0	0.0%
Property offence	6	4.3%
Other	4	2.9%
<hr/>		
139 hearings		100.0%

During the 139 observed hearings, it was recorded at 103 hearings(74.1%) that reference was made to 'direct physical violence'. This was highly significant as against all the

other alternative responses ($X_2(6D.F)=221.35 p < 0.001$) and against the specific response which was recorded on more occasions than any other; 'sexual assault' recorded on 51 occasions (36.7%) ($X_2(1D.F)=30.66 p < 0.001$)

During the 139 observed hearings, it was recorded on 65 occasions (46.8%) that 'direct physical violence' appeared to be viewed as the primary risk. This was highly significant as against other alternative responses ($X_2(2D.F)=65.31 p < 0.001$) and against the specific response which was recorded on the second most occasion; 'sexual assault' recorded on 37 occasions (26.6%) ($X_2(1D.F)=12.24 p < 0.001$)

Whilst the difference was not significant in the number of references to 'sexual assault' as against some other responses ('damage to property' and 'property offences'), 'sexual assault' was clearly the second to 'direct physical violence' in respect of the occasions it was viewed as the primary risk in comparison with any other risk. ($X_2(1D.F)=26.42 p < 0.001$). Even in respect of references to the risk during hearings, 'sexual assault' was significantly more important than 'endangering behaviour (mainly arson)', to which tribunal members referred during 33 hearings (23.7%) ($X_2(1D.F)=5.54 p < 0.05$).

Interview findings

Table 3 However you rated the danger, in your opinion, what is or was the one main risk or danger in regard to this particular patient?

	<u>Men</u>	<u>Women</u>	<u>Total</u>	
Direct physical violence	48	21	69	46.0%
Endangering behaviour	6	4	10	6.7%
Sexual assault	39	0	39	26.0%
Damage to property	4	4	8	5.3%
Psychological harm	0	0	0	0.0%
Property offence	6	0	6	4.0%
Other	5	3	8	5.3%
None	10	0	10	6.7%
	<hr/> 118	<hr/> 32	<hr/> 150	<hr/> 100.0%

The null hypothesis was clearly rejected with regard to this question ($X_2(6D.F)=188.61$ $p < 0.001$) Even in relation to the response which was clear second ('sexual assault' 39 responses 26.0%) the 69 responses (46.0%) of 'direct physical violence' were highly significant ($X_2(1D.F)=13.02$ $p < 0.001$).

Second to 'physical violence', the most significant response to this interview question in relation to other responses was clearly 'sexual assault'. ($X_2(5D.F)=58.66$ $p < 0.001$)

Support for the reliability of these findings was to be found in the close correlation in the responses to 'direct physical violence' and 'sexual assault' in respect of the observation question on the 'primary risk' and the interview question in regard to the 'one main risk or danger'. This was illustrated in the comparison between the findings in Tables 2 and 3.

Comparison of observation and interview findings on primary 'danger'

	<u>Observation(Table 2)</u>		<u>Interview(Table 3)</u>	
Direct physical violence	65	46.8%	69	46.0%
Sexual assault	37	26.6%	39	26.0%
Other primary risks	18	12.9%	32	21.3%
None/not clear	19	13.7%	10	6.7%
	<u>139</u>	<u>100.0%</u>	<u>150</u>	<u>100.0%</u>

There was some support in the responses to a secondary interview question to the view that tribunal members viewed the danger in specific terms rather than as a more complex concept. There was a significant number, compared to alternative responses available, of 'none' responses (78 out of 150 hearings 52.0%) to the question about 'other dangers' (Table 4)

Table 4 Apart from the main danger or risk, did you see any other danger associated with the person before you?

	<u>Men</u>	<u>Women</u>	<u>Total</u>	
Direct physical violence	12	5	17	11.4%
Endangering behaviour	7	1	8	5.3%
Sexual assault	6	0	6	4.0%
Damage to property	7	11	18	12.0%
Psychological harm	1	1	2	1.3%
Property offence	14	0	14	9.3%
Other	3	4	7	4.7%
None	68	10	78	52.0%
	<u>118</u>	<u>32</u>	<u>150</u>	<u>100.0%</u>

Excluding the 'none' responses, the null hypothesis was rejected also in respect of the other specific alternative responses ($X_2(5D.F)=23.17 p < 0.001$). Yet each specific response was significantly less than the 'none' response:

'damage to property' (18 responses, 12.0%), 'direct physical violence' (17 responses, 11.4%) and 'offences against property' (14 responses, 9.3%)

Perhaps there was a question of judgement in deciding whether this finding was supported by the recorded responses to the observation question on the references by the tribunal members to the danger in certain terms. Yet in respect of 139 hearings, there was only a mean average of 2.08 recorded references to the risks (290 references in total), presumably in each instance including the reference to the primary risk. References which could have been expected as secondary risks or factors in a more complex perception of 'danger' were relatively infrequently recorded (for example, 'endangering behaviour' 33 references, 23.7%; 'psychological harm' 6 references, 4.3%.

How did their perception of 'danger' compare with the actual offences or behaviour which had resulted in the detention of the persons before them?

It can be seen from Chapter 9 'Sample Group of Patients', that the criminal offences and behaviour which led to special hospital admission were as follows:

Violence/manslaughter etc	80	53.2%
Sexual assault	34	22.7%
Arson/endangering	13	8.7%
Property offences	7	4.7%
Damage to property	4	2.7%
Other	12	8.0%
	<u>150</u>	<u>100.0%</u>

Testing for statistical difference between actual offences and the primary risk as perceived by the tribunal chairmen (Table 3) demonstrated that the null hypothesis was not rejected, ($X_2(5D.F)=3.4$ $p > 0.05$). The difference between the 'danger' as perceived by the chairmen and the actual offences and behaviour which had led to the detention of the person before them was not statistically significant.

Similarly there was no significant statistical difference between the actual offences/behaviour and the observation responses in regard to apparent tribunal view of the primary risk (Table 2) ($X_2(5D.F)=5.72$ $p < 0.30$ null hypothesis not rejected).

Therefore the perception of 'danger' by the members of the tribunal compared closely with the actual offences and behaviour which had led to the detention of the persons before them.

How did the members of the tribunal rate the degree of danger?

From the available alternative responses to the interview question regarding 'danger to others', there was a clear significant tendency for the chairmen to select 'minimal' or 'moderate' danger, as opposed to 'no danger at all' or 'severe' or 'very severe' danger. Comparing 'minimal danger' and 'moderate danger' responses, there was a statistically significant difference in favour of 'minimal danger' ($X_2(1D.F)=4.18$ $p < 0.05$)

Table 5 How would you rate the patient you have just seen as a danger to others?

	<u>Men</u>	<u>Women</u>	<u>Total</u>	
No danger at all	7	3	10	6.7%
Minimal danger	48	15	63	42.0%
Moderate danger	34	12	46	30.7%
Severe danger	15	1	16	10.7%
Very severe danger	8	0	8	5.3%
Could not answer	6	1	7	4.6%
	118	32	150	100.0%

From the available alternative responses to the interview question regarding 'danger to self', there was no significant difference between the extent 'no danger at all' was selected and the total of all 'danger' responses ($X^2_{(D.F)}=1.92$ $p < 0.70$). There was a significant tendency to select 'no danger at all' (84 responses, 56.0%) as against any specific degree of danger; eg 'minimal danger' (48 responses, 32.0%) ($X^2_{(D.F)}=17.6$ $p < 0.001$)

Table 6 How would you rate the patient you have just seen as a danger to himself?

	<u>Men</u>	<u>Women</u>	<u>Total</u>	
No danger at all	79	5	84	56.0%
Minimal danger	31	17	48	32.0%
Moderate danger	4	7	11	7.3%
Severe danger	0	2	2	1.3%
Very severe danger	1	0	1	0.7%
Could not answer	3	1	4	2.7%
	118	32	150	100.0%

Therefore, whilst there was a pronounced tendency to rate the patients still as dangerous to others (although tending to 'minimal danger', 63, responses, 42.0%) the tribunal members were unlikely to

consider them even a moderate danger to themselves, with 132 responses (88.0%) being 'no danger at all' or 'minimal danger'.

How did the members of the tribunal perceive potential victims?

A number of research questions were concerned with who were perceived by the tribunal members as potential victims. The responses are presented in Tables 7,8 and 9. The hypothesis that there would be no tendency for tribunal members to identify particular categories of potential victims as at most risk was clearly rejected. The responses to the observation and interview research questions demonstrated a significant tendency to identify 'people generally' as potential victims as opposed to any other specific alternative response.

Observation Findings

Table 7. To whom did the tribunal refer as potential victims?

	<u>Yes</u>	<u>No</u>	<u>Total hearings</u>	
People generally	106	33	139	76.3%
Adults own sex	6	133	139	4.3%
Adults opposite sex	30	109	139	21.6%
Children	33	106	139	23.7%
Elderly	5	134	139	3.6%
Self	28	111	139	20.1%
Others-family	19	120	139	13.7%
patients	18	121	139	12.9%
staff	8	131	139	5.8%
miscellaneous	9	130	139	6.5%

Table 8 Who appeared to be seen as most at risk?

Not clear	29	20.9%
People generally	59	42.4%
Adults own sex	0	0.0%
Adults opposite sex	14	10.1%
Children	24	17.3%
Elderly	1	0.7%
Self	3	2.2%
Family	5	3.6%
Others	4	2.8%
<hr/>		
	139 hearings	100.0%
<hr/>		

During the 139 observed hearings, it was recorded at 106 hearings (76.3%) that reference was made to 'people generally' being at risk. This was significantly different from the number of references to any other specific category of victim; the closest being 'children' (33 occasions, 23.7%), 'adults opposite sex' (30 occasions, 21.6%), and 'self' (28 occasions, 20.1%).

During the 139 observed hearings, it was recorded at 59 hearings (42.4%) that 'people generally' appeared to be seen as most at risk. This was significant as against other alternative responses and as against the specific response recorded on the second most occasions. ($X_2(1D.F)=21.04$ $p < 0.001$); 'children' recorded on 24 occasions (17.3%). 'Children' and 'adults opposite sex' (14 occasions, 10.1%) were significant in relation to other alternative responses; but the difference was not significant between 'children' and 'adults opposite sex' ($X_2(1DF)=3.18$ $p > 0.05$).

Interview Findings

Table 9 Who did you see as most likely to be at risk from the person before you?

	<u>Men</u>	<u>Women</u>	<u>Total</u>	
People generally	52	21	73	48.7%
Adults own sex	3	0	3	2.0%
Adults opposite sex	16	0	16	10.6%
Children	24	4	28	18.7%
Elderly	0	0	0	0.0%
Self	3	3	6	4.0%
Family	3	1	4	2.7%
Others	2	1	3	2.0%
No one	1	0	1	0.7%
Could not answer	14	2	16	10.6%
	<hr/> 118	<hr/> 32	<hr/> 150	<hr/> 100.0%

The null hypothesis was not rejected in comparing 'people generally' with the total of specific victim-responses (60 responses, 40.0%). Yet there was a significant tendency toward 'people generally' as against any specific other response; for example in comparison with 'children', 28 responses (18.7%) ($\chi^2(1D.F) = 30.22$ $p < 0.001$). In turn, the difference was significant between 'children' and the response third in frequency, 'adults opposite sex' 16 responses (10.6%) ($\chi^2(1D.F) = 3.92$ $p < 0.05$).

Support for the reliability of these findings is to be found in the close correlation in the responses, 'people generally', 'children', and 'adults opposite sex', in respect of the observation question about who appeared 'to be seen as most at risk' and the interview question in regard to who was seen as

'most likely to be at risk'. This was illustrated in the comparison between the findings in Tables 8 and 9.

Comparison of observation and interview findings on potential victim

	<u>Observation(Table 8)</u>		<u>Interview(Table 9)</u>	
People generally	59	42.4%	73	48.7%
Children	24	17.3%	28	18.7%
Adults opposite sex	14	10.1%	16	10.6%
Other potential victims	13	9.3%	16	10.6%
None/not clear	29	20.9%	17	11.4%
	<hr/>		<hr/>	
	139	100.0%	150	100.0%
	<hr/>		<hr/>	

Contrast between men and women

The responses to the interview question about 'the one main risk or danger' (Table 3) in respect of women were:

Direct physical violence	21	65.6%
Endangering behaviour	4	12.5%
Damage to property	4	12.5%
Other	3	9.4%
	<hr/>	<hr/>
	32	100.0%
	<hr/>	<hr/>

As perhaps would be expected, none of the women had been convicted or detained because of sexual assault. If this one factor was excluded, there was no significant difference between the 'danger' associated with men and women, as perceived by the legal chairman ($X_2(5D) = 4.76$ $p > 0.05$).

There were some significant differences in the responses to the secondary question 'did you see any other danger associated with the person before you?' (Table 4) There was a greater tendency ($X_2(1DF)=7.27$ $p < 0.01$) for 'none' to be the response in regard to men; with the positive responses tending to 'damage to property' as secondary dangers with women and 'offences against property' with men.

The responses to the interview question 'How did you rate the patient you have just seen as a danger to others?' (Table 5), in respect of women were:

No danger at all	3	9.4%
Minimal danger	15	46.9%
Moderate danger	12	37.5%
Severe danger	1	3.1%
Could not answer	1	3.1%
	<u>32</u>	<u>100.0%</u>

The difference was not significant between women and men in regard to the perceived degree of danger to others, contrasting 'no danger at all', 'minimal/moderate danger', and 'severe/very severe danger' ($X_2(2DF)=4.99$ $p > 0.05$).

The responses to the interview question 'How did you rate the patient you have just seen as a danger to himself?' (Table 6), in respect of women were:

No danger at all	5	15.6%
Minimal danger	17	53.1%
Moderate danger	7	21.9%
Severe danger	2	6.3%
Could not answer	1	3.1%
	<u>32</u>	<u>100.0%</u>

In that only 36 of the 118 men(30.5%) were considered to present any danger at all to themselves, there was a highly significant difference between men and women in regard to the 'danger to self' as perceived by the legal chairmen. ($X_2(1D.F)=26.71$ $p < 0.001$) There were clearly contrasting tendencies, with the women normally being considered to present 'danger to self' and the men the opposite.

The responses to the interview question 'who did you see as most likely to be at risk from the person before you?'

(Table 9) in respect of women were:

People generally	21	65.6%
Children	4	12.5%
Self	3	9.4%
Family	1	3.1%
Others	1	3.1%
Could not answer	2	6.3%
	<u>32</u>	<u>100.0%</u>

There was a clear tendency toward 'people generally' as opposed to the total of specific victims in regard to the

women($X_2(\text{D.F.})=9.60$ $p < 0.01$). This applied in contrast with the men, even when the response 'adults opposite sex' (16 with the men) was excluded. Even though 'children' were considered at risk in the case of 24 men (20.3%), the difference in comparison with women was not statistically significant. ($X_2(\text{D.F.})=1.04$ $p > 0.50$)

Although the 'danger to self' was so significant with women(81.3%), 'self' was clearly not seen as the person most at risk; in other words, although 'danger to self' was clearly a greater concern with women, it was presumably not seen as a prime justification for detention.

Summary of findings

'Direct physical violence' was seen as the main danger with both men and women; with 'sexual assault' being perceived as second in significance.

This perception of 'danger' by the members of the tribunal compared closely with the actual offences and behaviour which led to the detention of the people before them.

There was a tendency not to see any other than the main danger associated with the men, in contrast with the women where 'danger to property' was seen as the secondary danger.

The 'danger to others' was rated as minimal or moderate, as opposed to no danger at all or more severe; with no significant difference between men and women.

'Danger to self' was not seen as significant with men, whereas it was perceived as present normally with women. Despite this, even with women 'self' was not seen as the person most at risk. 'People generally' were perceived as the most likely potential victims as against any more specific victims. This was apparent particularly with women; with a greater tendency towards specific ^{victims} and particularly adults of the opposite sex considered at risk from men.

Discussion

These findings did tend to support the definitions suggested in the introduction to this chapter. The perception of 'dangerous' by the members of the mental health review tribunal did appear to be in terms of 'impulsive violence' (Weinberg 1967)⁽³⁾, 'prospect of violence' (Goldstein 1968)⁽⁴⁾, 'more severe, aggressive or sexual activity' (Sturup 1968)⁽⁵⁾, 'propensity to cause serious physical injury' (Butler Report 1975)⁽⁶⁾ and 'tendency to inflict or risk serious injury' (Scott 1977)⁽⁷⁾. 'Direct physical violence' was the primary justification for the detention of the person seeing the tribunal and also was the main danger as perceived by the tribunal. As suggested by Sturup, 'sexual activity' was an important secondary aspect of 'danger'.

The second aspect of the Butler Report definition of dangerous as 'the propensity to cause lasting psychological harm' was not supported in terms of how the tribunal perceived 'dangerous'. Reference to 'psychological harm' was recorded on only 6 occasions, (4.3%) out of 139 observed hearings. It did not appear to be viewed as the primary risk during any of these observed hearings. Given 'psychological harm' as one of a number of alternative responses, the legal chairmen did not once select it as the 'one main risk or danger' and on only two occasions indicated 'psychological harm' as the secondary 'other danger associated with the person before you'.

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- (3) Weinberg 1967 - see footnote page 118
 - (4) Goldstein 1968 - see footnote page 119
 - (5) Sturup 1968 - see footnote page 119
 - (6) Butler 1975 - see footnote page 119
 - (7) Scott 1977 - see footnote page 119

There were three observation comments by the researcher during the 139 observed hearings in regard to 'psychological harm'. Tribunal members were quoted as referring to 'psychological distress to family' (in regard to child kidnapping), 'distress to parents' (sexual assault on children), and 'psychological damage to children'(sexual assault).

The only further comment on how they saw the danger, during the 150 interviews, which could be seen as explicitly bordering on psychological harm, was the comment: 'People bound to be anxious' (in regard to offence of arson).

The answers given by the chairmen who took the opportunity for further comment on how they saw the danger are presented in a supplement to this chapter. These comments did tend to support the link in their minds between the 'danger' and the actual offences and behaviour which led to detention. Fourteen of the comments referred to the particular crime or behaviour. These comments perhaps also supported the tendency to view the 'danger' in particular terms rather than more complex.

The comments reinforced the view that the risk was seen primarily in terms of 'danger to others'. Apart from the comment on one patient as 'exploitable', it is only by implication that the chairmen demonstrated concern about 'danger to self'.

These further comments by the chairmen did tend to support another aspect of the definitions of 'dangerous' suggested at the introduction to this chapter. 'Danger' and the threat to society

which warrants restraint was seen not simply in the violence itself but in its impulsive, inconsistent, or irrational nature. Weinberg spoke of 'impulsive violence' and 'uncontrollable'; Scott referred to the 'unpredictable' tendency to inflict injury. This emphasis was reflected by the chairmen, through comments such as: 'out of character', 'danger is a question of supposition', 'difficult to assess', and 'difficult to judge'.

There was limited support in the findings and further comments in regard to their perception of 'dangerous' for the view that concept of 'danger' or 'violence' is affected by the cultural and social context and the perceptions and attitudes of the people in the situation. Although explicitly and by implication 'danger' was largely being defined as 'fear of violence'.

There was some evidence that they did acknowledge 'danger' as being to some extent related to the social situation within which it had or was likely to express itself. This was expressed and implied in comments such as: 'main danger when out of hospital', 'dependent upon adequate support', 'most serious act of violence within domestic and emotional situation', 'danger related to drink and consequences', and 'relapse if social responsibilities are too much pressure'.

As an extension of the definition already quoted, Scott 1977⁽⁷⁾ acknowledged the desirability of an indication of 'probability of this or that sort of damaging behaviour occurring in this or

(7) Scott 1977 - see footnote page 119

that expected environment'. Further support for the view of 'dangerousness' as the physically violent behaviour of an individual reacting within a particular situation was reflected in the evidence to and conclusions of the Butler Committee on Mentally Abnormal Offenders.⁽⁶⁾ From his vast experience of mentally abnormal offenders in Denmark, Sturup tended to see the prognosis in terms of the likelihood of responding more adequately and stably to particular situations, which had contributed to difficulties in the past. 'The most important thing we can do for these people is to motivate them to avoid the dangerous situation rather than to look for it'.⁽⁵⁾

Any restriction of the definition of 'danger' or the perception of 'danger' in respect of an individual to a label to be attached out of context illustrated the 'dangerousness of dangerousness' (S H Shaw 1973).⁽⁸⁾ P.D.Scott⁽⁹⁾ began his final statement on dangerousness by warning that 'the label which is easy to attach but difficult to remove, may contribute to its own continuance'. E.I.Megaree 1976⁽¹⁰⁾ gave the sound advice that 'dangerousness is an unfortunate term, for it implies that there is a trait of dangerousness, which, like intelligence, is a relatively constant characteristic of a person. However, the degree of danger an individual represents to himself or others is a function of a number of variables'.

The findings in regard to the perception of 'dangerous' by the tribunal and the evidence yet to be considered from the wider

(5) Sturup 1968 - see footnote page 119

(6) Butler 1975 - see footnote page 119

(8) Shaw, S.H. 'Dangerousness of dangerousness' Med Sc and Law, Oct. 1973

(9) Scott, P.D. 'Assessing dangerousness in criminals'. British Journal of Psychiatry (1977) 131, p.127.

(10) Megaree, E.I. 'Prediction of dangerous behaviour' Criminal Justice and Behaviour, Vol. 3, No. 1. (March 1976) p.5.

study did suggest that the members of the tribunal were very aware of the limitations and 'unfortunate' effects of the concept of 'danger'.

ANSWERS FROM LEGAL CHAIRMAN TO THE QUESTION:

'Would you like to make any further comments on how you saw the danger in this case'

<u>Man</u> (murdered mother)	'Serious crime - out of character - no current violence'
<u>Man</u> (sexual assault)	'Past record and present hospital view of likely recurrence - therefore danger still present'
<u>Man</u> (sexual assault)	'Probably future larceny, but main danger in past to children'
<u>Man</u> (murdered friend)	'One act of violence as against 10 years away'
<u>Man</u> (sexual assault)	'Records unclear on this immature person'
<u>Man</u> (sexual assault)	'Happened in past yet main danger when out of hospital'
<u>Man</u> (sexual assault)	'Because of time in Rampton and insight into problems, danger diminished'
<u>Man</u> (murdered nurse)	'Classic psychotic'
<u>Man</u> (violence)	'Risk if did not take medication for epilepsy'
<u>Man</u> (sexual assault)	'Dependent upon adequate support and hospital care'
<u>Man</u> (murdered mother)	'If schizophrenic relapse, could be very dangerous to anyone'
<u>Man</u> (violence)	'Only two previous acts of violence, most serious one within domestic and emotional situation'
<u>Man</u> (violence)	'No sexual tendency, therefore no fear for opposite sex. Family perhaps at risk'
<u>Woman</u> (violence)	'Children definitely not at risk'
<u>Man</u> (violence)	'Epileptic personality with previous episodes of violence excellent present behaviour'
<u>Man</u> (arson)	'Paranoid schizophrenia with depression - currently ill - receiving ECT course'
<u>Man</u> (murdered prostitute)	'Murder - nine years ago and in Rampton - danger is a question of supposition'
<u>Woman</u> (violence)	'Other patients irritated by her behaviour'
<u>Woman</u> (violence)	'Epileptic personality reasonably well controlled'
<u>Man</u> (sexual assault)	'Record full of offences against young girls'
<u>Man</u> (attempted murder)	'Serious offence 14 years ago - no disagreement'

- Man (sexual assault) 'Very subnormal - likely to get into trouble - unlikely to be serious'
- Man (rape) 'Unsocialised adolescent - difficult to assess sex crime at age fifteen'
- Man (violence) 'Transfer list two years'
- Man (robbery) 'An aggressive young man - rather cold - labelled psychopathic'
- Woman (arson) 'Difficult to judge - people bound to be anxious'
- Man (violence) 'Danger related to drink and consequences - reaction to other aggressive Irishmen'
- Woman (violence) 'Length of stay! Behaviour should be looked at in light of 30 years institutionalisation'
- Man (arson) 'Borderline subnormal, epileptic, brain damage, immature'
- Woman (criminal damage) 'Relapse if social responsibilities are too much pressure'
- Man (sexual assault) 'Very naive and childlike - exploitable'
- Man (rape) 'Rape at 20, now Rampton 12 years'
- Man (rape) 'Bad record until age 35 - Rampton since then'

CHAPTER ELEVEN

THE EVIDENCE ON WHICH THE TRIBUNAL BASED THEIR JUDGEMENTS

'The degree of danger an individual represents to himself or others varies markedly as a function of a number of variables'.
(Megaree 1976)⁽¹⁾

To assess whether the 'danger to self and others was sufficient to warrant continued detention was unlikely to be a straight-forward process in view of the complexity of the concept of 'danger'. As with the concept, in practice there could be a tendency to simplify the process of assessing 'danger'. 'Danger' was perceived primarily as 'fear of physical violence or sexual assault'. Therefore the process of assessment was likely to be concerned with seeking evidence as to whether or not such behaviour could be expected to occur in the future. But even if the nature of the danger to be feared and the behaviour to be predicted was specified and simplified, the process of predicting human behaviour in general and dangerous behaviour in particular appeared complex in itself. Yet this was an important decision-process, on which depended the continued detention or liberty of the individual.

Which factors and variables were relevant and how were they identified by the tribunal and rated in relation to each other?

The review of literature in regard to the causation and assessment of 'dangerous' behaviour which preceeded this research indicated that a number of factors appeared to be influential.

(1) Megaree E.I. 'Prediction of Dangerous Behaviour'
Criminal Justice and Behaviour.Vol.3.No.1.(1976)p.5.

One over-riding factor appeared to be the nature and severity of the behaviour or offence which had drawn attention to the individual. Upon this appeared to depend whether there was considered to be a serious problem at all. 'In trivial offences it would be a waste of time enquiring too closely.....the more serious the charge the greater is the necessity for an examination of the person's mental state'. (Whitlock 1963)⁽²⁾

The suggestion that unexplained persistence in offending or abnormality of the offences could raise questions about the mental state of the offender, implied a relationship between serious offences and mental illness. A positive correlation between homicide in Britain and mental illness has been supported by some studies, such as by the Home Office Research Unit⁽³⁾, D.J.West(1965)⁽⁴⁾, and H.Gillies(1965)⁽⁵⁾. Their observation of surviving homicide offenders suggested that more than half revealed some psychological abnormality, and in Britain about one quarter of all homicides were followed by the suicide of the murderer. That this correlation was generally perceived was supported further by evidence that at least a quarter of all surviving homicides in England and Wales were detained in psychiatric hospitals, mainly the special hospitals such as Broadmoor and Rampton. Given the 'impulsive and unpredictable' nature of dangerous behaviour, it was perhaps to be expected that mental disorder would be linked with the 'fear of violence'.

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- (2) Whitlock.F.A. 'Criminal Responsibility and Mental Illness' Butterworths (London 1963)
- (3) Home Office Research Unit report. 'Murder' (1961) HMSO
- (4) West.D.J. 'Murder Followed by Suicide' Heinemann (London 1965)
- (5) Gillies.H. 'Murder in West of Scotland' British Journal of Psychiatry. Vol.3.(1965)

As indicated in Chapter One, in addition to such factors as the offences or anti-social behaviour and the presence of mental disorder, less tangible variables appeared to be an influence on the assessment of 'dangerous'. Uncertainty about causation or prognosis and intuitive feelings about the individual could be influential factors in the decision-process. Also concern about the 'personality' of the individual came close at times to the confusion of labelling an individual or behaviour which could not be explained otherwise, without adding to the understanding of causation. Gibbens(1968)⁽⁶⁾ warned of the danger of over-estimating the connection between psychopathy and crime. G.K. Sturup, with his long and vast experience of assessing and treating mentally abnormal offenders in Denmark, was quoted by Shaw(1973)⁽⁷⁾: 'Little is known about assessing dangerousness beyond intuitive feelings and general statistics that cover certain types of offender'. Sturup admitted that if he was 'unable to make real emotional contact with the man.....it was impossible to evaluate the dangerousness I advised against parole'. He saw the reactions of people with 'only personality problems' as less predictable(and therefore more dangerous?) than those of psychotic and mentally handicapped people. (Sturup 1968)⁽⁸⁾

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- (6) Gibbens.T, Briscoe, Dell 'Psychopathic Offenders' paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint(1968)
- (7) Shaw.S.H. 'Dangerousness of dangerousness' Medicine Science and Law. October 1973 p.271.
- (8) Sturup G.K. 'Will this man be dangerous?' paper presented at CIBA Symposium on 'Mentally Abnormal Offender'. CIBA Blueprint(1968)

The pattern of receiving evidence through the hearing

The prescribed procedures for the mental health review tribunal were detailed in Chapter Three. The pattern of operation of the tribunal meeting to consider applications and references at Rampton Hospital on the basis of these procedures was described in Chapter Six on the 'General approach to the research project'. It was explained that an assumption was made that this pattern of operation would continue to apply throughout the period of the research study. This assumption was proved to be generally correct with no serious variations from the prescribed pre-hearing procedures and the approach to receiving evidence at the hearing.

As described in Chapter Five under Aim 2, there was structured observation during the observed hearings of the reception of evidence through reports and interviews. In respect of the eleven hearings which were not observed by the researcher, the information in regard to these research questions were obtained through the examination of official records (in regard to interviews and reports) and by arrangement with such as the clerk to the tribunal (in regard to the length of time of the hearings).

(a) Was the patient interviewed? With^{out} exception, the 150 patients were interviewed by the tribunal during the tribunal hearing, normally remaining throughout the hearing until the private deliberations of the tribunal to reach their conclusion. Occasionally, the patient would be invited to withdraw from the hearing for a time to allow a relative or representative to speak confidentially to the tribunal; but this did not occur on more

than about ten occasions (from notes made by the researcher in a less systematic way). The fact that the patient was interviewed as a matter of course at every hearing was a reflection of the pattern of operation of the tribunal meeting at Rampton Hospital. Their policy was to make the availability of the patient for interview, a condition of considering any application or reference. As explained in Chapter Three on the 'Mental Health Review Tribunal', the tribunal was not obliged to interview the patient but the tribunal meeting at Rampton Hospital evidently considered this to be essential.

(b) Was any family interviewed? Every contactable nearest relative and other family known to be interested were informed of the arrangements and invited to attend the hearing. In response to this, 56 men(47.5%) and 12 women(37.5%) were accompanied by members of their family at the hearing. Considering that Rampton Hospital received patients from a national catchment area and many patients were long-stay with limited outside contacts, a value judgement could be made that the attendance of family at 68 of the 150 hearings (45.3%) was a reasonable response. The parents of the patients were well represented among the family who did attend. On 27 occasions(4 women), both parents attended. On eight occasions (one woman), only the father attended; and on 17 occasions(4 women) only the mother. In addition to the 52 occasions when the parents attended the hearings, on 12 other occasions(one woman) one or more siblings were interviewed by the tribunal. As perhaps would be expected from the information in Chapter Nine on the marital status of the patients, husbands and wives rarely attended the hearings. In fact, only one husband and one male fiancée were interviewed.

As all the eleven men who had been married were legally separated or divorced, it was perhaps unlikely that any wives would have attended. Other relatives sometimes accompanied parents and siblings; but on only two occasions (no women) did grandparents and uncles and aunts attend without parents or siblings.

(c) Was the subject legally represented? 112 men (94.9%) and 32 women (100.0%) were represented by a solicitor at the hearing, having received previously legal advice in preparing for the hearing. In addition, one man was represented by a lay representative provided by MIND (National Association for Mental Health). Therefore only five men and no women (3.3% of the total sample group of patients) were not represented at the hearing; having chosen to present their case without expert advice. Whilst this very high extent of representation was not related directly to the pattern of operation of the tribunal itself, it was a reflection of a legal advice service organised by the social work department at the hospital in response to the needs of patients applying or being referred to the tribunal.

(d) Were any hospital staff interviewed? It was not the normal procedure for the responsible consultant psychiatrist or any other hospital staff to be interviewed at the hearings. It did occur on 26 occasions (17.3%). The responsible consultant psychiatrists were interviewed by the tribunal in respect of 14 men (11.9%) and 4 women (12.5%). The social work members of the hospital team were interviewed in respect of 6 men (5.1%) and 2 women (6.3%). No members of the other hospital disciplines were interviewed during the 150 hearings; nor did the researcher note any evidence

of this being considered by the tribunal members.

(e) Were representatives of any community services interviewed?

Although the responsible local authority social services departments were approached in respect of the home circumstances of the nearest and other interested relatives, it was not the normal practice to inform the community services in the home area of the arrangements for the tribunal hearing. Their attendance was usually in response to some expression of special interest on their part, as opposed to an invitation on the initiative of the tribunal. Community services in the home area of patients were represented at 11 hearings(7.3%). Social services departments were represented by social workers in respect of four men and four women; and the probation service in respect of one woman and two men. The extent to which community services attended in respect of women in contrast with men was ^{not} statistically significant($X_2(1D.F)=2.70$ (corrected for continuity) $p > 0.05$). The reason for the suggestion in favour of the community services being slightly more likely to attend in respect of women was a matter for speculation. As a group, the women tended to be non-offenders and likely to have been in the hospital for longer-periods. There was no significant difference in the extent men and women had been in the care of local authorities. Possibly the community services were more reluctant to express a special interest in men detained in special hospitals in comparison with women.

(f) Were the usual hospital reports available? Without

exception, the tribunal received the statement from the hospital authority justifying the patient's continued detention. This

statement included a description of the background of the patient leading to his detention, his progress in hospital, and the opinion of the responsible consultant psychiatrist in regard to current condition. The provision of this statement was within the prescribed procedures of the tribunal and a condition of the tribunal meeting to consider a case at Rampton Hospital. It was for these reasons that no hearing took place without this statement being available. Similarly, it was a matter of course that the hospital file was available to the tribunal, containing the reports of the different disciplines.

(g) Were the home circumstances reports available from the social services? It was a matter of course to approach the responsible local authority social services for a report on the home circumstances of relatives of the patient; but it was not a condition that these should be available before the tribunal considered an application or reference. Sometimes no responsible relatives were available for assessment. Sometimes the tribunal would refer to the reports of the hospital social workers. The home circumstances reports were available in regard to 85 men(72.0%) and 27 women(84.4%) Again there was a greater response from social services departments in regard to women, but the difference was not statistically significant($X^2(1D.F)=2.18p < 0.20$). The importance of these reports to the tribunal and the recognition of this by the hospital authorities in obtaining them and the social services in providing them was evidenced in the extent reports were provided(112 hearings 74.7%).

(h) Were any other reports available? Other reports were available at 49 hearings, in respect of 39 men(33.0%) and 10 women(31.3%). These included 18 reports(including 4 women)

from social services in regard to rehabilitative resources, five other reports(one woman) in regard to residential provision, seven correspondence(2 women) from family and friends, seven further medical reports from the hospital(2 women), 4 hospital social work reports(no women) provided specifically for the hearing, 5 reports(no women) in regard to the previous records of patients(to supplement those in the hospital file), and letters and reports in regard to five other men and one other woman. A number of these reports, particularly those from the hospital, had been requested by the tribunal. Most of the social services reports on their facilities had been requested by the hospital authorities on behalf of the tribunal, sometimes when home circumstances reports were inappropriate. Other reports and letters had been initiated by the people concerned or occasionally arranged by the legal representatives of the patients.

(1) What was the length of time of the hearing?

	<u>Men</u>	<u>Women</u>	<u>Total</u>
Less than 30 minutes	8 6.8%	1 3.1%	9 6.0%
30-45 minutes	22 18.6%	8 25.0%	30 20.0%
45-60 minutes	46 39.0%	13 40.6%	59 39.3%
60-75 minutes	26 22.0%	7 21.8%	33 22.0%
Over 75 minutes	15 12.7%	3 9.5%	18 12.0%
Not known	1 0.8%		1 0.7%
	<u>118 100.0%</u>	<u>32 100.0%</u>	<u>150 100.0%</u>

Despite the tribunal scheduling about one hour for each hearing (11.00 am - 12.00 am; 12.00 am - 1.00 pm; 2.00pm - 3.00 pm), a large minority of hearings took more than one hour. 51 hearings (34.0%) took over 60 minutes, and 18 hearings(12.0%) took over 75 minutes. Inevitably some of the hearings were longer because of

the number of people appearing with the patient. Yet it did appear that the tribunal were concerned to be thorough, even with patients who were unaccompanied or unrepresented. The hearings were rarely decided within 30 minutes. Those which ended in such a short time usually concerned cases where for some reason the tribunal needed to defer or adjourn their consideration; perhaps because relatives had been unable to attend or the solicitor had requested an adjournment to allow for further enquiries.

On what evidence did the tribunal members base their judgements?

A number of research questions were concerned with the evidence on which the tribunal based their decisions and advice in regard to the 'danger' or risk associated with the patients. The results are presented within the statistical tables in this chapter.

The hypothesis that there would be no difference in the extent to which tribunal members took account of particular categories of evidence was clearly rejected. The responses to the observation and interview research questions demonstrated a tendency to be influenced by such factors as 'personality', 'mental disorder', 'immediate offence', and 'present behaviour'.

Observation findings

Table 1 In considering evidence, did the tribunal members show regard for the following?

	<u>Yes</u>	<u>No</u>	<u>Total hearings</u>	
Mental disorder	127	12	139	91.4%
Immediate offence/behaviour	131	8	139	94.2%
Circumstances of offence	88	51	139	63.3%
Previous offences/behaviour	132	7	139	95.0%
Personality of patient	130	9	139	93.5%
Family background	84	55	139	60.4%
Previous social life-career	126	13	139	90.6%
Current family circumstances	132	7	139	95.0%
Present behaviour/attitudes	139	0	139	100.0%
Community support services	65	74	139	47.8%
Social adequacy of patient	115	24	139	82.7%
Length of stay in Rampton	127	12	139	91.4%
Hospital opinion and planning	129	10	139	92.8%
Other	77	62	139	55.4%

Null hypothesis clearly rejected

This research question in the observation section of the research schedule was designed to cover a comprehensive range of categories of evidence. Any reference to the category was noted by the researcher. It was clear from Table 1 that the tribunal adopted a comprehensive approach to their enquiries during the interviews and deliberations of the hearing. Regard was shown for nine categories of evidence at over 90.0% of the 139 observed hearings: present behaviour, previous offences, family circumstances, immediate offence, personality, hospital opinion, mental disorder, length of stay at Rampton, and the previous life-career of the patient(work, social life etc). There was no significant difference between the extent regard was shown for these nine categories of evidence($X_2(8D.F) = 8.12$ $p < 0.50$).

The null hypothesis was rejected as soon as any of the other categories of evidence were included in the analysis. This was so even when comparing 'social adequacy of patient' (115 hearings 82.7%) with the nine more significant categories of evidence ($X_2(9D.F)=35.55$ $p < 0.001$ highly significant difference). Regard was shown to 'social adequacy' on significantly more occasions than 'circumstances of the offence' (88 hearings 63.3%) and 'Family background' (84 hearings 60.4%). In turn, these categories were considered on significantly more occasions than 'community support services' (65 hearings 47.8%)

Table 1 simply reflected whether or not regard was shown (any reference was observed) in respect of the pre-determined categories of evidence. This did give some indication of the relative importance of the different categories of evidence in terms of the total hearings. For example, it did appear that certain categories of evidence (such as information in regard to the community support services, the family background, and the circumstances of the offence) were relatively less important. It was possible that these particular categories of evidence became more important and influential as the tribunal gave more serious consideration to rehabilitative needs. The other categories could have been more relevant in determining the degree of risk or vulnerability and 'balanced justice', with 'parens patriae' considerations coming more to the fore when discharge was being seriously considered. It would appear that the social adequacy of the patient, the circumstances of the offence or misbehaviour, the family background, and the community support services were not primary factors in the decision-process determining 'danger' or risk.

As emphasised above, the information contained in Table I did not attempt to weigh the influence of difference factors in the decision-making within particular hearings. Note was taken simply of whether there was any reference at all to that category of evidence. The research question in Table 2 did attempt to identify from observation the factor which appeared more influential than any other in each of the observed 139 hearings.

Table 2 Did one factor appear to be more influential with the tribunal as a whole?

Not clear	24	17.3%
Mental disorder	25	18.0%
Immediate offence/behaviour	14	10.1%
Previous record	2	1.4%
Personality of patient	30	21.6%
Previous life-career	0	0.0%
Family circumstances	1	0.7%
Community support services	3	2.2%
Length of stay	10	7.2%
Present behaviour/attitudes	17	12.2%
Other	13	9.3%
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139 hearings		100.0%
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Null hypothesis clearly rejected

The recorded responses to the observation question in Table 2 involved a judgement on the part of the researcher and therefore the possibility of bias. There was some protection in the fact that the researcher was making a separate judgement at each separate hearing independent of each other. Also the reliability of the observation findings could be assessed by comparison with the responses to the equivalent interview questions.

At 24 hearings(17.3%), the researcher noted that it was not

clear as to which factor was more influential. Five categories of evidence appeared to be primary influences, in that they accounted for 96 of the 139 observed hearings (69.1%); personality of the patient, mental disorder, present behaviour and attitudes, immediate offence or behaviour which had led to detention, and the length of stay in Rampton Hospital. The difference between these five primary factors was highly significant ($X_2(4DF) = 16.12$ $p < 0.01$); with 'personality of patient' and 'mental disorder' being clearly the most influential categories of evidence.

The researcher was able to make a judgement in regard to the more influential factor at the majority of hearings (82.7%); and the aggregate findings contained in Table 2 did appear to complement and correspond generally with the findings in regard to references during the observed hearings to the predetermined categories of evidence. It was clear that nine categories of evidence were considered almost invariably relevant to their enquiry. Five of these factors were identified as the factors which appeared to be significantly more influential with the tribunal during the 139 hearings. The findings from structured observation of the hearings indicated that the 'personality of the patient' and 'mental disorder' were the main influences with the tribunal members as a whole.

To provide a more comprehensive description of the evidence on which they based their judgements and to alleviate the restrictions of pre-determined categories of response, there was provision with both the above observation question for noting 'other' evidence taken into account and 'other' factors which were more influential

at individual hearings. Regard was shown to 'other' evidence at only 77 hearings (55.4%). 109 items were noted in respect of these 77 hearings. 60 of these items related to the patient, including references to a drink problem(13 hearings), physical health(10 hearings), epilepsy(9 hearings), sexual interests (9 hearings), and leisure interests(2 hearings). 18 items were more related to the legal process, including references to previous tribunal decisions. On six occasions, the tribunal discussed or referred to previous unsuccessful discharges through the tribunal. On another six occasions, the implications of the fact they had already previously adjourned the particular case were discussed or mentioned by the tribunal members. The other items included 'balanced justice' considerations such as the patient having already served a prison sentence prior to being transferred to Rampton, and rehabilitative resource considerations such as resistances from hospitals in the home areas to accepting responsibility for their resident.

Interview findings

The interview findings tended to support the same conclusions in regard to the evidence which was more influential with the tribunal. This applied in respect of the interview question in regard to 'the most important influence'(Table 3) and the aggregation of the responses to the interview questions about the three most important factors(Table 6).

Table 3 In deciding whether or not this particular patient should continue to be detained in Rampton, which factor appeared to you the most important influence in that decision?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Mental disorder	21	17.8%	5	15.6%	26	17.4%
Immediate offence/behaviour	16	15.3%	2	6.3%	20	13.3%
Previous record	12	10.2%	0	0.0%	12	8.0%
Personality of patient	34	28.8%	11	34.4%	45	30.0%
Previous life-career	4	3.4%	2	6.3%	6	4.0%
Family circumstances	1	0.8%	1	3.1%	2	1.3%
Community support services	1	0.8%	2	6.3%	3	2.0%
Length of stay	7	5.9%	1	3.1%	8	5.3%
Present behaviour/attitude	11	9.3%	7	21.8%	18	12.0%
Other	6	5.1%	1	3.1%	7	4.7%
Could not answer	3	2.5%	0	0.0%	3	2.0%
	118	100.0%	32	100.0%	150	100.0%

The null hypothesis was clearly rejected in respect of the different factors which were considered by the legal chairmen to be the most important influences on their decisions.

'Personality of the patient' was clearly the most influential factor during the total of 150 hearings (45 hearings 30.0%), even in comparison with the factor which was identified on the second highest number of hearings; 'Mental disorder' 26 occasions (17.4%) ($\chi^2_{(1D.F)} = 6.67$ $p < 0.01$ highly significant difference). Second to 'personality of the patient', the null hypothesis was not rejected in regard to the four factors or categories of evidence considered 'most important': 'mental disorder' (26 hearings 17.4%), 'immediate offence/behaviour' (20 hearings 13.3%), 'present behaviour/attitude' (18 hearings 12.0%), and 'previous record' (12 hearings 8.0%) ($\chi^2_{(3D.F)} = 6.02$ $p < 0.05$). 'Length of stay', 'previous life-career', 'community support services', and

'family circumstances' were significantly less likely to be considered the most important influence on the decision. The 'other' factors included family attitudes and hospital plans.

Support for the reliability of these findings in regard to the evidence on which the tribunal based their judgements was to be found in the comparison between the observation findings (Table 2) and the interview findings (Table 3). There was no significant difference in the ranking of the five factors which appeared to be more influential nor between the responses to these categories of evidence in the two research methods.

Table 4 Comparison between observation and interview findings

	<u>Observation (Table 2)</u>		<u>Interview (Table 3)</u>	
Personality of patient	30	21.6%	45	30.0%
Mental disorder	25	18.0%	26	17.3%
Present behaviour/attitude	17	12.2%	18	12.0%
Immediate offence/behaviour	14	10.1%	20	13.3%
Length of stay	10	7.2%	8	5.4%
Other/not clear, etc.	43	30.9%	33	22.0%
	<hr/>		<hr/>	
	139	100.0%	150	100.0%
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Null hypothesis not rejected
 $(\chi^2_{(5D.F)}=5.33 \text{ } p < 0.50 \text{ no significant difference})$

There was no significant difference between the observation and interview findings in regard to the five factors and total of others and 'not clear'. Also, there was no significant difference when comparing the observation and interviews responses in individual categories (for example, 'personality of patient' $\chi^2_{(1D.F)}=2.68 \text{ } p < 0.70$).

The difference was significant in regard to 'previous record'. On only 2 occasions out of 139 observed hearings had the previous record appeared to be the more influential factor; whilst the legal chairmen identified the previous record as the most influential influence in 12 out of 150 hearings ($X_2(1D.F) = 6.65$ $p < 0.01$). As there was no significant difference between the observation and interview responses in regard to 'immediate offences', it did not appear likely that confusion between 'immediate offences' and 'previous record' had created any major bias in the responses of the legal chairmen. The difference in regard to 'previous record' could have been related in some way to the extent the researcher had recorded that the most important influence was 'not clear' (24 hearings 17.3%). Another possible influence could have been that it was the legal chairman who was responding to the interview questions. Yet the suggestion that the legal chairmen would have been more influenced by the criminal record was not supported by the observation of the researcher, as confirmed in the observation findings in regard to the individual tribunal members (see below).

Further interview questions supplemented the question in regard to 'the most important influence in that decision':

Which factor would you have said was second in importance as an influence on the decision?

Was there a further factor which was important in the decisions?

Table 5 presented the responses to these three interview questions for comparison. Table 6 aggregated the responses

in order to obtain a total statistical summary of the factors which the legal chairmen considered to be the three most important influences on their decision.

Table 5 Comparison of interview responses in regard to the evidence

	<u>'Most important'</u>		<u>'Second in importance'</u>		<u>'Further Factors'</u>	
Mental disorder	26	17.4%	18	12.0%	4	2.6%
Immediate offence	20	13.3%	21	14.0%	6	4.0%
Previous record	12	8.0%	20	13.3%	12	8.0%
Personality of patient	45	30.0%	27	18.0%	11	7.3%
Life career	6	4.0%	7	4.7%	7	4.7%
Family circumstances	2	1.3%	12	8.0%	20	13.3%
Community Services	3	2.0%	5	3.3%	10	6.7%
Length of stay	8	5.3%	11	7.3%	13	8.7%
Present behaviour/attitude	18	12.0%	12	8.0%	19	12.7%
Other	7	4.7%	13	8.7%	22	14.7%
None	0	0.0%	1	0.7%	23	15.3%
Could not answer	3	2.0%	3	2.0%	3	2.0%
	150	100.0%	150	100.0%	150	100.0%

The findings contained in Table 5 illustrated the relationship between the different categories of evidence and something of the decision-process in considering the release of men and women from special hospital care. The inter-action between 'balanced justice' and 'parens patriae' considerations will be discussed later. One specific interpretation from Table 5 was that certain factors related more directly to assessing the 'danger' or risks to others had the primary influence; with rehabilitative and welfare considerations coming to the fore only when and if the question of 'risk' had been adequately answered. This interpretation was supported when certain possible 'danger signals' (personality, mental disorder, and offences) and rehabilitative considerations (family circumstances, and community support services) were separately aggregated and their progressive influence compared.

	<u>Most important</u>	<u>Second influence</u>	<u>Further factor</u>
Personality } Mental disorder } Immediate offence }	91 60.7%	66 44.0%	21 13.9%
Family circumstances } Community services }	5 3.3%	17 11.3%	30 20.0%

This changing balance of emphasis was perhaps even more apparent when other categories of response (such as 'length of stay', 'other', and 'none') were included in the analysis. Evidently at 23 hearings (15.3%), the legal chairmen did not consider that more than one or two primary factors were important in the decision. This could have related to a strict application of the factors relevant to determining the justification for detention, or other factors not being considered relevant in respect of patients requiring continued detention on the basis of one or two factors (rehabilitative planning unnecessary).

The 'other' responses tended to be a miscellaneous variety of factors related mainly to the needs of the patient rather than the protection of others.

Table 6 Total responses to interview questions on influential evidence

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Mental disorder	37	10.5%	11	11.5%	48	10.7%
Immediate offence	40	11.3%	7	7.3%	47	10.4%
Previous record	36	10.2%	8	8.3%	44	9.8%
Personality of patient	66	18.7%	17	17.7%	83	18.5%
Previous life-career	15	4.2%	5	5.2%	20	4.4%
Family circumstances	20	5.6%	14	14.6%	34	7.6%
Community services	10	2.8%	8	8.3%	18	4.0%
Length of stay	27	7.6%	5	5.2%	32	7.1%
Present behaviour/attitude	38	10.7%	11	11.5%	49	10.9%
Other	36	10.3%	6	6.2%	42	9.3%
None	20	5.6%	4	4.2%	24	5.3%
Could not answer	9	2.5%	0	0.0%	9	2.0%
	<u>354</u>	<u>100.0%</u>	<u>96</u>	<u>100.0%</u>	<u>450</u>	<u>100.0%</u>

The aggregated interview responses confirmed the prominence of the 'personality of the patient' as an influence on the tribunal decision-making. Whilst also confirming the importance of such factors as 'mental disorder', 'immediate offences', 'previous record', and 'present behaviour', the total summary further illustrated the increasing importance of rehabilitative considerations. It was evident that rehabilitative considerations were particularly important with the women. There was a significant tendency toward women in comparison with men in regard to both 'family circumstances' ($X_2(1D.F)=7.41$ $p < 0.01$) and 'community support services'. ($X_2(1D.F)=4.75$ $p < 0.05$) (corrected for continuity). This finding was possibly related to the greater tendency toward non-offenders and more severe mental disability among the women.

Comparison between the different tribunal members

Within the observation section of the research schedule, supplementing the observation question in regard to the factor which appeared to be more influential with the tribunal as a whole, were questions in regard to the individual members of the tribunal. These were to test the hypothesis that there would be no difference in the extent individual member-groups (legal members, medical members, and lay members) took account of different categories of evidence:

Did one factor appear to be more influential with the legal member?

Did one factor appear to be more influential with the medical member?

Did one factor appear to be more influential with the lay member?

Table 7 Factors which appeared more influential with individual members

	<u>Legal member</u>		<u>Medical member</u>		<u>Lay member</u>	
Not clear	8	5.7%	7	5.1%	11	7.9%
Mental disorder	16	11.5%	61	43.9%	17	12.2%
Immediate offence/ behaviour	23	16.5%	8	5.7%	13	9.4%
Previous record	4	2.9%	3	2.2%	1	0.7%
Personality of patient	31	22.3%	26	18.7%	36	25.9%
Previous life-career	3	2.2%	0	0.0%	3	2.2%
Family circumstances	3	2.2%	1	0.7%	3	2.2%
Community support services	4	2.9%	1	0.7%	7	5.1%
Length of stay	12	8.6%	8	5.7%	12	8.6%
Present behaviour/ attitude	26	18.7%	13	9.4%	26	18.7%
Other	9	6.5%	11	7.9%	10	7.1%
	139 100.0%		139 100.0%		139 100.0%	

As with the observation question in regard to the tribunal as a whole, the recorded responses in regard to the individual members involved a judgement by the researcher and the possibility of bias. Again there was some protection in the fact that a separate judgement was made independently at each hearing. Comparison with interview findings was not available, as questions requiring the legal chairmen to respond on behalf of other members had been excluded from the research as unreliable. Some support for the reliability of the observation by the researcher was to be found in there being no significant difference between the observation and interview findings in regard to the primary factors of evidence (Table 4). There was also found to be no significant difference between the interview findings in regard to the five factors (Table 4) and the observation of the responses of the legal chairman in respect of those same five factors ($X_2(5D.F)=7.17$ $p < 0.30$).

On the basis of the observation findings about the more influential factors with the individual members, the hypothesis that there would be no difference in the extent they took account of different categories of evidence was rejected in regard to legal, medical, and lay members. How did the findings for individual members compare with each other (Table 7) and the findings for the tribunal as a whole (Table 2)?

The only significant difference between the observation responses about the tribunal as a whole and all three of the responses in regard to the individual tribunal members was in regard to the number of hearings where the researcher recorded that the more influential factor was 'not clear'. This occurred at 24 hearings in regard to the tribunal as a whole (17.3%) but no more than 11 hearings (lay member) with the individual members (7.9%) ($X_2(1D.F)=5.25$ $p < 0.02$). It was apparent that the responses of the individual members were clearer to record than those of the tribunal as a whole. Presumably this was a reflection to some extent of the different emphases of the individual members.

Legal member When the 'not clear' responses were excluded from the analysis it was found that there was no significant difference between the observation responses in regard to the legal chairman and the tribunal as a whole ($X_2(5D.F)=5.58$ $p < 0.50$), comparing the five main factors and total of others. Even though there might have appeared to have been a move on the part of the legal chairman toward 'immediate offence' and 'present behaviour' (49 compared to 31 hearings) and away from 'mental disorder' (16 compared to 25 hearings) in comparison with the tribunal as a whole, the difference was not significant ($X_2(1D.F)=3.05$ $p < 0.10$)⁽⁹⁾

(9) The significance of the trend between these factors was calculated within the context of the total responses rather than simply in relation to each other.

'Immediate offence or behaviour which led to detention' appeared to be significantly more influential with the legal member (23 hearings 16.5%) than with the medical member (8 hearings 5.7%) ($X_2(1D.F)=8.18$ $p < 0.01$) but not the lay member (13 hearings 9.4%) ($X_2(1D.F)=3.20$ $p < 0.10$). As perhaps would be expected of lawyers, there was a relatively greater concern for the offence as part of the legal chairmen's contribution to the consideration of evidence. Compared to the medical member (but not the lay member), there was also a greater concern for the 'present behaviour and attitude of the patient' ($X_2(1D.F) = 5.04$ $p < 0.05$ significant difference).

Medical member When the 'not clear' responses were excluded from the analysis, comparing the five main factors and the total of others, there was found to be a highly significant difference between the observation responses in regard to the legal member and the tribunal as a whole. ($X_2(5D.F)=16.97$ $p < 0.01$). As perhaps would be expected with doctors, this appeared to be due primarily to the predominant influence of 'mental disorder' with the medical member (61 hearings 43.9%). As indicated above, the medical members were significantly less influenced by the offences of patients compared to the legal member, and less influenced by the present behaviour and attitudes of the patients compared to both legal and lay members.

Lay member Although the observation responses recorded a higher influence of 'personality of patient' (36 hearings 25.9%) with the lay member, this was not significantly different from the responses in regard to the legal and medical members. As already indicated,

the lay member did show significantly greater concern for the present behaviour and attitude of the patient compared to the medical member. In regard to no category of evidence was there a significant difference from the legal chairman. As a general statement of the factors which appeared more influential with the lay member, there was a close accord with the legal chairman (but significant differences from the medical member.) (Spearman rank order correlation coefficient 0.9125 $p < 0.001$)

Uncertainty or doubt

The influence of uncertainty or benefit of the doubt will be discussed in more detail in the chapter concerned with 'restraints and difficulties in obtaining the evidence'. In respect of Aim 2 to examine the nature and relative importance of the evidence, the following observation and interview questions were included in the schedule to provide a more comprehensive description of the factors influencing the decisions of the tribunal:

Did they admit to being influenced by uncertainty or benefit of the doubt? (Observation question)

Was there any serious doubt in your mind about whether or not the patient should be released from Rampton? (Interview question)

Table 8 Influence of uncertainty or doubt

	<u>Observation question</u>		<u>Interview question</u>	
Yes	64	46.0%	43	28.7%
No	75	54.0%	102	68.0%
Could not answer			5	3.3%
	<u>139</u>	<u>100.0%</u>	<u>150</u>	<u>100.0%</u>

$(X_2(1D.F)) = 8.07$ $p < 0.01$ highly significant difference)

It was evident that uncertainty and doubt about the right course of action were clear and acknowledged influences on the decisions of the tribunal. In comparison with the other observed factors of evidence (Table 1), 'uncertainty and doubt' was one of the relatively less important factors (along with 'community support services'); but observed in about half of the hearings. In comparison with the observation findings, doubt was less acknowledged by the legal chairmen; yet it was acknowledged in regard to about one third of the hearings. The highly significant difference between the observation and interview findings could have been related to the wording of the research questions. Observations were noted of any reference to uncertainty or doubt, whereas the interview question referred to 'serious doubt'. Also the interview question asked about doubt in the mind of the legal chairman, whereas observations were of uncertainty or doubt expressed by any member of the tribunal.

Subjective feelings or intuition.

The influence of subjective feelings or intuition will be discussed in more detail in the chapter concerned with 'restraints and difficulties in obtaining the evidence'. In respect of Aim 2, the following observation and interview questions were included in the schedule to provide a more comprehensive description of the factors influencing the decisions of the tribunal:

Did they admit to being influenced by their subjective feelings or intuition about the patient? (Observation question)

Were you at all influenced by your subjective feelings or intuition about the patient?(Interview question)

Table 9 Influence of subjective feelings or intuition

	<u>Observation question</u>		<u>Interview question</u>	
Yes	72	51.8%	Definitely	25 16.7%
			Only moderately	50 33.3%
No	67	48.2%	Not at all	73 48.7%
			Could not answer	2 1.3%
	<hr/>		<hr/>	
	139	100.0%	150	100.0%
	<hr/>		<hr/>	

($X_2(1D.F)=0.04$ $p < 0.90$ no significant difference)

It was evident that subjective feelings and intuition about the patient were clear and acknowledged influences on the decisions of the tribunal. This factor was relatively less important than many other identified influences (Table 1); but observed in about one half of the hearings. There was no significant difference between the observation and interview findings. This correlation could support the suggestion that it was the wording of the research questions in regard to 'uncertainty and doubt' (rather than because the chairman was speaking only for himself), which created the significant difference between the observation and interview findings. The wording of the research questions in regard to 'subjective feelings or intuition' were very similar.

Summary of findings

'Personality of the patient' and 'mental disorder' appeared to be the more influential factors of evidence on the decisions of the tribunal. The other main factors were 'immediate offence or behaviour which led to the detention', 'present behaviour and

attitude', and 'length of stay'. Whilst this was not confirmed by observation, the interview finding was that the 'previous record' of the patient was also a main influence.

It appeared that the above 'balanced justice' and 'danger signals' were primary considerations; with 'parens patriae' welfare considerations (such as family circumstances and community support services) coming to the fore only when and if the question of 'risk' had been adequately answered.

There was some contrast in the separate emphases of the tribunal members, evidently influenced by their professional interests. The legal chairmen were significantly more concerned about the 'immediate offences or behaviour which led to detention' and the 'present behaviour and attitude of the patient' than the medical members. The medical members were significantly more concerned about the 'mental disorder' of the patient than either the legal or the lay members. The lay members did not differ significantly from the legal members, demonstrating a primary concern for the 'personality of the patient' and 'present behaviour and attitude'.

'Uncertainty and doubt about the right course of action' and 'subjective feelings and intuition about the patient' were clear and acknowledged influences on the decision-process of the tribunal.

Discussion

As anticipated from the review of literature in regard to the causation and assessment of 'dangerous' behaviour, the criminal offence or behaviour which had led to the detention was a primary concern with the tribunal. Whether it was the 'one over-riding factor', as suggested in the introduction to this chapter, was doubtful. The nature and severity of the offence was important but within the context of a group of important factors. It appeared that the offence was more of an 'over-riding factor' at the time of the initial decision to detain; yet less influential with the increasing length of time after the offence was committed. Other factors more related to the present condition and circumstances of the individual gained importance with time. In addition to this being supported by the observation and interview findings, one of the few further comments by the legal chairman which referred to the offence tended to reinforce this impression: 'Present behaviour, age, and length of stay should be weighed against severity of offence'. There was perhaps also a tendency for the tribunal members to take the severity of the offence for granted, in view of all the patients being detained in special hospitals because of 'their dangerous, violent or criminal propensities'. Although the tribunal showed regard for the offence during 131 of the observed hearings (Table 1), the researcher noted on a number of occasions that the offence was not explicitly acknowledged until very late in the hearing (sometimes being raised by other parties such as the representative or relative).

To find that the mental condition of the patient was a very

important consideration, second only to the personality of the patient as an influence on the tribunal, was perhaps to be expected. Whether the individual was suffering from 'mental disorder of a nature or disability which warranted the detention of the patient in a hospital' was one of the statutory questions requiring an answer from the tribunal (see Chapter 2). Yet, quite apart from being a separate criteria, it was clear that evidence of continued mental disorder was used as a guide to assessing the degree of risk. It was likely that the person was viewed as less 'impulsive and unpredictable' and therefore less 'dangerous', if there was some evidence of an improved or more stabilised mental state.

When the responses to the interview question 'was your decision or advice in favour of release from Rampton? were cross-tabulated with the responses to the interview question on 'the most important influence', the findings were significant and interesting. There was a highly significant tendency toward 'yes' in respect of 'personality of the patient' (19 out of 45, 42.2%) compared to 'offence' (5 out of 20, 25.0%) and 'mental disorder' (1 out of 26, 3.8%) ($\chi^2(2D.F)=12.27$ $p < 0.01$). This finding appeared to support the suggestion that the offence, and even more the continued evidence of mental disorder, were 'risk' factors supporting the need for continued detention. In regard to the total of other 'important influences' (apart from the three factors identified above), there was a greater tendency toward 'yes' in regard to release from Rampton (22 out of 59, 37.3%).

It was evident that the personality of the patient as perceived by the tribunal, in comparison with the offence and mental disorder, was to a significantly greater extent an influence in favour of release. In fact, in respect of the 47 men and women where the decision or advice was in favour of release, 'personality' was the most important influence in the case of 19(40.4%). This finding might have appeared to contradict the assertion of Sturup(1968)⁽¹⁰⁾ that the responses of people with 'only personality problems' were less predictable (and therefore more dangerous) than those of psychotic and mentally handicapped people. Yet the explanation of this apparent contradiction was possibly to be found in the suggestion that, whereas Sturup was referring to identifiable personality disorders, the tribunal could have been reacting on a more intuitive and emotional level in response to their impressions of the person before them. It was suggested in the introduction to this chapter that concern about the 'personality' of the individual came close at times to the confusion of labelling an individual or behaviour which could not be explained otherwise, without adding to the understanding of causation. This could be developed further to suggest that this same phenomenon could operate in favour of the individual. An emotion of warmth or sympathy for the individual or feeling of trust in his good intentions could be labelled 'personality'.

(10) Sturup G.K. "Will this man be dangerous?" CIBA blueprint (1968)

It was found during the review of literature that anti-social behaviour was sometimes linked with disorders of personality. Both Weinberg (1968)⁽¹¹⁾ and Gibbens(1968)⁽¹²⁾ contrasted the personalities of 'psychopathic' and 'neurotic' offenders. They agreed about the psychopathic inability to identify easily with others, the minimal feelings of guilt or anxiety and casualness about delinquent or immoral behaviour, the impulsiveness and tendency to be living very much for the moment, shallow emotional feelings towards others with a tendency to suspicion and aggressiveness, and the generally self-centred view of life. In contrast, both Weinberg and Gibbens found intensive feelings of guilt, anxiety, and inferiority among neurotic offenders. Although extremely self-centred, they were often very over-dependent at the same time as ambivalent about their attitudes towards others with a capacity for intensive hostility and self criticism which tended to obscure their ability to identify with others. Gibbens found a tendency among psychopaths to commit more offences although of a less severe aggressive nature than the neurotics. He suggested that there was a danger of over-estimating the connection between psychopathy and crime, in that he found that the first convictions of the neurotic offenders were much earlier and their criminal careers were longer. These findings from the review of literature appeared to illustrate the confusion and inappropriateness of the legal classification of 'psychopathic disorder'. The severity of behaviour and the personality traits which could lead to that classification were often more evidence of neurotic disorder than a clinical diagnosis of psychopathy.

(11) Weinberg.S.K. 'Sociology of Mental Disorders' Staples Press(London 1968)

(12) Gibbens T, Briscoe, Dell 'Psychopathic Offenders' paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint(1968)

Although the 'personality of the patient' appeared to be the predominant influence on the tribunal, it did not appear that their concept of personality was as definitely defined as above (Weinberg and Gibbens). Nor, as already indicated, did it appear that they were viewing personality necessarily in terms of a 'disorder'. It was found in the review of literature that there was often an assumption of relationship between violent behaviour and specific types of personality (in fact this appeared to be clearly identified through research, e.g. Megaree 1966⁽¹³⁾ and Blackburn 1970⁽¹⁴⁾ in regard to under-controlled and over-controlled personalities). Yet in demonstrating the clear and predominant influence of the personality of the patient on their decision-making, the tribunal members were not mainly responding to distinct types of personality nor necessarily specific personality traits. In so far as they were influenced by personality types or disorders, this could have overlapped with their concern for the mental disorder. In so far as they were influenced by distinct characteristics, this would have overlapped with their concern for the present behaviour and attitude of the patient. Yet both 'mental disorder' and 'present behaviour and attitudes' were primary factors in themselves and the 'personality of the patient' was still the predominant influence. This could support the interpretation that, in showing such a major concern for the personality of the patient, the tribunal were reflecting as much an emotional and intuitive reaction to the patient as acknowledging distinct observable

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- (13) Megaree, E.I. 'Undercontrolled and overcontrolled personality types' Psychol. Monogr. 80, Whole No 611 (1966)
- (14) Blackburn R. 'Personality types among abnormal offenders' Special Hospital Research Unit Report No. 1. DHSS (1970)

characteristics. This 'gut-reaction to the person was reminiscent of the experience and approach of G.K.Sturrrup, with his long and vast experience of assessing and treating mentally abnormal offenders in Denmark(1968).⁽¹⁵⁾ Whilst emphasising the importance of 'lengthy and elaborate examinations', he was greatly influenced by the consensus of intuitive feeling toward the patient. His own major criteria appeared to be the question of whether he had been able to establish reasonable communication and a constructive emotional relationship which could be used in the process of rehabilitation. He took the view that without satisfactory emotional contact he could not effectively evaluate a person nor be optimistic about treatment and rehabilitation.

Therefore it was evident that the 'personality of the patient' not only overlapped with the 'mental disorder' and 'present behaviour', but to some extent inter-acted with 'subjective feelings and intuition about the patient'. The influence of intuition and 'gut-feelings' was evident from observation and acknowledged by the tribunal chairmen. Whereas more tangible evidence such as the offences and mental disorder of the patient tended to be influences against release, the tribunal's more subjective response to the personality of the patient was more likely to favour release. The interpretation that the response to the personality was at least partially a subjective reaction

(15) Sturrrup G.K. 'Will this man be dangerous?' paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint(1968)

more likely to favour the release of the patient, could be supported by the finding that the tribunal were more likely to release those patients in regard to whom the legal chairmen had replied 'definitely' when asked if they were at all influenced by their subjective feelings or intuition about the patient. There was a significant tendency toward release in respect of the answer 'definitely' (12 out of 25 hearings, 48.0%) compared to the other responses (35 out of 125, 28.0%) ($\chi^2(1D.F) = 3.95$ $p < 0.05$).

It would appear that the 'one over-riding factor' with the tribunal was the personality of the patient. This applied both in that it was the one main influence in comparison with other factors and also in the sense that it overlapped and to some extent incorporated aspects of other factors. It overlapped both with more objective considerations such as offences and observable behaviour and with less tangible variables such as subjective feelings and intuition. There was the strong indication that the more subjective aspect of the reaction to the personality of the patient was at least as influential as any objective assessment of personality characteristics.

This interpretation could have been supported by the further comments of the legal chairmen about the evidence they took into account, which are presented in a supplement to this chapter. There was the possibility that 'personality of the patient' (and the objective reactions and subjective responses associated with acknowledging that factor) was an over-riding and inter-connecting consideration; to some extent resolving the difficulties and dilemmas implied in comments such as 'not easy to categorise', 'not clear', 'all influential and inter-related', and 'negative personality with

honest doubts about future - what to do?!

ANSWERS FROM THE LEGAL CHAIRMAN TO THE QUESTION:

'Would you like to make any further comments about the evidence you took into account in making your decision?

- Man (sexual assault) 'Take all circumstances into account - not easy to categorise'
- Woman (violence) 'Medical evidence important but not clear'
- Man (sexual assault) 'Mental disorder - family circumstances and previous life-career - all influential and inter-related'
- Man (sexual assault) 'Current family circumstances'
- Woman (violence) 'Needs care - failed at previous discharge'
- Man (sexual assault) 'Length of stay in his favour yet outweighed by need to test out improvement - decided to rely on discharge being planned by hospital'
- Man (violence) 'Give him a 'holiday' even if he breaks down'
- Man (sexual assault) 'Present behaviour, age, and length of stay weighed against severity of offence'
- Woman (violence) '(1) release from order previously did not lead to release from Rampton. (2) subsequent decline in behaviour. Difficult to decide how (1) affected (2)'
- Man (violence) 'Family circumstances also important'
- Woman (violence) 'Extremely long stay - looking for transfer'
- Woman (violence) 'If family had been able to cope perhaps would have discharged'
- Man (violence) 'Adjourned for further hearing therefore not investigated'
- Man (violence) 'Transfer from prison. Query mental illness and paranoid - only ten days before release - paranoia increased - no medication'
- Man (violence) 'Also family circumstances - also community support services in Eire'
- Man (violence) 'No further treatment - good work record'
- Woman (violence) 'Longstay patient needs sheltered accommodation, not maximum security'
- Man (sexual assault) 'Incident ten years ago apparently initiated by children'
- Man (sexual assault) 'No evidence of progress. Responsible medical officer doubtful about progress'

Man (violence) 'Institutionalised - excellent progress - epilepsy under control - needs transfer'

Man (rape) 'Rape at twenty - good behaviour in hospital - negative personality with honest doubts about future - what to do?'

CHAPTER TWELVE

RESTRAINTS AND DIFFICULTIES IN OBTAINING THE EVIDENCE

Introduction

'Sentencing is not a rational, mechanical process. It is a human process and is subject to all the frailties of the human mind' (Hogarth 1971)⁽¹⁾

J.Hogarth(1971) questioned the traditional legal view which assumed that judicial decisions were based entirely on identifiable legal 'facts'. 'One may be tempted to conclude that one has "explained" sentencing through an exhaustive analysis of the facts before the court. However, it must be concluded that this type of analysis gives only a partial and inadequate explanation of the processes involved'.⁽²⁾

Hogarth concerned himself with the 'meanings' that magistrates attached to the facts of the cases. He found that, whereas external facts were often significant variables in the decision-process(so supporting the input-output model), the 'facts' as perceived by the judges were more powerful in the predictive sense. It was explained in Chapter Four on 'Models appropriate to the study of legal decision-process' that, whilst not attempting to make any analysis of the attitudes which might influence perceptions, the research project would incorporate study of the

(1) Hogarth J. 'Sentencing as a Human Process' Toronto University Press (Toronto 1971) p.356.

(2) Hogarth J. 'Sentencing as a Human Process' Toronto University Press (Toronto 1971) p.349.

way they perceived 'danger' and the facts of the cases. Some of the findings related to this aspect of the research were presented and discussed in Chapters Ten and Eleven. The findings and discussion of the influence of identifiable 'facts', socio-demographic features of the patient, were presented in Chapter Sixteen below. This present chapter was concerned with something which was, in a sense, in between the observable and identifiable evidence and the perceptions of the tribunal members? What if the 'facts of the case' were not available or clearly understandable? What if the decision of the tribunal was required to be made on inadequate information?

What were the nature of any restraints or difficulties experienced by the tribunal in obtaining the evidence considered necessary to reach decisions? This question was incorporated into the research project as one of the 'crises' identified by Lemert(1970),⁽³⁾ when the formal structure and process of legal decisions were insufficient for the task. Lemert was concerned with the process of legal change and the influence of these 'crises' on that process. This present research project applied the same approach to 'crises' in the decision-process with particular cases. Did the tribunal experience any serious difficulties in obtaining the evidence they required? What was the nature of these difficulties and to what categories of evidence did they relate? To what extent was uncertainty a factor in the decision-process and the need to apply 'benefit of the doubt'?

The process of receiving evidence through reports and interviews

(3) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970)

was described in Chapter Three on the 'Mental Health Review Tribunal'. The actual extent of reports received and witnesses interviewed during the sample group of 150 hearings was summarised in Chapter Eleven on 'The evidence on which the tribunal based their judgements'. It was seen that the presence of the patient and reports from the hospital were required by the tribunal meeting at Rampton Hospital as invariable conditions before convening the hearing. Normally the patient was assisted by legal representation and reports on the home circumstances were provided by the responsible local authority social services agency in the home area; but these were not invariable conditions. Relatives of the patient were invited but did not always attend. Occasionally representatives of the hospital team or the community agencies attended, but normally they were not invited. Most of the tribunal hearings took between 45 and 75 minutes (92 hearings, 61.3%), with a further 18 hearings (12.0%) taking over 75 minutes.

Were difficulties experienced in obtaining the evidence?

The hypothesis that the tribunal members would not experience any serious difficulty in obtaining the evidence they required was rejected by the observation and interview findings. Although there was a significant difference between the observation and interview findings, both methods of study identified a high proportion of hearings where restraints and difficulties were apparent.

Observation Findings

In respect of the 139 hearings which were observed, there were

62 hearings(44.6%) when the researcher did not observe any references to difficulties in obtaining the evidence. These 62 hearings concerned 49 men(45.8%) and 13 women(40.6%); so there was no significant difference between men and women in regard to whether or not there were difficulties in obtaining evidence($X_2(1D.F)=0.29$ $p < 0.90$).⁽⁴⁾

Table 1 Did the tribunal members refer to difficulties in obtaining evidence required to reach decisions?

	<u>Yes</u>	<u>No</u>	<u>Total</u>	
Reports not available	28	111	139	20.1%
Available reports inadequate	35	104	139	25.2%
Hospital witnesses not available	11	128	139	7.9%
Family witnesses not available	21	118	139	15.1%
Community witnesses not available	5	134	139	3.6%
Health services unavailable	12	127	139	8.6%
Other evidence unavailable	7	132	139	5.0%

As indicated in Table 1 (total references to difficulties), there were 119 references to difficulties during the 77 hearings such references were observed. This was a mean average of 0.86 difficulties during the total sample group of observed hearings; and a mean average of 1.55 difficulties during the 77 hearings were difficulties were acknowledged.

Interview Findings

The difference between the observation and interview findings

(4) It was noticed that each of the eleven hearings which were unobserved by the researcher for different reasons(see page 55, Chapter Six) concerned men. Although this should perhaps be borne in mind when considering findings despite none of the unobserved hearings being concerned with women, the difference in this respect was not significant at 0.05 ($X_2(1D.F)=2.01$ $p < 0.20$ (corrected for continuity).

in regard to the number of hearings at which difficulties were identified was significant with the men ($X_2(1D.F)=12.97$ $p < 0.001$, highly significant difference) but not statistically significant with the women ($X_2(1D.F)=1.56$ $p > 0.05$), perhaps because of the

Table 2 Did you experience any difficulty in obtaining the evidence you required to reach your decision?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Serious difficulty	9	7.6%	3	9.4%	12	8.0%
Moderate difficulty	18	15.3%	8	25.0%	26	17.3%
Minimal difficulty	8	6.8%	3	9.4%	11	7.3%
None at all	82	69.5%	18	56.2%	100	66.7%
Could not answer	1	0.8%			1	0.7%
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	118	100.0%	32	100.0%	150	100.0%
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limited size of the sample of women. The researcher noted references to difficulties in obtaining evidence during the observed hearings on significantly more occasions than the chairmen acknowledged such difficulties. Perhaps the chairmen would be less likely to retrospectively acknowledge difficulties than they would be noted during the course of the hearings. Whatever the reasons for the difference (which could include bias in the different methods), in both approaches difficulties were identified on a significant number of occasions (researcher observed references to difficulties at 77 hearings, 55.4%; the chairmen acknowledged difficulties in respect of 49 hearings, 32.4%).

What were the nature of the difficulties experienced?

The hypothesis that difficulties in obtaining evidence would

not be due to any particular cause or restraint as against others was rejected by both the observation and interview findings. Although there was some difference in the extent of different causes of difficulty, there was a similar pattern of difficulties identified by the observation and interview methods.

Observation Findings

The observation findings in regard to the various causes of difficulty and restraint were presented in Table 1 above. In respect of reference to difficulties which were identified through observation, the inadequacy of reports (45.5% of 77 hearings where references observed) and the non-availability of reports (36.4%) appeared to be the primary difficulties. There was a significant difference when comparing these primary difficulties with the difficulty which was identified with the next highest frequency; family witnesses not available, 27.3% ($X_2(2D.F) = 8.25$ $p < 0.02$). Whilst the difference between the number of hearings where difficulties were identified and the number where difficulties were not acknowledged was not significant ($X_2(1D.F) = 3.24$ $p < 0.10$), the number of hearings where difficulties were not acknowledged was significantly greater than any specific cause of difficulty or restraint.

Interview FindingsTable 3 What was the nature of the difficulty?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
No difficulty	82	69.5%	18	56.2%	100	66.7%
Reports not available	7	6.0%	3	9.4%	10	6.7%
Available reports inadequate	9	7.6%	0	0.0%	9	6.0%
Hospital witnesses not available	2	1.7%	1	3.1%	3	2.0%
Family witnesses not available	1	0.8%	5	15.6%	6	4.0%
Community witnesses not available	1	0.8%	2	6.3%	3	2.0%
Health services unavailable	5	4.3%	3	9.4%	8	5.2%
Other	10	8.5%	0	0.0%	10	6.7%
Could not answer	1	0.8%	0	0.0%	1	0.7%
	118	100.0%	32	100.0%	150	100.0%

In respect of ten hearings (on each occasion concerning men), the chairmen chose to respond to the miscellaneous 'other' response-category. This could have distorted the comparison of the responses in respect of men and women; although on the whole the 'other' responses did appear to be appropriately classified as separate from the pre-determined responses-categories. The 'other' responses included concern for information about community resources (5 hearings), and single instances of the patient being reluctant to respond to questions, the legal representatives resisting the matter being decided without a further independent psychiatric opinion, contradictory reports, and the difficulty of not being able to persuade the responsible medical officer to undertake a certain course of enquiry.

In regard to the interview findings, the difference between the hearings where no difficulty was acknowledged (100 hearings,

66.7%) and the total of other hearings was highly significant.

Although four pre-determined categories of difficulty were selected with greater frequency by the chairmen, the difference between these four categories was not significant ($X^2(3D.F)=1.28$ $p < 0.80$): reports not available, 10 hearings (20.4% of 49 hearings where difficulties acknowledged), available reports inadequate, 9 hearings (18.4%), health services unavailable, 8 hearings (16.3%), and family witnesses not available, 6 hearings (12.2%). Three of these categories were identified as primary difficulties by the method of observation; and the other category 'health services unavailable' was the difficulty which was identified with the next highest frequency (see table 1).

Although there was some difference in the frequency with which these different categories of difficulty were identified by the two methods of observation and interview, both approaches produced a similar pattern of responses.

Table 4 Comparison between findings about difficulties obtaining evidence.

	<u>Observation findings</u>		<u>Interview findings</u>	
Reports not available	28	23.5%	10	20.4%
Available reports inadequate	35	29.4%	9	18.4%
Family witnesses not available	21	17.6%	6	12.3%
Health services not available	12	10.1%	8	16.3%
Hospital witnesses not available	11	9.3%	3	6.1%
Community witnesses not available	5	4.2%	3	6.1%
Miscellaneous 'other' difficulties	7	5.9%	10	20.4%
	<hr/>		<hr/>	
	119 difficulties		49 difficulties	
	<hr/>		<hr/>	

The pattern of responses tended to suggest that, where difficulties obtaining evidence were experienced by the tribunal, the primary cause of difficulty related to the non-availability and/or inadequacy of reports. The non-availability of witnesses appeared to be secondary to difficulties related to written reports (particularly as categories 'health services not available' and 'other' tended to relate to the absence of information about resources rather than the absence of witnesses).

To what categories of evidence did difficulties relate?

The hypothesis that difficulties in obtaining the evidence would not be in relation to particular categories of evidence was rejected by the observation and interview findings. Although there were some differences in emphasis between the observation and interview findings, both methods found that the problems mainly concerned certain categories of evidence.

Observation findings

Table 5 To which category of evidence did the difficulties mainly relate?

No difficulties	62	44.6%
Mental disorder	5	3.6%
Immediate offences/behaviour	6	4.3%
Previous life-career	2	1.4%
Family circumstances	17	12.2%
Community support services	12	8.6%
Present behaviour/attitudes	7	5.1%
Hospital treatment/planning	9	6.5%
Health service provision	12	8.6%
Other	4	2.9%
Could not say	3	2.2%
	<hr/>	
	139	100.0%

With the limited numbers involved in so many response-categories, the significance of the difference between some of the response-categories was not possible to establish. Yet there did appear to be a clear polarisation between the categories of evidence most affected by the difficulties and restraints (family circumstances, community support services, and health service provision), and those categories of evidence not normally associated with the difficulties (previous life-career, mental disorder, and immediate offences). There was no significant difference between the specific categories of evidence within each of these groupings, but a highly significant difference between the groupings as a whole. Where there were difficulties, the three categories of evidence primarily affected accounted for 53.2% of these hearings where difficulties were identified (compared to only 18.2% in respect of the other grouping of three categories of evidence).

Interview findings

Table 6 Did the difficulty relate to any particular category of evidence or information?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
No difficulties	82	69.5%	18	56.2%	100	66.7%
Mental disorder	3	2.5%	0	0.0%	3	2.0%
Immediate offence/behaviour	3	2.5%	0	0.0%	3	2.0%
Previous life-career	2	1.7%	0	0.0%	2	1.3%
Family circumstances	2	1.7%	5	15.6%	7	4.7%
Community support services	8	6.8%	4	12.5%	12	8.0%
Present behaviour/attitudes	2	1.7%	0	0.0%	2	1.3%
Hospital treatment/planning	2	1.7%	2	6.3%	4	2.7%
Health service provision	6	5.1%	3	9.4%	9	6.0%
Other	5	4.3%	0	0.0%	5	3.3%
Could not say	3	2.5%	0	0.0%	3	2.0%
	<hr/>		<hr/>		<hr/>	
	118	100.0%	32	100.0%	150	100.0%

As with observation findings, chance could account for the differences between the frequency of many of the responses: with

such a small sample of difficulties and so many categories. Yet again, there was the same polarisation between certain primary categories affected by the difficulties (community support services, health service provision, and family circumstances) and other categories of evidence not so affected. In regard to the 49 hearings where the chairmen acknowledged difficulties obtaining evidence, the three categories of evidence primarily affected account for 57.1%(28) of those hearings.

Table 7 Comparison between findings about categories of evidence

	<u>Observation findings</u>		<u>Interview findings</u>	
Family circumstances	17	22.1%	7	14.3%
Community support services	12	15.6%	12	24.4%
Health service provision	12	15.6%	9	18.4%
Hospital treatment/planning	9	11.7%	4	8.2%
Present behaviour/attitudes	7	9.1%	2	4.1%
Immediate offence/behaviour	6	7.8%	3	6.1%
Mental disorder	5	6.5%	3	6.1%
Previous life-career	2	2.5%	2	4.1%
Other/could not say	7	9.1%	7	14.3%
	<hr/>		<hr/>	
	77 hearings		49 hearings	
	<hr/>		<hr/>	

In Chapter Eleven on 'The evidence on which the tribunal based their judgements', the interpretation was made that certain factors were more influential in determining 'risk' and other evidence more concerned with welfare and rehabilitative considerations. It appeared that such categories of evidence as 'offences' and 'mental disorder' were primary factors in regard to assessing the 'danger' associated with a particular individual; with other 'parens patriae' considerations becoming increasingly important and influential as the possibility of release (based on a judgement of lessened risk) was a more likely outcome. It was evident

from the observation and interview findings in regard to difficulties obtaining evidence, that the problems and restraints were not associated with the 'risk' factors of evidence. The references observed by the researcher and the difficulties acknowledged by the chairmen mainly concerned such 'parens patriae' and rehabilitative resource considerations as 'community support services', 'health service provision', and 'family circumstances'. Why might this be?

There were three possible interpretations. These were briefly considered, not to anticipate the 'discussion' later in the chapter, but to lead on to the findings in regard to 'benefit of the doubt' and 'intuitions and feelings':

(a) One interpretation would be that the evidence in regard to such factors as 'immediate offences or behaviour which led to detention', 'mental disorder', and 'previous life-career', was more clear-cut and readily available in comparison with the here and now resource considerations. There was some truth in this, related to the extent the evidence about these factors was concerned with the past and documented in the various records and reports. Related to this was the possible influence that, as these factors were so concerned with the past, there could have been a tendency to assume there was less likelihood of rectifying the inadequacy or absence of information.

(b) The findings summarised in Chapter Eleven on the evidence, identified 'personality of the patient' as a further primary factor in determining the 'risk' associated with the person. Although an apparently less tangible and objective consideration than 'offences' and 'mental disorder', this factor appeared to be

used to compensate for inadequacies in regard to more objective evidence. Also it appeared to relate to the more emotive 'anxiety and threat' aspect of 'danger'. The fact that the tribunal appeared less concerned about difficulties obtaining evidence about such as 'mental disorder' and 'offences', could have been related to this tendency to determine whether to seriously consider release (having not decided against it on more 'tangible' grounds) on more emotive and intuitive influences.

(c) Similarly, and related to the above interpretations, 'uncertainty' and 'unpredictability' were found to be in the nature and definition of 'danger'. Therefore, in regard to the 'risk' factors such as 'immediate offence and behaviour which led to detention', 'present behaviour and attitudes', and 'mental disorder', difficulties could have been expressed more in terms of uncertainty and 'benefit of the doubt' rather than concern about obtaining evidence.

Were uncertainty and 'benefit of the doubt' an influence on decisions?

The findings in regard to the evidence on which the tribunal based their judgements (Chapter Eleven) found that 'uncertainty and doubt' was an influence on the decision.

Table 8 Comparison between findings in regard to 'uncertainty and doubt'

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	64	46.0%	43	28.7%
No	75	54.0%	102	68.0%
Could not answer			5	3.3%
	139	100.0%	150	100.0%

($X_2(1D.F) = 8.07$ $p < 0.01$ highly significant)

Although uncertainty and doubt was identified and acknowledged through the two main research methods on a substantial number of occasions, there was a significant difference between the observation and interview findings. This may have been due partially to the wording of the research questions ('Did they admit to being influenced by uncertainty or benefit of the doubt?' and 'Was there any serious doubt in your mind about whether or not the patient should be released from Rampton?'). The interview question was more specific and emphasised that the doubt should be 'serious'. Another influence could have been a greater reticence after the event to acknowledge doubt compared to the likelihood of it being observed during the hearing. Also the observation question was concerned with the tribunal as a whole, whereas the interview question asked about doubt 'in your mind'.

The chairmen were asked separate questions in regard to whether they would have said that the medical members and the lay members 'had any serious doubt about the right course of action'. As perhaps would be expected (Table 9), there was probably even greater reticence about answering on behalf of their colleagues (although the answers almost always a definite 'yes' or 'no').

Table 9 'Serious doubt' on the part of medical and lay members

	<u>Medical members</u>		<u>Lay members</u>	
Yes	17	11.3%	24	16.0%
No	128	85.4%	119	79.3%
Could not answer	5	3.3%	7	4.7%
	150	100.0%	150	100.0%

It would be inadvisable to come to firm conclusions in regard to the extent to which 'uncertainty and doubt' was present and a factor influencing decisions, nor in regard to the relative presence and influence of 'doubt' between the different tribunal members. It was in the nature of 'doubt' to be difficult to define and identify through observation and interview. There was a significant difference between the serious doubt in their own mind acknowledged by the chairmen (43 hearings, 28.7%) and that identified by the chairmen in respect of the lay members (24 hearings, 16.0%) ($X_2(1D.F)=6.58$ $p < 0.02$), and even more so in regard to medical members (17 hearings, 11.3%). It would be advisable to assume that this difference was primarily related to the openness of the legal chairmen on their own behalf and their reticence on behalf of their colleagues.

Although firm conclusions about the extent to which uncertainty and doubt were present and influential should be avoided, it was clear that they were present on a large minority of occasions. How far and in what ways was 'doubt' an influence on the decisions of the tribunal? The Interview question in regard to the 'benefit of the doubt' sought some information on this (Table 10).

Table 10 Could you say whether you gave the 'benefit of the doubt' in favour or against leaving Rampton?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Favoured release	21	17.8%	8	25.0%	29	19.3%
Favoured detention	9	7.6%	1	3.1%	10	6.7%
Neither	4	3.4%	0	0.0%	4	2.7%
No 'serious doubt'	79	66.9%	23	71.9%	102	68.0%
Could not answer	5	4.3%			5	3.3%
	118	100.0%	32	100.0%	150	100.0%

Where 'benefit of the doubt' was acknowledged as an influence, there was a significant tendency for this factor to influence in favour of release ($X_2(1D.F)=10.64$ $p < 0.01$, highly significant difference). Interpretation of this finding was discussed in 'discussion' section of this chapter.

A further finding in regard to uncertainty or doubt concerned the legal classification of the patient. In regard to applications from patients not further restricted under section 65(Home Secretary), the tribunal had only one power other than to discharge or continue the detaining order; to vary the legal classification. So the same question was asked through observation and interview: 'Was there any doubt expressed about the legal classification?' References to doubt about the legal classification were observed at 14 hearings (10.1%). The chairmen acknowledged doubt about the legal classification in respect of 11 hearings(7.3%). It will be seen in Chapter Fifteen on 'Tribunal decisions and innovations' that the tribunal exercised their authority to change the legal classification on only two occasions(2.8% of the applications).

Were intuition and feelings about the patient an influence on decisions?

The findings in regard to the evidence on which the tribunal based their judgements (Chapter Eleven) found that 'subjective feelings and intuition' were an influence on the decisions.

Table 11 Comparison between findings in regard to 'feelings and intuition.'

	<u>Observation findings</u>		<u>Interview findings</u>		
Yes	72	51.8%	Definitely	25	16.7%) 50.0%
			Only moderately	50	33.3%)
No	67	48.2%	Not at all	73	48.7%
			Could not answer	2	1.3%
	<hr/>			<hr/>	
	118	100.0%		150	100.0%
	<hr/>			<hr/>	

'Subjective feelings and intuition' was very much in evidence and there was a clear correlation between the extent it was identified and acknowledged through observation and interview. For similar reasons for those put forward in regard to 'uncertainty and doubt', despite this apparent close correlation, it would perhaps be advisable not to draw firm detailed conclusions in regard to the extent 'subjective feelings and intuition' was an influence on the decisions. Yet it was evident that subjective feelings and intuition were present and an influence at a substantial number of hearings. There was the strong impression from the further comments of the legal chairmen in regard to 'subjective feelings and intuition' that this factor was closely linked with their response to the 'personality of the patient' (as suggested in Chapter Eleven). Interpretation of these findings was discussed in the 'discussion' section of the present chapter.

Summary of Findings

It was evident that the tribunal members did often experience serious difficulty in obtaining the evidence they considered necessary to reach their decisions.

Where difficulties were experienced, the primary causes of difficulty appeared to be the non-availability of reports and the inadequacy of reports rather than necessarily the availability of witnesses. It appeared to be 'information' they were lacking and not necessarily 'people' as a source of that information.

There was a clear polarisation in respect of the categories of evidence affected by the restraints and difficulties obtaining evidence. The categories of evidence most affected were those concerned with rehabilitative resources and the welfare of the patient; in contrast with those factors concerned more with assessing the 'risk'. 'Mental disorder', 'immediate offence or behaviour leading to detention', 'previous life-career', and 'present behaviour and attitudes' were rarely identified as being affected by the difficulties obtaining evidence.

Uncertainty and doubt were observed and acknowledged influences on the decision-process of the tribunal. There was a significant difference between the serious doubt in their own mind acknowledged by the chairmen and that identified by the chairmen in respect of the medical and lay members. Where 'benefit of the doubt' was acknowledged as an influence, there was a significant tendency for the influence to be in favour of release rather than continued detention.

Subjective feelings and intuition were observed and acknowledged as influences on the decision-process. It was suggested that this was linked, not so much with the need to compensate for difficulties in obtaining evidence, but with the nature and definition of 'danger' and the influence of the 'personality of the patient' as a factor in determining 'risk' and the question of release.

Discussion

The findings in regard to the difficulties obtaining the evidence on which to base their decisions confirmed Hogarth's assertion that an exhaustive analysis of the facts before the court gave only 'a partial and inadequate explanation of the processes involved'.⁽⁵⁾ Yet even his analysis did not explicitly take account of the area of study covered by this chapter. He supplemented a straight-forward input-output model based on clearly identifiable facts, by emphasising the importance of the perceptions of the decision-makers and the meanings they attached to facts. A further aspect of the decision-process was the lack or uncertainty of facts upon which to base the decision. This could be an important influence on the decision itself and also upon the perceptions of the decision-makers. Uncertainty about facts and lack of information could contribute to the need for the decision-makers to supplement inadequate information through their own perceptions and interpretations.

(5) Hogarth J. 'Sentencing as a Human Process' Toronto University Press. (Toronto 1971) p.349

In terms of Lemert's 'socio-legal theory' about the process of legal change,⁽⁶⁾ to what extent were difficulties and restraints in obtaining the information contributing to 'crises' in the decision process? Lemert was concerned more specifically with crises arising because of an accumulation of anomalies where the prescribed rules and procedures were inadequate to protect the interests of the parties involved. The findings and discussion of this aspect were presented in Chapter Thirteen below, on 'Anomalies and dilemmas arising from their rules and powers'. The findings in this present chapter illustrated another form of 'crisis' in the decision-process, which could be considered separately but could also be seen to contribute to the anomalies where the rules and procedures are inadequate. Absence of information or inadequacy of reports created problems in themselves but also undermined the effectiveness and adequacy of the prescribed approach to making decisions on the basis of that information.

In regard to which of the criteria prescribed as the basis for the decisions of the tribunal, did difficulties obtaining the evidence create a potential crisis in the decision-process? As was outlined in Chapter Three, the mental health review tribunal was normally required to decide whether:

- (a) 'the patient is not now suffering from mental illness, psychopathic disorder, subnormality, or severe subnormality', and
- (b) 'It is not necessary in the interest of the patient's health or safety or for the protection of other persons that the patient should continue to be liable to be

(6) Lemert, E. 'Social Action and Legal Change' Aldine (Chicago 1970)

detained',

or

- (c) 'That the patient, if released, would not be likely to act in a manner dangerous to other persons or himself'.⁽⁷⁾

The findings suggested that difficulties obtaining evidence did not present serious problems in regard to determining whether the man or woman still suffered from mental disorder (as defined in the Mental Health Act 1959). Where difficulties were experienced, they were rarely concerned with the 'mental disorder' of the patient. Also doubt was rarely expressed in regard to the legal classification of the patient. There was the strong suggestion in the findings in regard to the evidence on which the tribunal based their judgement (Chapter Eleven), that the diagnosis, treatment, and prognosis of the mental disorder of the patient was the prime concern of the medical member of the tribunal. That this was acknowledged by the other members was further confirmed in the findings outlined in Chapter Fourteen on the 'Disagreements between members'. On the whole, decisions in regard to the criteria of 'suffering from mental disorder' were left to the medical member. In other words, any doubt or uncertainty arising from whatever cause was rarely apparent within the tribunal decision-process. In so far as it existed, it was normally contained within the separate supplementary medical decision-process in regard to the mental state of the patient. The medical member saw the patient separately prior to the full hearing and presented conclusions to the tribunal which were normally accepted by the other members. There was only controversy or crisis, when the hospital doctor and tribunal medical member were dramatically opposed in their view of the mental

(7) Mental Health Act 1959, section 123 (HMSO)

disorder and prognosis(as opposed to simply differing in emphasis) or when the mental condition was contested through a psychiatric opinion independent of the hospital or the tribunal (usually on the initiative of the legal representative).

The findings also appeared to suggest that difficulties in obtaining evidence did not primarily present problems in determining the issues of 'protection of other persons'. Difficulties were rarely identified as concerning those categories of evidence most applicable to determining 'risk'. It was suggested in Chapter Eleven on the evidence on which decisions were based, that 'risk' was determined primarily on three factors; 'mental disorder', 'offences', and 'personality'. On the whole, 'mental disorder' was determined by the medical member; and information in regard to the nature of offences(as opposed to the circumstances of offences) tended to be relatively straight-forward and available. 'Personality of the patient' was acknowledged as closely linked with 'subjective feelings and intuition'; being a reflection of the decision-makers emotive and intuitive response to the person rather than more abstract considerations of personality types and traits. Therefore, although the influence of 'subjective feelings and intuition' was discussed within this present chapter, the assessment of 'personality' through largely subjective reactions was not seriously affected by crises arising from difficulties obtaining information. Face-to-face contact with the individual appeared to be the primary means of determining this factor; and the tribunal required the presence of the patient as an invariable condition before convening the hearing.

Aspects of the criteria prescribed for the tribunal which were associated with the crises arising from difficulties obtaining evidence were 'the patient's health or safety' and the issues implied in 'the patient should continue to be detained'. The health and safety of the patient could be dependent on the provision of health or community resources and/or the support of the family. Even after deciding that 'the interest of the patient's health and safety' did not justify continued hospital care, the tribunal would normally wish to reassure itself of the necessary support from community services and family (particularly with a more disabled person) before exercising the 'duty' to discharge the order. It was evident that lack of information about available resources in the community (sometimes linked with the lack of the resources themselves) presented a dilemma for the tribunal and a crisis in their decision-process. Similarly, lack of information about family circumstances was evidently one serious problem for the tribunal.

A different, although related 'crisis' arose from the fact that it was the justification for detention (not care or treatment) which the tribunal was required to determine. The dilemmas arising from this were discussed further in Chapter Thirteen above, on the anomalies and dilemmas arising from their rules and powers. Difficulties in regard to obtaining evidence (in this case mainly in regard to further health care in the home area) contributed to this dilemma. This was confirmed in the findings, in that one of the categories of evidence most seriously affected was 'health service provision'. The tribunal could be restrained in their 'duty to discharge' (when the above criteria did not justify

continued detention) by the apparent need for continued health care. The option of remaining informally(voluntary) after the order was discharged was not available in a national security hospital; and information about health service provision in the home area(or the facilities themselves)could be unavailable.

The idea of a crisis arising in the decision-process due to difficulties obtaining the information necessary to reach a decision was confirmed in some of the further comments from the chairmen(presented as a supplement to this chapter). 'Could not understand why not yet seen by consultant from the half-way unit'. 'Pressed responsible medical officer to seek transfer'. 'Depends upon whether consultant ready to accept him'. 'Handicapped by not seeing the family'. These comments illustrated the dilemmas arising where (by implication) the tribunal were inclined to support movement but restrained by their dependence on information and resources beyond their control.

These dilemmas were illustrated further by the comments from the chairmen when they were asked 'could you say any more about this?' after admitting to serious doubt about release. These comments were concerned almost entirely with either doubts about the person themselves or doubts about rehabilitative resources.

'Would have liked to progress but needed to be sure of facilities'.

'Danger of relapse if not adequate care and support'.

'Needed control; local hospital could probably cope'.

'No doubt as to going but problems of ensuring adequate care'.

'Needed hospital if hospital would take him ;otherwise stay'.

'Typical local hospital patient'.

These were just a few of the comments illustrating the crisis arising from inadequate information about resources considered necessary to back up any decision to discharge the detaining order. It appeared that 'serious doubt' about the decision concerned the issue of rehabilitative resources and other support in the community as much as any other issue. As indicated above, the other primary concern in respect of 'doubt' was the person themselves. Again, this was illustrated in the further comments of the chairmen in regard to 'serious doubt'.

'The offence did not seem to be in character'.

'Greater probability of behaving properly'.

'Immature mental obsessions appeared over-stressed'.

'Appeared to be apathetic and lacking in resource but difficult to assess'.

'Higher than average intelligence, good talker, but unconvinced'.

'Apparent genuine self-awareness of problem could only be tested elsewhere'.

The above comments illustrated that, even though uncertainty and doubt can often contribute to the initial assessment of 'danger' and need for restraint, 'doubt' could often favour the patient. This was confirmed in the statistical findings in regard to 'benefit of the doubt', which appeared to be more influential in favour of the release of the person. Repeatedly, in their further comments, the chairmen used the phrase: 'give him a chance'.

This same phrase ('Give him a chance') arose within the further comments of the chairmen when they were asked 'could you say any more about this?' after acknowledging the influence of subjective

feelings and intuition. Although subjective assessment could be used to compensate for 'doubt' about the right course of action or difficulties in obtaining more objective information, there was limited explicit evidence of this as a regular practice. The extent to which this was observed and acknowledged as an influence and the nature of the further comments by the chairmen, supported the view that 'subjective feelings and intuition' was a distinct factor influencing decisions rather than simply a reactive expediency (i.e. filling a gap in knowledge, as implied in the term 'benefit of the doubt').

The further comments of the legal chairmen in regard to 'subjective feelings and intuition' tended to support its association with the 'personality of the patient'. Sometimes the comments illustrated an adverse reaction to the patient:

'Flat,gave little impression of being honest'.

'Spoke like a gramophone, repeating self in obtrusive way'.

'Appeared glib,with no insight'.

'Doubted honesty and reliability of his assurances'.

Other comments illustrated a favourable reaction to the person:

'Aware of nature and problems and limitations'.

'Impressed by attitude and honesty'.

'Influenced in favour after seeing her'.

'Interviewed exceptionally well'.

The concept of 'trust' arose often in the many comments from the chairmen in regard to their subjective reactions(66 chairmen

responded to this opportunity for further comment). It was expressed in terms of 'did not trust him', 'did not trust good intentions', or 'trusted to give him a chance'. It was noticed that, although the term 'trust' was used quite often, it was normally associated with 'not trusting' the person. Positive expressions of confidence usually applied other terms such as 'impressed with honesty' and 'believed'.

The discussion of findings in regard to difficulties obtaining the evidence considered necessary to reach decisions has been concerned primarily with the effect on the decision-process. It has illustrated further the inadequacy of the formal structural approach and the need to incorporate the 'crises' created by the difficulties and restraints into the decision-making model. It was found that this modification to the developing model often inter-acted with other considerations which had extended the model, such as the perceptions of the decision-makers and the influence of the subjective responses to the person receiving attention. Although focusing on the difficulties and restraints, there has been some indications of the responses and activity of the tribunal in seeking to over-come the difficulties. This will be considered in more detail in respect of the findings and discussion in regard to the 'tribunal decisions and innovations' (Chapter Fifteen).

ANSWERS FROM LEGAL CHAIRMAN TO THE QUESTION:

'Have you any further comments in regard to difficulties in obtaining the necessary information?'

- Man (arson) 'Detailed records at variance with medical view in the hospital statement'
- Man (Indecent assault) 'Cannot satisfactorily review because of the challenge about the guilt of the offence'.
- Man (murder) 'In the nature of the process that the tribunal only one element, although expected to take wider view'.
- Man (Indecent assault) 'Could not understand why not yet seen by consultant from half-way unit'.
- Man (arson) 'Pressed responsible medical officer to seek transfer'.
- Man (murder) 'How soon assess for half-way unit? Uncertainty about how soon could leave Rampton through half-way unit'.
- Woman (violence) 'No real difficulties as well documented'
- Man (violence) 'Information not specific enough, therefore still have doubts'.
- Man (violence) 'Handicapped by not seeing the family'.
- Man (theft) 'Doubt unless transfer possible; depends upon whether consultant ready to accept him'.
- Man (sexual assault) 'Adjourned at the request of the family'.
- Man (arson) 'Need to take action rather than adjourn again and again'.
- Man (arson) 'Solicitor's initiative - tribunal would have considered case - adjourned'.

CHAPTER THIRTEEN

ANOMALIES AND DILEMMAS ARISING FROM THEIR RULES AND POWERS

Introduction

'When the law fails to provide procedures, remedies, or positive orders for the purpose of safeguarding values, interests, or rights, it falls short of meeting human demands and is maladaptive'.(Lemert 1970)⁽¹⁾

E.Lemert(1970) questioned the traditional assumption that legal development was primarily evolutionary, in the sense of being 'a gradual, cumulative growth of rules, one building on another'. In addition, there was 'legal revolution' showing itself in 'discrete changes, discontinuities, or "new departures" in legal ideas and practices'. He proposed the 'socio-legal theory' that legal revolution resulted from 'crises in law' arising from an accumulation of 'legal issues' based on sufficient 'anomalies' where interests are unsatisfied or frustrated. Legal issues, where there was conflict of values and interests, became potential 'crises' when the conflicting values and interests could be articulated and communicated both in seeking support and in conflict with resistance.⁽²⁾

Lemert proposed that an accumulation of anomalies in the course of normal evolutionary development was a necessary antecedent of

(1) Lemert E. 'Social Action and Legal Change' Aldine(Chicago 1970)p.21.

(2) Lemert.E. 'Social Action and Legal Change' Aldine(Chicago 1970)p.4f

revolutionary change. An essential aspect of the concept of anomalies was the discrepancies between the legally prescribed rules and powers and the actual practice of the judiciary and other parties to the decision-process. Lemert developed his theory with the assertion that legal change did not result only from the growth of legal anomalies but from forceful and effective social action designed to bring about a different way of looking at the relevant facts. This present study was not concerned with crises and changes in the larger macro situation, but with the presence and influence of anomalies and crises within the decision-process and the response of the decision-makers. Did they experience any serious inadequacies in the prescribed rules and procedures in regard to the collection of evidence, the deliberations of the tribunal, or their powers? Did they experience any serious dilemmas in regard to the choices available to them in the practical situation?

Where there were anomalies and dilemmas faced by the tribunal, to what did they relate? In regard to his study of the reform of procedures in the juvenile courts in California, E.Lemert(1970)⁽³⁾ associated many of the anomalies and crises with the distinction between 'parens patriae' and 'balanced justice'. The distinction was illustrated in more detail in the following presentation, modified from Lemert:

	<u>PARENS PATRIAE</u>	<u>BALANCED JUSTICE</u>
(a) Ideology	Welfare and Protection	Justice and fairness
(b) Jurisdiction	Broad, vague, variable	Narrow, explicit, uniform
(c) Powers	i. Positivistic, outreaching, Limited, based on finding preventative. ii. Detention for less clearly defined reasons	and legal categories. Limited detention for specified reasons.

(3) Lemert, E. 'Social Action and Legal Change.' Aldine (Chicago 1970) Chapter 7 'Logic of revolution by law'.

PARENS PATRIAE

BALANCED JUSTICE

(d) Decision-Making	i. Limited accountability or means of accountability.	Prescribed accountability and complete records
	ii. based on mixture of legal and 'diagnostic' facts.	Decided by legal facts only
	iii. Decision after consultation 'in camera'.	Negotiation and bargaining between lawyers and court.

As suggested by Lemert, there were fundamental distinctions between 'parens patriae' and 'balanced justice' considerations, and therefore a source of conflict of interests and values. He was primarily concerned with this distinction in regard to conflict and social action outside and beyond the decision-process in particular cases. This present study was concerned with the extent and ways in which the formal structural approach was not sufficient or adequate to explain the decision-process of the mental health review tribunal in practice. Did the tribunal find themselves faced with situation where the rules were inadequate in themselves for the tasks they were designed to achieve? Were there considerations in practice not anticipated by the rules and powers of the tribunal? In regard to any anomalies and dilemmas, were these potential crises associated with the distinction between 'parens patriae' (welfare and protection) and 'balanced justice' (justice and fairness)?

Anomolies arising from inadequacies in the prescribed rules and procedures

The hypothesis that tribunal members would not experience any serious inadequacy in the prescribed rules and procedures was rejected by the observation and interview findings. This applied particularly to the prescribed powers of the tribunal and to a lesser extent the collection of evidence on which to base their

decisions. There was very limited evidence of such anomalies associated with the conduct of the tribunal hearing.

Observation findings

Table 1 Did the tribunal members refer to difficulties arising from inadequacies in the procedures and rules?

	<u>Obtaining evidence</u>		<u>Conduct of hearing</u>		<u>Powers of tribunal</u>	
Yes	24	17.3%	3	2.2%	49	35.3%
No	115	82.7%	136	97.8%	90	64.7%
	139	100.0%	139	100.0%	139	100.0%

It would be reasonable to conclude from the observation of references to difficulties during the 139 hearings that the prescribed rules and procedures did not present serious problems in regard to the conduct of the hearings. It would appear that such difficulties were mainly associated with the 'input' (obtaining and receiving evidence) and 'output' (decisions and advice) rather than anything distinct from these within the 'black box' (the framework of the composition and procedures of the tribunal established to process the input of 'facts' and respond with the appropriate decision or advice). The three occasions when references to difficulties arising from inadequacies in the procedures and rules were noted in relation to the conduct of the hearing, concerned;

- (a) the wish that it was easier to consult the responsible medical officer as the need arose during the hearing without great inconvenience to him,
- (b) the problem that the particular responsible medical officer could well be unavailable (i.e. on leave) at the time of the

hearing, and

- (c) the question of how to resolve a divergence of opinion among the members of the tribunal when a majority vote seemed inappropriate.

The causes of difficulties in regard to collecting evidence and their powers were discussed later along with those identified through the method of interview.

Interview findings

Table 2 Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the collection and receiving of evidence?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Serious difficulty	0	0.0%	1	3.1%	1	0.7%
Moderate difficulty	11	9.3%	2	6.3%	13	8.7%
Minimal difficulty	4	3.4%	3	9.4%	7	4.7%
None at all	102	86.4%	25	78.1%	127	84.6%
Could not answer	1	0.8%	1	3.1%	2	1.3%
	<u>118</u>	<u>100.0%</u>	<u>32</u>	<u>100.0%</u>	<u>150</u>	<u>100.0%</u>

There did not appear to be any significant difference between the extent difficulties had arisen in regard to men and women ($X_2(1D.F)=0.86$ p < 0.50).^(corrected for continuity) Even though the extent to which no difficulties were acknowledged in this connection was significant, the proportion of hearings at which difficulty was acknowledged was a substantial minority (21 hearings, 14.0%). Where there was difficulty, it was normally judged to be 'moderate' or 'minimal' rather than 'serious'.

Table 3 Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the conduct of the hearing?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Serious difficulty	0	0.0%	0	0.0%	0	0.0%
Moderate difficulty	2	1.7%	0	0.0%	2	1.3%
Minimal difficulty	1	0.8%	0	0.0%	1	0.7%
None at all	114	96.7%	32	100.0%	146	97.3%
Could not answer	1	0.8%	0	0.0%	1	0.7%
	<hr/>		<hr/>		<hr/>	
	118	100.0%	32	100.0%	150	100.0%

It was not possible to make a statistical judgement on any difference between men and women in respect of such a small sample of hearings where difficulties were acknowledged. As the difficulties were so few, it was reasonable to assume that there was not likely to be any relevant contrast. The responses to the supplementary question 'could you describe the difficulty?' overlapped with the comments noted during the observation (with one difference). The descriptions by the chairmen of the difficulties they acknowledged were;

- (a) the time involved in obtaining further information or arranging attendance of relative from Devon,
- (b) wanting to debate reports with the responsible medical officer who was unavailable, and
- (c) a majority decision not being considered an appropriate method of resolving divergence of opinion in view of the severity of the offence.

Table 4 Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the powers of the tribunal in this case?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Serious difficulty	9	7.6%	3	9.4%	12	8.0%
Moderate difficulty	15	12.8%	6	18.7%	21	14.0%
Minimal difficulty	7	5.9%	4	12.5%	11	7.3%
None at all	86	72.9%	19	59.4%	105	70.0%
Could not answer	1	0.8%	0	0.0%	1	0.7%
	<hr/>		<hr/>		<hr/>	
	118	100.0%	32	100.0%	150	100.0%

The difference between men and women in respect of this difficulty was not statistically significant ($X_2(1D.F)=2.34$ $p < 0.20$). Yet there was the suggestion of a tendency toward difficulties in relation to the powers of the tribunal affecting women relatively more than men. This 'suggestion' was supported by there being a highly significant difference in favour of 'no difficulties at all' with men; whereas this was not so with women ($X_2(1D.F)=2.24$ $p < 0.20$). The relevance of this will be discussed later.

In relation to the powers of the tribunal, it was evident that there were more serious difficulties arising from the rules and procedures; both in terms of the number of hearings at which difficulties were acknowledged and the judged severity of the difficulties.

Anomolies arising in relation to the collection and receiving of evidence.

Table 5 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	24	17.3%	Serious difficulty)	21 14.0%
			Moderate difficulty)	
			Minimal difficulty)	
No	115	82.7%	None at all	127 84.7%
			Could not answer	2 1.3%
	<hr/>			<hr/>
	139	100.0%		150 100.0%
	<hr/>			<hr/>

($X_2(1D.F)=0.51$ $p < 0.50$, no significant difference)

There was some support for these findings in the comparison between the findings of the research methods. Both methods supported the finding of a similar substantial minority of

hearings being judged to be affected by anomalies in relation to the collection and receiving of evidence.

What were the nature of the difficulties arising from the rules and procedures about the obtaining of evidence? Information was obtained through supplementary 'details' of the difficulties observed during the hearings and the supplementary interview question 'could you describe the difficulty?' These open-ended responses produced similar information from the different methods. The predominant concerns observed and acknowledged through the interviews related to difficulties resulting from the insufficiency of the rules and procedures to allow adequate direct contact with or obtain information about the health and community services in the home areas of the patients.

In respect of the 24 hearings where the researcher noted difficulties about the rules and procedures, 19 of the 'details' concerned references to difficulties communicating directly with outside services or obtaining further information about them. The predominant concern was in regard to the wish for the opportunity for more direct contact with the national health service hospitals in the home areas or some other means of obtaining information about the health service facilities more effectively. This same emphasis was found in the 'descriptions' by the chairmen of the difficulties. In respect of the 21 hearings where the interviews identified difficulties about the rules and procedures, on fifteen occasions the chairmen described the difficulty in terms of direct contact and information about facilities in the home areas

(again predominantly the health service facilities). In regard to only two hearings (with both observations and interview findings), did the difficulty relate to the community services.

The other difficulties identified by observation and interview involved the obtaining or questioning of reports from the hospital (4 observed hearings and 3 interview), the time which was necessary to obtain further information (2 interviews), contact with family (one interview), and particular difficulties related to a patient from another country, Eire (one observed hearing).

Anomalies arising in relation to the conduct of the hearing

Table 6 Comparison between observation and interview findings

	<u>Observation findings</u>					
Yes	3	2.2%	} Serious difficulty } Moderate difficulty } Minimal difficulty	3	2.0%	
No	136	97.8%		None at all	146	97.3%
				Could not answer	1	0.7%
	<hr/>	<hr/>		<hr/>	<hr/>	
	139	100.0%		150	100.0%	

These findings were presented again simply to confirm that 'anomalies' arising from rules and procedures about the conduct of the hearing (as distinct from the receiving of evidence and their powers) were not a serious problem. The difficulties identified by observation and interview were described above.

Anomalies arising in relation to the powers of the tribunal

Table 7 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>			
Yes	49	35.3%	Serious difficulty } Moderate difficulty } Minimal difficulty }	44	29.3%	
No	90	64.7%		None at all	105	70.0%
				Could not answer	1	0.7%
<hr/>		<hr/>	<hr/>			
	139	100.0%		150	100.0%	
<hr/>		<hr/>	<hr/>			

($\chi^2(1D.F)=1.07$ $p < 0.30$, no significant difference)

There was some support for these findings in the comparison between the findings of the research methods. Both methods supported the finding of a similar substantial minority of hearings being judged to be affected by anomalies in relation to the powers of the tribunal.

What were the nature of the difficulties arising from the powers of the tribunal? Information was obtained through supplementary 'details' of the difficulties observed during the hearings and the supplementary interview question 'could you describe the difficulty?'. These open-ended responses produced similar information from the different methods. The predominant concerns observed and acknowledged through the interviews related to difficulties arising from the restricted powers in response to applications and the impossibility of ensuring the necessary rehabilitative resources were available to support the patient exercising their right to leave hospital if the order to detain was discharged.

In respect of the 49 hearings where the researcher noted difficulties about the powers of the tribunal, 36 of the 'details'

concerned references to the insufficiency of their powers to obtain or ensure the necessary rehabilitative resources or residential care considered essential. 23 references were concerned specifically with the need for national health service hospital care; on 15 occasions indicating their dependence on the hospital team to initiate or continue their efforts to arrange a transfer to a local hospital and on eight occasions regretting they had no power to order such a transfer. At the other 13 hearings, the references concerned the need for community residential or rehabilitative resources and their inability to ensure their provision. In respect of the 44 hearings where the interviews identified difficulties about the powers of the tribunal, the same emphasis was found in the 'descriptions' by the chairmen. 24 of their descriptions concerned the need for local hospital care, although they placed their emphasis differently. Whereas the references noted by the researcher were concerned more with reliance on the hospital team and the need to influence the hospital team into ensuring hospital care (15 out of 23 references about hospital care), the chairmen emphasised more the restricted powers and inability to order transfer (16 out of 24 descriptions of difficulties about hospital care). As there was an inevitable overlap in the nature of these difficulties about obtaining national health service hospital care, it was considered appropriate to group them together. At the same time, it was perhaps not too surprising that the legal chairmen should emphasise more specifically their restricted legal powers. In addition to the 24 difficulties identified in regard to the need for hospital care, 12 other interview descriptions concerned the need for community residential or rehabilitative resources.

So the predominant concern of the tribunal in regard to their powers was their inability to enforce or even influence with reasonable confidence the provision of health or community facilities considered necessary for the rehabilitation of the patient(36 out of 49 observed difficulties about tribunal powers; 36 out of 44 such difficulties acknowledged in the interview). This was related to the fact(emphasised during Chapters Two, Three, and Four about the legal restraint of the mentally disordered) that it was the compulsion which was required to be justified and not the need for care and treatment as such. It was the duty of the tribunal to discharge the detaining order if they were satisfied that the compulsion was no longer justified. The insufficiency of their powers was illustrated by some of the descriptions provided by the chairmen. 'Discharge or not is too restricting'. 'Wanted to discharge but also wanted to be sure of facilities'. 'Firm belief in need to move from Rampton, yet full release would be cruel'. Often their description was a straightforward 'no power to order transfer'.

The other difficulties identified by observation and interview included the insufficiency of their powers to ensure certain clinical assessment or treatment was effected by the responsible medical officer(3 observed hearings and one interview), their inability to 'test out' a patient before reaching a final conclusion (2 observed hearings and one interview), their recommendations being dependent on the approval of the Home Secretary(2 observed hearings and one interview), and concern about the effect on the morale of the patient if the order was not discharged(one observed hearing and two interviews).

Dilemmas arising from the practical choices available to the tribunal

The hypothesis that tribunal members would not experience any serious dilemmas in regard to the practical choices available to them was rejected by the observation and interview findings. The hypothesis that, where they did experience serious dilemmas, they would not arise in regard to any particular aspect of the situation was also rejected. Dilemmas (defined as difficulties arising because of the need to choose between unsatisfactory alternatives) were associated mainly with the need or otherwise for continued hospital care and the behaviour or attitude of the patient himself.

Observation findings

There was no observation question concerned generally with whether or not the tribunal experienced any serious dilemmas. The observation research questions were concerned with whether the tribunal members referred to unsatisfactory choices in respect of specified aspects of the situation. The findings in regard to specific aspects were presented later in the present chapter. These findings confirmed that the tribunal members did experience difficulties in regard to the practical choices available to them. For instance, references to such difficulties were observed in respect of 'the need or otherwise for continued hospital care' (68 hearings, 48.9%) and 'the patient's own attitude and behaviour' (83 hearings, 59.7%).

Interview findings

Table 8 In reaching your conclusions, did you experience any difficulty which arose from the need to choose between unsatisfactory alternatives?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Serious difficulty	15	12.7%	3	9.4%	18	12.0%
Moderate difficulty	19	16.1%	8	25.0%	27	18.0%
Minimal difficulty	19	16.1%	6	18.7%	25	16.7%
None at all	63	53.4%	14	43.8%	77	51.3%
Could not answer	2	1.7%	1	3.1%	3	2.0%
	118	100.0%	32	100.0%	150	100.0%

There did not appear to be any significant difference between the extent difficulties had arisen in regard to men and women ($X_2(1D.F)=0.80$ $p < 0.50$). That there was no significant difference between the extent difficulties were or were not acknowledged for the total group ($X_2(1D.F)=0.67$ $p < 0.50$), illustrated that there had been difficulties on a substantial number of occasions (70 hearings, 46.7%). There was no significant difference between the extent difficulties were judged to be 'serious', 'moderate', or 'minimal'.

Dilemmas associated with need or otherwise for continued hospital care

Table 9 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	68	48.9%	56	37.3%
No	71	51.1%	93	62.0%
Could not answer			1	0.7%
	139	100.0%	150	100.0%

($X_2(1D.F)=3.767$ $p < 0.10$ not significant)

Although there was a face-value difference between the findings of the research methods, the difference was not statistically significant. The apparent tendency toward observing dilemmas about continued hospital care more than they were acknowledged in the interviews affected both men and women (difficulties were acknowledged in regard to 13 women, 40.6%). The wording in both the observation and interview research questions was 'the need or otherwise for continued hospital care'; yet one possible bias was that the researcher was observing references by 'the tribunal members' as a whole, whereas the chairman was asked 'did you face any dilemma?'

It was evident from both methods that the tribunal did experience dilemmas relating to the need for continued hospital care on a substantial number of occasions. Within both research methods, further 'details' were requested in regard to the dilemmas. The same preoccupation was reflected. In respect of the 56 hearings at which the chairmen acknowledged a dilemma in relation to the need or otherwise for continued hospital care, on 45 occasions the 'details' concerned their judgement that the patient needed further in-patient care with the national health service in the home area. They were unable to enforce or ensure this care was provided. The unsatisfactory choice was between continuing the detention of the applicant thus not reflecting their view that the patient was ready for progress or discharging the order with the risk to the patient and others if the necessary facilities were not provided. Although this dilemma was more acute with applicants, it applied to some extent also with their advice to the Home Secretary in regard to references. Whilst their recommendations did at least

have the option of transfer to national health service care, they were still dependent on the Home Secretary to approve this and the hospital team to initiate enquiries. They could face a situation where exhaustive enquiries by the hospital team into alternative hospital care had been unsuccessful, facing them with the same dilemma where hospital care was judged to be necessary but was unavailable. The 'details' of other dilemmas in regard to hospital care included patients resisting transfer to another hospital, other hospitals resisting the patient (or any patient from special hospital), not being able to arrange an initial trial in another hospital, and the question of whether to interrupt preparations already under-way for transfer to another hospital by discharging the detaining order.

Dilemmas associated with the behaviour and attitude of the patient

Table 10 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	83	59.7%	61	40.7%
No	56	40.3%	88	58.6%
Could not answer			1	0.7%
	139	100.0%	150	100.0%

$(X_2(1D.F)=10.13 \text{ } p < 0.01)$

There was a highly significant difference between the observation and interview findings, again in the direction of a greater proportion of difficulties being identified through observation. The difference did not appear to be significant in regard to men and women. The

chairmen had acknowledged difficulties in regard to 16 women, 50.0% ($X_2(1D.F)=1.38$ $p > 0.05$).

It was evident from both methods of data collection that the tribunal did experience dilemmas relating to the behaviour and attitude of the patient on a substantial number of occasions. Although in respect of each method the number of occasions was greater than that relating to the need or otherwise for continued hospital care, the difference was not significant (i.e. observation findings, $X_2(1D.F)=3.28$ $p > 0.05$). In contrast, dilemmas relating to 'need for continued hospital care' and 'behaviour and attitude of the patient' were identified by both methods on significantly more occasions than the other dilemmas presented and discussed below.

Within both methods of data collection, further 'details' were requested in regard to the dilemma associated with the behaviour and attitude of the patient. The same major preoccupations were reflected. In respect of the 61 hearings at which the chairmen acknowledged such a dilemma, on 38 occasions the 'details' concerned the dependence of the patient on support and/or control outside Rampton for his own welfare and/or the protection of others. 18 of these details tended to emphasise the risk to others (i.e. 'likely to relapse unless release carefully planned', 'Needed care to maintain good progress but not security'). 20 of the details were more concerned with the risk to the patient (i.e. 'Needed so much support and sheltering', 'risk of self-neglect if not in sheltered situation'). The other 23 interview 'details' included the difficulty in assessing the patient due to poor motivation or

presentation(7 interviews), the problem of how to test our the risk and/or good progress(5 interviews), the unlikelihood of the patient's attitude or condition ever changing(3 interviews), and miscellaneous others more related to the specific cases.

Dilemmas associated with the support or attitude of the family

Table 11 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>		
Yes	39	28.1%	33	22.0%	
No	100	71.9%	116	77.3%	
Could not answer			1	0.7%	
		<hr/>			
	139	100.0%	150	100.0%	
		<hr/>			

$$(X_2(1D.F)=1.31 \text{ } p < 0.30)$$

With the above dilemmas, in both cases the chairmen acknowledged difficulties in regard to women more than men, although the difference was not significant. With the dilemmas in regard to family support and attitudes, the interview findings reflected significantly more difficulties with women, being acknowledged at 12 hearings(37.5%) compared to 21 hearings(17.8%) with the men ($X_2(1D.F)=5.53 \text{ } p < 0.02$). Although both methods of data collection identified dilemmas about family support and attitudes on a substantial number of occasions, this particular aspect of the situation did not present as many such difficulties as the need for continued hospital care or the patient's behaviour and attitude.

Within both methods of research, further 'details' were requested in regard to the dilemmas associated with the family support and attitudes. The same major preoccupations were

reflected. In respect of the 33 hearings at which the chairmen acknowledged such a dilemma, the difficulties concerned the willingness but doubtful ability of family to cope with the patient(9 interviews), the non-availability or inadequate presence of family to give support(7 interviews), and the extent of other social problems already in the family (5 interviews). Other 'details' concerned the mixed attitudes of family members in view of severity of offence(4 interviews), family resistance to accepting responsibility(3 interviews), and anxiety that family could cover up any further offending(2 interviews).

Dilemmas associated with the provision of community services

Table 12 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	37	26.6%	32	21.4%
No	102	73.4%	116	77.3%
Could not answer			2	1.3%
	139	100.0%	150	100.0%

$(X_2(1D.F)=0.99 \text{ } p < 0.50)$

Again the interview findings reflected proportionally more difficulties with women(9 interviews, 28.1%), but the difference between men and women was not significant($X_2(1D.F)=1.02 \text{ } p < 0.50$). Although identified by both methods of data collection on a substantial number of occasions, this aspect of the situation did not present as many such difficulties as the need for continued hospital care or the patient's behaviour and attitude(although it did compare with dilemmas associated with family support and attitudes).

Within both methods of research, further 'details' were requested in regard to the dilemmas associated with the provision of community services. Both reflected the same major preoccupation with the inability to be sure that the appropriate community support and facilities would be available (19 out of 32 interviews where the dilemma acknowledged). Most of the other interview 'details' were allied to this concern: lack of information about community facilities(3 interviews), the resistance of the community services to accepting responsibility (3 interviews), the patient's resistance to accepting such support and supervision(2 interviews), and concern about whether available resources could in fact cope with the patient(2 interviews). On the other three occasions when this dilemma was acknowledged, the issue was whether or not to cut across hospital rehabilitative plans involving discharge into hostel care.

Dilemmas associated with the question of public attitudes

Table 13 Comparison between observation and interview findings

	<u>Observation findings</u>		<u>Interview findings</u>	
Yes	11	7.9%	8	5.3%
No	128	92.1%	139	92.7%
Could not answer			3	2.0%
	<hr/>		<hr/>	
	139	100.0%	150	100.0%
	<hr/>		<hr/>	

$(X_2(1D.F)=0.72 \text{ } p < 0.50)$ (corrected for continuity)

Concern about public attitudes did not appear to present as important dilemmas to the tribunal as the other aspects of the situation considered above. Where difficulties were acknowledged by the chairmen, they were described in such terms as 'danger of

public outrage if there were a relapse', 'danger to the public', 'Will two years be seen as appropriate for murder?', and 'How can we reassure the Home Office that, although there is still some risk, he does not need maximum security?'

Although there were sometimes significant differences between the findings of the two methods of data collection in regard to the dilemmas faced by the tribunal, both methods ranked the aspects of the situation which were affected in the same order:

	<u>Observation findings</u>		<u>Interview findings</u>	
(a) Behaviour and attitude of the patient.	83	59.7%	61	40.7%
(b) Need for continued hospital care.	68	48.9%	56	37.3%
(c) Support and attitude of family.	39	28.1%	33	22.0%
(d) Provision of community services.	37	26.6%	32	21.4%
(e) Public attitudes	11	7.9%	8	5.3%

Also, in regard to each aspect of the situation, dilemmas were acknowledged by the chairmen on proportionally more occasions with the women: 16(50.0%), 13(40.6%), 12(37.5%), 9(28.1%), and 2(6.3%) respectively.

Therefore, even though the differences in respect of specific aspects of the situation were not necessarily statistically significant, the above ranking and consistency of relationship between men and women was some support for that ranking of difficulties and that dilemmas were relatively more likely to be experienced with the women.

Summary of findings

It was evident that the tribunal members did often experience serious inadequacies in the prescribed rules and procedures. These anomalies related mainly to the 'input' to the tribunal (obtaining and receiving evidence) and the 'output' of the tribunal (their powers) rather than the conduct of the hearing. Primarily difficulties arose in relation to the powers of the tribunal.

The anomalies in relation to the collection and receiving of evidence concerned mainly the insufficiency of the rules and procedures to enable direct communication with national health service hospitals in the home areas nor ensure adequate information from the local health and community services.

The anomalies in the powers of the tribunal concerned mainly their lack of authority to order transfer to a national health service hospital and the impossibility of ensuring the necessary rehabilitative resources were available in the event of the patient exercising a right to leave hospital.

It was evident that the tribunal members experienced serious dilemmas in regard to the practical choices available to them. These dilemmas were associated mainly with the need for continued hospital care (the inability to ensure this care would be available) and the behaviour and attitude of the patient (dependence on support and control for own welfare and protection of others). Dilemmas associated with the support or attitude of family and the provision of community services were important but secondary

to the primary areas of difficulty.

Both in regard to the anomalies arising from the rules and powers of the tribunal and the dilemmas associated with the different aspects of the situation, there was a consistent pattern of proportionally more difficulties being identified with the women compared to the men. This was likely to relate to the greater social inadequacy and dependency among this group of women.

Discussion

The findings about the anomalies and dilemmas experienced by the mental health review tribunal did appear to support the application of Lemert's 'socio-legal theory' of legal change⁽⁴⁾ to the more specific situation of the decision-process in regard to the continued restraint or release of the mentally disordered. Just as the traditional view of legal development assumed 'a gradual, cumulative growth of rules', so the prescribed framework for such as the mental health review tribunal appeared to assume a smooth input-output decision-process. Just as Lemert suggested that the normal evolutionary development of law faced 'crises' resulting from an accumulation of anomalies, so decision-makers such as members of the tribunal experienced anomalies and dilemmas in the practical process of reaching decisions on the basis of the evidence and actual alternatives available to them.

(4) Lemert E. 'Social Action and Legal Change'. Aldine (Chicago 1970)

The responses of the mental health review tribunal were presented and discussed later in Chapter Fifteen on the 'tribunal decisions and innovations'. This present chapter was concerned with the nature of the anomalies and dilemmas faced by the tribunal. Did the tribunal find themselves faced with situations where the rules were inadequate in themselves for the tasks they were designed to achieve? Were there considerations in practice not anticipated by the rules and powers of the tribunal? In regard to any anomalies and dilemmas, were these potential crises associated with the distinction and possible conflict between 'welfare and protection' and 'justice and fairness' (as suggested in Lemert's analysis).

Lemert was concerned with anomalies where the prescribed rules and procedures were inadequate to protect the interests of the parties involved. This was an appropriate description of the situations often faced by the members of the mental health review tribunal. Their formal structure was established as a safeguard to ensure that an individual considered mentally disordered was only deprived of his liberty to refuse treatment through the application of fair and impersonal rules and authority. They had a 'duty to discharge' the order of the subject of any application to them if the clear criteria defined to justify compulsion were not satisfied. The formal structural framework established for the mental health review tribunal demonstrated a dominant concern for 'balanced justice'; whereas the anomalies and dilemmas faced by the tribunal in practice related mainly to 'parens patriae' considerations. Wood, 1976, emphasised the 'unique difficulties' under which the tribunals were working. 'The fundamental purpose of a review tribunal is to protect the

individual's right not to be unfairly deprived of his liberty'.⁽⁵⁾ He instanced the difficulties of maintaining the balances between civil liberties and public and personal safety, and between legal, medical and social considerations. He spoke of the impossibility of divorcing the laid-down 'narrow conceptual framework' from rehabilitative and wider social realities.

The empirical findings of this research project confirmed this statement from a lawyer speaking from his experience as a chairman of a mental health review tribunal. Whereas the prescribed rules, criteria, procedures and powers were explicitly defined and limited to ensure 'justice and fairness', often the tribunal members found that their task was impossible without reference to rehabilitative and preventative considerations concerned to promote the welfare and protection of the individual and others. The further comments from the legal chairmen in regard to the anomalies and dilemmas with which they were faced, which are presented in a supplement to this chapter, demonstrated 'the impossibility of divorcing' the prescribed 'justice and fairness' approach from welfare and protection considerations. The empirical findings and these further comments from the interviews were used below to illustrate the different balance of emphasis between these two fundamentally different approaches in response to the different situations as perceived by the tribunal members.

For the purpose of discussion, it was decided to present the findings in regard to anomalies and dilemmas within the context of

(5) Wood, J.C. 'Mental Health Review Tribunal and Social Work'. Social Work Today, Vol. 7, 11th August, 1976.

possible stages of the decision-process. Whilst the anomalies and dilemmas were only one aspect of the decision-process, they served to develop further the understanding of the progression of that process in practice. The stages of that progression were presented in terms of generalisations with particular reference to the anomalies and dilemmas.

(a) The first generalisation followed on from the conclusions of Chapters Eleven and Twelve about the evidence on which the tribunal based their judgements and the difficulties in obtaining the evidence. It was suggested in Chapter Eleven that 'risk' was determined primarily on three factors : 'mental disorder', 'offences', and 'personality'. Factors such as 'mental disorder' and 'offences' tended to be influences in favour of continued detention; with 'personality of the patient'(when it was influential) being largely subjective reactions tending to favour release from detention. The first generalisation was that an early stage of the decision-process was concerned with determining the presence or otherwise of continued 'risk', based on such factors as 'mental disorder' and 'offences' almost to the exclusion of any 'parens patriae' considerations. Only if the severity of these factors did not determine the need for continued detention, did other considerations come into play. Therefore, there would not be the opportunity for any conflict between 'parens patriae' and 'balanced justice'. In other words, the formal structural 'balanced justice' approach prescribed for the mental health review tribunal did appear to operate smoothly without serious anomalies or dilemmas, when the 'facts' before the tribunal clearly satisfied the specified criteria for continued detention(as opposed to discharge)

Support for this generalisation about the early stage of the decision-process was implied rather than explicit in the finding that dilemmas and anomalies were not mainly associated with 'risk' considerations and in the recurrence within the interview 'details' about anomalies and dilemmas of such wording as 'needed care but not security' in regard to patients where release was being seriously considered.

(b) A further generalisation was that, if continued detention was not justified by the reasonably tangible adverse 'risk' factors, the more subjective influences in respect of the 'personality of the patient' would come into play. It was confirmed in Chapters Eleven and Twelve that subjective feelings and intuition and 'benefit of the doubt' (associated with the perception of the personality of the patient) tended to favour release. Whilst this clearly implied sympathy and concern for the patient, on the whole this further stage of the decision-process appeared to be primarily concerned still with justice and fairness. For instance, the open-ended findings in the further comments about their subjective feelings and intuition illustrated a concern to relate length of stay to the severity of offences.

One of the further comments about dilemmas (see supplement at the end of the chapter) was 'dilemma is whether he is dangerous'. This suggested a form of 'approach-avoidance' conflict, with the fear of the risk heightening as the release was more seriously considered. But on the whole this second stage of the decision-process within the 'black-box' did not give rise to serious anomalies or dilemmas, being still primarily

concerned with determining whether the release of the patient should be seriously considered. If it was decided to 'take the risk' or give the 'benefit of the doubt', a decision to recommend release or order the discharge could follow within their prescribed powers and without necessarily any difficulty in regard to practical considerations.

(c) The next stage arose where, having decided provisionally in favour of release, rehabilitative considerations were taken into account. First and foremost, this was often concerned still with the 'risk to others' rather than necessarily the welfare of the patient. Although there were occasional references by the tribunal to their anomalous situation of not being able to 'test out' the good progress of the patient before making a final decision, the relationship of rehabilitative resources to the 'risk' was more clearly illustrated in respect of the dilemmas faced by the tribunal. In the further interview comments on the dilemmas about the need for continued hospital care, the emphasis was often on the risk to the patient and others if it was necessary to discharge directly into the community rather than transfer into the care of a hospital in the home area. The further details in regard to the dilemmas about the behaviour and attitudes of the patient emphasised the risk to others without the appropriate support and/or control. This stage was presumably resolved by continuing to consider release on the basis of reassurance that the necessary support and care was available, taking the risk of discharge without that reassurance, or deciding against release because of the non-availability of the resources necessary to minimise the risk. In so far as the concern was still for 'health, safety or protection' or 'dangerous', the tribunal would still be operating within their rules and criteria

as formally prescribed.

(d) As a further generalisation, the next stage would appear to be where rehabilitative or residential resources are considered necessary for the 'welfare and protection' of the individual, although not necessarily of a nature nor to the extent which would satisfy the 'patient's health and safety' criteria required to justify continued detention. At this stage, it would appear that the tribunal was faced with serious anomalies where the rules and criteria were insufficient to the task (related largely to the uncertainty about or non-availability of informal voluntary hospital care). The tribunal found that their rules and procedures were insufficient to enable direct communication with national health service hospitals nor ensure adequate information from the local health and community services; and their powers did not allow them to order transfer to another hospital nor ensure necessary rehabilitative resources were available. They were faced also with serious dilemmas (often allied with the anomalies) which were largely related to 'welfare and protection' considerations. Often they were acutely aware of the dependence of the individual on support and care, and their inability to ensure this care would be available. As indicated above, the patients who survived the decision-process to this stage were individuals who were not considered by the tribunal to represent sufficient risk in terms of the prescribed criteria (even without the desired supportive resources) to warrant continued detention. Yet they could be seen as dependent on support and care (on a voluntary basis) which were not available. This stage could be resolved by a decision to continue the detention (by implication on the grounds

that it was justified on the 'health and safety' criteria, but in practice often relying on the hospital to initiate or continue their efforts to arrange the transfer to informal hospital care in the home area). Occasionally the tribunal could decide to discharge the order on the grounds that continued detention was not justified (with the obvious implications for the care and welfare of the patient). Otherwise (as was presented and discussed later in Chapter Fifteen on the 'tribunal decisions and innovations'), the tribunal chose sometimes the alternative of adjourning their decision to allow for further enquiries.

So the findings of this research supported Lemert's theory that 'crises' arising from anomalies and dilemmas were predominantly associated with the distinction between 'parens patriae' (welfare and protection) and 'balanced justice' (justice and fairness). At the initial stages of responding to the 'facts' before them, the primary concern of the tribunal was the question of whether continued detention was justified from a largely 'balanced justice' approach. Problems obtaining evidence were not normally associated with these considerations. Serious anomalies and dilemmas presented difficulties at the stage the need for rehabilitative support and resources were identified either as a safeguard to minimise the risk to others or more often for the welfare and protection of the individual. At each of the stages, a decision could be made against release. At each stage, advice or decision to release from detention could be determined, with varied balance of emphases between objective considerations and the need to 'take risks' or give 'benefit of the doubt'. In terms of the above generalisations, the tribunal could progress through the suggested stages and still not have

reached a decision whether or not to advise release or discharge of the order. As the tribunal could only advise courses of action in regard to patients referred to them by the Home Secretary, the anomalies and dilemmas which could prevent decisions being based solely on the prescribed rules and powers mainly affected their consideration of applications. This was explicitly illustrated in a further interview comment on the problems arising from the rules and procedures, when one chairman said: 'Home Office case, so more discretion. Would have been problem if simple discharge decision'. It was evident that anomalies and dilemmas were experienced primarily in relation to the 'yes/no choice'(quote from further comment) and in terms of 'welfare and protection' considerations coming into conflict with the more narrow framework designed to emphasise 'justice and fairness'.

ANSWERS FROM THE LEGAL CHAIRMAN TO THE QUESTION:

'Have you any further comments in regard to problems arising from the rules and procedures laid down for the tribunals?'

- Woman(arson) 'Immediate decision inappropriate.
Good progress but not quite ready'.
- Man(indecent assault) 'Cannot be "court of appeal" in regard to
doubtful conviction.'
- Man(violence) 'Home Office case, so more discretion. Would
have been problem if simple discharge decision'
- Man(murder) 'No means of ensuring alternative if half-way
unit falls through'.
- Man(violence) 'Classic problem-yes/no choice inappropriate'
- Woman(criminal damage) 'How far are our present views taken into
account in the future?'
- Man(indecent assault) 'Need to reach final decision eventually, but
cannot ensure facilities'.
- Man(rape) 'Case where transfer needed, but no power'.
- Man(larceny) 'Should go but how can we ensure provision?'
- Woman(violence) 'Firm belief need to move from Rampton, yet
full release would be cruel as very dependent
and doubtful about leaving'
- Man(violence) 'Native of Eire, therefore less power than
usual'.
- Woman(violence) 'Vicious circle. Adjournment delays action
and does not ensure positive response from outside
services'.
- Man(indecent assault) 'Cannot order trial period elsewhere nor ensure
that the hospital makes such arrangements'.

ANSWERS FROM THE LEGAL CHAIRMAN TO THE QUESTION:

'Have you any further comments in regard to any dilemmas with which you were faced?'

- Woman(violence) 'How assess apparent offer of secure environment by friend?'
- Man(indecent assault) 'Difficulties judging progress with such uncertain earlier diagnosis of conduct?'
- Man(murder) 'Long-term patients should be given the opportunity to be brought up to date in regard to local hospital improvements?'
- Man(indecent assault) 'Delay for assessment for half-way unit?'
- Man(sexual assault) 'Imprisonment as against indeterminate stay?'
- Woman(violence) 'Impossible to resolve, therefore adjourned-hostel not yet available?'
- Man(murder) 'Was there danger of relapse? Tribunal doctor said "yes" ?'
- Man(violence) 'Clear rehabilitative needs, but minimal care not offered?'
- Man(robbery) 'Psychopath in psychiatric hospital only by chance. Should have been in prison. Should not be kept for longer than would have been in prison?'
- Man(violence) 'Dilemma is whether he is dangerous?'
- Man(arson) 'Would have liked to consider case for the sake of the patient, yet conceded to request of solicitor to adjourn as relatives seemed happy?'
- Man(arson) 'Does not need maximum security yet still obvious risk. How can we get this over to Home Office?'
- Man(violence) 'Correct legal course would be discharge after further period for enquiries?'
- Man(indecent assault) 'There is the danger of a public outrage if there is a relapse?'

CHAPTER FOURTEENDISAGREEMENTS BETWEEN THE MEMBERS

'Is this man dangerous? There is no clear cut yes-or-no answer to this question, but only probabilities' (Sturup 1968)⁽¹⁾

It was suggested that the uncertainty and anxiety arising in response to the perceived or felt 'danger' should be accepted as much a part of the definition and concept of 'dangerous' as the behaviour itself. The threat and anxiety to restrain arose as much from the senselessness, incongruity, and unpredictability of the behaviour (in the eyes of others) as from its excessively violent nature (Chapter Ten).

It was found that uncertainty and doubt about the right course of action were clear and acknowledged influences on the decisions of the tribunal. They were influenced also by a subjective 'gut-reaction' to the patient and their own perceptions of the 'facts' and the person himself. (Chapter Eleven). They had to rely on 'benefit of the doubt' and other means of filling gaps in their knowledge because of difficulties obtaining sufficient tangible evidence (Chapter Twelve); and sometimes the prescribed rules and powers were insufficient and they were faced with dilemmas which required innovation to reach some conclusion (Chapter Thirteen).

As Hogarth (1971)⁽²⁾ emphasised, 'sentencing is not a rational,

(1) Sturup G.K. 'General discussion' session at CIBA Symposium on 'Mentally Abnormal Offender' Churchill and Co (1968)

(2) Hogarth J. 'Sentencing as a Human Process' Toronto University Press (Toronto 1971)

mechanical process. It is a human process, and is subject to all the frailties of the human mind'. The evidence and the 'facts' were open to interpretation and the conclusions were not always self-evident from the procedures and criteria. In Hogarth's analysis, the magistrates made sense of the facts and responded to them through a process of attaching 'meanings' to the facts of the cases and the circumstances of the decision-process itself. 'In a variety of ways it was shown that the decision-making process in sentencing is not a neutral or mechanical one'. The meanings attached to the facts and the responses were influenced by the values and commitments of the decision-makers. In other words, the magistrates had attitudes which predisposed them to respond in particular ways.

Given all the above aspects of the decision-process in practice (the uncertainty and doubt, the subjective influences, the gaps in knowledge and information, the insufficiency of the rules and powers, and the influence of factors related to the decision-makers rather than the subject and facts of the case), it seemed inevitable to the researcher that there would be differences of emphasis and disagreements among the members of the tribunal. In his analysis, Hogarth clearly identified attitudes towards certain types of crime, towards the process of justice, and to their own approach to examining the case, which predisposed the magistrates to certain sentencing responses. Yet, whilst his analysis emphasised the predominant influence of the attitudes of the magistrate as opposed to the facts of the case, his analysis did not extend to the inevitable implications for any 'panel' of individual decision-makers reaching a conclusion. Similarly, in considering the crises faced by the legal decision-makers, Lemert(1970)⁽³⁾ did not extend his analysis of the anomalies and dilemmas

(3) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970)

which contributed to conflict and change to the effect of this 'conflict' within the decision-process of individual cases. This was an inevitable omission, as Lemert's approach adopted a group-interaction model and was not concerned with inter-personal inter-action. In this present research project, it was decided to apply Lemert's 'socio-legal theory' to the inter-personal interaction within the decision-process of the mental health review tribunal. Given all the opportunities for disagreement and differences of emphasis, it did seem inevitable that there would be differences of opinion.

Was there serious disagreement or conflict? To what did it relate? How was disagreement resolved? Were any member-categories of the tribunal more influential than others, and in what connection?

Differences of emphasis in regard to the facts of the case

The findings in regard to the factors which appeared to be more influential with individual members were presented and discussed in Chapter Eleven on 'The evidence on which the tribunal based their judgements'. The observation findings were presented in Table 7 of Chapter Eleven.

It was found that all three member-categories showed a primary concern for the same five factors of evidence: personality of the patient, mental disorder, present behaviour and attitude, immediate offence or behaviour which led to detention, and length of stay. Yet differences of emphasis between the member-categories were identified. It appeared likely that these differences were

influenced by their professional interests and role within the situation.

As summarised in Chapter Eleven, the legal chairmen were significantly more concerned about the 'immediate offence or behaviour which led to detention' and the 'present behaviour and attitude of the patient' than the medical members. The medical members were very significantly more influenced by the 'mental disorder' of the patient than the legal and lay members. The lay members did not differ significantly from the legal members in regard to any factors, demonstrating primary concerns for the 'personality of the patient' and the 'present behaviour and attitude of the patient'. The main common denominator between the three member categories was a predominant influence of the 'personality of the patient'. This factor was observed as the more influential factor on significantly more occasions with the legal members(31 hearings, 22.3%) and the lay members(36 hearings, 25.9%), and second only to 'mental disorder' (61 hearings, 43.9%) with the medical member(26 hearings, 18.7%).

The above findings were based on observation, without the comparison with interview findings (as questions of the legal chairmen in regard to other members had been excluded from the interview schedule as unreliable).

Was there serious disagreement or conflict of opinion between members?

Observation and interview questions related to different aspects of the case and were presented at different stages of the observation and interview schedules. The findings were presented in relation to the

different aspects of the case and the decision-process, both to illustrate the particular disagreements and to build up a picture of the total extent of disagreement and conflict during the decision-process.

Disagreement in regard to the degree of risk

Observation findings

Table 1 Did there appear to be any conflict of opinion among the tribunal members in regard to the degree of risk?

Yes	16	11.5%
No	123	88.5%
	<hr/>	
	139	100.0%
	<hr/>	

Interview findings

Table 2 Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the degree of risk?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Definite disagreement	3	2.5%	0	0.0%	3	2.0%
Moderate disagreement	14	11.9%	3	9.4%	17	11.3%
None at all	98	83.1%	29	90.6%	127	84.7%
Not clear	3	2.5%	0	0.0%	3	2.0%
	<hr/>					
	118	100.0%	32	100.0%	150	100.0%
	<hr/>					

Both methods of data collection identified disagreement in regard to the degree of risk on a number of occasions. The number of hearings at which disagreements were observed or acknowledged was too small to draw too many conclusions; other than the conclusion that disagreement in regard to the degree of risk was not a major difficulty. 'Further details' about the disagreement through observation and interview tended not to relate to the offences, but to the 'mental state' and 'personality' of the patient as

as perceived by the different members. Sometimes the further details referred to 'greater sympathy' or 'trust and confidence' on the part of one or more members. There was also some tendency at times for other members to question the prognosis(as opposed to the diagnosis) as presented by the medical member. Whilst the number of occasions was too small to draw certain conclusions, it did appear to tend to be the medical member(perhaps on the grounds of danger or relapse of mental disorder) who expressed greater concern about the degree of risk when there was disagreement. Support for the tentative conclusion that, on the relatively few occasions there was clear disagreement over the degree of risk, this related sometimes to other members questioning the medical view of the mental state of the patient was perhaps to be found in the responses to another observation question. In response to the research question, 'did there appear to be any conflict of opinion among the tribunal members in regard to the mental state of the patient?' the researcher noted that there was evidence of disagreement at 14 hearings(10.1%).

Disagreement in regard to the nature of the risk

Observation findings

Table 3 Was there any clear disagreement in regard to the nature of the risk?

Yes	1	0.7%
No	138	99.3%
	<hr/>	
	139	100.0%
	<hr/>	

Interview findings

Table 4 Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the nature of the risk?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Definite disagreement	0	0.0%	0	0.0%	0	0.0%
Moderate disagreement	3	2.6%	1	3.1%	4	2.7%
None at all	114	96.6%	31	96.9%	145	96.6%
Not clear	1	0.8%	0	0.0%	1	0.7%
	<u>118</u>	<u>100.0%</u>	<u>32</u>	<u>100.0%</u>	<u>150</u>	<u>100.0%</u>

The main finding supported by both methods of data collection was that disagreement in regard to the nature of the risk was not a serious problem nor source of crisis in the decision-process. This could compliment the finding from open-ended 'further details' in regard to disagreements about the degree of risk that these disagreements did not appear to relate to the offences or behaviour which led to the detention.

Disagreement in regard to the potential victims

Both methods of data collection produced similar results to those about the nature of the risk. Presumably these findings compliment each other. At only one hearing(0.7%) was 'clear disagreement in regard to the potential victims' observed. At only four hearings(2.7%) was 'moderate disagreement' in regard to the potential victims acknowledged by the legal chairmen.

Disagreement in regard to the question of releaseObservation findingsTable 5 Did there appear to be any conflict of opinion among tribunal members in regard to the question of release?

Yes	20	14.4%
No	119	85.6%
	<hr/>	
	139	100.0%
	<hr/>	

Interview findingsTable 6 Was there at any point in the hearing what you would call a serious difference of opinion between the tribunal members in regard to whether or not the patient should leave Rampton?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Yes	10	8.5%	2	6.3%	12	8.0%
No	107	90.7%	30	93.7%	137	91.3%
Could not say	1	0.8%	0	0.0%	1	0.7%
	<hr/>					
	118	100.0%	32	100.0%	150	100.0%
	<hr/>					

It was evident from both the observation and interview findings, that disagreement about the question of release was observed or acknowledged to be a serious difficulty on relatively few occasions. One value judgement could be that there was a remarkable degree of agreement and consensus among the tribunal members.

Further observation 'details' about disagreements tended to suggest that at times, whereas the researcher was noting observed evidence of conflict of opinion during the course of the hearing, the chairmen were responding more in terms of whether there was a serious difference of opinion after discussion. This did not

necessarily suggest there was any more disagreement than observed or acknowledged in the interview; but did give possible indicators to the process of resolving differences. This was illustrated in such examples as described below.

At one hearing, in connection with a man convicted of robbery and violence, the time taken for the hearing was one hour and forty minutes; much of the time being taken with the legal and lay members questioning the medical member's emphasis on the patient's general retardation and poor memory. The other members were pressing for discharge (particularly as the hospital team were already well advanced in planned a discharge into community hostel care), whereas the medical member was resisting discharge. Eventually they compromised on recommending transfer to national health service care (thus taking a more cautious approach than the hospital team).

At another hearing, the medical member appeared to be very resistant to movement from security care and concerned about the risk, particularly compared to the lay member. The legal member appeared to arbitrate in favour of giving the benefit of the doubt to the patient; and they recommended transfer to national health service care. On a further occasion, the lay member had strong reservations about discharge but was over-ruled by the other members, and the order was discharged. Another time, the medical member doubted the permanency of improved psychiatric condition and behaviour, whereas the others were more confident and sympathetic to the patient. It was decided to continue the detention as a result of that hearing. There was strong support for discharge from lay and legal members at a

further hearing, but again they compromised on recommending transfer in response to medical doubts about the social adequacy of the patient. Once, the legal member advocated the justice of discharge in view of the length of stay yet no action was taken because of the concern of the other members about the risk of relapse (sexual offences). In respect of another man convicted of sexual offences against a child, the legal and lay members appeared convinced the offence was out of character but eventually agreed to take no action because of the medical member being adamant about the risk. There were at least two hearings where the tribunal adjourned primarily because of difficulties reaching agreement between the members.

A common denominator with the above nine hearings where disagreement in regard to release was observed was a negative response during the interview to the question about 'serious difference of opinion' in regard to whether or not the patient should leave Rampton. Although the contrast was not significant (perhaps in view of the small numbers), differences tended to be observed more frequently than acknowledged in the interview. As suggested above, the chairmen could have been referring more specifically to difficulties actually reaching agreement, as opposed to differences and conflict arising during the deliberations. There was the hint of this in one of the few 'further comments' by the chairmen in regard to disagreements: 'Aired our views and reached an agreement' (in respect of a hearing where the chairman in fact answered 'no' to the question about serious difference of opinion). What appeared to happen in these borderline instances where disagreement was observed but not acknowledged by the

chairmen, was a process of 'airing' sometimes conflicting views and then moving relatively smoothly to a consensus.

Perhaps the main finding was summarised in the above 'value judgement' that there was a remarkable degree of agreement and consensus among the tribunal members. In comparison with 'crises' arising in the decision-process because of other difficulties, disagreement among members did not present as severe problems nor did it occur as often. For example, in contrast with the 12 hearings(8.0%) at which the interview findings identified a serious difference of opinion among the tribunal members, during the interview difficulties were acknowledged more often in regard to obtaining the evidence(49 hearings,32.6%), doubt and uncertainty(43 hearings, 28.7%), anomalies in relation to the powers of the tribunal(44 hearings,29.3%), and dilemmas in regard to such as the need for continued hospital care(56 hearings,37.3%) and the behaviour and attitude of the patient(61 hearings,40.7%).

By what process were disagreements resolved?

Having identified disagreement among the members through observation or interview, both research approaches presented the question in regard to 'how was this disagreement resolved?' with predetermined response-categories.

Table 7 The process of resolving disagreements

	<u>Observation findings</u>		<u>Interview findings</u>	
Agreement through discussion	15	60.0%	5	41.7%
Giving way to greater knowledge or experience	2	8.0%	1	8.3%
Majority decision	2	8.0%	1	8.3%
Adjourning decision	4	16.0%	3	25.0%
Avoiding decision	0	0.0%	0	0.0%
Other	2	8.0%	2	16.7%
	<u>25 hearings</u>		<u>12 hearings</u>	

The observation question related to the total hearings at which any disagreement had been observed (25 hearings, 18.0%); whereas the interview question followed immediately upon the question about serious difference of opinion about leaving Rampton (therefore 12 hearings, 8.0%). Although the samples are small for statistical interpretation, both research methods produced a similar pattern in regard to resolving disagreements. Where disagreements were observed or acknowledged, agreement appeared to be reached through discussion rather than simply giving way to greater knowledge or experience or avoiding the decision in some way. Both the 'other' responses produced by observation and interview involved acknowledging the difference of opinion in the advice to the Home Secretary.

Another finding could appear at first to contradict the conclusion that disagreements between tribunal members tended to occur infrequently and were resolved through discussion rather than giving way to the greater 'authority' of other members. Following the interview questions in regard to disagreements and their resolution, the chairmen were asked: 'At any point did the legal member have a greater influence than other members?' (and similarly in regard to the medical member and the laymember). Whereas the legal chairmen asked 'yes' in regard to only 3 hearings (2.0%) in respect of the legal members and one hearing (0.7%) for the laymembers, at 39 hearings they did consider the medical member had a greater influence (26.0%).

When asked further 'in what connection?' the medical member had greater influence, the open-ended response was almost invariably

in terms of the medical and psychiatric condition of the patient. Presumably this was linked with earlier findings in regard to the 'mental disorder' being the more influential factor with the medical member(61 hearings, 43.9%) compared to the legal member(16 hearings, 11.5%) and the lay member(17 hearings,12.2%). Also, rather than contradicting the above findings about disagreements being relatively rare and resolved through discussion, this 'greater influence' of the medical member could relate to the suggestions in Chapters Twelve and Thirteen that consideration of the 'mental disorder' criteria tended to be a separate decision-process involving the medical member. Therefore any difficulties experienced in that respect would tend not to be seen or experienced as difficulties for the tribunal as a whole.

Supplementing the interview questions on resolving disagreements and the relative influence of individual members, the question was asked 'At any point was it necessary to abide by a majority decision?' Even though this option was within their rules, it was clearly avoided where-ever possible. The interview response to this question, indicating a majority vote at only one hearing, was supported by the observation findings.

Summary of Findings

There was a difference of emphasis between the tribunal members in regard to the factors which were more influential, with this difference largely reflecting their professional interests and role within the situation. The medical members were predominantly concerned about the 'mental disorder'; and the legal members more

concerned about the offences and present behaviour and attitudes. Although the lay members were mainly influenced by the 'personality of the patient', they did not differ significantly from the legal members in any respect.

There was limited disagreement or conflict among the tribunal members. Where it did show itself, it was in relation to the degree of risk and the question of release. Disagreement mainly related to the allied concerns of the 'mental state' and 'personality' of the patient; conflict being in terms of whether the person could be trusted to maintain good progress outside a situation of clinical supervision and social control.

Even where there were disagreements, it appeared that the tribunal tended to move reasonably effectively and smoothly from a position of 'conflict' to a 'consensus'. This was reflected in the way in which the chairmen acknowledged (or sometimes did not acknowledge) disagreement and in the process by which disagreements were normally resolved.

Disagreements were normally resolved through discussion rather than confrontation, the need for any one member to exercise greater 'authority', or a majority vote. At the same time, it was evident that the medical member accepted a primary responsibility for determining the 'mental disorder' criteria, virtually as a separate decision-process.

Discussion

'The making of recommendations and decisions about the discharge and continued care of mentally disordered offenders entails, fundamentally, the assessment and prediction, by one group of human beings, of the probable future behaviour of another. Prescribed procedures can offer real safeguards against the chance of human error going undetected, but we do not believe that in this sort of situation there can be an absolute guarantee of infallibility. The complete elimination of any risk to the public could only be achieved by continuing to detain these patients perhaps indefinitely. We are sure that in our society this would be seen as an inhumane avoidance of the responsibility for making a proper judgement in each case'. (Aarvold Committee 1973)⁽⁴⁾.

Chapter Fifteen on the 'Tribunal decisions and innovations' will be considering the judgements made by the mental health review tribunal. In this chapter, another possible area of difficulty for the decision-process designed to achieve those judgements has been considered. As indicated in the above quotation from the Aarvold Committee report, the responsibility for reaching these judgements was an onerous one in view of the 'risk to the public' and the 'chance of human error'. Yet, in considering the disagreements between the members of the mental health review tribunal, further evidence was found that the tribunal as a whole and individual members did appear to approach and apply themselves

(4) Aarvold.C. 'Report on the Review of Procedures for the discharge of psychiatric patients subject to restrictions' Cmnd.5191. (HMSO 1973)

to the task with 'proper responsibility'. With all the potential for conflict and disagreement, this study demonstrated that agreement and consensus was sought by the tribunal and achieved to a remarkable degree.

This research project made no attempt to assess the influence of the personalities and attitudes of the members of the mental health review tribunal on the decision-process or as any source of conflict or influence between the members. In that relatively limited disagreement or conflict was observed or acknowledged, it was reasonable to assume that the personalities of members were not in evidence as a major influence on the decision-process, in terms of this research study. This assumption was not to deny the inevitable influence of personalities and attitudes on the 'human process'; but to acknowledge that they did not appear to be a major source of 'difficulty'. In approaching their responsibilities and in responding to the restraints and dilemmas, the tribunal appeared to adopt a consciously 'shared' approach to the responsibility and the difficulties to be over-come.

The main exception to this 'shared' approach was in regard to the diagnosis and prognosis of the psychiatric condition (both in respect of the criteria for continued detention and the needs of the patient). 'Mental disorder' was the primary concern of the medical member, and judgements about this tended to take place within a separate 'medical' decision-process supplementary and advisory to the main 'shared' tribunal decision-process. At the same time, it was evident that, where there were disagreements, these few 'conflicts' often concerned contesting the medical view

of the prognosis of the 'mental disorder'.

One possible interpretation was that, rather than uncertainty and doubt and the influence of subjective reactions to the patient and the procedural difficulties and practical dilemmas being in practice a potential for disagreement and conflict, they did in fact provide the flexibility to enable moving together to a consensus and the pressures toward a mutually-supportive 'group' approach to the task.

ANSWERS FROM THE LEGAL CHAIRMEN TO THE QUESTION:

'Have you any further comments in regard to disagreements and their resolutions?'

Woman (violence):

'Medical and lay members would have preferred trial period. Legal member inclined to discharge'.

Woman (violence):

'Aired our views and reached an agreement'

Woman (violence):

'Needed support which might not be available. Doctor doubtful about discharge'.

Man (violence):

'Lay member tentatively supported discharge yet accepted two tentative views in opposition. Risk hard to assess. Have to be faced sometime'.

Man (Indecent assault):

'Responsible medical officer's evidence looked both ways. Spoke highly of progress yet doubt about change of personality and progress'.

Man (Arson):

'Doubt in everyone's mind about the right course of action'.

CHAPTER FIFTEENTRIBUNAL DECISIONS AND INNOVATIONS

'Some may simply refuse to make such predictions on the grounds that the problems make errors inevitable. It is facile, but correct, to point out that someone has to make these predictions'. (Megaree 1976)⁽¹⁾

This chapter was not concerned with the basis on which the tribunal formed their judgements nor the process by which they made decisions. The aim was simply to examine the conclusions reached by the tribunal during the 150 hearings which were the focus of the empirical study. The tribunal had the duty to make a decision or give advice in respect of each application or reference. As they could not avoid reaching some clear conclusion, how far did their decisions conform to the prescribed choices and in what if any ways did they vary from those alternatives?

Megaree(1976)⁽¹⁾ asserted that error was inevitable in the prediction of behaviour. He claimed that this was particularly true in the case of dangerous behaviour because of 'the numerous pitfalls along the way'. These 'pitfalls' have been the subject of the earlier chapters: the varying perceptions of 'dangerous', the problem of identifying the relevant variables and the greater difficulties in assessing them, restraints in obtaining the evidence, anomalies in regard to procedures and powers, dilemmas in

(1) Megaree E.I. 'The prediction of dangerous behaviour' Criminal Justice and Behaviour. Vol.3.No.1.March,1976.

respect of the practical choices available, and disagreements between the decision-makers. Megaree went on to emphasise that, in addition to assessing dangerous behaviour being particularly prone to error because of all these difficulties, the consequence of the errors were greatly magnified by another factor peculiar to predicting infrequent forms of behaviour (such as dangerous behaviour). This was the base-rate problem identified by Meehl and Rosen (1955),⁽²⁾ whereby with attempts to predict infrequent events even a moderate false-positive rate can result in large numbers of people being erroneously diagnosed. 'Although the public is more concerned about the false negatives who are released and later attack someone, it is the false positives who, by sheer weight of numbers, call into question the possibility of accurately predicting dangerous behaviour'. (Megaree 1976)⁽³⁾

Megaree asserted that, even if a 'libertarian view' was adopted whereby people were detained only on strict criteria of 'dangerous', the number of individuals who were erroneously predicted to engage in dangerous behaviour would still be excessive. In fact, research quoted by Megaree had shown that clinicians were more inclined to overpredict violence and classify an excessive number of people as dangerous. (Monahan 1975)⁽⁴⁾ (Stone 1975)⁽⁵⁾

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- (2) Meehl P.E. and Rosen A. 'Antecedent probability and the efficiency of psychometric signs'. Psychological Bulletin 52 p 194-216(1955)
- (3) Megaree E.I. 'The prediction of dangerous behaviour' Criminal Justice and Behaviour Vol.3. No.1. March, 1976.
- (4) Monahan J. 'Community Mental Health and the Criminal Justice System' Pergamon (New York 1975)
- (5) Stone A.A. 'Mental Health and Law' Government Printing Office (Washington 1975)

Therefore, for various reasons, it did appear inevitable that the tribunal would reach different conclusions from the responsible medical officer against whose opinion an application or reference was a form of 'appeal'. The nature of 'dangerous', the process of assessing the degree of risk, and the anomalies and dilemmas faced by those seeking to reach a judgement all provided for varying conclusions in regard to release or continued detention. Also excessive caution was characteristic of the responsible medical officers and the hospital multi-disciplinary teams advising them. The tribunal, with the primary duty to protect the individual's right not to be unfairly deprived of his liberty, was more likely to draw the line of 'benefit of the doubt' in favour of release.

Given the restricted powers of the tribunal (particularly in regard to the discharge or otherwise of the detaining order in response to an application), what conclusions did they reach? Given the anomalies and dilemmas with which they were faced (mainly in regard to the lack of control and influence on rehabilitative resources), to what extent and in what way did they innovate beyond prescribed choices in seeking to overcome the difficulties? Lemert(1970)⁽⁶⁾ said that his 'theory' of the influence of an accumulation of anomalies in the process of law was only valid if the anomalies were expressed in terms of discrepancies between legal precept and practice. In practice, there was evidence in the decisions themselves (not simply the difficulties in the process of reaching a conclusion) of variation from the prescribed choices?

(6) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970).

Where there were innovations in the judgements reached at the hearings, to which difficulties in the decision-process did they appear to be related?

Decisions of the tribunal

Both the observation questions and interview questions were concerned with the decisions reached at the 150 hearings. In regard to the 11 hearings which were not observed and where confirmation was necessary in regard to either observation or interview, the method of examination of the official records was employed. The observation findings (supplemented by examination of records) in regard to the decisions and advice in response to applications and references were presented in Table 1.

Table 1 Decisions and advice of the tribunal

	<u>Applications</u>		<u>References</u>		<u>Total</u>	
Continued detention	32	44.4%	37	47.4%	69	46.0%
Adjourned decision	30	41.7%	4	5.2%	34	22.7%
Reclassified disorder	1	1.4%			1	0.7%
Discharged order	9	12.5%			9	6.0%
Transfer to NHS hospital			27	34.6%	27	18.0%
Discharge to community			5	6.4%	5	3.3%
Other advice			5	6.4%	5	3.3%
	72	100.0%	78	100.0%	150	100.0%

In respect of applications, it was only at 42 hearings(58.3%) that the tribunal reached a definite decision in terms of their prescribed choices(discharge order or not, reclassify disorder of patient). At the same time, the 30 instances of adjournment(41.7%) did not of themselves necessarily suggest any innovation from prescribed choices. Within their rules, they were entitled to 'adjourn

the hearing or evidence or representations or the consideration of an application to such date as they may determine.⁽⁷⁾

Whether the extent to which they found it necessary to adjourn the hearing was further evidence of the difficulties they faced, their thoroughness, and/or a variation from the 'expected' conclusion of tribunal hearings was a matter of speculation on the basis of the data presented in Table 1.

In respect of references, definite conclusions in regard to the advice to the Home Secretary were achieved at 74 hearings(94.8%). Yet the extent to which they advised continued detention(37 hearings, 47.4%) did not vary significantly from the extent they decided to continue detention in response to applications(32 hearings,44.4%). The significant difference between the decisions in response to applications and in regard to advice to the Home Secretary was in regard to advice to transfer to national health service care in an open psychiatric hospital(27 hearings, 34.6% of references). The equivalent of this alternative was not available in respect of applications, where the powers of the tribunal related only to the detaining order. This finding could be related to the findings in regard to so many of the difficulties faced by the tribunal in their decision-process(in regard to obtaining evidence, inadequacies in their rules and powers, and dilemmas about the practical choices) that difficulties were associated with their inability to ensure the necessary rehabilitative resources were available in the event of the detaining order being discharged. This had applied particularly to patients who were considered to require continued hospital care(although not compulsory care).

(7) The Mental Health Review Tribunal Rules,1960,S.I.No.1139.
HMSO Rule 15 (also rules 26 and 28)

The 'other advice' in response to references included support for hospital plans to review for transfer in three months, return to court for trial,⁽⁸⁾ discharge to the community if a transfer already approved was not effected within a reasonable time, trial period at the half-way unit at a local hospital, and the report of divergence of opinion among the tribunal members. In that there were no restrictions on the advice tribunals could offer to the Home Secretary, no advice could be considered an innovation from their prescribed choices. This greater flexibility of choice was reflected in their conclusions and in the ability to reach a conclusion at the majority of the hearings. On only 4 occasions (5.2% of the references) did they find it necessary to adjourn the hearing.

How did the tribunal chairmen view their conclusions?

There was some slight statistical variation between the interview responses in regard to the conclusions of the hearing and those conclusions observed during the hearing and confirmed through the examination of records. As the conclusions were cross-checked through the examination of records, these slight differences were probably related to the 'flexibility' of advice to the Home Secretary (and therefore open to some interpretation in defining or 'labelling' the advice) rather than serious research error.

In response to the research question, the legal chairmen indicated that they did 'make a definite decision about the application/advice on this occasion' in respect of 116 hearings(77.3%). These definite

(8) Under the Criminal Procedure(Insanity)Act 1964, trial proceedings in regard to an accused person considered unable to understand the proceedings can be abandoned and the person detained on a hospital order. The accused may be remitted for trial at a later date.

decisions related to 95 men(80.5%) and 21 women(65.6%)($X_2(1D.F)=3.09$ $p < 0.10$). In response to the further question, the chairmen confirmed that their decision or advice had been in favour of release from Rampton on 47 occasions(31.3% of the hearings). These decisions in favour of release had related to 41 men(34.7%) and 6 women(18.8%). The suggestion of a difference between women and men could relate to the findings in earlier chapters about women being affected more by difficulties in regard to rehabilitative resources. Definite decisions were not reached (this would mean the hearing was adjourned) in respect of 23 men(19.5%) and 11 women(34.4%). Where definite decisions were reached, continued detention in Rampton was the conclusion in respect of 54 men(56.8% of definite decisions) and 15 women(71.4%). Although care should be taken in interpreting the apparent difference between men and women(as specific findings such as above were not individually statistically significant, $p < 0.05$), there was the consistent suggestion of difficulties arising more with women, affecting the ability to reach conclusions and the likelihood of the order being discharged.

In their response to the interview question 'In your advice to the Home Secretary, did you recommend transfer to a local NHS hospital?', the chairmen indicated that they had recommended transfer in respect of 33 references(42.3%). These recommendations affected 29 men(40.3%) and 4 women(50.0% of references).

In a further interview question, the chairmen was asked whether they had made any other recommendations to the Home Secretary and for 'details' of that advice. On 36 occasions(46.2%), they said

that they had made other recommendations(31 men, 43.1% and 5 women, 62.5% of references). This question was supplementary to the question in regard to release from Rampton, changing the legal classification, or transfer to NHS hospital. The open-ended responses in regard to 'other recommendations' included advice in regard to alternative approaches to movement from Rampton in event of primary recommendation not being effected within reasonable time(10 references), further review of the situation after a period (10 references), further enquiries by the authorities in respect of such as the offences of the patient(5 references), specific treatment within the hospital(4 references), emphasis of the need for maximum security(2 references), transfer to another special security hospital(2 references), and acknowledging a divergence of opinion among the tribunal members.

So the interview findings confirmed those of the other methods of data-collection; in that definite conclusions were reached at the hearings to consider references with very few exceptions, whereas the tribunal found it necessary to adjourn their consideration of applications at a high proportion of hearings. In other words, they were often unable to exercise their straight-forward 'discharge-or-not' authority without delay and/or further enquiry. In respect of references for advice, where they had no authority to discharge and no restrictions on the advice they could give, they were normally able to reach a conclusion at the hearing although their advice often went beyond a straight-forward recommendation in regard to continued detention, transfer or discharge.

The hypothesis that the tribunal would not tend toward any particular category of decision or advice was proved generally correct.

Given that they acted as a form of 'appeal' against the detaining authority, it was evident that they did exercise clear independence of the hospital; both in regard to their decisions/advice and their readiness to adjourn for further enquiries or information. The hypothesis that they would/^{not}conclude in other than decisions or advice to release or not to release(i.e. a straight-forward yes-or-no approach) was rejected. In regard to many applications, they found this straight-forward approach and their restricted powers inappropriate; and often their advice was detailed and complex.

How did they overcome difficulties obtaining evidence?

The tribunal chairmen acknowledged difficulties obtaining evidence at 49 hearings(32.7%). They were asked a supplementary question in regard to over-coming the difficulties.

Table 2 How did you overcome the difficulty in obtaining evidence?

	<u>Men</u>		<u>Women</u>		<u>Total</u>	
Could not overcome difficulty	16	45.7%	2	14.3%	18	36.7%
Adjourned for enquiries	13	37.1%	7	50.0%	20	40.8%
Other action	6	7.1%	5	35.7%	11	22.4%
	35	100.0%	14	100.0%	49	100.0%

Within the responses presented in Table 2 was a suggested tendency to adjourn or take other action in respect of women as opposed to men ($X^2(1D.F)=2.92$ $p > 0.05$). This did not necessarily mean that the tribunal were necessarily more inclined to discharge the order with men without further enquiry(as could have been assumed in view of the greater dependence of the women). Of the eighteen

cases where the chairmen said that they could not overcome difficulties in obtaining evidence, in regard to ten of the patients their decision or advice had been against release.

The 'details' of the other actions by the tribunal in response to difficulties in obtaining evidence were consulting the hospital social work department(4 interview responses), deciding to take the risk of discharging the order(3 interview responses), approaching a NHS medical consultant direct, advising the hospital consultant to transfer the patient, and relying on information from the patient's legal representative. As they were entitled to request the attendance of the hospital staff and had the authority to discharge the order, only one or two of these actions could be considered innovations. Advising the hospital consultant and approaching another hospital direct were beyond their normal 'discharge-or-not' powers.

The purpose of adjournments

Observation findings

Table 3 In regard to any adjournment, what was the reason given or the nature of further enquiries?

Specifically accommodation	11	32.3%
Specifically hospital transfer	10	29.4%
To review patient's progress	4	11.8%
Other reasons	9	26.5%
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	34	100.0%
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The open-ended 'other reasons' responses included delay to

allow family to attend(2 hearings) and instances of seeking further information about previous history and family circumstances. On two occasions the tribunal requested further clinical investigation.

Interview findings

The chairmen were asked an open-ended question without any pre-determined categories of response: 'If you adjourned consideration of the application or reference, what was the purpose in adjourning?' The responses were subsequently grouped into the following categories:

Hospital transfer enquiries	10	29.4%
Community residential enquiries	6	17.7%
Hospital or hostel	6	17.7%
To allow time for trial leave	1	2.9%
To assess patient progress	4	11.8%
To allow family to attend	2	5.9%
To allow solicitor to make enquiries	1	2.9%
For further social work enquiries	3	8.8%
For further clinical investigation	1	2.9%
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	34	100.0%
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In that the tribunal was largely dependent on others such as the hospital to make further enquiries, often they had no means of ensuring the requested information was available. The adjournments related primarily to obtaining further information about resources to support the patient in the event of the order being discharged. In practice, these same adjournments appeared designed to influence the hospital toward making the necessary arrangements(particularly in respect of further hospital care) rather than necessarily with the intention of exercising their own powers in relation to the

order. This was perhaps reflected in the fact that on no occasion did they exercise their authority to require the presence of a witness.⁽⁹⁾ On the other hand, even though the adjournments were primarily concerned with obtaining further information, the 'information' was sometimes in regard to 'placement in the event of discharge'. These occasions appeared to be attempts to 'order' certain rehabilitative arrangements which were beyond their prescribed powers.

How did they overcome difficulties arising from their rules and powers?

Following each of the interview questions in regard to difficulties arising from rules and procedures in relation to the collection and receiving of evidence, the conduct of the hearing, and the powers of the tribunal, there was a supplementary question: 'Did you find the need to go beyond the given rules and take any unusual course of action in order to overcome this difficulty?'

In relation to the collection and receiving of evidence, the chairmen said that they had needed to go beyond the rules on 10 occasions (7 men and 3 women). They described their actions in terms of delaying to allow time for hospital enquiries to progress further, direct contact with the responsible medical officer to encourage enquiries about actions not open to the tribunal, indicating intention to discharge order as means of enforcing enquiries into accommodation for the patient, correspondence directly with Department of Health to encourage transfer, and direct contact with health authorities beyond Rampton.

(9) MHRT Rules 1960 S.I.No.1139 HMSO Rule 14.

In relation to the conduct of the hearing, the chairmen said that they had needed to go beyond the rules on only three occasions(3 men). They described their actions in terms of requesting the attendance of representatives of the community social services at the hearing, recommending hospital case conference to review clinical needs more fully, and needing to indicate their inability to reach agreement to the Home Secretary.

In relation to the powers of the tribunal, the chairmen said that they had needed to go beyond the rules on 21 occasions(14 men and 7 women). With a few exceptions, their actions concerned adjournments and approaches to the hospital designed to encourage rehabilitative arrangements to enable the patient to leave. Sometimes this took the form of pressing the hospital to take responsibility for the release; sometimes the adjournment was in the form of an implied 'ultimatum' that the tribunal intended to discharge the order after a given period. The exceptions included seeking to persuade a patient to accept the opportunity to leave the hospital which had been arranged by the hospital team, using other parties(such as solicitors, probation officers, and relatives of patient) to seek to obtain rehabilitative resources, and direct contact with the Department of Health to encourage transfer.

It should be noted that the above actions were those considered by the legal chairmen to 'go beyond the given rules and procedures'. Some of these actions did appear to be sanctioned by their rules and others had not previously been prevented by the rules. To some extent, the chairmen appeared to be responding as much in terms of 'unusual course of action'. Yet it did appear reasonable to

view some of their actions as innovatory in the sense of being 'practices' not anticipated by 'legal precept'; thus providing evidence to satisfy Lemert's criteria that to be influential in the process of change 'anomalies' should be expressed in terms of discrepancies between legal precept and practice.

Such innovatory developments reflected above included:

- (a) adjourning consideration of an application, exercising their authority to adjourn for further information, when in fact they were using this as a means of maintaining an interest in a patient in regard to whom the hospital team were already actively seeking to arrange the discharge or transfer to another hospital,
- (b) adjourning consideration and seeking to directly influence the hospital team into initiating a course of action not open to the tribunal,
- (c) making direct contact with the Department of Health (as managers of the special hospital) and/or with the health authorities beyond the special hospital seeking to initiate a rehabilitative plan which was not within their powers to implement,
- (d) seeking through direct contact with the hospital team and/or hospital managers to influence further clinical assessment and/or treatment whilst still in hospital, and
- (e) seeking to force accommodation or other rehabilitative arrangements by the hospital (which the hospital were unwilling to initiate because of reservations about the readiness of the patient for discharge) by 'adjourning' for fixed period with

stated intention to discharge order at the end of that period, often without reconvening for further review.

Further evidence of innovatory action

There were various open-ended research questions with no pre-determined categories of response presented in the observation schedule and during the interview. These responses reinforced the evidence summarised above from the interview question about 'going beyond the given rules and procedures'. It was evident from observation and acknowledged by the legal chairmen that, in response to difficulties in obtaining evidence and anomalies arising from their rules and powers and dilemmas in respect of practical choices, the tribunal found it necessary to adopt a more flexible and innovatory approach to exercising their powers than appeared to be anticipated in the legislation and rules. The innovations were primarily in response to applications, in that there was limited if any restriction on the advice they could give to the Home Secretary. Also, as they did not have the authority to 'free' patients referred to them (in contrast with applications), rehabilitative and social control considerations did not apply as acutely.

As suggested in Chapter Fourteen on 'Disagreements between the members', disagreements did not present the same severity of difficulties as the other causes and therefore did not give rise to the same need for innovatory action.

It has already been identified that definite decisions in response to applications were only achieved at 58.3% of the hearings included in the research sample. Otherwise (30 hearings) the hearings were adjourned to 'obtain further information'. With

few exceptions, the 'further information' concerned practical arrangements for the care and rehabilitation of the patient if the order was discharged or movement was arranged by the hospital. In respect of applications, the tribunal found that it was often not possible to exercise their straight-forward 'discharge-or-not' authority without delay and further enquiry. So innovatory action was often considered necessary in response to applications, and such action as summarised above in response to difficulties arising from the rules and powers frequently involved the use of 'adjournment' in one way or another.

After being asked about the 'purpose of adjourning', the legal chairmen were presented with a further interview question: 'Did you decide to take any additional action as a tribunal in response to this application or reference?' They responded positively on 24 occasions, which only once concerned a reference. On that one occasion, the chairmen indicated they had sent an interim report to the Home Secretary with the request they should be allowed to review the patient again in six months. The 23 'additional actions' in response to applications concerned the actions already identified above: making clear an intention to discharge after adjournment, pressing the hospital to make enquiries, contact with other hospitals and the Department of Health, and using other people to make enquiries.

In the observation schedule, there was an open-ended question specifically inviting 'further comments on any innovatory action or any unusual feature of this tribunal hearing'. The researcher noted 'further comments' in respect of 80 hearings(53.3%). The

details, which were summarised in the 'discussion' section of this chapter, generally reinforced the above findings; and the extent to which the researcher noted 'innovatory action or unusual features' tended to support the finding that action 'beyond the given rules and procedures' mainly in response to applications was not uncommon.

Summary of findings

Decisions and advice in response to the sample group of applications and references were in favour of continued detention in respect of 46.0% of the hearings, the proportion of such conclusions being similar with both applications and references.

Whereas definite conclusions were reached in regard to almost all of the references(94.8%), a definite decision was achieved in response to only 58.3% of the applications. Consideration of the remaining applications(30 hearings) was adjourned for further enquiries. There was the suggestion that difficulties affecting the ability to decide on applications were more likely to arise with women in comparison with men.

The purposes in adjourning reflected the inappropriateness of the straight-forward 'discharge-or-not' authority of the tribunal in relation to the detaining order of the applicant-patients. Adjournments were used as a means, not only of supplementing information, but of influence on the responsible authorities in the detaining hospital and in the home areas of the patients. Often they were not merely 'delaying' in the hope facilities would be made available, but using the 'threat' of discharge as an attempt to 'enforce'

action by the hospital and/or a tangible response from the responsible health and community services.

Innovatory action by the tribunal appeared to be mainly in response to applications where, although they had the authority to discharge the order detaining the patient, they had no power over the actual movement of the patient nor the resources they might consider necessary for rehabilitation. Innovatory action was mainly related to various attempts to extend the influence of the tribunal beyond the strictly legalistic 'duty to discharge' in respect of the detaining order.

Discussion

Megaree's implied criticism of those who 'simply refuse to make such predictions' about dangerous behaviour was salutary, as such 'refusal' could result in someone continuing to be detained for doubtful reasons. Megaree⁽¹⁰⁾ suggested that responsibility was refused on the grounds that predications about dangerous behaviour involved problems which made errors inevitable. These 'refusals' could take different forms. Within an establishment detaining mentally disordered people for indeterminate periods, the 'refusal' could take the form of an inertia arising from excessive caution and uncertainty. The higher authority, to whom the establishment may need to seek the sanction for the release of individuals, may demonstrate the 'refusal' in terms of demanding unrealistic assurances in regard to the risk associated with the individual. The 'refusal' of more 'open' residential or hospital situations and

(10) Megaree, E.I. 'The prediction of dangerous behaviour' Criminal Justice and Behaviour, Vol. 3, No. 1, March, 1976.

community services could be shown in the unwillingness to accept responsibility for the care and/or supervision of the individual because of the problems and inevitable error in regard to behavioural prognosis. The general public and their representatives may resist because of their 'fear' of the unpredictable.

Each and all of these 'refusals' have contributed to the great difficulty such as mentally abnormal offenders have found in obtaining the opportunity to gain their freedom and prove themselves. Yet, as Megaree emphasised, 'someone has to make these predictions'. The mental health review tribunal was chosen for this research project as representative of those who were expected to accept the responsibility for making predictions about the future behaviour of people who have been considered dangerous. It was evident from this research that the mental health review tribunal at Rampton Hospital exercised their responsibility conscientiously and thoroughly. The occasions when the tribunal delayed the exercise of their 'duty' to decide could not reasonably be called 'refusals' nor attempts to avoid responsibility. The delays were related to difficulties affecting their decision-process and the attempts of the tribunal to overcome these difficulties. These 'pitfalls' not only contributed to the likelihood of 'error', but also acted as restraints in the process of reaching conclusions. It appeared to the researcher that the tribunal did not normally give way to inertia (leaving the responsible hospital authorities to decide and act on their initiative) but made serious attempts to overcome the difficulties in order to exercise their own responsibility and influence.

If the decision-makers had not been concerned to overcome the

difficulties and exercise their 'duty' despite the restraints and anomalies and dilemmas, the 'crisis' in the decision-process would have been of a rather passive nature. In other words, if the tribunal made given way more often to the temptation to simply confirm the continued detention because of the lack of viable alternatives (thus relying entirely on the responsible authorities and leaving the patient without the additional safeguard of the tribunal), there would have been no crises in the decision-process in terms of the active presence and influence of interests in conflict or not being safeguarded. As Lemert emphasised in his analysis of revolutionary changes in law,⁽¹¹⁾ for the anomalies arising in the normal course of legal evolution to have a more dynamic influence toward more drastic change the anomalies should show themselves actively in discrepancies between legal precept and practice. Some of the actions considered by the tribunal chairmen to 'go beyond the given rules and procedures' appeared to be changes in their customary approach as opposed to developments beyond the prescribed procedures and powers. Yet many of their actions in response to difficulties, including some of the 'customary' developments, could validly be seen as 'practices' going beyond and therefore bringing into question the limitations and appropriateness of their rules and powers.

The observation and interview findings in regard to the decisions and actions of the tribunal demonstrated that innovatory developments were not uncommon. They were presented above in five groupings, which were then discussed below in more detail and illustrated by the

(11) Lemert E. 'Social Action and Legal Change' Aldine (Chicago 1970)

observation comments on 'any innovatory action or any unusual feature of this tribunal hearing'. These innovatory actions related primarily to the tribunal's response to applications and normally involved the use of their right to adjourn consideration of the application. In regard to applications, to adjourn the hearing was the only prescribed alternative to discharging or not discharging the order (apart from their authority to change the legal classification). Adjournment is sanctioned under Rule 26(1) of the MHRT Rules: (12)

"Where it appears to the tribunal that it is desirable to obtain further information on any point, the tribunal may adjourn for the information to be obtained in such manner as they may direct or for the applicant or any other person concerned to produce the information".

(a) It appeared that sometimes the tribunal exercised their right to adjourn as a means of exercising a 'watching brief' on the situation. This was normally where the hospital were actively engaged in planning the rehabilitation or movement of the patient out of the hospital. There were occasions (two applications) where the patient had progressed to the pre-discharge villa and was due for review by the hospital team after a period with a view to discharge or transfer. The tribunal adjourned these two applications for six months. Occasionally (at least six applications) the hospital team were awaiting a response from hospital or community resources as part of their attempts to release the patient; and again the tribunal adjourned to allow time for developments. Many of these actions could be seen as innovatory in terms of both the 'further information' and the tribunal's 'duty to discharge'. They were not 'obtaining

(12) MHRT Rules 1960 S.I.No.1139.HMSO Rule 26(1)

further information' in any active sense but more maintaining an interest before making a final decision on the application. Allied to this, they had a 'duty to discharge' if they considered the criteria for continued detention were not satisfied. This was evidently the case sometimes and occasionally explicit in their report to the hospital managers. Although it could be reasonably argued that it was in 'the interests of the patient's health and safety and the protection of others' to delay exercising the 'duty to discharge' to allow more time for the hospital plans to materialise, at the very least this approach was straying away from the strict focus on the justification for compulsory treatment (which the applicant was contesting) and the independence of the hospital authorities which appeared to be expected traditionally. The implication of these innovations was perhaps that the prescribed rules and powers assumed a separation of the needs for compulsion and treatment and also a separation between the hospital authority and the independent review tribunal which in practice was not realistic (particularly in respect of special hospitals where only compulsory treatment was available).

(b) Sometimes the tribunal attempted to influence the hospital team into a course of action not available to the tribunal. By implication this was a course of action which the hospital had not already initiated themselves. The researcher noted such attempts at influence at many hearings. Often it concerned the need for care and rehabilitation outside the hospital. The tribunal would write to the responsible medical officer, Department of Health, and/or the Home Office recommending transfer and then often adjourn for a period as a means of maintaining some continued influence on their recommendation. Many of these instances concerned the tribunal's

judgement ^{that} ^ the patient no longer required compulsory treatment but did require care in a national health service hospital which they were unable to achieve.

As these instances primarily concerned applications, they were clear innovations as (even if the resource were available) the tribunal had no authority to order or influence the patient to accept in-patient care in another hospital. They were restrained from discharging the order because of the need for sheltered care; yet they did not wish to renew the order because they did not consider the patient required compulsory treatment. In these instances, they disagreed with the hospital team in regard to the need for compulsory care and sought to influence the view of the hospital.

(c) It was clear within the Tribunal Rules that the tribunal had the right to seek information in whatever way and from whatever source they considered appropriate. Therefore to some extent the innovations in this grouping were changes of customary practice; extending the use of the rules rather than going beyond them. Normally the tribunal relied on the responsible government departments and the hospital authorities to provide or obtain the information required. Traditionally the tribunal appeared to have restricted its other direct contacts to the patients, the family, and the representatives. Any 'negotiation' in regard to facilities had tended to be contained within the context of discussion with parties attending the hearing. Even in regard to the local authority social services from whom reports were invariably requested, attendance at the hearing or other direct contact with the tribunal did not appear to have been on the initiative of the tribunal. In regard to the community services, this pattern

continued in evidence during the research project. The tribunal did not often make direct contact with the social services and only once requested their attendance at the hearing (the purpose of one adjournment). The eleven occasions when community social workers or probation officers attended the hearings appeared to be on the initiative of the hospital or the social workers themselves.

Innovations in regard to extending direct contact with agencies outside the hospital related almost entirely to the need for continued hospital care. Sometimes it took the form of writing directly to the Department of Health recommending transfer. They had no prescribed duty or authority to give such advice. On other occasions they made direct contact with the health care agency as an informal attempt to negotiate hospital care. On one occasion they directly approached the consultant responsible for a half-way hospital unit, obtained his commitment, and then recommended transfer to that unit to the Home Secretary. On another occasion, in response to the application of a patient who had been waiting some time for a place in a hospital in his home area, they wrote directly to the hospital concerned seeking urgent clarification on what was meant by the patient being on the 'urgent waiting list' (from a letter to the responsible medical officer). The innovation in these cases was not necessarily in the direct approaches (which were not prevented by the rules) but in the attempts to directly negotiate facilities not within their prescribed powers to influence (or even recommend in regard to applications).

(d) In response to a number of applications and references, the tribunal sought to influence through direct contact with the hospital team and/or the Department of Health further clinical

assessment and treatment whilst still in hospital. This was clearly beyond their 'brief' in regard to applications and questionable in regard to references where their advice was being sought in regard to 'restricting the discharge' for the 'protection of the public'. These actions were sometimes in the form of correspondence recommending courses of action, such as re-examination of justification for conviction, further clinical evaluation, 'testing-out' in the pre-discharge unit of the hospital, specific occupational training (catering course in the hospital), and specified courses of treatment. Sometimes they would request to see the responsible medical officer and seek to persuade him to consider such courses of action within the hospital. Occasionally this would be followed up by an adjournment to assess the response to their suggestions.

(e) The findings of both observation and interview was that the majority of adjournments were intended to allow time for rehabilitative and/or accommodation enquiries in regard to an applicant-patient the tribunal were inclined to discharge. It was observed and acknowledged through interview that the purpose of at least 21 adjournments was to allow for enquiries into community or alternative hospital accommodation. Distinct from the above groupings of innovations (where the tribunal were 'maintaining an interest', seeking to influence the hospital into discharge or transfer, seeking to initiate action through direct contact with outside agencies, or seeking to influence further care or treatment in the hospital), there were occasions identified through both methods of data-collection where the tribunal decided to 'force the issue'. The conclusion of ten hearings of applications was a definite decision to discharge expressed in terms of an adjournment 'to allow time for

accommodation to be arranged'. The letter to the hospital authorities and the responsible medical officer made clear the intention of the tribunal to discharge the order after a given period during which time 'placement' should be arranged.

The occasions where the tribunal did 'force the issue' through such a delayed discharge were not uncommon and even included patients who they judged to require sheltered or intensive social care. Therefore, in addition to the 44 hearings (9 applications and 35 references) which resulted in definite decisions to discharge or advice to release from the special hospital, there were at least 10 other hearings(all applications) where an equally definite conclusion to discharge was reached(and delayed through adjournment).

Summary of discussion

The review of the Mental Health Act 1959⁽¹³⁾ came to the conclusion that the extension of the powers of the mental health review tribunal to provide the authority for a 'delayed discharge' was appropriate and necessary. Considering that the tribunal during this research project discharged the order of applicant-patients on only 9 occasions (12.5%) and found it necessary to adjourn 30 hearings (41.7%), the conclusion of the 'Review' was strongly supported. . . . They 'delayed' a definite decision to discharge on more occasions than they discharged the order, thus suggesting that in regard to reviewing the detention of patients in special hospitals 'delayed discharge' was appropriate and necessary. There were various innovations in practice in the

(13) Review of the Mental Health Act 1959, HMSO CMND 7320 (1978)

response of the tribunal to applications and references, but this developing practice of 'delayed discharge' despite their 'duty to discharge' and the absence of any explicit prescribed power to delay the discharge (as opposed to adjourning a hearing) was the clearest evidence of anomalies which satisfied Lemert's criteria for anomalies with an influence for change. There were some indications in the tribunal discussions and the wording of their reports⁽¹⁴⁾ of a reluctance at times to state explicitly their intention to discharge after the defined period of one to six months. Some reports were expressed in terms of 'the tribunal were disposed to discharge the order' and 'the tribunal are likely to discharge the order when they reconvene' and 'if suitable accommodation had been available'. This could have been seen as a recognition of their limited powers. Yet in regard to the reports of the conclusions of at least ten hearings, the reasons for adjournment included a clear statement of 'intention to discharge'.

(14) The conclusions of hearings to consider applications were communicated to the parties concerned through correspondence (and a standard form for recording the decision). It was to this correspondence that 'reports' referred.

CHAPTER SIXTEENINFLUENCE OF SOCIO-DEMOGRAPHIC FACTS

'The traditional legal view of the sentencing process makes the assumption that the only "legally significant" variables governing judicial decisions, within a given legal framework, are differences in the factual make-up of the cases'.

(Hogarth 1971)⁽¹⁾

In discussing the models appropriate to the study of the legal decision-process in regard to the restraint of the mentally disordered(Chapter Four), one starting point was the traditional input-output approach to decision-making. The stimulus-response or input-output model of human behaviour appeared to be consistent with the formal-structural approach to the decision-process of the mental health review tribunal. Within such a model, the prescribed framework of the mental health review tribunal would process the input of 'facts' in regard to the patient and would respond with the appropriate decision on the basis of those facts(all other variables being constant).

The study of the evidence on which the tribunal based their judgements (Chapter Eleven) found that the influential evidence was not always the more 'observable' facts. One over-riding factor with the tribunal appeared to be 'the personality of the patient'; both in that it was the one main influence in comparison with other

(1) Hogarth J. 'Sentencing as a Human Process' Toronto University Press(Toronto 1971) p.341.

variables and also in the sense that it overlapped and to some extent incorporated aspects of other variables. It overlapped both with more objective considerations such as offences and observable behaviour and with less tangible variables such as subjective feelings and intuition. There was the strong indication that the more subjective aspect of the reaction to the personality was at least as influential as any objective assessment of personality characteristics.

Chapter Eleven was concerned with the evidence upon which the tribunal based their judgements, regardless of the decision actually reached. Yet the findings questioned the traditional view that the only significant variables affecting 'sentencing type' decision-making were those externally visible 'facts' available from such as judicial records. In developing this research project, it had been decided to test the input-output model directly by collecting factual information about the patients, with a view to determining the relationship of the factors to the judgements of the tribunal. The socio-demographic details to be collected in regard to the patients being seen at the 150 hearings were listed in Chapter Seven on 'The Research Schedule' (pages 69-70). These were collected from official documents and it was possible to cross-check the information from different sources to ensure a high level of accuracy. The relationship of these objective 'facts' to the decisions of the tribunal were presented in this chapter. Comparison with the relationship of the 'facts' as perceived by the tribunal to their decisions will be presented and discussed in Chapter Seventeen.

In order to assess the relationship of the 'facts' about the patient to the decisions of the tribunal, the information about the socio-demographic features of the patient were cross-tabulated with the responses to the interview question: 'Was your decision or advice in favour of release from Rampton?' In considering the findings, it should be remembered that 'no' responses would include occasions when the decision was adjourned as well as decisions against release.

Regional Health Authority from which the patient originated

Table 1: Home Area of the Patient

<u>Regional Health Authority</u>	<u>Yes</u>	<u>No</u>	<u>Total</u>
Northern	3	4	7
Yorkshire	4	15	19
Trent	10	12	22
East Anglia	2	3	5
North West Thames	1	4	5
North East Thames	3	9	12
South East Thames	1	8	9
South West Thames	2	2	4
Wessex	4	5	9
South Western	3	9	12
Oxford	3	4	7
West Midlands	5	14	19
Mersey	0	4	4
North West	2	2	4
Wales	4	7	11
Eire	0	1	1
	<hr/>	<hr/>	<hr/>
	47	103	150
	<hr/>	<hr/>	<hr/>

There would probably need to be a much larger sample in order to identify significant differences between the groups of patients from the various regional health authority areas. Even though there could have appeared to be tendencies against releasing patients from

certain regions (Yorkshire, the metropolitan health authority areas, and West Midlands), the difference was not significant in regard to particular regions. Nor did there appear to be any significant groupings of the regions in terms of release from Rampton; for instance, particular areas of the country, 'types' of region, or distance from the hospital. It was decided that it would not be appropriate to reach any definite conclusions in regard to the relationship of the home area of the patients to the decisions of the tribunal. The null hypothesis was not rejected by the findings.

Age of the Patient

Table 2: Age of the Patient

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Under eighteen years	0	0.0%	1	1.0%	1	0.7%
18 - 20 years	2	4.1%	3	2.9%	5	3.3%
21 - 24 years	9	18.4%	22	21.4%	31	20.7%
25 - 29 years	7	14.3%	24	23.3%	31	20.7%
30 - 39 years	13	26.5%	37	35.9%	50	33.3%
40 - 49 years	7	14.3%	12	11.7%	19	12.6%
50 - 59 years	9	18.4%	4	3.8%	13	8.7%
	47	100.0%	103	100.0%	150	100.0%

In terms of the pre-determined response-categories, the age of forty appeared to have some significance in respect of the relationship of age to the decisions of the tribunal. The decision or advice of the tribunal was in favour of release in regard to 16 patients aged forty and over (50.0%) compared to 31 patients aged under forty (26.27%) ($\chi^2(1D.F)=6.65$ $p < 0.02$). Although the numbers

were smaller, the difference and the significance were even greater with patients aged over 50 years($X_2(1D.F)=7.56$ $p < 0.01$), corrected for continuity.

The null hypothesis was rejected in respect of the age of the patient, with a significant correlation between a judgement in favour of release and being aged forty years and over(Contingency coefficient = 0.206) and being aged fifty and over($C = 0.219$)

Sex of the Patient

Table 3: Sex of the Patient

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Male	41	87.2%	77	74.8%	118	78.7%
Female	6	12.8%	26	25.2%	32	21.3%
	47	100.0%	103	100.0%	150	100.0%

Although there was a face-value tendency in favour of releasing men, the difference was not significant ($X_2(1D.F)=3.10$ $p \geq 0.05$). Therefore on the basis of this evidence, the null hypothesis was not rejected in respect of the sex of the patient.

Marital Status of the Patient

Table 4: Marital Status of the Patient

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Unmarried	39	83.0%	94	91.2%	133	88.7%
Married	1	2.1%	1	1.0%	2	1.3%
Widowed	1	2.1%	0	0.0%	1	0.7%
Separated	1	2.1%	4	3.9%	5	3.3%
Divorced	5	10.7%	4	3.9%	9	6.0%
	47	100.0%	103	100.0%	150	100.0%

As 133 patients(88.7%) had not been married, the sample group with experience of marriage was too small for statistical significance. On the basis of this evidence, the null hypothesis was not rejected in regard to the marital status of the patients ($X_2(1D.F)=1.49$ $p > 0.05$), corrected for continuity.

Legal Classification of the Patient

Table 5: Legal Classification

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Mental Illness	13	27.7%	31	30.1%	44	29.4%
Psychopathic Disorder	13	27.7%	36	35.0%	49	32.7%
Subnormality	16	34.0%	19	18.4%	35	23.3%
Severe Subnormality	4	8.5%	13	12.6%	17	11.3%
Unclassified	1	2.1%	4	3.9%	5	3.3%
	47	100.0%	103	100.0%	150	100.0%

In comparison with the other legal classifications, subnormality¹ appeared to have some significance in respect of the relationship of the legal classification to the decisions of the tribunal. The decision or advice of the tribunal was in favour of release in regard to 16 patients classified as subnormal(45.7%) compared to 31 of the other patients(27.0%) ($X_2(1D.F)=4.32$ $p < 0.05$).

The null hypothesis was rejected in respect of the legal classification of the patient, with a significant correlation between the legal classification of 'subnormality' and a judgement in favour of release ($C = 0.168$).

Nature of the Detention OrderTable 6: Nature of Detention

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Non-offenders (unrestricted)	7	14.9%	35	34.0%	42	28.0%
Offenders (unrestricted)	6	12.7%	24	23.3%	30	20.0%
Offenders (restricted)	34	72.4%	44	42.7%	78	52.0%
	47	100.0%	103	100.0%	150	100.0%

Table 6 presented the nature of the detention in terms of whether the patient was detained as an offender or non-offender and whether there was a further restriction on discharge under section 65 of the Mental Health Act 1959. Although there was no significant difference between the unrestricted non-offenders and the unrestricted offenders, there was a highly significant difference ($X_2(1D.F)=11.45$ $p < 0.001$) in favour of those patients who were further restricted on discharge 'for the protection of the public' (Section 65). Even though these restricted patients were inevitably more serious offenders as a group (to justify the further restriction), this finding did not mean the tribunal were more likely to release more serious offenders. The difference would have arisen mainly from the nature the role and powers of the tribunal in response to references from the Home Secretary. In comparison with their straight-forward authority to discharge or continue the order in response to an application without any control over the placement of the man or woman outside the security hospital, their advice in response to references could recommend movement to other hospitals

or any other facility(although without any control over the actual movement).

Therefore, in terms of the options open to the tribunal in response to applications and references, the null hypothesis was rejected in respect of the nature of the detaining order. There was a significant correlation between judgements in favour of release and restriction orders ($C = 0.266$); although the correlation was likely to have arisen mainly because of the restraints which the tribunal experienced in the decision-process in response to applications(described in previous chapters).

Table 7: Orders Under Which the Patients Detained

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Section 26	4	8.5%	26	25.2%	30	20.0%
Section 60	2	4.3%	17	16.5%	19	16.4%
Section 60/65	32	68.0%	37	35.9%	69	46.0%
Section 72(and 72/65)	6	12.8%	10	9.7%	16	10.7%
Other	3	6.4%	13	12.7%	16	10.7%
	<hr/>		<hr/>		<hr/>	
	47	100.0%	103	100.0%	150	100.0%
	<hr/>		<hr/>		<hr/>	

The above difference was illustrated further in Table 7 in regard to the specific orders under which patients were detained. Of 49 men and women detained directly into hospital care under a treatment order (section 26) or court order without the further restriction(section 60), the legal chairmen indicated they had decided in favour of release in response to only 6 applications (12.24%); compared to favourable advice in response to 32 of the men and women detained directly into hospital under a court order

with the further restriction(46.38%). It was shown in Chapter Fifteen on 'Tribunal decisions' that favourable advice to the Home Secretary was more often in terms of transfer to a national health service hospital rather than discharge into the community (which was likely to be the effect of discharging the order in response to an application).

Offences and behaviour which led to detention

Table 8: Offences and Behaviour

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Murder/manslaughter	4	8.5%	9	8.8%	13	8.7%
Violence	16	34.0%	51	49.5%	67	44.5%
Sexual assault	14	29.9%	20	19.4%	34	22.7%
Arson	7	14.9%	6	5.8%	13	8.7%
Child-stealing	0	0.0%	3	2.9%	3	2.0%
Property offences	1	2.1%	6	5.8%	7	4.7%
Criminal damage	1	2.1%	3	2.9%	4	2.7%
Other	4	8.5%	5	4.9%	9	6.0%
	47	100.0%	103	100.0%	150	100.0%

From the information presented in Table 6, there was a significant difference in respect of decision or advice in favour of release between non-offenders(7 individuals, 16.67%) and offenders (corrected for continuity) (40 individuals, 37.04%) ($X_2(1D.F)=5.83$ $p < 0.02$); although the difference was related to the different roles of the tribunal in response to applications and references. What was the relationship between particular categories of offence or behaviour and the decisions/advice of the tribunal? There was a face-value impression in the information presented in Table 8 that there was a tendency against the release of patients convicted or detained

because of violence(as opposed to the other response-categories of offences and behaviour), but the difference was not significant ($X_2(1D.F)=2.85$ $p > 0.05$). Although(perhaps because of the small numbers) the difference in relation to arson was not significant ($X_2(1D.F)=2.31$ $p > 0.05$), there did appear to be a significant relationship between the combined responses of arson and sexual assault and decision or advice in favour of release($X_2(1D.F)=5.72$ $p < 0.02$).

The null hypothesis was rejected in respect of the offences and behaviour which led to detention, with a significant correlation between a judgement in favour of release and arson/sexual assault offences and behaviour ($C = 0.192$).

The study of the relationship between offences and the decision of the tribunal was supplemented by data collected in regard to the victims of those offences or behaviour which led to the detention. The information was cross-tabulated with the interview question in regard to whether the decision or advice was in favour of release and presented in Table 9.

Table 9: Victims of the Offence or Behaviour

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
People generally	10	21.3%	31	30.1%	41	27.3%
Adults own sex	1	2.1%	1	1.0%	2	1.3%
Adults opposite sex	8	17.1%	14	13.6%	22	14.7%
Children	9	19.1%	20	19.4%	29	19.3%
Elderly	2	4.3%	1	1.0%	3	2.0%
Self	1	2.1%	0	0.0%	1	0.7%
Staff and/or patients in NHS hospitals	10	21.3%	25	22.3%	33	22.0%
Family and friends	5	10.6%	11	10.7%	16	10.7%
Other	1	2.1%	2	1.9%	3	2.0%
	47	100.0%	103	100.0%	150	100.0%

On the basis of the information presented in Table 9, the null hypothesis in respect of the victims was not rejected.

Years of in-patient care in Rampton Hospital

Table 10: Years in Rampton

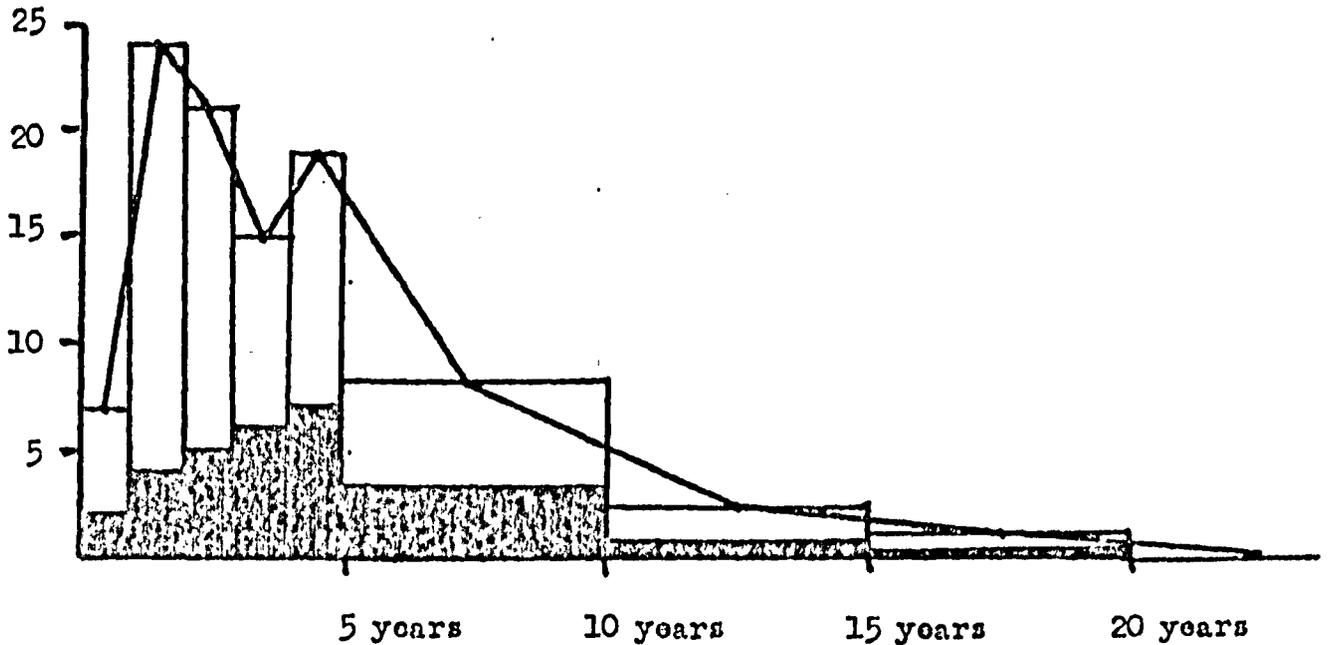
	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Less than one year	2	4.3%	5	4.9%	7	4.7%
Less than two years	4	8.5%	20	19.4%	24	16.0%
Less than three years	5	10.6%	16	15.5%	21	14.0%
Less than four years	6	12.8%	9	8.8%	15	10.0%
Less than five years	7	14.9%	12	11.6%	19	12.7%
Five to nine years	16	34.0%	27	26.2%	43	28.6%
Ten to fourteen years	4	8.5%	9	8.8%	13	8.7%
Fifteen to nineteen years	2	4.3%	3	2.9%	5	3.3%
Over twenty years	1	2.1%	2	1.9%	3	2.0%
	<hr/>		<hr/>		<hr/>	
	47	100.0%	103	100.0%	150	100.0%
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(see next page)

A histogram of the data/in regard to years in Rampton Hospital would illustrate the decreasing proportion of the total patient population in each higher category of number of years contrasting with an increasing proportion of patients to whom the tribunal responded with decision or advice in favour of release from the hospital. In terms of the pre-determined response categories in Table 10, three years appeared to be significant in respect of the relationship of years in the hospital to the decisions of the tribunal. The decision or advice in favour of release related to 36 of the patients who had been in the hospital for more than three years (36.73%) compared to 11 patients with three years or less stay (21.15%) ($X_2(1D.F)=3.842$ $p < 0.05$). In terms of the data and pre-determined response-categories presented in Table 10, the

TABLE 10: YEARS IN RAMPTON HOSPITAL

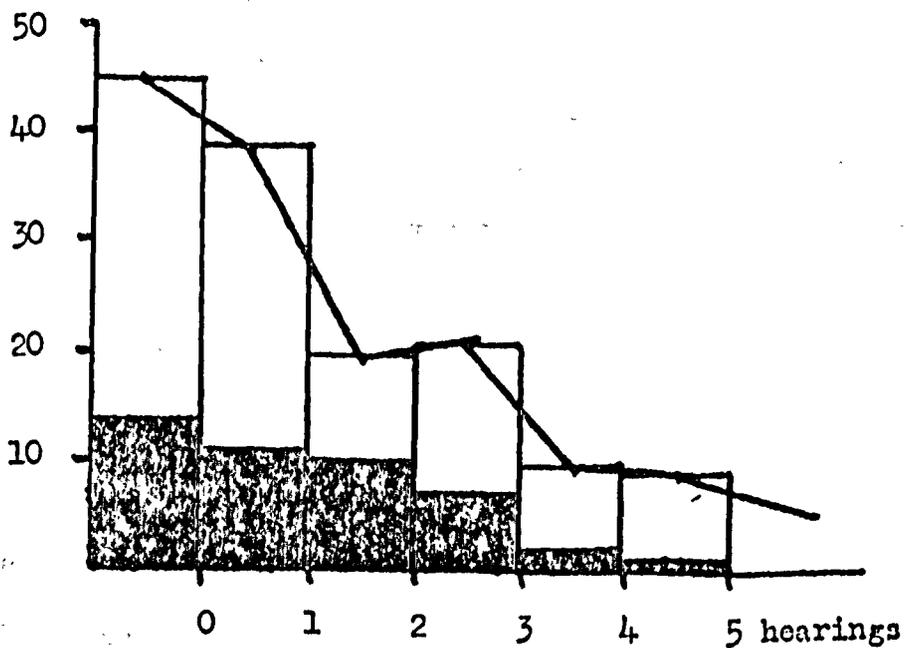
(Cross-tabulated with judgements in favour of release)



Number of patients (shaded area indicates judgements in favour of release)

TABLE 14: NUMBER OF PREVIOUS HEARINGS

(Cross-tabulated with judgements in favour of release)



Number of patients (shaded area indicates judgements in favour of release)

relationship was not significant at any other point. In other words, there was no evidence that increased length of stay beyond three years increased the relationship with the decision or advice to release from hospital.

The null hypothesis was rejected in respect of the years in Rampton, with a significant correlation between a judgement in favour of release and a length of stay of more than three years. ($C = 0.158$).

Previous hospital care

Table 11: Years in Previous Hospital Care

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
None	11	23.4%	11	10.7%	22	14.7%
Less than one year	9	19.1%	13	12.6%	22	14.7%
One to five years	12	25.6%	33	22.0%	45	30.0%
Six to ten years	5	10.6%	16	15.6%	21	14.0%
Eleven to fifteen years	2	4.3%	13	12.6%	15	10.0%
Sixteen to twenty years	4	8.5%	11	10.7%	15	10.0%
21 to 25 years	1	2.1%	4	3.9%	5	3.3%
Over twenty five years	3	6.4%	2	1.9%	5	3.3%
	47	100.0%	103	100.0%	150	100.0%

Any interpretation of the data presented in Table 11 (as was emphasised in regard to other variables such as criminal offences) should take account of the different roles and powers of the tribunal in response to applications and references. Inevitably a higher proportion of non-offenders had been transferred after periods of care in other hospitals and in respect of them the powers of the tribunal were restricted as discussed in various

contexts in the previous chapters.

Yet, in terms of the pre-determined categories and the data presented in Table 11, there were significant relationships between the presence of previous hospital care in the histories of patients (and time spent in previous hospitals) and the decisions and advice in favour of release from Rampton. The decision or advice to release related to 11 patients who had not previously received hospital in-patient care at all (50.0%) compared to 36 patients who have previously been in hospital (28.1%) ($X_2(1D.F)=4.16$ $p < 0.05$). The significance was even greater in respect of patients who had less than one year in previous hospital care (20 patients, 45.45%) compared to those with at least one year in previous hospital care (27 patients, 25.47%) ($X_2(1D.F)=5.77$ $p < 0.02$).

The null hypothesis was rejected in respect of previous hospital care, with a significant correlation between a judgement in favour of release and no previous hospital care ($C = 0.164$) or less than one year previously in hospital ($C = 0.192$).

Previous criminal offences and sentences

Tables 12 and 13 presented the data about criminal convictions and sentences previous to the offences or behaviour which led to the current detention, cross-tabulated with the interview responses in regard to decisions or advice in favour of release from Rampton. Whilst the data about criminal offences concerned only the most serious offence of which each patient had been convicted, previous sentences have been grouped to include an indication of all previous sentences.

Table 12: Most Serious Previous Criminal Offence

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
None	9	19.1%	37	35.9%	46	30.7%
Petty theft	6	12.8%	8	7.8%	14	9.3%
Serious property	7	14.9%	10	9.7%	17	11.3%
Indecent assault	11	23.4%	18	17.5%	29	19.3%
Rape	1	2.1%	3	2.9%	4	2.7%
Criminal damage	0	0.0%	3	2.9%	3	2.0%
Arson	2	4.3%	8	7.8%	10	6.7%
Violence	10	21.3%	12	11.6%	22	14.7%
Manslaughter/murder	1	2.1%	1	1.0%	2	1.3%
Child-stealing	0	0.0%	3	2.9%	3	2.0%
	47	100.0%	103	100.0%	150	100.0%

With one exception, there did not appear to be a significant relationship between a judgement in favour of release and any one of the pre-determined response-categories. The exception was in regard to the group of patients who had not been convicted previously of criminal offences of any nature (30.7% of the total sample group). The decision or advice to release related to 9 of the patients without previous convictions(19.56%), compared to 38 patients with previous convictions(36.54%)($X_2(1D.F)=4.25$ $p < 0.05$).

Table 12a: Previous Criminal Offences

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Property offences	13	34.2%	18	27.3%	31	29.8%
Sexual offences	12	31.6%	21	31.8%	33	31.7%
Arson/criminal damage	2	5.3%	11	16.7%	13	12.5%
Violence/manslaughter	11	28.9%	13	19.7%	24	23.1%
Child stealing	0	0.0%	3	4.5%	3	2.9%
	38	100.0%	66	100.0%	104	100.0%

That there was no significant difference in terms of particular offences in relation to judgements in favour of release was reinforced by presenting the data about previous offences separate from the previous non-offenders (Table 12a). The main face-value difference was in respect of offences of arson and criminal damage but this was not significant ($X_2(1D.F)=2.02$ $p > 0.05$) (corrected for continuity)

Table 13: Previous Sentences of Total Sample Group.

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
None	9	19.1%	37	35.9%	46	30.7%
Fines only	1	2.1%	1	1.0%	2	1.3%
Probation only	7	14.9%	9	8.7%	16	10.7%
Prison/borstal	12	25.6%	12	11.6%	24	16.0%
Hospital order only	8	17.1%	19	18.5%	27	18.0%
Hospital order and other sentences	7	14.9%	21	20.4%	28	18.6%
Care order only	3	6.3%	3	2.9%	6	4.0%
Other	0	0.0%	1	1.0%	1	0.7%
	47	100.0%	103	100.0%	150	100.0%

As sentences were linked with convictions, inevitably there was the same finding in regard to patients without previous sentences as with those without previous convictions. There was the same significant difference against patients without previous sentences in regard to judgements in favour of release. In addition, there was another significant finding which was illustrated more clearly when the previous sentences were presented separate from the previous non-offenders (Table 13a).

Table 13a: Previous Sentences of Previous Offenders

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Non-custodial sentences (fines, probation, care orders)	11	28.9%	14	21.2%	25	24.0%
Custodial sentences only (prison, borstal, etc)	12	31.6%	12	18.2%	24	23.1%
Hospital orders (with or without other sentences)	15	39.5%	40	60.6%	55	52.9%
	38	100.0%	66	100.0%	104	100.0%

The decision or advice to release from Rampton related to 15 patients with previous hospital order sentences (27.27%), compared to 23 patients without hospital orders in their previous history (46.94%) ($X_2(1D.F)=4.33$ $p < 0.05$). This finding applied to hospital orders regardless of whether or not other sentences were in the history of patients.

Therefore the null hypotheses were rejected in respect of previous offences and previous sentences, in that there was a significant correlation between a judgement in favour of release and the presence of previous convictions and sentences in the patient's history (as opposed to those without any previous criminal record) ($C = 0.167$). The null hypothesis was not rejected in respect of particular previous offences. Yet the null hypothesis was rejected in regard to previous sentences, with a significant correlation between judgements in favour of release and previous offenders without hospital orders in their record ($X_2(1D.F)= 8.13$ $p < 0.01$) ($C=0.227$)

Residential care as a child

The null hypotheses in regard to residential child care and residential schooling were not rejected. The legal chairman responded in favour of release in respect of 20 patients with child care in their background(28.57%), compared to 26 without child care experience (32.92%). Similarly, the responses in favour of release related to 24 patients with residential schooling experience(32.44%), compared to 22 without residential schooling experience(29.34%). On the basis of this data, there was no significant relationship between residential care as a child and a judgement in favour or against release.

Number of previous tribunal hearings

Table 14: Number of Previous Hearings

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
None	14	29.7%	31	30.1%	45	30.0%
One hearing	11	23.4%	28	27.2%	39	26.0%
Two hearings	10	21.3%	10	9.7%	20	13.3%
Three hearings	7	14.9%	14	13.6%	21	14.0%
Four hearings	2	4.3%	8	7.7%	10	6.7%
Five hearings	1	2.1%	8	7.7%	9	6.0%
Over five hearings	2	4.3%	4	4.0%	6	4.0%
	47	100.0%	103	100.0%	150	100.0%

(see diagram following page 296)

A histogram of the data/in regard to number of previous hearings would illustrate a steadily decreasing number of patients with the increasing categories of number of hearings, but with the face-value impression of a peak in interview responses favourable to release after two previous hearings. Decisions or advice in

favour of release from Rampton related to 10 patients with two previous hearings(50.0%), compared to 25 patients with less than two previous hearings(29.76%) and 12 patients with more than two previous hearings(26.09%). Despite this interesting phenomenon, the difference in respect of two previous hearings as against any other or all other response-categories was not significant ($X_2(1D.F)=2.90 p > 0.05$ corrected for continuity)

Stage of progress in hospital

As described in Chapter Seven on 'The research schedule', a further item of information was made a standardised item on the schedule very early in the main study. The researcher took note of the stage the patient had reached in the progress through the hospital system as some evidence of the opinion of the hospital team about the patient's progress. Progress was noted in terms of (a) 'admission ward'(indicating that the patient was still within the early initial assessment period of 4 - 6 months), (b) 'maximum security' (the secure 'block' wards in the hospital where the patient remained until he was no longer considered to require maximum security), (c) 'secure villa' (relatively less secure situations within the hospital to which the patient progressed from the 'block' wards), and (d) 'pre-discharge villa' (including the preparatory and pre-discharge villas for patients identified as being prepared for release from the security hospital).

Table 15: Stage of Progress in Hospital

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Admission ward	1	2.1%	2	1.9%	3	2.0%
Maximum security	13	27.7%	46	44.7%	59	39.3%
Secure villa	28	59.6%	38	36.9%	66	44.0%
Predischarge villa	5	10.6%	17	16.5%	22	14.7%
<hr/>						
	47	100.0%	103	100.0%	150	100.0%
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The data about the stage of progress of patients on the initiative of the hospital team was cross-tabulated with the decision or advice of the tribunal 'in favour of release from Rampton' (Table 15). The interview response was in favour of release in relation to one patient still in the 'admission ward' (33.3% of patient group), 13 in 'maximum security' (22.0%), 28 from 'secure villa' (42.4%), and 5 'predischarge' patients (22.7%). As a general guide to the opinion of the hospital team, it could be assumed that hospital would not be supporting the release of patients within 'admission', 'maximum security', and 'secure villas'. The 22 'pre-discharge' patients were in the process of being prepared for release. As a general guide to any 'conflict of opinion' between the hospital team and the tribunal, it could be assumed that there was disagreement in regard to the 42 patients who had not reached 'predischarge' and the tribunal judgement was in favour of release. It could not be assumed that there was disagreement in regard to the 17 'pre-discharge' patients where the tribunal did not decide or advise in favour of release. There was disagreement in some instances, with the tribunal recommending against the release preparations of the hospital, but these were rare occurrences. More often these

'predischarge' patients were the subject of tribunal adjournments or other innovatory actions as described in Chapter Fifteen on 'Tribunal decisions'; where their view supported release but they either relied on hospital planning or delayed action before forcing the issue themselves.

Yet in respect of decisions and advice determined at the tribunal hearings within the research sample, the null hypothesis in regard to the stage of progress in the hospital was rejected. There was a significant correlation between a judgement in favour of release and the 'secure villa' stage ($X_2(1D.F) = 6.70$ $p < 0.01$, $C = 0.207$).

Legal chairmen

During the period of the research study and in connection with the sample of 150 tribunal hearings, twelve individual legal members were involved as chairmen: being responsible for numbers of hearings ranging from three to 48. It was explained in Chapter Three on 'Mental health review tribunal' that the legal member was the 'President of the Tribunal' (referred to as 'legal chairmen' within this study) in respect of the particular application or reference; with one legal member being the 'Chairman of the Tribunal' in that health region. The 'Chairman of the Tribunal' in the Trent Regional Health Authority area undertook responsibility for a high proportion of the hearings at Rampton Hospital (48 hearings during this research project, 32.0%). Four other legal members undertook the responsibility of 'chairman' at between eleven and nineteen hearings, with the other legal members taking less than ten hearings each.

The coded data in regard to the legal chairmen was collected through observation. Therefore it was cross-tabulated with the responses to the observation questions in regard to the decisions and advice of the tribunal. With the exception of the 'Chairman of the Tribunal', there was no significant difference in relation to the different chairmen (partly because of the small samples of hearings chaired by them). The data in Table 16 was presented to compare the findings in respect of the 'Chairman of the Tribunal' with the other eleven chairmen.

Table 16: Legal Chairmen

<u>Decision or advice</u>	<u>'Chairman of Tribunal'</u>		<u>Other Chairmen</u>		<u>Total</u>	
No action	16	33.3%	53	52.0%	69	46.0%
Adjournment	14	29.2%	20	19.6%	34	22.7%
Discharge order	2	4.2%	7	6.9%	9	6.0%
Advise transfer	11	22.9%	16	15.7%	27	18.0%
Advise discharge	3	6.2%	2	1.9%	5	3.3%
Other advice	2	4.2%	4	3.9%	6	4.0%
	48	100.0%	102	100.0%	150	100.0%

The 'Chairman of the Tribunal' chaired hearings in response to 24 applications and 24 references, so there was no difference in the proportions of decisions and advice required of the chairmen. The differences illustrated in Table 16 could be assumed to relate to the 'Chairman of the Tribunal' himself; although whether any differences were a function of his authority, his greater experience (at least in terms of frequency and numbers of hearings), or some other factor such as personality was a matter for speculation.

The null hypothesis in regard to the legal chairmen was rejected

with a significant correlation between 'no action' and the legal chairmen other than the 'Chairman of the Tribunal' ($X_2(1D.F)=4.44$ $p < 0.05$, $C = 0.170$). Although there was a face-value tendency for the 'Chairman of the Tribunal' to recommend transfer more frequently than the total of other chairmen, the difference did not appear to relate to any particular course of action. For example, there was a further face-value impression that the 'Chairman of the Tribunal' used the authority to adjourn their consideration more frequently.

Influence of the family

Table 17: Family Attended Hearing

	<u>Did attend</u>		<u>Did not attend</u>		<u>Total</u>	
No action	35	51.5%	34	41.5%	69	46.0%
Adjournment	10	14.7%	24	29.3%	34	22.7%
Discharge order	8	11.8%	1	1.2%	9	6.0%
Advise transfer	8	11.8%	19	23.2%	27	18.0%
Advise discharge	3	4.4%	2	2.4%	5	3.3%
Other advice	4	5.8%	2	2.4%	6	4.0%
	68	100.0%	82	100.0%	150	100.0%

As the data in regard to attendance of the family at the tribunal hearing was collected through observation, the information was cross-tabulated with the responses to the observation questions about the decisions and advice of the tribunal. The family of patients attended 31 hearings in response to applications and 37 hearings to advise on references, so significant differences were likely to relate to the influence of the presence of the family. The tribunal found it necessary to adjourn their consideration in

regard to 10 patients where family attended(14.7%), compared to 24 where family did not attend(29.3%) ($X_2(1D.F)=4.47$ $p < 0.05$). They discharged the order or advised community discharge at 11 hearings where family attended (16.2%), compared to only 3 hearings where family did not attend (3.7%) ($X_2(1D.F)=5.62$ $p < 0.02$)^(corrected for continuity). There was a face-value tendency to advise transfer to a national health service hospital as opposed to any other course of action when family did not attend. Whilst this was not statistically significant within the context of the total responses including 'no action' and 'adjournment' ($X_2(1D.F)=3.12$ $p > 0.05$), there was a highly significant difference between the hearings where family did not attend and those where family did attend when comparing 'advise transfer' with the total of other actions in favour of release from the security hospital. ($X_2(1D.F)=9.42$ $p < 0.01$).

The null hypothesis in regard to family attending the hearing was rejected, with a significant correlation between a judgement in favour of community discharge and the attendance of the family ($C = 0.190$). Within the context of decisions or advice in favour of release(i.e. excluding 'no action' and 'adjournment'), there was a highly significant correlation between family not attending and advice to transfer as opposed to discharge.

Although the family attended only 68 hearings(45.3%), reports on the home circumstances were provided by the area social services at 112 hearings(74.7%). As some evidence of the influence of written reports about the family circumstances, this observed data was cross-tabulated with the observation questions about the decisions and advice of the tribunal(Table 17a).

Table 17a: Home Circumstances Reports Available

	<u>Report available</u>		<u>Not available</u>		<u>Total</u>	
No action	55	49.1%	14	36.8%	69	46.0%
Adjournment	22	19.6%	12	31.6%	34	22.7%
Discharge order	7	6.1%	2	5.3%	9	6.0%
Advise transfer	18	16.1%	9	23.7%	27	18.0%
Advise discharge	4	3.6%	1	2.6%	5	3.3%
Other advice	6	5.4%	0	0.0%	6	4.0%
	112	100.0%	38	100.0%	150	100.0%

On face-value impression, there was an interesting similarity between the patterns of relationship of family attendance and reports available to the decisions and advice of the tribunal. When the family were in attendance or the reports available, there was the same tendencies toward making a definite judgement rather than adjourning, and toward community discharge and against hospital transfer in comparison with when family and/or reports were not available. In respect of the data about home circumstances reports, these tendencies were not statistically significant in themselves. Yet the similarities in the findings in regard to family attendance and home circumstances reports did add weight to accepting that as the pattern of influence of the family.

Legal representation at the hearing

As the patients were represented at all but six hearings(4.0%), it was not thought possible to assess the relationship of legal representation to the decisions or advice of the tribunal. For interest only, it was recorded that in respect of the six hearings where the patient was without legal representation(three applications

and three references), two resulted in 'no action', two were adjourned, and two were recommended for discharge into the community. The one patient(of the six) who was represented by other than a legal representative(a lay representative provided by MIND) was one of the adjourned cases.

As only five of the references(total sample of 78) resulted in advice to discharge into the community(6.4%), it was remarkable that two of the three references where the patients were unrepresented in any way resulted in such a recommendation(66.7%). Even with such a small sample, this was highly significant($X_2(1D.F)=9.10$ $p < 0.01$). On the basis of this surprising evidence, the null hypothesis in regard to legal representation was rejected, with a highly significant correlation between the patient being unrepresented and recommended for community discharge($C = 0.239$). The above statistical testing was applied within the total sample group of 150 for comparison with the other variables. Applied within the sample group of 78 references produced the results:
 $X_2(1D.F)=7.88$ ($p < 0.01$).(2)

Staff interviewed at the hearing

The attendance of hospital staff at the hearing was recorded through observation and cross-tabulated with the observation questions about the decisions and advice of the tribunal.(Table 18)

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- (2) Although corrected for continuity, these interesting statistical conclusions should be treated with great caution because of the small sample involved.

Table 18: Hospital Staff Interviewed

	<u>None interviewed</u>		<u>Psychiatrist</u>		<u>Social Worker</u>	
No action	62	50.0%	4	22.2%	3	37.5%
Adjournment	20	16.1%	12	66.6%	2	25.0%
Discharge order	7	5.6%	1	5.6%	1	12.5%
Advise transfer	25	20.2%	0	0.0%	2	25.0%
Advise discharge	4	3.2%	1	5.6%	0	0.0%
Other advice	6	4.9%	0	0.0%	0	0.0%
	124	100.0%	18	100.0%	8	100.0%

Although the sample of hearings where staff were interviewed was small (17.3%), there were a number of significant findings mainly in respect of the responsible consultant psychiatrist. The tribunal decided or advised 'no action' in relation to 62 hearings where staff were not interviewed (50.0%), compared to 7 hearings where staff were interviewed (26.9%) ($X_2(1D.F) = 4.68$ $p < 0.05$)^(corrected for continuity). Possibly, there was considered to be little benefit in interviewing staff if the tribunal were inclined to 'no action'. This could also have applied where they were inclined to a particular course of action (perhaps already supported by hospital reports). For example, the tribunal advised transfer to NHS care in relation to 25 hearings where staff were not interviewed (20.2%), but did not recommend transfer at any of the hearings where they interviewed the responsible psychiatrist ($X_2(1D.F) = 3.22$ $p > 0.05$)^(corrected for continuity). It was perhaps significant that the majority of the occasions when the psychiatrist was interviewed (14 hearings, 77.8%) concerned applications, in response to which the tribunal did not have the authority to arrange or advise transfer. A finding which was probably related to the above was in regard to adjournments. There was a highly significant correlation between the adjournment of hearings and interview of psychiatrists ($X_2(1D.F) = 19.84$ $p < 0.001$, $C = 0.342$). It

was evident from previous findings (Chapter Fifteen) that, when faced with a dilemma concerning their inability to order transfer, sometimes the tribunal supported or encouraged the psychiatrist in seeking to make arrangements and adjourned to maintain an interest.

Length of time of hearing

The length of time of the hearings was recorded through observation (supplemented where possible and necessary by the tribunal clerk providing the information). This data was cross-tabulated with the response to the observation questions about the decisions and advice of the tribunal (Table 19).

Table 19: Length of Time of Hearing

<u>Minutes:</u>	<u>0 - 30</u>	<u>30 - 45</u>	<u>45 - 60</u>	<u>60 - 75</u>	<u>Over 75</u>	<u>Not known</u>
No action	2	18	27	15	6	1
Adjournment	6	6	12	7	3	
Discharge order	1	0	3	3	2	
Advise transfer	0	6	10	5	6	
Advise discharge	0	0	2	2	1	
Other advice	0	0	5	1	0	
	9	30	59	33	18	1

As suggested in Chapter Eleven on 'The evidence on which the tribunal based their judgements', the hearings which ended within 30 minutes usually concerned situations where the tribunal chose to adjourn their consideration. There were various face-value trends which were not significant statistically; such as the tendency for order or advice to discharge to involve hearings over

(corrected for continuity)

45 minutes ($X_2(1D.F)=1.88$ $p > 0.05$), and the tendency for any advice or decision in favour of release to involve over 75 minutes ($X_2(1D.F)=2.37$ $p > 0.05$). One trend which was significant was the tendency for hearings involving over 45 minutes to result in definite decisions or advice in favour of release (36.4%) compared to hearings taking less than 45 minutes (17.9%) ($X_2(1D.F)=4.39$ $p < 0.05$). In that respect, the null hypothesis in respect of the length of time of the hearing was rejected, with a significant correlation between a judgement in favour of release and the hearing requiring over 45 minutes to reach a conclusion ($C = 0.169$).

Summary

The relative magnitude of the association between the different 'facts' and a tribunal judgement in favour of release was presented in Table 20. The probability values were based on the X_2 values from which the contingency coefficients were adjusted. As the contingency coefficient was affected by the number of rows and columns, a 2 x 2 table was used for each of the variables to enable direct comparison. Also the variables included in the table were only those which had been cross-tabulated with the interview question: 'Was your decision or advice in favour of release from Rampton?'. Direct comparison was possible with other variables which had been cross-tabulated with the observation questions about the decision and advice of the tribunal. The 103 'no action' and 'adjournment' responses equated with the 'no' responses to the interview question; with the various actions such as 'discharge order' totally to the 47 'yes' interview responses.

The decision not to include these other variables within the

presentation in Table 20 was related more to the nature of the variables. Whereas the socio-demographic facts related to the patient and background and socio-legal 'situation', the other variables related to the tribunal and the hearing in response to the application or reference. For instance, the directly comparable contingency coefficient in respect of the length of time of the hearing of over 45 minutes was 0.169. This was as significant statistically as some of the socio-demographic facts, but comparison would be inappropriate as the length of time of the hearing was more part of the response of the tribunal rather than a feature of the 'facts' about the patient. Other features of the tribunal such as the attendance of family ($C = 0.049$) and the influence of the 'Chairman of the Tribunal' ($C = 0.091$) could have been seen as more comparable. Yet, apart from the length of time of the hearing, none of these other variables were significant on the basis of the data collected through this research project.

TABLE 20Association of Socio-Demographic Facts with Decision or Advice
in Favour of Release from Rampton Hospital.

Number of hearings : 150	Contingency coefficient
Restricted under section 65(Home Secretary)	0.266 p < 0.001
No previous record of hospital order	0.227
Age over fifty years	0.219 p < 0.01
'Secure villa' stage of progress	0.207
Age over forty years	0.206 p < 0.02
Offender as opposed to non-offender	0.193
Less than one year previous hospital care	0.192
Sexual or arson offences as against others	0.192
Subnormality(compared to other categories)	0.168 p < 0.05
Previous record of criminal offences	0.167
No previous hospital care	0.164
Length of stay of more than three years	0.158
Male as opposed to female	0.142 p < 0.10
Two previous tribunal hearings	0.138
Absence of violence in history	0.136
Arson offences as against others	0.123 p < 0.20
Length of stay of more than two years	0.116
No previous history of arson	0.115
Sexual offences as against others	0.114

Discussion

The following conclusions were drawn. Statistical analysis indicated that a number of the 'observable' facts were more closely associated with a judgement in favour of release from Rampton Hospital (Table 20). There was some indication that occasionally other factors (such as the sex of the patient and number of hearings) were associated with the decision or advice, but the association was not significant. Many of the significant 'facts' related to the nature of the detention of the patient and previous record of criminal offences or hospital care. In the case of some of these variables, the influence on the judgements of the tribunal was not so much in the 'facts of the case' as in the nature of their different roles and the options open to them in response to applications and references.

As discussed in previous chapters, the task of the tribunal was more flexible in response to references from the Home Secretary, in that they were not faced with the 'discharge-the-order-or-not' choice. Also, as they could only advise, they were not so directly concerned with the problem of ensuring the necessary resources were available to support their judgement. Therefore, they were able to come to a definite conclusion more easily without the need to adjourn or continue the detention simply because of the lack of any viable alternative. So it was inherent in their powers in response to references, that they were more likely to make a judgement in favour of release in comparison with applications (where 'transfer' was not available and the tribunal were more restricted by their choices and the practical implications).

It was necessary to take the above contrast between references and applications into account when considering the influence of the 'facts' on the judgement of the tribunal. The variables which were most affected by this contrast were 'restricted under Section 65', 'offender as opposed to non-offender', and 'previous record of criminal offences'. The restricted cases (references) included a much higher proportion of offenders both in terms of the reason for their current detention and their history. There was the tendency for many of the men and women to be admitted to Rampton Hospital through one of two distinct channels of a background of either 'criminal' or 'health' problems and official response. 'References' tended to have a criminal background with little if any previous hospital care; 'applications' were often non-offenders with extensive previous hospital care experience. Therefore, other variables such as 'less than one year previous hospital care' and 'no previous hospital care' were affected by the contrast between applications and references.

That the tendency toward 'criminals' and against non-offenders with previous hospital experience was not entirely a consequence of the different powers in response to applications and references was supported by other findings. There was a significant association between a judgement in favour of release and 'no previous record of hospital order'. As a hospital order was a court order in response to criminal offences, this factor was likely to favour non-offenders and applications. Therefore there appeared to be other influences toward the tribunal 'favouring' offenders without previous hospital experience. As a 'legal appeal' body, it was possible they were particularly influenced by considerations of 'justice' in response to applications and references about offender-patients (perhaps

seeking to equate the offences with appropriate sentences in terms of time). Also, they would have been less restricted by rehabilitative resources considerations with the more able 'offenders' with less experience of institutional care(hospital). In terms of the risk to the health and safety of the patient, it appeared that the tribunal were more likely to seek to force the issue with relatively more oscially adequate people.

Other influential variables were more directly associated with the patient and his situation: age, 'subnormality', length of stay of more than three years, and having progressed to 'secure villa' stage in the hospital. That 'subnormality' was not affected primarily by the contrast between applications and references was supported by the interview responses to the question about 'degree of danger to others'. The chairman considered there was 'no danger' or 'minimal danger' in respect of 22 patients classified 'subnormality' (64.7%) compared to a total of 51 for the other classifications(44.0%) ($X_2(1D.F)=4.61$ $p < 0.05$).

The general conclusion was that the findings in regard to socio-demographic facts gave some support to the traditional model of sentencing behaviour which assumed that the significant variables affecting sentencing were those externally visible 'facts' available to the decision-makers and observable by others. There was evidence that a number of 'observable' facts were associated with the judgement to release from Rampton Hospital(Table 20). At the same time the findings in respect of the other six aims of this research project(Chapters Ten to Fifteen) have supported the view that a straight-forward 'input-output' model was not adequate to explaining the decision-process of the mental health review tribunal in practice.

Before this process was reviewed in its entirety in the 'General Analysis', it was decided to consider the extent to which other variables, identified through the study of the perceptions of the tribunal and the difficulties they faced, were associated with judgements about release(Chapter Seventeen).

CHAPTER SEVENTEENWERE THE OBJECTIVE 'FACTS OF THE CASE' THE ONLY SIGNIFICANT VARIABLES?

In Chapter Sixteen on 'Influence of socio-demographic facts', a number of 'observable' facts were identified as significantly and positively associated with the decisions or advice in favour of release from Rampton Hospital. Chapter Nine on 'Sample group of patients' demonstrated that the 150 applications and references to which the tribunal were responding during this research study, were adequately representative of the men and women applying or being referred to the tribunal at Rampton Hospital. The extent to which the findings could be generalised to other groups of men and women considered mentally disordered and 'dangerous' and other decision-making situations was a matter for discussion and speculation.

The assumption was made for the 'General Analysis' of the decision-process of the mental health review tribunal (Part Four) that the analysis of findings could be generalised to the decision-processes in other mental health review tribunals and to a reasonable extent in other situations concerned with the mentally disordered. It was assumed that the findings and analysis of the decision process were applicable to the extent the decision-makers were responding to the same prescribed criteria and procedures, a similar presentation of facts, and the same restraints and difficulties in the situation. This assumption of relevance was made with a view to the knowledge and understanding gained from the study of the decision-process being applied to other situations and by other decision-makers.

Aspects of the research were the testing of the appropriateness of the formal-structural approach to explaining the decision-process and the assumptions of a more traditional input-output model of behaviour. The formally prescribed criteria in regard to the legal restraint of the mentally disordered were outlined in Chapter Two. The advantages of using the decision-process of the mental health review tribunal at Rampton Hospital as the focus of empirical research were discussed in Chapters Three and Six. One advantage was the requirement on the tribunal to reach early conclusions within prescribed time-limits as part of the formally-prescribed approach. This facilitated the study of the decision-process in its entirety and the extent to which the formal-structural and input-output approaches were sufficient and adequate to explain the decision-process in practice. The input-output or stimulus-response model did receive some support in the findings about the 'influence of socio-demographic facts'. This present chapter was concerned with the extent to which other variables than the objective 'facts of the case' might have been significantly associated with judgements in favour of release.

The findings in regard to the earlier aims of the research (Chapters Ten to Fifteen) were concerned with aspects of aspects of the decision-process of the tribunal in practice, largely regardless of the actual judgements which concluded the process. In order to assess the extent to which other than the 'facts of the case' were associated with judgements in favour of release, the approach adopted was to cross-tabulate the interview responses in regard to the different aspects of the decision-process in practice with the responses to the same interview question to which the

socio-demographic facts were related:

'Was your decision or advice in favour of release from Rampton Hospital?'

AIM I: To examine how the members of the tribunal perceive the nature of the 'dangerousness' or risk associated with the person before them.

The perception of 'dangerous' by the members of the tribunal did appear to be in terms of 'physical violence', with sexual assault being an important secondary consideration. The risk was seen primarily in terms of 'danger to others' rather than self-injury. It was concluded that, explicitly and by implication, 'danger' was largely being defined as 'fear of violence'. 'People generally' were perceived as the most likely potential victims as against any more specific victims(Chapter Ten).

Table 1: However you rated the danger, in your opinion, what is or was the one main risk or danger in regard to this particular patient?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Direct physical violence	17	36.2%	52	50.5%	69	46.0%
Endangering behaviour	5	10.6%	5	4.9%	10	6.7%
Sexual assault	11	23.4%	28	27.2%	39	26.0%
Damage to property	3	6.4%	5	4.9%	8	5.3%
Psychological harm	0	0.0%	0.	0.0%	0	0.0%
Property offence	4	8.5%	2	1.9%	6	4.0%
Other	2	4.3%	6	5.7%	8	5.3%
None	5	10.6%	5	4.9%	10	6.7%
	47	100.0%	103	100.0%	150	100.0%

Although there was a face-value tendency against 'direct physical violence'(Only 24.6% responses in favour of release) compared to the total of other categories(37.0%), the difference was not

statistically significant($X_2(1D.F)=2.66$ $p > 0.05$). Comparing the combination of direct physical violence and sexual assault (25.9% responses in favour of release) with the total of other categories(45.2%), the difference was significant($X_2(1D.F)=4.96$ $p < 0.05$). In other words, there did appear to be a significant relationship between the perception of the danger as other than violence or sexual assault and a judgement in favour of release from Rampton Hospital (contingency coefficient = 0.179).

When considering the perception of 'dangerous' by the mental health review tribunal(Chapter Ten), it was often found that apart from the main danger or risk the chairmen did not see 'any other danger associated with the person before you' (78 hearings, 52.0%). When comparing the responses in favour of release, there was found to be a significant difference between those where no further danger was perceived(31 hearings, 39.4%) and where there was a danger other than the main risk(16 hearings, 22.2%). ($X_2(1D.F)=5.34$ $p < 0.05$). There was a significant relationship between there being perceived to be no other danger than the main risk and a judgement in favour of release($C = 0.185$).

It was perhaps not surprising to find that there was a highly significant relationship between the judgement in favour of release and the judgement in regard to the degree of risk to others.

There was a very highly significant relationship between a judgement of 'no danger' or 'minimal danger' and a judgement in favour of release from Rampton Hospital($X_2(1D.F)=24.76$ $p < 0.001$) ($C = 0.376$). (Table 2)

Table 2: How would you rate the patient you have just seen as a danger to others?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
No danger at all	5	10.6%	5	4.9%	10	6.7%
Minimal danger	32	68.1%	31	30.1%	63	42.0%
Moderate danger	9	19.2%	37	35.9%	46	30.7%
Severe danger	1	2.1%	15	14.6%	16	10.7%
Very severe danger	0	0.0%	8	7.7%	8	5.3%
Could not answer	0	0.0%	7	5.8%	7	4.6%
	47	100.0%	103	100.0%	150	100.0%

In regard to the interview question about 'danger to self', there was a significant difference between a judgement of 'no danger' (33 hearings, 39.3% in favour of release) and any degree of danger against self (14 hearings, 21.2%) ($X^2_{(1D.F)} = 5.61$ $p < 0.02$). There was a significant relationship between a judgement of 'no danger to self' and a judgement in favour of release ($C = 0.190$).

Table 3: Who did you see as most likely to be at risk from the person before you?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
People generally	17	36.2%	56	54.3%	73	48.7%
Adults same sex	2	4.3%	1	1.0%	3	2.0%
Adults opposite sex	6	12.7%	10	9.7%	16	10.6%
Children	6	12.7%	22	21.4%	28	18.7%
Elderly	0	0.0%	0	0.0%	0	0.0%
Self	2	4.3%	4	3.9%	6	4.0%
Family	2	4.3%	2	1.9%	4	2.7%
Others	3	6.4%	0	0.0%	3	2.0%
No one	1	2.1%	0	0.0%	1	0.7%
Could not answer	8	17.0%	8	7.8%	16	10.6%
	47	100.0%	103	100.0%	150	100.0%

On face-value, there were two significant findings in the data presented in Table 3. There appeared to be a tendency against the release of men and women where the potential victims were

'people generally' as opposed to specific categories of people at risk. Also there appeared to be a tendency against release where children were considered to be at most risk. Comparing people generally at risk (23.3% responses in favour of release) and the total of more specific categories of response (40.0%), there was a significant difference ($X^2_{(1D.F)} = 4.28$ $p < 0.05$). Within the context of the total sample of 150, the tendency against the release of people where children were at risk was out-weighted by the tendency against the release where people generally were seen to be at risk. Yet, although direct comparison with other findings could not be made because of different number of cases in the sample, ($N = 61$), there was a significant difference between children at risk (21.4% responses in favour of release) and the total of other more specific categories of potential victim (48.5%) ($X^2_{(1D.F)} = 4.81$ $p < 0.05$).

There was a significant relationship between other than people generally being seen at risk and a judgement in favour of release from Rampton Hospital ($C = 0.167$). The 'other than people generally' included both more specific categories of potential victim and where the legal chairmen 'could not answer'.

AIM 2: To examine the nature and relative importance of the evidence upon which tribunal members base their judgement in response to the dangerousness or risk.

'Personality of the patient' and 'mental disorder' appeared to be the more influential factors of evidence in the decision-making of the tribunal. It was concluded that 'risk' factors such as 'mental disorder' and 'offences' were influential in determining the need or

otherwise for continued detention, with other factors such as the personality of the patient as perceived by the tribunal tending to influence toward release. 'Personality of the patient' appeared to be an 'over-riding factor', over-lapping both with more objective considerations such as mental disorder and behaviour and with the more subjective reactions of the tribunal members to the patient. In addition to the objective 'facts of the case', uncertainty and doubt about the right course of action and subjective feelings and intuition about the patient were clear and acknowledged influences on the decision-process. (Chapter Eleven)

Table 4: In deciding whether or not this particular patient should continue to be detained in Rampton, which factor appeared to you the most importance influence in that decision?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Mental disorder	1	2.1%	25	24.3%	26	17.4%
Immediate offence/behaviour	5	10.6%	15	14.6%	20	13.3%
Previous record	4	8.5%	8	7.7%	12	8.0%
Personality of patient	19	40.5%	26	25.2%	45	30.0%
Previous life-career	1	2.1%	5	4.9%	6	4.0%
Family circumstances	2	4.3%	0	0.0%	2	1.3%
Community support services	0	0.0%	3	2.9%	3	2.0%
Length of stay	4	8.5%	4	3.9%	8	5.3%
Present behaviour/attitude	8	17.0%	10	9.7%	18	12.0%
Other	2	4.3%	5	4.9%	7	4.7%
Could not answer	1	2.1%	2	1.9%	3	2.0%
	47	100.0%	103	100.0%	150	100.0%

There was a face-value tendency toward 'personality of the patient' which was not statistically significant ($X_2(1D.F)=3.54 p > 0.05$). One finding which was highly significant was in regard to 'mental disorder'. Comparing 'mental disorder' being seen as the most important influence (3.8% responses in favour of release) with the total of other responses (37.1%), it was evident that 'mental

disorder' was a highly influential factor against release
 $(\chi^2_{(1D.F)}=9.60 \text{ } p < 0.01, \text{ corrected for continuity})(C = 0.246)$.

In considering 'the evidence on which the tribunal based their judgements', the responses to the three interview questions in regard to 'the most important influence', 'second in importance' and 'further factor' were aggregated(Chapter Eleven, Table 6). Whilst confirming the importance of such factors as 'mental disorder', 'immediate offences' and 'previous record', the total summary further illustrated the increasing importance of other more rehabilitative considerations as release was more seriously considered. The same aggregated data was cross-tabulated with the interview response to 'decision or advice in favour of release' (Table 5 below).

Table 5: Total responses to interview questions on influential evidence.

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Mental disorder	8	5.7%	40	12.9%	48	10.7%
Immediate offence	13	9.2%	34	11.0%	47	10.4%
Previous record	11	7.8%	33	10.7%	44	9.8%
Personality of patient	29	20.6%	54	17.5%	83	18.5%
Previous life career	7	5.0%	13	4.2%	20	4.4%
Family circumstances	16	11.3%	18	5.8%	34	7.6%
Community services	7	5.0%	11	3.6%	18	4.0%
Length of stay	15	10.6%	17	5.5%	32	7.1%
Present behaviour/attitude	14	9.9%	35	11.3%	49	10.9%
Other	11	7.8%	31	10.0%	42	9.3%
None	8	5.7%	16	5.2%	24	5.3%
Could not answer	2	1.4%	7	2.3%	9	2.0%
	<u>141</u>	<u>100.0%</u>	<u>309</u>	<u>100.0%</u>	<u>450</u>	<u>100.0%</u>

Although care should be taken in making direct comparisons because of the different number of cases(normally contingency coefficient calculated on sample number of 150), the aggregated

data did tend to support the findings in regard to the relative importance and influence of 'risk' and rehabilitative considerations ('balanced justice' and 'parens patriae'). Comparing the 'risk' factors (mental disorder, immediate offence, and previous record) (23.0% responses in favour of release) and the total of other responses (35.0%), there was significant support for the interpretation that certain factors were primarily important in determining 'risk' with other considerations coming to the fore as release was a more serious possibility ($X_2(1D.F)=6.51$ $p < 0.02$).

In which direction, if any, were uncertainty and subjective feelings influences on decisions and advice?

Table 6: Were you at all influenced by your subjective feelings on intuition about the patient?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Definitely	12	25.5%	13	12.6%	25	16.7%
Only moderately	15	31.9%	35	34.0%	50	33.3%
Not at all	19	40.5%	54	52.4%	73	48.7%
Could not answer	1	2.1%	1	1.0%	2	1.3%
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	47	100.0%	103	100.0%	150	100.0%
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Table 7: Was there any serious doubt in your mind about whether or not the patient should be released from Rampton?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Yes	17	36.2%	26	25.2%	43	28.7%
No	30	63.8%	72	69.9%	102	68.0%
Could not answer	0	0.0%	5	4.9%	5	0.7%
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	47	100.0%	103	100.0%	150	100.0%
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On face-value, both 'serious doubt' and 'subjective feelings' were influences in support of release; but in neither case was the tendency statistically significant.

The occasions when subjective feelings were definitely or moderately influential (36.0% responses in favour of release) were compared with when subjective feelings were not acknowledged as an influence (26.7%) ($X_2(1D.F)=1.88$ $p > 0.05$). Further, the occasions when subjective feelings were acknowledged as definitely influential (48.0% responses in favour of release) were compared with when subjective feelings were only a moderate influence or not acknowledged at all (28.0%) ($X_2(1D.F)=3.07$ $p > 0.05$). Therefore, even though subjective feelings and intuition about the patient were clear and acknowledged influences on the decision-process of the tribunal, the influence in favour of release was not significant at 0.05 ($C = 0.142$; $N = 150$).

The occasions when 'serious doubt' was acknowledged (39.5% responses in favour of release) were compared with when doubt was not acknowledged (28.0%) ($X_2(1D.F)=1.89$ $p > 0.05$). Therefore, even though uncertainty and doubt about the right course of action were clear and acknowledged influences on the decision-process of the tribunal, the influence in favour of release was not significant at 0.05 ($C = 0.112$; $N = 150$). This was investigated further in the interview question in regard to the 'benefit of the doubt' (Table 8).

Table 8: Could you say whether you gave the 'benefit of the doubt' in favour or against leaving Rampton?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Favoured release	16	34.0%	13	12.6%	29	19.3%
Favoured detention	2	4.3%	8	7.8%	10	6.7%
Neither	0	0.0%	4	3.9%	4	2.7%
No 'serious doubt'	28	59.6%	74	71.8%	102	68.0%
Could not answer	1	2.1%	4	3.9%	5	3.3%
	47	100.0%	103	100.0%	150	100.0%

Although there was not a significant relationship between 'serious doubt' and a judgement in favour of release, the acknowledgement of 'benefit of the doubt' was significant'. The occasions when benefit of the doubt was acknowledged (41.9% responses in favour of release) were compared with when benefit of the doubt was not acknowledged (26.1%) ($X^2(1D.F) = 5.38$ $p < 0.05$). As would be expected, the significance was even greater in respect of 'benefit of the doubt in favour of release' ($X^2(1D.F) = 9.48$ $p < 0.01$).

There were significant relationships between a judgement in favour of release and 'benefit of the doubt' being acknowledged ($C = 0.186$) and even more where 'benefit of the doubt' was acknowledged in favour of release ($C = 0.244$).

AIM 3: To examine the nature of any restraints or difficulties experienced by the tribunal in obtaining the evidence considered necessary to reach decisions.

It was evident that the tribunal members did often experience serious difficulty in obtaining the evidence they considered necessary to reach their decisions. It appeared to be 'information' they were lacking and not necessarily 'people' as a source of information. The 'crises' arising in the decision-process from difficulties obtaining evidence related largely to the 'patient's health or safety' which could be dependent on facilities and support outside the hospital about which the tribunal had limited information (Chapter Twelve).

Table 9: Did you experience any difficulty in obtaining the evidence you required to reach your decision?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Serious difficulty	3	6.4%	9	8.8%	12	8.0%
Moderate difficulty	7	14.9%	19	18.4%	26	17.3%
Minimal difficulty	4	8.5%	7	6.8%	11	7.3%
None at all	33	70.2%	67	65.0%	100	66.7%
Could not answer	0	0.0%	1	1.0%	1	0.7%
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	47	100.0%	103	100.0%	150	100.0%
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On the basis of the data presented in Table 9, there was no relationship between the severity of difficulties obtaining information and the judgement about release from Rampton. The apparent percentage trend toward judgements in favour of release decreasing with increasing difficulty obtaining information was not statistically significant. At the same time, it was perhaps worthy of comment that, as difficulties obtaining evidence arose mainly in respect of rehabilitative considerations, it was likely that the occasions when there were serious or moderate difficulties and the judgement was not in favour of release would probably often relate to hearings which were adjourned for further information. This interpretation was confirmed by cross-tabulating the responses to the interview question 'How did you overcome the difficulty?' with those in regard to 'decisions or advice in favour of release' (Table 10).

Table 10: How did you overcome the difficulty?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Could not overcome	8	17.0%	10	9.7%	18	12.0%
Adjourned for enquiries ₁		2.1%	19	18.4%	20	13.3%
Other action	5	10.6%	6	5.8%	11	7.3%
Not applicable	22	70.2%	68	66.0%	101	67.3%
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	47	100.0%	103	100.0%	150	100.0%
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The apparent tendency to judge in favour of release where the difficulties about obtaining evidence could not be overcome could be related to the finding of 'benefit of the doubt' favouring release. Yet even when assessed within the group where difficulties were acknowledged (N = 49), the tendency toward release where difficulties could not be overcome was not significant ($X^2(1D.F) = 2.49$ $p > 0.05$). The negative association between judgements in favour of release and adjournments was inherent in the fact that adjournment was an alternative to reaching a decision or advice. The one instance where the chairman responded both that they had adjourned and judged in favour of release presumably related to an instance where adjournment was with a view to definite discharge.

Table 11: Did the difficulty relate to any particular category of evidence or information?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
No difficulties	33	70.2%	67	65.0%	100	66.7%
Mental disorder	1	2.1%	2	1.9%	3	2.0%
Immediate offence/ behaviour	2	4.3%	1	1.0%	3	2.0%
Previous life-career	1	2.1%	1	1.0%	2	1.3%
Family circumstances	0	0.0%	7	6.8%	7	4.7%
Community support services	5	10.6%	7	6.8%	12	8.0%
Present behaviour/ attitudes	1	2.1%	1	1.0%	2	1.3%
Hospital treatment/ planning	1	2.1%	3	2.9%	4	2.7%
Health service provision	1	2.1%	8	7.7%	9	6.0%
Other	1	2.1%	4	3.9%	5	3.3%
Could not say	0	0.0%	1	1.0%	3	2.0%
	47	100.0%	103	100.0%	150	100.0%

In view of the small numbers of cases in the response categories, the data in Table 11 was presented largely for interest. Although the face-value impression supported the findings about difficulties

obtaining evidence and the release decision itself largely concerning rehabilitative considerations, the samples were not large enough for significant comparison. Comparison between the responses about 'risk' factors (mental disorder, offences, life-career, and present behaviour) (50% responses in favour of release despite difficulties obtaining evidence) and the other considerations where difficulties had arisen (21.6%) suggested a difference which was not significant on the basis of this limited data ($X_2(1D.F)=2.31$ $p > 0.05$ corrected for continuity; $N = 49$). The relationship between judgements in favour of release and there being no difficulties obtaining information in regard to rehabilitative resources was not significant at 0.05 ($X_2(1D.F)=2.17$ $p < 0.20$; $N = 150$) ($C = 0.119$).

AIM 4: To examine the nature of any restraints or difficulties experienced by the tribunal arising from anomalies and dilemmas where prescribed procedures and rules are not adequate.

It was evident that the tribunal did often experience serious inadequacies in the prescribed rules and powers and serious dilemmas in regard to the practical choices available to them. The anomalies and dilemmas were primarily related to problems in regard to communicating directly with or obtaining information about health and community services; and the need for continued care and/or control outside the security hospital. The crises in the decision-process arising from anomalies and dilemmas were predominantly associated with the distinction and potential conflict between 'welfare and protection' and 'balanced justice' considerations (Chapter Thirteen).

Table 12: Did you experience difficulty which arose from the rules and procedures of the tribunal in relation to the collection of evidence?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Serious difficulty	1	2.1%	0	0.0%	1	0.7%
Moderate difficulty	2	4.3%	11	10.7%	13	8.7%
Minimal difficulty	3	6.4%	4	3.9%	7	4.7%
None at all	41	87.2%	86	83.5%	127	84.6%
Could not answer	0	0.0%	2	1.9%	2	1.3%
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	47	100.0%	103	100.0%	150	100.0%
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Table 13: Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the powers of the tribunal in this case?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Serious difficulty	2	4.3%	10	9.7%	12	8.0%
Moderate difficulty	7	14.9%	14	13.6%	21	14.0%
Minimal difficulty	2	4.3%	9	8.7%	11	7.3%
None at all	36	76.5%	69	70.0%	105	70.0%
Could not answer	0	0.0%	1	1.0%	1	0.7%
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	47	100.0%	103	100.0%	150	100.0%
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On the basis of the data presented in Tables 12 and 13, there was no relationship between difficulties in the rules and procedures and the judgement about release from Rampton. As with the difficulties obtaining evidence, there was the strong possibility that the occasions the tribunal faced difficulties from the rules and procedures and did not judge in favour of release included many of the adjournments.

Table 14: In reaching your conclusions, did you experience any difficulty which arose from the need to choose between unsatisfactory alternatives?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Serious difficulty	3	6.4%	15	14.6%	18	12.0%
Moderate difficulty	8	17.0%	19	18.4%	27	18.0%
Minimal difficulty	8	17.0%	17	16.5%	25	16.7%
None at all	28	59.6%	49	47.6%	77	51.3%
Could not answer	0	0.0%	3	2.9%	3	2.0%
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	47	100.0%	103	100.0%	150	100.0%
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There was a face-value tendency for judgements in favour of release to decrease with increasing difficulty arising from unsatisfactory alternatives: none at all(36.4% responses in favour of release), minimal difficulty(32.0%), moderate difficulty(29.6%), and serious difficulty(16.7%). Serious and moderate difficulties(24.4%) were compared with minimal and no difficulties(35.3%)($X_2(1D.F)=2.38$ $p > 0.05$, no significant difference).

Judgements in favour of release were cross-tabulated with the interview responses in regard to specific dilemmas. Where dilemmas were acknowledged in regard to the need for continued hospital care, the behaviour and attitude of the patient, the provision of community services, and the question of public attitudes, there was no significant relationship with the judgement in favour of release. The greatest significance was reflected in respect of the support and attitude of the family, the closest other category of dilemma being the provision of community services ($X_2(1D.F)=0.82$ $p < 0.50$).

Table 15: Did you face any dilemma which related in any way to the support or attitude of the family?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Yes	6	12.8%	27	26.2%	33	22.0%
No	41	87.2%	75	72.8%	116	77.3%
Could not say	0	0.0%	1	1.0%	1	0.7%
	47	100.0%	103	100.0%	150	100.0%

The occasions when dilemmas in regard to the family (18.2% responses in favour of release from Rampton) were compared with when such dilemmas were not acknowledged (35.3%) ($X_2(1D.F) = 3.82$ $p > 0.05$, difference not significant) ($C = 0.157$).

AIM 5: To examine the disagreements between the members of the tribunal and the process by which they are received.

There was limited disagreement or conflict among the tribunal members. Where it did show itself, it was in relation to the degree of risk and the question of release. Disagreements were mainly in terms of whether the person could be trusted to maintain good progress outside a situation of clinical supervision and social control. They were normally resolved through reaching a consensus through discussion (Chapter Fourteen).

As there was such limited disagreement between the tribunal members, the number of responses to many of the interview questions were too small for significant analysis. Where any reasonable degree of disagreement had been acknowledged, the responses were cross-tabulated with the interview responses about judgements in favour of release.

Table 16: Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the degree of risk?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
None at all	38	80.8%	89	86.4%	127	84.7%
Only moderate disagreement/	9	19.1%	8	7.8%	17	11.3%
ment	0	0.0%	3	2.9%	3	2.0%
Definite disagreement	0	0.0%	3	2.9%	3	2.0%
Not clear	0	0.0%	3	2.9%	3	2.0%
	<u>47</u>	<u>100.0%</u>	<u>103</u>	<u>100.0%</u>	<u>150</u>	<u>100.0%</u>

The occasions when disagreement was acknowledged (45.0% responses in favour of release) were compared to when disagreement was not recognised (29.2%) ($X_2(1D.F)=1.33$ $p > 0.05$, corrected for continuity). There was a stronger relationship between 'only moderate disagreement' and judgements in favour of release, although still not significant at 0.05 ($X_2(1D.F)=3.17$ $p < 0.10$, corrected for continuity) ($C = 0.144$).

Table 17: Was there at any point in the hearing what you would call a serious difference of opinion between the tribunal members in regard to whether or not the patient should leave Rampton?

	<u>Yes</u>		<u>No</u>		<u>Total</u>	
Yes	4	8.5%	8	7.7%	12	8.0%
No	43	91.5%	94	91.3%	137	91.3%
Could not say	0	0.0%	1	1.0%	1	0.7%
	<hr/>		<hr/>		<hr/>	
	47	100.0%	103	100.0%	150	100.0%
	<hr/>		<hr/>		<hr/>	

Whereas there was the suggestion that 'moderate disagreement' about the degree of risk was sometimes associated with a judgement in favour of release (perhaps giving the 'benefit of the doubt'), even on face-value there was no evidence of association between disagreement about the release itself and judgements in favour of release.

As the medical member was acknowledged to have a greater influence at 39 hearings (compared to only 3 hearings with the legal member and one hearing with the lay member), the interview responses in regard to the medical member were cross-tabulated with those concerned with decisions and advice in favour of release. The 39 hearings where

the medical member was acknowledged to have a greater influence (13 hearings, 33.3% responses in favour of release) were compared with the other 111 hearings (34 hearings, 30.6% responses in favour of release) ($\chi^2(1D.F)=0.10$ $p < 0.95$). There did not appear to be any relationship between the medical member having a greater influence and judgements in favour of release.

Summary

The relative magnitude of the association between the various perceptions and responses of the tribunal and a judgement in favour of release was presented in Table 18. The probability values were based on the X_2 values from which the contingency coefficients were adjusted. A 2 x 2 table was used for each of the variables to enable direct comparison. All the variables included in the table had been cross-tabulated with the interview question: 'Was your decision or advice in favour of release from Rampton?' These conditions were applied also to the contingency coefficients in respect of the socio-demographic facts (Chapter Sixteen, Table 20); thus allowing comparison between the influence of the perceptions and responses of the tribunal and the objective 'facts'.

Although children as potential victims had been shown to relate to significantly less responses in favour of release in comparison with other specific potential victims (as opposed to people generally), this influence was not included in the presentation in Table 18 because of the difference in the number of cases in the sample ($N = 61$). For similar reasons, the findings in respect of the relative influence of 'risk' and 'rehabilitative' factors identified through the aggregated data about influential factors were not included ($N = 450$).

The findings in regard to the length of time of the hearings were excluded from the presentation about the socio-demographic facts in Chapter Sixteen, as the length of time of the hearing

was judged to relate to the response of the tribunal rather than the 'facts' about the patient. It could be appropriate to compare with the data in Table 18 the association with decisions or advice in favour of release with the length of time of the hearing: over 45 minutes ($C = 0.169$), over 60 minutes ($C = 0.125$).

TABLE 18

ASSOCIATION OF PERCEPTIONS AND RESPONSES OF TRIBUNAL WITH DECISION
OR ADVICE IN FAVOUR OF RELEASE FROM RAMPTON HOSPITAL

Number of hearings: 150	Contingency coefficient
Rated as no danger or minimal danger to others	0.376 p < 0.001
Most influential evidence perceived as other than mental disorder.	0.246 p < 0.01
Acknowledged 'benefit of doubt' in favour of release	0.244
Rated as no danger to self.	0.190 p < 0.02
Acknowledged 'benefit of doubt' (for or against release)	0.186 p < 0.05
Apart from main risk, did not associate any other danger with person	0.185
Main danger perceived as other than violence or sexual assault	0.179
Potential victims 'at risk' considered to be other than 'people generally'	0.167
Did not face any dilemma about the attitude or support of the family	0.157 p < 0.10
Main influence seen as 'personality of patient'	0.152
Moderate disagreement on degree of risk	0.144
Subjective feelings acknowledged as definite influence	0.142
Main danger seen as other than violence	0.132 p < 0.20
Not faced with dilemmas (or of no more than minimal difficulty)	0.125
No difficulty obtaining information about rehabilitative resources.	0.119
Apart from main potential victim, none other considered 'at risk'	0.115
Serious doubt about release acknowledged	0.112
Admitted to being influenced by subjective feelings or intuition about the patient.	0.111

Discussion

The findings in regard to socio-demographic facts(Chapter Sixteen) gave some support to the traditional model of sentencing behaviour which assumed that significant variables affecting sentencing were those externally visible 'facts' available to the decision-makers and observable to others from the records. There was evidence from this research project that a number of 'objective' facts were associated with the judgement in favour of release from Rampton Hospital. To supplement the findings about the tribunal decision-process which demonstrated that a straight-forward 'input-output' approach did not provide an adequate total explanation of the decision-process in practice, it was decided to consider the extent to which other than the 'objective' facts were associated with the decisions and advice of the tribunal.

The following conclusions were drawn. Statistical analysis indicated that a number of other variables were closely associated with a judgement in favour of release from Rampton Hospital(Table 18). The magnitude of the association(contingency coefficient) of some of the variables was greater than that of the influential 'objective' facts identified in Chapter Sixteen. In addition to the significant variables identified through the study of the decision-process, there was some indication that occasionally other facts(such as moderate disagreement about the degree of risk and the acknowledged influence of subjective feelings and intuition) were associated with the decision or advice to release(although not

significant at 0.05). Many of the significant variables related to the perception of the danger by the tribunal. None of the significant variables appeared to be affected by the nature of the detention and the role of the tribunal (i.e. application or reference).

In the discussion of the association of the socio-demographic facts with judgements in favour of release(Chapter Sixteen), it was suggested that the magnitude of the association in respect of certain 'facts' was inflated because of the greater ease of making a judgement in favour of release with references in comparison with applications. This contrast most affected the variables, 'restricted under section 65' (C = 266), 'offender as opposed to non-offender' (C = 0.193), and 'previous record of criminal offences' (C = 0.167). Despite the 'inflation' of the importance of these factors by an influence which did not appear to affect greatly the perception and response of the tribunal' variables, three of these other variables were found to have as highly significant association with the judgement in favour of release($p < 0.01$)

These highly significant variables were:

Rated as no danger or minimal danger to others	C = 0.376
Most influential evidence perceived as other than mental disorder	C = 0.246
Acknowledged 'benefit of doubt' in favour of release.	C = 0.244

Apart from 'restricted under section 65(Home Secretary)', none of the objective facts were as significantly associated with the

decisions or advice as the above three variables.

One approach to discussing these more influential variables would be to consider the 'converse' as an influence on the judgements of the tribunal. For instance, the positive association of the degree of danger being perceived as none or minimal with a judgement in favour of release had a converse: 'moderate and severe danger' negatively associated with judgements in favour of release. To find that the tribunal were less likely to decide or advise the release of a man or woman they considered moderately or seriously dangerous was perhaps not surprising. This high negative correlation between 'danger' and 'release' was implied in the prescribed criteria. Also, within the context of this research project on the assessment of 'danger to self and others', there was an assumed close relationship between assessing the danger and reaching a conclusion about continued detention or release. In fact, the tribunal did decide or advise release from Rampton of a minority (10 hearings, 16.1%) of the patients rated as moderate or severe danger(although none of those rated 'very severe danger').

In response to the interview question about the most important influence on the decision whether or not to continue the detention, a very high proportion of the 'mental disorder' responses related to a judgement not to release from Rampton Hospital(25 hearings, 96.5%). This finding reinforced the view that evidence of continued mental disorder was used as a guide to assessing the degree of risk(quite separate from being one of the statutory criteria for detention). It was likely that the person would be perceived as more 'impulsive and unpredictable' and therefore more 'dangerous', if there was limited evidence of improved or more stabilised mental

state. This would militate against release, which would be decided on other factors and influences once the mental condition of the man or woman had been determined.

The converse of the association between acknowledging benefit of the doubt in favour of release and a decision or advice in favour of release was an association between 'no doubt' and 'no release'. This association was confirmed by other influential variables in Table 18. The acknowledgement of 'benefit of doubt' (regardless of the direction of its influence) was significantly associated with judgements in favour of release. Also there was a suggestion of a positive association between the acknowledgement of 'serious doubt' and judgements in favour of release ($C = 0.112$ $p < 0.20$). This finding tended to support the conclusions in regard to both the nature of 'dangerous' behaviour and the stages of decision-process of the tribunal (and others considering the release or otherwise of the mentally disordered). It was suggested previously that the need to exercise control and restraint on the individual arose from the 'impulsive and unpredictable' nature of the behaviour and the 'sense of threat and anxiety experienced by others' about the 'risk of physical harm from violence'. Once identified as 'dangerous', doubt was almost inherent in the attitude of others (particularly those with responsibility for his release or continued detention). The interpretation would be that where there was 'no doubt', it would be in regard to the need for continued detention because of clear evidence of continued 'danger' (such as mental disorder). Once it was determined that there was 'doubt' about the need for continued detention, the decision-makers would then begin to consider all the implications of possible release. It

was inherent in the nature of 'dangerous' behaviour and a consequence of the various difficulties arising in the decision-process, that there would be doubt about the right course of action. 'Benefit of the doubt' was often a necessary component of the situation and the process of reaching a conclusion about whether to release someone in regard to whom there was doubt about the need for continued detention.

Even though the patients in the sample group were rarely considered more than minimal danger to themselves (18 hearings, 12.0%), 'danger to self' as perceived by the tribunal was significantly associated with their decision and advice. Of the 47 responses in favour of release, only one concerned a response of more than minimal danger (2.1%). The 'no danger' and 'minimal danger to self' responses (46 hearings, 34.8% responses in favour of release) were compared with the other 'danger to self' responses (One hearing, 5.6%) ($X_2(1D.F)=5.03$ $p < 0.05$, corrected for continuity) ($C = 0.180$). As indicated above, the association was greater when comparing 'no danger at all' to self with the other 'danger to self' responses ($C = 0.190$). Therefore, despite 'danger to self' not appearing to be an important aspect of the perception of 'dangerous' by the tribunal with the decision-process, it was evident that the perception of any danger to the individual himself was a restraint or influence against actual decision or advice to release. It was one of the variables with the more significant relationship ($p < 0.02$). As the 'danger to others' and 'danger to self' questions were the first to be presented during the interview (and therefore also the furthest away in time from the interview question about 'decision or advice in favour of release'), it was unlikely that the actual

presentation of questions had influenced this significant association. An interpretation would be that the perception of the individual being more than minimally at risk from himself was a serious restraint against release (perhaps linked with the difficulties in regard to ensuring adequate care and support facilities), rather than a justification for detention. 'Danger to self' would therefore become important at the stage release was being considered (i.e. after the 'risk' to justify detention had been assessed).

Further evidence for the link between uncertainty and 'danger' was to be found in some of the other significant associations with judgements in favour of release. Both in regard to the perceived nature of the danger and the perceived potential victims, there appeared to be a greater tendency to release where the danger or victim were more certain rather than generalised. Potential victims being perceived as 'people generally' was negatively associated with judgements in favour of release. 'None other' danger and victims were positively associated with decisions or advice to release.

Therefore 'objective' facts available to the decision-makers and others through the records were not the only significant variables associated with the decision of the tribunal. This provided further evidence that the traditional 'input-output' model was not adequate for a full explanation of the decision-process of the mental health review tribunal and others concerned with the mentally disordered.

PART FOUR

GENERAL ANALYSIS

CHAPTER EIGHTEEN The decision-process of the mental health
review tribunal

1. Review of literature and research

CHAPTER NINETEEN The decision-process of the mental health
review tribunal

2. Analysis of research findings

CHAPTER TWENTY The influence of the concept of 'danger'
on the assessment of 'danger to self and
others'

CHAPTER TWENTY-ONE Towards a model of decision-making in
regard to mentally disordered men and
women considered a 'danger to self and
others'

APPENDIX

Framework for the assessment of the
'dangerous individual'

CHAPTER EIGHTEEN

THE DECISION-PROCESS OF THE MENTAL HEALTH REVIEW TRIBUNAL

1. REVIEW OF LITERATURE AND RESEARCH

Introduction

The aims and intentions of this analysis are:

a) To review the literature and previous research about the mental health review tribunals from the time they were established by the Mental Health Act 1959 and commenced operation in 1961, and

b) To consider the findings of this particular research project ⁽¹⁾ on the decision-process of the mental health review tribunal with reference to the previous literature and research.

The research by Cyril Greenland (1970) ⁽²⁾ will be taken as a 'half-way' or 'turning-point' for various reasons. Prior to 1970, very little was written about the mental health review tribunals. What was written was mainly by people directly involved in the operation of the tribunals, and such literature tended to give almost unquestioning support to the success of the tribunals in practice. Greenland published the first and for a long time only specialised piece of research into the mental health review tribunals. It was following his research and during the 1970s that questions were raised about the effectiveness of the tribunals in their duty to protect the liberty of the individual. It was only later in the 1970s that there was sufficient interest for other pieces of research to be initiated.

(1) Chapter nineteen

(2) Greenland C. 'Mental Illness and Civil Liberty' G Bell and Sons (London 1970)

Writings about the tribunals up to 1970

With only one or two exceptions, writings about the mental health review tribunals up to 1970 were by people involved in the operation of the tribunals. They tended to be uncritical or defensive to possible criticisms.

'It is heartening to know that at least one small section of the health service seems to be working satisfactorily'

(Hunter 1966) (3)

'All in all, it will be appreciated that the subject is very well protected and it is not easy to see what other possible rights of application there might be'

(Webb 1966) (4)

'The hundreds of appeals heard ... had passed off smoothly and almost without untoward incident'

(Freer 1966) (5)

Although there was such evidence of unquestioning support, difficulties were acknowledged but usually in the form of a defence of the operation of the tribunal in practice. This is illustrated by comments from writers who had acted as legal chairman (president) of the tribunal in what was then the Sheffield Health Region. Freer assured an audience of psychiatrists that a tribunal order to discharge should not be seen as 'telling the responsible authority that it had erred'. (5) Webb emphasised that it was 'no part of the tribunal's function to decide whether the patient was unlawfully detained'. (4) Webb also defended restrictions on

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- (3) Hunter A.H.D. 'Functioning of the Mental Health Review Tribunals' Brit Journal Psychiatry January 1966 p 7 - 12
- (4) Webb P.R.H. 'Review Tribunals in the Sheffield Regional Hospital Board' New Zealand Medical Journal Vol 65 p 602-607 (1966)
- (5) Freer C.E.J. 'Review Tribunals, with special reference to Rampton Hospital' Brit Journal Psychiatry Jan 1966 p 12 - 13

representatives at that time. 'This discretion to exclude is again sound, for it can well be imagined what might happen if a patient elected to be represented by some mentally disordered fellow patient whom the tribunal could not exclude'. On the same issue of representation, Wood (1970) adopted a defensive stance: 'It is arguable how far qualified assistance at a hearing is important. The nature of the hearing and of the decision to be made (i.e. to discharge or not) makes the patient's own attitude and performance of more than crucial importance. Assistance which masks this must do more harm than good since it must hinder the tribunal's ability to make the necessary judgement'. (6)

It would appear that none of the more serious criticisms received determined attention. Very early in the tribunal's operation, Fleming (1963) advocated the needs for an amendment to the criteria for discharge to include the requirement that the tribunal should only direct discharge after 'full consideration of the home circumstances of the patient and/or the facilities to be offered by the local authority in relation to accommodation and/or employment'. (7) This approach seemed to assume that the legal criteria and prescribed procedures were rigid restrictions on action rather than guidelines for operation and was rather contradicted by other writers. In contrast with the picture of restrictive criteria and procedures, another legal chairman Cooke (1969) (8) reported 'there is no settled procedures for tribunal hearings. As each tribunal is autonomous, different methods of conducting hearings have been adopted in various regions'. Speaking from his experience, Webb

(6) Wood J.C. 'Mental Health Review Tribunals' Medicine Science and the Law Vol 10, p 86 - 92 (1970)

(7) Fleming A.C. 'Appeals to Mental Health Review Tribunals' The Lancet No 7275, p 263 - 264 (1963)

(8) Cooke J.A. 'Mental Health Review Tribunals' Solicitors Law Journal 843 (7.11.1969)

described a consistently structured approach by the tribunals in the Sheffield region which included as 'most important ... an account of the facilities available for the care of the patient if he was discharged'. (9) From his later experience in the same region, Wood (1970) acknowledged 'the tribunal has wide discretion to put the interests of the patient first and structure the hearing accordingly'. (10)

Another concern raised by Wood was the subject of an earlier complaint acknowledged but not persevered with by the Council on Tribunals. 'Nothing destroys a tribunal so easily as a barely relevant wrangle about the accuracy of some remark about, for example, earlier irresponsible behaviour at another hospital or suspicion that he was concerned with crime'. (Wood 1970) (10)

The Annual Report of the Council on Tribunals 1963 expressed concern about the inclusion in reports of unsubstantiated statements prefixed by 'the charge nurse reports' or 'a member of staff alleges'. In one instance the prefix was 'he denies that ...'

The proposed solution was that the tribunals should be instructed to attach no weight to such statements. (11) The Council on Tribunals reported in their Annual Report 1965 that no action had been taken in response to their concern other than one specific hospital being advised. Despite this, 'we decided that it was unnecessary to press the matter further'. (12)

(9) Webb P.R.H. 'Review Tribunals' New Zealand Medical Journal Vol 65, p 602 - 607 (1966)

(10) Wood J.C. 'Mental Health Review Tribunals' Med Sc Law Vol 10, p 86 - 92 (1970)

(11) Annual Report of the Council on Tribunals (1963) para. 29(4)

(12) Annual Report of the Council on Tribunals (1965) para. 63-66

As already indicated, writings about the tribunal up to 1970, with only one or two exceptions were by people directly experienced as members of the tribunal. The exceptions, prior to Greenland, were Stephens (1968) ⁽¹³⁾ and Bell (1970). ⁽¹⁴⁾ Stephen's research was of a descriptive nature, concerned with the legal procedures. Bell was concerned with a limited description of the function of the tribunal as attempting to achieve a balance between social interest in the liberty of the individual and social interest in treatment of mental disorder and protection of society.

The issues raised by this balance are reflected in the writings during the 1960s, but it was not really until 1970 that it was acknowledged clearly as a problem. When Freer (1966) acknowledged 'there had never been in his recollection a clear and obvious case for discharge ... due to different degrees of importance attaching to the same set of facts', it was as a means of reassuring the psychiatrists that the tribunal reached their decisions after much hesitation and not as any criticism of the responsible authority. Yet in 1970, Wood concluded his first article on the tribunals by emphasising the extreme problems which 'spring from the need for balance between the legal, medical and social factors'.

The problem of achieving a balance was closely linked with the 'discharge-or-not' powers of the tribunal. Sometimes it was regretted simply as a fact of life for the tribunal inherent in their situation. 'There was considerable criticism of the 'all-or-none' principle of the tribunals. The patient either continues to be detained or is discharged forthwith, with possibly little preparation for his return to the community'. (Hunter 1966) ⁽¹⁵⁾ At other times,

(13) Stephens D.J. 'Mental Health Review Tribunal' LL M Thesis University of Wales (1968)

(14) Bell K. 'Mental Health Review Tribunal: a Question of Balance.' Case Conference Vol 16, p 385 - 391 (1970)

(15) Hunter A.H.D. 'Functioning of the Mental Health Review Tribunals Brit Journal Psychiatry January 1966 p 7 - 12

solutions were suggested. With his primary concern to avoid flooding the community with the mentally disordered when the community was unable to accept the responsibility, Fleming (1963)⁽¹⁶⁾ advocated that the tribunal should only be able to direct discharge after full consideration of the home circumstances and the facilities to support discharge. Wood (1970) raised the issue in relation to the need for hospital care other than in the security hospital. 'The limited powers of tribunals on an application so that they consider merely whether to discharge or not springs from the medical insistence upon transfer of patients being, wherever possible, voluntary. Obviously maximum security hospitals cannot choose their patients but less secure hospitals cling to this right ... A fresh look might perhaps be taken at the possibility of allowing tribunals to order transfer'.⁽¹⁷⁾

It was in the same comprehensive article that Wood acknowledged other problems, in regard to conflict between different professionals, the tribunal dependence on written reports, and the difficulties and tensions arising within the tribunal:

'Lawyers, doctors and social workers notoriously belong to professions which find it hard to communicate with each other successfully'

'It will be appreciated that the problem, as so often is one of communication. The point being made here is that this will be improved, both in relation to the hospital and the home circumstances report compilers, if thought is always given to why the tribunal wants the report'.

'These are largely matters for observation and judgement than for empirical study'

(16) Fleming A.C. 'Appeals to Mental Health Review Tribunals' The Lancet No 7275, p 263 - 264 (1963)

(17) Wood J.C. 'Mental Health Review Tribunals' Med Sc Law Vol 10, p 86 - 92 (1970)

'Mental Illness and Civil Liberty' (18)

Greenland's research, published in 1970 as 'Mental Illness and Civil Liberty', was significant as the first serious indication of the move from 'observation and judgement' by participants in the tribunal operation to empirical study of the decision-process.

Greenland aimed to outline the 'problem' of mental illness and civil liberty and answer the questions: 'How good are tribunals at predicting a satisfactory outcome following discharge?' and 'How can tribunals be improved to better protect the civil liberty of patients detained in mental hospitals?' He used the philosophy of J.S.Mill 'On Liberty' as the starting point for his analysis:

'The sole end for which mankind are warranted in interfering with the liberty of action of any of their number, is self-protection. His own good, either physical or moral, is not sufficient warrant'.

(Mill 1859) (19)

He acknowledged that Mill was referring to 'human beings in the maturity of their faculties', and discussed the problem of defining such terms as 'maturity of faculties' and 'dangerous'. He saw that there was an inherent conflict between the demands of mental illness and civil liberty, which exhibited itself in the 'complicated legal machinery to protect people from needless confinement' and the tensions and disputes which arose between the legal, medical and social viewpoints. People who were detained as mentally disordered did not have the same opportunity to defend themselves. Instead they had access to the semi-judicial mental health review tribunal 'charged with protecting the civil liberties of those detained'

(18) Greenland C. 'Mental Illness and Civil Liberty' G Bell and Sons (London 1970)

(19) Mill J.S. 'On Liberty' Dent and Sons (London 1910)
(First published 1859)

He made a statistical study of one complete year of tribunal applications from the whole of England and Wales. This amounted to 1250 valid applications during 1963. He collected data about the social, legal and clinical characteristics of applicants, and sought to identify differences between those discharged and not discharged as well as describing regional differences. 215 applications were withdrawn before the hearing took place, which Greenland saw as some indication of the unrecorded function of the tribunals influencing responsible medical officers to take action on their own authority. It appeared that some hospitals were more inclined to avoid confrontation with the tribunal than others.

In regard to the personal characteristics of the applicants, he found that, although there were more women than men in hospital, compulsory powers to detain were used more frequently with men. Three-quarters of the applicants were under 45 years of age, with the women being slightly older than the men. A high majority of applicants were unmarried. Over half the applicants were classified 'severe subnormality' or 'subnormality', about one third 'mental illness', with the remainder being classified as 'psychopathic disorder' and to be found mainly in the special hospitals. Almost half were detained under Schedule 6, indicating they had been detained before the implementation of the 1959 Act. About one third had been detained under section 26 (compulsory treatment), with the remainder under section 60 (court hospital order) and again mainly in the special security hospitals.

The tribunals came to definite conclusions in response to most applications, adjourning consideration of only 31 (3%). Patients

were reclassified on only eighteen occasions and this power was used in only five of the fifteen regions of England and Wales. More men than women were discharged by the tribunals but the difference was not statistically significant. The decisions to discharge or not did not appear to be related to age or marital status. Only 13% of the applications were by relatives but these appeared more likely to succeed. The long-stay mentally handicapped appeared to have the greater chance of discharge, with the opposite being true of people being detained under court orders. Only 38 of the applicants were represented and, although this appeared to increase the likelihood of success, the difference was not significant.

Greenland also made a study of the number of detained patients 'at risk' (eligible to apply) and the proportion who made valid applications. He found some variation between different detaining orders in respect of the proportion who had exercised their rights: section 60 (14%), section 26 (11%), Schedule 6 (8%). He found a regional variation, with the metropolitan regions having a low proportion of applications in comparison with Sheffield, Manchester, and Liverpool. This led him to study more closely the situation in the London regions. He found variations between hospitals of 5 to 50% exercising their right to apply to the tribunal. Some hospitals (particularly large hospitals for mentally handicapped) appeared proud of their patients' disinclination to leave. During the twelve month period ending May 1967, about one quarter of the applications submitted in the London regions did not lead to a hearing. Greenland found that this was primarily because the responsible medical officer had discharged the order or had promised to do so and the application was withdrawn by the applicant. Apparently one doctor viewed the application as a

breach of the doctor-patient relationship. Greenland concluded from this part of the study that there was a need to remind staff of a Ministry of Health injunction not to advise or in any way influence patients against applications to the tribunal.

The further stage of his research was to seek to observe all the hearings which did take place in the London regions during the year ending May 1967. The details of his research methodology and specific findings are to be found in 'Mental Illness and Civil Liberty'. He came to certain general conclusions which are illustrated in the following quotations:

'In a difficult case it was virtually impossible for an observer to describe the ineffable constellation of circumstances which influenced the tribunal to over-rule the detaining authority. Whatever their formal reasons, privately tribunal members admit to a 'hunch', shared by others, that this patient was ready for discharge'.

'Despite these efforts to limit the field of observation, unequivocal conclusions were still difficult to reach. This was particularly true when what might be termed the 'judicial' function of the tribunals was considered. The object here was to determine the extent to which tribunals succeeded in doing what they were intended by law to do. With experience, I found that five key questions, about the conduct of the hearings, got fairly close to the heart of the matter:

1. Was the applicant, patient or relative, given a full opportunity to present himself and his case in the best possible manner?
2. Did the tribunal establish that the statements, made by the detaining authority, were accurate?
3. Was the applicant given an opportunity to refute any allegations about him?
4. Was the conduct of the tribunal designed to protect, rather than undermine, the future relations between the doctor and the patient?
5. Were the proceedings conducted with dignity, impartiality and proper concern for the liberty of the individual?'

(Greenland 1970) (20)

On the basis of these criteria, Greenland concluded that with a few exceptions 'hearings were conducted with dignity and painstaking care to see that patients, relatives and hospital officials had an ample opportunity to present their differing points of view. The quality of the hearings depended, to a large extent, on the experience of the President and the initiative and competence of the medical member. The lay member's contribution was equally important when they represented a truly commonsense point of view. Considerable diligence and tact was needed by all concerned to avoid putting the patient and responsible medical officer into adversary positions'. (21)

Whilst generally concluding that 'with varying degrees of success, the mental health review tribunals are doing what Parliament intended them to do', Greenland made certain recommendations designed to improve their ability to protect the civil liberties of detained patients. These recommendations concerned improving the information to patients about their rights, not allowing applications to be withdrawn without some enquiry as to the reasons, ensuring reports of local authority facilities are available before hearings take place, and widening the brief of the medical member to interview the responsible doctor and other members of the clinical team in preparing his report to the tribunal. In respect of the hearings, he recommended improvement of the accommodation provided for the hearings, removing the distinction between 'formal' and 'informal' hearings, and improving the provision for representation. The powers of the tribunal should be extended to include recommending trial leave and the provision for reclassifying abandoned.

(21) Greenland C. 'Mental Illness and Civil Liberty' G Bell and Sons (London 1970) p 89

Reviews and enquiries during the 1970s

Much of the literature during the 1970s and the various government enquiries were in response to publicised 'scandals' about mentally abnormal offenders (Graham Young, Patrick Mackay). Prins (1975) ⁽²²⁾ developed the preventative importance of being alert to 'premonitory signs' of impending violence on the part of someone known to have been mentally ill. He emphasised the need to correct the balance from the current 'preoccupation with the rights of individuals and ... fear of invasion of privacy' with a greater willingness to enquire more directly into the lives and thoughts of individuals under supervision. Prins warned of the heightened risks when the professionals 'identify too closely with the patient and become too sympathetic with his problem' (quoting Johnson 1967) ⁽²³⁾ or 'over-elaborate proceedings weaken the sense of personal responsibility' (quoting Aarvold 1973). ⁽²⁴⁾ In their analysis of 'The case of Patrick Mackay', Clark and Penycate (1976) ⁽²⁵⁾ illustrated the difficulties associated with predicting the future 'danger to self and others' of someone presenting as responsible and 'normal' at the time of being examined. Patrick Mackay had been discharged following a successful application to the mental health review tribunal at Moss Side Hospital. Therefore it was evident from the considerations brought to the fore in the literature by these 'scandals' in the early 1970s that the almost unquestioning support to the effectiveness of the tribunals which had characterised the literature in the 1960s had come to an end.

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- (22) Prins H. 'A danger to themselves and others' British Journal Social Work 5(3) (1975) p 297 - 309
- (23) Johnson W. 'Releasing the dangerous offender' in 'Clinical Evaluation of Dangerousness of Mentally Ill' Rappoport J.R. (ed) Charles C. Thomas (Illinois 1967)
- (24) Aarvold 'Report on the Review of Procedures for the discharge of psychiatric patients subject to restrictions' Cmnd 5191 HMSO (1973)
- (25) Clark T. and Penycate J. 'The case of Patrick Mackay' Routledge and Kegan Paul (London 1976)

A number of reports published in the early 1970s were by committees set up by the government in response to concern about the management and discharge of mentally abnormal offenders, and had implications for the mental health review tribunals. The Aarvold Committee ⁽²⁶⁾ was specifically concerned with the procedure for the discharge of psychiatric patients subject to restrictions. The Butler Committee was given a wider brief in respect of the law concerning mentally abnormal offenders. They submitted an Interim Report ⁽²⁷⁾ in 1974 recommending the urgent provision of secure hospital units in each regional health authority area and presented their full report in 1975. ⁽²⁸⁾ The government accepted the primary recommendation of the Aarvold Committee that an Advisory Board should be established to advise the Home Secretary as an additional safeguard for the protection of the public. It was emphasised that this advisory board had a distinct and separate function to that of the mental health review tribunals who retained the primary responsibility in respect of safeguarding the patient from unjustified detention. The importance of this distinction was confirmed by the Butler Committee ⁽²⁸⁾ in response to complaints about delays in the Home Secretary and the Advisory Board dealing with recommendations from the mental health review tribunal. They suggested that such complaints were based on 'misapprehension that the function of the tribunals and the Home Secretary in this matter are the same'. 'The main responsibility is different and their roles are complimentary'. The main complaints about the tribunal received in evidence by the Butler Committee were to some extent contradictory. On one hand, one of the main criticisms

(26) Aarvold Committee Report Cmnd 5191 HMSO (1973)

(27) Interim Report of Butler Committee HMSO (1974) Cmnd 5698

(28) Butler Committee Report on 'Mentally Abnormal Offenders' Cmnd 6244 HMSO (1975)

concerned 'the failure, or at any rate the failure of some of them, to ensure that appropriate arrangements have been made before they order the discharge of a patient'. In contrast, in view of the tribunal's primary duty to be concerned for the justification for detention rather than rehabilitative considerations, other witnesses had expressed criticism of an over-protective approach working against the rights of the individual.

In response to these rather contrasting criticisms, the Butler Committee reported:

'We recommend that tribunals should not reach a formal decision that any mentally disordered offender-patient should be discharged until they have established that whatever needs to be done to return him to as satisfactory a situation as possible in the community has, so far as may be practicable, been done'

(29)

(Butler Committee, paragraph 7.10)

'Finally, we think it right to add that if the mental health review tribunals carry out in the spirit as well as the letter the primary function for which they were established, they will take every precaution to ensure that the patient's natural rights are safeguarded, and that he receives whatever help he needs in putting his case'

(29)

(Butler Committee, paragraph 7.29)

Although these reports contributed to a fairly radical change in government policy and practice in respect of mentally abnormal offenders generally, they did not result in any change in the legislation and procedures specifically concerning tribunals.

Other writings about the tribunals during the 1970s

In contrast with the 1960s, writings about the tribunal after 1970 tended to be more critical of the operation of the tribunals and involve writers less directly involved in that operation.

(29) Butler Committee Report Cmnd 6244 HMSO (1975)

In their thorough review of 'Crime and insanity in England', Walker and McCabe (1973)⁽³⁰⁾ displayed a primary concern for the protection of the public in their references to the tribunals. They supported the condemnation by the Court of Appeal of the committal to special hospital without an additional restriction order:

'There have also been cases in which a court has decided that the prisoner must be detained under conditions of special security in one of the special hospitals and yet no restriction order has been made. In the result he may well be able to secure his discharge on application to a mental health review tribunal on the ground he is not at the time suffering from mental disorder, even though relapses may be expected'

(Practice note in Gardiner's case 1967 Crim LR 231 quoted by Walker and McCabe)

In various other instances, Walker and McCabe reflected their concern about the greater risk to the public in respect of the mental health review tribunals. Life sentences were seen as preferable response to serious offences because of hospital orders allowing patients to claim the right to discharge if 'cured'. They questioned why the Percy Commission⁽³¹⁾ had used the tribunals to give offenders and non-offenders the 'same substitute for judicial protection' rather than distinguishing between them. They high-lighted a particular case where the tribunal had discharged a man 'despite the possible need to protect others' (previous indecent assaults on boys) as 'the applicant is not able to benefit from medical treatment'.

Walker and McCabe came to very firm conclusions about the position of the mental health review tribunal in respect of offenders considered dangerous enough to require special hospital detention.

(30) Walker N. and McCabe S. 'Crime and Insanity in England' Vol 2 Edinburgh University Press (1973)

(31) Royal Commission on the Law relating to Mental Illness and Mental Deficiency, Cmnd 159 HMSO (1957)

First, they recommended that such offenders 'should invariably be subject to restriction order, so that he cannot secure his discharge by persuading a mental health review tribunal'. (32) As the Parole Board carried more credibility with the Home Office, they recommended that the advisory function of the tribunals should be taken over by the Parole Board. They criticised the way psychiatric hospitals could 'get rid of untreatable offenders' through the tribunal, and suggested that the disordered offender 'deserved better treatment' or 'has enough of burden to bear without punishment'. These utilitarian conclusions were based on an assumption that on the whole a psychiatric hospital regime was less destructive to a human being than a prison.

Compared to the 1960s, there were fewer articles during the 1970s written from direct experience of the operation of tribunals. Hepworth (1975) (33) was concerned to address to social work colleagues in the community services the practical implications for them of the dilemmas faced by tribunals. 'They may have before them a man or woman in whom they can see no further justification for detention in a special hospital. The patient may have been approved and been waiting two or three years for a place in a local hospital. The home situation may be unsatisfactory or non-existent. If they believe that continued detention can no longer be justified on the grounds of protecting the individual or other people, their strict duty is to order discharge'. Too often, the tribunal had to choose between the risks of discharge into less satisfactory conditions and the injustice of prolonged stay in a special hospital, with the inevitable effects on the person's confidence and ability. Hepworth advocated a 'valuable legislative change' to empower the tribunal to authorise a patient to leave the hospital within a given period, rather than their order automatically having an

(32) Walker N. and McCabe S. 'Crime and Insanity in England' Vol 2 Edinburgh University Press (1973) p 239

(33) Hepworth D. 'Tribunal Discharge from Rampton' Social Work Today Vol 6 No 1 (31-75)

immediate effect. At the same time, he appealed for a greater sense of responsibility for their residents in special hospitals on the part of responsible local authorities.

There were further articles during the 1970s by Wood, writing from his experience as Chairman of the Tribunals in the Trent Regional Health Authority area. Addressing himself to the social work profession, ⁽³⁴⁾ he discussed the conflict of loyalties for social workers resulting from their greater integration into the hospital inter-disciplinary approach. There was the need for frank discussion of professional tensions and conflicts between the professionals involved. He also appealed for the understanding and assistance of the social work profession in respect of the conflicts and dilemmas faced by the tribunal. In the further article, Wood ⁽³⁵⁾ acknowledged the need for a 're-appraisal' after fifteen years of operation. He took exception to the Butler Committee statement that tribunals 'are not primarily concerned with public safety'. Tribunals worked within a narrow legalistic framework within which it could not operate effectively. Reform was necessary to make the exact functions of the tribunal more explicit and to widen the powers of the tribunal from the limited discharge-or-not to require changes in the type of care.

In special reports published by MIND (National Association for Mental Health), Gostin made detailed examinations of the civil law of mental illness (Volume One) and the criminal aspects of mental health legislation (Volume Two) with a view to promoting reform.

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- (34) Wood J.C. 'Mental Health Review Tribunals and Social Work' Social Work Today Vol 7 No 11 (19.8.76)
- (35) Wood J.C. 'Mental Health Review Tribunals - a reappraisal' Medicine Science and Law Vol 16 No 3 (1976)

The mental health review tribunal was one of the main focuses of Volume One of 'A Human Condition'.⁽³⁶⁾ The tribunals were seen as primary examples of 'little informed criticism of the Mental Health Act 1959.. and blithely assumed .. functioning smoothly primarily because they aroused little or no publicity'. Gostin criticised the law, procedures and practices of the tribunals in various respects. He questioned the 'efficacy and fairness' of the Rules of Procedures which allowed so much variation between tribunals and regions and excessive discretion to the decision-makers. In respect of the adequacy of the tribunals as a safeguard against unnecessary detention, he high-lighted the 'gaps' arising from lack of eligibility (i.e. observation orders) and lack of initiative on the part of less able and long-stay patients. He advocated extending the right of application to people detained on observation orders, introducing automatic referrals for long-stay patients, and shifting the burden of 'coming forward' from the patient to the state. In respect of the hearings, he proposed more formal procedures and open exchange of information: 'formal procedure is fundamental to fair adjudication. The atmosphere should be informal, but informality of procedure is inimical to the efficient gathering of facts and argument'. Decisions should be supported in writing by a reasoned statement, there should be right of appeal on questions of law and fact, and the publication of selected decisions would help to promote more consistency in decision-making.

Volume Two of 'A Human Condition' was concerned with the law relating to mentally abnormal offenders.⁽³⁷⁾ Gostin focused mainly on the patients in respect of whom the responsible medical officers and mental health review tribunals were restricted to an advisory function. In defining a 'tribunal' as a body 'empowered to inquire

(36) Gostin L. 'A Human Condition' Vol 1 Special MIND Report (1975)

(37) Gostin L. 'A Human Condition' Vol 2 Special MIND Report (1977)

into and decide on an issue', Gostin concluded that an advisory mental health review tribunal was not functioning as a tribunal. The decision did not have a 'conclusive effect'. Whilst the tribunals continued to exercise an advisory function, he proposed that the Rules of Procedure should be amended to ensure that they acted judicially and fairly in accord with natural justice. Yet he concluded that the advisory function was incompatible with their primary role, particularly in view of their limited credibility with the Home Office. He confirmed the greater credibility of the Parole Board, identified by Walker and McCabe, and found the same of the Advisory Board established as a result of the Aarvold Committee. Gostin suggested that the Aarvold Board was further evidence of the lack of confidence of the Home Office in the tribunals. Rather than continuing the mental health review tribunals and the advisory board, he proposed that the Advisory Board should take over the advisory function of the tribunals with a wider brief than acting 'exclusively as a safeguard to the public'.

Government reviews during the later 1970s

Although 'Better services for the mentally ill' (1975) did not refer specifically to the mental health review tribunals, it helped to consolidate a developing community-orientated philosophy which sought to 'provide local, integrated services rather than care based on large specialised institutions'.⁽³⁸⁾ Government recognition to this philosophy was bound to be an influence on decision-makers concerned with protecting individuals from unjustified detention. There are various reasons why this later White Paper could have been more influential in this respect than the earlier 'Better services for the mentally handicapped' (1971).⁽³⁹⁾

(38) 'Better services for the mentally ill' Cmd 6233 HMSO (1975)

(39) 'Better services for the mentally handicapped' Cmd 4683 HMSO (1971)

Timing could have been one factor. It was only during the 1970s that critical attention to issues relating to the detention and release of the mentally disordered built up. Another influence could have been the mental health legislation which was framed in a way more appropriate to the mentally ill than to the mentally handicapped. In response, such as the tribunals have tended to adopt a common approach to both the mentally ill and handicapped.

In the 'Review of the Mental Health Act 1959' (1978),⁽⁴⁰⁾ it was acknowledged that the existing mental health legislation and therefore the white paper concentrated on the compulsory powers of admission and detention in hospital. Statutory powers for the provision of services for the mentally ill and handicapped were contained in more general legislation.⁽⁴¹⁾ Whilst acknowledging that only a very small majority of the mentally disordered required compulsory admission, even in the consideration of resource implications the white paper gave no serious consideration to the inter-relationship between the operation of compulsory powers and the wider services for the mentally disordered. As a separate committee were considering the tribunal procedures, the white paper concentrated on the function, powers and constitution of the tribunals. It supported the halving of periods of detention and renewals and so increase the opportunities to apply to the tribunal. Automatic reviews were proposed rather than leaving the onus to apply completely with the patients. The powers of the tribunals in response to applications would be extended to empower delayed discharges and recommend trial leave, transfer or conditional discharge. The distinction between the tribunals and the Aarvold advisory board was emphasised, and the proposal for the board to take over the tribunal advisory function rejected.

(40) 'Review of the Mental Health Act 1959' Cmnd 7320 HMSO (1978)

(41) For example, Health Service and Public Health Act 1968, Chronic Sick and Disabled Act 1971, National Health Service

The Committee on Mental Health Review Tribunal Procedures was formed in 1977 to undertake the first thorough review of the procedures and produced a discussion paper in 1978. ⁽⁴²⁾ The discussion paper considered improvements in the procedures and recommended similar legislative changes to those proposed in the white paper. The main emphasis of the procedural recommendations concerned the need for a greater uniformity through a structured system of procedures to apply to all hearings in all regions. This was to ensure consistency and proper safeguards. The Committee proposed strengthening the safeguards for applicants and patients in respect of ease of application, access to the statement of the responsible authority prior to the hearing, speeding up Home Office procedures, greater recognition to the role of representative, disclosure of information to the patient, and detailed recording of reasons for decisions.

Recent research into mental health review tribunals

Fennell considered the decision-process of the mental health review tribunals as 'a means of resolving the tension between the conflicting demands of two distinct movements for reform of the law'. ⁽⁴³⁾ The first movement, represented by psychiatric professionals, saw the problem of mental health law as the problem of 'legalism', of unduly cumbersome procedures delaying treatment. A conflicting concern, which has grown in importance in recent years, viewed the problem of mental health law as that of 'medicalism', the wide discretion granted to professionals which could infringe individual liberty.

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- (42) 'The procedures of the mental health review tribunals' Discussion paper by Committee on MHRT Procedures DHSS (1978)
- (43) Fennell P. 'Mental Health Review Tribunals: a question of imbalance' Br J Law and Society Vol 2 (1977) p 186 - 219 (also unpublished research papers)

Fennell's analysis of the operation of the tribunal was based upon observation of eighteen tribunal hearings in 1974 - 1975, which mainly concerned references in respect of people detained under section 65. He related his findings to a review of the legislative emergence of the mental health review tribunal, the philosophy behind the legislation, and the procedures and practice of the tribunal as 'understood' by the tribunal members. He viewed the Mental Health Act 1959 as the culmination of 'the move away from procedural safeguards towards the safeguards of professional expertise and integrity' and sought to examine how 'the operational ascendancy of the ideology of medicalism' was manifested in practice.

Fennell's conclusions could be summarised in the following quotation:

'The discharge of compulsorily detained mental patients is viewed as a risk-taking operation by those whose duty it is to determine upon fitness for discharge, and that the lack of community care facilities means that the area of risk is increased, thus effectively restricting the options open to the discharging authorities. Given the operational ascendancy of the social defence function of psychiatry the safe decision is always to retain a patient under detention in hospital'

(Fennell 1977)⁽⁴⁴⁾

Fennell found 'a predominantly inquisitorial rather than adversarial procedure' in the hearings he observed. He observed a fact-finding process concerned mainly with justifying or otherwise the responsible authority's report supporting the need for further detention. He was concerned about the extent to which hearsay evidence was regarded as 'fact' and the influence of the concept of insight undermining the patient's credibility as an informant.

(44) Fennell P. 'Mental Health Review Tribunals: a question of imbalance' British Journal of Law and Society Vol 2 (1977) p 203

In respect fo the first question required to be answered by the tribunal, Fennell observed little difficulty in establishing whether or not mental disorder was present. He saw this occurring at an early stage of the hearing. 'Each patient is given an opportunity to address the tribunal and in the course of this the tribunal may discover fairly early on that the patient still manifests symptoms of mental disorder'. (45) In respect of the need to determine whether or not continued detention was necessary for the protection of the patient or others, the important information appeared to be the past behaviour of the person and an assessment of the prospects of the patient outside the hospital. (46) He found the tribunal to be largely powerless to organise a less restrictive alternative to hospital treatment and the patient was greatly dependent on the representative 'as a social worker and a fixer, than as an advocate'. (47) This led to his final conclusion that the tribunal was best understood as a 'patient's welfare assessment panel' rather than a system of procedural safeguards, with the patient being seen largely as a source of information by the tribunal, responsible medical officer, and even the representative. (48)

Peay focused on the interpretation and application of mental health legislation by individual tribunal members and the influence on the individual approaches of the group context. (49) After a preliminary pilot study involving the observation of eleven tribunal hearings, her main research was based on a self-report questionnaire administered to tribunal members, a retrospective statistical analysis of tribunal decisions, and an experimental study of the decision-process using a videotape

(45) Fennell P. Br J Law and Society Vol 2 (1977) p 213
 (46) Fennell P. Br J Law and Society Vol 2 (1977) p 214-215
 (47) Fennell P. Br J Law and Society Vol 2 (1977) p 218
 (48) Fennell P. Br J Law and Society Vol 2 (1977) p 219
 (49) Peay J 'Mental Health Review Tribunals: Just or Efficacious Safeguards' Law and Human Behaviour Vol 5, No 2/3 (1981)
 (also unpublished Ph.D. thesis Birmingham University 1980)

of a hypothetical application. Some of her main conclusions were reminiscent of those of Fennell.

'Members did not appear to conceptualize their role as that of a judicial body, but rather as an informal reviewing panel intended to assess the most appropriate course of action, taking into consideration their conception of the patient's "best interests". In order to achieve this the tribunal rules were apparently frequently disregarded or circumvented'.

(Peay 1981)⁽⁴⁹⁾

Peay also found the same preoccupation with the statement of the responsible authority and a tendency for tribunal members to focus on unfavourable facts from the patient's history.

Her research focused particularly on the attitudes of tribunal members which could predispose their decisions. She found significant group differences, with the medical members demonstrating attitudes relatively more disposed to discharge and enlightened in regard to mental disorder and treatment. Non-medical members were more likely to conceptualise mental disorder as dangerous and permanently disabling. Members were generally satisfied with the operation of the tribunal system and confident in their use of the term 'dangerous'. This finding contrasted with the great variation in the use of the term 'dangerous' and the apparent ignorance of many members of the legal criteria on which their decisions were to be based. The members were very much aware of the limitations of their powers but ill-informed about the outcome of tribunals generally and the success rate of discharges (in each case tending to underestimate discharge and success rates).

Her retrospective statistical analysis of 4218 hearings in thirteen regions demonstrated significant variations between regions and

(49) Peay 'Mental Health Review Tribunals: Just or Efficacious Safeguards' Law and Human Behaviour Vol 5, No 2/3 (1981)

individuals in respect of discharge rates, with most of the discharge decisions being taken by a small proportion of the members. ^{She}Should found that the tribunals generally were twice as likely to recommend discharge to the Home Office in response to references, than they were to order discharge in response to applications. This was probably linked with the high rate of rejection of tribunal recommendations by the Home Office.

Her experimental study found a considerable variation in response to identical facts presented to different individuals and groups. She found the rate of discharge by the tribunals groups (27%) was considerably lower than that of groups of non-tribunal members, some with experience in mental health (74%) and others with no special experience (67%). She found a tendency for tribunal members to focus only on the unsuccessful aspects of the patient's history and interpret facts in support of their cautious and pessimistic attitudes.

Peay made two strong recommendations from the findings of her research. There was the need for further training and preparation, particularly for the lay members of the tribunal. To counteract the undue influence of the responsible authority's statement and the tendency to focus on unfavourable facts, there was a need for a report in support of the patient to be prepared for the tribunal, perhaps by the representative.

THE DECISION-PROCESS OF THE MENTAL HEALTH REVIEW TRIBUNAL

2. ANALYSIS OF RESEARCH FINDINGS

Introduction

The general research aim was to examine the process by which the mental health review tribunal decided on the 'dangerousness' of the person before them as a basis for their judgement about release or continued detention. It was assumed that the formal-structural approach was insufficient to study and explain the decision-process in practice, because of the social nature of 'dangerous' and the anomalies and dilemmas with which the decision-makers were faced.

The research incorporated the study of the relationship between socio-demographic facts and the tribunal decisions, a study of the way the facts were perceived by the tribunal, and consideration of the dilemmas and conflicts experienced in practice and innovatory action arising from anomalies in their rules and powers. The methods of data-collection adopted in respect of 150 tribunal hearings held at Rampton Hospital commencing in September 1977 were the systematic observation of the hearings, the structured interviewing of the tribunal legal chairmen, and the structured examination of written records for details of the subjects.

The findings of the research will be summarised and discussed within the context of the specific research questions.

How did the tribunal members perceive the 'danger'?

The perception of 'dangerous' by the members of the mental health review tribunal did appear to be mainly in terms of 'direct physical violence', with 'sexual assault' being perceived as second in significance with the men. This was in accord with commonly accepted definitions of 'dangerous behaviour'.⁽¹⁾ The second aspect of the Butler Committee definition of dangerous as 'the propensity to cause lasting psychological harm'⁽²⁾ was not supported by the tribunal's perceptions, even though 'psychological harm' was given as one of the alternative responses from which to choose. The perception of 'danger' by the members of the tribunal did compare closely with the actual offences and previous behaviour which had led to the detention of the people before them.

The risk was seen primarily in terms of 'danger to others' rather than 'danger to self'. 'Danger to self' was not seen as significant with men, whereas it was perceived as present with most of the women. Despite this, even with women 'self' was not seen as the person most at risk. 'People generally' were perceived as the most likely potential victims as against any more specific victims. This was particularly apparent with the women, with a greater tendency towards specific victims (often adults of the opposite sex) considered at risk from men.

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- (1) For example, Scott P.D. 'Assessing dangerousness in criminals' British Journal of Psychiatry (1977) 131, p 129 ('Tendency to inflict or risk serious irreversible injury'); Butler Committee Report on 'Mentally Abnormal Offenders' Cmnd 6244, HMSO (London 1975) ('The propensity to cause serious physical injury or lasting psychological harm')
- (2) Butler Committee Report on 'Mentally Abnormal Offenders' Cmnd 6244 HMSO (London 1975)

'Danger' and the threat to society which warranted restraint was seen not simply in the violence itself but in its impulsive, inconsistent, or irrational nature. Writers on the subject of dangerous behaviour have spoken of 'impulsive violence' and 'uncontrolled' (Weinberg 1967)⁽³⁾ and the 'unpredictable' tendency to inflict injury (Scott 1977)⁽⁴⁾. This emphasis was reflected by the tribunal chairmen, through comments such as: 'out of character', 'danger is a question of supposition', and 'difficult to judge'.

There was limited support in the findings and interview comments for the view that the concept of 'danger' or 'violence' was affected by the cultural and social context and the attitudes of other people in the situation. Yet explicitly and by implication 'danger' was largely being defined by the tribunal members as 'fear of violence'. There was some evidence that the 'danger' was acknowledged as being to some extent related to the social situation when the tribunal were giving serious consideration to possible discharge. This was expressed and implied in comments such as: 'main danger when out of hospital', 'dependent upon adequate support', 'danger related to drink and consequences', and 'relapse if social responsibilities are too much pressure'. From his vast experience of mentally abnormal offenders in Denmark, Sturup saw the prognosis very much in terms of the social situation: 'The most important thing we can do for these people is to motivate them to avoid the dangerous situation rather than to look for it'.⁽⁵⁾

(3) Weinberg S.K. (1967) 'Sociology of Mental Disorders' Staples Press

(4) Scott P.D. 'Assessing dangerousness in criminals' British Journal of Psychiatry (1977) 131 p 127 - 142

(5) Sturup G.K. 'Will this man be dangerous?' in report of CIBA Symposium 'Mentally Abnormal Offender' Churchill and Co (1961)

To supplement the above findings from observation and the interviews, the interview responses from the tribunal chairmen were cross-tabulated with decisions in favour of release from Rampton Hospital. There was found to be significant relationships between judgement in favour of release and five aspects of their perception of the danger:

- 1) The perception of the danger as other than violence or sexual assault,
 - 2) There being perceived to be no danger other than the main risk,
 - 3) A lesser degree of risk to others,
 - 4) No danger at all to self,
- and 5) 'other than people generally' (i.e. specific people) considered to be at risk.

On what evidence did the tribunal base their judgements?

'Personality of the patient' and 'mental disorder' appeared to be the more influential factors of evidence in the decision-making of the tribunal. It was concluded that 'risk' factors such as mental disorder and offences were influential in determining the need or otherwise for continued detention, with other factors such as the personality of the patient as perceived by the tribunal tending to influence toward release. The 'personality' of the person appeared to be an over-riding factor, over-lapping both with more objective considerations such as mental disorder and behaviour and with the more subjective reactions of the tribunal members to the patient. In addition to the objective 'facts of the case', uncertainty and doubt about the right course of action and subjective feelings and

intuition about the patient were clear and acknowledged influences on the decision-process. There was the possibility that 'personality of the patient' (and the objective reactions and subjective responses associated with acknowledging that factor) was used to resolve the difficulties and dilemmas faced by the decision-makers.

This 'gut-reaction' to the person was again reminiscent of the experience and approach of G K Sturupp. He was greatly influenced by the consensus of intuitive feeling toward the patient. His own major criteria appeared to be the question of whether he had been able to establish reasonable communication and a constructive emotional relationship which could be used in the process of rehabilitation. He took the view that without satisfactory emotional contact he could not effectively evaluate a person nor be optimistic about treatment and rehabilitation. (5)

The cross-tabulation of the interview responses about the evidence they took into account with the decisions of the tribunal demonstrated that the recognition of continued mental disorder was a highly significant influence against release. The main significant relationship with decisions in favour of release was in respect of 'benefit of the doubt' being acknowledged by the tribunal chairmen. Even though uncertainty and doubt about the right course of action were clear and acknowledged influences on the decision-process of the tribunal, the acknowledgement of doubt in itself was not a significant influence in favour of release (as opposed to the further interview response acknowledging giving the benefit of the doubt for or against leaving Rampton Hospital).

(5) Sturupp G.K. 'Will this man be dangerous?' CIBA Symposium 'Mentally Abnormal Offender' CIBA Blueprint Churchill and Sons (1968)

Did the tribunal experience difficulty obtaining evidence?

It was evident that the tribunal members did often experience serious difficulty in obtaining the evidence they considered necessary to reach their decisions. Where difficulties were experienced, the primary causes of difficulty appeared to be the non-availability or inadequacy of reports rather than problems about the availability of witnesses. It appeared to be information they were lacking and not necessarily people as a source of that information.

There was a clear polarisation in respect of the categories of evidence affected by the restraints and difficulties. The categories of evidence most affected were those concerned with rehabilitative resources and the welfare of the patient, in contrast with those factors more directly concerned with assessing the risk. Mental disorder, offences, previous life-career, and present behaviour and attitudes were rarely identified as being affected by the difficulties obtaining evidence. The crises arising in the decision-process from difficulties obtaining evidence related largely to the 'interests of the patient's health or safety' which could be dependent on facilities and support outside the hospital about which the tribunal had limited information.

The tribunal appeared to experience little difficulty in determining whether or not mental disorder was present. This was not for the reason identified by Fennell,⁽⁶⁾ who suggested

(6) Fennell P. 'Mental Health Review Tribunals; a question of imbalance' Br J Law and Society Vol 2 (1977) p 186 - 219

that as the patient addressed the tribunal 'the tribunal may discover early on that the patient still manifests symptoms of mental disorder'. It was evident from the observations and interview responses of the research project, that the diagnosis, treatment and prognosis of the mental disorder was treated as a distinct decision-process which was the prime concern of the medical member. On the whole, decisions in regard to the criteria of 'suffering from mental disorder' was left to the medical member. There was only controversy or crisis, when the hospital psychiatrist and tribunal medical member were dramatically opposed in their view of the mental disorder and prognosis (as opposed to simply differing in emphasis) or when the medical condition was contested through a further independent psychiatric opinion (usually on the initiative of the legal representative).

Although the personality of the patient had been identified as the primary influence on the tribunal, the assessment of personality was not seriously affected by crises arising from difficulties obtaining evidence. This factor was mainly determined through the face-to-face contact with the individual which was an invariable aspect of any tribunal hearing.

The cross-tabulation of the interview response about difficulties obtaining evidence with the tribunal decisions did not demonstrate a significant relationship, although there was an apparent percentage trend towards judgements in favour of release to decrease with increasing difficulty obtaining information. As difficulties obtaining evidence arose mainly in respect of rehabilitative considerations, such difficulties could result in adjourning for further information rather than a decision.

Taking this into account, it is likely that the apparent tendency to judge in favour of release where the difficulties about obtaining evidence could not be overcome was related to the finding of 'benefit of the doubt' favouring release.

Did anomalies and dilemmas arise from their rules and powers?

It was evident that the tribunal did often experience serious inadequacies in their prescribed rules and powers and dilemmas in regard to the practical choices available to them. The anomalies and dilemmas were primarily related to problems in regard to communicating directly with or obtaining information about health and community services; and the need for continued care and/or control outside the security hospital.

Wood (1976)⁽⁷⁾ emphasised the 'unique difficulties' under which the tribunals were working and the impossibility of divorcing the prescribed 'narrow conceptual framework' from rehabilitative and wider social realities. The crises in the decision-process observed during the research project were predominantly associated with the distinction and potential conflict between considerations of 'welfare and protection' and 'justice and fairness'.

When the interview responses were cross-tabulated with judgements in favour of release, the greatest significance was reflected in respect of dilemmas about the support and attitude of the family. There was some tendency against release when faced with practical dilemmas about family support and to a lesser extent the provision of community services.

(7) Wood J.C. 'Mental Health Review Tribunals and Social Work' Social Work Today Vol 7 No 11 (19.8.76)

What was the nature of disagreements between tribunal members?

There was a difference of emphasis between the tribunal members in regard to the factors which were more influential, with this difference largely reflecting their professional interests and role within the situation. The medical members were predominantly concerned about the mental disorder; and the legal members more concerned about the offences and present behaviour and attitudes. Although the lay members were mainly influenced by the personality of the patient, they did not differ significantly from the legal members in any respect.

There was limited disagreement or conflict among the tribunal members. Where it did show itself, it was in relation to the degree of risk and the question of release. Disagreements were mainly in terms of whether the person could be trusted to maintain good progress outside a situation of clinical supervision and social control. Disagreements were normally resolved through reaching a consensus through discussion.

It was evident that the medical member accepted and was expected to accept a primary responsibility for determining the criteria of mental disorder, virtually as a separate decision-process from the main collective decision-process.

One possible interpretation was that, rather than uncertainty and doubt and the influence of subjective reactions to the patient and the procedural difficulties and practical dilemmas being a cause of and potential for disagreement and conflict, they did in practice provide the flexibility to enable moving together to a consensus and the pressures toward a mutually-supportive group approach to the task.

What were the decisions and innovatory actions of the tribunal?

The proportion of decisions and advice in favour of continued detention were similar with both applications and references (46.0% of 150 hearings). Whereas definite conclusions were reached in response to almost all the references, a definite decision was achieved in response to little over half the applications (58.3% of 72 applications). The purposes in adjourning consideration of so many of the applications reflected the inappropriateness of the straightforward discharge-or-not powers of the tribunal. Adjournment was used as a means, not only of supplementing information as sanctioned in the MHRT Rules, but also of seeking to influence the responsible authorities in the detaining hospital and in the home areas of the patients. Often the tribunals were not merely delaying in the hope facilities would be made available, but using the threat of discharge as an attempt to enforce action by the hospital or a response from the responsible health and community services.

Innovatory action by the tribunal appeared to be mainly in response to applications where, although they had the authority to discharge the order detaining the patient, they had no power over the actual movement of the patient nor the resources they might consider necessary for rehabilitation. Innovatory action was mainly related to attempts to extend the influence of the tribunal beyond the strictly legalistic 'duty to discharge' in respect of the detaining order.

What was the influence of socio-demographic facts?

The traditional legal view of the sentencing process assumed that the only significant variables which influenced judicial decisions were the observable and verifiable 'facts of the case'. Yet a formal-structural approach and input-output model of human decision-making did not seem adequate to explain the decision-process of the mental health review tribunal. Despite this, an assessment of the relationship of the 'facts of the case' to the decision of the tribunal was incorporated into the research project.

The information about the socio-demographic features of the patient were cross-tabulated with the judgements of the tribunal. Statistical analysis did indicate that a number of the 'facts' were more closely associated with a judgement in favour of release from Rampton Hospital. Many of the significant facts were related to the nature of the legal detention. It was evident that often the influence on the judgements of the tribunal was not so much from the facts about the person as from the differing nature of the tribunal role and options open to them in response to applications and references.

As also supported by other research (Peay 1981),⁽⁸⁾ mental health review tribunals are significantly more likely to advise release from detention where the authority of the Home Secretary is required (section 65) than they are to order discharge where they have the authority to do so. The highly significant association of restricted under section 65 with judgements in favour of release from Rampton Hospital ($p < 0.001$) did not mean

(8) Peay J. 'Mental Health Review Tribunals: Just or Efficacious Safeguards' Law and Human Behaviour Vol 5, No 2/3 (1981)

the tribunal were more likely to release more serious offenders. It was more a reflection of the restraints which the tribunals experienced in the decision-process in response to applications. This contrast between applications and references would have affected other variables which were found to be closely associated with judgements in favour of release: offender as opposed to non-offender, and previous record of criminal offences. The restricted cases (references) included a higher proportion of offenders both in terms of the reason for their current detention and their previous history. There was a tendency for many of the men and women to be admitted to Rampton Hospital through one of the two distinct 'criminal' and 'health' channels of social problems and official response. 'References' tended to have a criminal background with little if any previous hospital care; 'applications' were often non-offenders with extensive previous hospital care experience. Therefore, other variables closely associated with judgements in favour of release could have been affected by the contrast between applications and references: no previous hospital care or less than one year previous hospital care.

The tendency toward 'criminals' and against non-offenders with previous hospital experience was not entirely a consequence of the different tribunal powers in response to applications and references. There was a significant association between a judgement in favour of release and no previous record of court hospital orders. This factor was likely to favour non-offenders and applications. Therefore there appeared to be other influences favouring offenders without previous hospital experience. As a 'legal appeal' body, it was possible they were influenced by

considerations of justice in response to offender-patients (perhaps seeking to equate the offences with appropriate periods of detention). They could have been less restricted by rehabilitative resource considerations with the more able offenders with less experience of institutional care. In terms of the risk to the health and safety of the patient, it appeared the tribunal were more likely to force the issue with relatively more socially adequate people.

Other variables which appeared to favour release were clearly related more to the person than the legal situation: aged over forty years, achieved 'secure villa' stage of progress in the security hospital (as opposed to high-security wards or pre-discharge villas), classified 'subnormality' (as opposed to 'severe subnormality', 'mental illness', or 'psychopathic disorder'), and length of stay in the hospital of more than three years.

Were the 'facts of the case' the only significant variables?

In order to assess the extent to which other than the 'facts of the case' were associated with judgements in favour of release, the approach adopted was to cross-tabulate the interview responses about the different aspects of the decision-process with decisions or advice in favour of release. Statistical analysis did indicate that a number of other variables were significant influences on the tribunal decision. The magnitude of the association of some of the variables was greater than that of many of the influential 'facts of the case', despite the importance of these facts being inflated by the contrast between applications and references.

More significant than the objective facts (apart from restricted under section 65). were three other variables from the interviews:

- 1) Rated as no danger or minimal danger to others,
- 2) Most influential evidence perceived as other than mental disorder,
- and 3) Acknowledged benefit of the doubt in favour of release.

One approach to discussing these more influential variables was to consider the 'converse' as an influence on the judgements of the tribunal. The converse of the positive associations would be that 'moderate or severe danger', concern about continued mental disorder, and acknowledging no doubt about the right course of action were each negatively associated with judgements in favour of release. The correlation between 'danger' and 'no release' was perhaps to be expected as it was clearly implied to the prescribed criteria for the tribunal. The correlation between 'mental disorder' and 'no release' reinforced the view that evidence of continued mental disorder was used as a guide to assessing the degree of risk (quite separate from being one of the prescribed criteria for detention). It was likely that the person would be perceived as more 'impulsive and unpredictable' and therefore more 'dangerous', if there was limited evidence of improved or more stabilised mental state.

The association between 'no doubt' and 'no release' was confirmed by other variables which were found to be influential. The acknowledgement of benefit of the doubt was significantly associated with judgements in favour of release. Also there was a suggestion of a positive association between the acknowledgement

of serious doubt about release and judgements in favour of release. These findings could support certain conclusions about the nature of dangerous behaviour and the stages of the decision-process of the tribunal.

The need to exercise control and restraint on the individual arose from the impulsive and unpredictable nature of the behaviour and the sense of threat and anxiety experienced by others about the risk of physical harm from violence. Once identified as dangerous, doubt was almost inherent in the attitude of others (particularly those with responsibility for his release or continued detention). The interpretation would be that where there was 'no doubt', it would be in regard to the need for continued detention because of clear evidence of continued 'danger' (such as mental disorder). Once it was determined that there was doubt about the need for continued detention, the decision-makers would then begin to consider all the implications of possible release. It was inherent in the nature of dangerous behaviour and a consequence of the various difficulties arising in the decision-process, that there would be doubt about the right course of action. 'Benefit of the doubt' was often a necessary component of the situation and the process of reaching a conclusion about whether to release someone in regard to whom there was doubt about the need for continued detention.

Further evidence for the link between uncertainty and 'danger' was to be found in some of the other significant associations with judgements in favour of release. Both in regard to the perceived danger and potential victims, there appeared to be a greater tendency to release where the danger or victim were more certain

rather than generalised. Potential victims being perceived as 'people generally' was negatively associated with judgements in favour of release. Where the interview responses acknowledged none other than the main danger or victim, there was a positive association with decisions or advice to release.

Therefore 'objective' facts were not the only significant variables associated with the decisions of the tribunal. This provided further evidence that the traditional model was not adequate for a full explanation of the decision-process of the mental health review tribunal.

Discussion.

Lemert (1970)⁽⁹⁾ questioned the traditional assumption that legal development was primarily evolutionary, in the sense of being 'a gradual, cumulative growth of rules, one building on another'. He proposed his 'socio-legal theory' that legal revolution resulted from 'crises in law' arising from an accumulation of 'legal issues' based on sufficient 'anomalies' where interests were unsatisfied or frustrated. An essential aspect of his concept of anomalies were the discrepancies between the legally prescribed rules and powers and the actual practice of the parties to the judicial decision-process. In his study of the reform of procedures in the juvenile courts in California, Lemert associated many of the anomalies and crises with the distinction between 'parens patriae' and 'balanced justice'. There were fundamental distinctions between 'welfare and protection' and 'justice and fairness' considerations, and therefore a source of conflict of interests and values.

(9) Lemert E. 'Social Action and Legal Change'
Aldine, (Chicago 1970)

The findings about the anomalies and dilemmas experienced by the mental health review tribunal did appear to support the application of Lemert's 'socio-legal theory' of legal change to the more specific situation of the decision-process in regard to the continued restraint or release of the mentally disordered. The prescribed framework for the mental health review tribunal appeared to assume a smooth input-output decision-process, when in fact the tribunal experienced anomalies and dilemmas in the process of reaching decisions on the basis of the evidence and actual alternatives available to them.

Lemert was concerned with anomalies where the prescribed rules and procedures were inadequate to protect the interests of the parties involved. This was an appropriate description of the situations often faced by the members of the tribunal. Their formal structure was established to ensure that an individual was not unfairly deprived of his liberty, and they had a duty to discharge the order of anyone where the clear criteria were not satisfied. Whilst the formal structural framework demonstrated a dominant concern for 'balanced justice', the anomalies and dilemmas faced by the tribunal in practice related mainly to 'parens patriae' considerations. Whereas the prescribed rules, criteria, procedures and powers were explicitly defined and limited to ensure justice and fairness, often the tribunal members found that their task was impossible without reference to rehabilitative and preventative considerations concerned to promote the welfare and protection of the individual and others.

Megaree's implied criticism of those who 'simply refuse to make such predictions' about dangerous behaviour was salutary, as such refusal could result in someone continuing to be detained for doubtful reasons (Megaree 1976).⁽¹⁰⁾ Megaree suggested that responsibility was refused on the grounds that predictions about dangerous behaviour involved problems which made errors inevitable. These refusals could take different forms. Within an establishment detaining mentally disordered people, the refusal could take the form of an inertia arising from excessive caution and uncertainty. The government authority required to sanction release may demonstrate the refusal in terms of demanding unrealistic assurances about the risk. The refusal of more open residential or hospital situations and community services could be shown in the unwillingness to accept responsibility because of potential problems. The general public and their representatives may resist because of their fear of the unpredictable.

Each and all these 'refusals' have contributed to the great difficulty mentally abnormal offenders and others have found in obtaining the opportunity to gain their freedom and prove themselves. Yet, as Megaree emphasised, 'someone has to make these predictions'. The mental health review tribunal was chosen for this research project as representative of those who were expected to accept the responsibility for making predictions about the future behaviour of people who have been considered dangerous. It was evident from the research that the mental health review tribunal at Rampton Hospital did exercise their responsibility conscientiously and thoroughly. The occasions when the tribunal delayed the exercise of their duty to decide could not reasonably be called 'refusals' not attempts to avoid

(10) Megaree E.I. 'The prediction of dangerous behaviour' Criminal Justice and Behaviour Vol 3 No 1 (March 1976)

responsibility. The delays were related to difficulties affecting their decision-process and their attempts to overcome the difficulties.

If the decision-makers had not been concerned to overcome the difficulties and exercise their duty despite the restraints and anomalies and dilemmas, the crises in the decision-process would have been of a rather passive nature. As Lemert emphasised in his analysis of revolutionary changes in law, for the anomalies arising in the normal course of legal evolution to have a more dynamic influence toward more drastic change the anomalies should show themselves actively in discrepancies between legal precept and practice. Some of the actions considered by the tribunal chairmen to 'go beyond the given rules and procedures' appeared to be changes in their customary approach as opposed to developments beyond the prescribed procedures and powers. Yet many of their actions in response to difficulties could validly be seen as 'practices' going beyond and therefore bringing into question the limitations and appropriateness of their rules and powers.

The innovatory actions related primarily to the response of the tribunal to applications and normally involved the use of their right to adjourn consideration of the application 'to obtain further information'⁽¹¹⁾. These innovatory developments could be grouped together in the following way:

1) The tribunal exercised their right to adjourn as a means of exercising a 'watching brief'. This was normally where the hospital was actively engaged in planning the

(11) MHRT Rules 1960 S.I.No 1139 HMSO, Rule 26(1)

rehabilitation or movement of the patient out of the hospital. The implications of these innovations were that the prescribed rules and powers assumed a separation of the needs for compulsion and treatment and also a separation between the hospital authority and the independent review tribunal which in practice was not realistic (particularly in respect of special hospitals where only compulsory treatment was available).

2) Sometimes the tribunal attempted to influence the hospital into a course of action not available to the tribunal, yet which the hospital had not yet initiated themselves. The tribunal would make a written recommendation to the hospital authorities or government department and then adjourn as a means of maintaining some continued influence on their recommendation. These instances mainly concerned patients who the tribunal judged to no longer require compulsory treatment but did require care in a national health service hospital which they were unable to achieve.

3) Innovations in regard to extending direct contact with agencies outside the hospital related almost entirely to the need for continued hospital care, and very rarely the community services. Sometimes it took the form of writing directly to the Department of Health recommending transfer. On other occasions they made direct contact with the health care authority as an informal attempt to negotiate hospital care. The innovation in these cases was not necessarily in the direct approaches (which were not prevented by the rules) but in the attempts to directly negotiate facilities not within their prescribed powers to influence.

4) On occasions the tribunal sought to influence through direct contact with the hospital team or Department of Health further clinical assessment or treatment whilst still in hospital. This was clearly beyond their role in regard to applications and questionable in regard to references where their advice was being sought about 'restricting the discharge' for the 'protection of the public'. Clearly they could not always divorce in practice their role in respect of discharge from the needs of the patient in hospital.

5) Distinct from the above groupings of innovations, it was not uncommon (at least ten out of 34 adjournments) for the tribunal to 'force the issue' through a delayed discharge. These instances even included patients who they judged to require sheltered or intensive social care. Although the legislation and tribunal procedures do not provide for 'delayed discharge', in practice the tribunal used their right to adjourn for further information as a means of a delayed discharge on more occasions than they actually discharged the order with immediate effect (9 out of 72 applications).

The need for legislative change

Their use of adjournment as a means of delayed discharge is perhaps the clearest illustration of the application of Lemert's 'socio-legal theory' of legal change to the mental health review tribunals. Faced with crises in their decision-process arising from an accumulation of anomalies where the prescribed rules and procedures were inadequate to protect the interests of the parties involved, they found their task to be impossible without

actively creating discrepancies between their practice and the prescribed legal framework.

The need for legislative change in respect of the powers of tribunals in response to applications was acknowledged in the white paper 'Reform of Mental Health Legislation'.⁽¹²⁾ The associated Mental Health Bill⁽¹³⁾ provides tribunals with the power to order delayed discharge by a given date.

The Bill also gives patients more opportunities to apply to a mental health review tribunal and introduces automatic tribunal hearings for patients who have not been reviewed by a tribunal for three years. Particularly as the right of application is being extended to people admitted under section 25 (twenty eight days for observation), this improved access to the tribunal could be some protection to safeguard some patients in the future from the dilemmas which result from unnecessarily prolonged periods of hospital care. Yet the proposed legislation will not provide a solution to the dilemmas when they do arise.

The dilemmas experienced by the tribunal were mainly associated with their inability to ensure that the necessary health, residential or other rehabilitative resources were made available in the event of the person being allowed to leave the security hospital. Their inability to enforce informal hospital care, community residential provision, or even after-care supervision is related to wider considerations than simply the tribunal rules and powers. The deficiencies can be traced back to more general legislation and government policy.

(12) 'Reform of Mental Health Legislation' White Paper Cmnd 8405 HMSO (1981)

(13) Mental Health (Amendment) Bill, HMSO (1981)

Although legislation does place general responsibilities on health authorities to provide health care in hospital where it is required, it does not appear that legislation can be used to require a particular health authority to provide further treatment and care in a psychiatric hospital or hospital for the mentally handicapped to enable a particular resident from their area who is judged to require that continued care to leave a national security hospital. This is so even when the security hospital authorities and the government departments involved have approved the release from the security hospital. The responsible government departments, the Department of Health and Social Security and the Home Office, have shown themselves unable or unwilling to require the responsible area health authority to make provision for their resident to return to hospital care in his home area. Therefore to suggest that the tribunal should have the authority to order transfer to national health service care brings into question the inability of the responsible government authorities to do so. Legislation and/or government policy should be changed to require responsible health authorities to accept their responsibilities.

Similarly, although legislation does place on local authority housing and social services departments a general responsibility to provide residential care to the mentally ill and handicapped and accommodation for the homeless, it does not appear that the local authority can be forced to exercise their responsibilities in respect of particular residents from their area awaiting the opportunity to leave the security hospital or NHS psychiatric hospital. The legislation which defines local government responsibilities should be strengthened and the necessary resources made available to fulfil the responsibilities without jeopardising the needs of their other residents requiring such help.

Although local authorities are required to provide after-care support and supervision to the mentally disordered under the National Health Service Act 1977, the responsibility is non-obligatory in respect of any particular individual. Even when statutory after-care supervision is a condition of discharge, patients restricted under section 65 (Mental Health Act 1959) can be delayed in hospital for some time by the unwillingness of the responsible local authority to accept responsibility for their supervision. Therefore, this is a greater problem in respect of unrestricted patients, whether discharged by the responsible medical officer or as a result of a tribunal application. Two distinct but related legislative changes would assist in ensuring that men and women leaving psychiatric hospitals after periods of involuntary care and treatment receive the support and supervision which can be essential to their social adjustment. The trend against statutory supervision in the community of the mentally ill and handicapped should now be reversed in respect of men and women whose behaviour has caused sufficient concern to warrant detention in hospital. Just as the 'open door' emphasis in psychiatric hospitals has been harmful to some people who required social control at times, so the emphasis in mental health legislation on voluntary care in the community has been detrimental to the needs of some people who required a degree of social control to support their resettlement into the community. A period of statutory after-care (even if only for six months in line with present leave provision for unrestricted patients) should be a condition of the discharge of anyone still subject to section 26 or 60. In addition, there should be a statutory requirement for the responsible local authority to provide such supervision.

The above legislative changes in respect of hospital care, community residential care, and after-care supervision would benefit men and women discharged from detention in hospital on the authority of the responsible medical officer. Such changes are a pre-requisite of any improvement in the powers of the mental health review tribunal. Given the above legislative and policy changes, the extension of tribunal powers to include recommendations for transfer or conditional discharge, or orders to discharge by a given date would be more likely to have the required practical effect of enabling people to leave hospital with an improved rehabilitative prognosis.

Both Fennell ⁽¹⁴⁾ who observed eighteen hearings and Peay ⁽¹⁵⁾ through observation of eleven hearings (and a questionnaire and experimental study) concluded that the tribunals were excessively cautious about discharge and pessimistic about prognosis. A different impression was gained from the observation of 150 hearings of the mental health review tribunal at Rampton Hospital. On the whole, the tribunals appeared to be very conscious of their primary duty to defend people from unnecessary detention and actively seeking means of over-coming the procedural and practical restraints. Fennell and Peay found a preoccupation with the statement of the responsible authority and with unfavourable facts which was not so apparent during this study. The tribunal could be very questioning and critical of the hospital reports justifying detention and pleased to facilitate any means of obtaining more favourable information from any other source. It was perhaps surprising that they did not use their authority to require the presence of witnesses (such as local authority

(14) Fennell P. 'Mental Health Review Tribunals: a question of imbalance' Br J Law and Society Vol 2 (1977) p 186 - 219
(15) Peay J. 'Mental Health Review Tribunals: Just or Efficacious Safeguards' Law and Human Behaviour Vol 5, No 2/3 (1981)

or health service staff) at the hearings. Yet they did sometimes seek to make use of more available indirect sources of information about health and community services (such as the representatives or hospital social workers). This contrasted with the marked scepticism about representatives displayed by tribunal members during the 1960s (Webb 1966,⁽¹⁶⁾ Wood 1970.⁽¹⁷⁾) The position of the patient's representative as essential to both the civil rights of the individual and the effective operation of the mental health review tribunal should be acknowledged and strengthened.

It has been suggested that it can be very difficult to clarify the reasoning behind tribunal decisions which at times appear to be based on a 'hunch' (Greenland 1970).⁽¹⁸⁾ The impression gained during this research was that the tribunal was usually reasonably clear in its thinking but perhaps hesitant to admitting to the valid influence of subjective inter-personal reactions to the patient. There would be various benefits if the tribunals were required to record the reasons for their decisions rather than simply giving their conclusions in terms of the prescribed criteria. It was evident that their advice to the Home Secretary was normally in the form of a reasoned statement, so it would be feasible in response to applications. The benefits would be related to justice being seen to be done, consistency in and between tribunals, the monitoring and sharing of information about tribunal decisions, an informed understanding by the patient and his family, and the opportunity for decisions to be questioned. Also, for the hospital and other authorities to be informed of the reasons behind tribunal judgements would be more helpful and influential than simply being informed of the judgement.

(16) Webb P.R.H. 'Review Tribunals in the Sheffield Regional Hospital Board' New Zealand Medical Journal Vol 65 (1966)p602/607

(17) Wood J.C. 'Mental Health Review Tribunals' Medicine Science and the Law Vol 10, p 86 - 92 (1970)

(18) Greenland C. 'Mental Illness and Civil Liberty' G Bell and

Walker and McCabe ⁽¹⁹⁾ came to firm conclusions about the position of mentally abnormal offenders in relation to the tribunal. They recommended that anyone considered to warrant detention in maximum-security hospitals should always be further restricted under section 65 to prevent 'his discharge on application to a mental health review tribunal!'. Because of the greater credibility of the Parole Board demonstrated by the Home Office, the advisory role of the tribunals should be transferred to the Parole Board. On the basis of similar reasoning, Gostin ⁽²⁰⁾ proposed the Aarvold advisory board should take over the advisory function. Walker and McCabe were primarily concerned for public protection and Gostin for the civil rights of the individual, yet they came to similar conclusions. Both concerns would be eased more by clarifying and strengthening the position of the tribunal rather than transferring the advisory function to another body in such a different relationship to the Home Office. Walker and McCabe were concerned about the anomaly of a body dealing largely with non-offenders being able to advise discharge of offenders; Gostin was concerned about the anomaly of a decision of a tribunal not having 'conclusive effect'. The 'judicial' status of the tribunals should be strengthened to gain the greater credibility required to correct their anomalous position, particularly in respect of patients detained in special hospitals.

The contrast between the characteristics of the patients and the tribunal decisions in Greenland's study (1970) ⁽²¹⁾ and that

(19) Walker N. and McCabe S. 'Crime and Insanity in England' Vol 2 Edinburgh University Press (1973)

(20) Gostin L. 'A Human Condition' Vol 2 Special MIND Report (1977)

(21) Greenland C. 'Mental Illness and Civil Liberty' G Bell and Sons (London 1970)

of Hepworth (1982) ⁽²²⁾ illustrate the legislative changes required for patients in special hospitals. Some of the differences are the result of other changes which had taken place during the decade between the studies (for example, the drastic decrease in the proportion of patients detained under Schedule 6, and increase in those represented). Other differences resulted from the patient/applicant sample-group in the second study being in a special hospital (for example, a higher proportion of offenders, restricted under section 65, and classified as 'psychopathic disorder'). The special problems of both the special hospital and the tribunal relate to the dependence on the local health and community authorities for rehabilitative resources and the inability of the security hospital to provide informal care and treatment. When considering discharge from a local NHS psychiatric hospital or responding to a successful application to the tribunal, the responsible medical officer and hospital team have control over their own local facilities and have local working relations with allied community services. Also they have the option of continued care and treatment on a voluntary basis. The special hospital has control over no rehabilitative resources in the home area and is bound to be restricted in its working relations with so many services throughout a national catchment area.

Various changes would benefit patients in special hospitals. The security service being provided by the national hospitals to the various area and regional authorities should be backed by clear statutory recognition of the ultimate responsibility for their residents by the home health authorities. This would strengthen the position of the special hospital and/or mental

(22) Chapter nine: 'Sample group of patients'
Chapter fifteen: 'Tribunal decisions and innovations'

health review tribunal when seeking to impliment a judgement that 'compulsory' care and treatment was no longer required. The closer working relations which would be essential to the effective implimentation of joint responsibility between the special hospital and area/regional authorities would be very difficult to achieve without much greater 'regionalisation' of the special hospital service. Either within the special hospitals or in association with the special hospitals, the facilities necessary to allow a man or woman to remain informally for a time after their detaining order has been discharged. This facility should not be used extensively nor for prolonged periods. But such a facility is necessary to rescue some patients in special hospitals from an anomaly peculiar to them. The legislation which governs their detention and discharge by either the responsible medical officer or mental health review tribunal relates to the 'compulsion' and not the need for treatment in itself. Yet, for them, 'discharge' of their detaining order means that continued care and treatment can no longer be offered in that situation. Even when the special hospitals seek to be flexible in respect of someone requiring time and assistance in finding somewhere to go, the individual is choosing to remain in a 'detaining' not a 'free' situation. The security hospitals should be sanctioned to provide a rehabilitative 'informal' facility to provide the time for the responsible health and social service authorities to plan an effective response.

That this facility for a limited period of informal care would ease the tribunal's difficulties was illustrated in the contrast between Greenland's national group and Hepworth's special hospital

group in respect of the extent of tribunal adjournments. In response to 1035 applications during 1963, the tribunals adjourned consideration of only 31 (3%) (Greenland 1970). In response to the 72 applications in the special hospital sample, the tribunal adjourned on thirty occasions (41.7%), often with the clear intention of eventually discharging the order.

Summary of recommendations

- 1) In response to applications, the tribunal should have the power to order delayed discharge by a given date.
- 2) Improved access to the tribunal should help to safeguard some patients in the future from the dilemmas resulting from unnecessarily prolonged periods of hospital care.
- 3) Legislation and/or government policy should be changed to require responsible health authorities to provide health care in hospital to enable a resident leave maximum security.
- 4) The legislation which defines local authority responsibilities to provide residential care should be strengthened to allow their residents to leave security hospital care and the necessary resources made available.
- 5) A period of statutory after-care (six months at least) should be a condition of discharge under section 26 or 60.
- 6) There should be the statutory requirement for local authorities to provide supervision to patients discharged from detention under mental health legislation.

7) Tribunal powers should be extended to include recommendations for transfer or conditional discharge, or trial leave during the period of delayed discharge or adjourned consideration in response to applications.

8) The tribunal authority to require the attendance of witnesses should be strengthened.

9) The position of the patient's representative as essential both to the patient and the operation of the tribunal should be acknowledged and strengthened.

10) The tribunal should be required to record the reasons for their decisions, for the information of all parties concerned.

11) The 'judicial' status of the tribunals should be strengthened to gain greater credibility and authority, particularly in respect of patients detained in special hospitals.

12) There should be clear statutory recognition of the continued responsibility of the responsible health authorities while their residents are in special hospitals, this joint responsibility to be reflected in the working relations between the health authorities and special hospitals.

13) Closer and more effective working relations between special hospitals and health and social services should be promoted by greater 'regionalisation' of the special hospital service.

14) Special hospitals should be sanctioned to provide facilities for short-term 'informal' rehabilitative care in cooperation with health and community services.

CHAPTER TWENTY

THE INFLUENCE OF THE CONCEPT OF 'DANGER' ON THE ASSESSMENT OF 'DANGER TO SELF AND OTHERS'

Introduction

The mental health review tribunal was used as a means of research into the decision-process in regard to mentally disordered individuals considered a danger to themselves or other people. In seeking to generalise from the tribunal to other groups concerned with assessment of 'danger to self and others', care should be taken to acknowledge any differences in context, constitution and powers. This further analysis is based on the assumption that the research findings about the tribunal decision-process can increase knowledge and understanding in other situations where the following conditions apply:

- (a) A formally-prescribed decision-process within which the holders of particular offices and/or designated clinical practitioners are required to make decisions about the release or continued detention of:
- (b) An individual previously identified as 'dangerous' in the sense of objective evidence of serious offences or behaviour involving the risk of physical harm or sexual assault, serious 'threat and anxiety' on the part of others, and a considered decision to restrain the individual for the protection of others or himself.

The aims and intentions of this further analysis are:

- a) To review the literature about the assessment of dangerous behaviour in the light of some of the primary research findings, and
- b) To attempt to build a more sufficient model of the decision-process in regard to mentally disordered men and women

(1)
considered a 'danger to self and others'.

The concept of 'dangerous behaviour'

Deviant behaviour could be defined as 'the individual's departure from the norms, standardised practices, and approved outlets for his specific role in a given society' (Weinberg 1967).⁽²⁾ Despite his primary emphasis on the relativity of normality and therefore deviant behaviour, Weinberg also identified disorders which were recognised cross-culturally: 'impulsive violence, uncontrollable frenzy, or impulsive attacks upon others'.

There is a strong social anthropological tradition arising largely from Lorenz in respect of the 'biological value of aggression' advocating that even the maintenance of social stability depends upon aggression (Swanson 1976).⁽³⁾ Yet even Lorenz acknowledged that aggressive behaviour could 'become exaggerated to the point of the grotesque and inexpedient'.⁽⁴⁾ In his view, aggressive behaviour became pathological when competition between members of the same species was taken to inappropriate and destructive extremes. Just as the positive survival value of aggression was justified by its benefits to the species as a whole, the destructive effects were seen in the harm to the total group rather than particular victims. The 'danger' was in respect of the social instability arising from inconsistent or distorted use of aggression or where aggression was used against the recognised social values. In this tradition, there was no

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- (1) Chapter twenty-one
(2) Weinberg S.K. 'Sociology of Mental Disorders' Staples Press (London 1967)
(3) Swanson H. 'The biological value of aggression' in 'Violence' Tutt N.(ed) DHSS SWS Development Group (HMSO 1976)p. 56-75
(4) Lorenz K. 'On Aggression' Methuen and Co (London 1963) p. 34

attempt to identify with specific individuals concerned in such as predator or territorial defence situations.

To whatever extent society may be aiming to restrain 'dangerous' individuals for the protection of society as a whole, within the operation of criminal law and mental health legislation danger is defined more in terms of the damage done by individuals against individuals, the threat from an individual as perceived by others, concern about behaviour infecting other individuals, and the risk of repetition of specific harmful acts. Attempts to study the restraint of dangerous individuals have found the need to define the danger in terms of specific incidents of observable (5) behaviour such as convictions for assault and acts of violence. Yet Tutt (6) illustrated that the problem of defining and identifying such as violent acts was affected by the cultural context and the legitimacy of the behaviour, the perception of the situation by the participants, the social context of the behaviour, and the general social attitudes at the time. In effect, he concluded that the labelling of behaviour as unacceptably violent or dangerous depended often upon who threw the punch and in what circumstances (Tutt 1976). This was reminiscent of the Lorenz view that the expression of the aggressive competitive instinct was often contained within cultural ritualisation, which helped to make the behaviour acceptable, predictable and restrained within recognised boundaries.

(5) For example, Steadman H.J. and Cocozza J.J. 'Carcers of the criminally insane' Lexington Books, Heath and Co (Mass. 1974); Thornberry T.P. and Jacoby J.E. 'The criminally insane' University of Chicago Press (1979)

(6) Tutt N. Introduction to 'Violence' Tutt N. (ed) DHSS SWS Development Group (HMSO 1976)

Therefore, although 'violence' would appear to be very much part of the definition and concept of 'danger' in human behaviour, the danger was not exclusively or necessarily in the behaviour itself. The concept of danger and the concept of violence are not co-terminous. A simplistic beginning would be to define 'danger' as the 'fear of violence'. 'Danger' appears to imply a potential source of violence perceived as threatening by someone who is concerned for themselves or others as potential victims. Whilst actual or potential violence appears to be an important component of the concept of danger, also important is the 'fear' aroused in others. The 'offence' arises not simply from the risk of physical harm or other assault, but also from its inappropriateness or unpredictability. Where is the danger? Is it in the 'fear', as to a large extent suggested by Tutt? Is it in the violence, as implied by such definitions as 'more severe, aggressive or sexual activity involving risk to life and health' (Sturup 1968)⁽⁷⁾ and 'impulsive, uncensored personal violence toward others and sometimes toward self' (Prins 1975)?⁽⁸⁾

Justice would require an individual to be restrained as 'dangerous' only on the basis of observed and observable behaviour. Pfohl (1979)⁽⁹⁾ warned that unless the criteria for detention were defined in terms of observed behaviour, it would be impossible to avoid idiosyncratic psychiatric 'expert' assessment of the 'person'. Judge David Bazelon was quoted

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- (7) Sturup G.K. 'Will this man be dangerous?' in CIBA Blueprint 'Mentally Abnormal Offender' Churchill and Co (1968)
- (8) Prins H. 'A danger to themselves and others' Br. J. Social Work 5(3) (1975) p. 297
- (9) Pfohl S.J. 'From whom will we be protected?' Inter. J. Law and Psychiatry Vol 2 (USA 1979) p 55 - 78

by Steadman and Coozza (1974):⁽¹⁰⁾ 'To be dangerous, one must be likely to attack or otherwise inflict injury, loss, pain, or other evil. The court must also determine the harm, if any, that is likely to flow from these acts. A mere possibility of injury is not enough; the statute requires that harm be likely'.

Although Pfohl favoured the 'philosophy that someone would not be categorised as dangerous and classified for maximum security unless there was compelling behavioural evidence that he or she acted violently',⁽¹¹⁾ he acknowledged that this approach could not 'claim to validly assess the likelihood of future dangerousness'.⁽¹¹⁾ The concept of danger would seem to be more complex than incorporating acts of violence and/or 'fear of violence'. The concept and nature of danger could be seen as social-interactionist both in respect of involving the perceptions of others and in expressing itself within a social situation. Sturup saw the danger not merely in the person himself but in the particular situations which triggered off the violent behaviour, and he emphasised the rehabilitative importance of motivating the person to avoid the 'dangerous situation'.⁽¹²⁾ Again there was the parallel with Lorenz' concept of uncontrolled aggression and impulsive violence being perverted intra-specific competitive behaviour reacting to its own triggers in the situation (as instinctive behaviour reacted to the appropriate stimuli). The real influence of external factors was stressed by Byohowski (1967): 'Even if we discount the natural tendency for the patient to find a scapegoat in his environment, we

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- (10) Steadman H.J. and Coozza J.J. 'Careers of the criminally insane' Lexington Books, Heath and Co (Mass. 1974) p. 172 - 173 (quoting Bazalon on Millard v. Cameron 1966 and Cross v. Harris 1969 in District Court of Washington, D.C.)
- (11) Pfohl S.J. 'From whom will we be protected?' Inter. J. Law and Psychiatry Vol 2 (1979) p 74 and 77
- (12) Sturup G.K. 'Will this man be dangerous?' CIBA Blueprint 'Mentally Abnormal Offender' Churchill and Co (1968)

must admit that in many instances his claims are not altogether unjustified, and that, were it not for certain definite external circumstances, his anti-social acting out might not have taken place'. (13)

It would seem that an adequate definition of the concept of 'dangerous' in human behaviour would need to include reference to 'the threat and anxiety experienced by others' in regard to 'the risk of physical violence or assault' from an 'individual' whose behaviour was judged to be 'impulsive and/or unpredictable' and likely to react inappropriately or incongruously in response to certain aspects of any particular 'social situation'.

The social identity of the dangerous individual

The above conclusion could suggest a rational view of dangerous behaviour, such as taken by the Butler Committee who concluded that dangerous behaviour arose as a result of an individual with his own particular dispositions and threshold of tolerance entering particular situations or circumstances which could act as a trigger for the behaviour. (14) Whilst such a rational view is desirable, it is necessary to take into account the dynamic effect of the anxiety of others in response to the individual and the complexity and confusion in regard to causation. The dangers inherent are illustrated by the following quotations:

(13) Bychowski G. 'Dynamics and predictability of dangerous psychotic behaviour' in Rappoport J.R. (ed) 'Clinical evaluation of dangerousness of mentally ill' Charles C Thomas (Illinois 1967)

(14) Butler Committee 'Report of the Committee on Mentally Abnormal Offenders' Cmnd. 6244 HMSO (London 1975)

'It is inadmissible to use the term schizophrenia for the lack of a better one simply because of incomprehensible crimes of violence by people who may even display some characteristics why may remind one of schizophrenia'.

(Kloek 1968)⁽¹⁵⁾

'Almost by definition psychopaths are rejected and feared members of society. Characteristically few officials wish to hear further about a person so labelled, and most reactions are negative'.

(Craft 1968)⁽¹⁶⁾

The misleading and improper uses of the concept of 'psychopathy' were discussed more fully by West (1968).⁽¹⁷⁾ The tendency to assume someone was mentally disordered on the basis of acts which were considered 'unnatural' was discussed by Johnson (1967).⁽¹⁸⁾ These uses and tendencies have persisted despite evidence that the connection has been over-emphasised between crime and violence and psychopathy⁽¹⁹⁾ and mental illness.⁽²⁰⁾ Whilst few would take an extreme view of denying any value in the concept of mental illness (Szasz 1962 and 1967),⁽²¹⁾ the warning should be heeded to

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- (15) Kloek J. 'Schizophrenia and delinquency' CIBA Blueprint 'Mentally Abnormal Offenders' Churchill and Co (1968)
- (16) Craft M.J. 'Treating psychopaths at Garth' in 'Psychopathic Offenders' West D.J. (ed) University of Cambridge Press(1968)
- (17) West D.J. 'Psychopaths: an introductory comment' in West D.J. (ed) 'Psychopathic Offenders' University of Cambridge (1968)
- (18) Johnson W. 'Releasing the dangerous offender' in 'Clinical Evaluation of Dangerousness of Mentally Ill' Charles C.Thomas (Illinois 1967)
- (19) Gibbens T., Briscoe and Dell 'Psychopathic and Neurotic Offenders' CIBA Blueprint 'Mentally Abnormal Offenders' Churchill and Co (1968)
- (20) Rappoport J.R. 'Review of the literature on dangerousness of mentally-ill' in 'Clinical Evaluation of Dangerousness of Mentally Ill' Rappoport J.R.(ed) Charles C.Thomas (1967)
- (21) Szasz T. 'Myth of Mental Illness' Seeker and Warburg (1962)
Szasz T. Article in 'Sociology of Mental Disorders' Weinberg S.K.(ed) Staples Press (london 1968)

avoid the risk of seeing the labelling of someone as mentally ill as saying anything at all about the causation of any anti-social behaviour. In describing the discrimination which can arise through stigma, Goffman (1968) said that 'we construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalising an animosity based on other differences'. (22)

These quotations and references illustrated the process whereby the 'danger' can be transferred from the behaviour to the individual. This process could be initiated by evidence of violent or assaultive behaviour, with the 'fear' becoming associated with the individual, culminating in the social identity of that individual being transformed. He becomes a 'dangerous individual'. As implied by the quotation from Goffman, the initiative for this process of social identity transformation can arise from 'other differences' than evidence of violent behaviour; a difference which is in some way associated with the 'threat and anxiety experienced by others'.

What is the social identity of a dangerous individual? Sarbin (1967)(23) commenced his exposition of the 'dangerous individual' with a semantic study of the meaning of 'danger'. He emphasised that the word 'danger' derived, not from concern about physical harm to objects or people, but from linguistic roots that 'signified relative position in a social structure, a relationship between roles in a power dimension'. Whilst

(22) Goffman E. 'Stigma' Pelican (London 1968)

(23) Sarbin T.R. 'The dangerous individual' Br. J. Criminology Vol 7 (1967) p. 285 - 295

the concept of 'violence' denoted action on someone's part, the concept of 'danger' denoted a social relationship and inter-action. Sarbin advanced the thesis that the violent or assaultive behaviour associated with the person being labelled 'dangerous' was partly the consequence of a process of social identity transformation. One of his conclusions was that 'the dangerous offender is the outcome in large measure of the institutions we have created to manage and mould him'. This may appear an extreme view, particularly in respect of men and women detained in special hospitals where evidence of 'action' on their part is legally required to justify the detention. Yet his thesis does help to advance a social-interactionist understanding of 'dangerous'.

Sarbin developed his thesis by reference to the social psychological assumption that effective functioning and a satisfactory social identity required a reasonably accurate placement of oneself and others in the role-system. Social identity was defined as the complexity of roles validated through actual or symbolic interaction with the others occupying complementary roles. Changes in the social identity and the placement in the role-system of an individual occurred all the time, without necessarily any extreme disruption or 'danger'. Rather than accepting the traditional categorising of roles into 'ascribed' or 'achieved' (Linton 1936),⁽²⁴⁾ Sarbin proposed more of a continuum with roles being more or less ascribed and achieved. Also he suggested further dimensions which he defined as 'value' and 'involvement'. The 'proper' performance of ascribed roles was simply expected by society,

(24) Linton R. 'The study of man' Appleton-Century (New York 1936)

attracting little or no positive value; whereas the unsatisfactory or non-performance of such roles attracted strong negative valuations. 'When women kill their children, they seldom go to trial ... this is such an unnatural act that almost always in New York, in spite of their mental state, they are sent to Matteawan' (Johnson 1967).⁽²⁵⁾

P.T.d'Orban (1979)⁽²⁶⁾ found a similar pattern in England and Wales. Of 84 women convicted of killing their children, only eleven were sentenced to prison or borstal. 42 were placed on hospital orders or probation orders with conditions or residence in hospital for psychiatric treatment. 23 women were placed on probation without conditions of residence. Any mother who does not respond appropriately to the health and welfare needs of her child can be considered a bad mother or even a non-mother, perhaps involving her removal from the role of 'mother' (e.g. by the removal of the child for 'care and protection').

Extreme negative valuation involves not simply the loss of specific roles but the status of a 'non-person' or 'brute' (Platt and Diamond 1965).⁽²⁷⁾ Sometimes more euphemistic labels are employed, such as 'offender' or 'patient'. A person so labelled tends to be without status and negatively valued. Their 'involvement' in the acquired 'non-person' role tends to be total, just as others are 'persons' all the time. Scheff (1966)⁽²⁸⁾ discussed how the 'role of being

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- (25) Johnson W. 'Releasing the dangerous offender' in 'Clinical Evaluation of Dangerousness of Mentally Ill' Rappoport J.R. (ed) Charles C.T mas (Illinois 1967)
- (26) d'Orban P.T. 'Women who kill their children' Br.J.Psych. 134 (1979) p 560 - 571
- (27) Platt A.M. and Diamond B.L. 'The origin and development of the "wild beast" concept of mental illness' Journal Hist.Beh.Science Vol 1 (1965) p 355 - 367
- (28) Scheff T.J. 'Being Mentally Ill' Aldine (Chicago 1966)

mentally ill' could become stabilised because of the labelling expectations and the role-taking received from others. Scheff presented his sociological labelling model as an alternative to the traditional medical model of mental disorder, and the same model was subsequently applied to some extent to mental retardation (Rowitz 1981).⁽²⁹⁾ The depersonalising or brutalising effects of the social dynamics of 'total institutions' have been well documented (Sykes 1958;⁽³⁰⁾ Goffman 1961;⁽³¹⁾ Rosenham 1973⁽³²⁾).

The brutalising effects of total institutions may seem far removed from the concept of 'danger'; but they are connected by a concern for the social identity of the individual. The social identity of the 'dangerous individual' is that of a non-person, not allowed the minimal rights granted to all 'persons' in society. The 'dangerous' label tends to over-ride other considerations and roles in the eyes of others. Sarbin argued that the dangerous behaviour itself could arise from the individual resisting the status of 'brute', applying violence to upset the role structure. The process was then exacerbated as those in authority became even more aware of the individual as dangerous.

What is the relevance of the concept of the social identity of the 'dangerous individual' to the issue of assessing the 'danger' with a view to continued detention or release? It is suggested that the social identity of the individual is an important aspect of the decision-process with respect to the issue of whether

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- (29) Rowitz L. 'A sociological perspective on labelling in mental retardation' *Mental Retardation* (April 1981) p 47-51
(30) Sykes G.M. 'The society of captives' Princeton University Press (Princeton 1958)
(31) Goffman E. 'Asylums' Aldine Press (Chicago 1961)
(32) Rosenhan D.L. 'On being sane in insane places' *Science* Vol 179 (January 1973) p 250-258

the decision-makers should now trust the individual as a 'person' with the rights and responsibilities that status implies.

Assessing the 'danger'

Although this research project was not a prediction study nor concerned with prediction studies, it was concerned with the problems of decision-makers attempting to anticipate the future behaviour of men and women. After reviewing about forty prediction studies and her association with the extensive probation prediction study, Simon (1971)⁽³³⁾ concluded that 'the study shared the general fate of criminological prediction studies in failing to produce an instrument of high power'. 'While greater predictive power obviously would be desirable, efforts put into refining predictive studies based on pre-treatment data may have reached the point of diminishing returns'.⁽³³⁾

Scott linked the problems of prediction with the anxieties about the person. 'We strive after accurate prediction of dangerousness because this would quell our anxieties, enable us to draw clear lines between dangerous and non-dangerous, and avoid the necessity of continuing contact with or concern for them' (Scott 1977).⁽³⁴⁾ He concluded that in fact 'no such magical process' was possible, and 'involvement on a long-term basis and good communications are therefore the inescapable bases for assessment of dangerousness'. This long-term involvement was necessary because the more immediate objective evidence was reliable as a guide to behaviour in the short-term only. 'It

(33) Simon F.H. 'Prediction methods in criminology' Home Office Research Studies (HMSO 1971) p 156 and 158

(34) Scott P.D. 'Assessing dangerousness in criminals' British Journal Psychiatry, 131 (1977) p 127 - 142

was realised that it is an economy to aim straight for the personal contact'.

Despite the doubtful reliability of 'pro-treatment data', any review of literature such as that which preceded the empirical research of this study would probably identify certain themes and categories of factual evidence as influential in assessing the risk to others from a particular individual: the severity of the offences which led to detention, previous offences or abnormal behaviour, the circumstances of the anti-social behaviour, the social background and life-career of the individual, the presence or assumption of mental disorder, and the social control and support available.

Practical experience and observation would also acknowledge the influence of relatively less objective factors: uncertainty about the cause and the unexpectedness or perceived abnormality of the behaviour, and intuitive feelings about the individual.

The research findings were that certain of the objective 'risk' factors (mental disorder, offences, previous criminal record, and present behaviour and attitudes) were influential in determining whether or not continued detention was necessary (Chapter Eleven). The one 'over-riding' factor appeared to be the personality of the patient, which over-lapped with the more objective considerations such as mental disorder and behaviour and with the more subjective reactions of the decision-makers to the individual.

One interpretation could be that, in showing such a major

concern for the personality of the person before them, the tribunal were reflecting as much an emotional and intuitive reaction to the individual as acknowledging distinct observable characteristics. Just as the initial concern about the 'personality' of someone considered to require restraint could come close at times to the confusion of labelling the person without adding to the understanding of causation, the same phenomenon could operate in favour of the individual being considered for release. An emotion of warmth or sympathy for the individual or feeling of trust in his good intentions could sometimes be perceived as responding to his 'personality'. This is in accord with the suggested definition of 'dangerous' (page 408). The sympathy and trust could be the counterpart of and response to the 'threat and anxiety' in the nature of the 'danger' which led to the original restraint.

Such a response could be in contrast with the excessive consciousness of the 'threat and anxiety' by hospital staff, identified by various writers and researchers. 'The Baxtrom demonstration did not show as is sometimes said, that mentally ill criminals are no more a risk to others than men and women who do not bear that label. What it did suggest was (a) hospital staff had been too apprehensive about future behaviour, (b) staff decisions should have been subject to outside review, and (c) the release of the majority earlier would not have resulted in a politically unacceptable number of incidents of violence' (Walker 1979).⁽³⁵⁾ Steadman and Coozza described the cautiousness in terms of the 'psychiatrist as a conservative agent of social control' (Steadman 1972)⁽³⁶⁾ and 'over-prediction' in response

(35) Walker N. Foreword to 'The Criminally Insane' Thornberry T.P. and Jacoby J.E. University of Chicago Press (Chicago 1979)

(36) Steadman H.J. 'The psychiatrist as a conservative agent of social control' Social Problems 20 (1972) p 263 - 273

to doubt: 'Because psychiatrists cannot accurately predict who will become violent, they frequently err ... on the safe side. They assume that since some of the patients are dangerous, the one under consideration might be' (Steadman and Coccozza).⁽³⁷⁾ This deliberate over-prediction in response to the general 'threat and anxiety' roused in society by the group has been termed 'political prediction' (Thornberry and Jacoby 1979).⁽³⁸⁾

The interpretations about the response to the 'personality of the patient' appear to complement Sarbin's thesis about the social identity transformation of the dangerous individual. Initially the 'threat and anxiety' in response to the perceived 'danger' had led to the 'need to restrain' the 'dangerous individual', thus transforming his social identity to that of 'non-person' (not to be trusted with the normal rights and responsibilities of 'persons'). Release from detention depended on the individual regaining the status of 'person' in the eyes of the decision-makers; thus reversing the 'depersonalising' process as the individual was invested again with trust and confidence and the expectation of normal roles in society.

Similarly, 'uncertainty' and 'unpredictability' are in the nature and definition of 'danger', with 'benefit of the doubt' being the counter-part in the process of assessing the danger with a view to release. In the discussion of Sarbin's thesis, it was pointed out that the 'proper' performance of ascribed roles such as 'person' was simply expected and taken for granted (i.e. given the benefit of the doubt) by society, unless there was clear evidence to the contrary. Once some-one was socially

(37) Steadman H.J. and Coccozza J.J. 'We can't predict who is dangerous', Psychology Today (January 1975) p 32 - 35

(38) Thornberry T.P. and Jacoby J.E. 'The Criminally Insane' University of Chicago Press (Chicago 1979) p 32

identified as a 'dangerous individual', the 'doubt' could operate against the 'non-person'. The research findings confirmed the importance of 'uncertainty and doubt' and 'benefit of the doubt' as influences on the decision-process of the mental health review tribunal. Also 'benefit of the doubt' was found to be significantly associated with advice and decisions in favour of release. The interpretation was made of this association that where there was 'no doubt', it would be in regard to the need for continued detention. Once it was determined that there was doubt about the need for continued detention (on the basis of more objective considerations such as the offences, mental disorder, present behaviour etc), the decision-makers would then begin to consider all the implications of possible release. 'Benefit of the doubt' would often be a necessary component of the situation, both in response to the 'doubt' aspect of the danger and as part of the process of re-investing the individual with the role of 'person'.

Conclusions

This analysis has serious implications for the process of assessing dangerous individuals and resettlement back into society.

(1) One serious implication is summarised in Sturup's view that without satisfactory emotional contact he could not effectively evaluate a person nor be optimistic about treatment and rehabilitation. (39) It could be assumed that

(39) Sturup G.K. 'Will this man be dangerous?' CIBA Blueprint Churchill and Co (1968)

the tribunal had too little time and contact with the individual to form such a personal contact on which to base their judgement. It could be suggested that the hospital staff were best able to evaluate the progress of a patient because of their long-term and more intensive contact. Yet this should be tested against the evidence of research into relationships in closed institutions (Goffman, Sykes, Rosenhan, Scheff) and into the conservatism of psychiatrists and hospital staff (Steadman and Cocozza, Thornberry and Jacoby).

It could be argued that, if the tribunal are approaching the situation with the purpose of protecting 'the individual's right not to be unfairly deprived of his liberty' (Wood 1976) ⁽⁴⁰⁾ and meeting an individual with whom they are unfamiliar, they would be more likely to respond to him as a 'person' in his own right. The one over-riding influence identified by this research was the personality of the person before them as they perceived it and the emotional and intuitive reaction to the individual. The evidence illustrated a tendency to give the benefit of the doubt in favour of the individual, thus acknowledging his status as a 'person'.

Once the need for detention is in doubt on the basis of objective consideration of such as mental condition and behaviour, personal contact is an essential factor in assessing the danger. The emphasis should be on the 'personal' nature of the contact and inter-action and response to the individual. Whilst the mental health review tribunal considering applications against detention are disadvantaged by time, members of the

(40) Wood J.C. 'Mental Health Review Tribunals' and Social Work' Social Work Today, Vol 7 (11 August 1976)

hospital team suffer from the depersonalising effects of total institutions.

(2) Another serious implication concerns the resettlement of the person into the community. Once it is acknowledged that decision-makers are influenced by a subjective 'gut-reaction' to the 'person' in expressing their confidence in his readiness to return to open society, various questions follow from this. It makes sense that, if the 'danger' incorporated the sense of threat and anxiety about the individual, one of the main influences which helped to overcome the sense of 'danger' would be a feeling of trust and sympathy and confidence in the person concerned. Yet, on whose behalf is the confidence in the person being expressed? In an abstract sense, the decision-makers are acting on behalf of society as a whole. But the people more directly affected by the decision to release (members of the family, staff of local health and social services, neighbours) may not have overcome their sense of threat and anxiety. They could still perceive and relate to the individual as 'dangerous' and resist him as a 'person'.

Sturup suggested that the primary aim of rehabilitation was to form the kind of constructive emotional relationship which could be used to help the person regain his self-respect and a responsible place back in society.⁽⁴¹⁾ This approach needs to be extended, particularly in respect of resettlement from national security institutions such as Rampton Hospital, to establish a 'bridge' of intuitive confidence and emotional support involving all the parties concerned. Given an adequate response in respect of factors such as psychiatric treatment and

(41) Sturup G.K. 'Will this man be dangerous?' CIBA Blueprint Churchill and Co (1968)

and social training and education, the one main key to successful rehabilitation is the confident expectations of the decision-makers not only reinforcing the self-confidence as a 'person' of the individual but also being communicated through close consultation and involvement with all the other links in the chain.

There was one finding of Thornberry and Jacoby (1979)⁽⁴²⁾ which was particularly challenging to social work and other community support services. This was that the 'generally favourable adjustment' of the Dixon patients released because of a court ruling rather than planned resettlement 'was achieved in the absence of strong and frequent contact with social service agencies'.⁽⁴²⁾ In contrast, Strachen (1982),⁽⁴³⁾ writing of the very thorough and comprehensive assessment of mentally abnormal offenders at the Peter Baan Centre, concluded that 'such careful diagnostic work is only fully relevant if therapeutic facilities are available to implement suggestions arising from the final report'.⁽⁴³⁾ These conclusions are not incompatible if the support facilities are viewed as important not merely in their own right but also as evidence of the confident expectations and emotional support toward the person. Grudging and apprehensive provision of rehabilitative support could militate against confident readjustment into the community.

It is the regular experience of hospital teams and mental health review tribunals in England and Wales that this 'bridge of confidence' is the opposite of what happens in practice.

(42) Thornberry T.P. and Jacoby J.E. 'The Criminally Insane' University of Chicago Press (Chicago 1979) p 204

(43) Strachen J.G. 'Psychiatric Assessment of the Dangerous Offender in the Netherlands' Med.Sci.Law Vol 22, No 1 (1982) p 16 - 20

There is often resistance by the responsible authorities to making contact and assessing for themselves or even to providing information to assist in the decision-process. The man or woman is faced with very pessimistic expectations which result in either remaining indefinitely in the security hospital or moving into a reluctant and anxious situation vulnerable to provoking problems.

The assessment, care, and rehabilitation of people considered a danger to themselves and others is not something which any one person or profession can manage effectively in isolation. Careful and close cooperation is required at each stage, as is the willingness of each link in the chain to play its part in ensuring continuity and a partnership of confidence in the 'person' concerned. The emphasis on the person is essential to avoid an excessive paternal or over-protective attitude which could prolong rather than ease the dependent 'non-person' status of the individual.

(3) A further serious implication is related to the social identity of the individual and the power of semantics. Various labels in the social context of mental disorder and criminal behaviour carry much of the meaning of 'non-person'. In Sarbin's terms, the one so labelled is classified as being without status (being in a primarily ascribed role), negatively valued, and tends to be highly involved in the 'non-person' role. Within the context of decision-making about 'dangerous' 'mentally abnormal' 'patients' or 'offenders', there is often a dynamic inter-action between the labels and the perception of the individual by other people, with the subsequent effects on his social identity.

Much of this inter-action is related to the value component of Sarbin's model, where strong negative valuations and sanctions resulted from the non-performance of ascribed roles such as man, father, and person. For as long as the individual continued to be viewed as 'patient' or 'offender' by the decision-makers, they were likely to perceive him as a non-person, not to be trusted with normal responsibilities (i.e. still dangerous). This perception could be based on an objective judgement of evidence of continued risk or dangerous behaviour or in response to some 'other difference' as part of a stigma 'theory'. In so far as the decision-makers are able to acknowledge other roles in the individual, such as parent, worker, or student, to that extent the role and identity of 'patient', 'offender', or 'non-person' is becoming less predominant and the individual is being perceived as less 'dangerous'. Continued negative valuation of the individual as a 'non-person' (in whatever way labelled) tends to involve resistance on the part of those in authority over him to allowing him to be 'involved' in other more specific and valued roles such as parent or student. Conversely, the acknowledgement and encouragement of the 'patient-offender' to be involved in other valued roles would be evidence that the decision-makers were responding to the individual more as a 'person' and perceiving him as less 'dangerous'.

This analysis could be an aid to further understanding of the conflicts which can arise within total institutions such as hospitals and prisons, in regard to the involvement of patients and prisoners in activities beyond those normally accepted as appropriate to their role within the institution. The conflicts

of opinion and practice, which arise in respect of contacts with relatives and others outside the institution and attempts to give patients or prisoners greater responsibility within the institution, could be related to the social identity of the 'in-mates' as perceived by the different personnel. The strength of opposition to allowing the 'in-mates' involvement in more valued social roles could imply some awareness that this could contribute to further resistance to the 'non-person' role. Such resistance in a total institution could be expressed in violent behaviour.

As with the 'dangerous' social identity, the perception of the person as less dangerous and to be trusted with other roles and responsibilities could be based on an objective judgement of observable evidence and/or in response to counter-parts to the 'other differences' which contributed to the stigma-response. Once the objective evidence is no longer considered sufficient to justify the continued restraint as a dangerous individual, those counter-parts come very much to the fore. The counter-parts of the 'animosities based on other differences' are the feelings of trust and sympathy and the benefit of the doubt associated with acknowledging the individual as a 'person' with the same rights and responsibilities as others.

Some practical implications

The following guidelines are some of the practical implications of the above analysis for anyone concerned with assessing the need or otherwise for continued detention of a 'dangerous individual'. They are not intended as fully comprehensive guidelines nor as a model for the decision-process in regard to people considered a danger to themselves and others. They are designed to supplement and complement knowledge and skill and experience already being applied by decision-makers, by emphasising the implications of the social-interactionist nature of danger and the social identity of the dangerous individual.

- (a) To avoid perpetuating any inappropriate stigma or animosity in response to the social identity of a 'dangerous individual', the individual should be approached with conscious respect as a 'person' with rights and responsibilities inherent in that ascribed social role.

(Although this approach could be justified also on philosophical and rehabilitative criteria, it is here presented as a practical aid to effective assessment).

- (b) Any variation from the normal rights and responsibilities of the individual (such as to speak and act for himself) should be justified only on experience and clear evidence of special needs rather than any assumptions based on generalised responses to stereotypes or 'non-persons'.
- (c) The extent to which the need for continued detention could be justified on objective evidence about offences, mental disorder, and current behaviour and attitudes should be clearly established to avoid confusion with less objective considerations.
- (d) Where there is doubt about the continued 'danger' and need for detention, this should be acknowledged.

(Although this is presented as an aid to assessment, there is a philosophical consideration in view of 'reasonable doubt' in court leading to acquittal).

- (e) The decision-makers should consider whether they continued to experience subjective 'threat and anxiety' and ensure that this was in response to the individual and not to stereo-type or 'non-person'.
- (f) The decision-makers should consider whether they trusted the individual and would be inclined to give him the benefit of the doubt.
- (g) If continued threat and anxiety and lack of trust is experienced in response to the individual, the aspects of the responsibilities of a person in society which were not likely to be performed satisfactorily should be identified.

(In other words, the individual should not simply be left as a dangerous 'non-person' without acknowledgement of ascribed roles performed satisfactorily and the 'dangers' clearly identified).

- (h) Where there is trust and sympathy and lessened threat and anxiety, an attempt should be made to identify the specific achievements to which the decision-makers are responding in the person.

(In other words, the involvement in the ascribed and achieved roles, which are receiving positive valuations from the decision-makers and contributing to his social identity as a person again, should be high-lighted for the reinforcement of the social identity and the extending of the confidence to others).

CHAPTER TWENTY-ONE

TOWARDS A MODEL OF DECISION-MAKING IN REGARD TO MENTALLY DISORDERED MEN AND WOMEN CONSIDERED A 'DANGER TO SELF AND OTHERS'.

Introduction

The research approach and findings described in Part Two and Three attempted to show how the mental health review tribunal made decisions in response to applications and references. The research orientation did not assume that the only significant variables affecting decisions were those externally visible 'facts' available from official records. It was found through observing the hearings and interviewing the tribunal chairmen that the formal-structural approach and input-output model were not sufficient to explain the decision-process in practice. An attempt was made to build a more sufficient model through the study of various aspects of the decision-process. The study focused, not only on the facts of the cases being considered by the tribunal, but also on how they perceived the facts and their situation and consideration of the dilemmas and conflicts with which they were faced and the anomalies in their rules and powers which might lead to innovative action.

Although the constitution, procedures and powers of the mental health review tribunal were formally prescribed by legislation and rules, the decision-making of the tribunal was found to be a far more complex process than could be explained entirely in terms of a formal-structural model. There were supplementary or subsidiary decision-processes, some of which could be seen adequately in

straight-forward input-output terms. External difficulties imposed restraints, there were influences which could not be explained in 'objective' terms, and anomalies and dilemmas created the need to go beyond the prescribed procedures and powers.

It was found that the formal-structural approach and an input-output model were more sufficient to account for the decision-process in response to references from the Home Secretary. The difficulties arising from external factors and the anomalies in respect of their powers did not present the same problems and restraints with references where the tribunal had no authority to act but could only advise. In this respect, the findings in regard to the tribunal decision-process in response to applications would have more in common with the decision-process of others concerned directly with mentally disordered men and women considered a 'danger to self or others'. Even in respect of men and women further restricted under section 65(Home Secretary), the responsible medical officers and clinical teams in hospital had to take account of the rehabilitative resources and attitudes of other people in connection with plans for release from detention. This could give rise to the same difficulties and restraints as faced with the decisions which did not require the approval of the Home Secretary; as the hospital team had the same responsibility to implement agreed release plans in co-operation with external health and community agencies.

The more complete model of decision-making in regard to mentally disordered men and women considered a 'danger to self

and others' appeared to involve various stages or subsidiary decision-processes:

- a) An assessment of the risk and the need for continued detention on the basis of objective evidence.
- b) A more subjective and emotional response to the person and the anxiety and threat aroused by the 'danger',
- c) An evaluation of the rehabilitative facilities required to provide the control and care necessary in the interests of the patient's health or safety or for the protection of other persons,
- d) The process of dealing with restraints and difficulties in regard to obtaining information in regard to the necessary rehabilitative resources,
- e) The process of dealing with doubt about the need for continued detention and determining the 'benefit of the doubt'.

Although the model was developed and discussed within the above five stages, at least ten distinct subsidiary decision-processes were identified within the total process.

- (a) An assessment of the risk to others and the need for continued detention on the basis of objective evidence.

At this initial stage, the decision-makers were primarily concerned with evidence of continued risk of physical harm or assault to others and continued lack of self-control and socially responsible behaviour. There were two distinct decision-processes during this primary stage, one of which did not involve completely the whole decision-making team:

- 1) 'Clinical' decision-process

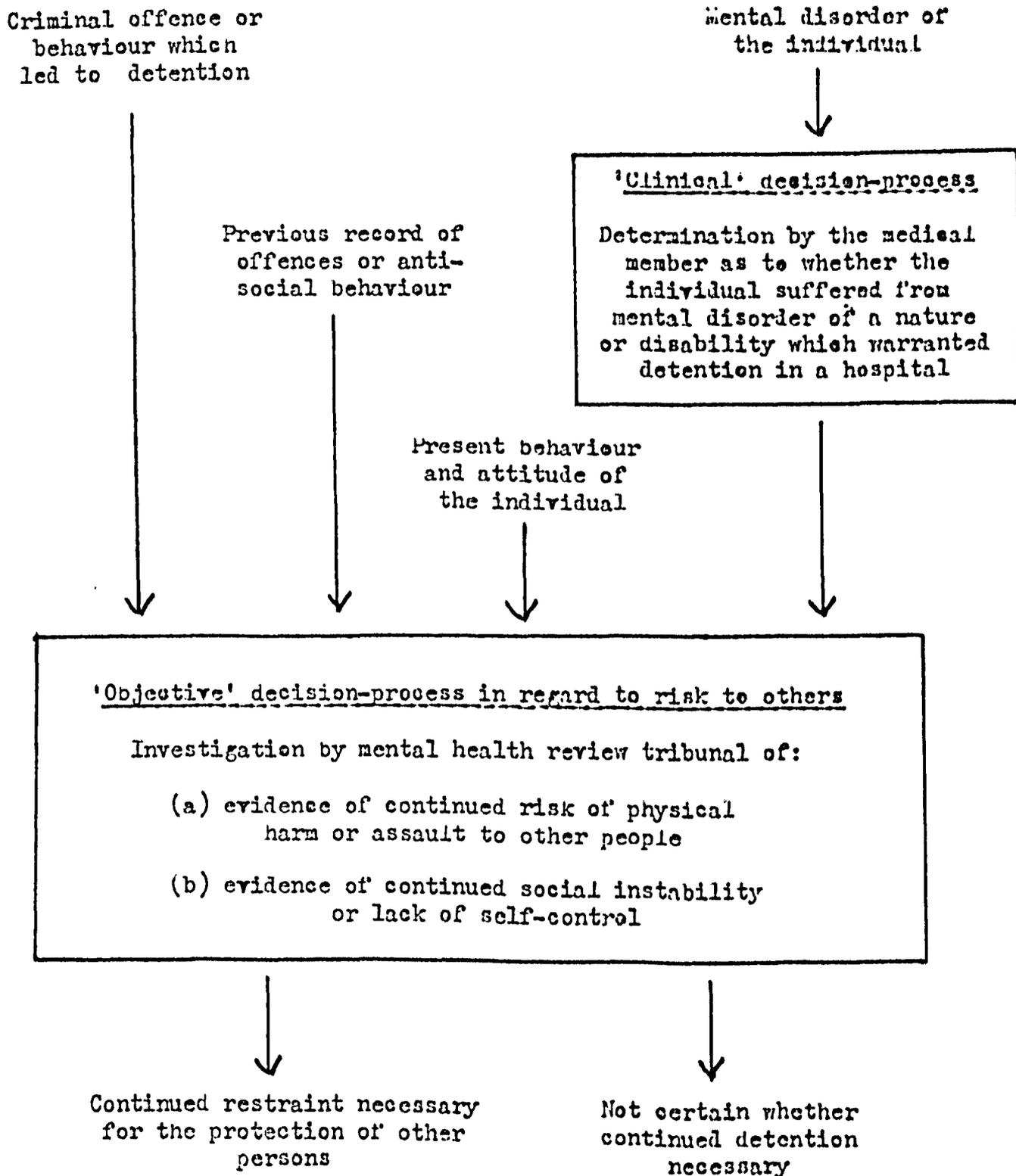
Determination of the mental disorder by the medical member.

2) 'Objective' decision-process in regard to risk to others

Assessment of objective evidence of the risk of further physical harm or assault to people generally or specific potential victims.

This stage was presented diagrammatically (Diagram A) to illustrate the inter-relationship between the 'clinical' and 'objective' assessment of risk decision-processes. The clinical assessment of mental disorder was separate and distinct in various ways. Whether the individual was 'suffering from mental disorder of a nature or disability which warranted the detention of the patient in a hospital' was one of the distinct statutory questions requiring an answer from the tribunal. As perhaps would be expected, the research findings demonstrated that the diagnosis, treatment, and prognosis of the mental disorder of the patient was the prime concern of the medical member of the tribunal. That this was acknowledged by the other members was further confirmed in the findings in respect of disagreements between members. On the whole, decisions in regard to the criteria of 'suffering from mental disorder' were left to the medical member. There was a separate supplementary medical decision-process. The medical member saw the patient separately prior to the full hearing and presented conclusions to the tribunal which were normally accepted by the other members. Quite apart from being separate criteria, it was clear that evidence of continued mental disorder was used as a guide to assessing the degree of risk. It appeared to be used as a means of assessing the extent to which the individual continued to be 'impulsive and unpredictable' and therefore 'dangerous'. The medical opinion of the mental state of the individual tended to be accepted with the other evidence of his social stability and

DIAGRAM A: OBJECTIVE ASSESSMENT OF RISK TO OTHERS



self-control as an aspect of the objective assessment of the risk to others. One of the highly significant empirical findings of this research project was a negative correlation between tribunal judgements in favour of release and mental disorder being perceived by the tribunal as the most influential evidence.

It was evident that, in addition to the mental disorder as judged mainly by the medical member, there were other factors of evidence which were influential in determining the risk and tending to be influences against release: the immediate offence or behaviour which led to the current detention, the previous record of offences and anti-social behaviour, and the present behaviour and attitude of the individual.

The nature and severity of the offence was one of the primary factors at each stage of decision about the 'dangerousness' of an individual. It was probably the major factor in determining the need for the initial detention; but its importance was increasingly a matter of inter-action with other factors. Where an offence had been relatively minor, there would be less pressure on other factors to justify release or bring continued detention into question. Where the offence had involved more serious physical violence or sexual behaviour, there would be greater emphasis on the need for clear evidence of clinical improvement, personal stability and maturation, etc. The severity of the offence was perhaps the major factor in determining whether the decision-makers would lean toward the welfare and liberty of the individual or the protection of others and restraint of the individual. There was likely to have been an inter-action between

the offence and other factors identified as positively associated with tribunal judgements in favour of release: age of the individual and length of stay in the hospital.

Attempts to predict future criminal or dangerous behaviour on the basis of objective 'facts' have tended to look to the previous criminal record. Steadman and Coccozza(1973)⁽¹⁾ devised a measure to predict subsequent criminal activity which they named the Legal Dangerousness Scale. This measure was designed to indicate the seriousness of the criminal background and was composed of: the presence of a juvenile criminal record, number of previous arrests, presence of convictions for violent crimes, and the severity of the offence which had resulted in their latest detention(in New York State's hospitals for the criminally insane). They found that this measure was significantly associated with subsequent criminal activity. Further analysis by Coccozza and Steadman (1974)⁽²⁾ considered the association more specifically with dangerous behaviour(defined as violent assaultive behaviour against persons) and the importance of various social and demographic factors. Only one other variable, age, was found to be significantly associated, with the largest difference in subsequent criminal activity being between those under the age of 50 and those aged 50 and over. Although the tribunal decisions had no predictive validity, it was interesting that the same factor(age over fifty years) was found to have the greatest magnitude of association with judgements in favour of release(other than that of being restricted under section 65, which was affected by the relative

(1) Steadman.H.J. and Coccozza.J.J. 'The criminally insane patient: who gets out?' Social Psychiatry Vol.8.p.230-238 (1973)

(2) Coccozza J.J. and Steadman H.J. 'Some refinements in the measurement and prediction of dangerous behaviour'. American Journal Psychiatry.131, p.1012-1014(1974)

powers of the tribunal as discussed in Chapter Sixteen).

Cocozza and Steadman found that there was a marked improvement in predictive power when the two variables (legal dangerousness scale and age over fifty years) were applied together. They found also a strong relationship between the two variables and subsequent dangerous assaultive behaviour.

The above predictive measure identified by Cocozza and Steadman had a seductive attraction; particularly as it would appear that the tribunal were influenced by similar objective evidence in their deliberations. Cocozza and Steadman found that 30.6% (11 individuals) of the released patients aged less than fifty years and with a high legal dangerousness scale score subsequently engaged in dangerous behaviour, compared to only 4.8% (three individuals) aged 50 and over with low LDS scores. Yet these statistics also illustrated the problem of false-positives. While most of the patients who engaged in dangerous behaviour were under the age of 50 and had more serious criminal backgrounds, most of the patients who fell into this category did not display assaultive behaviour.

Although the tribunal were not applying such standard measurements in their approach to assessing the objective evidence of the continued risk to others, their decision-process could further illustrate the phenomenon of the false-positive problem. In practice, it was clear that this early stage of the decision-process was concerned with the issue of whether or not the individual continued to be a risk to others and continued to require restraint. Normally, the conclusion of the objective

assessment of the risk to others was a judgement that detention continued to be necessary or uncertainty as to whether continued detention was required (i.e. not a definite decision or advice to release). In other words, this stage was simply a first hurdle for the individual. A definite decision would be in favour of continued detention; doubt about the need for continued restraint would be dealt with by progressing to a further stage of the decision-process rather than a judgement to release. Even if it was assumed (as suggested by the findings of Steadman and his associates in respect of the Baxtrom patients) that a higher proportion of the individuals considered by the tribunal to require continued detention on the basis of objective evidence such as criminal offences and present behaviour were more likely to commit further dangerous acts, already the numbers of false-positives were beginning to accumulate. It did appear that, at each stage, the definite decision was in support of continued detention with uncertainty about this normally resulting in progressing to the next stage of the decision-process.

b) A more subjective and emotional response to the person and the anxiety and threat aroused by the 'danger'.

Where there was uncertainty about the risk to others and continued need for restraint on the basis of objective assessment of the risk from the individual, this appeared to be resolved through a more subjective response to the 'personality' of the individual and the 'threat and anxiety' aspect of 'danger'. There appeared to be a distinct subsidiary decision-process:

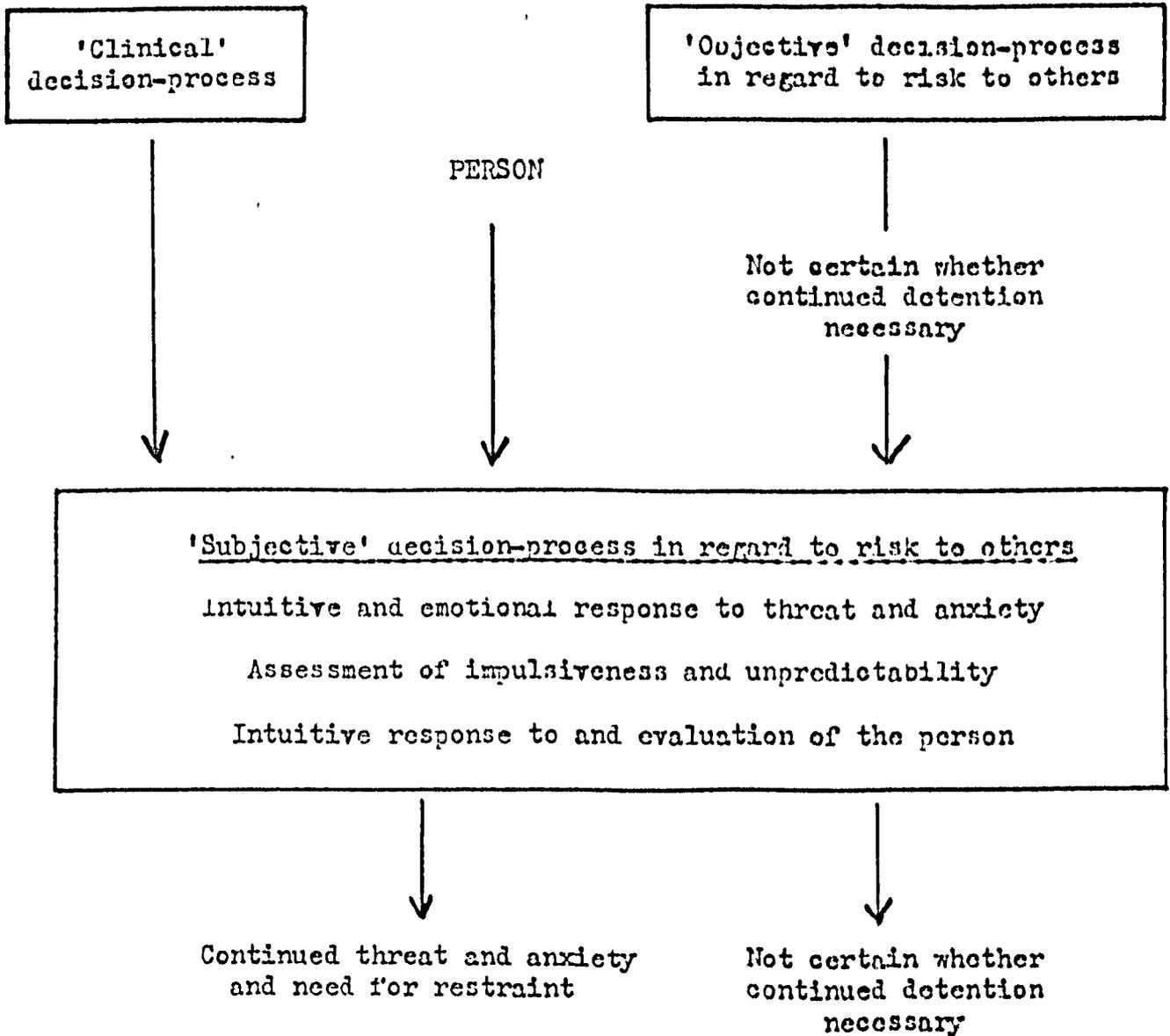
3) 'Subjective' decision-process in regard to risk to others

Intuitive and emotional response to the individual, assessing extent to which still presenting as impulsive and unpredictable, arousing threat and anxiety in others.

This stage was presented diagrammatically (Diagram B) to illustrate the central importance of the 'personality of the patient' as perceived and experienced by the tribunal or other decision-makers in determining the 'danger' and the need or otherwise for continued detention. In contrast with the more objective 'risk' factors (such as criminal offences and mental disorder) which appeared to weigh against the release of the individual, around what tended to be called 'personality' were various influences which tended to be more supportive of release.

The research findings in regard to the evidence on which the tribunal based their judgements (Chapter Eleven) concluded that the one over-riding factor with the tribunal was the personality of the patient. It was the one main influence in comparison with other factors. It overlapped with and incorporated aspects of other factors. It overlapped both with more objective considerations such as offences and observable behaviour and with less tangible variables such as subjective feelings and intuition. It was suggested that, as other factors were acknowledged as important in their own right, when the tribunal acknowledged the predominant influence of the personality of the patient they were reacting on a more intuitive and emotional level in response to their impressions of the person before them. An intuitive sympathy and trust could counteract the threat and anxiety aspect of the 'danger'. An emotion of warmth and confidence toward the person could in effect reverse the 'labelling' process which has

DIAGRAM B: SUBJECTIVE RESPONSE TO THE DANGER AND THE PERSON



determined the 'personality' to be 'dangerous'. This was analysed more fully in terms of the concept of 'danger' and the social identity of the 'dangerous individual' in Chapter Eighteen.

This 'gut-reaction' to the person was reminiscent of Sturupp's emphasis on the consensus of intuitive feeling toward the patient and the need for satisfactory emotional contact before he could effectively evaluate the person or be optimistic about treatment and rehabilitation. The influence of intuition and 'gut-feelings' on the tribunal was evident and it was likely to be in favour of release (in contrast with when the influence was not acknowledged). It was shown that the 'risk' factors (offences, mental disorder etc) tended to be negatively associated with the judgements in favour of release when they were acknowledged to be the main influences. Therefore some decisions or advice in favour of continued detention would have been determined at the earlier stage of the objective decision-process in regard to the risk, before the more subjective reactions to the person came to the fore.

Despite 'subjective feelings and intuition' being positively associated with judgements in favour of release, it appeared that this stage of the subjective decision-process in regard to the risk was still primarily concerned with determining whether or not continued detention was necessary. It was a further hurdle for the individual. A definite decision would tend to be in favour of continued detention; sufficient trust and sympathy to overcome the 'anxiety and threat' would simply progress the

process to a further stage rather than directly to a judgement to release. When the tribunal remained doubtful about the need for continued detention (and perhaps disposed to decide or advise release), there were still further implications of release to be considered before a final conclusion was reached.

- (c) An evaluation of the rehabilitative facilities required to provide the control and care necessary in the interests of the patient's health or safety or for the protection of other persons

Having not determined that continued detention was necessary on the basis of the objective and subjective assessment of the risk to others, the tribunal directed attention to rehabilitative considerations. The research findings in regard to the evidence on which the tribunal based their judgements (Chapter Eleven) demonstrated that 'parens patriae' welfare considerations came to the fore when the question of risk had been assessed on the 'danger' factors of evidence. Having survived the first two primary hurdles, it had to be shown that the necessary control was available for the protection of others and/or care for the health or safety of the individual. The 'protection of other persons' and the 'health or safety of the patient' appeared to receive separate attention:

4) 'Control' decision-process

Assessment of the control necessary for the protection of others and the risk involved in release without those controls being available.

5) 'Care' decision-process

Assessment of the care required for the health and safety of the individual and the risk to the person in being released without those care facilities.

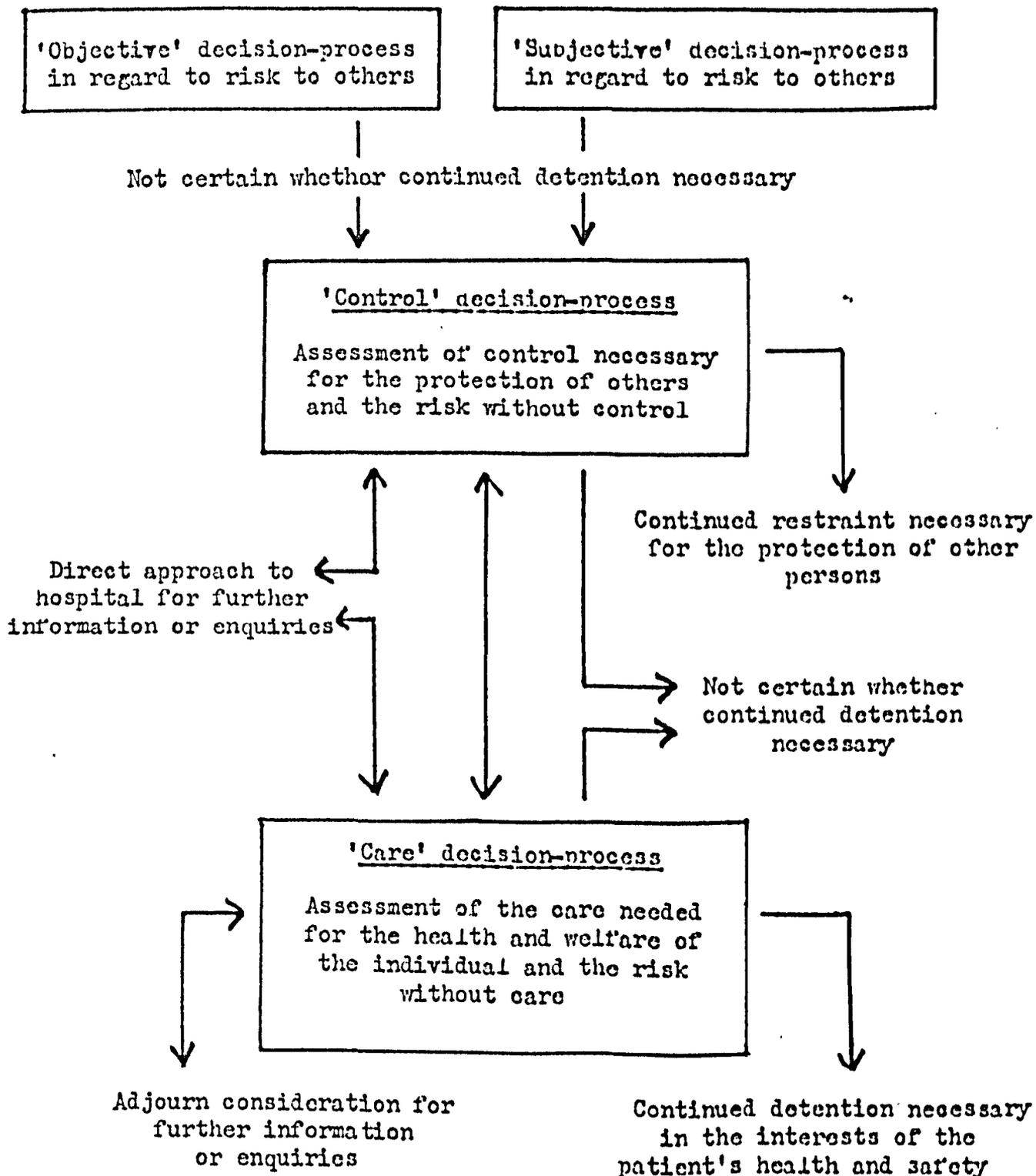
This stage was presented diagrammatically (Diagram C) to illustrate that uncertainty about continued detention on the basis of objective and subjective assessment of the person was processed through consideration of factors external to the individual. Although the factors considered as possibly necessary for care or control were similar (continued health care, community residential and/or other rehabilitative facilities and/or family support), 'protection of other persons' and 'patient's health or safety' were separate considerations with distinct starting-points.

At the core of the assessment of the control necessary for the protection of others and the risk involved in release without those controls, was the very nature of 'dangerous'. There was evidence in the perception of 'dangerous' by the mental health review tribunal (Chapter Ten) that they acknowledged 'danger' as being to some extent related to the social situation within which it was likely to express itself. This was indicated in comments such as: 'dependent upon adequate support', 'violence within domestic and emotional situation', 'danger related to drink and consequences', and 'relapse if social responsibilities are too much pressure'. Their assessment was concerned with the 'probability of dangerous behaviour occurring in this or that expected environment'⁽³⁾ and 'avoiding the dangerous situation'.⁽⁴⁾

(3) Scott.P.D. 'Assessing dangerousness in criminals' British Journal of Psychiatry. (1977) 131, p.129.

(4) Sturupp.G.K. 'Will this man be dangerous?' Paper presented at CIBA Symposium on 'Mentally Abnormal Offender' CIBA Blueprint (1968)

DIAGRAM C: EVALUATION OF THE REHABILITATIVE REQUIREMENTS



In the study of the evidence on which the tribunal based their judgements (Chapter Eleven), it appeared that 'parens patriae' considerations such as community support services and family circumstances only came to the fore once the 'risk' factors had been considered. It was then shown that difficulties obtaining the evidence were observed or acknowledged primarily in relation to the 'parens patriae' welfare and protection considerations such as family circumstances, community support services and health services provision. (Chapter Twelve). When the risk and need for continued detention was still in doubt on the basis of the objective and subjective assessment, the tribunal sought to reach a conclusion on the basis of the control and care required for welfare and protection ; and it was at this stage that various difficulties arose including the problems associated with obtaining evidence about the necessary 'control' and/or 'care' facilities. Various interpretations were offered in Chapter Twelve as to why the difficulties in regard to obtaining evidence appeared to create a 'crisis' at this stage of the decision-making rather than in respect of the consideration of 'risk' factors.

The primary causes of difficulty obtaining evidence about control and/or care resources appeared to be the non-availability or inadequacy of reports rather than necessarily the non-availability of witnesses. It appeared to be 'information' they were lacking and not necessarily 'people' as a source of that information. This impression was reinforced by the fact that, despite all their efforts to overcome restraints and difficulties, on no occasion did they exercise their authority to require the presence of a witness. (Chapter Fifteen). Whilst the crisis in the decision

process did appear to affect primarily the 'patient's health or safety' and the issues implied in 'the patient should continue to be detained', there was evidence that there was separate consideration of facilities required to provide control for the 'protection of other persons'. It was evident that the dilemmas in regard to the behaviour and attitude of the patient (Chapter Thirteen) concerned the risk to others without support and control outside the special hospital. That 'risk to others' was a primary concern in considering rehabilitative needs was reflected in references by the tribunal in their inability to 'test out' the good progress and to the risk to others through a discharge direct into the community as opposed to transfer to a hospital in the home area. The predominant concern in relation to the anomalies in their rules and powers was their inability to ensure continued hospital care on a more voluntary basis for someone no longer considered to require maximum security care for the protection of others but vulnerable to relapse if discharged direct into the community. Although this problem primarily affected applications, it was experienced occasionally in respect of references when the hospital may have exhausted its own attempts to arrange transfer to another hospital and the tribunal could be aware that their own advice in support of transfer was unlikely to achieve the movement any sooner. Although the tribunal rarely found the need to adjourn consideration of references (4 occasions, 5.2%), these adjournments tended to involve allowing the hospital further time for hospital transfer enquiries with a view to recommending an alternative such as discharge should these enquiries continue to be unsuccessful. In respect of applications, where they had no authority to even recommend transfer, adjournments and other actions often concerned attempts

to support or influence the hospital in making such arrangements.

The 'control' decision-process was resolved by deciding against release because of the non-availability of the resources necessary to minimise the risk, or continuing to consider release with a view to relying on less tangible reassurances of support or taking the risk of discharge without such assurances.

In respect of the prescribed criteria upon which the tribunal were required to base their judgement, the crises arising from difficulties obtaining evidence did mainly relate to 'the patient's health or safety' and therefore the 'care' decision-process. The health and safety of the individual could be dependent on the provision of health or community resources and/or the support of the family. Even after deciding that 'the interest of the patient's health or safety' did not justify continued hospital detention, the tribunal did normally wish to reassure itself of the necessary support from community services and family before exercising the 'duty' to discharge the order. An allied crisis arose in respect of the issues implied in 'the patient should continue to be detained'. The duty was to discharge if detention was no longer considered justified ; yet they could be restrained in their 'duty to discharge' by the apparent need for continued health care or other rehabilitative support. The option of continued voluntary care was not available in the national security hospital and there could be uncertainty about the health service or other provision in the home area.

So the focus of the 'care' decision-process was on the

rehabilitative or residential resources considered necessary for the welfare and protection of the individual, beyond simply satisfying the 'patient's health and safety' criteria required to justify continued detention. It was particularly during this subsidiary stage or decision-process, that the tribunal was faced with dilemmas where the practical choices available to them were inadequate and with anomalies where their rules and powers were insufficient to the task. Their rules and procedures were insufficient to enable direct communication with national health service hospitals nor ensure adequate information from the local health and community services. Their powers did not allow them to order transfer to another hospital nor ensure necessary rehabilitative resources were available. When they did determine to continue the detention, they did justify it in 'the interest of the patient's health or safety'. Yet sometimes the decision was reached in the absence of any more satisfactory alternative. If they had been able to order transfer to voluntary care in a national health service hospital in the home area or ensure other rehabilitative care, they would perhaps not have chosen the option of continued compulsory care.

It was evident in the responses of the tribunal to applications (Chapter Fifteen), that this stage was yet a further hurdle for the applicant-patients which did not normally result in a definite decision to discharge the order. In fact this particular stage or subsidiary decision-process did not normally result in a definite decision to discharge or continue the detention. The tribunal decided to continue the detention of only 32(44.4%) applications, and at least a number of those would have fallen

at the previous hurdles in the tribunal decision-process. Only 9 (12.5%) of the applications considered during the empirical research resulted in a definite decision to discharge the order. A high proportion of applications (30,41.71%) were adjourned 'for the information to be obtained in such manner as they may direct or for the applicant or any other person concerned to produce the information'.⁽⁵⁾ It was evident that the judgments to adjourn were determined mainly at the stage of the 'care' decision-process (Chapters Twelve, Thirteen, and Fifteen).

The analysis of the tribunal decisions (Chapter Fifteen) demonstrated clearly that the use of adjournment by the tribunal was the primary evidence of innovatory action designed to overcome the dilemmas and anomalies with which they were faced. Various innovatory uses of their power to adjourn were identified:

- a) Using adjournment as a means of exercising a 'watching brief' as opposed to obtaining further information,
 - b) Attempting to influence the hospital team into a course of action not available to the tribunal,
 - c) Attempting to negotiate the health care provision in the home area through direct contact or indirect influence,
 - d) Seeking to influence through direct contact with the hospital team and/or the Department of Health, further clinical assessment or treatment whilst still in hospital,
- and
- e) 'Forcing the issue' through delayed discharge, making clear their intention to discharge the order after a given period.

(5) Mental Health Review Tribunal Rules 1960 S.I.No.1139
H.M.S.O. Rule 26(1)

It was evident through the empirical observation and interviewing after the hearings, that the tribunal would have exercised an option of 'delayed discharge' on a number of occasions had they that power. It was the conclusion of the researcher (Chapter Fifteen) that, in addition to the nine definite decisions to discharge in response to applications, there were at least ten other hearings (applications) where an equally definite decision to discharge was reached and delayed through adjournment to allow time for rehabilitative or residential resources to be arranged. This strongly supported the conclusion of the Review of the Mental Health Act⁽⁶⁾ that the extension of the powers of the mental health review tribunal to provide the authority for 'delayed discharge' was appropriate.

The evaluation of the rehabilitative facilities required to provide the necessary control and care was the stage of the tribunal decision-process at which the various crises were experienced, primarily in relation to their consideration of applications. They experienced great difficulties obtaining the information necessary to evaluate the rehabilitative facilities, they were faced with various anomalies and dilemmas in respect of their rules and procedures and the practical situation, and found their powers insufficient to resolve the conflict between 'balanced justice' and 'parens patriae' considerations. This conflict and the distinction between 'parens patriae' and 'balanced

(6) Review of the Mental Health Act 1959 HMSO Cmnd.7320 (1978)

justice' was presented and discussed more fully in Chapter Thirteen. (7) Prior to this stage, the primary concern of the tribunal was the question of whether continued detention was justified from a largely 'balanced justice' approach. Crises in the decision-process arose at the stage the need for rehabilitative support and resources were identified either as a safeguard to minimise the risk to others or more often for the welfare and protection of the individual. At each of the previous stages, a judgement had been reached as to whether or not the tribunal was certain that continued detention was necessary. Crises in the decision-process were unlikely to arise where they were certain of the continued 'danger' and need for detention.

It was at this stage of the tribunal decision-process that it became most evident that serious anomalies and dilemmas were experienced primarily in relation to their 'yes-no' powers

(7) Lemert, E. 'Social Action and Legal Change'
Aldine (Chicago 1970)

In this research project the social interactionist approach of such as Lemert (see also 'Social Pathology' McGraw-Hill New York 1951) has been used as one aid to studying the decision-process including the conflict between justice and welfare considerations. P. Parsloe ('Social Work and the Justice Model' Br. J. Social Work 6, 1 p. 71-89, Oxford, 1976) presented what she called the 'community or community involvement approach' as a distinct influence on judicial systems separate from the justice and welfare approaches. She saw the distinction in that, whereas the justice and welfare approaches saw criminals as different from non-criminals, the inter-actionist community approach saw the criminal as 'like any other citizens except that he is a victim of a selection process operated on behalf of society by its police, social workers and court officials'.

in response to applications and in terms of 'welfare and protection' considerations coming into conflict with the more narrow framework designed to emphasise 'justice and fairness'. It was at this stage that external restraints and difficulties imposed upon their deliberations and the tribunal found the need to go beyond their prescribed committee 'receiving information' approach to deal directly with external resources and/or seek to influence the provision of those resources. As part of the total model, these restraints and the tribunal activities in response were presented as a distinct parallel stage of the decision-process, arising alongside and as a consequence of the evaluation of the rehabilitative facilities required to provide control and care.

- (d) The process of dealing with restraints and difficulties in regard to obtaining information about the necessary rehabilitative resources.

Having not determined that continued detention was necessary because of the need for control and/or care which was unlikely to be available, the tribunal appeared to focus more determined attention on ensuring or seeking to influence the provision of rehabilitative resources to enable the individual to leave the security hospital. They tended to focus on distinct areas of care and support:

6) 'Hospital care' decision-process

Seeking to support or initiate hospital plans for transfer to national health service care and/or undertake direct investigations into health care provision.

7) 'Community services' decision-process

Investigations into community residential or other support services considered necessary for rehabilitation.

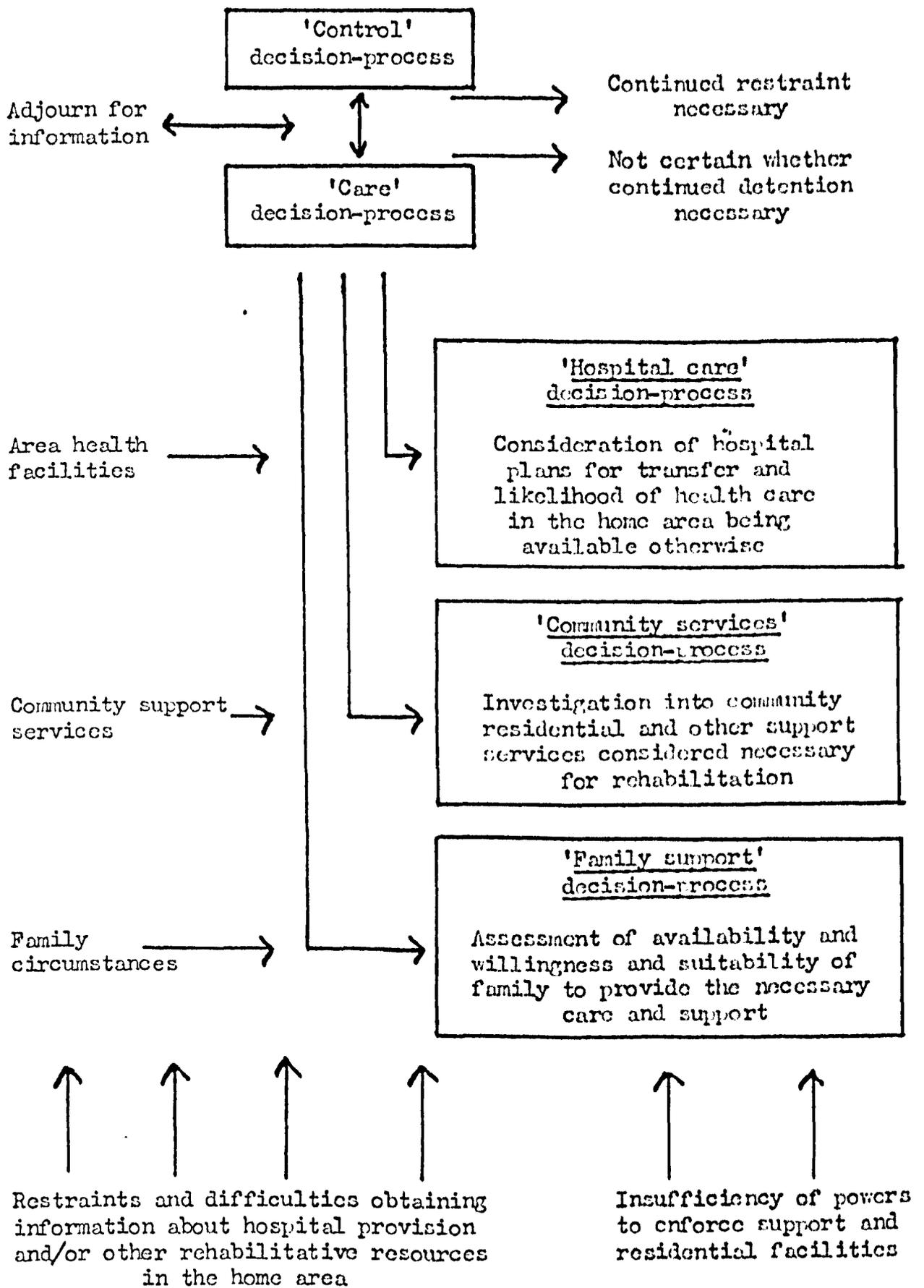
8) 'Family support' decision-process

Assessment of the availability of family and their willingness and suitability to provide the necessary care and support.

This stage was presented diagrammatically (Diagram D) to illustrate that enquiries into health care, community services, and the family were distinct and subsidiary to the 'control' and 'care' decision-processes which they were serving. They tended to take the form of 'cul-de-sacs' in that the tribunal did not have the power to enforce the provision of any resource or support considered necessary nor negotiate with any certainty a formal agreement with external agencies, the family or the patient. In their advice to the Home Secretary, they could only advise with no certainty their advice would be accepted nor that the rehabilitative resources would be provided. In response to applications, they could only discharge the order with no means of ensuring care and/or support nor that the patient would co-operate with any specific rehabilitative intentions on the part of the tribunal. Even if they had obtained reliable information on the availability of such as accommodation in a community hostel and decided to discharge on that understanding, it was inherent in the discharge of the detaining order that the individual could not be required to comply with the residential arrangements.

In considering the anomalies and dilemmas faced by the

DIAGRAM D: REHABILITATIVE RESTRAINTS AND DIFFICULTIES



tribunal (Chapter Thirteen); it was found that the predominant concerns in regard to difficulties arising from their rules and procedures related to the health care provision in the home area. Concern was observed and acknowledged about the need for more direct contact with the national health service hospitals in the home areas or some other means of obtaining information about the health service facilities more effectively. Similarly, in respect of their powers (particularly in response to applications), the main concerns were difficulties arising from their restricted powers and the impossibility of ensuring the necessary continued health care if the order detaining the individual was discharged. The tribunal were dependent upon the hospital team to initiate or continue their efforts to arrange a transfer to a local hospital. It was noted in Chapter Thirteen that the chairmen particularly emphasised their restricted legal powers being unable to order transfer to national health service care.

Dilemmas in regard to the need for continued hospital care were observed and acknowledged at a substantial proportion of the hearings. The unsatisfactory choice was between continuing the detention (in respect of an application) thus not reflecting their view that the patient was ready for progress or discharging the order with the risk to the patient or others if the necessary facilities were not provided. This dilemma could arise even when the hospital team were in support of the transfer. The tribunal could face a situation where exhaustive enquiries by the hospital and Department of Health into alternative hospital care had been unsuccessful. In advice to the Home Secretary, they could recommend transfer, knowing that this had already been

approved on the recommendation of the responsible medical officer. In response to applications, their powers were insufficient to influence the provision of informal hospital care elsewhere. They found the need to resort to the various innovatory actions identified and discussed above and in Chapter Fifteen. About half of the adjournments were acknowledged by the chairmen to be related to the need for continued hospital care. Direct contact with the responsible medical officer often related to their view of the need for continued hospital care in the home area, as did correspondence with the Department of Health and occasional direct contacts with health authorities beyond the special hospital.

In regard to the community support services, it was found that anomalies and insufficiencies in the tribunal rules did not present the same extent of problems in relation to obtaining evidence as with health care services(Chapter Thirteen). Yet serious problems were experienced in respect of their powers in response to applications. They were faced with the same restrictions whereby they were unable to ensure the necessary rehabilitative resources were available to support the patient on discharge. There was particular concern when there was judged to be the need for community residential care. Where dilemmas were acknowledged in regard to community support services, they reflected mainly their inability to ensure community residential provision. Again the concern was not expressed usually in terms of the need for information, but in respect of their limited powers. As with the health care, the decision-process in respect of the community support services involved an assessment of the services which were needed to support discharge from hospital, the likelihood of the hospital team arranging this or it being provided in ^{other} some way,

and the risks to the individual and/or others of discharge without those support facilities being available. Although adjournments were authorised as a means of obtaining further information, in fact they were applied as attempts to influence the provision of services through exerting pressure on the hospital. It was identified in relation to the obtaining of evidence(Chapter Eleven) and the tribunal decisions and actions (Chapter Fifteen), that on no occasion did they exercise their authority to require the presence of a witness from the community services. Also, the 'information' requested from the hospital in connection with the adjournment could be expressed explicitly as 'placement in the event of discharge'.

It was evident that the involvement of members of the family in the hearing and information about the family circumstances were influences on the tribunal decisions(Chapter Sixteen). There was a significant association between the attendance of family and decisions or advice in favour of discharge; with a tendency to advise transfer rather than discharge when the family were not involved. The tribunal were more likely to adjourn their consideration at hearings where the family did not attend. A similar pattern of relationship with judgements to discharge or transfer and adjournments in respect of the availability of reports on family circumstances supported the influence of family on the tribunal. Despite this finding, it was not evident that obtaining information about the family was considered to present serious difficulties at many of the hearings (Chapter Twelve). Yet, references to difficulties arising because of the non-availability of family witnesses were observed on more occasions than in respect of hospital or community witnesses, even though family were

present at about half the hearings (compared to hospital and community witnesses attending relatively few hearings) (Chapter Eleven).

There was something of a different emphasis with the family support decision-process in contrast with those in respect of the health care and community support services. On the one hand, there was the same assessment of the need for support, the likelihood of it being available, and the risk involved in discharge without the preferred support. Yet equally if not more influential was the response of the tribunal to the family. The evidence of their continued care and willingness to accept responsibility for the patient (reflected in their attendance at the hearing and other ways) appeared to be a positive influence toward judgements in favour of release. Whilst this phenomenon was observed with other 'witnesses', it was more apparent with the family. Although the sample was too small for statistical significance, there were occasions when the concerned support of such as a social worker or probation officer expressed through their attendance at the hearing was a positive influence on the tribunal. But the family provided the primary illustrations to suggest that it was not only in response to the patient that the tribunal could be influenced on a more 'personal' and subjective level. Presumably another practical consideration was that the presence of the family to make their own commitments to the tribunal provided a greater assurance of support on discharge that was normal with the statutory and other services.

The family support decision-process illustrated that the subsidiary decision-processes within the tribunal deliberations could in turn be analysed in more detail. In respect of the family,

closer study would probably confirm that the tribunal (or other decision-makers) were influenced by objective considerations and subjective responses, and faced with various restraints. Although anomalies in respect of the tribunal rules and powers did not appear to present serious problems in relation to the family, it was evident that the tribunal were faced with various dilemmas about family support and attitudes (Chapter Thirteen). These dilemmas were related, not only to tangible evidence of the availability and willingness or otherwise of family support, but also conflicts such as the willingness but doubtful ability of family to cope with the responsibility, the mixed attitudes of family members to the offences and the individual, and anxiety that the family could cover up any further offending.

These subsidiary decision-processes, concerned with evaluating 'hospital care', 'community services', and 'family support' considerations, were 'cul-de-sacs' in the total tribunal process which were particularly important in respect of applications. Having established that the need for continued detention was uncertain on the basis on objective and subjective assessment of the risk to others, issues of 'care' and 'control' came to the fore. Having determined that continued detention was not likely to be justified given the availability and acceptance by the individual of necessary support or safeguards, the decision-makers focused on the rehabilitative resources themselves. Whilst this stage applied to references, it was less important and did not present the same crises in the decision-process as with applications. Although the need and availability of rehabilitative resources were taken into account in giving their advice to the Home Secretary, the tribunal were not presented with the same immediate dilemmas and

conflicts as with their straight-forward 'yes-no' decisions about the need for continued detention. Rather than find the need to adjourn in an attempt to ensure the required facilities, they could incorporate in their advice to the Home Secretary the recommendation that certain rehabilitative arrangements should be a condition of release.

- (e) The process of dealing with doubt about the need for continued detention and determining the 'benefit of the doubt'.

A more complete model of the decision-process of such as the mental health review tribunal in regard to the assessment of 'danger to self and others' would identify an ultimate stage of the process which was concerned with dealing with 'doubt' about the need for continued detention. Normally, in response to serious offenders and such as special hospital patients, a definite conclusion at an earlier stage would be in favour of continued restraint. At each stage, doubt about the continued restraint would result in progressing to a further stage of the total decision-process before determining in favour of release. At each stage or 'hurdle', a number of individuals could 'fall' and be judged to require continued restraint for the protection of others or themselves. Eventually, there was a final stage where the residue of doubt about continued detention or release of the 'surviving' individuals was the focus of the decision-process, requiring a definite judgement response from the decision-makers:

9) 'Doubt' decision-process

Clarifying the nature of any serious doubt in respect of continued detention of the requirements to justify release.

10) 'Benefit of doubt' decision-process

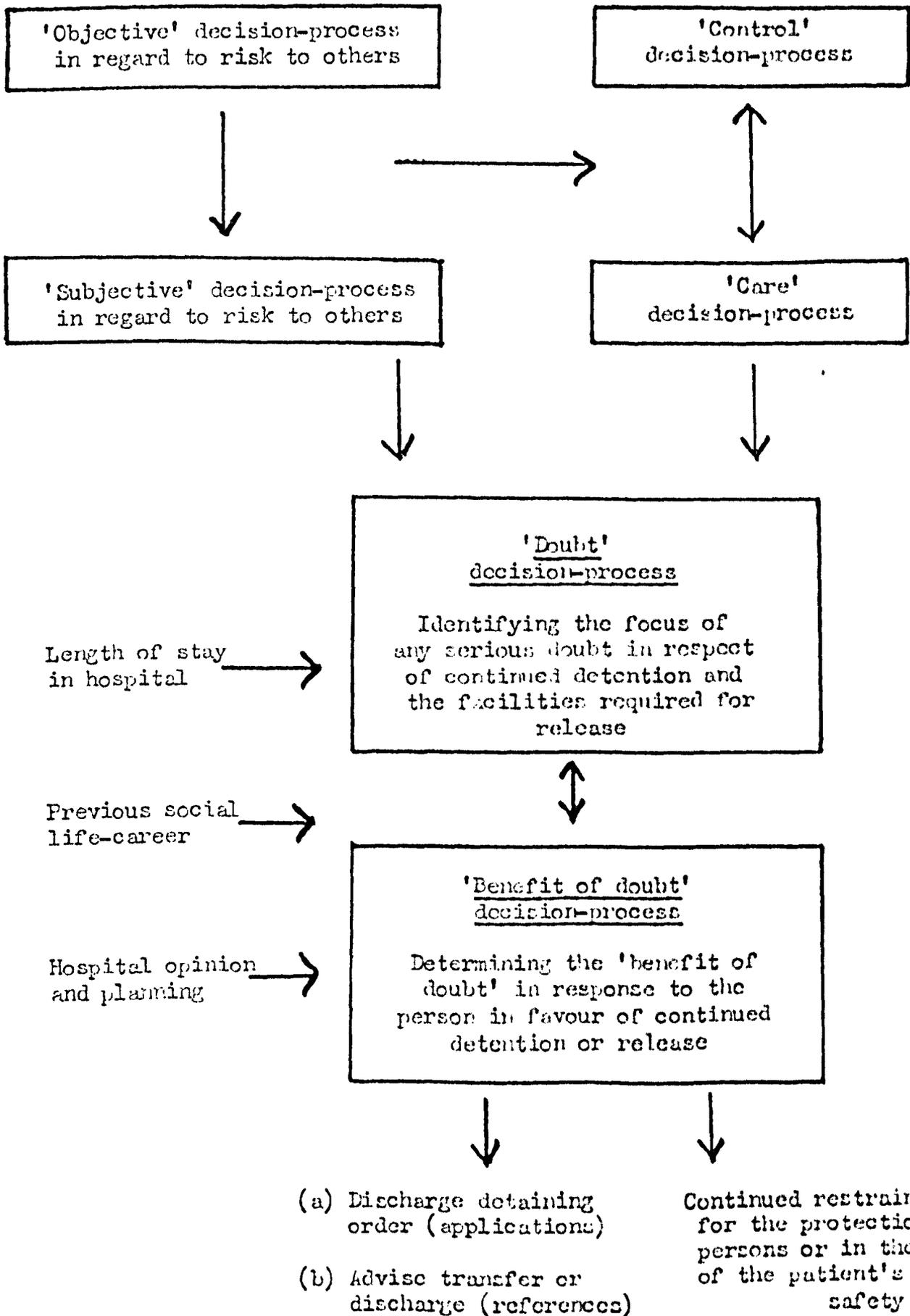
Determining the 'benefit of doubt' in response to the person in favour of continued detention or release.

This ultimate stage was presented diagrammatically (Diagram E) to illustrate that the implications of the nature of 'danger', the limitations of objective assessment, the uncertainties of subjective responses to the person, and all the doubts and difficulties about the need for control and/or care culminated in the need to give the benefit of the doubt in favour of the liberty of the individual or the protection of others.

In considering the evidence on which the tribunal based their judgements (Chapter Eleven), it was clear and acknowledged that uncertainty and doubt about the right course of action were influences on the judgements of the tribunal. In terms of the number of hearings at which it was identified, 'doubt' was one of the relatively less important factors (along with rehabilitative considerations). As with rehabilitative factors, 'doubt' evidently became an important influence once certainty about the need for continued detention had not been determined on more tangible 'risk' criteria. In considering the difficulties in obtaining evidence (Chapter Twelve), Hogarth's model⁽⁸⁾ was extended beyond the identifiable facts and the perceptions of the decision-makers to take account of the influence of the lack or uncertainty of facts. Uncertainty about facts and lack of information could contribute to the need for the decision-makers to supplement inadequate information through their own perceptions and interpretations.

(8) Hogarth J. 'Sentencing as a Human Process' Toronto University Press (Toronto 1971)

DIAGRAM E: DETERMINATION OF DOUBT AND 'BENEFIT OF DOUBT'



In connection with the anomalies and dilemmas with which they were faced (Chapter Thirteen), the tribunal made various references to being unable to 'test out' the person and the question of whether or not to 'take the risk'. This was evidently related both to their own subjective uncertainty about whether or not to trust the individual and their inability to ensure the necessary support and safeguards on discharge. In regard to the disagreements between members (Chapter Fourteen), it was suggested that, rather than being a potential for disagreement and conflict, the uncertainty and doubt contributed to the flexibility which enabled the tribunal to move together to a consensus and the pressures toward a mutually-supportive 'group' approach to their difficult task.

So 'doubt' was an invariable component of a decision to release a serious mentally abnormal offender. If doubt had been resolved at an earlier stage, it would have been in favour of continued detention. The doubt did not arise from a single source nor was it a straight-forward factor of influence. Doubt was associated with:

- i. the impulsive and unpredictable nature of 'danger',
 - ii. the inadequacy and non-availability of objective information,
 - iii. the insufficiency of their rules and powers,
 - iv. the uncertainties inherent in the subjective response to the dangerous individual,
- and
- v. uncertainties about rehabilitative provision and social support.

'Doubt' and 'risk' were closely associated concepts. It was evident that 'doubt' was resolved through a process of determining

whether or not to 'take the risk'. The evidence of this research was that, having not determined the need for continued detention at the previous stages of the decision-process, the 'benefit of the doubt' was likely to favour the individual and his release from detention. (Chapter Seventeen) The association between the nature of 'danger' and the social identity of a 'person' was discussed in more detail in Chapter Eighteen.

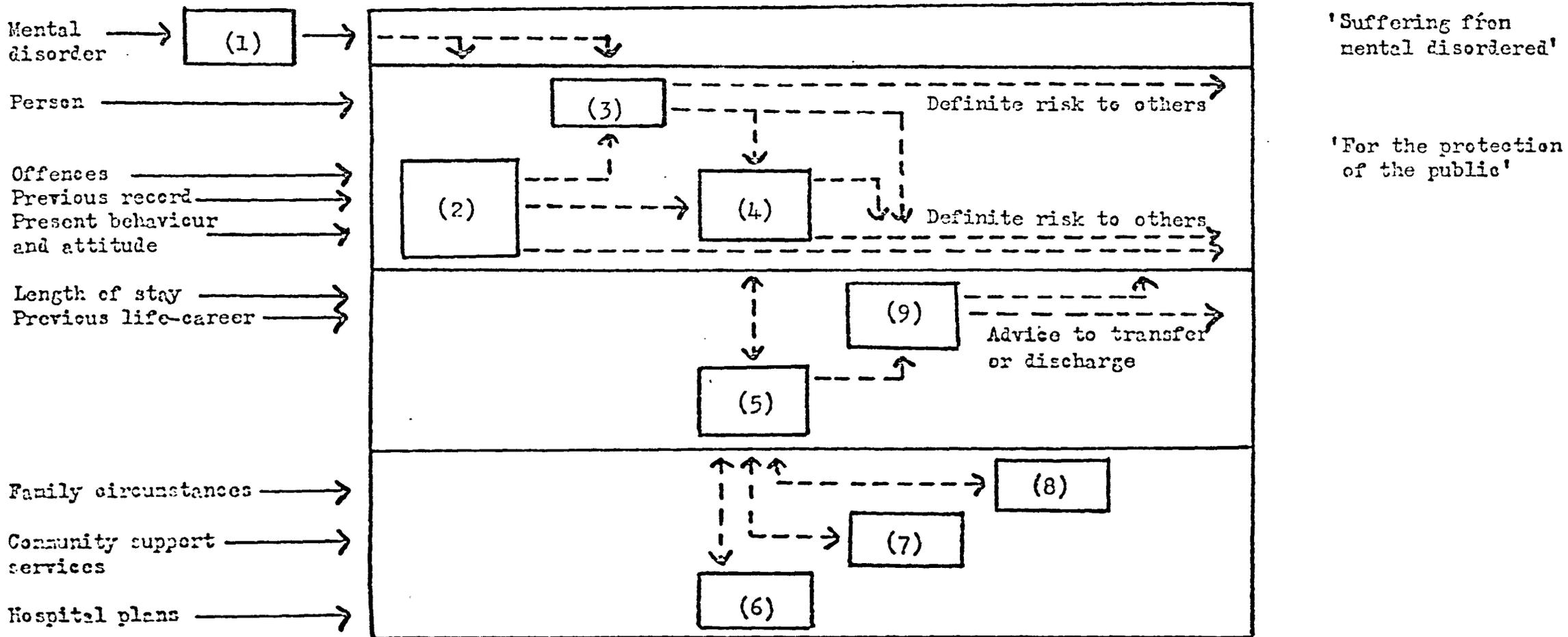
In regard to the tribunal decision-process, the ultimate stage of dealing with doubt and determining the benefit of the doubt was more straight-forward with the hearings concerned with giving advice to the Home Secretary. Whilst 'doubt' was still a component of any judgement in favour of release, it did not have the same immediate influence nor present the same acute crisis as could be the case with applications. Doubts still arose from the nature of 'danger' and the insufficiency of objective and subjective assessment; but the same difficulties did not arise in respect of their powers and the rehabilitative resources. As they had no power to order the release of the individual (being able only to advise the Home Secretary), they were able to recommend the need for specified care or support without the same immediate concern for their availability. In this respect, the 'benefit of doubt' decision-process was not as relevant and distinct from identifying areas of doubt as with applications, where the tribunal had the power and 'duty' to discharge the detaining order if detention was no longer justified.

The decision-process in response to references from Home Secretary

The complete decision-process in response to references from the Home Secretary was presented diagrammatically (Diagram F). It

DIAGRAM F

TRIBUNAL DECISION-PROCESS IN RESPONSE TO REFERENCES



IN-PUT

DECISION-PROCESS

OUT-PUT

was presented separately from the decision-process in response to applications because of the various distinctions identified above. In response to references, the mental health review tribunal did not have the authority, nor the power to free the individual through discharging the order authorising detention. Therefore they did not have the responsibility of determining the 'benefit of the doubt' nor deciding whether to 'take the risk'. As they were unable to force the issue through their authority to release the individual from detention, they had little negotiating power to influence the action of others. In exercising the responsibility to advise the Home Secretary, they were not normally faced with the anomalies and dilemmas which applied to decision-makers with a more practical responsibility for release. Where such occasional crises did arise, the anomalies and dilemmas did not so much affect the decision-process of the tribunal but more the wider decision-making context. This was illustrated by their ability to recommend transfer to an open national health service hospital or conditional discharge into the community. In making such recommendations, they could be aware that the hospital team had already obtained approval for such a course of action and had been attempting unsuccessfully to gain the cooperation of the responsible health and/or community authorities for some time. The anomalous nature of the situation was not related directly to their own rules and powers.

Therefore, as illustrated in Diagram F, the formal-structural approach and straight-forward input-output model were more sufficient to account for the decision-process in response to references. All the five stages identified above applied (with the various subsidiary decision-processes), but there was not the need to incor-

porate the restraints arising from external difficulties and the insufficiency of their powers. Although the model was more complex than a single 'black-box' processing the input, each of the subsidiary decision-processes could be presented more adequately in input-output terms within the formal structure. In this, the tribunal were representative of any body acting in an 'advisory' capacity in respect of 'dangerous individuals' without any authority or responsibility for the implementation of release decisions. The subjective evaluation of the person was just as necessary and important, in response to the 'anxiety and threat' aspect of 'danger' and the 'doubt' inherent in any objective assessment. Yet the determination of the 'benefit of the doubt' was not as demanding when the role was advisory with the responsibility elsewhere.

The crises which were identified in practice within the tribunal decision-process in response to references related mainly to the tribunal choosing to extend their interest and involvement beyond a strictly advisory role. Given the very distinct differences in their responsibilities in response to applications and references, it was not surprising that at times they should seek to influence the actual implementation of their judgements. When this was evident through occasional adjournments and direct approaches to health agencies, the activity was extraneous to their advisory role.

Although the findings and conclusions about the tribunal's consideration of applications were more representative of decision-making about people identified as 'mentally abnormal' and 'dangerous', there were certain practical implications of the findings in regard

to references:

- a) The roles and responsibilities of the mental health review tribunal were so distinct and different in response to applications and references that it brought into question one body being required to fulfil such distinct roles,
- b) As even their 'advisory' judgements about the 'dangerous' individual involved the important subjective reaction to the person, the effectiveness of other advisory bodies without the same face-to-face contact with the individual concerned was brought into question.
- c) Similarly, so many of the ultimate decisions in regard to the initial detention and release of mentally abnormal offenders were made by people in such government agencies as the Home Office with no direct involvement with the individual.

It was possible that the distinct roles of the tribunal created difficulties more through the 'confusion' in other people's minds than in the decision-making of the tribunal itself. They appeared to be conscious of the unrealistic expectations on them in respect of their advice to the Home Secretary, as patients and others looked to them to exercise an authority they did not have. Conversely, the unlimited nature of their discretion to advise the Home Secretary may have contributed to an expectation from such as relatives of the patient that the tribunal had the authority or influence to arrange transfer to health care in the home area of patients who were not further restricted under the Home Secretary. Even if the mental health review tribunal continued to fulfil such distinct roles in response to applications for discharge and references for advice, some form of greater 'separation' (perhaps in the organization and preparation of the hearings) appeared to be

required to alleviate the confusion between the roles.

In addition to receiving the advice of the mental health review tribunal, the Home Office was able to refer the case of a mentally abnormal offender to the Aarvold advisory board.⁽⁹⁾ This was a central body advising the Home Office on a national basis, as opposed to being regionally based as with the mental health review tribunal. Although both advisory, the tribunal and the Aarvold Board had distinct emphases. Whilst the tribunal was primarily concerned with protecting the individual from unjustified detention, the Aarvold Board was established as a further safeguard for the protection of the public. As a central body, the Aarvold Board was more dependent on the written evidence of others, not only about objective considerations but also in respect of the trust and confidence in the individual. Although 'regionalisation' could be a means of bringing the Aarvold decision-makers closer to the people they were assessing, it would also high-light the over-lap with the advisory function of the mental health review tribunal.

It was likely that where the detaining authority (such as the Home Office) relied on the advice of others (such as the responsible medical officer and the mental health review tribunal), there would be an excessive emphasis on a strictly 'objective' approach to their decision-making. The emphasis on objective evidence to

(9) Established as a result of the Aarvold Committee 'Report on the Review of the Procedures for the discharge and supervision of psychiatric patients subject to special restrictions' Cmnd.5191.HMSO, (1973)

justify the release of a mentally abnormal offender would be excessive if the more subjective response to the 'threat and anxiety' aspect of danger was denied. Any emphasis on requiring the absolute confidence of the advising decision-makers denied the 'doubt' and 'risk' inherent in dealing with a 'dangerous individual'. As the distance between the individual and the ultimate decision-makers widened, it was inevitable that greater caution would prevail and the proportion of false-positives would increase.

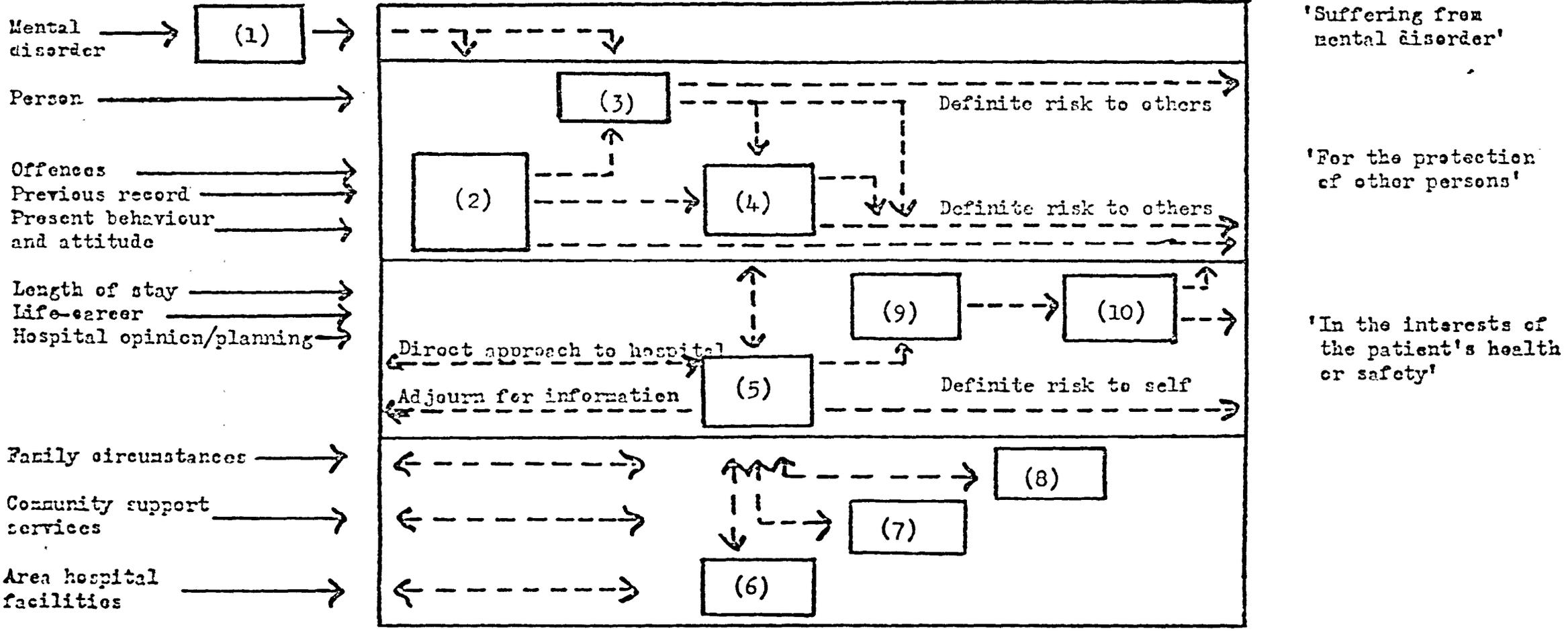
A more complete model of decision-making about 'danger to self and others'

The complete decision-process in response to applications, as presented in Diagram G, was more representative of the decision-making about the release or continued restraint of individuals considered mentally disordered and a danger to others. Using the hospital clinical team as the comparison, the main differences were in the degree of direct contact with the individual available to the hospital team and the opportunity for planned rehabilitation in cooperation with other care and support agencies. Despite these differences, all the subsidiary decision-processes applied as did the external restraints and difficulties in respect of support facilities outside the hospital.

Therefore, Diagram G was presented as a more complete model of the decision-process in respect of individuals previously identified and restrained as 'dangerous' and being considered for release. The only variations with decision-makers with the direct responsibility for the care and restraint of the individual would be the ability to approach rehabilitative support

DIAGRAM 6

TRIBUNAL DECISION-PROCESS IN RESPONSE TO APPLICATIONS



Restraints and difficulties obtaining information about hospital provision and/or other rehabilitative resources in the home area



Insufficiency of powers to enforce support and residential facilities

INPUT

DECISION-PROCESS

OUT-PUT

facilities more directly and to maintain a continuous review assessment without the same need of an appellate body such as the tribunal to adjourn. In other words, the 'direct approach to hospital' and 'adjourn for information' was part of the model for appellate bodies such as the tribunal but not with decision-makers with more direct responsibility for the 'dangerous individual'.

In recommending that there should be an independent body to review the use of compulsory powers of admission, the Percy Commission advised that the tribunal should '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 be more appropriate, or whether he could not be discharged from care altogether'.⁽¹⁰⁾ This appeared to assume an ability to organise or require the movement of the individual to less restrictive care which did not apply in practice. This was acknowledged in the actual legislation in respect of the mental health review tribunal which had only the authority to 'direct that the patient be discharged'.⁽¹¹⁾

The inability of the tribunal (and even the responsible medical officer) to require the provision of rehabilitative or care provision to enable the individual to move to a less restricted

(10) Royal Commission on the Law relating to Mental Illness and Mental Deficiency, Cmnd.159.HMSO.(1957)

(11) Mental Health Act 1959, section 123.

situation brought into question the effectiveness of the tribunal as a safeguard of the liberty of the individual. There was often a conflict between considerations of 'welfare and protection' and 'balanced justice', when the tribunal were reluctant to exercise their 'duty to discharge' without the assurance of support facilities. As clearly evidenced through this research project, the tribunal used their right to adjourn in attempts to resolve this conflict and protect the rights of the patient. They clearly demonstrated that they would have used the power of a 'delayed discharge' on a number of occasions in preference to adjournment if that preferred method of resolving the conflict and protecting the liberty of the individual had been available.

Even though the tribunal consideration of applications was as much if not more concerned with the 'health, safety or the protection of other persons' than with 'danger to self and others', the lack of obvious and observed recognition of any distinction between these phrases during the tribunal hearings was likely to be representative of other decision-makers such as the hospital team.

A framework for the assessment of 'danger to self and others' or the 'dangerous individual' was presented as an appendix to this chapter. This framework was based on the implications for the process of assessing 'danger' arising from the findings of the research project and the more complete model of decision-making developed from the research findings. The researcher did not present the framework as an aspect of the empirical research findings but as a useful guide for approaching the assessment of a 'dangerous individual' based on the findings.

Whilst the model (Diagram G) and the framework for assessment could apply to some extent to individuals where the 'danger' was less severe and aroused less anxiety, they were presented as relevant primarily to the assessment of individuals, previously identified as 'dangerous' in the sense of:

- (a) objective evidence of serious offences or behaviour involving the risk of physical harm or sexual assault
 - (b) Serious 'threat and anxiety' about the individual on the part of others.
- and
- (c) A considered decision to restrain the individual for the protection of other persons and/or self.

The framework made no attempt to apportion different responsibilities to the various disciplines who were likely to be involved with the care and rehabilitation of people identified as 'dangerous individuals'. Certain aspects of the assessment process were traditionally expected of specific professionals such as psychiatrists, psychologists, social workers and educationalists. Yet the framework was presented as a guide to the 'human' process of a group of individuals with the prescribed responsibility of assessing another individual previously defined as 'dangerous'. This approach left the members of the group to apportion their own allocation of assessment responsibilities. Also it served to emphasise that, after all the professional expertise and skill had been applied, the process was essentially 'human' requiring a personal response by the decision-makers to the 'dangerous individual'.

APPENDIX

FRAMEWORK FOR THE ASSESSMENT OF THE 'DANGEROUS INDIVIDUAL'

STAGE ONE : ASSESSMENT OF RISK ON BASIS OF OBJECTIVE EVIDENCE

1. A careful distinction should be made between objective considerations and the more subjective evaluation of the person, the offence and the situation.

The decision-makers should aim to;

- (a) clarify the extent to which continued restraint of the individual was justified on the basis of observable facts and verified information,
 - and (b) ensure that such objective facts and information was not used inappropriately to justify a more subjective 'anxiety and threat' arising from the reactions of the decision-makers to the person.
-
2. The objective assessment of the risk to others should be based on:
 - (a) The nature and severity of the offences and/or behaviour which led to the current detention,
 - (b) The previous record of offences and/or anti-social behaviour,
 - (c) The 'dangerous situation' and/or circumstances within which the offences and/or behaviour occurred and the 'triggers' in the situation,
 - (d) The present social performance and achievements compared to previous social achievements and social life-career,

- (e) The present attitudes of the individual towards the past behaviour and future responsibilities,
 - (f) Clinical assessment of the 'psychiatric' condition of the person, as a contribution to the previous 'dangerous' behaviour and with regard to future clinical prognosis.
3. In respect of the particular 'dangerous individual' the decision-makers should seek to clearly identify the nature of the risk associated with the individual and the potential victims at risk.
4. A decision should be reached whether the risk to the potential victims on the basis of the objective evidence was sufficient to justify the continued restraint of the individual.
5. Whether or not the decision-makers were certain of the need for continued detention, they should seek to identify:
- (a) The aspects of the objective assessment where the factual information was insufficient and further investigation was desirable,
 - (b) The nature and focus of any 'doubt' about the need for continued detention on the basis of the objective evidence,
 - (c) The nature of any continuing 'risks' from the individual which required further attention, regardless of whether they were sufficient to justify continued detention or not.

STAGE TWO : EVALUATION OF SUBJECTIVE RESPONSE TO INDIVIDUAL

6. If the need for continued restraint was in doubt through the assessment of the risk on the basis of objective evidence, there should be a studied evaluation of the subjective responses and perceptions of the decision-makers and others towards the individual and the prospect of release from detention.

7. The 'subjective' evaluation should be based on:
 - (a) The extent to which the decision-makers and others continued to experience 'threat and anxiety' within their relationship with the individual or in response to face-to-face interaction with him,
 - (b) The extent to which the decision-makers and others experienced feelings of sympathy and confidence in the individual and were able to perceive him as a person to be trusted,
 - (c) An attempt to identify the cause of the anxiety of others and the nature of the threat feared by others,
 - (d) An attempt to identify the justification for the feeling of confidence and the willingness to trust the person with social responsibilities again.
 - (e) Evidence of the formation of or potential for constructive emotional relationships with the decision-makers and/or other significant people which could be used to help the person regain his self-respect and a responsible place back in society.

8. A decision should be reached whether the 'threat and anxiety' which others continued to experience in response to the individual, in support of the objective evidence of the risk to others, was sufficient to justify continued restraint.

9. Whether or not the decision-makers were certain of the need for continued detention, they should seek to identify:
 - (a) The aspects of the subjective evaluation which were restricted by insufficient information and/or experience of the individual,
 - (b) The nature and focus of any 'doubt' about the need for continued detention on the basis of the subjective evaluation,
 - (c) The nature of any continuing 'risks' from the individual in respect of his relationships with others and the opportunities available or to be created for the formation of the constructive emotional relationships necessary for rehabilitation.

STAGE THREE : ASSESSMENT OF REHABILITATIVE NEEDS

10. If the need for continued restraint was in doubt through the assessment of the risk on the basis of objective evidence and subjective evaluation, there should be an examination of the rehabilitative considerations necessary for the release from detention and resettlement of the individual into open society.

11. The assessment of the rehabilitative needs of the individual and for the protection of others should be based on:
 - (a) An assessment of the ability of the individual to live an independent social life in the community without serious self-neglect or exploitation by others,
 - (b) An assessment of the social controls considered necessary for the protection of others in any potential 'dangerous situation',
 - (c) Clinical assessment of the further medical and psychiatric treatment and support required before and/or following release from detention,
 - (d) An assessment of further social training and educational needs,
 - (e) An assessment of the need for 'half-way' residential rehabilitation and/or continued social work support to the resettlement into open society,
 - (f) An assessment of family circumstances and relationships with the individual,
 - (g) An assessment of formed or potential constructive emotional relationships with support agencies and others in open society.
12. A decision should be reached as to whether the further help and support available or likely to be available to meet the specific care and control needs of the individual was sufficient to justify release from detention.
13. The decision-makers should seek to identify:
 - (a) The aspects of the care and control needs of the individual and the support facilities available in

- response to those needs which required further investigation before a decision can be finalised,
- (b) The nature and focus of any 'doubt' about the care and control required in support of release from detention,
 - (c) The nature of any continuing 'risks' to the individual or others in respect of the need for continued care and/or control.

STAGE FOUR : PRELIMINARY DETERMINATION OF 'BENEFIT OF THE DOUBT'

14. Before the decision-makers responsible for the restraint of the individual could proceed to negotiating a rehabilitative release plan with the individual and the various support facilities, they were required normally to reach a preliminary decision in regard to the justification for release. If the need for continued detention remained in doubt on the basis of objective evidence and subjective evaluation and examination of rehabilitative considerations, this preliminary decision should be based on an examination of the areas of doubt.
15. The preliminary determination of the 'benefit of the doubt' should be based on an examination of:
- (a) The nature and focus of any 'doubt' about the need for continued detention on the basis of the objective evidence,
 - (b) The nature and focus of any 'doubt' about the need for continued detention on the basis of the subjective evaluation,

- (c) The nature and focus of any 'doubt' about the care and control required in support of release from detention,
- (d) The availability of the further information identified as desirable in respect of the objective assessment and the subjective evaluation and the care and/or control needs,
- (e) Length of stay in detention in relation to the offences and/or behaviour which led to the detention,
- (f) The confidence and 'trust' expressed in the individual by others with whom he had a significant relationship,
- (g) The emotional responses of the decision-makers to the individual.

16. A decision should be reached as to whether, taking into account the areas of doubt which were inevitable because of the nature of 'danger' and the insufficiency of information, the 'benefit of the doubt' should be given in favour of the individual and release from detention.

STAGE FIVE : INVESTIGATION OF REHABILITATIVE SUPPORT

17. If the decision-makers were inclined to give the 'benefit' of the doubt' in favour of release from detention, there should be an examination through direct involvement of the care and support available or which could be negotiated to aid the successful resettlement of the individual into open society.

18. The development of the plan to rehabilitate the

particular 'dangerous individual' into open society

should be based on:

- (a) Investigation into the further information identified as desirable in respect of the objective assessment and the subjective evaluation and the care and/or control needs,
- (b) The nature of any continuing 'risks' from the individual which required further attention,
- (c) The nature of any continuing 'risks' from the individual in respect of his relationships with others,
- (d) The nature of any continuing 'risks' to the individual or others in respect of the need for continued care and/or control,
- (e) Investigation into continued health care provision in open society,
- (f) Investigation into community residential or other support services considered necessary for rehabilitation,
- (g) Assessment of the availability of family and their willingness and suitability to provide care and support,
- (h) The opportunities available or to be created for the formation of the constructive emotional relationships necessary for rehabilitation.

19. A decision should be reached as to whether the care and support available and/or negotiated as part of the rehabilitative plan was sufficient to justify release from detention.

20. The decision-makers should seek to identify:

- (a) The aspects of rehabilitative support considered essential to the rehabilitative release plan but which are unavailable or uncertain.
- (b) The aspects of the desired rehabilitative support which are unavailable or uncertain yet not considered essential,
- (c) The resistances from health or community services and/or family which could put at risk the rehabilitation of the individual,

STAGE SIX : ULTIMATE DETERMINATION OF 'BENEFIT OF DOUBT'

21. As 'doubt' was an invariable component of a decision to release a 'dangerous individual' and 'benefit of the doubt' was inherent in the acceptance of the individual as a 'person' to be returned to society, the final stage of assessing whether the individual should continue to be restrained as 'dangerous' should involve the acknowledgement of the areas of doubt and the subjective trust and sympathy of the decision-makers towards the individual.

22. The final decision should be based on:

- (a) The nature and focus of any remaining 'doubt' about the need for continued detention in respect of the objective assessment and the subjective evaluation and the care and/or control needs,
- (b) The nature of any continuing 'risks' from the individual on the basis of objective evidence and subjective evaluation and the need for continued care and/or control,
- (c) The aspects of the rehabilitative support plan which were unavailable or uncertain.

- (d) Length of stay in detention in relation to the offences and/or behaviour which led to the detention,
- (e) The confidence and 'trust' expressed by significant others with whom the individual had formed or had the potential to form constructive emotional relationships,
- (f) The emotional responses of the decision-makers to the individual.

23. A decision should be reached as to whether, despite the remaining 'doubts' and continuing 'risks', the 'benefit of the doubt' should be determined in favour of the individual and the implementation of the rehabilitative release plan.

24. As the areas of doubt and continuing 'risks' had been identified as clearly as possible, once the decision to support release was determined the emphasis in the 'constructive emotional relationship' with the individual should be on the 'trust and confidence' in him as a 'person' inherent in the 'benefit of the doubt' and 'taking the risk'. This was important to the rehabilitative prognosis as a positive aspect of the 'equation' which had determined that release was justified.

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ASSESSMENT OF DANGEROUSNESS (MENTAL HEALTH REVIEW TRIBUNAL)

QUESTIONNAIRE - STRICTLY CONFIDENTIAL

Q.No.	Question	Code	Col. No.
<u>SECTION ONE OBSERVATION OF TRIBUNAL HEARING</u>			<u>Card One</u>
1.	What is the name of the subject?(uncoded)	_____	
2.	What is the date of the hearing?(uncoded)	Day ... Month ... Year ...	
3.	What is the code number of the hearing?	_____	1 2 3
4.	Who was the legal chairman? (code to be added)	_____	4
5.	Who was the medical member? (uncoded)	_____	
6.	Who was the lay member? (uncoded)	_____	
7.	Who was the tribunal clerk? (code to be added later)	_____	5
8.	Was the patient interviewed?	Yes 1 No 0	6
9.	Was any family interviewed?	Yes 1 No 0	7
	Details	_____	
10.	Was the subject legally represented?	Yes 1 No 0	8
	Name of solicitor	_____	
11.	Were any hospital staff interviewed?	None 0 RMO only 1 RMO and social worker 2 RMO and nurse 3 RMO and other 4 social worker only 5 nurse only 6 other 7	9

12.	Were representatives of any community services interviewed?	Yes	1	No	0	10
	Details	<hr/>				
13.	Were the usual hospital reports available (hospital statement, ward file, etc)?	Yes	1	No	0	11
	Details of any variation	<hr/>				
14.	Were the home circumstances reports available from social services?	Yes	1	No	0	12
15.	Were any other reports available?	Yes	1	No	0	13
	Details	<hr/>				
16.	What was the length of time of the hearing?	Time of starting	_____			14
		Completion	_____			
		Length of time	_____	mins		
		Less than 30 mins			0	
		30 - 45 mins			1	
		45 - 60 mins			2	
		60 - 75 mins			3	
		more than 75 mins			4	

DID THE TRIBUNAL MEMBERS REFER TO THE NATURE OF THE RISK ASSOCIATED WITH THE PERSON BEFORE THEM IN THE FOLLOWING TERMS:

17.	Risk of direct physical violence	Yes	1	No	0	15
18.	Indirectly endangering others	Yes	1	No	0	16
19.	Sexual assault	Yes	1	No	0	17
20.	Damage to property	Yes	1	No	0	18
21.	Psychological harm	Yes	1	No	0	19
22.	Property offence (eg larceny)	Yes	1	No	0	20
23.	Other	Yes	1	No	0	21
	Details	<hr/>				
		<hr/>				

24.	How did the tribunal as a whole appear to view the primary risk (which of above)?	Not clear	0	22
		Direct physical violence	1	
		Endangering behaviour	2	
		Sexual assault	3	
		Damage to property	4	
		Psychological harm	5	
		Property offence	6	
		Other (specify)	7	

25.	Was there any clear disagreement in regard to the nature of the risk?	Yes	1	No	0	23
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Details

26. Further comments on the nature of risk as perceived by the tribunal members.

TO WHOM DID THE TRIBUNAL MEMBERS REFER AS POTENTIAL VICTIMS

27.	People generally	Yes	1	No	0	24
28.	Adults own sex	Yes	1	No	0	25
29.	Adults opposite sex	Yes	1	No	0	26
30.	Children	Yes	1	No	0	27
31.	Elderly	Yes	1	No	0	28
32.	Self	Yes	1	No	0	29
33.	Specific other	Yes	1	No	0	30

Details

34	Other (specify)	Yes	1	No	0	31
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35	Who appeared to be seen as most at risk?	Not clear	0	32
		People generally	1	
		Adults same sex	2	
		Adults opposite sex	3	
		Children	4	
		Elderly	5	
		Self	6	
		Specific other	7	
		Other	8	

36.	Was there any clear disagreement in regard to the potential victims?	Yes	1	No	0	33
	Details	<hr/>				
37.	Further comments on potential victims as perceived by the tribunal members.	<hr/>				
		<hr/>				

IN CONSIDERING EVIDENCE, DID THE TRIBUNAL MEMBERS SHOW REGARD FOR THE FOLLOWING:

38.	Mental disorder	Yes	1	No	0	34
39.	Immediate offence/behaviour	Yes	1	No	0	35
40.	Circumstances of immediate offence	Yes	1	No	0	36
41.	Previous offences/behaviour	Yes	1	No	0	37
42.	Personality of patient	Yes	1	No	0	38
43.	Family background	Yes	1	No	0	39
44.	Previous social life-career (school, work, social, etc)	Yes	1	No	0	40
45.	Current family circumstances	Yes	1	No	0	41
46.	Present behaviour/attitudes	Yes	1	No	0	42
47.	Community support services	Yes	1	No	0	43
48.	Social adequacy of patient	Yes	1	No	0	44
49.	Length of stay in Rampton	Yes	1	No	0	45
50.	Hospital opinion and planning	Yes	1	No	0	46
51.	Other	Yes	1	No	0	47

Details

52.	Did they admit to be influenced by uncertainty or benefit of the doubt?	Yes	1	No	0	48
53.	Did they admit to be influenced by their subjective feelings or intuition about the patient?	Yes	1	No	0	49

54.	Did one factor appear to be more influential with the legal member?	Mental disorder	1	50		
		Immediate offence/behaviour	2			
		Previous record	3			
		Personality of patient	4			
		Previous life-career	5			
		Family circumstances	6			
		Community support services	7			
		Length of stay	8			
		Other (specify)	9			
		<hr/>			Not clear	0
55.	Did one factor appear to be more influential with the medical member?	Mental disorder	1	51		
		Immediate offence/behaviour	2			
		Previous record	3			
		Personality of patient	4			
		Previous life-career	5			
		Family circumstances	6			
		Community support services	7			
		Length of stay	8			
		Other (specify)	9			
		<hr/>			Not clear	0
56.	Did one factor appear to be more influential with the lay member?	Mental state	1	52		
		Immediate offence/behaviour	2			
		Previous record	3			
		Personality of patient	4			
		Previous life-career	5			
		Family circumstances	6			
		Community support services	7			
		Length of stay	8			
		Other (specify)	9			
		<hr/>			Not clear	0
57.	Did one factor appear to be more influential with the tribunal as a whole?	Mental state	1	53		
		Immediate offence/behaviour	2			
		Previous record	3			
		Personality of patient	4			
		Previous life-career	5			
		Family circumstances	6			
		Community support services	7			
		Length of stay	8			
		Other (specify)	9			
		<hr/>			Not clear	0
58.	Was there any doubt expressed about the legal classification or diagnosis?	Yes	1	No	0	54

59. Was there any clear disagreement in regard to the evidence to be taken into account? Yes 1 No 0 55

Details _____

60. Further comments on the evidence taken into account by the tribunal members. _____

DID THE TRIBUNAL MEMBERS REFER TO DIFFICULTIES IN OBTAINING EVIDENCE REQUIRED TO REACH DECISIONS:

61. Reports not available Yes 1 No 0 56

Details _____

62. Available reports inadequate Yes 1 No 0 57

Details _____

63. Hospital witnesses not available Yes 1 No 0 58
Details _____

64. Family witnesses not available Yes 1 No 0 59
Details _____

65. Community services witnesses not available Yes 1 No 0 60
Details _____

66. Other evidence unavailable Yes 1 No 0 61
Details _____

67. To which category of evidence did the difficulties mainly relate?

	Not clear/not applicable	0	
	Mental disorder	1	
	Immediate offences/behaviour leading to detention	2	
	Previous life-career	3	
	Family circumstances	4	
	Community support services	5	
	Present behaviour/attitudes	6	
	Hospital treatment/planning	7	
	Other (specify)	8	

68. Further comments on:
 (a) difficulties obtaining evidence,
 (b) expressed concern about lack of knowledge,
 (c) expressed 'benefit of doubt' for or against release.

DID THE TRIBUNAL MEMBERS REFER TO DIFFICULTIES ARISING FROM INADEQUACIES IN THE PROCEDURES AND RULES

69.	In regard to the obtaining of evidence Details	Yes	1	No	0	63
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70.	In regard to the conduct of the tribunal hearing Details	Yes	1	No	0	64
-----	---	-----	---	----	---	----

71.	In regard to the powers of the tribunal Details	Yes	1	No	0	65
-----	--	-----	---	----	---	----

72. Further comments on references to inadequacies in the procedures and rules

DID THE TRIBUNAL MEMBERS REFER TO DIFFICULTIES ARISING BECAUSE OF THE NEED TO CHOOSE BETWEEN UNSATISFACTORY ALTERNATIVES

73.	Dilemmas associated with the need or otherwise for hospital care	Yes	1	No	0	66
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74.	Dilemmas associated with the patient's attitude and behaviour	Yes	1	No	0	67
-----	---	-----	---	----	---	----

75.	Dilemmas associated with family support and attitudes	Yes	1	No	0	68
76.	Dilemmas associated with community support services	Yes	1	No	0	69
77.	Dilemmas associated with public attitudes	Yes	1	No	0	70
78.	Any other dilemmas	Yes	1	No	0	71
79.	Further comments on references to difficulties in choices					

DID THERE APPEAR TO BE ANY CONFLICT OF OPINION AMONG THE TRIBUNAL MEMBERS

80.	In regard to the mental state of the patient?	Yes	1	No	0	72
81.	In regard to the degree of risk?	Yes	1	No	0	73
82.	In regard to the question of release?	Yes	1	No	0	74
83.	Further comments on the nature of any disagreements between members of the tribunal					

84.	By what process were disagreements mainly resolved?	Agreement through discussion	1			75
		Giving way to greater knowledge or experience	2			
		Majority decision	3			
		Adjourning decision	4			
		Avoiding decision	5			
		Other (specify)	6			
	Not applicable		7			

85.	Further comments on disagreements and the relative influence of members		
86.	What was the decision of the tribunal?	Not applicable (reference)	0 76
		No action	1
		Adjourn decision	2
		Reclassification	3
		Discharge order	4
		Other	5
87.	What was the advice given by the tribunal?	Not applicable (application)	0 77
		No action	1
		Adjournment	2
		Transfer to other hospital	3
		Discharge to community	4
		Other	5
88.	In regard to any adjournment, what was the reason given or nature of further enquiries?	Not applicable (no adjournment)	0 78
		Specifically accommodation	1
		Specifically hospital transfer	2
		Other rehabilitative (specify)	3
		To review patient's progress	4
		Other reasons (specify)	5
		Not clear	6
89.	Further comments on any innovative action or any unusual feature of this tribunal hearing		
90.	Further comments on the participants to this hearing		
	(a) legal member		
	(b) medical member		
	(c) laymember		
	(d) tribunal clerk		
	(e) patient		
	(f) family		
	(g) solicitor		
	(h) other		
91.	Card number	One	79

SECTION TWO

DETAILS OF SUBJECT FROM EXAMINATION OF RECORDS

Card Two

	What is the code number of the hearing?	_____	_____	_____	1	2	3
92.	From which Regional Health Authority did the subject originate? (code to be added)	Home town .. _____ RHA _____					4
93.	What is the subject's date of birth and age?	Date of birth	D ...	M ...	Y ...		5
		Under 18	0	30 - 39	4		
		18 - 20	1	40 - 49	5		
		21 - 24	2	50 - 59	6		
		25 - 29	3	Over 59	7		
94.	What is the sex of the subject?	Male	0	Female	1		6
95.	What is the subject's marital status?	Unmarried	0				7
		Married	1				
		Widowed	2				
		Legally separated	3				
		Divorced	4				
96.	What is the legal classification of the subject?	Mental illness	0				8
		Psychopathic	1				
		Subnormality	2				
		Severe subnormality	3				
		Unclassified	4				
97.	Under what order is subjectx detained?	6th Schedule (unrestricted)	0				9
		Section 26	1				
		Section 60	2				
		Section 72	3				
		6th Schedule (restricted)	4				
		Section 60/65	5				
		Section 72/65	6				
		Section 5(1)(c)	7				
		Other (specoify)	8				
98.	What were the/ ^{criminal} offences which led to current detention? Detail	None	0				10
		Petty theft/larceny etc	1				
		Serious property (robbery etc)	2				
		Indecent assault	3				
		Rape	4				
		Criminal damage	5				
		Arson	6				
		Violence against person	7				
		Manslaughter/murder	8				
		Other (specoify)	9				

99.	If not admitted from court for criminal offences, what was source?	Transfer from other hospital	0	11
		Transfer from prison	1	
		Transfer from borstal	2	
		Direct from community	3	
		Other source (specify)	4	
		<hr/>		
100.	If not criminal offences, for what behaviour was subject detained in Rampton?	Violence to persons	0	12
		Damage to property	1	
		Endangering behaviour	2	
		Self injury	3	
		Absconding	4	
		Other (specify)	5	
<hr/>		Not applicable	6	
101.	Who were the victims of the offences or misbehaviour?	People generally	0	13
		Adults own sex	1	
		Adults opposite sex	2	
		Children	3	
		Elderly	4	
		Self	5	
		Other (specify)	6	
<hr/>				
102.	For how many years has subject been in Rampton?	Date admitted D ... M ... Y ...		14
		_____ years, _____ months		
102.	Current ward/villa	Less than one year	0	
		Less than two years	1	
		Less than three years	2	
		Less than four years	3	
		Less than five years	4	
		Less than ten years	5	
		Less than fifteen years	6	
		Less than twenty years	7	
		Less than twenty-five years	8	
		Twenty-five years and over	9	
103.	For how many years was subject previously in hospitals for the mentally disordered?	_____ years approximately		15
		None	0	
		Less than one year	1	
		One to five years	2	
		Five to ten years	3	
		Ten to fifteen years	4	
		Fifteen to twenty years	5	
		Twenty to twenty-five years	6	
		Over twenty-five years	7	
		Not known	8	

104.	Of what offences has the subject been previously convicted? (indicate most serious)	No previous convictions	0	16
		Petty theft/larceny only	1	
		Serious property (robbery?)	2	
		Indecent assault	3	
	Fuller details	Rape	4	
	.....	Criminal damage only	5	
	.....	Arson	6	
		Violence against person	7	
		Manslaughter/murder	8	
		Other (specify)	9	
<hr/>				
105.	What were the previous sentences?	None	0	17
		Fines only	1	
		Probation only (incl. fines)	2	
	Details	Detention centre/borstal	3	
	.....	Prison only	4	
	.....	Probation and DC/borstal	5	
		Probation and prison	6	
		Probation, DC/borstal, prison	7	
		Hospital order	8	
		Other	9	
<hr/>				
106.	Is the subject known to have been in residential child care (away from home)?	No	0	18
		Yes	1	
		Not known	2	
<hr/>				
107.	Is the subject known to have received residential special schooling?	No	0	19
		Yes	1	
		Not known	2	
<hr/>				
108.	What made the application or requested the reference to the tribunal?	Patient (subject)	0	20
		Nearest relative	1	
		Responsible medical officer	2	
		Home Office initiative	3	
		Other (specify)	4	
<hr/>				

SECTION THREE

INTERVIEWING OF LEGAL CHAIRMAN

Card Two

109.	How would you rate the patient you have just seen as a danger to others? (choose from:-)	No danger at all Minimal danger Moderate danger Severe danger Very severe danger Could not answer Other (specify)	0 1 2 3 4 5 6	21
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110.	How would you rate the patient you have just seen as a danger to himself? (choose from:-)	No danger at all Minimal danger Moderate danger Severe danger Very severe danger Could not answer Other (specify)	0 1 2 3 4 5 6	22
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111.	Howeverx you rated the d' anger, in your opinion what is or was the one main risk or danger in regard to this particular patient? (choose from:-)	Direct physical violence Behaviour likely to indirectly endanger Sexual assault Damage to property Psychological harm Offences against property Could not answer Other (specify)	0 1 2 3 4 5 6 7	23
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112.	Apart from the main danger or risk, did you see any other danger associated with the person before you?	Direct physical violence Endangering behaviour Sexual assault Damage to property Psychological harm Offences against property None Other	0 1 2 3 4 5 6 7	24
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113.	Who did you see a s most likely to be at risk from the person before you?	People generally Adults same sex Adults opposite sex Children Elderly Self (person) Specific other Other (specify)	0 1 2 3 4 5 6 7	25
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	Could not answer	8	
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114.	Did you consider anyone else also to be at risk?	People generally	0	26
		Adults own sex	1	
		Adults opposite sex	2	
		Children	3	
		Elderly	4	
		Self (person)	5	
		Specific other	6	

Other (specify)	7
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None other/could not answer	8
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115. Would you like to make any further comments on how you saw the danger in this case?

116.	Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the degree of risk?	None at all	0	27
		Only moderate disagreement	1	
		Definite disagreement	2	
		Not clear	5	

117. If so, could ^{you} give more details of the disagreement?

118.	Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the nature of the dangerousness or risk?	None at all	0	28
		Only moderate disagreement	1	
		Definite disagreement	2	
		Not clear	3	

119. If so, could you give more details of the disagreement?

120.	Would you have said there was any clear disagreement or difference of opinion between members of the tribunal in regard to the potential victims?	None at all	0	29
		Only moderate disagreement	1	
		Definite disagreement	2	
		Not clear	3	

121. If so, could you give more details of the disagreement?

122. Was there any doubt expressed about the legal classification of the patient?	No Yes Not clear	0 1 2	30
123. If so, could you give any details about this doubt?	<hr/> <hr/> <hr/>		
124. In deciding whether or not this particular patient should continue to be detained in Rampton, which factor appeared to you the most important influence in that decision? (choose from:-)	Mental disorder 0 Immediate offence/behaviour 1 Previous record 2 Personality of patient 3 Previous life-career 4 Family circumstances 5 Community support services 6 Length of stay 7 Other (specify) 8 <hr/> Present behaviour/attitude 9	31	
125. Which factor would you have said was second in importance as an influence on the decision?	Mental disorder 6 Immediate offences/behaviour 1 Previous record 2 Personality of patient 3 Previous life-career 4 Family circumstances 5 Community support services 6 Length of stay 7 Other (specify) 8 <hr/> Present behaviour/attitude 9	32	
126. Was there a further factor which was important in the decision (third in importance)?	Mental disorder 0 Immediate offences/behaviour 1 Previous record 2 Personality of patient 3 Previous life-career 4 Family circumstances 5 Community support services 6 Length of stay 7 Other (specify) 8 <hr/> Present behaviour/attitude 9	33	
127. Would you like to make any further comments about the evidence you took into account in making your decision?	<hr/> <hr/> <hr/>		

128.	Were you at all influenced by your subjective feelings or intuition about the patient?	Definitely Only moderately Not at all Could not answer	0 1 2 3	34
129.	Could you say any more about this?	_____		
130.	Was there any serious doubt in your mind about whether or not the patient should be released from Rampton?	Yes No Could not answer	0 1 2	35
131.	Could you say any more about this?	_____		
132.	Could you say whether you gave any 'benefit of the Doubt' in favour or against leaving Rampton?	Favoured release Favoured continued detention Neither Could not answer	0 1 2 3	36
133.	Why was that?	_____		
134.	Would you have said that the medical member had any serious doubt about the right course of action?	Yes No Could not say	0 1 2	37
135.	Would you have said that the lay member had any serious doubt about the right course of action?	Yes No Could not say	0 1 2	38
136.	Did you experience any difficulty in obtaining the evidence you required to reach your decision?	Serious difficulty Moderate difficulty Minimal difficulty None at all Could not answer	0 1 2 3 4	39
137.	What was the nature of the difficulty? Details	No difficulty Reports not available Reports inadequate Family witnesses unavailable Hospital witnesses unavailable Community witnesses unavailable Other witnesses unavailable Other (specify)	0 1 2 3 4 5 6 7	40

138. Did the difficulty relate to any particular category of evidence or information?
- | | | |
|---|---|----|
| Mental Disorder | 0 | 41 |
| Immediate/offences/behaviour leading to detention | 1 | |
| Previous life-career | 2 | |
| Family circumstances | 3 | |
| Community support services | 4 | |
| Present behaviour/attitudes | 5 | |
| Hospital treatment/planning | 6 | |
| Other (specify) | 7 | |
| | 8 | |
| <hr/> | | |
| Could not say/uncertain | 9 | |
139. How did you overcome the difficulty?
- | | | |
|-------------------------------|---|----|
| Could not overcome difficulty | 0 | 42 |
| Adjourned for enquiries | 1 | |
| Other action (specify) | 2 | |
| <hr/> | | |
| Not applicable | 3 | |
- Details
140. Have you any further comments in regard to difficulties in obtaining the necessary information?
- _____
- _____
141. Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the collection and receiving of evidence?
- | | | |
|---------------------|---|----|
| Serious difficulty | 0 | 43 |
| Moderate difficulty | 1 | |
| Minimal difficulty | 2 | |
| None at all | 3 | |
| Could not answer | 4 | |
142. Could you describe the difficulty?
- _____
- _____
143. Did you find the need to go beyond the given rules and take any unusual course of action in order to overcome this difficulty?
- | | | |
|------------------|---|----|
| No | 0 | 44 |
| Yes | 1 | |
| Could not answer | 2 | |
- Details _____
- _____
144. Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the conduct of the hearing?
- | | | |
|---------------------|---|----|
| Serious difficulty | 0 | 45 |
| Moderate difficulty | 1 | |
| Minimal difficulty | 2 | |
| None at all | 3 | |
| Could not answer | 4 | |
145. Could you describe the difficulty?
- _____
- _____

146.	Did you find the need to go beyond the given rules and take any unusual course of action in order to overcome this difficulty?	No Yes Could not answer	0 1 2	46
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Details

147.	Did you experience any difficulty which arose from the rules and procedures of the tribunal in relation to the powers of the tribunal in this case?	Serious difficulty Moderate difficulty Minimal difficulty None at all Could not answer	0 1 2 3 4	47
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148. Could you describe the difficulty? _____

149.	Did you find the need to go beyond the given rules and take any unusual course of action in order to overcome this difficulty?	No Yes Could not answer	0 1 2	48
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Details

150. Have you any further comments in regard to problems arising from the rules and procedures laid down for tribunals? _____

151.	In reaching your conclusions, did you experience any difficulty which arose from the need to choose between unsatisfactory alternatives?	Serious difficulty Moderate difficulty Minimal difficulty None at all Could not answer	0 1 2 3 4	49
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152.	Did you face any dilemma which related in any way to the need or otherwise for continued hospital care?	Yes No Could not answer	0 1 2	50
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Details

153.	Did you face any dilemma which related in any way to the behaviour or attitude of the patient himself?	Yes No Could not answer	0 1 2	51
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Details

154.	Did you face any dilemma which related in any way to the support or attitude of the family?	Yes No Could not answer	0 1 2	52
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Details

155.	Did you face any dilemma which related in any way to the provision of community services?	Yes No Could not answer	0 1 2	53
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Details

156.	Did you face any dilemma which related in any way to the question of public attitudes?	Yes No Could not answer	0 1 2	54
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Details

157.	Have you any further comments in regard to any dilemmas with which you were faced?			
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158.	Was there at any point in the hearing what you would call a serious difference of opinion between the tribunal members in regard to whether or not the patient should leave Rampton?	Yes No Could not say	0 1 2	55
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Details

159.	How was this disagreement resolved?	Agreement through discussion	0	56
		Greater knowledge or experience prevailing	1	
	Details	Majority decision	2	
	.....	Decision adjourned	3	
	.....	Decision avoided	4	
	.....	Other (specify)	5	
			<hr/>	
			Not applicable	6

160.	At any point did the legal member have a greater influence than the other members?	Yes	0	57
		No	1	
		Could not answer	2	

In what connection?

161.	At any point did the medical member have a greater influence than the other members?	Yes	0	58
		No	1	
		Could not answer	2	

In what connection?

162.	At any point did the lay member have a greater influence than the other members?	Yes	0	59
		No	1	
		Could not answer	2	

In what connection?

163.	At any point was it necessary to abide by a majority decision?	Yes	0	60
		No	1	
		Could not answer	2	

In what connection?

164. Have you any further comments in regard to disagreements and their resolution?

165.	Did you make a definite decision about the application/ your advice on this occasion?	Yes	0	61
		No	1	

166.	Was your decision or advice in favour of release from Rampton?	Yes No	0 1	62
167.	Was your decision or advice in favour of changing the legal classification?	Yes No	0 1	63
168.	to Home Secretary, In your advice did you recommend transfer to a local NHS hospital?	Not applicable (applic.) Yes No	0 1 2	64
169.	Did you make any other recommendation to the Home Secretary? Could you give details?	Not applicable Yes No	0 1 2	65
170.	If you adjourned consideration of the application or reference, what was the purpose in adjourning? (code to be added)			66
171.	Did you decide to take any additional action as a tribunal in response to this application or reference? (code to be added)			67
172.	Have you any further comments in regard to the particular hearing?			
173.	Card number	Two		68

