deemed withdrawn if the patient fails, rather than refuses, to attend a medical examination is highly unsatisfactory. Apart from the fact that the patient may not have received the letter of appointment, there are many reasons associated with a person's mental condition which might reduce his ability to attend an examination. Not all of those grounds would necessarily be reasons for not terminating the supervision application which it is the tribunal's duty to review. It is also highly unsatisfactory that the power can be exercised if the patient has not provided a reasonable explanation for his failure, not where the tribunal has reason to believe that he has refused to attend without good cause. In summary, the Act does not expressly provide that the rules may deem an application to be withdrawn, so rule 19 should be interpreted restrictively. It is one thing for the rules to provide that an application shall be deemed withdrawn if the patient is no longer subject to the particular provision. That is essentially procedural. It is quite another for them to empower a tribunal to withdraw an application by a patient who may still wish it to deal with his case. There is nothing in the statute to suggest that tribunals may do so or that the rules can single out a certain class of patient for such treatment. The appropriate and polite course is to ask the patient to contact the tribunal about fixing a date for the examination and the hearing and to await his response, thereafter appointing a representative, or adjourning the proceedings *sine die,* until contact is established. It is submitted that the rule is *ultra vires* the Act.

11. Obtaining reports on the patient

INTRODUCTION

Where an application or reference has been made to a tribunal, the Mental Health Review Tribunal Rules 1983 impose on the "responsible authority" and, in cases involving restricted patients, the Secretary of State a duty to furnish to the tribunal a statement about the patient.[1] The precise nature of this obligation, and the information and reports which the statement must include, are set out in the rules. The persons whom the authority or the Secretary of State has asked to write the reports should be aware of the need in certain circumstances to prepare the report in two separate parts or to indicate clearly whether part of the report should be withheld from a particular person (**702**).

THE "RESPONSIBLE AUTHORITY"

Rule 2(1) defines the body or authority which is the "responsible authority" for the purposes of the tribunal proceedings—

- In cases involving patients who are liable to be detained in a hospital or mental nursing home, the managers of the hospital or home are the "responsible authority."[2]

- In the case of patients subject to guardianship, the "responsible authority" is the "responsible local social services authority," that is the local authority which is the patient's guardian or, where a private guardian has been appointed, the local social services authority for the area within which the guardian resides.[3]

- In relation to a patient subject to after-care under supervision, the "responsible authority" is "the Health Authority which has the duty under section 117 of the Act to provide after-care services for the patient."[4]

- In cases involving conditionally discharged patients, there is no "responsible authority" but the rules require the Secretary of State to furnish a statement.[5]

1 This power to require a statement derives from Mental Health Act 1983, s.78(2)(g).
2 Mental Health Review Tribunal Rules 1983, r.2(1); Mental Health Act 1983, s.145(1).
3 Mental Health Review Tribunal Rules 1983, r.2(1); Mental Health Act 1983, s.34(3).
4 Mental Health Review Tribunal Rules 1983, r.2(1), as inserted by the Mental Health Review Tribunal (Amendment) Rules 1996, r.2(c).
5 This is because conditionally discharged patients are not liable to be detained in any specific hospital and the Secretary of State is never a party to, nor the responsible authority in, tribunal proceedings.

Patients not yet subject to after-care under supervision

The definition of the responsible authority in proceedings relating to after-care under supervision should be noted. The Act and the rules distinguish between a patient "subject to after-care under supervision" and a patient who "is to be" subject to after-care under supervision.[6] In the latter case, the patient is still liable to be detained or in hospital, or both, and hence he is not yet subject to supervision.

The tribunal with jurisdiction

Section 77(3) provides that a tribunal application made by a patient who *is to be* subject to after-care under supervision is to be made to the tribunal for the area in which he is to reside when he leaves hospital and becomes subject to supervision. It is this tribunal which has jurisdiction to deal with the case.[7] The patient may, of course, be detained in a hospital situated outside that tribunal's area. If so, and he has also appealed against his liability to detention, a separate application will be pending before a different tribunal.

The responsible authority

The application must therefore be made to the tribunal for the area where the patient is to reside, and it is the Health Authority for that area which will be responsible for providing him with after-care and which will be the responsible authority in any tribunal proceedings held after he has left hospital. However, rule 2(1) provides that the Health Authority is only the responsible authority in relation to a patient "subject to after-care under supervision" — not one who *is to be* so subject — whereas the managers of the relevant hospital are the responsible authority in cases involving patients who are liable to be detained. As drafted, the main problem arising from the definition is that there is no responsible authority if the patient is residing in hospital informally before becoming subject to supervision. In practice, the managers will no doubt be asked to fulfil this role. The alternative construction, that the Health Authority is always the responsible authority in any proceedings involving after-care under supervision, is difficult to reconcile with the drafting. This is because the other rules do distinguish between patients subject to after-care under supervision and those who are to be so subject. There will be a change of responsible authority if the patient leaves hospital before the proceedings are determined, but this also happens in the case of hospital transfers and so is nothing new.

THE BASIC FRAMEWORK

The 1983 Rules prescribe the information and reports to be furnished following the commencement of tribunal proceedings and they refer to Schedule 1, Parts A to F of which specify the precise information which each statement or report is to include and any documents to be furnished. In all cases except assessment cases the basic obligation to provide the tribunal with certain information and reports is specified in rule 6. As to the disclosure of reports, see page 702. As to the submission of observations on reports furnished, see pages 710 and 928. As to the commissioning of reports by or on behalf of the patient or a nearest relative applicant, see pages 711 and 926. As to the giving of directions that further information or reports be furnished, see page 783.

6 See *e.g.* Mental Health Act 1983, ss.25A(2) and (6), 25D(1) and (2).

7 Mental Health Review Tribunal Rules 1983, r.2(1), as amended by the Mental Health Review Tribunal (Amendment) Rules 1996.

PROVISION OF STATEMENTS : MHRT RULES 1983, rr.6 and 32

Patients liable to be detained for treatment or subject to guardianship

6.—(1) The responsible authority shall send a statement to the tribunal and, in the case of a restricted patient, the Secretary of State, as soon as practicable and in any case within 3 weeks of its receipt of the notice of application; and such statement shall contain—

(a) the information specified in Part A of Schedule 1 to these Rules, insofar as it is within the knowledge of the responsible authority; and
(b) the report specified in paragraph 1 of Part B of that Schedule; and
(c) the other reports specified in Part B of that Schedule, in so far as it is reasonably practicable to provide them.

Additional statement if patient restricted

(2) Where the patient is a restricted patient, the Secretary of State shall send to the tribunal, as soon as practicable and in any case within 3 weeks of receipt by him of the authority's statement, a statement of such further information relevant to the application as may be available to him.

Conditionally discharged patients

(3) Where the patient is a conditionally discharged patient, paragraphs (1) and (2) shall not apply and the Secretary of State shall send to the tribunal as soon as practicable, and in any case within 6 weeks of receipt by him of the notice of application, a statement which shall contain—

(a) the information specified in Part C of Schedule 1 to these Rules, insofar as it is within the knowledge of the Secretary of State; and
(b) the reports specified in Part D of that Schedule, in so far as it is reasonably practicable to provide them.

Proceedings in respect of supervision applications

(3A) Where the patient is (or is to be) subject to after-care under supervision paragraph (1) shall not apply and the responsible authority shall send a statement to the tribunal as soon as practicable, and in any case within 3 weeks of the responsible authority's receipt of the notice of application, and this statement shall contain—

(a) the information specified in Part E of Schedule 1 to these Rules, in so far as it is within the knowledge of the responsible authority;
(b) the reports specified in Part F of that Schedule;
(c) the details of the after-care services being (or to be) provided under section 117 of the Act; and
(d) details of any requirements imposed (or to be imposed) on the patient under section 25D of the Act;

and shall be accompanied by copies of the documents specified in paragraph 3 of Part E of that Schedule.

Patients detained under section 2

32.—(1) On receipt of the notice of an assessment application, or a request from the tribunal, whichever may be the earlier, the responsible authority shall provide for the tribunal copies of the admission papers, together with such of the information specified in Part A of Schedule 1 to these Rules as is within the knowledge of the responsible authority and can reasonably be provided in the time available and such of the reports specified in Part B of that Schedule as can reasonably be provided in the time available.

PATIENTS LIABLE TO DETENTION OR UNDER GUARDIANSHIP

Where a patient is liable to be detained in hospital for treatment or is subject to guardianship, rule 6(1) provides that the "responsible authority" shall as soon as practicable, and in any case within three weeks of its receipt of notice of the application, send a statement to the tribunal and, in the case of a restricted patient, to the Secretary of State. There will, of course, be no notice of application if the proceedings were commenced by reference. If the patient's case was referred by the Secretary of State, the tribunal gives notice of the reference to the responsible authority and the three-week period begins with the day on which this notice is received. If the patient's case was instead referred to a tribunal by the managers of the hospital in which he is detained, those managers are also the responsible authority for the purposes of the ensuing tribunal proceedings. No notice of the reference will be given to them, for the obvious reason that they are fully aware that the reference has been made. The rules provide instead that the tribunal shall, on receiving the reference, send to the managers a request for the usual statement and the three-week period begins with the day on which the request is received.

The responsible authority's statement

This information and reports which collectively constitute the authority's statement are specified in Parts A and B of Schedule 1. In addition to providing this statement, the responsible authority must, if practicable and upon being requested to do so by the tribunal, also provide it with any of the information specified in rule 3(2) or 30(2) which was not included in the written application (**620**).

Patients who are liable to be detained in hospital or subject to guardianship

Responsible authority's statement		
▪ Factual statement ("Part A statement")	Sched. 1, Pt. A	**671**
▪ Medical report	Sched. 1, Pt. B, para. 1	**680**
▪ Social circumstances report	Sched. 1, Pt. B, para. 2	**682**
▪ The views of the authority on the suitability of the patient for discharge	Sched. 1, Pt. B, para. 3	
▪ Any other information or observations on the application which the authority wishes to make	Sched. 1, Pt. B, para. 4	
Additional statement required in restricted cases		
▪ Secretary of State's statement	No prescribed format	**700**

The Part A statement

The information specified in Part A of Schedule 1 (known as the "Part A statement") comprises basic factual information about the patient, such as his date of birth, the authority for his detention or guardianship, and details of persons involved in his treatment. The duty here is to provide the specified information insofar as it is within the knowledge of the responsible authority and, in the case of patients detained for assessment, in so far as it can reasonably be provided in the time available.

The medical report

The duty to provide a medical report is unqualified in all cases except those involving patients detained for assessment. In their case, such a report must still be provided if it "can reasonably be provided in the time available"[8] and it is exceptional for there not to be a report. Any medical report must be up-to-date, prepared for the tribunal, and include the relevant medical history and a full report on the patient's mental condition. Patients who have a private guardian will have both an appropriate medical officer/nominated medical attendant and a responsible medical officer. In such cases, it is for the responsible social services authority to decide which of them should prepare the medical report. The tribunal may, however, direct that a further medical report is provided by the other practitioner and that both of them attend the hearing in due course.[9]

The other reports which comprise the authority's statement

The other reports which make up the responsible authority's statement must be provided "in so far as it is reasonably practicable to provide them" and, in the case of patients detained for assessment, in so far as they can reasonably be provided in the time available.[10] These reports are an up-to-date social circumstances report containing the information specified in the schedule, the views of the authority on the suitability of the patient for discharge,[11] and any other information or observations on the application or reference which the authority wishes to make.

Patients detained for assessment

It can be seen that, in the case of patients detained for assessment, the rules provide that, if time permits, the responsible authority shall provide the tribunal with the same reports and information as are required under rule 6 in cases involving other patients liable to detention in hospital. However, in addition, the tribunal must be furnished with a copy of the admission papers and this requirement takes account of the likelihood in practice that the reports and information furnished will be less comprehensive than in other types of case.

Organising the responsible authority's statement

The responsible authority usually asks the hospital's Mental Health Act Administrator to prepare the factual Part A statement; the patient's responsible medical officer to provide the medical report; and requests that the relevant social services authority nominates a social worker to undertake the social circumstances report. The rules do not, however, require that the medical report is prepared by the responsible medical officer, nor that a social worker writes the social circumstances report. In practice, medical reports are not infrequently written by junior medical staff on the consultant's team.

8 Mental Health Review Tribunal Rules 1983, r.32(1).
9 *Ibid.*, rr.14(1) and 15(1).
10 *Ibid.*, r.32(1).
11 The equivalent provision in the 1960 Rules was rather more pointed and required the responsible authority to set out the reasons why it was not itself willing to discharge the patient.

Restricted cases — the Secretary of State's statement

Because the Secretary of State also has a responsibility for restricted patients, rule 6(2) provides for an additional statement to be furnished in such cases, comprising any further information relevant to the proceedings as may be available to him. The usual form and contents of this statement are dealt with later (**700**).

Provision of separate statements

In cases other than those involving patients detained for assessment, rule 6(4) provides that if the responsible authority or the Secretary of State is of the opinion that part of their statement should be withheld from the applicant or (where he is not the applicant) the patient, on the ground that its disclosure would "adversely affect the health or welfare of the patient or others," that part shall be made in a separate document in which shall be set out the reasons for believing that disclosure would have that effect (**704**). In assessment cases, because of the limited time for preparing even a single report, the rules provide instead that the responsible authority shall indicate if any part of the admission papers or reports should, in their opinion, be withheld from the patient on any of these grounds (**704**).

Service of statements

The rules provide that statements provided under rule 6 may be served either by delivering them by hand or by sending them by pre-paid post to the tribunal office or, as the case may be, the Home Office.[12] It may be noted that the Secretary of State's duty to furnish a statement, and the time limits for doing so, are only activated upon receipt by him of the responsible authority's statement.

Time limits

The primary duty imposed on the responsible authority and the Secretary of State is to send the prescribed statement to the tribunal "as soon as practicable." Rule 26 deals with requests for extensions of time limits prescribed by the rules. Where the statement has not been sent by the time the three week period expires, and no extension of the three week time limit has been applied for, rule 28 applies and it makes provision for dealing with procedural irregularities (**806**). In practice, responsible authorities rarely observe the three-week time limit but, equally, applications for an extension of that time limit are exceptional. Where, in a case involving an unrestricted patient, no medical report has been furnished after five weeks, this is often a good indication that the responsible medical officer intends, or hopes, to himself discharge the patient prior to the hearing. A decision not to furnish a report in such circumstances reflects his opinion that it is unproductive to prepare reports for hearings which are unlikely to take place. Occasionally, the responsible medical officer may defer writing the report for the alternative reason that it will be out of date by the time of the hearing. Although it is for the tribunal, not the responsible authority, to extend time limits if it thinks fit, the absence of effective sanctions has resulted in a relaxed view being taken in practice. Which, in matters concerning individual liberty, is to be deplored.

12 Mental Health Review Tribunal Rules 1983, r.27.

Assessment cases

The rules state that the responsible authority shall "provide" the tribunal with the required reports and information and this takes account of the fact that the reports will often be handed to the Clerk to the Tribunal shortly prior to the commencement of the hearing, rather than sent or delivered to the tribunal's regional office.[13]

Postponement of proceedings

A tribunal is required to send notice of an application to the responsible authority whether or not it postpones consideration of that application.[14] Where consideration is postponed, a further notice of application is sent at least seven days before the expiration of the postponement period.[15] It would appear therefore that the three-week period during which the responsible authority must send their statement commences afresh upon receipt of the second notice of application, even if this is received prior to the expiration of the postponement period.

CASES INVOLVING CONDITIONALLY DISCHARGED PATIENTS

Where an application is made by a conditionally discharged patient, rule 6(3) provides that the Secretary of State shall send a statement to the tribunal as soon as practicable, and in any case within 6 weeks of receipt by him of the notice of application. Not all of the information specified in Parts A and B would be relevant to cases involving conditionally discharged patients, who may have been living in the community without being subject to compulsory powers for some time. In their case, the rules provide that the statement shall instead include the basic factual information specified in Part C of Schedule 1 and the reports specified in Part D. The Part C statement corresponds to the Part A statement required in other cases while the reports specified in Part D are similar to those set out in Part B and also include the observations of the Secretary of State.

Conditionally discharged patients		
Secretary of State's statement		
▪ Factual statement ("Part C statement")	Sched. 1, Pt. C	**675**
▪ Medical report	Sched. 1, Pt. D, para. 1	**680**
▪ Supervisor's report	Sched. 1, Pt. D, para. 2	**682**
▪ Report on patient's home circumstances	Sched. 1, Pt. D, para. 3	**682**
▪ The views of the Secretary of State on the suitability of the patient for absolute discharge	Sched. 1, Pt. D, para. 4	**680**
▪ Any other observations on the application which the Secretary of State wishes to make	Sched. 1, Pt. D, para. 5	**700**

13 Mental Health Review Tribunal Rules 1983, r.32(1).
14 *Ibid.*, r.4(2).
15 *Ibid.*, r.9(5).

The Part C statement

As with a Part A statement, the obligation is to provide the information specified in so far as it is within the knowledge of the Secretary of State.

The medical report

Where there is a medical practitioner responsible for the care and supervision of the patient in the community, the statement must in so far as it is reasonably practicable include an up-to-date medical report prepared for the tribunal, including the relevant medical history and a full report on the patient's mental condition. In practice such a report is invariably furnished.

The other reports

Where there is a social worker or probation officer responsible for the patient's supervision in the community, the statement must insofar as is reasonably practicable include an up-to-date report prepared for the tribunal on the patient's progress in the community since discharge from hospital. Again, in practice, there is invariably such a report, which also includes the required details of the patient's home circumstances, and it is equivalent to the social circumstances report provided in other kinds of case. The other matters referred to in the schedule are then furnished in a single separate document completed by the Home Office. These are the views of the Secretary of State on the suitability of the patient for absolute discharge and any other observations on the application which the Secretary of State wishes to make.

Providing separate statements

Rule 6(4) applies to proceedings involving conditionally discharged patients as it applies to restricted patients who are liable to be detained. The Secretary of State may therefore provide the statement in two parts if of the opinion that any part of his statement should be withheld from the applicant on the ground that its disclosure would "adversely affect the health or welfare of the patient or others" (**704**).

Discretionary references

There is necessarily no notice of application where the Secretary of State refers the case of a conditionally discharged patient to a tribunal. Following such a reference, no provision is made in the rules for the Secretary of State's statement to be provided within a particular period.[16]

CASES CONCERNING SUPERVISION APPLICATIONS

As with proceedings involving patients who are liable to be detained in hospital for treatment or subject to guardianship, the responsible authority must send a statement to the tribunal as soon as practicable, and in any case within three weeks of its receipt of the notice of application.[17] And that statement must include a basic factual statement and an up-to-date medical report. However, in this case, details of the

16 Mental Health Review Tribunal Rules 1983, rr.2(1), 6(3), 29(b) and (c). This is probably a drafting error and, in practice, the Secretary of State will no doubt endeavour to provide his statement within the usual six week period.

17 Mental Health Review Tribunal Rules 1983, r.6(3A), as inserted by Mental Health Review Tribunal (Amendment) Rules 1983, r.4.

after-care services being (or ...e) provided under section 117 and of any essential requirements imposed (or to be imposed) on the patient under section 25D must also be provided, together with copies of certain documents. These are the supervision application, any renewal reports, and any record of the modification of the after-care services provided. The precise kind of social report provided depends on whether the patient is in the community subject to after-care under supervision or still waiting to leave hospital.

Tribunal proceedings concerning after-care under supervision

Responsible authority's statement

▪ Factual statement ("Part E statement") including ▪ Details of the after-care services provided (or to be provided) and of any essential requirements imposed under section 25D; and ▪ Copies of the supervision application, any renewal reports, and any record of the modification of the after-care services provided	Rule 6(3A), Sched. 1, Pt. E	**677**
▪ Medical report	Sched. 1, Pt. F, para. 1	**680**
▪ Social circumstances report if patient has not yet left hospital	Sched. 1, Pt. F, para. 2	**670** **682**
▪ Supervisor's report if patient has left hospital	Sched. 1, Pt. F, para. 3	**670**

The Part E statement and supporting documents and details

The documents referred to in Part E must be provided, as must details of the after-care services and any essential requirements imposed on the patient. In addition, such of the other information specified in Part E which is within the knowledge of the responsible authority must be furnished to the tribunal.

The medical report

As with cases involving liability to detention and guardianship, the duty to provide a medical report is unqualified. It must be up-to-date, prepared for the tribunal, and include a full report on the patient's mental condition. If the patient has left hospital he will have a community responsible medical officer and this doctor must prepare the report. Thus, in contrast to other kinds of proceedings, the responsible authority cannot ask a doctor other than the person in charge of the patient's treatment to prepare it and nor may the community responsible medical officer delegate the function to a junior member of his team. Nor is it enough for the doctor in charge to sign a report prepared by a junior doctor in his team. He must actually prepare it himself. If the patient has not yet left hospital he will not yet have a community responsible medical officer. In this case, the report is to be prepared by his responsible medical officer or, where there is none, his last responsible medical officer. Again, this duty cannot be delegated. The reference to the patient's last responsible medical officer clearly refers to the situation where a patient has remained in hospital after

ceasing to be liable to be detained there for treatment. Since he is no longer detained he does not have a responsible medical officer but, equally, since he is not yet subject to after-care under supervision he does not yet have a community responsible medical officer.

The other reports

Where the patient has not yet left hospital he will similarly not yet have a supervisor. Nor will there be any progress in the community to report on. The rules therefore provide that the statement shall include a social circumstances report the contents of which are in all material respects identical to those of a social circumstances report prepared in respect of a person who is detained or subject to guardianship. This report is to be prepared "by a person professionally concerned with the nature of the patient's social circumstances." That qualification is new, as is the fact that such a report must be provided. The responsible authority cannot assert that it is not reasonably practicable to provide such a report and this reflects the fact that the relevant social services authority as well as health service professionals should all by now be involved in the discharge process. Where the patient has left hospital, a report is required from the patient's supervisor. Again, the question of the practicality of that does not arise and the report must be prepared by that person rather than by any other person willing to act. The new specificity in the rules reflects the fact that there must at all times be a community responsible medical officer and a supervisor, and the duty to provide these reports reflects their central role in the supervision process. The content of the supervisor's report must include details of the patient's progress in the community and home circumstances, as with conditionally discharged patients. It must also include an assessment of the effectiveness of the supervision, together with details of the attitude of the nearest relative and any non-professional primary carers. This reflects the fact that, the tribunal apart, only the community responsible medical officer can terminate after-care under supervision but the patient's nearest relative and any primary carers are generally entitled to be consulted about statutory developments. If the supervisor and non-professionals have reservations about the efficacy of supervision, this requirement ensures that the tribunal knows that the community responsible medical officer's view is not shared by the other relevant individuals. The age-old general requirement that the authority's statement shall include any observations it wishes to make, including its view about the patient's suitability to be discharged, has been omitted. Presumably, this reflects the fact that it has no power to terminate the authority for the patient's supervision.

MHRT RULEs 1983 AND REPORTS : SUMMARY OF PROVISIONS

▪ Patients detained for assessment	Rule 32, Sched. 1, Pts. A and B.
▪ Supervision application proceedings	Rule 6(3A), Sched. 1, Pts. E and F.
▪ All other unrestricted patients	Rule 6(1), Sched. 1, Pts. A and B.
▪ Conditionally discharged patients	Rule 6(3), Sched. 1, Pts. C and D.
▪ All other restricted patients	Rule 6(1) and (2), Sched. 1, Pts. A and B.

FACTUAL STATEMENTS

It has been noted that in every kind of tribunal proceedings a factual statement must be provided to the tribunal, setting out basic information about the patient and the history of his detention, guardianship and supervision since the application, order or direction being reviewed was made.

FACTUAL STATEMENT REQUIRED

Patient's status	*Statement required*
Application or reference concerning patient who is liable to be detained or subject to guardianship	▪ Part A statement
Application or reference concerning conditionally discharged patient	▪ Part C statement
Application or reference concerning patient who is, or is to be, subject to after-care under supervision	▪ Part E statement

FORM AND CONTENT OF A "PART A STATEMENT"

The purpose of the Part A statement is to provide the tribunal with certain basic factual information about the patient, including the authority for his detention or guardianship, and details of persons involved in his treatment and care. As under the 1960 Rules, the duty imposed on the responsible authority is limited to providing information which is within its knowledge. There is no requirement that it takes reasonable steps to acquire the information. However, if the statement is inadequate, the tribunal may direct that the responsible authority shall obtain further information about the patient.[18] Part A of Schedule 1 comprises thirteen different paragraphs[19] —

1. The full name of the patient

The Part A statement commences with the patient's full name. In some cases, this may differ from that given on the tribunal application form or the authority for the patient's detention or guardianship. This may be because the patient has changed his name by deed poll, a practice which is not uncommon in special hospital cases and may be an early indication that the circumstances surrounding the index offence attracted widespread publicity or local hostility at the time. Alternatively, an adopted name may be a pointer to the patient's mental state and reflect a delusional belief held by him. Of greater legal significance, the patient may have married or divorced since the time of admission, in which case there will have been a change of nearest relative. The person now qualified to exercise those functions may be willing to

[18] Mental Health Review Tribunal Rules 1983, r.15(1).

[19] Paragraphs 1 to 6 derive from and, with minor modifications, repeat corresponding provisions in the 1960 Rules. Paragraphs 7–13 were introduced by the 1983 Rules. Under the 1960 Rules, if the responsible authority considered that the applicant was not entitled to make the application, it was also required to state its reasons for this opinion. This particular provision was not re-enacted, although the present rules do allow the authority to include in its statement any additional information or observations it wishes to make.

make an order for the patient's discharge under section 23 but, not having been given a statutory rights leaflet, be unaware of his power to do so. Where a patient's name is incorrectly spelt on a Part II application, or in the supporting medical recommendations, this will generally be inconsequential in terms of the legal validity of his detention. Rarely, a Part II application may not give the name of the person being detained, stating only "a person unknown." Inevitably, this tends to reflect the severity of the patient's condition at the time of his admission.

2. The age of the patient

In guardianship cases, the authorised representative should verify that the patient was aged 16 or over at the time of his reception into guardianship. In any proceedings involving a patient aged under 18, the representative should ascertain whether the patient has a guardian under children's legislation, is in care, or the subject of a residence order. If so, the usual provisions as to who is his nearest relative will not apply (**106**). Where the person who has been treated as the nearest relative is not in fact the nearest relative, any tribunal proceedings commenced by that person will be invalid, as may be any Part II application under which the patient is detained or subject to guardianship. A guardianship application may not be made in respect of a ward of court. Nor may any other application under Part II, or a tribunal application, be made except with the court's leave.

3. The date of admission of the patient to the hospital or mental nursing home in which the patient is currently detained or liable to be detained, or of the reception of the patient into guardianship.

When considered together with paragraph (5), the date of admission recorded in paragraph (3) enables a tribunal to know whether the patient has been transferred under section 19 or section 123 and, in many cases, whether he was originally admitted to hospital as an informal patient.

4. Where the patient is treated in a mental nursing home under contractual arrangements with a health authority, the name of that authority.

In non-assessment cases, the Health Authority and the registration authority of that home will be parties to the proceedings and must, on receipt of the authority's statement by the tribunal, be given notice of the proceedings.[20] The Health Authority itself has power to discharge the patient and either he or his authorised representative may wish to invite it to do so.[21]

5. Details of the original authority for the detention or guardianship of the patient, including the Act of Parliament and the section of that Act by reference to which detention was authorised and details of any subsequent renewal or change in authority for detention.

Apart from providing basic information about the history of the patient's detention or guardianship, paragraph 5 serves three purposes. When considered with paragraph (9), it enables the tribunal to ascertain whether the application or reference is

20 Mental Health Review Tribunal Rules 1983, rr.2(1), 7(a) and (e).

21 Mental Health Act 1983, ss.23–24. For the same reason, details of any NHS trust contracting with a mental nursing home should be included here. Otherwise, the reference to such a trust in rule 7, which was inserted by the Mental Health Review Tribunal (Amendment) Rules 1996, is ineffective.

authorised (**604**), to identify any break in the authority for the patient's detention and also, therefore, to know whether consideration of the application may be postponed (**641**).

6. The form of mental disorder from which the patient is recorded as suffering in the authority for detention [including amendments, if any, under section 16 or 72(5) of the Act, but excluding cases within section 5 of the Criminal Procedure (Insanity) Act 1964[22]].

Although not required by paragraph 6, details of any reclassification effected under section 20 and 21B may also be entered here, in order to ensure that the tribunal is aware of the patient's present classification and of all previous reclassifications.[23]

7. The name of the responsible medical officer and the period which the patient has spent under the care of that officer.

The functions of the patient's responsible medical officer have already been summarised (**147**). Renewal reports furnished under section 20 and any outstanding Form 38 should be checked by an authorised representative, to confirm that they were completed by the responsible medical officer.

8. Where another registered medical practitioner is or has recently been largely concerned in the treatment of the patient, the name of that practitioner and the period which the patient has spent under his care.

If a private guardian has been appointed, he is required to appoint a "nominated medical attendant" for the patient, who is the "appropriate medical officer" for the purposes of sections 16 (reclassification) and 20 (renewals of guardianship). Where a patient is residing in a hospital under leave of absence, a situation which most commonly arises in cases involving special hospital patients, the name of the doctor in charge of the patient's treatment at the hospital where he has leave to reside should appear here. The responsible authority may sometimes provide details of the registrar who has been involved in the patient's treatment; of the patient's General Practitioner; or of the consultant psychiatrist usually responsible for the patient's treatment (in cases where all patients on a locked ward, or an admission ward, temporarily have the same responsible medical officer).

9. The dates of all previous tribunal hearings in relation to the patient, the decisions reached at such hearings and the reasons given. (In restricted patient cases this requirement does not relate to decisions before September 30, 1983[24]).

When considered in conjunction with paragraph (5), the information will enable the tribunal to determine whether the application or reference is authorised or its consideration may be postponed. Where the previous tribunal deferred a direction for the conditional discharge of a restricted patient until suitable arrangements could

22 Patients detained under section 5 of the Criminal Procedure (Insanity) Act 1964 do not have a classification although the responsible authority often states here that the patient suffers from "mental illness." Because of this, tribunals have reclassified such patients.

23 The paragraph has been copied from the 1960 Rules and so fails to take account of the additional reclassification provisions introduced in sections 20(9) and 21B of the 1983 Act.

24 On account of the fact that, prior to 30 September 1983, tribunals had no power to discharge a restricted patient.

be made for him in the community, but those arrangements have not been made by the time his case next comes before a tribunal, its decision is treated as never having been made.[25]

10. Details of any proceedings in the Court of Protection and of any receivership order made in respect of the patient.

Where the patient's financial affairs are subject to the Court of Protection, the Court must, on receipt of the authority's statement by the tribunal, be given notice of the proceedings and, accordingly, becomes a party to those proceedings.[26] The court will sign legal aid forms on the patient's behalf and need to authorise any legal fees incurred by an authorised representative if a private arrangement is contemplated. Where a patient is both subject to guardianship under the Act and under the Court of Protection, it may be possible for the authorised representative to argue that the guardianship is superfluous to the patient's welfare.[27]

11. The name and address of the patient's nearest relative or of any other person who is exercising that function.

The person exercising the functions of the nearest relative must, unless he made the application, be given notice of the proceedings and thereupon becomes a party to them.[28] The information should be carefully verified with the patient since mistakes are commonplace. Where the person recorded as exercising the functions is a person appointed by the county court under section 29 (**111**) or authorised under regulation 14 of the 1983 regulations (**109**), a copy of the relevant court order or authority should be obtained. Social workers sometimes believe that a county court order made under section 29 remains in force until discharged by the court and section 3 applications may be made over a number of years on this assumption, without the patient's nearest relative being consulted. Similarly, some social workers believe that a nearest relative may informally delegate his functions to another person without using the procedure set out in regulation 14. In the case of Irish patients, any relatives ordinarily resident in the Republic must be discounted unless the patient himself ordinarily resides there.[29]

12. The name and address of any other person who takes a close interest in the patient.

Persons recorded here may include other relatives, friends, or an advocate appointed for the patient under a local scheme. They may be willing to give oral evidence or to provide a letter in support of the patient's application for discharge, or be able to provide support if the patient is discharged. With the patient's permission, the authorised representative will usually wish to discuss the case with any person whose details are recorded here.

25 Mental Health Act 1983, s.73(7).
26 Mental Health Review Tribunal Rules 1983, rr.2(1) and 7(c).
27 If the main purpose behind the guardianship is to require a patient who neglected himself when living alone to reside in supported accommodation, it is often unlikely that the court will approve the payment of rent to a private landlord, in which case the patient will be unable to move even if the guardian's authority is rescinded.
28 Mental Health Review Tribunal Rules 1983, rr.2(1) and 7(d).
29 Mental Health Act 1983, s.26(5)(a).

13. Details of any leave of absence granted to the patient during the previous 2 years, including the duration of such leave and particulars of the arrangements made for the patient's residence while on leave.

The details of any leave of absence which has been granted should be scrutinised. If the patient has leave to reside at a hospital other than that where he is liable to be detained, the hospital where he is liable to be detained is the responsible authority for the purposes of the tribunal proceedings.[30] Furthermore, the conventional view is that an unrestricted patient's liability to detention cannot be renewed if he has leave to reside at another hospital (**282**). Any unrestricted patient who, on a day prior to 1 April 1996, was continuously absent from hospital with leave for a period of six months, ceased to be liable to be detained at the expiration of that period (**300**).

FORM AND CONTENT OF A "PART C STATEMENT"

Not all of the information required in a Part A statement would be relevant to cases involving conditionally discharged patients, since they are living in the community without being subject to compulsory powers.[31] In their case, the rules provide that the more limited factual information specified in Part C of Schedule 1 shall be furnished instead. However, in addition to the limited information specified in Part C, a tribunal may direct that further information be furnished.[32] The authorised representative will usually wish to obtain the following supplementary information contained in Part A statements insofar as it is not provided under Part D: details of any other medical practitioners who are or have been recently concerned with the patient's treatment; the dates of all previous tribunal hearings in relation to the patient (so as to verify his entitlement to make the application and to know the reasons for previous decisions); details of any proceedings in the Court of Protection and of any receivership order made in respect of the patient; details of any persons who take a close interest in the patient. The representative will also wish to see a copy of the restriction order and he will require details of the original conditions of discharge and any subsequent variations of them.

1. The full name of the patient.

Paragraph 1 of the Part C statement is the same as paragraph 1 of the Part A statement (**671**).

2. The age of the patient.

Paragraph 2 of the Part C statement is also the same as the corresponding paragraph of the Part A statement (**672**). A person under the age of 14 may not be committed to the Crown Court under section 43(1) with a view to the making of a restriction order. That limitation apart, a restriction order may be made in respect of an offender of any age.

30 Mental Health Act 1983, ss.17–18; Mental Health Review Tribunal Rules 1983, r.2(1).
31 They cannot be compelled to adhere to the conditions of discharge although the option of recall is, of course, available to the Secretary of State.
32 Mental Health Review Tribunal Rules, r.15(1).

3. The history of the patient's present liability to detention including details of offence(s), and the dates of the original order or direction and of the conditional discharge.

A conditionally discharged patient is liable to be detained in the sense that the relevant hospital order or transfer direction remains in force notwithstanding his discharge from hospital and he may be recalled to hospital for further treatment. The details of the index offence should enable the representative to obtain the court papers or the trial solicitor's file. This is particularly important if the patient's case was disposed of following a finding that he was not guilty by reason of insanity or unfit to plead. It may still be possible to hold a trial, although this is rare following conditionally discharge. If the restrictions cease to have effect during the proceedngs, the patient is deemed to be absolutely discharged and his tribunal application is similarly deemed withdrawn.[33] This will be the effect if a limited-term restriction order, or the prison sentence of a patient liable to detention under section 45A or 47, expires. If the patient is recalled prior to the hearing then his application is deemed withdrawn. However, if he is admitted to hospital informally or under Part II, any tribunal proceedings initiated under section 75 continue until such time as he is formally recalled to hospital under section 42.

4. The form of mental disorder from which the patient is recorded as suffering in the authority for detention. (Not applicable to cases within section 5 of the Criminal Procedure (Insanity) Act 1964.)

Paragraph 4 of the Part C statement corresponds to paragraph 6 of the Part A statement (**673**). However, the reclassification provisions in sections 16, 20 and 21B do not apply to restricted patients. The fact that a restricted patient is not for the time being suffering from mental disorder does not mean that he is entitled to be absolutely discharged.[34]

5. The name and address of any medical practitioner responsible for the care and supervision of the patient in the community and the period which the patient has spent under the care of that practitioner.

Conditionally discharged patients do not have a responsible medical officer. However, it will almost invariably be a condition of discharge that the patient attends appointments with a medical practitioner (his medical supervisor) and complies with any programme of treatment prescribed by him. Failure to do so may lead to the patient's recall to hospital. The medical supervisor will be asked to prepare a report for the tribunal (**663, 681**).

6. The name and address of any social worker or probation officer responsible for the care and supervision of the patient in the community and the period which the patient has spent under the care of that person.

It will generally be a condition of discharge that the patient submits to supervision by a social worker or probation officer and attends appointments with that person. He will also be required to prepare a tribunal report (**663, 682**).

33 Mental Health Review Tribunal Rules 1983, r.19(2).

34 See *R. v. Merseyside Mental Health Review Tribunal, ex p. K.* [1990] 1 All E.R. 694, C.A. (**527**)

FORM AND CONTENT OF A PART E STATEMENT"

Where the tribunal proceedings involve a patient who is subject to after-care under supervision, or is to be so subject when he leaves hospital, the factual statement required is that set out in Part E. The statement must be accompanied by the various documents referred to in paragraph 3 below (**436, 663, 668**).

1. The full name, address and age of the patient.

As in the case of guardianship, a supervision application may not be made in respect of a patient under 16 years of age.[35] If the patient's address is not one within the area of the tribunal dealing with the case, the most likely explanation is that the patient's application has been sent to the wrong tribunal. If so, the tribunal has no jurisdiction.[36]

2. The date of the acceptance of the supervision application in respect of the patient.

A supervision application may not be accepted after the date on which the patient leaves hospital in the statutory sense, that is after the day on which he has both ceased to be liable to be detained for treatment and ceased to be an in-patient. Conversely, if a patient does not leave hospital in this statutory sense during the six month period following the application's acceptance, the authority to supervise him ceases at the expiration of that period.

3. A copy of the original supervision application, details of the after-care services provided (or to be provided) under section 117 of the Act, details of any requirements imposed (or to be imposed) under section 25D(1) of the Act, a copy of any report furnished under section 25G(3)(b) of the Act in relation to renewal of the supervision application and a copy of any record of modification of the after-care services provided.

According to the Act, a supervision application must be "accompanied" by details of the after-care services to be provided and of any requirements to be imposed under section 25D. The details of the after-care services will no doubt usually consist of a copy of the after-care plan which was attached to the application. As to the imposition of essential requirements, the prescribed application form includes a space for setting out the requirements which the responsible medical officer personally considers should be imposed. However, he has no power to impose any requirements on the patient by virtue of his position as the patient's responsible medical officer. Such requirements may only be imposed after the application has been accepted and then only by both responsible after-care bodies acting jointly — unless they have authorised some other body, such as an NHS trust, to undertake this function on their behalf. If the after-care services and any requirements imposed on the patient have subsequently been modified, the tribunal is to be furnished with any record of those modifications so that it knows the present position. Authorised representatives will wish to scrutinise the application and to ensure that the persons

35 Mental Health Act 1983, s.25A(1)(b), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995. It was the date when the application was made rather than the date on which it was accepted which was material.

36 Mental Health Act 1983, s.77(3).

entitled to be consulted prior to any application, renewal report or ...difications being made were consulted (**455**).

4. Any reclassification of the form of mental disorder from which the patient is recorded as suffering in the supervision application reported in accordance with section 25F(1) of the Act.

Reclassification under section 25F gives rise to a right to apply to a tribunal (**611**). However, it has no consequences in terms of the duration of the authority for the patient's supervision or the likelihood of it being renewed for a further period: the renewal criteria are the same in all cases, whatever the form of disorder recorded. Where, after the date of any report reclassifying the patient under section 25F(1), the authority for the patient's supervision has been renewed then his current classification will be the form or forms of disorder specified on the last renewal report.

5. The name of the person who is (or is to be) the community responsible medical officer and the period (if any) during which he has been in charge of the patient's medical treatment.

According to the Act, a supervision application must be "accompanied" by statements from the persons who are to be the patient's community responsible medical officer and supervisor, stating that they are to fulfil those statutory roles. However, these statements have been incorporated into the supervision application form. Part II of the application form comprises these signed statements. If the patient is subject to after-care under supervision, a medical report prepared by the community responsible medical officer will form part of the responsible authority's statement. If the arrangements have changed by the time the patient leaves hospital, the interested parties must be informed of this fact when he leaves hospital and, similarly, they must be notified of any subsequent changes (**443**).

6. The name of the person who is (or is to be) the patient's supervisor.

See **424**. If the patient is subject to after-care under supervision, a report prepared by the supervisor will form part of the responsible authority's statement.

7. Where a registered medical practitioner other than the community responsible medical officer is or has recently been largely concerned in the treatment of the patient, details of the name and address of the practitioner and the period which the patient has spent under his care.

If the patient has not yet left hospital, it will be appropriate to provide details here of who is his responsible medical officer. While a supervised patient's community responsible medical officer must be approved under section 12 of the Act, his General Practitioner may nevertheless also be involved in providing treatment. Until the patient leaves hospital only a tribunal may terminate the authority to supervise him.

8. The name and address of any place where the patient (if he has been discharged) is receiving medical treatment.

This is likely to be the out-patient department of the local psychiatric unit or a community mental health centre managed by the same NHS trust.

9. The name and address of t...ospital where the patient was detained or liable to be detained when the supervision application was made.

This information somewhat duplicates paragraph 3 because the supervision application includes these details.

10. The dates of any previous tribunal hearings in relation to the patient since he became subject to after-care under supervision, the decisions reached at such hearings and the reasons given.

Although a patient does not become subject to after-care under supervision until he has ceased to be liable to be detained and left hospital, it would clearly be useful to include here particulars of any hearings concerning the same supervision application which took place before the patient left hospital. Likewise, if the supervision application was made in response to a recommendation made by a tribunal under section 72(3A), it would be important to know that and the reasons given by the previous tribunal for its recommendation. Even if these points do not apply, the reasons why previous tribunals did not discharge the patient from liability to detention for treatment may contain important information about the perceived risks to his health and safety, or to others, outside hospital.

11. Details of any proceedings in the Court of Protection and of any receivership order made in respect of the patient.

Where the patient's financial affairs are subject to the Court of Protection, the Court must, on receipt of the Part A statement by the tribunal, be given notice of the proceedings and, accordingly, becomes a party to those proceedings (**779**).[37]

12. The name and address of the patient's nearest relative or of any other person who is exercising that function.

The person who appears to be the patient's nearest relative must, unless he made the application, be given notice of the proceedings and thereupon becomes a party to them.[38] This new rule is inconsistent with the statutory framework. The Act itself provides that, unless dangerousness is an issue, the patient may prevent his nearest relative from being consulted about a statutory step being taken, in which case that relative is not to be told that it has been taken (**456**). It may therefore often be the case that, in accordance with the patient's wishes and rights, the nearest relative has not been told of the supervision application's acceptance or notified of subsequent developments, in terms of modifications to the after-care plan, and so forth. Nevertheless, the rules provide that the relative automatically becomes a party to any subsequent tribunal proceedings and so is made aware of the fact that the patient is subject to statutory supervision. The *vires* of the rule is therefore open to question insofar as it seems to require the service of such a notice in all cases. It should be noted that any county court order previously made under section 29(3)(c) or (d) ceases to have effect when the patient ceases to be liable to be detained. Accordingly, the authority of the person appointed by the county court to exercise the nearest relative's functions also ceases at that time, and the actual nearest relative's functions are again exercisable in person.

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37 Mental Health Review Tribunal Rules 1983, rr.2(1) and 7(c).

38 Mental Health Review Tribunal Rules 1983, rr.2(1) and 7(bb), as inserted by r.5(a) of The Mental Health Review Tribunal (Amendment) Rules 1996.

13. The name and address of any other person who takes a close interest in the patient.

Non-professionals who are considered to play a substantial part in the patient's care, or will do when he leaves hospital, have quite extensive statutory rights to be consulted before any statutory step other than reclassification is taken. In particular, they must be consulted before an application is made or before the authority conferred by it is renewed or terminated. In keeping with this, once the patient has left hospital, the report prepared for the tribunal by his supervisor must include a report on the attitude of such a person to the supervision. As to other persons who may be listed here, see page 674.

THE MEDICAL REPORT

A medical report must be provided in all cases except those involving conditionally discharged patients who do not have a doctor. However, this caveat is of theoretical interest only and in a practice a medical report is always prepared. The content of any psychiatric report is the product of two things: the content of the patient's mind interpreted by the content of the doctor's mind. The evidence of mental disorder consists of facts (things actually said to or observed by the writer), inferences from these facts, hearsay (facts communicated to the doctor), inferences from hearsay, assumptions and suppositions about matters not reported or observed, and presumptions about what causes and alleviates severe mental distress. Many matters presented as fact are nothing more tangible than suppositions or inferences based on the assumed content of the patient's mind. The quality and accuracy of health service records, and of Home Office records relating to the index offence, are highly variable and necessarily mostly hearsay. There is often scope for hearsay gradually to acquire by virtue of frequent repetition the status of hard fact, or for established facts to become distorted, and the Mental Health Act Commission has been involved in several cases where serious errors have crept into a case history.[39] While a report or case note will record any symptoms or signs of mental disorder, it will not specify all of the questions asked and the matters raised which, when dealt with, were indicative of normal mental functioning. That being so, a report or note may conceal a great deal of normal mental phenomena and the greater truth is sometimes to be found not in what a report says but in what it does not say. The representative must seek out and draw attention to this silent evidence.

Patients liable to be detained or subject to guardianship

A medical report provided under rule 6 or 32 must be up-to-date; prepared for the tribunal; include the relevant medical history; and include a report on the patient's mental condition.[40] The obligation to furnish such a report in respect of a patient who is subject to guardianship or detained otherwise than for assessment is absolute and not qualified by words such as "insofar as it is reasonably practicable."[41] In section 2 cases, a medical report is required if it can reasonably be provided in the time available. Exceptionally, only oral medical evidence is given.[42]

39 Mental Health Act Commission, *Second Biennial Report 1985–87* (H.M.S.O., 1987), para. 18.4.

40 Mental Health Review Tribunal Rules 1983, Sched. 1, Pt. B, para. 1; Sched. 1, Part D para. 1.

41 As was the case with the other reports specified in Part B of the Schedule.

42 Mental Health Review Tribunal Rules 1983, r.32(2).

Conditionally discharged patients

A medical report is required if it is reasonably practicable for the Secretary of State to provide one.[43] In theory, there might be no medical practitioner responsible for the patient's care and supervision in the community, in which case a report is not required.[44]

Patients subject to after-care under supervision

An up-to-date medical report prepared for the tribunal, and including the relevant medical history and a full report on the patient's mental condition, must be provided. In the case of patients subject to after-care under supervision, this must be prepared by the patient's community responsible medical officer. In the case of patients who have not left hospital and who are therefore not yet subject to after-care under supervision, it must be prepared by the patient's responsible medical officer or, where there is none, his last responsible medical officer (**669**).

MEDICAL ISSUES

Medical issues are largely dealt with in Part II of this book and the reader is referred to the following material relevant to any consideration of the medical report. Chapter 17 examines basic concepts such as disorder, disease, illness, psychosis, and what constitutes normal mental health. Chapter 18 explains the assessment process, in particular the mental state examination and special procedures such as EEGs and blood tests. Part of this chapter is devoted to explaining medical terms used in psychiatric reports, and the various terms are listed in the index. Chapter 19 then deals with the diagnosis and classification of medical disorders. The various treatments for mental disorder are outlined in chapter 20, which includes details of the common side-effects of medication, abbreviations used in prescribing, and the reasons why treatment may be ineffective. The remaining chapters in Part III focus on particular forms of mental disorder and their treatment: personality disorders (chapter 21); mood disorders (chapter 22); schizophrenia and related psychoses (chapter 23); and organic disorders, such as dementia (chapter 24). Chapter 16 deals with the role of the authorised representative and includes advice on taking a case history and matters such as questions to put to medical witnesses. Risk assessment and health service guidelines concerning discharge from hospital are considered in chapter 12.The organisation and management of the National Health Service and the functions of professionals employed within that service were covered in chapter 3. Defective or inadequate medical reports (**783**), directions for the preparation of further reports (**783**), the commissioning of independent medical reports (**711, 926**), and the medical member's examination (**793**) are considered where indicated.

43 Mental Health Review Tribunal Rules 1983, r.6(3)(b). The exemption from furnishing a report where it is not reasonably practicable to provide one does not extend to medical reports concerning detained patients. The purpose of the phrase appears to be to provide for events outside the control of the responsible authority. Although the hospital managers may require a medical practitioner to prepare a report, ultimately they may only request that a local social services authority instructs a social worker to prepare the social circumstances report. Similarly, the Secretary of State relies on the willingness of medical and social supervisors to prepare tribunal reports at his request. Thus, where such requests are not complied with, or not within the specified time limits, the responsible authority or the Home Secretary is not *per se* in breach of rule 6. The appropriate remedy is for the tribunal to then direct that the missing report be furnished, under rule 15(1).

44 *Ibid.*, Sched. 1, Pt. D, para. 1.

SOCIAL CIRCUMSTANCES AND SUPERVISORS' REPORTS

The main purpose of a social circumstances report is to inform the tribunal of what are likely to be the patient's circumstances if he is discharged and no longer subject to compulsion. In particular, what medical and social services, and other kinds of support, will be available to him. These matters not only have a bearing on the tribunal's discretionary power of discharge but also affect whether the criteria for mandatory discharge are fulfilled. This is because whether a tribunal is satisfied that further treatment in hospital is unnecessary, or that continued liability to detention there is inappropriate, may depend on the existence of a viable alternative. As to this, health and social services authorities have a duty under section 117 of the 1983 Act to provide after-care to patients who have been detained in hospital for treatment. The nature of this obligation was considered in chapter 6. The existence of separate health and social services authorities and concern about the premature discharge of patients has resulted in there being a number of enactments, directions, guidelines and codes concerning the discharge of patients and their after-care. The most important of them, and the way in which they interrelate, are summarised in the following chapter (**745 et seq.**). As to inadequate social circumstances reports, and the commissioning of further reports, see pages 783 and 926.

CONDITIONALLY DISCHARGED PATIENTS

If there is a social worker or probation officer responsible for the patient's care and supervision in the community, the rules provide that an up-to-date report shall be prepared for the tribunal on the patient's progress in the community since discharge from hospital and also a report on the patient's home circumstances. The role of a supervisor is not the same as that of a key-worker or social worker although in practice the same person fulfils all of those functions. Supervision literally means to oversee and this function is one of monitoring the patient's mental state, functioning and behaviour in the community and ensuring that appropriate action is taken if his circumstances appear to be unsatisfactory. A social worker may therefore be both the agent of the local authority, in terms of co-ordinating and providing after-care, and an agent of the Home Secretary, in terms of reporting on the patient's progress and any developments which have a bearing on the exercise of the latter's functions.

AFTER-CARE UNDER SUPERVISION

A patient who has not yet left hospital will not yet have a supervisor. Nor will there be any progress in the community to report on. The rules therefore provide that the statement shall include a social circumstances report the contents of which are in all material respects identical to those of a social circumstances report prepared in respect of a person who has appealed against his detention or guardianship. This report is to be prepared "by a person professionally concerned with the nature of the patient's social circumstances." Where the patient has left hospital, a report is required from the patient's supervisor. The content of the supervisor's report must include details of the patient's progress in the community and home circumstances, as with conditionally discharged patients. It must also include an assessment of the effectiveness of the supervision, together with details of the attitude of the nearest relative and any non-professional carers. As to the precise nature of the obligation to provide a social circumstances or supervisor's report, and the reasoning behind the drafting, see page 670.

SOCIAL REPORTS IN SUPERVISION APPLICATION CASES

Mental Health Review Tribunal Rules 1983, Schedule 1, Part F

REPORTS RELATING TO PATIENTS SUBJECT (OR TO BE SUBJECT) TO AFTER-CARE UNDER SUPERVISION

2. Where the patient is subject to after-care under supervision an up-to-date report prepared for the tribunal by the patient's supervisor including reports on the following—

(a) the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting and the attitude of any person who plays a substantial part in the care of the patient but is not professionally concerned with any of the after-care services provided to the patient;

(b) his progress in the community whilst subject to after-care under supervision including an assessment of the effectiveness of that supervision.

3. Where the patient has not yet left hospital an up-to-date social circumstances report prepared for the tribunal by a person professionally concerned with the nature of the patient's social circumstances including reports on the following—

(a) the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting;
(b) the opportunities for employment or occupation and the housing facilities which would be available to the patient upon his discharge from hospital;
(c) the availability of community support and relevant medical facilities;
(d) the financial circumstances of the patient.

ALL OTHER CASES

In any case involving a patient who is liable to be detained or subject to guardianship, the responsible authority is required to provide the tribunal with a social circumstances report insofar as that is reasonably practicable and, in the case of patients detained for assessment, insofar as it can reasonably be provided in the time available.[45] The various reports collectively referred to as the "social circumstances report" serve to inform the tribunal of the alternatives to in-patient treatment and the patient's likely circumstances should he be discharged by the tribunal and leave hospital. The social circumstances report should include evidence of discharge and after-care planning even if the view of those responsible for the patient's treatment and care is that discharge is presently inappropriate.

Legal requirements

Any social circumstances report shall be up-to-date, prepared for the tribunal, and include reports on the following [46]—

[45] Mental Health Review Tribunal Rules 1983, r.32(1).

[46] *Ibid.*, Sched. 1, Pt. B, para. 2. The equivalent provision in the 1960 Rules required the responsible authority only to provide an account of the facilities available for care of the patient if the authority for detention or guardianship were discharged.

a. the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting (**687**);

b. the opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged (**687, 690**);

c. the availability of community support and relevant medical facilities (**687, 690**);

d. the financial circumstances of the patient (**692**).

FORMAT OF THE REPORT

Before considering these different requirements, and any legal provisions relating to them, it is useful to set out a sample report illustrating the basic format. The following example includes material not required under the rules, in particular details of the medical history. This is partly because the medical report is often wholly inadequate but mainly because it is important to set out the basis of any opinion that the patient can or cannot be treated or cared for in the community, whether informally or under guardianship or statutory supervision. Ultimately, however, it is a matter of personal preference as to whether the report goes further than merely detailing the factual information specified in the Schedule.

MENTAL HEALTH REVIEW TRIBUNAL

Social circumstances report dated 1 March 1997

John Smith	***Date of birth: 05.04.62***
Pinel Ward, Metropolitan Hospital	***Section 3***
Address at time of admission	***45 Clove Gardens, London N5***

Introduction

The relevant statutory events, in terms of the use made of compulsory powers, should first be briefly recited. The information given here should include the date of the patient's admission to hospital; the sections of the Act under which he has been detained during the present period of continuous detention; the date on which the present authority to detain him was last renewed; any transfers to different hospitals; and any extended leave of absence which is still in force.

Brief example

John Smith was admitted to the Metropolitan Hospital as an informal patient on 3 January 1995. On 6 January 1995, he was detained under section 2 and a section 3 application was then accepted on 21 January 1995. The current authority for his detention will expire at midnight on 20 January 1998, unless he is discharged before then or the authority is renewed for a further period.

Sources of information

The next paragraph should set out the sources of the information referred to in the report, the writer's position and involvement in the case, and any legal responsibilities of the local authority employing him.

Brief example

I am an approved social worker employed by [authority], which is the local social services authority which will be responsible for providing after-care to this patient under section 117 when he leaves hospital. The patient's case has been allocated to me. My report is based on interviews with the patient on 20 February and 26 February. I have recently spoken at length with Dr. Richard Smith, the patient's consultant and responsible medical officer, and with Mrs. Rachel Smith, the patient's mother and nearest relative. I have also spoken to ward staff and have had access to medical, nursing and social work notes.

The current admission

Events surrounding the patient's admission and the present use of compulsory powers should be summarised early on in the report since they provide the context for what follows. For convenience, the recent history can be dealt with in three stages: the events leading up to the admission, the admission itself, and the developments since admission. The future provision of treatment and after-care requires knowing for how long the patient has been ill, what triggered the present illness or relapse, whether he unilaterally stopped treatment, and his attitude to voluntary treatment. With compulsory admission, matters usually come to a crisis and some event occurs which persuades family members or professionals that there is no other realistic course of action. It is important to identify what occurred immediately prior to the decision to invoke compulsory powers. Having established the general history and the circumstances preceding and surrounding the use of compulsory powers, the way in which matters have developed since admission should briefly be dealt with. It is particularly important to highlight any matters which have a bearing on the suitability of any facilities in the community which the report later refers to: compliance with treatment in hospital, periods of absence without leave, episodes of violence or self-harm, etc.

Home and family circumstances

The rules require a report on the patient's home and family circumstances including information about the attitude of the nearest relative. These details enable the tribunal to know the level of family support likely to be available to the patient if discharged; why the nearest relative has not exercised any personal power to discharge the patient; alternatively, whether he would discharge the patient if he had that power. It is useful to list here close family members (any spouse or partner, parents, children, and siblings), and to specify their ages and relationship to the patient, in order to verify that the nearest relative has been correctly identified. That person's views can then be summarised.

Accommodation

The rules require a report on the patient's home circumstances and the housing facilities available to him if discharged. If the client has no accommodation to go to but is detained for treatment, he will be entitled to after-care under section 117 on leaving hospital. If he needs to reside in supported accommodation, but is reluctant to do so, guardianship, after-care under supervision, or conditional discharge may need to be considered.

Employment and occupational opportunities

The rules require a report on the patient's opportunities for employment or occupation if discharged. The client's employment history may reveal information about the duration and causes of any illness or relapse; may help to define the severity of any illness or disability; is often a good, if not wholly reliable, yardstick against which to assess his current level of mental functioning; and a pointer to the likely opportunities for him in the immediate future. Improving his underlying mental state and self-esteem, as opposed to merely suppressing the worst symptoms, often necessitates improving his social situation and opportunities. There remains a tendency to regard people with schizophrenia as unfit for any sort of employment or training which does not involve mundane tasks. However, it is often better to emphasise the importance of accepting medical treatment and supervision as ways of achieving stability and maximising the prospect of returning to some activity which interests the client and which he finds fulfilling. The risk of non-compliance with treatment and relapse may well be greater if the message is that insight and treatment involves living the life of an invalid. For most people, treatment is a means to an end and there is little incentive in accepting that one is ill and would benefit from medication if the benefits of doing so are put in these terms.

Financial circumstances

The rules require a report on the patient's financial circumstances. This part of the report should set out his savings, assets and sources of income; the benefits currently being received; his entitlement to benefits following discharge; all known financial liabilities; any litigation, current or pending, concerning debts; and any arrangements which have been made for managing his financial affairs, *e.g.* the appointment of a receiver or appointee or the execution of a trust or an enduring power of attorney.

Client's physical health

Any relevant medical history should be briefly summarised. Although the rules require the responsible authority to furnish a medical report which includes the relevant medical history, it is important to highlight any physical illnesses or disabilities which may necessitate special social services provision in the community, or which may undermine the effectiveness of any programme of treatment and care outside hospital, *e.g.* addiction to drugs or alcohol.

Forensic history

Because social services authorities are involved in providing after-care, it is important to draw attention to any evidence which suggests that the client may require careful supervision following discharge or be unsuitable for discharge. In restriction order cases, the circumstances of the index offence should be explored, paying particular attention to the considerations considered by the Home Office to be relevant when assessing a patient's suitability to be discharged. The forensic history is an important indicator of the likelihood of harm to others associated with mental disorder, although people with mental health problems may be predisposed to crime as much as any other individual from the same background. Because diverting people away from the criminal courts is now widely encouraged, the absence of criminal convictions does not necessarily reflect an absence of criminal conduct.

Psychiatric history

Any proposals about after-care, and the suitability of resources outside hospital, should take account of the success or failure of previous arrangements made for the patient. In general terms, events in the past reveal the nature of any illness,

and the patient's response to and to treatment, and the purpose of taking any history is to look for patterns of events which have an explanatory or predictive value. The link may be that the patient tends to default on treatment and then relapses, that the illness is cyclical in nature, or that particular anniversaries or kinds of event precipitate periods of illness. It is helpful to obtain a clear idea of the duration of any periods which the client has spent outside hospital relative to periods spent as an in-patient. If all or most of the periods of in-patient treatment are relatively short or relatively prolonged, the discharge process and tribunal case can be approached with that in mind.

After-care, community support and medical facilities

The rules require a report on the availability of community support and relevant medical facilities. These should be summarised in detail. The report should then analyse whether the community resources are a viable alternative detention and treatment in hospital. If further time is required to perfect a realistic programme of after-care, it may nevertheless be the case that the client is willing to remain in hospital informally while these arrangements are made.

Conclusion and recommendations

The report should conclude by summarising (a) the most important conclusions drawn in the course of the report and (b) the writer's recommendations.

HOME AND FAMILY CIRCUMSTANCES

The details of the patient's home and family circumstances should reveal who is the nearest relative. Having ascertained that, any Part II application should be examined to verify that the nearest relative was correctly identified at the time of admission. If the report indicates that the nearest relative considers that a Part II patient should be discharged, it may be that he is not aware of his power to make an order for discharge under section 23 (**610**). If the patient was residing with a family member prior to admission but that family member is not willing for him to return then, unless the patient has a right of occupancy, alternative accommodation will be required (**692**). It may, of course, be the case that the patient is unaware of this or cannot accept that his parents, or other relatives, will not allow him to return home.

EMPLOYMENT, OCCUPATION AND COMMUNITY SUPPORT

A number of statutes require or authorise social services authorities to make arrangements for promoting the welfare of persons suffering from mental disorder, including making provision for the employment or occupation of such persons.

National Assistance Act 1948, s.29

Local authorities are required to publish a plan for the provision of "community care services" in their area, including therefore services which an authority may provide, or arrange to be provided, under Part III of the National Assistance Act 1948.[47] Section 29 provides that a local authority may with the Secretary of State's approval, and to such extent as he directs shall, make arrangements for promoting the welfare of persons ordinarily resident in the authority's area who, being aged 18 or over, suffer from mental disorder of any description.[48] Arrangements may in particular be

[47] National Health Service and Community Care Act 1990, s.46.
[48] National Assistance Act 1948, s.29.

made for providing them with recreational facilities and with suitable work, including providing workshops and hostels where persons engaged in workshops may live.[49] A local authority may employ as their agent any voluntary organisation or any person carrying on, professionally or by way of trade or business, activities which consist of or include the providing these services.[50] Every local authority is required to inform itself of the number of persons within its area to whom section 29 applies,[51] to keep registers of such persons,[52] to inform itself of the need to make arrangements for them under section 29,[53] to periodically publish general information as to the services provided,[54] and to inform users of any of its services of any section 29 service which in its opinion is relevant to their needs.[55] Where it appears to a local authority that a person may be in need of *any* service which it may provide or arrange under section 29, the authority is required to assess the individual's need for such services and to decide whether his needs call for it to provide such a service.[56] More particularly, where a local carries out such an assessment of a person's need for community care services, or a person to whom section 29 applies so requests, it shall decide whether his needs call for the provision by it of the following kinds of welfare services : practical assistance in his home; assistance in arranging for carrying out works adapting his home; the provision of meals in his home or elsewhere; the provision of lectures, games, outings or other recreational facilities outside his home, or assistance in taking advantage of available educational facilities; the provision of a telephone, wireless, television, library or similar recreational facilities, or assistance in obtaining them; the provision of facilities for travelling to and from home for the purpose of participating in any services provided under section 29, or assistance with such travel.[57] Where the authority is satisfied that any such arrangements are necessary in order to meet the needs of that person, it is their duty to make those arrangements under section 29.[58]

National Health Service Act 1977, s.21 and Sched. 8

Section 21(1) states that the services described in Schedule 8 to the Act in relation to prevention, care and after-care are functions exercisable by local social services authorities. The schedule provides that a local authority may with the Secretary of State's approval, and to such extent as he directs shall, make arrangements for the provision of centres or other facilities for training or keeping suitably occupied persons who require care or after-care as a result of illness.[59] The Secretary of State has directed local authorities to provide centres or other facilities (including day centres, training centres and domiciliary establishments) for training or occupational purposes; social work and related services to help in the identification, diagnosis, assessment and social treatment of mental disorder; social work support and other domiciliary and care services for people living in their own homes.[60] Where it appears to a local authority that a person may be in need of *any* service which it may provide or arrange under schedule 8, the authority is required to assess the individual's need for such services and to decide whether his needs call for it to provide such a service.[61]

Disabled Persons (Employment) Acts 1944 and 1958

The statutes apply to a "disabled person," that is a person who, on account of injury, disease,[62] or congenital deformity, is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which would otherwise be suited to his age, experience and qualifications.[63] The Secretary of State for Employment is required to maintain a register of disabled persons[64] and registered persons are issued with a "green card" issued by the local Disablement Resettlement Officer. A person whose name appears in the register is referred to as a "person registered as handicapped by disablement."[65] Section 29 of the National Assistance Act 1948 and paragraph 2 of Schedule 8 to the National Health Service Act 1977 do not apply to registered persons who ordinarily reside within the area of the local authority and are, by reason of the nature or severity of their disablement, unlikely to be able to obtain employment or to work on their own account for a prolonged period.[66] However, the authority may, with the Secretary of State's approval, make arrangements for providing facilities enabling them to obtain employment or to undertake work under special conditions ("sheltered employment"), to receive training to that end,[67] and also hostel accommodation where persons for whom work or training is being provided may live.[68]

Health Services and Public Health Act 1968

Section 45 provides that a local authority may with the Secretary of State's approval make arrangements for promoting the welfare of old people. A local authority may employ as their agent any voluntary organisation or any person carrying on, professionally or by way of trade or business, activities which consist of or include the provision of services for old people, being an organisation or person appearing to the authority to be capable of promoting the welfare of old people. The enactment is not specifically concerned with providing for elderly persons suffering from mental disorder. Its purpose is to promote the welfare of elderly persons who are not substantially or permanently handicapped and thus to prevent or postpone as far as possible personal or social deterioration or breakdown.[69] The Secretary of State has approved (*inter alia*) making arrangements to provide older people with meals and

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49 The Secretary of State has directed authorities to make arrangements to provide such advice and support as may be needed for people in their own homes or elsewhere, and facilities for social rehabilitation and for occupational, social, cultural and recreational activities: *D.H.S.S. Circular No. 13/74*, paras. 8(l) and 9.

50 National Assistance Act 1948, s.30. Unless the context otherwise requires, the expression "voluntary organisation" means "a body the activities of which are carried on otherwise than for profit, but does not include any public or local authority": *ibid.*, s.64(1).

51 Chronically Sick and Disabled Persons Act 1970, s.1.

52 National Assistance Act 1948, s.29(4)9(g); *D.H.S.S. Circular No. 13/74*, paras. 8(l) and 9.

53 Chronically Sick and Disabled Persons Act 1970, s.1.

54 *Ibid.*, s.1(2)(a).

55 *Ibid.*, s.1(2)(b).

56 National Health Service and Community Care Act 1990, s.47(1).

57 Disabled persons (Services Consultation and Representation) Act 1986, ss.4(a) and 16; Chronically Sick and Disabled Persons Act 1970, s.2(1); National Health Service and Community Care Act 1990, s.47(1), (2) and (7).

58 Chronically Sick and Disabled Persons Act 1970, s.2(1).

59 National Health Service Act 1977, s.21(1) and Sched. 8, para. 2(1)(b).

60 *D.H.S.S. Circular LAC 19/74*, paras. 1 and 4.

61 National Health Service and Community Care Act 1990, ss.46(3)(c), 47(1) and (8).

62 "Disease" was to be construed "as including a physical or mental condition arising from imperfect development of any organ." *Ibid.*, s.1(2).

63 Disabled Persons (Employment) Act 1944, s.1(1).

64 Disabled Persons (Employment) Act 1944, s.6(1); Secretary of State for Employment and Productivity Order 1968 (S.I. 1968 No. 729); Secretary of State for Trade and Industry Order 1970 (S.I. 1970 No. 1537).

65 Disabled Persons (Employment) Act 1944, s.6(3).

66 Disabled Persons (Employment) Act 1958, s.3(2).

67 *Ibid.*, s.3(1).

68 *Ibid.*, Sched. 1, para. 1.

69 *D.H.S.S. Circular No. 19/71*, para. 2.

recreation in the home and elsewhere; assistance in adapting their homes; warden services; visiting and advisory services; and social work support.[70]

Day centres and drop-in centres

Two of the most common forms of community support provided for discharged patients are day centres and drop-in centres. Day centres provide rehabilitation and continuing support. They should be provided in locations separate from day hospital services, but have close links with them, and be integrated with community services as far as possible. Drop-in facilities allow social contact to be gradually increased.

ACCOMMODATION AND MEDICAL FACILITIES

One function of a combined health and social services assessment is to determine the setting within which any medical treatment and social care should be provided. The *Health of the Nation Key Area Handbook* summarises the different possible service settings for adults.[71]

SERVICE SETTINGS

Service setting	*Acute/emergency care*	*Rehabilitation/continuing care*
Home based	▪ Intensive home support ▪ Emergency duty teams ▪ Sector teams	Domiciliary services Key workers Care management
Day care	▪ Day hospitals	Drop-in centres Support groups Employment schemes Day care
Residential support	▪ Crisis accommodation ▪ Acute units ▪ Local secure units	Ordinary housing Unstaffed group homes Adult placement schemes, hospital hostels Residential care homes Mental nursing homes 24 hour NHS accommodation Medium secure units High security units

70 *D.H.S.S. Circular No. 19/71*, para. 4.

71 *The Health of the Nation, Key Area Handbook: Mental Illness* (Department of Health, 2nd ed., 1994), para. 6.8 and Appendix 6.1.

Patients' homes

According to the handbook, home care is unsuitable for those at significant risk to themselves or others and people who live in markedly adverse social circumstances. However, day hospitals provide alternatives to hospitalisation for even quite psychotic patients and are suitable settings for group therapies and more intensive support for out-patients. A person cared for at home may be supported by regular visits from a community psychiatric nurse, his key worker or a social worker, receive medical treatment as an out-patient or as a day-patient, and receive additional medical treatment from his General Practitioner. Arrangements may be made for him to attend a day centre or drop-in centre. In most areas there will be a multidisciplinary community mental Health centre or resource centre.

Unstaffed group homes

Unstaffed group homes or "flatlets" supported by regular visits from relevant professionals, included designated domiciliary home care workers, may be available.

Adult placement schemes

If private board and lodging houses are used for accommodation, those arranging the service should ensure that it is close to friends, family, or the user's previous residence, and that quality standards. The of selection of carers and patients, and the provision of training and continuing support, particularly in emergencies, are crucial to the success of such schemes. The quality of the service should be monitored on an ongoing basis by the key worker or care manager.

Residential care homes

Small groups of patients need the support of group homes within which staff are present either continuously or for extended periods of the day. Sleeping-in staff provide the least restrictive option for many patients who require a high level of support. Some schemes have developed on a "core and cluster" model with staff from the more highly staffed hostels also supporting those which are more independent. Care homes should be local to friends and families or to the user's previous residence. Voluntary sector organisations such as Turning Point, Making Space, the Guidepost Trust, the Mental After Care Association, and the Richmond Fellowship have particular experience in this area.

Mental nursing homes

Mental nursing homes provide an asylum for extended periods. Care should be provided in as domestic a setting as possible. If the home is registered to receive detained patients, it is a hospital for the purposes of tribunal proceedings. A patient may therefore be transferred there under section 19, or given leave to reside there, as an alternative to discharging him from liability to detention under the Act.

24 hour NHS residences

Hospital hostels may be suitable for younger people. Permanently staffed residences tend to be more appropriate for "revolving-door" patients than repeated admissions to acute wards. Although the hostels are situated away from the mother hospital,

sometimes in converted hotel or bed and breakfast premises, they rema art of the "mother" hospital. Whatever appearances may suggest, the legal position is therefore that the patient remains an in-patient.

Homeless persons

It may be that a person does not require supportive accommodation and could be treated from home but is homeless. Whatever treatment setting is appropriate, if a patient has no fixed abode then problems may arise in terms of obtaining the agreement of a health or social services authority to assess him and to accept responsibility for providing services following discharge. If the patient's district of residence is in dispute, reference may be made to section 117(3) and to the following guidelines: *Ordinary residence* (Local Authority Circular (93)7), *Establishing District of Residence* (Department of Health, 1993).

THE PATIENT'S FINANCIAL CIRCUMSTANCES

The majority of patients receive income support while in hospital and are likely to remain dependent on benefits for a period of time following discharge. If necessary, a person may be appointed to administer any benefits to which the patient is entitled. In the case of persons who were in employment or receiving a pension immediately prior to admission, various statutes provide for arrangements to be made for their payment to a third party during any period for which the recipient is incapable of managing his property and affairs (**696**). A patient who has significant capital may object to a proposal to discharge him to residential or nursing home accommodation, because the cost of the accommodation is means-tested. The fees will quite rapidly erode capital which he has saved over the years. The property of a patient who has significant capital may be under the authority of the Court of Protection, in which case the court will need to approve any discharge arrangements which involve private expenditure.

Benefits and appointees

The most important benefits to which a patient may be entitled are set out in the table on the following pages. An appointee may be authorised under the relevant statute to receive benefits on the patient's behalf. An appointee's functions include finding out what benefits the patient is entitled to claim, completing claim forms, cashing benefits, using the benefit to pay bills and to buy food and any other necessary items, dealing with correspondence from the Benefits Agency, and notifying it about changes in the patient's financial circumstances. The proposed appointee fills in a standard the form available from agency, following which both he and the patient are visited. If it is agreed that the patient needs an appointee, the agency confirms this in writing. An appointee may resign after giving the agency one month's notice and the patient should notify it if he no longer needs an appointee or the arrangement is not working.

	Non-means-tested contributory benefits	
▪ **Statutory Sick Pay**	This is paid by the patient's employer during the first 28 weeks he is unable to work because of illness, at the standard rate of £55.70 per week. After this, the patient will need to claim incapacity benefit, which is payable for the following 28 weeks at the higher short-term rate — also £55.70 per week. If the person is still unable to work after a year, IB is then payable at the long-term rate. SSP is taxable and taken into account if the patient claims Income Support.	The standard rate is £55.70 per week.
▪ **Incapacity benefit**	Payable to persons who are incapable of work, including persons who are certified by the Benefits Agency Medical Service as having a severe learning disability or a severe mental illness. Persons with a regular occupation during the previous 21 weeks who are not entitled to statutory sick pay receive incapacity benefit at the short-term lower rate for 28 weeks from the beginning of their illness, provided they have paid sufficient national insurance contributions. The higher short-term rate is payable after 28 weeks and the long-term rate after one year on IB. IB is taken into account for the purposes of income support and other income-related benefits. Those on the long-term rate do, however, qualify for a disability or severe disability premium in respect of any income support, housing benefit or council tax benefit payable. The benefit is taxable except when paid at the short-term lower rate.	The short-term benefit is paid at two rates: higher (£55.70), lower (£47.10). The long-term rate is £62.45, with age-related additions of £6.60 per week for those aged between 35 and 44 and £13.15 for those aged under 35. Additional amounts are payable if there are child dependants.
	Non-means-tested, non-contributory benefits	
▪ **Severe Disablement Allowance**	This is a weekly benefit paid to people aged 16–64 who are incapable of work and who became so incapable before the age of 20 for a period lasting at least 28 weeks. Alternatively, the person must be 80% disabled and have been so disabled for a consecutive period of 28 weeks. SDA is not taxable but is fully taken into account for income support purposes, although it does entitle the IS claimant to a disability or severe disability premium. Days spent in prison or other legal custody do not count towards the 28 weeks (SS(SDA)Regs., reg.7).	The allowance is payable at a basic rate of £37.75 per week, with age-related additions of £13.15 for persons aged under 40; £8.30 for persons aged between 40 and 49, and £4.15 for those aged between 50 and 59.

▪ **Disability living allowance**	The person must be 65 or under when he first claims. DLA consists of two components: a mobility component and a care component. The lower mobility rate is payable to a person who is sufficiently mentally or physically disabled that, familiar routes aside, he is unable to walk outdoors for most of the time without guidance or supervision. The higher mobility rate is payable inter alia to people who cannot walk and to severely mentally impaired persons with severe behavioural problems who qualify for the highest rate of DLA. The lower rate care component is payable to persons aged 16 or over who are not receiving institutional care in a hospital or home but who are so severely mentally or physically disabled that they could not prepare a cooked main meal for themselves if given the ingredients. It is also payable to persons who, not being in an institution, are so severely disabled physically or mentally that they require attention or supervision from another person. The person must have continuously satisfied at least one of the attention and supervision conditions during the three months preceding the claim and be likely to continue to do so for the next six months. In this case, the care component is payable at three different rates, depending on how much care or supervision is needed. DLA ceases after 28 days in hospital although there is a concession for recipients who had been in hospital informally for one year when this restriction was introduced in July 1996. As to the tax position and effect on other benefits, see the brief note on attendance allowance.	The mobility component is payable at two rates: higher (£34.60), lower (£13.15). The care component is payable at three rates: higher (£49.50 per week), middle (£33.10), lower (£13.15).
▪ **Attendance Allowance**	This is a weekly benefit paid to people aged 65 or over who need a lot of looking after. The rules concerning entitlement are similar to those for the higher and middle rate DLA care component. Both AA and DLA are not taxable and are additional benefits, *i.e.* they are not taken into account as income and, indeed, other benefits such as IS are paid with a premium if the individual is in receipt of AA or DLA. Invalid care allowance may also be payable if the AA or DLA care component is being paid at the middle or higher rate.	The higher rate is £49.50 per week, the lower rate £33.10 per week.
▪ **Invalid Care Allowance**	This is a weekly benefit paid to people who look after someone getting Attendance Allowance or the Disability Living Allowance Care at the middle or higher rate. The carer must regularly look after the person being cared for at least 35 hours per week and earn less than £50 p.w. after expenses.	Invalid care allowance is payable at a rate of £37.35 per week.

▪ **Income Support and Income-based jobseeker's allowance**	In general, a person must be aged 18 or over to claim IS although 16-17 year-olds with mental health problems will usually be eligible. People in receipt of AA, DLA, SDA or IB at the long-term rate are entitled to an additional disability premium payment. Persons entitled to income support who first entered a residential care home or nursing home after 31 March 1993 only receive a residential allowance of £54 a week towards the home's fees (£60 in Greater London). They must therefore apply to the local social services authority for funding. If this is forthcoming, the local authority will then claw back most benefits paid to the assisted person by Central Government. For those who have to look for work in order to qualify for benefit, Jobseeker's Allowance (JSA) replaced income support on 7 October 1996.	The basic personal allowance is £38.90 for a single person aged 18–24 and £49.15 for a person aged 25 or over. For a couple both aged over 18 the personal allowance is £77.15. Additional allowances are paid in respect of dependant children. The disability premium for a single person is £20.95 and the severe disability premium £37.15.
▪ **Housing benefit**	Persons on low incomes who pay rent may be entitled to housing benefit if their savings and other capital do not exceed £16,000.	
▪ **Council tax benefit**	Persons living alone who are severely mentally impaired are exempt from paying the council tax. Persons on low incomes with savings and other capital of £16,000 or less may eligible for council tax benefit.	
▪ **Community Care Grants and crisis loans**	A person entitled to income support or income-based Jobseeker's Allowance may be eligible for a community care grant if he is moving from hospital or residential care into his own home, needs to buy an item or service, or needs help with fares. Mentally handicapped and mentally ill people are a priority group. If the claimant has savings of over £500, only part of the item's cost may be met. People leaving hospital may also be entitled to a crisis loan from the Benefits Agency if rent has to be paid in advance to a private landlord.	

Notes: levels of benefit are revised annually. Sources: National Welfare Benefits Handbook, 27th Ed. (1997/98), Child Poverty Action Group, London 1997; Rights Guide to Non-Means Tested Benefits, 20th ed. (1997/98), Child Poverty Action Group, London 1997.

Payment of salaries and pensions

Where the statutory requirements are satisfied, periodic payments (including pensions) may be administered on behalf of a mentally disordered person by the Court of Protection, by a government department (under section 142 of the 1983 Act), or by a local authority (under section 118(3) of the Local Government Act 1972).

Government salaries and pensions

Where a salary or employment-related pension is payable directly from monies provided by Parliament, or payable by a government department, the body by whom the sum in question is payable, if satisfied after considering medical evidence that the patient is incapable by reason of mental disorder of managing and administering his property and affairs, may instead of paying the sum to the patient—

- pay the sum, or such part of it as they think fit, to the institution or person having the care of the patient, to be applied for his benefit;
- pay the remainder (if any), or part of it, to or for the benefit of members of the patient's family,[72] or towards the patient's debts.

Local authority payments and pensions

Section 118(3) of the Local Government Act 1972 confers upon a local authority limited powers to administer any remuneration or pension payable to an officer or pensioner of that authority who is mentally disordered. The authority must be satisfied on medical evidence that the person to whom the monies would ordinarily be payable is by reason of mental disorder incapable of managing and administering his property and affairs. Before exercising the power, the local authority must give notice to the patient and to the Court of Protection, specifying the funds involved and how it intends to administer them.

Services pensions

A services pension may be administered on the patient's behalf in a manner similar to that above, under powers granted by Royal Warrant.

The Court of Protection

The property of some patients is subject to the jurisdiction of the Court of Protection. The Court is an office of the Supreme Court situated at Stewart House, 24 Kingsway, London WC2B 6JX. It comprises the Master of the Court of Protection, the Assistant Master, a Legal Officer and Registrar.

Public Trust Office

A body called the Public Trust Office, situated a the same address, carries out the administrative functions of the court. Part VII of the 1983 Act deals with the Court of Protection.

[72] Or to other persons for whom the patient might be expected to provide if he were not mentally disordered.

Functions of the Judge

The functions of the judge under Part VII are exercisable where, after considering medical evidence, he is satisfied that a person is "incapable, by reason of mental disorder, of managing and administering his property and affairs."[73] The judge's functions under the Act are exercisable by the Lord Chancellor, by any nominated Judge, and (subject to certain statutory exceptions) by the Master of the Court of Protection, the Public Trustee (subject to the Master's directions), and by any nominated officer (subject to the Master's directions and so far only as provided by the instrument by which he is nominated).[74] The judge may by order appoint a specified person or the holder for the time being of a specified office as the patient's receiver.[75] Any receiver so appointed shall do all such things in relation to the patient's property and affairs as the judge orders or directs him to do and may do any thing in relation to the patient's property as the judge authorises him to do.[76] In normal circumstances, the patient's nearest relative should be proposed as the receiver. However, if no one personally connected with the patient is willing or able to act, a professional person may be appointed in appropriate cases or, failing all else, the Public Trustee. The appointment of joint receivers is not favoured.

Applications for the appointment of a receiver

The application is usually made by the patient's nearest relative. If some other individual, such as an officer of a local authority, makes the application then the reason for this should be clearly stated. The prescribed forms to be lodged by the applicant are a notice of application, a certificate of family and property, and a medical certificate. An application fee is payable and relatives of a degree equal to, or nearer than, the applicant must be notified of the application. When the application is issued, it is normally stamped, "Attendance not required unless notified," and the order is then made without the holding of a hearing. The order appointing a receiver will include directions as to the management of the patient's estate. The receiver opens a separate bank account ("J. Smith as receiver for P.Smith") and collects in all cash belonging to the patient. Any Notice of Appeal in respect of the appointment of a receiver must be served within eight days of the order. If the patient later recovers, an application for an order "determining the proceedings" should be made in the prescribed form, supported by a medical certificate and a certificate of the funds in court. Legal aid is not available for proceedings in the Court of Protection.

The powers exercisable over the patient's property

Section 95 empowers the Judge to do, or to secure the doing of, all things as appear to be necessary or expedient for the patient's maintenance or benefit; for his family's maintenance or benefit; for providing for other persons whom the patient might be expected to provide if not mentally disordered; for providing for purposes which the patient might be expected to provide if not mentally disordered; or for administering his affairs.[77] Without prejudice to the generality of these powers, the judge may in particular make orders or directions for the control and management of his property; the acquisition, sale, exchange, or disposal of any property; the execution for the patient of a will; the carrying on by a suitable person of any profession, trade

[73] Mental Health Act 1983, s.94(2).
[74] *Ibid.*, s.94(1).
[75] *Ibid.*, s.99(1).
[76] *Ibid.*, s.99(2).
[77] *Ibid.*, s.95(1).

or business of the patient; the dissolution of a partnership of which the ent is a member; the carrying out of any contract entered into by the patient; the conduct of legal proceedings in the patient's name or on his behalf; and the reimbursement of money applied by any person in payment of his debts or for the maintenance of him or his family.[78]

When it may not be necessary to appoint a receiver

It may not be necessary to apply to the Court for the appointment of a receiver in the following circumstances: where the patient's only income is in the form of social security benefits (**692**); where the patient's only asset consists of a pension or salary payable by a Government department (**696**); where the patient's only asset consists of a service pension (**696**); where the patient's only asset consists of a local authority pension (**696**); where the property is subject to a trust; where an Enduring Power of Attorney exists (*infra*); where the patient's needs are otherwise being provided. If an application is required but the estate is small, it may be possible to make all the necessary arrangements by way of a single order, thereby avoiding the need to appoint a receiver. For example, the order may direct that periodic payments be made to the hospital where the patient is receiving treatment, to be applied for his benefit.

Powers of attorney

A power of attorney is a particular form of agency. The person giving the power is known as the "donor" and the recipient of the power as the "attorney" or "donee." Unlike a trust, the donor remains the owner of the property. However, the attorney may deal with the property subject to the terms of the power granted. The problem with an ordinary power of attorney of this kind is that the powers granted come to an end if the donor later becomes incapable by reason of mental disorder of personally supervising or directing his attorney. These limitations led to the enactment of the Enduring Powers of Attorney Act 1985.

Enduring Powers of Attorney

The 1985 Act provided for the creation of enduring powers of attorney which survive the onset of mental incapacity. It is, of course, still necessary that a person is mentally capable when he grants the power. EPAs must be made on special forms and they may be expressed to come into force immediately or upon a specified occasion. The donor may consider limiting the property covered by the instrument, the transactions which may be undertaken, and the purposes for which his property may be used. This is because a general Enduring Power of Attorney confers authority on the attorney to do on the donor's behalf anything which a donor can lawfully do by his attorney.

Donor becoming mentally incapable

If the attorney has reason to believe that the donor is, or is becoming, mentally incapable, he must as soon as practicable apply to the court for the registration of the instrument creating the power. The effect of actual incapacity is to prevent the attorney from taking any action under the power until an application for registration has been made. Because an application can generally be made only after various notices have been given, there will be a period during which the attorney's powers are suspended. However, the 1985 Act empowers the court to give directions

[78] Mental Health Act 1983, s.96(1).

concerning the management of the donor's affairs prior to the making of an application if of the opinion that it is necessary to do so.[79] Necessary means more than merely desirable or convenient; there must be some real urgency. Once registration has been applied for, the attorney acquires a limited power to act pending the initial determination of the application. He may take action to maintain the donor or to prevent loss to his estate. However, it is only after registration that the attorney's previous authority is, at least in principle, restored. At that point, he has the same powers under the instrument as he had prior to the onset of mental incapacity, but subject now to the court's power to give directions.

The application procedure

A medical report is not necessary. Notice of the intention to apply for registration must be given in Form EP1 to the donor in person and also by first-class post to those relatives entitled to receive such notice by virtue of Schedule 1 Part I to the 1985 Act. All notices must be served within 14 days of each other. The application, in Form EP2, must be lodged with the Public Trust Office not later than 10 days after the date on which the last of the necessary notices was given. The application fee is £50.00 and the application must be accompanied by the original instrument. Five weeks after the last notice was given, the Court will consider whether there have been any valid objections. The valid grounds for objection are that the instrument is invalid, that it no longer subsists, that the application is premature,[80] that fraud or undue pressure was used on the donor to create it, or that the attorney is unsuitable. If there are no objections, and the Court has no reason to believe that there might be if inquiries were made, it must register the instrument. Having registered and sealed the instrument, the Public Trustee returns the original to the attorney (with any office copies requested). The donor may revoke an EPA prior to registration but, thereafter, revocation requires the Court's confirmation.

The effect of registration

The general intention behind the statute is that registration will usually make little difference to the attorney's authority and duties. The court will not normally act in the same manner as if a receiver had been appointed. Spot checks, investigations and the scrutiny of the attorney's management of the donor's affairs are not routine. Nevertheless, the court has wide powers to supervise the conduct of the attorney . It may require him to furnish information or to produce documents or things in his possession as attorney; give any consent or authorisation to act which the attorney would have been able to obtain from a mentally capable donor; (subject to any conditions or restrictions in the instrument) authorise him to act beyond the statutory powers so as to benefit himself or persons other than the donor; and relieve him wholly or partly from any liability which he has or may have incurred on account of a breach of his duties. It may also give certain directions as to the management or disposal of the donor's property and affairs; the rendering of accounts; and the remuneration or expenses of the attorney, whether or not in accordance with any provision made by the instrument. An attorney is bound to keep proper accounts of transactions involving the donor's money and must keep such money separate from his own. However, the statutory scheme is that an attorney (unlike a receiver) is not required as a matter of routine to prepare accounts in a special form. The attorney

[79] The procedure is set out in *Practice Direction — Mental Health (Enduring Powers of Attorney: Applications Prior to Registration)* [1986] 2 All E.R. 42. Any application prior to registration must inter alia be accompanied by the original instrument.

[80] That refers to the donor not becoming, rather than not actually being,, mentally disordered.

may initially apply for some form of relief or determination by letter, such letter must include including the attorney's name and address (as the applicant); the donor's name and address, the form of relief or determination required, and the grounds for the application. Any subsequent disclaimer of the attorneyship is not valid unless and until the attorney has given notice both to the donor and the court.

The Enduring Power of Attorney Rules 1994

The Court of Protection (Enduring Powers of Attorney) Rules 1994 (S.I. 1994 No. 3047) came into force on 22 December 1994. Rule 6(1) provides that the Public Trustee may exercise the functions of registering an instrument and giving directions under section 6(3) of the Act. The Public Trustee may refer such a matter to the court for determination. The address is: Protection Division, Public Trust Office, Stewart House, 24 Kingsway, London WC2B 6JX).

THE SECRETARY OF STATE'S STATEMENT

Where a patient detained for treatment is subject to restrictions, the Secretary of State is required to furnish to the tribunal a statement of such further information relevant to the application or reference as may be available to him. The documentation within the Home Secretary's file commonly includes witness statements concerning the index offence, a copy of the restriction order, a record of previous convictions, the medical recommendations relied upon by the court imposing the order, and other documentation subsequently received, such as the periodic reports on the patient's progress from his responsible medical officer, decisions of previous tribunals, records of case conferences, and so forth.

Cases involving restricted patients who are liable to be detained

If the responsible authority's statement relates to a restricted patient who is liable to be detained, it must also send a copy of the statement to the Secretary of State.[81] The rules provide that the Secretary of State shall, as soon as practicable, and in any case within three weeks of receipt of the authority's statement, then send to the tribunal "a statement of such further information relevant to the application or reference as may be available to him" (known as "the Secretary of State's statement"). As to the disclosure of the statement to the patient, see page 702.

Proceedings involving conditionally discharged patients

There is no responsible authority in cases involving conditionally discharged patients. Where an application is made by such a such a patient, the rules require the Secretary of State to send a statement to the tribunal as soon as practicable and in any case within six weeks of receipt by him of the notice of application. This statement must include the statement and reports referred to in Schedule 1 (**667**).

FORMAT OF THE STATEMENT

There are no other formal requirements as to the format of the Secretary of State's statement but the standard format is as follows.

[81] Mental Health Review Tribunal Rules 1983, r.6(1).

Statement by the Secretary of State for Consideration by the Tribunal

The statement by the responsible authority in respect of the below-named patient's case was received in the Home Office on (date)

The Home Secretary offers the following information and observations for consideration by the Tribunal.

Patient's name:
Name and address of hospital in which the patient is currently detained:

The Home Secretary has no objection to this statement being disclosed to the patient/considers that the information in the attached document should be withheld from the patient.

A. Circumstances of the offence leading to admission to hospital

On (date) at the [name of court] Mr -- was convicted of --.

On (date) [at (name of court if different to that convicting the patient)] he was reported to be suffering from [form of mental disorder] and the court made an order under section -- of the [statute] authorising his detention in -- Hospital, [together with an order under section --- of the Act making him subject to the special restrictions set out in that section for an unlimited period.]

[By virtue of para. 3 of Sched. 5 of the Mental Health Act 1983, the patient is now detained as if he were subject to an order under sections 37 and 41 of the 1983 Act.]

Details of the offence or alleged offence leading the order being imposed —

It was reported that ... *the summary of the index offence is commonly 100–200 words in length and highlights any aspects of it which, in the Secretary of State's opinion, were particularly significant or grave and which, in his role as guardian of the public's safety, require to be in the forefront of the tribunal's mind when assessing the patient's suitability for discharge and the risks such a decision might involve.*

B. Observations on Part A of the responsible authority's statement

This may involve correcting factual inaccuracies in the responsible authority's statement, for instance an incorrectly spelt name or date of birth, or providing details required under Part A but which the authority itself did not provide or was unable to do so. For instance, dates of leave of absence. It is generally a short section within the statement, often taking the form of brief numbered points.

C. Observations on Part B of the responsible authority's statement and the Secretary of State's observations on the patient's suitability for discharge

The Home Secretary has read the reports of [responsible medical officer's name] and of [name of social worker providing the social circumstances report] and is satisfied that Mr -- continues to suffer from [form of mental disorder]. *If the reports recommend the patient's discharge then the Home Secretary's objections to this will be set out here.*

Enclosures

A record of the patient's recorded convictions is attached.

CONTENT OF THE HOME SECRETARY'S STATEMENT

Home Office statements provide factual information about the patient, including a full list of convictions and an account of the circumstances of the index offence(s) — or the reported circumstances of the alleged offence if the patient is awaiting trial or was found to be under a disability. The account is normally based on information provided by the police, the courts, or the Crown Prosecution Service. Where appropriate, the tribunal's attention is drawn to issues such as the patient's fitness to plead, the position of life sentence prisoners in relation to the Parole Board, the arrangements for repatriating a patient under section 86, the reasons for making any discretionary reference, and any relevant High Court judgments. The Home Office statement represents the Home Secretary's principal opportunity to seek to ensure that a restricted patient is not discharged where it is believed that his continued detention is necessary for the protection of the public. The cases in which the Home Secretary wishes particularly to influence the tribunal are those where it appears that discharge is a likely outcome and the Home Office has already reached a decision not to grant discharge or those where, although no firm decision has been reached in the Home Office, there are grounds for believing that the patient could still be dangerous. If the responsible medical officer has reported to the tribunal that the patient would be dangerous if discharged, the Home Office is unlikely to disagree and might only wish to support that view with additional evidence from their files. The most important points the Home Office looks for in a responsible medical officer's assessment of a patient's dangerousness are whether there is an adequate understanding of how the patient came to commit the index offence and any previous serious offences, and sound evidence that the patient and circumstances have changed in such a way as to make the repetition of such offences unlikely. The key issue is whether the recommendation for discharge is soundly based and adequate arrangements have been made to ensure public safety. If the responsible medical officer's report does not cover these points to the Home Office's satisfaction, it draws this inadequacy to the tribunal's attention and conveys the Home Secretary's view that in the absence of such evidence it would not be safe to conclude that the patient's detention in hospital is unnecessary for the protection of the public. Home Office statements may also comment on any discharge plans contained in the responsible authority's statement, including the adequacy of proposed accommodation and supervision; compliance with medication; the importance of day-time occupation; and possible future alcohol or drug abuse. Because of his paramount responsibility for public safety, the Home Secretary errs on the side of caution.

DISCLOSURE OF STATEMENTS

Section 78(2)(h) of the Act provides that the rules may in particular make provision for making available to a patient or applicant copies of any documents obtained by or furnished to the tribunal in connection with the application, except where the tribunal considers it undesirable in the interests of the patient or for other special reasons. The grounds upon which part of a statement may be withheld from a patient or a nearest relative applicant under the 1983 rules are the same in all cases, namely that the material's disclosure would adversely affect the health or welfare of the patient or others. A tribunal must always consider whether disclosing a document to a patient or applicant would have this effect, irrespective of whether a request has been made for the document, or part of it, to be withheld.

Statements by the responsible authority and the Secretary of State

6.—(4) Any part of the authority's statement or the Secretary of State's statement which, in the opinion —

(a) (in the case of the authority's statement) the responsible authority; or
(b) (in the case of the Secretary of State's statement) the Secretary of State,

should be withheld from the applicant or (where he is not the applicant) the patient on the ground that its disclosure would adversely affect the health or welfare of the patient or others, shall be made in a separate document in which shall be set out the reasons for believing that its disclosure would have that effect.

(5) On receipt of any statement provided in accordance with paragraph (1), (2) or (3), the tribunal shall send a copy to the applicant and (where he is not the applicant) the patient, excluding any part of any statement which is contained in a separate document in accordance with paragraph (4).

Disclosure of documents

12.—(1) Subject to paragraph (2), the tribunal shall, as soon as practicable, send a copy of every document it receives which is relevant to the application to the applicant, and (where he is not the applicant) the patient, the responsible authority and, in the case of a restricted patient, the Secretary of State and any of those persons may submit comments thereon in writing to the tribunal.

(2) As regards any documents which have been received by the tribunal but which have not been copied to the applicant or the patient, including documents withheld in accordance with rule 6, the tribunal shall consider whether disclosure of such documents would adversely affect the health or welfare of the patient or others and, if satisfied that it would, shall record in writing its decision not to disclose such documents.

(3) Where the tribunal is minded not to disclose any document to which paragraph (1) applies to an applicant or a patient who has an authorised representative it shall nevertheless disclose it as soon as practicable to that representative if he is—

(a) a barrister or solicitor;
(b) a registered medical practitioner;
(c) in the opinion of the tribunal, a suitable person by virtue of his experience or professional qualification;

provided that no information disclosed in accordance with this paragraph shall be disclosed either directly or indirectly to the applicant or (where he is not the applicant) to the patient or to any other person without the authority of the tribunal or used otherwise than in connection with the application.

Note: There is a minor drafting error in rule 6(5). The paragraph should clearly be read as referring also to statements provided in accordance with paragraph (3A).

NON-ASSESSMENT CASES

In non-assessment cases, rule 6(4) provides that, if either the responsible authority or the Secretary of State is of the opinion that part of their statement should be withheld from the applicant or (where he is not the applicant) the patient on the stated grounds, that part shall be made in a separate document in which shall be set out the reasons for believing that disclosure would have that effect. Upon receiving a statement prepared in two parts, the tribunal shall send a copy of it to the patient or applicant excluding that part contained in the separate document.

ASSESSMENT APPLICATIONS

The rules take account of the fact that it will generally be impractical for the responsible authority to provide its statement in separate documents. Where the responsible authority provides a tribunal with admission papers and other documents in connection with an assessment application, it shall indicate if any part of them should, in their opinion, be withheld from the patient[82] on the ground that disclosure would adversely affect the health or welfare of the patient or others, and shall state their reasons for believing that its disclosure would have that effect. Rule 32 provides that the tribunal shall make available to the patient papers and documents which it receives "excluding any part indicated by the responsible authority."

DISCLOSURE OF REPORTS AND DOCUMENTS: ASSESSMENT CASES

Provision of admission papers, etc.

32.—(1) On receipt of the notice of an assessment application, or a request from the tribunal, whichever may be the earlier, the responsible authority shall provide for the tribunal copies of the admission papers, together with such of the information specified in Part A of Schedule 1 to these Rules as is within the knowledge of the responsible authority and can reasonably be provided in the time available and such of the reports specified in Part B of that Schedule as can reasonably be provided in the time available.

(2) The responsible authority shall indicate if any part of the admission papers or other document supplied in accordance with paragraph (1) should, in their opinion, be withheld from the patient on the ground that its disclosure would adversely affect the health or welfare of the patient or others and shall state their reasons for believing that its disclosure would have that effect.

(3) The tribunal shall make available to the patient copies of the admission papers and any other document supplied in accordance with paragraph (l), excluding any part indicated by the responsible authority in accordance with paragraph (2).

General procedure, hearing procedure and decisions

33.(a) rule 12 shall apply as if any reference to a document being withheld in accordance with rule 6 is a reference to part of the admission papers or other documents supplied in accordance with rule 32 being withheld.

[82] The rules presume that in practice an application will not be made by the nearest relative of a section 2 patient, although such applications are legally possible.

CONSIDERATION OF THE REASONS FOR NON-DISCLOSURE

The effect of the above provisions is to release a tribunal from the usual requirement that it shall as soon as practicable disclose to a patient and an applicant any reports and information which it receives. That is all. Rule 12(2) requires the tribunal to then consider whether the material's disclosure would, in its opinion, adversely affect the health or welfare of the patient or others.[83] Unless the tribunal is satisfied that disclosure would have such an effect, it must direct the disclosure of the previously withheld material.

"Adversely affect the health or welfare of the patient or others"

The previous rules provided for withholding a document on the grounds that its disclosure would "be undesirable in the interests of the patient" or for "other special reasons."[84] The criteria under the 1983 rules are rather more specific, namely that disclosure would "adversely affect the health or welfare of the patient or others." Documents must be disclosed unless the tribunal is satisfied that disclosure would have this effect so that, where non-disclosure is sought, the onus is on the person seeking non-disclosure to satisfy the tribunal as to the grounds. This is an example of a "double-negative" phrased in the patient's favour. However, as drafted, the tribunal has no discretion if it is satisfied that disclosure would have such an effect. This is because the present rules do not expressly refer to the interests of the patient generally, such as his interest in being discharged, or to other special reasons such as the interests of justice. According to the rules, these are not factors to be balanced against those specified. If the tribunal is satisfied that non-disclosure would be contrary to the interests of justice, it nevertheless cannot disclose the material if it is also satisfied that to do so would adversely effect some person's health or welfare. As to this, the tribunal must act judicially and the rules must be interpreted in accordance with, and are subservient to, the interests of justice. The rule must therefore be read as requiring the tribunal not to disclose material which would adversely affect the health or welfare of the patient or others unless of the opinion that the interests of justice require its disclosure. To the extent that rule 12 goes further than the restrictions on disclosure envisaged by section 78(2)(h), it is submitted that that part of it is *ultra vires*. It may be noted that in practice it is extremely rare for a tribunal to withhold part of a document from the patient, notwithstanding that an objection has been made to its disclosure.[85] The rule is therefore interpreted in a way which is consistent with the interests of justice, even if the justification given is that a high standard of proof is required before a tribunal can be satisfied that the grounds for non-disclosure exist.

DISCLOSURE TO AUTHORISED REPRESENTATIVES

Where, on considering the issue of disclosure, a tribunal "is minded" not to disclose a document to the patient or applicant, it must nevertheless disclose it as soon as practicable to any authorised representative of that person who is a solicitor or barrister, a registered medical practitioner or, in the tribunal's opinion, a "suitable

[83] Prior to the hearing, the regional chairman may exercise the tribunal's powers under rule 12. Mental Health Review Tribunal Rules 1983, rr. 5, 12(2) and 33(a).

[84] Mental Health Review Tribunal Rules 1983, rr.6(1) and 13(1). The rule therefore precisely matched the wording in the statute, now set out as section 78(2)(h) of the 1983 Act.

[85] Confidentiality is perhaps most often sought for that part of the social circumstances report setting out the views of the patient's family and that part of the medical report which includes the diagnosis. Only rarely are such objections accepted as grounds for non-disclosure.

person by virtue of his experience or professional qualification" — provided that the information shall not be disclosed "either directly or indirectly to the applicant or ... the patient or to any other person without the authority of the tribunal or used otherwise than in connection with the application."[86] The consequence of this provision is that a suitable authorised representative always receives all relevant documents and, furthermore, receives sensitive material before any final decision as its disclosure to his client is made. This allows the representative an opportunity to make representations before a decision is reached.

DECISIONS NOT TO DISCLOSE INFORMATION

Where, having considered the issue including any representations, a tribunal is satisfied as to the statutory grounds, it must record in writing its decision not to disclose the document or information to the patient and/or the applicant.[87] The rules provide only that the decision shall be recorded in writing, not the reasons for the tribunal's opinion.[88] Having decided that information should be withheld in a case involving an unrepresented patient, it is important that the tribunal goes on to consider the effect of its decision on the future conduct of the proceedings, proceeding on the basis that the reasons for non-disclosure will remain valid until the case is disposed of. The patient (or other applicant) will have to be excluded from the hearing when the significance of the information withheld from him is considered, and the reasons for the tribunal's discharge decision avoid any reference to that evidence.[89] If the information is relevant to the discharge issue (and the fact of its disclosure to other parties suggests relevance[90]), the possibility immediately arises that the patient may not be discharged for reasons he is unaware of, being reasons based on evidence the accuracy of which he has had no opportunity to contest or rebut. In such circumstances, a tribunal should, where possible, authorise a representative to act on the relevant person's behalf, to ensure the fair conduct of the proceedings.[91]

DOCUMENTS RECEIVED LATER ON DURING THE PROCEEDINGS

Documents provided under rule 6 or 32 aside, a tribunal may receive supplementary reports or documents about the patient later on during the proceedings. For example, reports which it has directed shall be obtained (under rule 15) or letters from

86 Mental Health Review Tribunal Rules 1983, rr.12(3) and 33(a).

87 Non-disclosure is mandatory where the tribunal (or the chairman) is satisfied as to the criteria for withholding the material. Although the rules do not explicitly provide for the situation where a tribunal decides that only part of the material for which confidentiality is sought should be withheld, it may direct under rule15 that a supplementary report be submitted which includes the information specified by it.

88 This is in contrast to the position under rule 21(1), which provides that a tribunal shall record in writing its "reasons" to hold a hearing in private and inform the patient of those reasons, and rule 21(4), which provides that a tribunal shall inform any person excluded from a hearing of its "reasons" and record those "reasons" in writing. The rationale may be that it would be difficult, if not impossible, to give the person affected any meaningful explanation of the reasons for non-disclosure without revealing the nature of the material which it has been decided he should not see, for his own sake or that of others. On the other hand, the rule could, but does not, provide for the reasons to be recorded and communicated to any suitable authorised representative. However, he will have seen the separate document, and any reasons set out therein as to why the material should be withheld, and may therefore infer that those arguments have been preferred to any representations which he has made.

89 See Mental Health Review Tribunal Rules 1983, rr.21–22 and 24(2).

90 The tribunal is only required to furnish the responsible authority and the Secretary of State with documents relevant to the application or reference, which can only mean relevant to the statutory matters which a tribunal must consider when reaching its discharge decision.

91 See Mental Health Review Tribunal Rules 1983, r.10(3).

relatives of the patient. The general rule is that the tribunal shall, as soon as practicable, send a copy of every document it receives which is relevant to the proceedings to the applicant, the patient (where he is not the applicant), the responsible authority and, in the case of a restricted patient, the Secretary of State, and any of those persons may submit comments thereon in writing to the tribunal.[92] However, before disclosing the document to a patient or applicant, the tribunal is required to consider whether its disclosure would adversely affect the health or welfare of the patient or others. Again, if satisfied that it would, it must record in writing its decision not to disclose it. The rules do not provide for documents not forming part of the responsible authority's or the Secretary of State's statement to be provided in two parts, nor for disclosing only part of any document received.

STATUTORY RIGHTS OF ACCESS TO INFORMATION

Authorised representatives sometimes apply as their client's agent for access to his health or social work records, with the specific aim of obtaining more detailed information than is provided in the reports prepared under the 1983 rules. The provisions relating to access to personal information are complicated, and their detailed consideration lies outside the scope of this work, but they are briefly summarised below. In the case of long-stay patients or those with chronic problems, it will paradoxically often be more important to see the first volume of case notes, too often filed away unread for up to thirty years, than to read the current volume. The recent material is often uninformative, referring to the individual in terms such as "a long-stay chronic schizophrenic with negative symptoms first admitted to hospital in 1962." Only if one knows the beginning can one understand the man, the causes of his breakdown, his suffering, the lost opportunities, the forgotten treatments which helped him, his undiminished desire to be a freeman, and the esteem with which his desire for liberty should be held. The gratitude at being treated as a human being, rather than as a biological organism, is in most cases truly pathetic.

ACCESS TO HEALTH AND SOCIAL WORK RECORDS

	Manual records	*Computerised data*
Health service records	Access to Health Records Act 1990.	Data Protection Act 1984; The Data Protection (Subject Access Modification) (Health) Order 1987.
Social work records	Access to Personal Files Act 1987; The Access to Personal Files (Social Services) Regulations 1989.	Data Protection Act 1984; The Data Protection (Subject Access Modification) (Social Work) Order 1987.
Medical reports for employment/insurance purposes	Access to Medical Reports Act 1988.	Not applicable.

92 A court, authority or person given notice of the proceedings under rule 7 thereby becomes a party to the proceedings and may be represented and appear at the hearing. However, rule 12 does not provide that they shall, as parties to the proceedings, be sent copies of documents which the tribunal receives and given an opportunity to comment on them. The Home Secretary, who is not a party, must, however, be sent documents received as soon as practicable.

Data Protection Act 1984

The Data Protection Act 1984 applies to computerised health service and social work personal data. In general, an individual is entitled to be told whether a data user has personal data of which he is the subject and, where that it the case, to be supplied with a copy of that information.[93] However, section 29 provides that the Secretary of State may modify the usual access provisions where the personal data consists of information about the subject's mental health and orders have been made to this effect.[94]

Access to Personal Files Act 1987

The 1987 Act applies to non-computerised personal information held by local social services authorities. It provides that "accessible personal information" shall be disclosed to a person in the circumstances specified by regulations made under the Act.[95] Accessible personal information" is any information contained in records kept by a local social services authority for the purpose of any past, current or proposed exercise of its social services functions (**153**) and which relates to a living individual who can be identified from that information (or from that and other information in the authority's possession), including expressions of opinion about the individual but not any indication of the authority's intentions with respect to him.[96] Information is not accessible personal information if recorded before 11 November 1987, except to the extent that access to it is required to make intelligible information recorded on or after that date.[97]

Access to Medical Reports Act 1988

The Act provides that an individual has a general right of access to any medical report relating to him which is to be, or has been, supplied by a medical practitioner for employment or insurance purposes.[98]

Access to Health Records Act 1990

The 1990 Act provides a general right of access to health records, or any part of such records, made before 1 November 1990, other than those held on a computer.[99] A health record in this context is a record which consists of information relating to the physical or mental health of an individual and has been made by or on behalf of a health professional in connection with the care of that individual.[100] The definition of a "health professional" is a broad one and includes a registered medical

93 Data Protection Act 1984, s.21(1).

94 The Data Protection (Subject Access Modification) (Health) Order 1987 and The Data Protection (Subject Access Modification) (Social Work) Order 1987.

95 Access to Personal Files Act 1987, s.1(1).

96 *Ibid.*, s.2 and Sched. 1, para.4.

97 *Ibid.*, s.2(4).

98 Access to Medical Reports Act 1988, s.1(1).

99 Access to Health Records Act 1990, ss.1(1), 3(2), 5(1)(b) and 12(2). Access to any part of a health record made before 1 November 1990 may, however, be given if the holder of the record considers that necessary in order to make intelligible information recorded on or after that date (s.5(2)).

100 Access to Health Records Act 1990, ss.1 and 11. "Care" includes examination, investigation, diagnosis and treatment. It may be noted that section 11, in which various expressions are defined, does not commence with the words, "unless the context otherwise requires."

practitioner, registered pharmaceutical chemist, registered nurse, registered occupational therapist, clinical psychologist, art therapist, or music therapist, employed by a health service body.[101] The effect of the statutory definitions is that virtually any record relevant to tribunal proceedings which was made after 31 October 1990 in connection with a patient's medical treatment will be a "health record" for the purposes of the 1990 Act. [102]

Grounds for refusing access

Where a general statutory right of access exists, access may nevertheless be refused in any case on the ground that the information's disclosure would be likely to cause serious harm to the physical or mental health of the patient or, computerised health records apart, be likely to have such consequences for a third party.[103] Access may also be refused to any part of a record which is likely to enable the patient to identify or deduce the identity of another person referred to (unless he consents to the information's disclosure) or the source of the information, unless that third party is a health or social work professional involved in the care of the patient.[104]

Access and Mental Health Review Tribunals

Because statutory applications made to a local authority or health service body for access to personal records take around 40 days to process, there is no point in applying if the sole purpose is to obtain information which might support a tribunal application made by a section 2 patient. In other cases, the grounds upon which a document received by the tribunal may be withheld from the patient (that disclosure would adversely affect the health or welfare of the patient or others) are wider than those generally applicable under the legislation governing access to personal records (that disclosure would be likely to cause serious harm to the physical or mental health of the patient or others), leaving open the possibility that access might be gained to the same information under one of the above enactments.[105] However, the existence of an alternative "confidentiality" ground for withholding information under the legislation — that access would allow a third party or the source of information to be identified — is likely to prevent the disclosure of information concerning the patient given in confidence to a health service professional or a social worker by a third party and furnished in turn to a tribunal. In practice, because of the

101 Access to Health Records Act 1990, s.2(1). Subsection (4) states that the Act applies to health professionals in the public service of the Crown as it applies to other health professionals.

102 The extent to which a patient may have a general common law right of access to medical records compiled before 1 November 1990 was touched upon, but not determined, by the Court of Appeal in *R. v. Mid-Glamorgan Family Health Services and Another, ex. p. Martin*, The Times, 16 August 1994.

103 Access to Health Records Act 1990, s.5(1)(a)(i); Access to Medical Reports Act 1988, s.7(1); Data Protection (Subject Access Modification) (Health) Order 1987, Art. 4(2)(a); Data Protection (Subject Access Modification) (Social Work) Order 1987, Art. 4(3)(a); Access to Personal Files (Social Services) Regulations 1989. In the case of computerised social work records, an additional ground exempting access is that serious harm to the "emotional condition" of the patient or a third party would be likely to be caused.

104 Access to Health Records Act 1990, s.5(1) and (2); Access to Medical Reports Act 1988, s.7(2) and (3); Data Protection (Subject Access Modification) (Health) Order 1987, Arts. 4(2)(b) and (3); Data Protection (Subject Access Modification) (Social Work) Order 1987, Arts. 4(3)(b), (4) and (6); Access to Personal Files (Social Services) Regulations 1989.

105 Moreover, section 1(5) of the Access to Personal Files Act 1987 specifically provides that the obligation to give access under the Act applies notwithstanding any enactment or rule of law authorising the withholding of information.

paperwork involved in dealing with formal applications under the 199(t, access is often agreed between the responsible medical officer and the patient, or his authorised representative, on an informal basis. The patient's case notes may also be inspected by an independent psychiatrist instructed by the patient or his representative.[106] Misunderstandings are only likely to arise if a representative obtains access to the case notes without first obtaining proper authorisation and then seeks to cross-examine the responsible medical officer by persistent, detailed, references to entries in those notes. Although the practice take places, it is unbefitting conduct for a solicitor to inspect case notes given to him by a nurse or junior doctor who is clearly under the impression that solicitors engaged in a tribunal case automatically have access to them under the 1983 Act or rules.[107]

COMMENTING ON THE AUTHORITY'S STATEMENT

Subject to the power in rule 12(2) not to disclose certain documents to the patient or the applicant, rule 12(1) provides that any person to whom a tribunal sends a copy of a document which it has received in connection with the proceedings may submit comments in writing to the tribunal.

COMMENTS ON DOCUMENTS RECEIVED BY THE TRIBUNAL

> **12.**—(1) Subject to paragraph (2), the tribunal shall, as soon as practicable, send a copy of every document it receives which is relevant to the application to the applicant, and (where he is not the applicant) the patient, the responsible authority and, in the case of a restricted patient, the Secretary of State and any of those persons may submit comments thereon in writing to the tribunal.

The accuracy of the reports

Rule 12 is a highly useful rule because it enables the issues and any matters in dispute to be clarified and itemised in advance of the hearing. From the patient's point of view, it ensures that when the tribunal members receive the authority's statement in advance of the hearing they will read this with his observations as to their accuracy and with the benefit of any counter-balancing points helpful to discharge. Because the responsible authority's statement is necessarily adverse to discharge, the written observations therefore ensure that the members do not come to the hearing aware only of the reasons for not discharging and perhaps with an unconscious inclination against discharge. Early observations may also allow the medical member to be aware of the issues likely to be canvassed at the hearing and he can then examine the patient with these in mind before forming his preliminary opinion. If the patient has difficulty communicating his opinion and feelings, or is likely to have difficulty understanding some questions put to him at the hearing, perhaps because he is severely mentally impaired or has a poor grasp of English, it is also fairer to him to take the time to set out his case in writing.

106 Mental Health Act 1983, s.76.
107 Solicitors' Practice Rules 1990, rule 1(a) and (d).

OBTAINING FURTH REPORTS AND INFORMATION

Apart from the reports which must be furnished by the responsible authority or the Secretary of State under the rules, there are a number of other ways in which a tribunal may receive medical evidence and other information about the patient—

- If the reports are inadequate in some respect, the tribunal may direct that further reports or information are provided (**783**)
- Following the appointment of a tribunal to hear the case, the medical member is required to examine the patient and to take such other steps as he considers necessary to form an opinion of the patient's mental condition. The medical member may see the patient in private, examine his medical records, and take such notes and copies of them as he may require for use in connection with the proceedings (**793**).
- The patient, or his authorised representative, may commission a medical report or a social circumstances report from a practitioner of his choosing (*infra*).
- Similarly, where the patient's nearest relative is the applicant that person may commission reports on the patient (*infra*).

REPORTS PREPARED FOR A PATIENT OR APPLICANT

Following the commencement of tribunal proceedings, a patient or applicant will often wish to instruct a medical practitioner, generally a psychiatrist, to prepare a report on the patient's mental health. Section 76 provides that, for the purpose of furnishing information as to the patient's condition for the purposes of an application, any registered medical practitioner authorised by or on behalf of the patient or a nearest relative applicant may at any reasonable time visit the patient and examine him in private, and may require the production of and inspect any records relating to the detention or treatment of the patient in any hospital (**616, §926**). An unrestricted patient whose case is referred to a tribunal has a similar right to authorise a doctor to examine both him and his records, but not it seems a restricted patient whose case is referred.[108]

Confidentiality of reports

The extent to which a medical report prepared on behalf of the patient or a nearest relative applicant is confidential was considered in *W. v. Egdell*. Under section 76, the relationship between doctor and patient is contractual and whether the report's disclosure without the patient's consent amounts to a breach of contract turns not on what the doctor thinks but on what the court rules. The law recognises an important public interest in maintaining professional duties of confidence. The fact that a patient has a strong private interest in barring a report's disclosure does not affect this fact. However, such duties are not absolute and are liable to be overridden where there is a stronger public interest in disclosure. The breadth of the doctor's duty therefore depends on the circumstances. In a case involving a restricted patient

108 Mental Health Act 1983, ss.67, 68, 71 and 76.

who has committed very serious crimes of violence, the crucial questi_ s how, on the special facts of the case, the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence. If the doctor becomes aware of information which *properly* leads him to fear that a decision about the patient's release may be made on the basis of inadequate information, with a real risk of consequent danger to the public, he is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities. In making its ruling the court will give such weight to the considered judgment of the psychiatrist as seems in all the circumstances to be appropriate.

W. v. Egdell and others

[1989] 2 W.L.R. 689 — *Chancery Division, Scott J.*

W. had been detained in special hospitals for some ten years under a restriction order without limit of time. The circumstances of the index offence were that he had shot and killed five people and wounded two others. In March 1985, his responsible medical officer recommended to the Secretary of State that he be transferred to a regional secure unit and a place for him became available in June 1986. A previous tribunal had supported this recommendation but the Home Secretary's consent to transfer had not been granted. In April 1987, the patient again applied to a tribunal.

Tribunal medical report prepared by responsible medical officer

The responsible medical officer's report of 19 May 1987 repeated her earlier recommendation that W. be transferred to a regional secure unit. She stated that he suffered from schizophrenia but had been stable on medication for the past 5 years. He had considerable insight into his mental state, accepted the need to continue medication, and realised that his mental state required close and careful monitoring.

The Home Secretary's statement and observations

The Home Secretary remained unwilling to consent to the patient's transfer. He considered that the case called for the utmost caution and W. would first need to show a very long period of stable behaviour, bearing in mind his history of indiscriminate violence. In particular, his interest in weapons needed to be more fully explored and explained. The Home Secretary would be prepared to reconsider the issue of transfer in about 18 months' time following such exploration. He would in all probability wish to refer any future proposals to the Advisory Board on Restricted Patients.

Independent medical report prepared under section 76

The patient instructed a solicitor to act as his authorised representative. As provided for by section 76, they commissioned a report on his behalf from a consultant psychiatrist, Dr. Egdell. Dr. Egdell's ten-page report of 29 July 1987 contained new information concerning the risk to the public. The patient had described to him a life-long interest in making and exploding home made bombs, which he called "fireworks." He was aware of the precautions necessary to avoid injury to himself but, in relation to the index offence, had been prepared to use them to "scare people off " with no apparent regard for the risk of injury to others. His interest in guns was similarly profound, prolonged and, in the last years before the offence, manifestly abnormal. While agreeing that the patient was suffering from a mental illness at the time of the index offences, Dr. Egdell referred to the possibility first raised in July 1984 that the illness might be a paranoid psychosis rather than paranoid schizophrenia. The

relevance of the distinction w_ hat medication would be less effective in the former case in protecting against a relapse. He was not convinced that the patient really had insight into his illness and there was a striking lack of remorse. For example, the wife at the garage "made a fuss" so she was shot. He showed no concern for those who were wounded, their relatives or the effects of his offence on his own family. Although reluctant to say on the basis of one interview that he suffered from a psychopathic personality, he clearly had an abnormal personality. All these issues needed to be highlighted and resolved before a decision was made on his departure from the special hospital. Consequently, Dr. Egdell concluded by strongly recommending that W. not be considered for transfer, let alone discharge, until this had been done.

Withdrawal of tribunal application and disclosure of report

On considering Dr. Egdell's report, W. withdrew his tribunal application on 18 August 1987 and his solicitors did not disclose the report to the tribunal or to any third party. On learning of the non-disclosure, Dr. Egdell telephoned the assistant medical director at the secure hospital. He explained his concern that important matters relating to W.'s interest in firearms and explosives had not been properly explored. It was his opinion that a copy of the report ought to be supplied to the Home Office because it contained evidence to suggest that W.'s interest in guns and explosives was long standing and pre-dated his illness, which were pointers to a psychopathic disorder. The assistant medical director indicated that additional information was always helpful but asked Dr. Egdell to contact W.'s solicitors as a matter of courtesy, to see if they would agree to the report's disclosure. In accordance with their client's instructions, the solicitors declined to agree. Dr. Egdell pressed his case with the hospital and was eventually asked to forward a report of his concerns to the assistant medical director. This he did by sending a copy of his tribunal report, having simply substituted the assistant director's name for that of the solicitors who had commissioned it. In November 1987, copies of the report were then sent by the hospital to the Home Office and the Department of Social Security, upon Dr. Egdell indicating that he would have no alternative but to do this himself if the hospital did not comply with his request. The Home Secretary then referred W.'s case to the tribunal, as he was required to do under section 71(2), and forwarded a copy of the report to it.

The writs

On 22 December 1987, W. issued a writ against Dr. Egdell, seeking an injunction restraining him from further disclosure of the contents of his medical report; delivery up of all copies of the report; and damages for breaching his duty of confidentiality. On 19 July 1988, he issued a second writ against the Secretary of State for Social Services, the Home Secretary, the relevant Hospital Board and the Mental Health Review Tribunal, all of whom had received a copies of the report, seeking an injunction to restrain them from disclosing the contents of Dr. Egdell's report; delivery up of all copies of the report; and, as against the Home Secretary and the hospital board, damages for breach of the duty of confidentiality.

Relevant guidelines

At the time, paragraphs 80–81 of the General Medical Council's "Advice on Standards of Professional Conduct and of Medical Ethics" included the following guidance on the principles which should govern the confidentiality of information relating to patients—

80. It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any

third party information about a patient which he has learnt directly or i[illegible]ctly in his professional capacity as a registered medical practitioner. The death of the patient does not absolve the doctor from this obligation.

81. The circumstances where exceptions to the rule may be permitted are as follows—

(a) If the patient or his legal adviser gives written and valid consent, information to which the consent refers may be disclosed.

(b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence.

(g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.

Scott J.

It was important to notice that the nature of a hearing before a mental health review tribunal was inquisitorial, not adversarial. That appeared particularly from rules 11, 14, 15(1) and 22(2), which concerned medical examinations, evidence, further information, and hearing procedures. It was open to W. and his solicitors, having received the report, to decide not to use it. The basis of W.'s case was that his interview with Dr. Egdell on 23 July 1987, and the report written by Dr. Egdell on the basis of that interview was, or ought to have been, protected from disclosure. It was claimed that Dr. Egdell was in breach of his duty of confidence in telling the assistant medical director about the report, in sending a copy of the report to him and in urging the despatch of a copy to the Home Office. The hospital ought to have recognised the confidential character of the report, that it came under a duty not to disclose it and that it broke that duty by sending a copy to the Home Office. The Home Office likewise came under a duty to respect the confidential character of the report and broke that duty by sending a copy to the tribunal. The claim against the Secretary of State for Health and against the tribunal was for an order that each be required to deliver up or destroy the copies of the report that each held. The case against each defendant was therefore based on the confidential character of the communication between W. and Dr. Egdell and of Dr. Egdell's report because of the doctor–patient relationship. It was clear from *A-G v. Guardian Newspapers Ltd*[109] that the duty to maintain confidentiality was not necessarily the same in relation to third parties who became possessed of confidential information as it was in relation to the primary confidant. The reason was that the third party recipient could be subject to some additional and conflicting duty which did not affect the primary confidant or might not be subject to some special duty which did affect that confidant. That being so, the cases against the respective defendants were not identical and the breadth and nature of the duty of confidence that affected each of them had to be separately assessed.

109 *A.-G. v. Guardian Newspapers Ltd. (No 2)* [1988] 2 W.L.R. 805 at 873.

The case against Dr. Egdell

It was plain that the circumstances imposed a duty of confidence on Dr. Egdell. The question here was not whether he was under a duty of confidence but the breadth of that duty. It was well established that the public interest in the preservation of confidences could be outweighed by some other countervailing public interest which favoured disclosure. The General Medical Council's advice did not provide a definitive answer to the question raised but was valuable in showing its approach to the breadth of a doctor's duty of confidence. It showed that the duty though important was not absolute. The duty of confidence did not prevent a doctor from disclosing confidential information to other doctors charged with the care or treatment of the patient or, in rare cases, where the public interest overrode this duty. The duty of confidence owed by Dr. Egdell to W. was both created and circumscribed by the particular circumstances of the case. They were that W. had killed five people and seriously wounded two others. He had been diagnosed as suffering from mental illness and had been ordered to be detained without limit of time. The psychiatrist responsible for his treatment regarded him as no longer a danger to the public provided he remained on suitable medication. She regarded the index offences as having been occasioned by mental illness from which he had been cured. The circumstances did not impose on Dr. Egdell a duty not to disclose his opinions and his report to the assistant medical director at the hospital since the doctor's opinions were relevant to the nature of the patient's treatment and care there.

The duties owed by Dr. Egdell

The duty owed to W. was not Dr. Egdell's only duty. W. was not an ordinary member of the public. He was, consequent on the killings he had perpetrated, held in a secure hospital subject to a regime whereby decisions concerning his future were to be taken by public authorities — the Home Secretary or the tribunal. W.'s own interests would not be the only nor the main criterion in the taking of those decisions. The safety of the public would be the main criterion. A doctor called on to examine a patient such as W. owed a duty not only to his patient but also a duty to the public. His duty to the public would require him to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so whether or not the patient instructed him not to do so.

W.'s interest only a private interest

W. had a strong private interest in barring disclosure of the report to the Home Office and, probably, to the hospital authorities as well. The public interest in non-disclosure had been put in terms that in about 80 per cent. of the tribunal cases independent psychiatric reports were submitted. If patients were held to be unable to suppress unfavourable reports, they would be unwilling to commission such reports or might not be wholly frank when being examined. The value of the independent reports would then be reduced. Those propositions did not seem to have much weight. The possibility of a lack of frankness was always present and the suggestion that the commissioning of independent reports would be reduced did not seem in the least self-evident. If the private interest of W. was set in the balance against the public interest served by disclosure, the weight of the public interest prevailed.

Conclusions regarding Dr. Egdell's liability

If a patient in W.'s position commissioned an independent psychiatrist's report, the duty of confidence on the doctor making the report did not bar him from disclosing the report to the hospital charged with his care if the doctor judged the report to be relevant to the patient's care and treatment. Nor did it bar him

from disclosing the report to the Home Secretary if the doctor judged the report to be relevant to the exercise of the Home Secretary's' discretionary powers in relation to that patient. That was an inevitable result of the circumstances that led to W. being subjected to a restriction order. This limitation of W.'s rights was justified by the need for the following bodies to be fully informed about him: (1) the hospital in charge of his clinical management; (2) the Home Secretary, in whom very important discretionary powers were reposed; and (3) the tribunal on whom an obligation to order his discharge was placed in certain circumstances.

Legal privilege

There was a clear and important distinction to be drawn between instructions given to an expert witness and the expert's opinion given pursuant to those instructions. In the case of expert witnesses, the rule was that legal professional privilege attached to confidential communications between the solicitor and the expert. The instructions were covered by that privilege and the expert could be barred when giving evidence of his opinion from referring to documents which, in the solicitors' hands, would be covered by legal professional privilege. However, legal professional privilege did not attach to the chattels or documents on which the expert based his opinion or to the independent opinion of the expert himself. There was no property in an expert witness any more than there was in any other witness. The court was entitled, in order to ascertain the truth, to have the actual facts which the expert has observed adduced before it in considering his opinion. The information acquired from W. formed part of the facts on which the opinion expressed by Dr. Egdell in his report was based. Neither Dr. Egdell's opinion, nor the facts on which it was based, were privileged.

The hospital's liability

The hospital's legal position had to be considered on the hypothesis that the disclosure of the report to it was a breach by Dr. Egdell of the duty of confidence he owed to W. The restriction order scheme set out in the 1983 Act required co-operation between the Home Secretary and the hospitals in which patients were held. The Home Secretary, when deciding whether or not to exercise any of his discretionary powers, depended on the hospital in which the patient was held to supply him with relevant information about that patient. It could never be right for the authorities of such a hospital to withhold from the Home Secretary relevant information about a patient subject to a restriction order. The importance for public safety that the Home Secretary should be fully informed required that that be so. Accordingly, even if Dr. Egdell were in breach of duty in disclosing his report to the hospital authority, that authority was not in breach of any duty in forwarding it to the Home Secretary. On the contrary, the hospital had a duty to send a copy to him. *A fortiori*, the Home Secretary was under a duty to send a copy of the report to the tribunal. Rule 6(2) of the 1983 rules placed a statutory obligation on the Home Secretary to send to it a statement of such further information relevant to the application as might be available to him. The Home Secretary's statutory duty under rule 6(2) overrode any confidentiality attaching to the report.

The tribunal's liability

As to the position of the tribunal, it was entitled to retain its copies and to make such use of them as it thought fit at the hearing. Both the public interest in a tribunal being fully informed and the inquisitorial nature of its proceedings overrode any confidentiality attaching to the report.

Disposition

The actions failed because Dr. Egdell's report was relevant material to be taken into account by the hospital, by the Home Office and by the tribunal in the discharge of their respective functions and because, in the very special circumstances of W.'s case, the duty of confidence owed by Dr. Egdell to his patient did not bar disclosure of the report to those recipients. It was for those recipients of the report to attribute to it such weight as they thought it merited. *Actions dismissed.*

W. v. Egdell and others

[1990] Ch. 359 *C.A. (Sir Stephen Brown P., Bingham L.J., Sir John May)*

In the Court of Appeal, W.'s counsel acknowledged that there were two competing public interest considerations. However, he submitted that the dominant public interest was the duty of confidence owed to W. The burden of proving that that duty was overridden by public interest considerations rested fairly and squarely on Dr. Egdell. Where the public interest relied on to justify a breach of confidence was alleged to be the reduction or elimination of a risk to public safety, it must be shown (a) that such a risk was real, immediate and serious; (b) that it would be substantially reduced by disclosure; (c) that the disclosure was no greater than was reasonably necessary to minimise the risk; and (d) that the consequent damage to the public interest protected by the duty of confidentiality was outweighed by the public interest in minimising the risk. Furthermore, in common with other professional men, the doctor was under a duty not to disclose without his patient's consent any information which he had gained in his professional capacity, save in very exceptional circumstances.

Sir Stephen Brown P.

This appeal raised in an unusually stark form the question of the nature and quality of the duty of confidence owed to a restricted special hospital patient by an independent consultant psychiatrist who had been engaged on his behalf in connection with a forthcoming tribunal. In this case, the number and nature of the killings committed by W. inevitably gave rise to the gravest concern for the safety of the public. The authorities responsible for his treatment and management must be entitled to the fullest relevant information about his condition. It was clear that Dr. Egdell did have highly relevant information about W.'s condition which reflected on his dangerousness. The position therefore came within the terms of rule 81(g) of the General Medical Council's rules. The suppression of the material contained in his report would have deprived both the hospital and the Secretary of State of vital information directly relevant to questions of public safety. Insofar as the judge referred to the private interest of W., that passage in his judgment did not accurately state the position. There were two competing public interests. This was not a case of legal professional privilege although it was relevant as part of the background which gave rise to the issue of confidentiality. Dr. Egdell was clearly justified in taking the course that he did.

Bingham L.J.

The philosophy underlying the statutory regime was clear. A man who committed crimes, however serious, when subject to severe mental illness was not to be treated as if he were of sound mind. Although he required treatment in hospital, not punishment, he might represent a great and continuing danger to the public. So his confinement in hospital could be ordered to continue until the

Home Secretary, as guardian of the public safety, adjudged it safe to release him or relax the conditions of his confinement. But a decision by the Home Secretary adverse to the patient was not conclusive. The patient had recourse to an independent tribunal which, if certain conditions were satisfied, must order his discharge, and it could also make non-binding recommendations. Lest an inactive patient be forgotten, the patient's case must be reviewed by the tribunal at three-yearly intervals. These provisions represented a careful balance between the legitimate desire of the patient to regain his freedom and the legitimate desire of the public to be protected against violence. The heavy responsibility of deciding how the balance should be struck in any given case at any given time rested in the first instance on the Home Secretary and in the second instance on the tribunal. It was only by making a careful and informed assessment of the individual case that the potentially conflicting claims of humanity to the patient and protection of the public could be fairly and responsibly reconciled.

The duty of confidence

It had never been doubted that the circumstances imposed on Dr. Egdell a duty of confidence to W. The breadth of that duty was dependent on the circumstances. The decided cases very clearly established (1) that the law recognised an important public interest in maintaining professional duties of confidence but (2) that the law treated such duties not as absolute but as liable to be overridden where there was held to be a stronger public interest in disclosure. Thus, the public interest in the administration of justice might require a clergyman, a banker, a medical man, a journalist or an accountant to breach his professional duty of confidence. Likewise, a solicitor's duty of confidence towards his clients was held to be overridden by his duty to comply with the law of the land, which required him to produce documents for inspection under the Solicitors' Accounts Rules. Those qualifications of the duty of confidence arose not because the duty was not accorded legal recognition but because of the overriding public interest.

The public interest in W.'s right to confidence

It was nevertheless important to insist on the public interest in preserving W.'s right to confidence because the court of first instance had concluded that, while W. had a strong private interest in barring disclosure of Dr. Egdell's report, he could not rest his case on any broader public interest. Here, the judge fell into error. W. had a strong personal interest in regaining his freedom and no doubt regarded Dr. Egdell's report as an obstacle to that end. So he had a personal interest in restricting the report's circulation. But those private considerations should not be allowed to obscure the public interest in maintaining professional confidences. The fact that Dr. Egdell as an independent psychiatrist examined and reported on W. as a restricted mental patient under section 76 did not deprive W. of his ordinary right to confidence, underpinned, as such rights are, by the public interest. But it did mean that the balancing operation fell to be carried out in circumstances of unusual difficulty and importance.

Advice of the General Medical Council

Rule 81 of the General Medical Council's advice listed the exceptions to the rule of professional secrecy. The judge had regarded rule 81(b) as accurately stating the law and held that Dr. Egdell's disclosure in the present case fell squarely within it. However, that paragraph was directed towards the familiar situation in which consultants or other specialised experts report to the doctor with clinical responsibility for treating or advising the patient. The second sentence showed that the doctor whose duty was in question was regarded as having a continuing professional relationship with the patient. It was doubtful if the draftsman of

paragraph (b) had in mind consultant psychiatrist consulted on a single occasion but it was not necessary to reach a final view. In any case, the judge preferred to rest his conclusion on the exception set out in rule 81(g) and, if the disclosure could not be justified under that exception, it would be unsafe to justify it under any other. It was this exception which the judge upheld and applied when he held that a doctor called on to examine a patient such as W. owed a duty not only to his patient but also a duty to the public. This duty to the public would require him to place before the proper authorities the result of his examination if, in his opinion, the public interest so required, whether or not the patient instructed him not to do so. Counsel for W. had criticised that passage as wrongly leaving the question of whether disclosure was justified or not to the subjective decision of the doctor. He made the same criticism of the judge's opinion that, if a patient in W.'s position commissioned an independent psychiatrist's report, the duty of confidence on the doctor did not bar him from disclosing the report to the hospital charged with his care if he, the doctor, judged the report to be relevant to that care and treatment. Nor, the judge had said, did it bar him from disclosing the report to the Home Secretary if the doctor judged the report to be relevant to the exercise of his discretionary powers. Those criticisms were just. Where, as here, the relationship between doctor and patient was contractual, the question was whether the doctor's disclosure was or was not a breach of contract. The answer to that question must turn not on what the doctor thought but on what the court ruled. In making its ruling the court would give such weight to the considered judgment of a professional man as seemed in all the circumstances to be appropriate.

The balance to be struck between the two public interests

The crucial question was how, on the special facts of the case, the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence.

Submissions of counsel for W.

Counsel for W. had submitted that the following features of the case indicated that the public interest in maintaining confidences was shown to be clearly preponderant—

(1) Section 76 of the 1983 Act showed a clear parliamentary intention that a restricted patient should be free to seek advice and evidence for the specified purposes from a medical source outside the prison and secure hospital system. Section 129 ensured that the independent doctor could make a full examination and see all relevant documents. The examination could be in private, so that the authorities did not learn what passed between doctor and patient.

(2) The proper functioning of section 76 required that a patient should feel free to bare his soul and open his mind without reserve to the independent doctor he had retained. This he would not do if a doctor was free, on forming an adverse opinion, to communicate it to those empowered to prevent the patient's release from hospital.

(3) Although the present situation was not one in which W. could assert legal professional privilege, and although tribunal proceedings were not strictly adversarial, the considerations which had given rise to legal professional privilege underpinned the public interest in preserving confidence in a situation such as the present. A party to a forthcoming application to a tribunal should be free to unburden himself to an adviser he had retained without fearing that any material damaging to his application would find its way without his consent into the hands of a party with interests adverse to his.

(4) Preservation of confidence was conducive to the public safety. ...ents would be candid, so that problems such as those highlighted by Dr. Egdell would become known, and steps could be taken to explore and if necessary treat the problems without disclosing the report.

(5) It was contrary to the public interest that patients such as W. should enjoy rights less extensive than those enjoyed by other members of the public.

The first of these considerations was a powerful consideration in W.'s favour. A restricted patient who believed himself unnecessarily confined had, of all members of society, perhaps the greatest need for a professional adviser who was truly independent and reliably discreet. The second consideration was also accepted, subject to the comment that, if the patient was unforthcoming, the doctor was bound to be guarded in his opinion. If the patient wished to enlist the doctor's wholehearted support for his application, he had little choice but to be (or at least convince an expert interviewer that he was being) frank. There was great force in the third of the points. Only the most compelling circumstances could justify a doctor in acting in a way which would injure the immediate interests of his patient, as the patient perceived them, without obtaining his consent. The fourth point did not, however, impress His Lordship. It appeared to suggest that the problems highlighted by Dr. Egdell could be explored and if necessary treated without the hospital authorities being told what the problems were thought to be. This was not very satisfactory. As to the final submission, His Lordship agreed that restricted patients should not enjoy rights of confidence less valuable than those enjoyed by other patients save in so far as any breach of confidence could be justified under the stringent terms of rule 81(g).

Submissions of counsel for Dr. Egdell

Counsel for Dr. Egdell justified his client's disclosure by relying on the risk to the safety of the public if the report were not disclosed. The steps of his argument, briefly summarised, were as follows. Dr. Egdell believed that W. had had a long-standing and abnormal interest in dangerous explosives dating from well before his period of acute illness; this interest had been overlooked or insufficiently appreciated by those with clinical responsibility for W.; this interest could throw additional light on W.'s interest, also long-standing and in this instance well documented, in guns and shooting; that exploration of W.'s interest in explosives, and further exploration of W.'s interest in guns, and shooting might lead to a different and more sinister diagnosis of W.'s mental condition. Dr. Egdell's opinions in these respects although not accepted were not criticised as ill-founded or irrational. Dr. Egdell believed that these explorations could best be conducted in the secure hospital where W. was; that W. might possibly be a future danger to members of the public if his interest in firearms and explosives continued after his discharge; and that these matters should be brought to the attention of those responsible for W.'s care and treatment and for making decisions concerning his transfer and release. While W. would no doubt be further tested, such tests would not be focused on the source of Dr. Egdell's concern, which he quite rightly considered to have received inadequate attention up to then. Dr. Egdell had to act when he did or not at all.

The decisive consideration

There was one consideration which weighed the balance of public interest decisively in favour of disclosure. It could be shortly put. Where a man had committed multiple killings under the disability of serious mental illness, decisions which might lead directly or indirectly to his release from hospital should not be made unless a responsible authority was properly able to make an

informed judgment that the ... f repetition was so small as to be acceptable. A consultant psychiatrist who became aware, even in the course of a confidential relationship, of information which led him, in the exercise of what the court considered a sound professional judgment, to fear that such decisions might be made on the basis of inadequate information, and with a real risk of consequent danger to the public, was entitled to take such steps as were reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities. There was no doubt that the judge's decision in favour of Dr. Egdell was right on the facts of this case. Nor could it be said that if Dr. Egdell was entitled to make some disclosure he should have disclosed only the crucial paragraph of his report and his opinion. An opinion, even from an eminent source, could not be evaluated unless its factual premise was known, and a detailed 10-page report could not be reliably assessed by perusing a brief extract.

European Convention on Human Rights

No reference had been made in argument to the European Convention on Human Rights. However, the court's decision appeared to be in accordance with it. Article 8(2) envisaged that circumstances might arise in which a public authority could legitimately interfere with the exercise of a legal right against the disclosure of information protected by the duty of professional secrecy where necessary in a democratic society in the interests of public safety or the prevention of crime. There was here no interference by a public authority.
Appeal dismissed.