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An Overview of Aspects of the Mental Health Care Act 17 of 2002 in South Africa and The United Kingdom Mental Health Act Of 1983 with Focus on Review Boards and Tribunals

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ABSTRACT

There is consensus that Review Boards are not efficiently managed and operated in South Africa. These boards are solely guided by the principle of legality in that they may act only if legally permitted to do so. There are no general procedural rules applicable to all review boards. A comparison can be made to the United Kingdom's Review Tribunal as it relates to mental health care law. The United Kingdom Review Tribunals have rules of procedure and mechanisms aimed at case management. The South African Mental Health Care Act 17 of 2002 provides a right to legal representation for the mentally ill at the proceedings. This right does not extend to representation in any instances other than during the proceedings before a review board or any other court. The South African National Alliance on Mental Illness (NAMI) however publishes information about mental health and offers resources such as classes and training, mental health programs and events, and a helpline to recommend non-emergency resources and solutions. This all to try and better the position is South Africa. Focus is placed on the Mental Health Care Act 17 of 2002 and the UK Mental Health Act of 1983 (as amended in 2007). Further focus is placed on the shortcomings in the South African legislation and how these shortcomings can be addressed.

Introduction

We live in an increasingly complicated world and it becomes more and more difficult to know where to seek the answers to many health care problems which affect so many of us. One area of particular importance is mental health care in South Africa.

The first purpose of this comparative article is to provide a discussion on mental health review boards in terms of the Mental Health Care Act 17 of 2002 and the Mental Health Review Tribunal (MHRT) in the United Kingdom. The UK has already dealt with the protection of the human rights of mental health care users now facing South Africa. A further purpose of this comparative article is to focus on the role of the bodies created under the mental health care laws in the United Kingdom and the lessons that South Africa can learn from this jurisdiction. More so it points out shortcomings in the legislation and provides certain recommendations to address these shortcomings. The UK mental health laws are comparable to South African laws in many respects and it is often instructive to refer to the law of the UK. Before the discussion can begin it is important to discuss the concept of mental illness as part of the scope of the article as a background to it.

Methodology

The following research methodologies are employed: A literature study/review of statutes, and case law as primary sources of law is followed. In addition, textbooks and writings of authors as secondary sources of law are utilised. Other sources include the internet and electronic databases.

Hypothesis

Rapid progress has undoubtedly been made regarding South Africa's dedication to the improvement of mental health care and the regulation of the medical profession in the country. For example, government has included clauses in the Constitution of the Republic of South Africa, 1996 protecting the rights of the mentally ill patient, for example, the right not to be discriminated against (the right to equality), the right to bodily and psychological integrity, the right to dignity, the right to privacy as well as access to health care services, and has also promulgated extensive domestic legislation for example the Mental Health Care Act 17 of 2002 and the National Health Act 61 of 2003. However, regardless of these developments, it is put forward that legislation regulating the mentally ill patient remains fragmented and ineffective. Specific reference would be made to the Mental Health Care Act. It is proposed that the current legal framework (including mental health review boards) is still responsible for some improper, fragmented and inadequate management and provision of health care services at present, including mental health care services in South Africa. The proposition advanced by this research is that the absence of a centrally co-coordinated health care structure has attributed to confusion and overlaps. In essence, this research attempts to propose recommendations for the regulation of mentally ill patients with specific focus on the Mental Health Care Act and more specifically mental health review boards.

Aim and scope

The aim of this article is to discuss the work and functions of mental health review boards and tribunals in South Africa. The focus is therefore on legislation that regulates these mental health review boards and tribunals. It covers shortcomings in the legislation and in the practical implementation on the provisions of the acts and recommendations in how to address some of these shortcomings and problems.

The concept of mental illness[1]

Mental illness is an illness (or a disease) of the mind that is judged by experts to interfere substantially with a person's ability to cope with the demands of life on a daily basis. It can profoundly disrupt a person's thinking, feeling, moods and ability to relate to others. Mental illness is manifested in behaviour that deviates notably from normal conduct.[2] The landmark analysis of mental illness by the United States surgeon general states that it is "the term that refers collectively to all diagnosable mental disorders".[3] However, according to Bartol[4] the word "illness" encourages us to look for etiology, symptoms and cures and to rely heavily on the medical profession both to diagnose and to treat. It further encourages us to excuse the behaviour of persons diagnosed with the "illness". The term mental illness need not imply that a person is sick, to be pitied, or even necessarily less responsible for his or her actions. Therefore, although the term mental illness (psychiatric illness) is more frequently used in the legal literature, and despite the difference between the technical interpretations of these terms, both are used interchangeably throughout the article.[5]

Mental illnesses have been defined by a variety of concepts, for example, distress, disadvantage, disability, inflexibility, irrationality, and statistical deviation. Each is a useful indicator for a mental illness, but none is equivalent to the concept and different situations call for different definitions.

Despite the different concepts mentioned above, mental illness in a clinical context is defined as:[6] a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (for example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual…

Mental illness in a legal context is defined as:[7] a positive diagnosis of a mental health related illness in

terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis.[8]

In addition, the term "disease of mind" is rarely encountered in psychiatric and psychological writing, but is, however, crucial for legal practitioners and has been the subject of considerable judicial analysis, which has been considered largely with determining what particular conditions of impaired consciousness come within the scope of the term as used in the M'Naghten Rules. As a corollary the issue has become important in context of automatism in criminal cases.[9] Two decisions have served to clarify the distinction between a "disease of the mind" and other abnormal mental conditions. In *Rabey v R*,[10] the Canadian Supreme Court adopted the following statement:

The distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily internal to the accused, having its source in his psychological or emotional makeup, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect produced by some specific external factor such as, for example, concussion.

In *R v Sullivan*[11] Diplock LJ (House of Lords) ruled that a "disease of the mind" was any disease, which had the effect of so severely impairing the mental faculties as to prevent the accused from knowing that it was wrong. It is unimportant whether the impairment is the result of organic factors (as in epilepsy) or whether it is functional. It is further irrelevant whether it is transient or permanent. Mason and McCall-Smith[12] state that the decision in *Sullivan* confirms that, in English law, epilepsy constitutes a disease of the mind.[13]

Contrary to the concepts of mental (psychiatric) illness or disorder or disease of mind, "mental health" again is defined as the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and to cope with adversity.[14]

The two main current systems of classification in South Africa are the ICD-1 and the DSM-5.[15] It is important to note that there are textual differences between ICD-11 and DSM-5, but according to treaties between the United States and the World Health Organization, the diagnostic code numbers must be identical to ensure uniform reporting of national and international psychiatric statistics.[16] ICD-11 is a uniaxial system, which attempts to standardise by using descriptive definitions of the syndromes and operational criteria, as well as producing directives on differential diagnosis. DSM-5 is a multiaxial system, which relies on operational criteria, rather than descriptive definitions. It states which symptoms need to be present (often quantifying their number and requiring a specific length of time for symptoms to be present) as well as exclusion criteria.[17]

THE SOUTH AFRICAN LEGAL SYSTEM

THE MENTAL HEALTH CARE ACT 17 OF 2002

The overall aim of the Mental Health Care Act is the regulation of the mental health environment so as to provide mental health services in the best interest of the patient. The provision of care at all levels becomes the responsibility of the state. The Act promotes treatment in the least restrictive environment with active integration into general healthcare being required. Furthermore, respect for individual autonomy and decreased coercion procedures have been introduced in the management of the acute stages of illness. The Act also addresses the potential and alleged malpractices in institutions and provides for prevention and detection. This is related to reports of human rights abuses of those with mental illnesses, which required attention. Psychiatric hospitals' stigmatisation of patients used to occur. This is an important aspect in terms of the Constitution of the Republic of South Africa, 1996, which requires that there be no discrimination towards persons with disabilities. Mentally ill people have the right to be treated under the same professional and ethical standards as any other ill person. Zabow states that this must include efforts to promote the greatest degree of self-determination and personal responsibility on the part of patients. He further states that admission and treatment should always be carried out in the patient's best interest. The National Health Act 61 of 2003 further provides a legal framework, based on consent, for the regulation of mental health with regard to adults and children.

THE ROLE AND FUNCTIONING OF MENTAL HEALTH REVIEW BOARDS[18]

There is very little[19] academic literature in South Africa that discusses the functions of mental health review boards in detail and therefore the author (as a former member of the Mental Health Review Board of Gauteng, South Africa) provides much of the information from practical experience in trying to explain how review boards assist in the protection of mentally ill individual's rights. Focus is placed on specific provisions in the Mental Health Care Act with regard to admission procedures and decisions regarding further care, treatment and rehabilitation services.

Mental health review boards are quasi-judicial structures that have been established in terms of the Mental Health Care Act. The establishment of mental health review boards by members of the Executive Council in provinces commenced in 2005. By April 2013, twenty mental health review boards were established in all provinces. These boards serve as "watch-dogs" when it comes to mental health related issues and have to see that mental institutions comply with the provisions of the Mental Health Care Act and therefore ensure that the rights of individuals with mental illness are protected.

The powers and functions of review boards as stipulated in the Act are to:[20]

- Consider appeals against decisions of the head of a health establishment;
- Make decisions with regard to assisted or involuntary mental health care, treatment and rehabilitation services;
- Consider reviews and make decisions on assisted or involuntary mental health care users;
- Consider seventy-two-hour assessment made by the head of a health establishment and make decisions

to provide further involuntary care, treatment and rehabilitation;

- Consider applications for transfer of mental health care users to maximum security facilities; and
- Consider periodic reports on the mental health status of mentally ill prisoners.

As quasi-judicial authorities review boards must within their legal powers administer their functions with clear knowledge and understanding of the intentions of the Mental Health Care Act. It is therefore important that proper and continuous systems be put in place to ensure effective functioning of the mental health review boards. The current Mental Health Review Board of Gauteng consists of six members. The board is comprised of two medical doctors, three psychiatric nurses and one legal practitioner.

A review board may determine its own procedures for conducting business.[21] Whenever a Review Board is considering a matter that involves a health establishment at which one of the members of the review board is a mental health care practitioner, that mental health care practitioner may not be involved in the consideration of the matter.

Mental health review boards inter alia oversee the following procedures: When a person presents with symptoms of mental illness at a health establishment that person must be assessed to determine if a medical condition exists. If a medical condition exists, the person must be managed and stabilized by the medical specialists. According to section 25 (voluntary care, treatment and rehabilitation services) a voluntary mental health care user who submits voluntarily to a health establishment for care, treatment and rehabilitation is entitled to appropriate care, treatment and rehabilitation services and referral to an appropriate establishment.

The procedure differs with regard to assisted and involuntary mental health care users.[22] Assisted care, treatment and rehabilitation services means a user is not capable of making an informed decision but is not refusing treatment. Involuntary care, treatment and rehabilitation services means a user is not capable of making an informed decision and is also refusing treatment, but needs such treatment for their own safety and the safety of others. If following stabilization at a health establishment the user is diagnosed as having a mental illness and the conditions for either emergency admission and treatment without consent, involuntary treatment or assisted treatment exist – then only can the procedures of the Mental Health Care Act be applied.

Of importance is the specified Mental Health Care Act Forms (MHCAF) that have to be completed by the health establishments. Institutions do not always comply with the provisions of the Act, which creates a range of serious practical problems. If the relevant procedures are not followed it would mean that the patient is illegally admitted and can lead to liability issues. For example, with regard to an emergency admission or treatment without consent a MHCAF 01 has to be completed by a mental health care practitioner. This document must be forwarded to the Mental Health Review Board for review.

With regard to assisted users an application for admission is made on a MHCAF 04. This document must be commissioned by a commissioner of oath and the date of application and date of commissioning must be the same. Then the user has to be assessed by two mental health care practitioners for which MHCAF's 05 are used. One of the two mental health care practitioners must be qualified to conduct a physical examination. These two practitioners must conduct their own assessments of the patients and not copy the findings of their colleagues, which unfortunately happens often in practice. The practitioners who complete the MHCAF 05's cannot complete the MHCAF 04 as well. When these assessments had been done the Head of the Health Establishment has to complete a MHCAF 07 in which the Mental Health Review Board is informed of the decision of the health establishment with regard to future care, treatment and rehabilitation. The Mental Health Review Board then completes a MHCAF 14 with a recommendation for future care, treatment and rehabilitation. The board has to ensure that all documentation is in order and that the user is indeed legally admitted. One review board member completes the form – another review board member counter signs the form and it is then signed by the chairperson of the board.

With regard to involuntary users the same procedure is followed as in the paragraph above but there is additional documentation that has to be completed. Two MHCA06's have to be completed after assessment by two mental health care practitioners. This assessment has to be done over a period of 72 hours. One of the two mental health care practitioners has to be a medical practitioner and the other any one of the other categories of mental health care practitioners. Those practitioners completing the MHCAF 05's are allowed to also complete the MHCAF 06's provided that one is a medical practitioner and that new individual assessments are done. If the decision is made for further care, treatment and rehabilitation services, the head of the health establishment has to complete a MHCAF 08. A mental health care user cannot be admitted as an involuntary user if there is not a completed MHCAF 08. If the user has to be transferred to another psychiatric hospital a MHCAF 11 must be completed. All these documents are sent to the Review Board for review and the board members will complete a MHCAF 14. Only if all the documents are in order the user can be deemed to be legally admitted under the provisions of the Mental Health Care Act.

From a practical point of view review boards still struggle to get institutions to fully comply with the provisions of the Act. This is due to a lack of proper training for hospital staff and is also due to a lack of resources. These assessments take time and hospital staff is limited.

With regard to time frames for the submission of forms, all original MHCAF must be submitted to the Mental Health Review Board within seven days of the head of the health establishment signing the MHCAF 07 and (if necessary) MHCAF 08. With regard to assisted users the

MHCAF 07 must be completed within three days of completion of the MHCAF 05's. With regard to involuntary users the MHCAF 08 must be completed within three days of completion of the MHCAF 06's. Once the user is admitted under the Act, the Act supersedes all other conditions and processes. The user's rights are now limited to ensure the safety of the user, his or her property, hospital staff and the environment. If the user is assessed at a later stage and his or her condition does not warrant inpatient admission but still requires monitoring and supervision the user can then be managed as an involuntary outpatient under very strict conditions.

The United Kingdom's Legal Framework[23]

The United Kingdom is used as a comparative country as big parts of South African Law developed from English Law. We can therefore learn a lot from English Law. When the South African Mental Health Care Act 17 of 2002 was drafted the Mental Health Act 1983 (amended by Mental Health Act 2007) from the UK was mostly used as an example. There are therefore many similarities between the two Acts. Within an article of limited scope it was chosen to only use one country for comparative research than many countries being or not from the Commonwealth.

Although English law continued to trail scientific growth during the eighteenth and nineteenth centuries, advances in mental health knowledge began to infiltrate. The United Kingdom produced two great minds, one legal and the other psychiatric. Thomas Erskine[24] was considered England's leading trial lawyer. Alexander Cricghton[25] authored *An inquiry into the nature and origins of mental derangement* in 1798. His work focused on the influence of emotions on thinking processes and he had an influence on the development of modern mental health care. When James Hadfield[26] attempted to assassinate George III in 1800, Erskine was called to defend him, and he challenged Cricghton as his expert witness. Hadfield was acquitted of attempted murder by reason of insanity. Law and mental health were joined. Law was used to address the complexities of mental illnesses, focusing on the relevance of delusions in legal insanity.[27]

Forensic psychiatry was germinating, nurtured by a spectrum of developments in the psychological- and -neurosciences. William Cullen,[28] a pathologist, published his study of insanity, and his influence was extended by his students to America. But the English courts were still grappling with the issues of mental illness, reluctant to give up old notions of global cognitive dysfunction as the legal definition of mental illness in criminal cases.[29] In 1813, Samuel Tuke made the York Retreat into one of the most renowned "moral treatment" asylums in the world by publishing a widely-read book.[30] The Royal College of Psychiatrists, which in 1853 founded the *Asylum Journal* is today known as the *British Journal of Psychiatry* that publish world-wide on issues with regard to mental health and illness.[31]

The regulation of mental illness

Mental health treatment is regulated in England and Wales by the Mental Health Act 1983 (amended by Mental Health Act 2007) and the Mental Capacity Act 2005, in Scotland by the Mental Health (Care and Treatment) (Scotland) Act 2003, and in Northern Ireland by the Mental Health (Northern Ireland) Order 1986, which has been amended by the Mental Health (Amendment) (Northern Ireland) Order 2004.

Mental Health Review Tribunal in the United Kingdom

The UK-Mental Health Act applies to the reception, care, and treatment of mentally ill patients, the management of their property, and other related matters.[32] Mental disorder is defined as any disorder or disability of the mind, but does not include a learning disability not associated with abnormally aggressive or seriously irresponsible conduct or dependence on drugs and/or alcohol.[33] The UK-MHA provides for the admission of mentally ill persons for purposes of assessment.[34] The mentally ill person may only be detained for assessment for a period not exceeding twenty-eight days[35] It is permitted only if he or she is suffering from a mental disorder which warrants detention and the detention is in the interests of the mentally ill person or is necessary to protect other persons. The application for assessment must be accompanied by a written recommendation from two medical practitioners.[36] An application to detain a mentally ill person may be made in terms of section 3 of the UK-MHA and requires proof that: the person suffers from a mental disorder which requires treatment; the detention is necessary; and appropriate medical treatment is available. The application for admission must be accompanied by written recommendations from two medical practitioners.[37] The UK-MHA also recognises that in some instances an application for assessment may need to be made on an urgent basis[38] or in respect of a patient already in hospital.[39] If the application for admission complies with the requirements set out above, it will provide sufficient authority for the detention of the mentally ill person.[40] The UK-MHA introduces a system in terms of which detained patients may be discharged under supervision for treatment on an outpatient basis with continued medication.[41]

Ndou submits that the UK-MHA does not differ materially from the South African Mental Health Care Act 17 of 2002 as regards basic principle and it is unnecessary to discuss the UK-Mental Health Act in greater detail. However, the provisions regarding the MHRT and the IMHA are very important and could prove useful in the South African context. Section 65 of the UK-Mental Health Act provides for the constitution of MHRTs to deal with applications and referrals by and in respect of patients under the UK-Mental Health Act.[42] The application may be made to the tribunal in respect of:[43]

- a patient admitted for assessment;
- a patient admitted for treatment; and
- a detained patient in respect of whom a community treatment order is
- made or revoked.

The manager of the hospital is required to refer the patient's case to the tribunal six months after his or her admission for assessment or treatment.[44] The manager of the hospital is also required to submit the patient's case after three years subsequent to the case having been

considered by the tribunal, or after the community order has been revoked.[45]

Conclusion

Rapid progress has undoubtedly been made regarding South Africa's dedication to the improvement of mental health care and the regulation of the mental health care profession. For example, government has promulgated extensive domestic legislation for example the Mental Health Care Act, which established the existence of mental health review boards. As discussed above review boards have been created to ensure more supervision and accountability of care provision within health establishments and to ensure that individuals suffering from mental illness are protected during periods of vulnerability.

According to Ndou[46] there is a need for uniform rules of procedure applicable to all MHRBs. The impression created with regard to MHRBs in South Africa, is that they are free to formulate their own procedure provided it complies with the rule of legality and natural justice. There needs to be a shift from MHRBs in their current form, to the establishment of a review body with procedural rules similar to those of the UK-MHRT and the First-Tier Tribunal as regards mental health care. The MHCA needs to enact uniform rules of procedure for the MHRBs in order to ensure their operation and that all review boards function uniformly. Therefore, it is recommended that the UK-MHRT model should serve as a point of reference in establishing a new MHRB system for South Africa.

It remains for strategies to be developed that change negative perceptions and inequities for individuals with mental illness. Above all the strategies should be underpinned by the inalienable respect for mentally ill individuals. No matter how similar or how different mentally ill individuals might otherwise appear to be from other people in their communities, they are all part of mankind, and they should not be denied their equal share of opportunities to thrive as human beings. It is indeed a matter of recognising the importance of justice as a basic human need for the mentally ill, as for everyone else.

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[2] Bartol CR *et al Criminal behaviour: A psychosocial approach* (2008) 228-229.

[3] "Mental Health: Report of the surgeon general" 1999 in *Mental illness* 4.

[4] Bartol *Criminal behaviour: A psychosocial approach* 228-229.

[5] Another term that must be distinguished from mental illness and mental disorder is "mental retardation", professionally known as developmental disability. This is a cognitive deficiency - measured by IQ tests (specifically, IQ below 70), which cannot be cured. It is a syndrome of delayed or ill brain development evident before age 18 years. It results in difficulty learning information and skills needed to adapt quickly and adequately to environmental changes. See Ainsworth P *et al Understanding mental retardation* (2014) 3.

[6] According to the American Psychiatric Association the term "mental illness" unfortunately implies a distinction between "mental illnesses" and "physical illnesses", which is a reductionistic anachronism of mind / body dualism. A compelling literature documents that there is much "physical" in "mental illnesses" and much "mental" in "physical illnesses". However, the problem raised by the term mental illness has been much clearer than its solution, and the term will have to persist until an appropriate substitute is found. See American Psychiatric Association *DSM-5* xxi. See also the definition of mental illness according to ICD-10: "a mental illness is a clinically recognisable collection of symptoms or behaviour associated in most cases with distress or interference with personal functions. A deviant pattern of behaviour, whether political, religious, or sexual, or a conflict between an individual and society, is not a mental illness unless it is symptomatic of a dysfunction in the individual".

[7] Section 1 of the Mental Health Care Act.

[8] See also the definition of "severe or profound intellectual disability": "means a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self-care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care". See section 1 of the Mental Health Care Act.

[9] Mason & McCall-Smith 164.

[10] *Rabey v R* (1981) 114 DLR (3d) 193.

[11] *R v Sullivan* [1983] 2 All ER 673 HL.

[12] Mason & McCall-Smith 164-165.

[13] See also *R v Foy* [1960] Qd R 225; *R v O'Brien* (1966) 56 DLR (2d) 65; *R v Kemp* [1956] 3 All ER 249. In *Kemp*, the accused suffered from arteriosclerosis, which interfered with the supply of blood to the brain. It was ruled, as a matter of law, that arteriosclerosis, being capable of affecting the mind, was therefore a disease of the mind in context of the M'Naghten Rules. Compare *R v Quick* where it was held that automatism due to hypoglycaemia in a diabetic was not the result of the underlying disease, but rather, was due to the external factor of injected insulin. The somewhat perverse implication to be derived from *Quick* is that diabetes *per se* is a disease of the mind. See *R v Quick* [1973] 3 All ER 347; [1973] QB 910.

[14] Thompson 4. Compare also the definition of "mental health status": "[M]eans the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis". See section 1 of the Mental Health Care Act.

[15] Allan A "Psychiatric diagnosis in legal settings" 2005 11 *South African Journal of Psychiatry* 2: 55.

[16] *Sadock & Sadock* (eds) viii.

[17] *Katona & Robertson* 11.

[18] See Swanepoel M & Mahomed S "Involuntary admission and treatment of mentally ill patients – The accountability of mental health review boards." South African Journal of Bioethics and Law 2021;14(3):89-92.

[19] See however Swanepoel & Mahomed *South African Journal of Bioethics and Law* 2021 89-92.

[20] Section 19 of the Mental Health Care Act.

[21] Section 24 of the Mental Health Care Act.

[22] Section 1 of the Mental Health Care Act.

[23] See Ndou MM "A comparative discussion of the regulation of Mental Health Review Boards in South Africa and the Mental Health Review Tribunal in the United Kingdom" The Comparative and International Law Journal of South Africa" 56-83.

[24] (1750-1823.) See Barak G *et al Battleground: Criminal Justice* (2007) 259ff.

[25] (1763-1856.) See Robinson DN *Wild beasts and idle humours: The insanity defense from antiquity to the present* (1996) 142ff.

[26] (1771/1772 – 1841.) Also spelled Hatfield.

[27] Barrel J *Imagining the king's death: Figurative treason, fantasies and regicide 1793-1796* (2000) 370ff.

[28] (1710-1790.) Tuke DH *A Dictionary of psychological medicine: Giving the definition, etymology and synonyms of the terms used in medical psychology with the symptoms, treatment, and pathology of insanity and the law of lunacy in Great Britain and Ireland* (1892) 641ff.

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[30] (1784–1857.) See Tuke S *Description of the retreat: An institution near York, for insane persons of the Society of Friends* (1813) 1ff.
[31] Sadock BJ & Sadock VA (eds) *Kaplan & Sadock's comprehensive textbook of psychiatry* (2000) 3304; Katona C & Robertson M *Psychiatry at a glance* (2005) 62.
[32] Section 1 of the UK-Mental Health Act.
[33] Section 1(2)-(4) of the UK-Mental Health Act.
[34] Section 2 of the UK-Mental Health Care Act.
[35] Section 2(4) of the UK-Mental Health Act.
[36] Section 3(3) of the UK-Mental Health Act.
[37] Section 3(3) of the UK-Mental Health Act.
[38] Section 4 of the UK-Mental Health Act.
[39] Section 5 of the UK-Mental Health Act.
[40] Section 6 of the UK-Mental Health Act.
[41] Section 17 A of the UK-Mental Health Act.
[42] Section 65 (1A) of the UK-Mental Health Act. Ndou 78-79.
[43] Section 65 of the UK-Mental Health Act.
[44] Section 68(2) of the UK-Mental Health Act.
[45] Section 68(6) of the UK-Mental Health Act.
[46] Ndou 82-83.

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