require an individual to 'give up one set of assumptions about the world and adopt another', examples of which are leaving home in adolescence, losing one's job in adulthood, and retirement in older age groups. These times of transition are times of high risk for psychological disorder. Secondly, recognizing that not everyone undergoing a transition becomes ill, the report sets out a number of factors that are protective, and others that increase vulnerability to psychological disorder.

The principles of prevention are then described, under the headings of anticipatory guidance, supportive intervention, early treatment and referral. For the first two categories in particular, the emphasis is on practical guidance as to what the general practitioner can, and should, do.

Having discussed these general issues, the report deals separately with preventing psychological illness in childhood and adult life. Under the latter heading are included depression, parasuicide, problem drinking and functional deterioration in dementia. In each case, a number of specific recommendations are made. These are by and large, realistic: for example, it is recognized that, despite recent research effort, the opportunities available for the general practitioner to reduce vulnerability to depression are limited.

The final three sections of the booklet discuss organization, educational implications and research. A plea for further research is made, but in this case it should be taken more seriously than the obligatory statement that appears at the end of every research paper. There is a pressing need for more knowledge in this area, and it is to be hoped that this report will stimulate grant-giving bodies and researchers alike to devote some attention to this field. The report, however, is mainly directed to practising clinicians and general practitioners, and psychiatrists should not feel that there is therefore nothing in it for them. At present, hospital psychiatrists rarely see disorders in their early stages, and hence are not well equipped to deal with them. Given the continuing trend towards community psychiatry and the growing establishment of general practitioner-psychiatrist liaison schemes, early identification and preventive management of psychiatric disorder become increasingly important aspects of the psychiatrist's work.

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## *Towards a New Mental Health Act: Sections 60 and 65 and the European Commission of Human Rights*

ROBERT BLUGLASS, Chairman, Special Committee of Council for the Review of the Mental Health Act

**Section 65 of the Mental Health Act (restriction order)**

The Mental Health Act 1959 empowers a Crown Court (but not a Magistrates' Court) to make a Restriction Order when a Hospital Order is made and if it appears to the Court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if released, that it is necessary for the protection of the public to do so. The Judge must hear oral evidence from one of the doctors recommending the Hospital Order.

The restrictions rescind the provisions relating to the duration, renewal and expiration of authority for the detention of patients as long as the Restriction Order is in force. The patient's case may be referred to a Mental Health Review Tribunal by the Home Secretary at any time for advice, and the patient may request him to do so after twelve months, after a further year and then at two-yearly intervals, but neither the patient nor his nearest relative may apply to the Tribunal directly. After recall from conditional discharge the patient may request an application to the Tribunal after six months.

Without the consent of the Home Secretary the patient may not be given leave of absence, be transferred to another hospital or to guardianship, or be discharged, and if given leave of absence the six-month limit on further detention (applicable to Hospital Orders under Section 39) does not apply. The Home Secretary also has power to recall a conditionally discharged patient at any time.

A Restriction Order ceases to have effect at the end of any period named by the Court (with limit of time). It can also be ended at any time by the Home Secretary, or the Home Secretary may discharge the patient at any time by warrant either absolutely or conditionally (and subject to requirements that he is under supervision and is liable to recall).

The patient may appeal to the Court of Appeal (Criminal



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Division) against the Restriction Order in the same way as he may appeal against his conviction.

**Habeas Corpus**

The compulsory detention of a patient may, in certain circumstances, be challenged by a writ of habeas corpus. Any person who is detained, or someone acting on his behalf, may apply to the Queen's Bench Division of the High Court (or during vacation to any High Court Judge) to make an order for a rule *nisi* for the issue of the writ (habeas corpus) to the person responsible for his detention. If the order is made that person must appear before the Court 'to show cause' why the person is so detained. If no lawful cause can be shown the Court will make the rule absolute and the person must be immediately released.

**Powers of Tribunals**

A Mental Health Review Tribunal may only advise the Home Secretary in the case of a patient on a Restriction Order with respect to the advisability of continued detention, discharge or re-classification.

**The European Convention of Human Rights**

The European Convention of Human Rights gave specific legal content to human rights in an international agreement and combined this with machinery for supervision and enforcement. The European Convention was signed in Rome on 4 November 1950 and came into force on 3 September 1953. The United Kingdom is one of the signatories, accepting the right of individual petition to the European Commission and the compulsory jurisdiction of the European Court of Human Rights.

The Articles of the Convention relevant to the present matter are extracted as follows:

> *Article 3:* No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
>
> *Article 5:* (1) . . . no-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.
>
> . . . (e) the lawful detention of . . . persons of unsound mind . . .
>
> (2) Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
>
> *Article 5:* (4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take court proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

**Case of X against the United Kingdom**

This case concerns a recalled Special Hospital patient. He was committed to Broadmoor on the 7 November 1968 after conviction by a criminal court with a Restriction Order without limit of time. His condition improved and he was conditionally discharged by the Home Secretary on 19 May 1971. He was arrested and recalled on 5 April 1974, having been in the community for three years. His wife had reported to his supervising probation officer that he had delusions, and his behaviour was such that after consideration by his Responsible Medical Officer it was decided to recall him. In successful proceedings for a writ of habeas corpus the official reason given for the applicant's recall was that his 'condition was giving cause for concern'. The applicant claimed that he was not mentally ill, that his recall was unjustified and that he had no effective way to challenge the decision, as it rested entirely with the Home Secretary.

The applicant complained to the European Commission of Human Rights that his recall to Broadmoor constituted inhuman and degrading treatment contrary to Article 3 of the Convention and an unjustified deprivation of liberty contrary to Article 5 (1), as he was not a person of unsound mind whose detention could be authorized under Article 5 (1) (e). He complained that he was not properly given reasons for his arrest, contrary to Article 5 (2) and that there did not exist a procedure by which he could have had the lawfulness of his detention decided speedily by a court, contrary to Article 5 (4).

He applied to the Commission on 14 July 1974.

**Conclusions of the European Commission on Human Rights**

1. The Commission considered that the patient could only be detained if he was of 'unsound mind'. The fact that his original detention related to a conviction for a criminal offence was not relevant alone. The Commission found that at the time of his recall Mr X was of 'unsound mind' and he was therefore lawfully detained.

2. The Commission considered that Her Majesty's Government was in breach of Article 5 (2) for not informing Mr X soon enough about the reasons for his detention. (Fresh guidance has now been issued to Health Authorities and consultants in relation to this.)

3. In accordance with Article 5 (4) a restricted patient in England should be entitled to periodic review of his case by a court and to release if his continued detention is not justified on the basis of 'unsound mind'. The Commission did not consider that the habeas corpus procedure gives this opportunity for review. The mental state of the patient may change over a period of time and the patient should have the right to have the lawfulness of his detention reviewed periodically by a court. Similarly, a recalled conditionally discharged Restriction Order patient should be entitled to have his case reviewed speedily by a court.

The implication of the latter ruling is that the present procedure which places the Home Secretary between the patient and the court, and gives the Home Secretary the power to make the final decision with respect to discharge and recall is unacceptable to the Commission. The patient is entitled to direct access to a court.

It is probable that these decisions will be endorsed by the European Court of Human Rights.



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