3. Relevant terms and parties

INTRODUCTION

Many different individuals and bodies may be involved in the detention, treatment or care of an individual and in any subsequent tribunal proceedings. It is important to have some understanding of their functions and any statutory definitions relating to them. Where a term is defined in section 145(1) of the Mental Health Act 1983, the meaning given there applies "unless the context otherwise requires."

- The patient (**098**) is the focus of the tribunal proceedings and the other private individual with a statutory role is the patient's nearest relative (**100**). Special considerations may apply if the patient is a child (**115**).
- Unless he has been received into guardianship, or is subject to supervision, the patient will be liable to detention in a hospital (**131**). It is the managers of that hospital (**141**) who have authority to detain him there in accordance with the provisions of the 1983 Act.
- Unless the hospital is a private establishment, it will form part of the National Health Service for which the Secretary of State for Health (**126**) is accountable to Parliament. NHS hospitals are managed by NHS trusts (**131**). Health Authorities (**130**) purchase in-patient and other medical services from these trusts.
- Various health service professionals will then be involved in the patient's treatment. In addition to their clinical duties, medical practitioners (**146**) and nurses (**149**) have a number of statutory functions to perform.
- Patients who leave hospital or who are subject to guardianship will require support from local social services authorities (**151**), including community care (**154**). Many statutory functions under the 1983 Act may only be exercised by approved social workers (**160**), that is by social workers who have undergone special training in the statutory procedures.
- A number of executive or judicial bodies may be involved. The Home Secretary (**162**) has responsibility for some patients whose discharge from hospital may place the public at risk of serious harm. The Mental Health Act Commission (**169**) is a quasi-independent body which visits detained patients and investigates certain complaints made by or in respect of them. Mental Health Review Tribunals (**190**) are independent judicial bodies which review whether a patient should be subject to compulsory powers at all.

THE PATIENT

The Mental Health Act 1983 provides that, unless the context otherwise requires, and except in relation to matters concerning the Court of Protection, the word "patient" means "a person suffering or appearing to suffer from mental disorder.[1] By section 1(1), the provisions of the Act have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. In the context of tribunal proceedings, the "patient" is simply the person whose case is under review. During the year ending on 31 March 1996, 271,000 people were admitted to hospital for in-patient psychiatric treatment, of whom some 26,000 were detained under the 1983 Act.

RESTRICTED PATIENTS

A "restricted patient" is a patient who is subject to a restriction order or a restriction direction, or an order having like effect.[2] Where the Crown Court orders the admission of a defendant to hospital at the conclusion of criminal proceedings, it may also make what is known as a restriction order. Similarly, where the Home Secretary directs the transfer of a person from prison to hospital, he may further direct that the patient shall be subject to a "restriction direction." If such restrictions are in force, their effect is that the patient cannot be transferred to another hospital, or granted leave to be absent from the hospital grounds, without the Home Secretary's consent. Furthermore, the patient's discharge from hospital requires either the Home Secretary's consent or a direction made by him or by a Mental Health Review Tribunal. A restricted patient's discharge may initially only be conditional, in which case he can be recalled to hospital for further treatment if his mental state or behaviour deteriorates or he breaches one of the condition of his discharge. Notwithstanding the wording of section 1(1), a restricted patient remains a "patient" for the purposes of the Act until such time as he is absolutely discharged from the restrictions — that is, regardless of whether or not he appears to be suffering from mental disorder at a particular moment in time.[3]

The restricted population

There are approximately 100,000 in-patients in psychiatric units in England and Wales of whom 1,900 or so are restricted patients. About 1,200 of them are detained in special hospitals, the remainder being in regional secure units and local hospitals. The great majority have been convicted of serious offences of violence — 530 of homicide, 700 of other violent offences, 230 of a sexual offence, and 250 of arson. In addition to the in-patient population, there are about 1,000 conditionally discharged restricted patients living in the community.

INFORMAL PATIENTS

The vast majority of people undergoing in-patient psychiatric treatment are not liable to be detained and of those who are detained only a small minority are subject to special restrictions. Patients who are treated without resort to formal compulsory

1 Mental Health Act 1983, s.145(1).
2 *Ibid.*, s.79(1).
3 *R. v. Merseyside Mental Health Review Tribunal, ex p. K* [1990] 1 All E.R. 694, *per* Butler-Sloss L.J. at 699.

powers are known as "informal patients." Section 131(1) of the Mental Health Act 1983 provides that nothing in the statute "shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act."

Voluntary patients

Not all "informal patients" are "voluntary patients" and the terms are not synonymous. A significant number of informal patients lack the capacity to consent to their admission, are mentally incapable of organising and arranging their own discharge, or remain in hospital informally only because compulsory powers will be invoked if they refuse treatment or attempt to leave. The 1983 Act provides three mechanisms for protecting these citizens. Firstly, it is an offence to ill-treat or to wilfully neglect them.[4] Secondly, certain invasive treatments such as psychosurgery must be independently authorised and may only be administered to an informal patient who is able to give a valid consent to the treatment.[5] Thirdly, the statute empowers the Secretary of State to extend the Mental Health Act Commission's remit so that it includes keeping under review the care and treatment of informal patients.[6] However, no such direction has yet been given. Informal admission may be particularly disadvantageous for people who are mentally incapacitated in that the necessity for their being in hospital, and the treatment and care which they receive there, are not susceptible to periodic external review by the Mental Health Act Commission or a Mental Health Review Tribunal. Whilst the use of compulsory powers deprives the person affected of certain legal rights, it also confers other rights in substitution. Since these are framed as duties exercisable by third parties on the patient's behalf, they may in practice more than compensate the patient for the loss of rights the existence of which he is unaware or, if aware of them, incapable of exercising. Although most formal patients understandably wish to be informal, there are nevertheless a number of patients who are incapable of understanding or exercising the legal rights which constitute the practical benefits of being an informal patient.

OTHER ASPECTS OF A PATIENT'S LEGAL STATUS

Having regard to the above, a patient's legal status under the 1983 Act may be that he is an informal patient, a person who is liable to be detained in a hospital, or someone subject to guardianship or statutory supervision in the community. If a child, he may also be subject to some order made under the Children Act 1989. His legal status in other respects is relative and depends on his relationship to the individual involved in his detention, treatment or care, and the activity being undertaken. He is his doctor's patient, and his solicitor's or social worker's client, so these professionals owe him a duty of care and are bound by certain professional rules of conduct. In other contexts he may be a complainant, a plaintiff, a testator, a resident of a local authority, a Member of Parliament's constituent, a patient of the Court of Protection, and so forth. In constitutional terms, he is a subject of the reigning sovereign in proceedings before English and Welsh courts but, in essence, a

4 Mental Health Act 1983, s.127.
5 *Ibid.*, s.57.
6 *Ibid.*, subss. 121(4) and (5).

citizen for the purpose of proceedings before the European Court of Human Rights. Hence, interventions justified domestically as the lawful exercise of the sovereign's historical powers over subjects of the realm have not infrequently later been reinterpreted as abuses by the executive of a citizen's rights. To summarise, a patient's legal status is defined with a particular purpose in mind and his status determines his legal rights and duties, the powers and duties exercisable by others in respect of him, and the legal procedures to be followed.[7]

THE NEAREST RELATIVE

The patient's nearest relative has several important functions under the Act. These include—

- power to apply for the patient's admission to hospital or reception into guardianship;
- power to require that an approved social worker (an ASW) assesses the patient, with a view to that person making an application under the Act;
- power to object to the making of a guardianship application or a section 3 application by an approved social worker;
- power to discharge the patient from detention or guardianship under Part II of the Act;
- power in some cases to apply to a tribunal for the patient's discharge.

A patient's other relatives may apply to the county court for the appointment of an acting nearest relative (**111**) and an approved social worker must have regard any wishes expressed by them before deciding whether to make an application for the patient's admission to hospital or reception into guardianship. Subject to these exceptions, they have no powers or rights under the Act.

THE STATUTORY FRAMEWORK

Section 145(1) provides that, unless the context otherwise requires, the term "nearest relative" in relation to a patient has the meaning given in Part II of the Act.[8]

7 Conventionally, the statutory term "legal functions" means powers and duties. A person's "rights" may be said to consist of his lawful expectation that (1) other people will not exercise power over him which they do not lawfully possess; (2) that they will exercise duties legally owed by them to him; and (3) that they will not impede the exercise by him of legal powers or duties vested in him and exercisable over or owed to others. For every right there must always exist a corresponding duty so that, at any given time, the volume of rights and duties in a society is always equal and precisely balanced.

8 Note, however, that in those rare cases where a patient is removed to England and Wales from Scotland under Part VII of the Mental Health (Scotland) Act 1984, the nearest relative under Scottish law at the time of his removal is to be treated as his nearest relative under the 1983 Act: Mental Health (Scotland) Act 1984, ss.77(1) and 128. The main difference relates to the priority given to carers over persons with whom the patient resides.

Within Part II of the Act—

- Sections 26–28 define who are a patient's relatives for the purposes of the Act and which of them is to be regarded as the "nearest relative";
- Sections 29–31 provide that the county court may in certain circumstances by order direct that some other person or authority exercises a patient's nearest relative's functions under the Act;
- Section 32 states that a nearest relative may, in the circumstances prescribed by regulations, appoint some other person to exercise his statutory functions on his behalf.

When these provisions are considered together, the basic framework for determining who is entitled to exercise the nearest relative's powers and duties is that set out in the table immediately below.

NEAREST RELATIVE PROVISIONS — THE BASIC FRAMEWORK	
▪ If a section 29 order is in force, statutory references to the nearest relative are to be construed as referring to the person authorised by the order and one need go no further. However, such orders are rare in practice.	**111**
▪ In the case of patients aged under 18, the usual rules set out in section 26 for determining who is the nearest relative apply unless he is in care, subject to a residence order, or has a guardian appointed under children's legislation, in which case sections 27 and 28 apply.	**106**
▪ *In all other cases*, the nearest relative is determined according to the provisions of section 26. That being so, where the patient ordinarily resides with, or is cared for, by a relative (whether his spouse or someone else) then that person will generally be the nearest relative.	**103**
▪ If more than one relative ordinarily resides with or cares for the patient, priority is given to the person who ranks highest on the statutory list of relatives and, as between persons of equal rank (*e.g.* children), to the eldest of them.	**104**
▪ The person who qualifies as the nearest relative may authorise some other person to exercise on his behalf his statutory functions.	**109**

"RELATIVE"

Before it is possible to ascertain who is a patient's nearest relative, it is necessary to know the group of people who are his relatives. Section 26 lists the categories of people who constitute a patient's relatives for the purpose of the Act. A relationship of the half-blood is to be treated as a relationship of the whole blood and an illegitimate child treated as the legitimate child of his mother and, if his father has parental responsibility for him, of his father also.[9] The table immediately below sets out the "statutory list" of persons who constitute a patient's "relatives."

9 Mental Health Act 1983, s.26(2)(b).

RELATIVES FOR THE PURPOSES OF THE 1983 ACT

Relative	Section
"husband or wife," which includes a person who has been living with the patient as her/his husband or wife for a period of not less than six months or, in the case of in-patients, had been so living with the patient before the patient was admitted to hospital;	s.26(1)(a)
children, including adopted children but excluding step-children;	s.26(2)(b)
parents, including the parents of an adopted child;	s.26(2)(c)
brothers and sisters;	s.26(2)(d)
grandparents;	s.26(2)(e)
grandchildren;	s.26(2)(f)
uncles and aunts;	s.26(2)(g)
nephews and nieces;	s.26(2)(h)
any other persons with whom the patient has ordinarily resided for a period of not less than five years or who, in the case of in-patients, had so resided with him for such a period prior to admission.	s.26(7)

Priority of relatives

Although all of the above persons are relatives of the patient, the order of the statutory list is significant. When determining who is a patient's "nearest relative," the Act may give priority to first living person on the list, so that a child of the patient, being a person coming within the second category, takes priority over a parent of the patient, being a person in a category further down the list.

Children born to unmarried parents

Because an illegitimate child is treated as the legitimate child of his mother so any of the listed persons related to that child through his mother will necessarily also be relatives under the Act. Likewise, any children of that illegitimate child will be regarded as the legitimate grandchildren of their unmarried grandmother and related to her for statutory purposes. Conversely, if the father of an illegitimate child is not a relative of that child under the Act, because he does not have parental responsibility, then so too are all the father's blood-relatives disqualified from being relatives under the Act.

Unmarried fathers and parental responsibility

The unmarried father of a child will acquire parental responsibility for the child, *inter alia*, by entering into a parental responsibility agreement with the child's mother[10] or by virtue of a court order that he shall have parental responsibility.[11]

10 Children Act 1989, s.2(2)(b).
11 *Ibid.*, s.4(1)(b).

Persons ordinarily residing with the patient for 5 years

The provision that persons "with whom" a patient has ordinarily resided for five years are deemed to be relatives of his under the Act has given rise to considerable comment. In *Shah v. Barnet London Borough Council*,[12] it was said that, unless the statutory framework or the legal context require a different meaning, "ordinarily" resident refers to a man's abode in a particular place which he has adopted *voluntarily* and for settled purposes for the time being, as part of the regular order of his life. Some writers have suggested that persons living with a patient for five years in a residential or nursing home, long-stay ward, special hospital, prison or monastery may therefore be relatives of his under the Act. Consequently, in the absence of any known spouse or blood-relative with a prior entitlement, the eldest of them will be his "nearest relative" and have power to apply for his admission to hospital, to discharge him from detention under Part II, and so forth. It is, however, submitted that Parliament cannot have intended that the phrase should be construed in so indiscriminate a way, and the precise wording of section 26(7) is against such a view. Ordinarily residing at the same address as the patient does not suffice; the person must be someone "with whom" he ordinarily resides. A person cannot be said to reside "with" the tenants of another flat or bedsit in the same building nor, in the case of student or other residential accomodation, to reside with persons who occupy different rooms in the same building, even if they share a common place of residence and certain communal facilities.[13] To ordinarily reside with someone indicates a voluntary agreement to live with a particular person rather than an involuntary or institutional requirement that a prison cell or a ward bedroom is shared with him. There must be some element of choice before a person may be said to "ordinarily" reside "with" another such that, as matters stand, if one of them moves the other, being a person who ordinarily resides with him, would be likely to also move with him, either immediately or as soon as circumstances permit. Conversely, the fact that one of the occupants of a house or flat is temporarily absent from that place, for example as a result of being admitted to hospital, does not of itself alter the fact that they ordinarily reside together. The question whether a person resides "with" another is one of fact in each case.[14]

"NEAREST RELATIVE"

It is convenient to summarise the effect of sections 26–28 by dealing separately with three different situations commonly encountered in practice (and it may be noted that in the first two situations described it is legally impossible for more than one person to be the "nearest relative") —

- cases where there is a relative who ordinarily resides with or cares for the patient, whether that person is his spouse or some other person;
- cases where that is not so;
- cases involving patients aged under 18 who are in care, or in respect of whom a residence order has been made or a guardian appointed under children's legislation.

12 *Shah v. Barnet London Borough Council* [1983] 1 All E.R. 226, H.L., *per* Lord Scarman at 235.
13 See *e.g. Evans v. Evans* [1948] L.J.R. 276; *Wheatley v. Wheatley* [1950] K.B. 39; *Curtin v. Curtin* [1952] 2 Q.B. 552. In these cases on maintenance, a wife was held not to be "residing with" her husband if they occupied different parts of a house.
14 *Middleton v. Bull* [1951] W.N. 517.

It should be noted that a person's nearest relative may change during period of his detention, for example because a relative attains the age of 18 or because the patient and his spouse separate.[15] Furthermore, the Act does not expressly provide that a nearest relative who makes a tribunal application, but ceases to qualify as the nearest relative prior to the hearing, shall be deemed to remain the patient's nearest relative for the remainder of the proceedings.[16] Rather, it is for the new nearest relative to decide whether to continue them or to request that the application be withdrawn.[17]

Patients who ordinarily reside with or are cared for by a relative

The general rule is that where a patient ordinarily resides with or is cared for by a relative, that relative is his "nearest relative" unless s/he is a person other than the patient's husband or wife[18] who is less than 18 years old.[19]

Hospital in-patients

In the case of in-patients, the relative who ordinarily resided with, or cared for, the patient immediately prior to admission will be the nearest relative *unless* s/he is the patient's husband or wife and the couple have since separated either by agreement or under a court order, or one of them has deserted the other for a period which has not come to an end, *or* (in the case of other relatives) is a person aged under 18.[20]

Patients residing with or cared for by more than one relative

Where more than one relative is, or has been, ordinarily residing with or caring for the patient, preference is given to the one who ranks highest in the statutory list **(102)** and, if two or more of them are still equally entitled, to the eldest relative within that class — subject to the caveat that relatives of the whole blood, even if younger, are preferred to those of the half-blood within the same class.[21]

15 See *e.g.* the wording of s.26(5)(c) ("is a person ... for the time being under 18 years of age" *c.f.* "at the time of admission"), s.30(6) ("notwithstanding that the person who was the patient's nearest relative when the order was made is no longer his nearest relative"), and s.30(1)(b).

16 There is no provision equivalent to that in Mental Health Act 1983, Sched. 5, para. 11, which provided that "Where at any time before 30th September 1983 an application to a Mental Health Review Tribunal has been made by a person who at that time was the patient's nearest relative and the application has not then been determined and by reason of the coming into force of section 26 of this Act that person ceased to be the patient's nearest relative on that date, that person shall nevertheless be treated for the purposes of the application as continuing to be his nearest relative."

17 Allied to this point, the wording of section 25(1)(b) suggests that the new nearest relative may immediately give notice of his intention to discharge the patient notwithstanding that his predecessor was barred from doing for a period of six months, which period has not yet expired.

18 As defined in the table of relatives **(102)**.

19 For the avoidance of doubt, a person who ordinarily lives with the patient, but who is not a blood relative or the patient's husband or wife, is not a "relative" (and therefore cannot possibly be the "nearest relative" under this rule) unless s/he has ordinarily resided with the patient for five years.

20 A person who qualifies as the nearest relative because, prior to the patient's admission, he ordinarily resided with him or cared for him in the United Kingdom, the Channel Islands or the Isle of Man, must also be discounted if he later takes up residence outside those territorial boundaries. The fact that priority may be given to the relative who ordinarily resided with or cared for the patient prior to his admission is unsatisfactory in the case of some long-stay patients. That person may no longer ordinarily care for, or reside with, the patient. The better view may therefore be that the effect of s.26(4) is limited to ensuring that a relative who does ordinarily reside with or care for the patient does not lose his priority by virtue only of the fact that the latter is in hospital. If, following admission, that relative ceases to ordinarily reside with or care for the patient then his priority ceases also.

21 Where a patient ordinarily resides with two relatives, only one of whom ordinarily cares for him, the carer is not thereby preferred to the other. For example, where a patient and his adult brother ordinarily reside with an aunt who cares for the patient, the brother is the nearest relative.

Example

An unrealistically complicated example illustrates the principles. Immediately prior to admission, a male patient ordinarily resided with his wife, widowed mother aged 55, two sisters aged 19 and 17, and a half-brother aged 30. There are no other relatives. His spouse will therefore be the nearest relative since of the various persons in the household she ranks first in the list of relatives above. If, following admission, the patient and his spouse separate or one of them deserts the other, the patient's mother will at that point become his nearest relative. If the patient's mother then dies, the sister aged 19 will be the nearest relative. If she in turn dies, the patient's half-brother will assume the title until such time as the youngest sister assumes the age of 18, at which point she (being a relative of the whole blood) will have a prior entitlement.

Married patients

The Act provides that where a married patient has lived with someone else as that person's man or wife for at least six months, the cohabitee shall not be treated as the nearest relative unless the parties to the marriage are permanently separated, either by agreement or by order of a court, or one of them has deserted the other for a period which has not yet come to an end.[22] In practice, it will be rare for a patient to have lived with someone else as that person's man or wife for such a period and yet not be in desertion. The Act similarly provides that unless the parties to a marriage are separated or one of them is in desertion, a person who is deemed to be a relative because he has been ordinarily residing with the patient for five years is not to be treated as the patient's nearest relative in preference to the legal spouse.[23] Again, the qualification is generally of only academic interest: a husband or wife, ranking highest in the list of relatives, will automatically have a prior entitlement unless s/he ordinarily resides at a different address from the patient, in which case one of them has usually deserted the other or they are separated by agreement.

Patients who have not resided with or been cared for by a relative

The second situation concerns patients who have no relatives who ordinarily reside with or care for them or who, prior to admission, were not ordinarily residing with or being cared for by a relative on such a basis. In the case of married patients, this will generally be because the parties have separated or one of them has deserted the other, in which case, unless the separation or desertion has proved not to be permanent, the spouse must be discounted; if there has been a reconciliation, the spouse is the nearest relative. Subject to this, the Act provides that the nearest relative is the person ranking highest in the statutory list of relatives who is not disqualified from acting as such under either of the following grounds[24]—

22 Mental Health Act 1983, s.26(6).

23 *Ibid.*, s.26(7)(b).

24 The 1983 Act originally included a third ground. Section 38 of the Sexual Offences Act 1956 provided that, where a person was convicted of incest under section 10 or 11 of that Act, the court could divest that person of all authority over the girl or boy. Section 26(5)(d) of the Mental Health Act 1983, since repealed by the Children Act 1989, in turn disqualified a person against whom a divesting order was in force from being the victim's nearest relative. The effect of the repeal is that, unless the court appointed a guardian for the victim when making the divesting order, and that guardianship remains in force, the fact that a divesting order was made is irrelevant when determining a person's nearest relative.

- that he is for the time being under the age of 18;
- in the case of a patient ordinarily resident in the United Kingdom, the Channel Islands or the Isle of Man, that he is a person who ordinarily resides outside those countries.[25]

As before, preference is given as between two or more persons within a particular class to relatives of the whole blood and, if more than one, to the eldest of them.

Example

A patient who is detained under section 3 lived alone prior to admission and was not cared for by any of his relatives. His wife deserted him some years previously. He has three other relatives, being a brother aged 40 who lives in Wales; a daughter aged 24 who lives and works in the Republic of Ireland; and a son aged 17 who lives in England. The nearest relative is the patient's brother as both children are to be discounted in determining the issue. However, the patient's son will assume the function on his eighteenth birthday.

No nearest relative

One effect of the statutory scheme is that a patient may have no nearest relative. Where this is so, or it is not reasonably practicable to ascertain whether he has such a relative, an application may be made to the county court for an order appointing an individual or a local social services authority to exercise the functions of a nearest relative (**111**).

Nearest relative mentally or physically incapacitated

Where the nearest relative is incapable of acting as such by reason of mental disorder or other illness, he nevertheless remains the patient's nearest relative until such time (if any) as the County Court directs that his statutory functions shall be exercisable by some other person or by a local social services authority (**111**).

Patients aged under 18

In the case of patients aged under 18, the usual rules for determining who is the nearest relative apply unless a residence order[26] is in force, or the patient is in the

[25] Where a patient is himself ordinarily resident outside the United Kingdom, the Channel Islands or the Isle of Man, the ordinary place of residence of his relatives is immaterial when determining which of them is the nearest relative for the purposes of the Act. See Mental Health Act 1983, s.26(5)(a); *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, (D.H.S.S., 1987), para. 68. The point most commonly arises in respect of patients who are citizens of the Republic of Ireland or who are detained whilst visiting England or Wales on holiday.

[26] A "residence order" means an order settling the arrangements to be made as to the person with whom a child is to live (Children Act 1989, s.8(1)). An order ceases to have effect when the child reaches the age of 16 unless the court making the order directed that it should continue beyond that date (Children Act 1989, s.91(10)), in which case it will cease when the child reaches 18 (*ibid.*, s.91(11)). Except in exceptional circumstances, a court shall not make an order in respect of a child aged 16 or over (Children Act, s.9(7)). A residence order may be made in favour of two or more persons (*Ibid.*, s.11(4)). The making of a residence order with respect to a child discharges any existing care order (*ibid.*, s.91(1)).

care of a local authority,[27] or a guardian has been appointed under children's legislation.[28] The fact that a patient is a ward of court has no bearing on who is his nearest relative.[29]

Care order in force

Where a care order is in force, the local authority in whose care the patient is "shall be deemed to be the nearest relative of the patient in preference to any person except the patient's husband or wife (if any)."[30] In this context, the reference to a patient's "husband or wife" excludes relationships outside marriage.[31]

Residence order in force

Where a residence order is in force, the Act provides that "the person named in the residence order shall, to the exclusion of any other person, be deemed to be his nearest relative."[32] In fact, more than one person may be named in a residence order, in which case both (or all) of them are probably deemed to be the nearest relative (see below).

Guardian appointed under children's legislation

Where a guardian has been appointed for a patient under children's legislation, "the guardian (or guardians, where there is more than one) ... shall, to the exclusion of any other person, be deemed to be his nearest relative."[33] Where a patient has a guardian and is also the subject of a residence order, it is probably the case that the guardian(s) and the person(s) named have an equal entitlement.

Joint nearest relative(s)

In the case of a patient aged under 18, it is possible for more than two individuals to be the nearest relative. This will occur where more than one guardian has been appointed, where a residence order names more than one person, or where, for example, a patient who has a guardian is also the subject of a residence order. The fact that more than one person might be named in a residence order seems not to

[27] Section 31 of the Children Act 1989 provides that a court may make an order placing a child who has not reached the age of 17 in the care of a designated local authority (ss.31(1) and (3)). The court must be satisfied that the child is suffering, or is likely to suffer, significant harm which is attributable to the care given to the child, or likely to be given to him if the care order is not made, not being care which it is reasonable to expect a parent to give to him (s.31(2)). A care order continues in force until the child reaches the age of 18 unless discharged earlier (Children Act 1989, s.91(12)). The making of a care order with respect to a child who is a ward of court brings that wardship to an end (s.91(3)).

[28] Mental Health Act 1983, s.28(3), as substituted by the Children Act 1989, s.108(5), Sched. 13, para. 48, provides that the term "guardian" in this context does not include a guardian appointed under the Mental Health Act. Section 5(13) of the Children Act 1989 provides that a guardian may only be appointed in accordance with the provisions of that section. Guardianship ends when the child reaches the age of 18, unless brought to an end earlier (*ibid.*, s.91(7)(8)).

[29] It does, however, affect the exercise by the nearest relative of his functions under the Act.

[30] Mental Health Act 1983, s.27(a), as substituted by the Children Act 1989, s.108(5), Sched. 13, para. 48(1). In normal circumstances, an approved social worker considering whether to make an application for admission for treatment must therefore consult the local authority before applying.

[31] The definition of a husband or wife in section 26(6) commences with the words, "In this section ..."

[32] Mental Health Act 1983, s.28(1)(b), as substituted by the Children Act 1989, s.108(5), Sched. 13, para. 48. Section 26(5) applies if relevant.

[33] Mental Health Act 1983, s.28(1)(a), as substituted by the Children Act 1989, s.108(5), Sched. 13, para. 48. Section 26(5) applies if relevant. Where a patient who has a guardian is in care, the local authority will be the nearest relative.

have been foreseen. In the case of guardians, the wording of sec 28(1) is ambiguous. The intention may be that there is only ever one statutory nearest relative, albeit that more than one person may be involved in fulfilling the statutory functions of "the" nearest relative.[34] Alternatively, the wording allows the alternative interpretation that a patient has two or more nearest relatives in such circumstances.[35] Clearly, disputes could arise between two or more persons equally entitled. For example, one may object to a section 3 application being made by an approved social worker but not the other. Similarly, one guardian might apply for the patient's admission without the other's consent and against his wishes. Conversely, one them might make an order for the patient's discharge but the other not join in the making of that order. Although it is possible to devise ways of dealing with such problems in the medium term, for example by making an application under the Children Act 1989,[36] this does not resolve the issue of whether any power exercised by one of the persons entitled is valid, nor is of much assistance to a social worker or the managers of a hospital faced with such predicaments.

Mental Health Act 1959

Section 28 derives from section 51 of the Mental Health Act 1959 which provided that "the person or persons having the guardianship or custody of the patient shall, to the exclusion of any other person, be deemed to be his nearest relative." The Guardianship of Infants Act 1925 was in force at the time and it provided that the widowed mother of an infant "shall be guardian of the infant, either alone or jointly with any guardian appointed by the father";[37] that a guardian appointed by deed or will "shall act jointly" with the surviving parent;[38] and that "where two or more persons act as joint guardians ... and they are unable to agree on any question affecting the welfare of the infant, any of them may apply to the court for its direction, and the court may make such order regarding the matters in difference as it may think proper."[39] Parliament's intention would therefore appear to be that if two people are jointly the nearest relative, the exercise of any statutory power vested in the nearest relative — for example, to apply for a patient's admission, to object to his admission, or to discharge him — is only valid if it constitutes a joint decision. That this is so is supported by the following passage in the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*[40]—

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

34 In the same way that the office of "The Secretary of State" is one in law.
35 Because the 1959 Act allowed emergency applications under section 29 to be made by any relative of the patient, it might be argued that Parliament did not balk at the idea that there could be more than one person qualified to exercise a statutory power. Likewise, it might have envisaged that disputes between guardians could be dealt with under children's legislation.
36 Or, arguably, by making an application under section 29 of the Mental Health Act 1983.
37 Guardianship of Infants Act 1925, s.4(1).
38 *Ibid.*, s.5(3).
39 *Ibid.*, s.6.
40 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 426.

DELEGATION OF THE NEAREST RELATIVE'S FUNCTIONS

The Act expressly provides that the Secretary of State may make regulations enabling the functions of a nearest relative under Part II of the Act to be performed by any person authorised by the nearest relative.[41] The regulations provide that any authority, and any notice revoking such an authority, shall be made in writing[42] and shall take effect on receipt of that written authority or revocation by the person authorised.[43] A nearest relative may not authorise to act on his behalf a person who is disqualified from acting as a patient's nearest relative by virtue of section 26(5) of the Act.[44] Where at the time any authority or revocation is made, the patient to whom it relates is liable to be detained under the Act, a copy must also be given forthwith to the managers of the hospital where the patient is liable to be detained.[45] Similarly, where a patient is at the time subject to guardianship, a copy shall be given forthwith to the responsible local social services authority and, if a private guardian is acting, to the guardian also.[46]

Revocation of the authority

While the nearest relative may revoke an authority previously given to another person, the regulations do not expressly provide that the person authorised may later refuse to act further on the nearest relative's behalf. Although it has been suggested that the authority continues until such time (if ever) as the nearest relative revokes it, this seems unlikely. As drafted, the regulations do not make it an express condition of delegating authority that the person named consents to exercise the functions at time the authority is given. However, this must be presumed[47] as therefore may the right of the person authorised to later withdraw any consent to act which he originally gave. Section 32(1)(e) is specifically an "enabling" provision and its purpose is limited and confined to displacing the statutory presumption that a function given to a particular person by statute cannot be delegated to, or performed by, another (*delegatus non potest delegare*). In the absence of such a provision, any exercise of those functions by another person would, even if done with the nearest relative's consent, be *ultra vires*. It is submitted therefore that an authority validly given under section 32 and regulation 14 ceases to have effect if—

- The nearest relative who gave it dies or by notice revokes the authority.
- The person authorised becomes a person to whom section 26(5) applies, *e.g.* he takes up ordinary residence outside England and Wales, the Channel Islands or the Isle of Man.
- The person authorised renounces the authority.
- A person other than the person who gave the authority becomes the nearest relative, *e.g.* a child of the patient upon attaining the age of 18.[48]

41 Mental Health Act 1983, s.32(2)(e).
42 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, regs. 14(1), 14(2)(a).
43 *Ibid.*, reg.14(3).
44 *Ibid.*, reg. 14(1).
45 *Ibid.*, reg. 14(2)(b).
46 *Ibid.*, reg. 14(2)(c).
47 Unless one presumes this, it would be lawful to authorise a third party (even a stranger) to exercise the functions without obtaining his prior consent.
48 One could alternatively argue that the authority continues until such time as it is revoked by the person who has subsequently, by process of law, become the nearest relative.

The effect of an authority given under section 32

A person duly authorised under regulation 14 does not thereby become the patient's statutory nearest relative. Rather, he has authority to exercise the nearest relative's functions under Part II of the Act on the latter's behalf. Section 32(1)(e) provides that regulations may in particular make provision for enabling the functions of the nearest relative "under this Part of this Act" to be performed by any person authorised by that relative, in such circumstances and subject to such conditions as the regulations may prescribe. Regulation 14(1) of the 1983 Regulations then states that the nearest relative may authorise another person to perform the "functions conferred upon the nearest relative by or under Part II of the Act." In contrast to the wording used in section 29(1) and (6), in relation to county court appointments, a person authorised under section 32 is therefore authorised only to exercise the nearest relative's functions under Part II. Moreover, section 32(1) does not provide, as section 29(6) does, that references to the nearest relative elsewhere in the Act shall be read as referring to the person having the functions of that relative.

Whether authorised person can exercise rights under Part V

The question arises whether any authority given under regulation 14 also enables the person authorised to fulfil the nearest relative's functions under the other Parts of the Act, in particular his rights of application to a tribunal, and other functions, under Part V. There appears to be no obvious justification for enabling a nearest relative to authorise another individual to exercise his functions under Part II but not those exercisable under Part V. Indeed, such a construction gives rise to the anomalous position that the person authorised is thereby empowered to discharge the patient but not to apply to a tribunal for the patient's discharge, for example if the responsible medical officer bars the patient's discharge under section 25. Similarly, although a notice of reclassification under section 16 would be served on the person authorised under section 32, it would nevertheless be for the nearest relative to decide whether to apply to a tribunal following the reclassification.

Mental Health Act 1959

Section 32(1)(e) of the 1983 Act derives from, and is identical to, section 56(2)(f) of the 1959 Act. Under the 1959 Act, patients' and nearest relatives' rights to apply to a tribunal were also set out in the same Part of the Act as section 56. Consequently, the reference in section 56 to the person appointed being authorised to exercise the nearest relative's functions "under this Part of this Act" included exercising his tribunal rights of application. However, when the new Act was drafted, the various references to tribunal rights of application were removed from that Part of the Act and placed in a separate Part dealing with Mental Health Review Tribunals (Part V). Unfortunately, the draftsman clearly overlooked the need consequentially to amend section 32 so as to take account of the fact that the nearest relative's powers were no longer concentrated in one Part of the Act.

Summary

The reference to Part II of the Act in section 32 appears to be a drafting error rather than to reflect any intention on Parliament's part to draw a fine distinction between the various powers. In other words, the intention remained that the person appointed was thereby authorised to exercise any tribunal rights of application.

ORDERS APPOINTING ACTING NEAREST RELATIVE

The county court may by order direct that a local social services authority, or a person whom it considers to be a proper person to act as a patient's nearest relative, shall exercise the functions of a patient's nearest relative under the Act. An order may not be made unless the proposed authority or individual consents to act in that capacity. A person or authority appointed by the court under section 29 is referred to below as the "acting nearest relative."

The application

An application may be made by an approved social worker, by a relative of the patient, or by any person with whom the patient is residing (or last resided before he was admitted to hospital).[49]

The grounds of the application

An order may be made on one or more of the following grounds —

The no fault grounds

a that the patient has no nearest relative within the meaning of the Act, or that it is not reasonably practicable to ascertain whether he has such a relative, or who that relative is (s.26(3(a));

b that the nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness (s.26(3(b));

The fault grounds

c that the nearest relative of the patient unreasonably objects to the making of a guardianship application or a section 3 application in respect of the patient (s.26(3(c));

d that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power under Part II to discharge the patient from hospital or guardianship, or is likely to do so (s.26(3(d)).

It should be emphasised that the first ground refers to an individual who is unable to exercise his functions, rather than to a person who is capable of acting but acting in a wholly irrational way.[50] As concerns the last ground, where the nearest relative gives notice of his intention to discharge the patient and the grounds for issuing an order barring discharge exist (**612**), the responsible medical officer will exercise this power and it is unusual for the local authority to then apply to the county court for the nearest relative's displacement.

[49] Mere residence at the material time suffices and it is not necessary that the applicant ordinarily resides with the patient.

[50] See e.g. Mental Health Act 1983, s.29(4), which links ground (b) to ground (a) rather than to grounds (c) or (d), from which it may be inferred that if ground (b) exists this will not give rise to any need to extend the duration of the section 2 period. This is because the nearest relative will be incapable of making any objection to a proposed section 3 application.

The significance of the grounds of an application or order

Applications and orders made under ground (c) and (d) relate to the way in which the nearest relative has exercised, or is likely to exercise, his statutory powers. In contrast, applications and orders made upon grounds (a) and (b) involve no assertion or finding of inappropriate or unreasonable conduct. The ground upon which an order is made affects its duration and who may later apply for its discharge. Likewise, the precise effect of lodging an application under section 29 turns on the grounds upon which it is sought.

The effect of a pending application

A section 2 application generally authorises the patient's detention for up to 28 days only. However, where a county court application made under one or both of the fault grounds is pending at the expiration of that period, the period for which the patient may be detained under section 2 is extended until the court application is finally disposed of; and, if an order appointing an acting nearest relative is made, for a further seven days. However, this extension of the section 2 period does not prevent the patient from being discharged under section 23 before the county court case is disposed of, including by the nearest relative whose displacement is being sought.[51] It should be emphasised that a county court application based *solely* on one or both of the no-fault grounds does not have this effect of extending the section 2 period.

The effect of an order under section 29

The general position is that, while an order under section 29 is in force, the nearest relative's functions under the Act are exercisable by the acting nearest relative and references in the Act to a nearest relative's functions are to be construed accordingly. In particular, it is the acting nearest relative who may make an application under Part II, discharge the patient in the circumstances specified in sections 23–25, and exercise the ordinary rights of a nearest relative to apply to a tribunal under sections 66 and 69. Where a local social services authority is appointed and the patient is detained in hospital, that authority is required to arrange for visits to be made to the patient on behalf of the authority and to take such other steps in relation to the patient as would be expected to be taken by his parents.[52] By way of compensation, the displaced nearest relative may make one application to a tribunal for the patient's discharge during each year the order remains in force.[53]

Duration of orders

An order made under one of the no-fault grounds may be made for a specified period in which case the order, unless previously discharged, ceases to have effect on that date. In the case of a county court order made for an unspecified period, the date on which it expires depends upon the patient's legal status on the day the order was made —

51 See *e.g. Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX*, (D.H.S.S., 1960), para. 131. The nearest relative's power of discharge is, however, qualified by the power to bar discharge under section 25, except in cases involving guardianship.

52 Mental Health Act 1983, s.116(2)(c). The duty applies whatever the age of the patient.

53 Mental Health Act 1983, s.66(1)(h). There is a difference between being displaced and replaced. The patient's nearest relative remains unchanged by the county court order but the court appointee is authorised to exercise his functions.

• Patients who at the time when the county court order was made were subject to guardianship or liable to be detained under section 3, 37, 47 or 48	The county court order will expire on the date the application, order or direction authorising the patient's detention or guardianship comes to an end (transfers under section 19 are to be disregarded).
• Patients who at the time the county court order was made were informal patients or detained under sections 2, 4, 5, 35, 36, 38, 135 or 136 of the Act.	The county court order will expire if the patient is not received into guardianship or detained under section 3, 37, 47 or 48 within the period of three months beginning with the date of the county court's order. If the patient is so detained or received within that period, the county court order expires on the day that application, order or direction comes to an end.

The fact that the authority conferred by a section 29 order expires upon the patient ceasing to be liable to be detained for treatment or subject to guardianship is commonly not appreciated by social workers, who often believe that the order remains in force until such time as it is discharged by the court. As a result, further section 3 applications may be made in the mistaken belief that the nearest relative's power to object to the patient's admission is still exercisable by the court appointee.

Discharging county court orders

While a county court order remains in force, an application for its discharge may be made to the court by the "acting nearest relative" or, where the order was made on one of the no-fault grounds, by the patient's nearest relative.[54] However, if the court order was instead made on one of the fault grounds, the displaced nearest relative may not apply to the court for its discharge. This prohibition takes account of the fact that s/he previously exercised the powers in a way which caused the court to appoint someone else to exercise them.[55]

Variation of county court orders

During the period the court's order remains in force, the "acting nearest relative" or an approved social worker may apply to the county court for the order to be varied, by substituting for the authority or person previously appointed any other local social services authority or individual who, in the opinion of the court, is a proper person to act in that capacity and is willing to do so.[56]

54 For example, a nearest relative who was previously incapacitated but who has since recovered may apply for the order's discharge. Similarly, where the order was made because the patient had no known nearest relative at the time, if a nearest relative is later identified or located, he may apply for the order's discharge. Mental Health Act 1983, s.30(1)(b).

55 If the displaced person later ceases to be the patient's nearest relative, because some other relative subsequently acquires a prior entitlement, his successor may apply for the order's discharge. This reflects the fact that the newly entitled individual was not the person whose unreasonable conduct led to the court order being sought and then made. Mental Health Act 1983, s.30(1)(b).

56 Mental Health Act 1983, s.30(2).

Procedure concerning section 29 applications

The court procedure is set out in Order 49, Rule 12 of the County Court Rules 1981. The application is made by originating application, supported by an affidavit. A fee is payable. The application, together with any supporting documents, is filed in the court for the district in which the patient's place of residence is situated. If the patient is receiving in-patient treatment at the time, his place of residence is deemed to be the hospital. The nearest relative must be made a respondent to the application, unless it is being made because the patient has no identifiable nearest relative, and the patient must not made a respondent.

Evidence

The judge may interview the patient in the presence of or separately from the parties, either at court or elsewhere. Alternatively, the judge may direct the district judge to interview the patient and to report to him in writing. The hearing is held in chambers unless the court orders otherwise. The publication of information relating to the proceedings is a contempt of court.[57] The court may accept any report made by a doctor as *prima facie* evidence of the facts stated in that report, and may similarly accept any report by a social worker or officer of the hospital where the patient is receiving in-patient treatment. The nearest relative must be told the substance of any part of the report bearing on his fitness or conduct which the judge considers to be material to the fair determination of the application. In *B. v. B. (mental health patient)* [1980] 1 W.L.R. 116, the Court of Appeal held that it was sufficient that the medical reports were handed to the nearest relative's legal adviser in circumstances where the adviser could give advice and take instructions.

Case law

The leading case is *W. v. L* [1974] Q.B. 711 (**064**).[58] The issue in that case was how the county court should approach the question of whether a nearest relative's objection to a section 3 application being made was unreasonable. The following passage is taken from Lord Denning M.R.'s judgment (at 717H–718D) —

> "This brings me to the final question: is the wife unreasonable in objecting to the making of an application for the husband's detention? This is a difficult question ... No doubt she feels that she can cope. She says that she knows her husband better than anyone else does; she will see that he takes his tablets; she is quite satisfied that neither she nor the baby will be in danger. So if you look at it from her own point of view, she may not be unreasonable. But I do not think it correct to look at it from her own point of view. The proper test is to ask what a reasonable woman in her place would do in all the circumstances of the case ... So we come to this: looking at it objectively, what would a reasonable woman in her place do when faced with this wife's problem? It seems to me that a reasonable woman would say: my husband ought to go in for treatment and he ought to be detained until he is cured. It is too great a risk to have him at home whilst the baby is so small. Her objection is therefore unreasonable."

57 Administration of Justice Act 1960, s.12.

58 Although not legally binding, various county court judgments are also referred to in the textbooks: *N. v. S.*, Croydon County Court, 1 January 1983; *Re B*, Liverpool County Court, 29 November 1985; *S. v. G.*, Sheffield County Court [1981] J.S.W.L. 174.

CHILDREN

The law concerning the psychiatric assessment and treatment of children can be considered under four main headings: (1) the statutory provisions in the Mental Health Act 1983; (2) the statutory provisions in the Children Act 1989 and related legislation; (3) wardship and the High Court's inherent jurisdiction; (4) the common law. Some of the provisions of the Children Act supplement the powers available under the 1983 Act, whilst others may provide an alternative, and sometimes less restrictive, method of managing the child's case. In appropriate cases, the High Court's inherent jurisdiction may be invoked, so as to enable a child to be detained and given compulsory treatment otherwise than under the 1983 Act.

MENTAL HEALTH ACT 1983

Where a child is in care, a guardian has been appointed for him under children's legislation, or a residence order is in force, special rules apply when determining who is the child's nearest relative (**106**). Subject to a few exceptions, most of the powers exercisable under the 1983 Act apply to children as they apply to adults. Under Part II of the Act, neither a guardianship application nor a supervision application may be made unless the person concerned is 16 or older. Similarly, under Part III, a guardianship order may only be made if the accused has attained the age of 16 years, and nor may a child be committed to the Crown Court under section 43. However, for the purposes of Part III, the term "child" means a person under the age of 14 years, while a "young person" is someone who is aged 14 or over but not yet 18.[59] Unless subject to restrictions, the cases of detained children aged under 16 must be referred to a tribunal at yearly intervals (**631**).

CHILDREN ACT 1989

For the purposes of the Children Act 1989, a child is a person under the age of 18.[60] The main orders of relevance to the mental health of children are summarised in the table on the following pages. A child who is in hospital informally, or who is subject to guardianship under the Mental Health Act 1983, may not be kept in secure accommodation for more than 72 hours during any consecutive 28-day period without the authority of a family proceedings court (**121**). Various provisions in the 1989 Act enable a court to authorise the psychiatric examination or assessment of a child, but a child of sufficient understanding to make an informed decision has a statutory right to refuse to be examined or assessed. If it is necessary to have in place some statutory framework for supervising a child in the community, only the Children Act orders are available if the child is aged 15 or younger. Conversely, if the child is aged 17, the available orders are a guardianship application or a supervision application under the Mental Health Act 1983. It is only in the case of 16 year-olds that a local authority contemplating an unsupervised child's case may choose between the two frameworks. The definition a "hospital" in the Children Act 1989 excludes a High Security Hospital, but is otherwise the same as that found in section 145(1) of the Mental Health Act 1983.

59 Mental Health Act 1983, s.55(1); Children and Young Persons Act 1933, s.107(1). Section 99 of the 1933 Act (which relates to the presumption and determination of age) applies for the purposes of Part III of the 1983 Act: see Mental Health Act 1983, s.55(7).

60 Children Act 1989, s.105(1).

CHILDREN ACT 1989 ORDERS

Order or authority	*Sect.*	*Power*	*Statutory criteria*
▪ **Police protection**	s.46	Where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, he may remove the child to suitable accommodation and keep him there *or* take such steps as are reasonable to ensure that the child's removal from any hospital in which he is being accommodated is prevented. Maximum duration of 72 hours.	46.—(1) Where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm he may— (a) remove the child to suitable accommodation and keep him there; or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which he is then being accommodated is prevented.
▪ **Emergency protection order**	s.44	An order directing the production of a child and authorising *either* his removal to accommodation provided by or on behalf of the applicant *or* the prevention of the child's removal from hospital — a court making such an order may give directions with respect to the psychiatric examination or assessment of the child (s.44(6)). Maximum initial duration of 8 days, but may be extended for a further 7 days.	Unless there have been problems gaining access to a child, the court may make the order if, but only if, it is satisfied that— (a) there is reasonable cause to believe that the child is likely to suffer significant harm if— (i) he is not removed to accommodation provided by or on behalf of the applicant; *or* (ii) he does not remain in the place in which he is then being accommodated.
▪ **Local authority enquiries**	s.47	A local authority may be under a duty to make enquiries to enable them to decide whether they should take any action to safeguard or promote a child's welfare.	47.—(1) Where a local authority— (a) are informed that a child who lives, or is found, in their area— (i) is the subject of an emergency protection order; or (ii) is in police protection; or (b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.
▪ **Child assessment order**	s.43	An order authorising a child's assessment, *e.g.* a psychiatric examination or assessment. A court may treat the application as an application for a child protection order and no court shall make a child assessment order if satisfied that there are grounds for making an emergency protection order and that it ought to make such an order. Maximum duration of 7 days.	The court may make the order if, but only if, it is satisfied that— (a) the applicant has reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm; (b) an assessment of the state of the child's health or development ... is required to enable the applicant to determine whether or not the child is suffering, or is likely to suffer, significant harm; and (c) it is unlikely that such an assessment will be made, or be satisfactory, in the absence of an order made under this section.

Order or authority	*Sect.*	*Power*	*Statutory criteria*
▪ **Interim care order**	s.38	An order made upon adjourning an application for a care order or supervision order — the court may give directions with regard to a psychiatric examination or assessment (s.38(6)). Maximum initial duration of 8 weeks with renewals of 4 weeks at a time.	38.—(2) A court shall not make an interim care order or interim supervision order under this section unless it is satisfied that there are reasonable grounds for believing that the circumstances with respect to the child are as mentioned in section 31(2) (see below)
▪ **Interim supervision order**	s.38	An order made upon adjourning an application for a care order or supervision order — the court may direct that the child should undergo a psychiatric examination or assessment (s.38(6)). Maximum initial duration of 8 weeks with renewals of 4 weeks at a time.	
▪ **Care order**	s.31	An order placing the child in the care of the designated local authority, which authority becomes the child's nearest relative under the 1983 Act. No care order or supervision order may be made with respect to a child who has reached the age of 17 (or 16, in the case of a child who is married).	"31.—(2) A court may only make a care order or supervision order if it is satisfied— (a) that the child concerned is suffering, or is likely to suffer, significant harm; and (b) that the harm, or likelihood of harm, is attributable to— (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or (ii) the child's being beyond parental control.
▪ **Supervision order**	s.31	An order putting a child under the supervision of a designated local authority — the order may require the child to live at a specified place; to present himself to specified persons at specified times; to participate in specified activities; to submit to a medical or psychiatric examination; to undergo out-patient or in-patient psychiatric treatment. Lasts one year but may be extended to maximum period of 3 years.	
▪ **Secure accommodation order**	s.25	Section 25 applies to children who are not detained under the 1983 Act. A child to whom section 25 applies may not be kept in secure accommodation for more than 72 hours in any period of 28 consecutive days without the authority of a family proceedings court.	A child may not be placed or kept in accommodation provided for the purpose of restricting liberty ("secure accommodation") unless he is likely to injure himself or other persons if kept in any other description of accommodation or he has a history of absconding, is likely to abscond from any other description of accommodation, and, if he absconds, is likely to suffer significant harm (s.25(1)(a)).

Statutory definitions: "harm" means ill-treatment or the impairment of health or development; "development" means physical, intellectual, emotional, social or behavioural development; "health" means physical or mental health; "ill-treatment" includes forms of ill-treatment which are not physical. Where the question of whether harm suffered by a child is significant turns on the child's health or development, his health or development shall be compared with that which could reasonably be expected of a similar child. See s.31(9) and (10).

CHILD ASSESSMENT ORDERS

A child assessment order is an order authorising the assessment of a child, *e.g.* a psychiatric examination or assessment. Such an order must specify the date by which the assessment is to begin and shall have effect for such period, not exceeding seven days beginning with that date, as may be specified in the order.[61] It is the duty of any person who is in a position to produce the child to produce him to such person as may be named in the order and to comply with any directions made by the court.[62] The child may only be kept away from home if it is necessary for the purposes of the assessment and insofar as specified in the order.[63]

The statutory grounds

A court hearing an application for a child assessment order may make the order if, but only if, it is satisfied that[64]—

a. the applicant has reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm;

b. the assessment of the state of the child's health or development, or of the way in which he has been treated, is required to enable the applicant to determine whether or not the child is suffering, or is likely to suffer, significant harm;

c. it is unlikely that such an assessment will be made, or be satisfactory, in the absence of an order under this section; *and it is not satisfied that*

d. there are grounds for making an emergency protection order and that it ought to make such an order instead.

Psychiatric examinations and assessments

A child assessment order authorises any person carrying out the assessment to do so in accordance with the terms of the order.[65] However, regardless of this, if the child is of sufficient understanding to make an informed decision, he may refuse to submit to a medical or psychiatric examination or other assessment.[66]

Related law

Notwithstanding a child's statutory right to refuse to submit to a psychiatric examination or assessment specified in a child assessment order, all children, including those over 16, can be treated without their consent if a person with parental responsibility, or the High Court exercising its inherent jurisdiction, gives consent **(124)**.

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[61] Children Act 1989, s.43(5).
[62] *Ibid.*, s.43(6).
[63] *Ibid.*, s.43(9).
[64] *Ibid.*, s.43(1).
[65] *Ibid.*, s.43(7).
[66] *Ibid.*, s.43(8).

CARE ORDERS AND SU[illegible]VISION ORDERS[67]

On an application by a local authority, or the NSPCC., a court may make an order placing the child in the care of a local authority, or putting him under the supervision of such an authority or of a probation officer.[68] In the case of an application for a care order, the court may instead make a supervision order, and vice-versa.[69] Where an application for a care or supervision order is adjourned, the court may make an interim care order or an interim supervision order with respect to the child.[70] No care order or supervision order (or interim order of such a kind) may be made with respect to a child who has reached the age of 17 (or 16, in the case of a child who is married). Such orders cease to have effect when the child reaches 18.

The statutory grounds

A court may only make a care order or supervision order if it is satisfied[71]—

a. that the child concerned is suffering, or is likely to suffer, significant harm; *and*

b. that the harm, or likelihood of harm, is attributable to—

i the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or

i the child's being beyond parental control.

Deciding whether any harm is significant

"Harm" in this context means the impairment of health or development or ill-treatment (including sexual abuse and non-physical ill-treatment). Where the question of whether harm suffered by a child is significant turns on the child's physical or mental health, or his physical, intellectual, emotional, social or behavioural development, his health or development shall be compared with that which could reasonably be expected of a similar child.[72]

Effect of a care order

While a care order is in force, the designated local authority has parental responsibility for the child and has the power to determine the extent to which a parent or guardian may meet his parental responsibility for him.[73] However, the local authority shall not limit the extent of their involvement unless they are satisfied that it is necessary to do so in order to safeguard or promote the child's welfare.[74]

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[67] Children Act 1989 s.31; Sched. 3, Pts. I and II.
[68] *Ibid.*, s.31(1). The local authority designated in the order must be the authority within whose area the child is ordinarily resident or, if applicable, the authority within whose area any circumstances arose in consequence of which the order is being made: see s.31(8). Such an application may be made on its own or in any other family proceedings. *Ibid*, s.31(4).
[69] *Ibid.*, s.31(5).
[70] *Ibid.*, s.38(1).
[71] *Ibid.*, s.31(2).
[72] *Ibid.*, s.31(10).
[73] *Ibid.*, s.33(3).
[74] *Ibid.*, s.33(4).

Effect of a supervision order

While a supervision order is in force, it is the duty of the supervisor to advise, assist and befriend the supervised child; to take such steps as are reasonably necessary to give effect to the order; and, if the order is not complied with, or the supervisor considers that the order may no longer be necessary, to consider whether or not to apply to the court for its variation or discharge.[75] The relevant law concerning supervision orders and medical treatment is set out in Schedule 3 to the Children Act 1989, although paragraphs 3 and 4 of that Schedule (which concern medical examinations and treatment) do not apply to interim supervision orders. The effect of the provisions in the Schedule is similar to that of a guardianship order made under the 1983 Act combined with a supervision and treatment order, or a psychiatric probation order, made under criminal legislation. For example, a supervised child may be required to comply with directions given by the supervisor which require him to live at a specified place; to present himself at specified places on specified days; and to participate in specified activities. The order may also require the supervised child to undergo a psychiatric examination or to submit to a specified period of psychiatric treatment, including in both cases as a resident patient. However, if the child has sufficient understanding to make an informed decision, such medical requirements may not be included in the order unless the court is satisfied that the child consents to their inclusion.

Interim orders and psychiatric assessments

A court may not make an interim care order or an interim supervision order unless it is satisfied that there are reasonable grounds for believing that the child's circumstances are such that the statutory grounds for making a full order exist.[76] Where the court makes an interim order, "it may give such directions (if any) as it considers appropriate with regard to the medical or psychiatric examination or other assessment of the child; but if the child is of sufficient understanding to make an informed decision he may refuse to submit to the examination or other assessment."[77] The court may alternatively direct that there is to be no such examination or assessment, or no such examination or assessment unless the court directs otherwise.[78] Any of the directions just referred to may be given at the time the interim order is made or at any time it is in force, and provision is made for persons involved in the case to apply for the variation of directions previously given.[79]

Supervision orders and the inherent jurisdiction

A child's refusal to submit to an examination or assessment may be overridden by the High Court in the exercise of its inherent jurisdiction. In *South Glamorgan County Council v. W. and B.* [1993] 1 F.L.R. 574, the court made an interim care order and directed that the 15-year old child in that case should receive a psychiatric examination and assessment, if necessary at an assessment unit. She exercised her statutory right of veto, under section 38(6), and refused to be examined. The local authority next applied for leave to invoke the inherent jurisdiction of the High Court,

75 Children Act 1989, s.35(1).
76 *Ibid.*, s.38(2).
77 *Ibid.*, s.38(6).
78 *Ibid.*, s.38(7).
79 *Ibid.*, s.38(8).

so as to overrule her wishes. The High Court granted leave and made an order that she be examined against her wishes, using force if necessary.[80]

SECURE ACCOMMODATION[81]

Secure accommodation orders are made under section 25 of the 1989 Act. That section, and the associated regulations, do not apply to any child who is detained under the 1983 Act.[82] They do apply to children subject to guardianship under that 1983 Act, and to those admitted to hospital as informal patients by a parent or (if in care) by the local authority. A child to whom section 25 applies may not be kept in secure accommodation for more than 72 hours (whether or not consecutive) during any period of 28 consecutive days without the authority of a family proceedings court.[83] Secure accommodation is accommodation provided for the purpose of restricting liberty and includes a behaviour modification unit at a hospital where the regime is intended to restrict liberty.[84] Whether or not a hospital unit, mental nursing home or clinic is provided for that purpose is a matter of fact. Where a secure accommodation order has been made, it permits, but does not require, the child to be kept in secure accommodation. It is therefore for the applicant to decide whether it is in the child's best interests to seek the order and whether or not to give effect to any order then made.

The statutory grounds

Criminal proceedings aside, the criteria for making a secure accommodation order are the same in all cases, that is regardless of whether the child is being accommodated in a community home or in secure hospital accommodation. A child who is in care or who is being accommodated by a local authority, Health Authority or NHS trust, or being provided with accommodation in a mental nursing home—

> "may not be placed or kept in accommodation provided for the purpose of restricting liberty ("secure accommodation") unless he is likely to injure himself or other persons if kept in any other description of accommodation[85] or he has a history of absconding, is likely to abscond from any other description of accommodation, and, if he absconds, is likely to suffer significant harm.[86]

The application and evidence

Any necessary court application should be made by the relevant NHS trust or Health Authority unless the child is in care or is provided with accommodation by a local authority, in which case the local authority must make the application. The court must appoint a guardian ad litem unless it is satisfied that this is not necessary in

80 See also *Re J (A Minor) (Medical Treatment)* [1992] 2 F.L.R. 165, which involved a child subject to supervision who was suffering from anorexia nervosa.
81 See Children Act 1989, s.25; The Children (Secure Accommodation) Regulations 1991 (S.I. 1991 No. 1505); The Children (Secure Accommodation) (No. 2) Regulations 1991 (S.I. 1991 No. 2034); The Children Act 1989 Guidance and Regulations, Vol. 4, Residential Care (Department of Health, 1991). The regulations do not apply to children detained under the Mental Health Act 1983.
82 Children (Secure Accommodation) Regulations 1991 (S.I. 1991 No. 1505), reg. 5(1).
83 Children (Secure Accommodation) Regulations 1991, reg. 10(1).
84 *R. v. Northampton Juvenile Court, ex p. London Borough of Hammersmith* [1985] Family Law 25.
85 Children Act 1989, s.25(1)(b).
86 *Ibid.*, s.25(1)(a). The welfare of the child is a relevant but not paramount consideration and the principles of section 1 do not apply: *Re M (a Minor) (Secure accommodation order) The Times, 10 November 1994.*

order to safeguard the child's interests.[87] It is desirable to have a psyc... ...ic report available as evidence[88] and hearsay evidence is admissible.[89] A court which adjourns an application may make an interim order permitting the child to be kept in secure accommodation during the adjournment period.[90] In the case of interim orders, there is no maximum period of detention but the proceedings should be heard without delay and take note of the serious nature of restrictions of liberty.[91]

The decision and appeals

The family proceedings court must determine whether the statutory grounds set out in section 25 are satisfied.[92] It is obliged to make the order if satisfied as to the statutory grounds, but has a discretion as to the length of the order.[93] An order should be for no longer than is necessary and unavoidable.[94] Thus, while the maximum period for which a court may authorise a child to be kept in secure accommodation is three months,[95] the court should not automatically make an order of that length but consider what is necessary in the particular circumstances.[96] Unless the child has been remanded to secure accommodation by a criminal court, the court may further renew the authority for periods not exceeding six months at a time.[97] The magistrates must give full reasons for their decision.[98] Appeals against the granting or refusal of applications are heard in the High Court.[99] They should be listed for an early hearing because the matter involves deprivation of liberty.[100]

CHILDREN ACCOMMODATED BY NHS BODIES

Where a child is provided with accommodation by a Health Authority or NHS trust for a consecutive period of at least three months, or with the intention of accommodating him for such a period, the authority or trust must notify the local authority within whose area the child appears to be ordinarily resident.[101] The local authority must take such steps as are reasonably practicable to determine whether the child's welfare is adequately safeguarded and promoted while he is so accommodated. They must further consider the extent to which (if at all) they should exercise any of their functions under the Children Act with respect to the child.[102] The departmental guidance states that authorities should find out whether contact between the child and his parents is adequate; obtain written assurances from the authority or trust that proper parental contact is being established or maintained; if appropriate, contact the parents; and arrange to visit the child within 14 days if contact has ceased, or there are other matters which suggest that the child's welfare

87 Children Act 1989, s.41(1).
88 *R.(J.) v. Oxfordshire County Council* [1992] 3 All E.R. 660.
89 Hearsay Evidence Order (S.I. 1991 No. 1115).
90 Children Act 1989, s.25(5).
91 *Oxfordshire C.C. v. R.* [1992] 1 F.L.R. 648.
92 Children Act 1989, s.25(3).
93 *Ibid.*, s.25(4).
94 *W v. North Yorkshire County Council* [1993] 1 F.C.R. 693
95 Children (Secure Accommodation) Regulations 1991, reg.11.
96 *Re W (A Minor) (Secure Accommodation Order)* [1993] 1 F.L.R. 692.
97 Children (Secure Accommodation) Regulations 1991, reg.12.
98 Family Proceedings Court (Children Act 1989) Rules 1991, r.21; *Oxfordshire C.C. v. R.* [1992] 1 F.L.R. 648.
99 Children Act 1989, s.94.
100 *Oxfordshire CC v. R.* [1992] 1 F.L.R. 648.
101 Children Act 1989, s.85(1) and (3).
102 *Ibid.*, s.85(4).

is not being safeguarded. ...he Health Authority or trust must also notify the local authority when they cease to accommodate the child.[104]

Mental nursing homes

Similar provisions apply in the case of mental nursing homes, the obligation to give notice being placed on the person carrying on the home.[105] In this case, it is an offence to fail, without reasonable excuse, to give such notice.[106]

Mental Health Act 1983

Where a child or young person in care who appears to be suffering from mental disorder is admitted to a hospital or nursing home, the authority must arrange for visits to be made to him on behalf of it, and take such other steps as would be expected to be taken by his parents.[107]

PROVIDING SERVICES FOR CHILDREN IN NEED

The general legislative provisions concerning the provision of community care services **(154)** do not apply to children or only in a qualified way. For example, sections 21 and 29 of the National Assistance Act 1948 apply only to persons aged over 18. Similarly, section 21 of, and Schedule 8 to, the National Health Service Act 1977 do not apply to children. However, under the Children Act 1989, every local authority has a "general duty" to safeguard and promote the welfare of children in need within their area by providing a range and level of services appropriate to those children's needs.[108]

Children in need

A child is, *inter alia*, to be taken to be in need if he is disabled or if, without the provision for him of such services, he is either unlikely to achieve or maintain a reasonable standard of mental health or development or his mental health or development is likely to be significantly impaired.[109] Development in this context includes intellectual, emotional, social or behavioural development.[110]

Services provided

The services provided may include giving assistance in kind or, in exceptional circumstances, in cash.[111] Furthermore, a service may be provided for the family of a child in need, or for any member of his family, if it is provided with a view to safeguarding or promoting the child's welfare.[112] Services provided under the section are means-assessed but cannot be imposed unless a care or supervision order is in force. Being a general duty, the duty to provide services under section 17 does not give rise to any right enforceable by an action for damages.

103 *Guidance*, Vol. 4, para. 1.99.
104 Children Act, s.85(2).
105 *Ibid.*, s.86(1).
106 *Ibid.*, s.86(4).
107 Mental Health Act 1983, s.116.
108 Children Act 1989, s.17(1)(a). For the purpose principally of facilitating the discharge of this general duty, each local authority has the specific powers and duties set out in Part 1 of Schedule 2 to the Act. *Ibid.*, s.17(2).
109 *Ibid.*, s.17(10).
110 *Ibid.*, s.17(11).
111 *Ibid.*, s.17(6).
112 *Ibid.*, s.17(3).

Section 8 of the Family Law Reform Act 1969 provides that a child aged 16 or 17 who is capable of expressing his own wishes can give valid consent to medical treatment.[113] More particularly, section 131(2) of the Mental Health Act 1983 provides that nothing in that Act shall prevent a child aged 16 or 17 who is capable of expressing his own wishes from arranging his own informal admission to hospital, or from remaining in hospital after he has ceased to be detained.[114] The position of children aged under 16 was considered in *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112. It was held that a child aged 15 or under may be capable of giving a valid consent to medical treatment including medical examination and, if so, that consent cannot be overridden by his parents. Whether a particular child of such an age can give a valid consent to proposed treatment depends on the circumstances, including his intellectual capacity to understand advice.[115]

Overriding children who do not consent

Section 8 of the Family Law Reform Act 1969 does not explicitly address the situation of a competent 16 or 17-year old child who refuses to consent to treatment. The position here is that the child's parents may override his decision to refuse treatment. The effect of section 8 is limited to enabling a competent minor aged 16 or over to consent to treatment: it does not remove the parents' co-existing right to give consent on the child's behalf. Likewise, if a "Gillick-competent" child aged 15 or under refuses treatment, but someone with parental responsibility consents, the treatment can be given notwithstanding the child's refusal.[116] Accordingly, in *Re K, W. and H. (Minors: Medical Treatment)* [1993] 1 F.L.R. 854, a High Court application for a specific issue order, declaring that it was permissible to treat three adolescent girls whose behaviour was highly disturbed, was dismissed as unnecessary because the hospital had for each of them the consent of a person with parental responsibility. Where a care order is in force, the local authority has parental responsibility and may therefore give any necessary consent.[117] The case of

[113] "8.–(1)The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian ...(3) Nothing in this section shall be construed as making ineffective any consent which would have been ineffective if this section had not been enacted."

[114] "131.–(1) Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained. (2) In the case of a minor who has attained the age of 16 years and is capable of expressing his own wishes, any such arrangements as are mentioned in subsection (1) above may be made, carried out and determined [even though there are one or more persons who have parental responsibility for him (within the meaning of the Children Act 1989)]."

[115] Speaking of medical treatment generally, Lord Scarman said: "It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a valid consent in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child, or inability to find the parents, are examples of exceptional situations in which it will be reasonable for a doctor to proceed without the parent's consent."

[116] *Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All E.R. 177; *Re W* [1992] 3 W.L.R. 758.

[117] In the absence of any parental responsibility, the local authority could seek a court direction, under s.8 of the Children Act 1989, or through the exercise of the inherent jurisdiction of the court.

R. v. Kirklees Metropolitan Borough Council, ex p. C [1993] 2 F.L.R. 187 concerned a 12-year old child in care who was admitted by the local authority to hospital for assessment. The court held that she was not "Gillick-competent" to accept or reject treatment and, furthermore, the council acting *in loco parentis* was competent to assent on her behalf.

Overriding the parent

A decision by a parent to consent, or to refuse to consent, to an operation may in turn be overridden by the court. In *Re C (A Minor) (Wardship: Medical Treatment)* [1990] Fam. 26, the ward of court was terminally ill and it was held that the court could and would authorise treatment to relieve the ward's suffering. In *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 F.L.R. 386, a 15-year old Jehovah's Witness suffering from leukaemia was made a ward of court. Leave to perform a blood transfusion was given on the basis that the boy's welfare "should be looked at objectively."

Obtaining court approval

Section 8 of the Children Act 1989 makes provision for specific issue orders, which are orders giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child. However, no court may make such an order with respect to a child who is in the care of a local authority.[118] This means that the local authority can only obtain court approval for some step involving a child in care by invoking the court's inherent jurisdiction, under section 100 of the Children Act 1989.

The inherent jurisdiction

Section 100 of the Children Act 1983 limits the circumstances in which the High Court's inherent jurisdiction may be exercised.[119] However, the jurisdiction is sometimes invoked in relation to difficult questions about medical treatment. In *Re W (A Minor) (Medical Treatment)* [1993] Fam. 64, the child was a 16-year old girl in care who was suffering from anorexia nervosa. The local authority decided that treatment without her consent might be necessary. It therefore applied for the High Court to exercise its inherent jurisdiction so that the local authority could move the child to a treatment unit and give her medical treatment without her consent. Lord Donaldson M.R. held that there was "now ample authority for the proposition that the inherent powers of the court under its *parens patriae* jurisdiction are theoretically limitless and they certainly extend beyond the powers of the natural parent. The court does have the power to override the refusal of a minor, whether over or under 16, and even if 'Gillick-competent.'"

Detention under the inherent jurisdiction

In *Re C (Medical treatment: court's jurisdiction) The Times,* 21 March 1997, the 16 year old child had a history of absconding from a clinic which was treating her for

[118] Children Act 1989, s.9(1).

[119] "100.–(2) No court shall exercise the High Court's inherent jurisdiction with respect to children— (a) so as to require a child to be placed in the care, or put under the supervision, of a local authority; (b) so as to require a child to be accommodated by or on behalf of a local authority; (c) so as to make a child who is the subject of a care order a ward of court; or (d) for the purpose of conferring on any local authority power to determine any question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child."

anorexia nervosa. The clinic would not take her back without a court or[illegible] or a care order. The local authority did not wish to apply for a care order and so asked the court, under its inherent jurisdiction, to make an order detaining her for treatment, using reasonable force if necessary. The court held, firstly, that the clinic did not constitute secure accommodation and, secondly, that it had such an inherent power to direct that a minor should be detained in a specified institution for treatment using reasonable force if necessary. Such an order should be of limited duration and subject to early review.

THE NATIONAL HEALTH SERVICE

The structure of the National Health Service (NHS) was reorganised on 1 April 1996. The previous structure and the new structure are shown in the diagrams on the following pages.

SECRETARY OF STATE FOR HEALTH

The Secretary of State for Health is accountable to Parliament for the Department of Health and the National Health Service in England.[120] The Department's health strategy for England is set out in the 1992 White Paper *The Health of the Nation.*[121] It is the Secretary of State's duty to continue to promote a comprehensive health service designed to secure improvement in the mental health of the people of England and Wales and, for that purpose, to provide or secure the effective provision of services in accordance with the National Health Service Act 1977. More specifically, the Secretary of State has a duty to provide hospital accommodation and such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service, and to such extent as he considers necessary to meet all reasonable requirements. The Department's funding is negotiated annually with the Treasury, through the public expenditure survey.

NHS Policy Board

The Secretary of State sets the Department of Health's strategy and objectives and approves the allocation of resources to meet those objectives. In relation to the objectives and performance of the NHS, the Secretary of State is supported by the NHS Policy Board which he chairs.

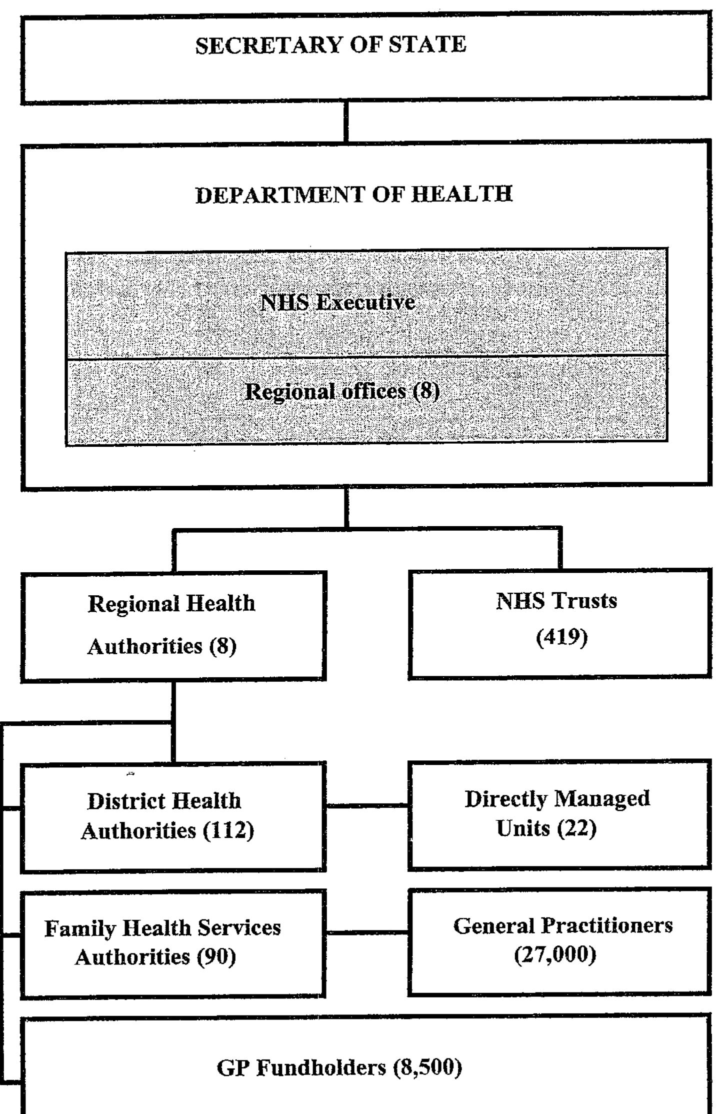
NHS Executive

The Secretary of State is not normally involved in the day-to-day management of the National Health Service although he is consulted on the handling of matters that give rise to Parliamentary or public concern. The NHS Executive, the headquarters of which is based in Leeds, provides the central management of the NHS, dealing with all operational matters in accordance with the overall strategy set by the Policy Board. The body is responsible for assessing health needs, research and development, formulating operational policy, securing and allocating resources, developing and regulating the internal market, and supporting Ministers.

120 The Secretary of State for Wales is mainly responsible for health and social services in the principality.

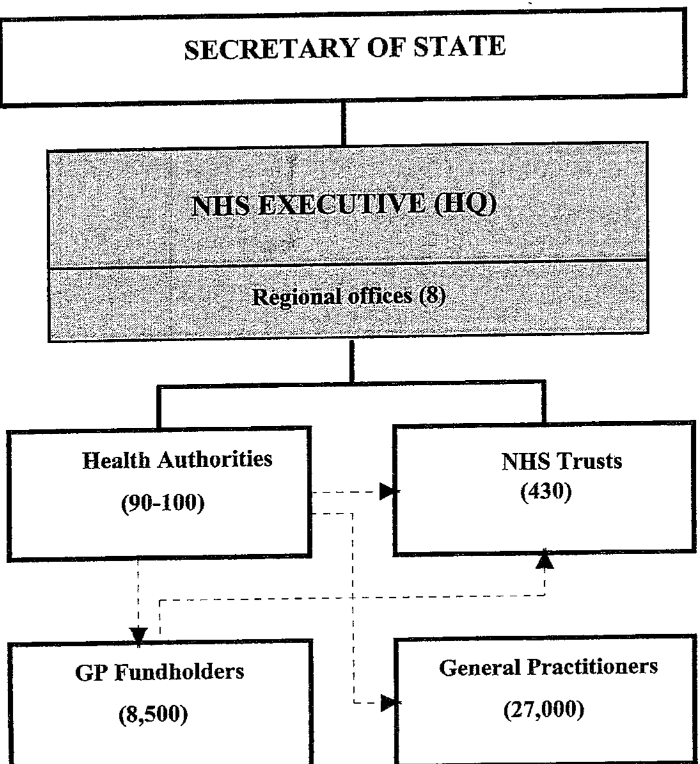
121 The Health of the Nation, Cm. 1986 (1992).

NHS STRUCTURE PRIOR TO 1 APRIL 1996



NEW STRUCTURE OF THE NHS

POST 1 APRIL 1996



NHS Executive regional ofi

The size and complexity of the NHS means that its central management must operate through a regional structure. Eight NHS Executive regional offices were established in April 1994 so as to be able to take over the responsibilities of the Regional Health Authorities on 1 April 1996, upon their abolition. The regional offices monitor the NHS trusts but do not become involved in detailed operational matters, which are the responsibility of local health authorities and the trusts themselves.

The regions

The regions covered by the eight regional offices are as follows: East Anglia and Oxford (Area 1), North Thames (2), South Thames (3), South West England (4), West Midlands (5), North West England (6), North East England and Yorkshire (7), and Trent (8). There is one Mental Health Review Tribunal for each region.

HEALTH AUTHORITY STRUCTURE PRIOR TO APRIL 1996

The Health Authorities Act 1995 came into force on 1 April 1996. Previously, three different kinds of health authority had been responsible for NHS functions at a regional or local level—

- District Health Authorities assessed the local population's need for health care and purchased hospital and community health services for the people in their area. Some DHAs merged to form larger purchasing units or collaborated together in "purchasing consortia."
- Family Health Services Authorities regulated and managed services provided by General Practitioners, dentists, pharmacists and opticians. They paid GPs in accordance with previously agreed contracts and investigated complaints relating to such services.
- In many parts of the country, DHAs and FHSAs established joint management arrangements but the law required them to maintain separate existences.
- Eight Regional Health Authorities allocated resources to the DHAs and FHSAs, directed them to perform certain functions, and themselves provided a range of region-wide services.
- The Secretary of State, in turn, gave directions to the RHAs about the performance of their functions.

HEALTH AUTHORITIES ACT 1995

The main purpose of the Health Authorities Act 1995 was to streamline central management and to encourage the integrated purchasing of primary and secondary care. The main changes effected by the Act were two-fold—

- Firstly, the abolition of the Regional Health Authorities and their replacement by regional NHS Executive offices (see above). The regional offices are responsible for monitoring NHS trusts and developing the purchasing function within the health service; providing a link between central management and the NHS trusts, and so ensuring that agreed national policies are implemented; approving applications for GP fundholder status and setting GP fundholder budgets (see below); arbitrating in the event of disputes.

- Secondly, the merger of District Health Authorities (DHAs) and Family Health Services Authorities (FHSAs) to form new unitary Health Authorities; in effect, joint purchasing bodies. The new authorities are expected to work with local authority social services departments in the commissioning of social care, so as to ensure a more integrated strategy for local services.

HEALTH AUTHORITIES

The establishment of the new health authorities meant the creation of a single authority at local level with responsibility for implementing national health policy. The core functions taken over from the old DHAs and FHSAs included the following —

- evaluating the health and healthcare needs of the local population.

- establishing a local health strategy to implement national priorities and meet local health needs in collaboration with local people and the providers of health services.

- implementing that local health strategy by purchasing health services for patients through contracts with NHS and other providers, and working with GPs, NHS trusts and non-NHS providers to shape the delivery of services and improve the effectiveness of health care.

- monitoring the delivery of health services to ensure that objectives are achieved including regulating and managing services provided through GPs, dentists, opticians and pharmacists ("Family Health Services Contractors").

- bringing pressure to bear on providers to raise the quality of care and efficiency by setting standards, monitoring performance, and exercising choice between competing providers.

- working with and influencing other statutory and voluntary organisations to improve people's health.

SPECIAL HEALTH AUTHORITIES

Under the National Health Service Act 1997, the Secretary of State may establish Special Health Authorities for the purpose of performing any functions which he may direct the body to perform on his behalf. The Mental Health Act Commission is a Special Health Authority.

NHS TRUSTS

Individual hospitals are managed by NHS trusts, which therefore provide hospital and community services on behalf of the Secretary of State. Prior to their establishment, hospitals were directly managed by the local District Health Authority. The core function of an NHS trust is to deliver health services according to the purchasing Health Authority's specifications. NHS trusts are responsible to their purchasers for meeting standards of service and "cost and volume targets." They are required to break even financially, to earn a six per cent. return on their capital, and to comply with financial targets set by the Secretary of States. The NHS regional offices are responsible for monitoring their performance and for approving their "business plans." The Secretary of State may by order made by statutory instrument dissolve an NHS trust if he considers it appropriate in the interests of the health service.

Constitution and functions

Every NHS trust is a body corporate having a board of directors consisting of a chairman appointed by the Secretary of State and executive and non-executive directors (that is to say, directors who respectively are and are not employees of the trust). All of the trust's directors are full and equal members of the Board and jointly responsible for carrying out the functions of the trust. Orders establishing an NHS trust must be made by statutory instrument and specify the functions of the trust. Those functions will include any statutory functions under the Mental Health Act 1983. The trust is required to carry out these functions "effectively, efficiently and economically" and to comply with any directions given to it by the Secretary of State. A trust may enter into contracts for the carrying out of any of its functions jointly with any Health Authority, with another NHS trust or with any other body or individual. trusts should appoint a committee to undertake the duties of managers under the 1983 Act and it should comprise "informed members of the trust and appointed outsiders, suitably informed."[122]

GP FUNDHOLDERS

All General Practitioners provide medical services and some of them may also purchase hospital services. GP fundholders may purchase a defined range of services for their patients, including out-patient services and drugs. Other services are purchased for the patients of GP fundholders by health authorities. As the number of fundholders increases, they will share with such authorities joint responsibility for purchasing services for their patients.

HOSPITALS

Various provisions in the Mental Health Act 1983 provide for a person's admission to or detention in a hospital. Although it may seem obvious what a hospital is, the legal position is in fact far from clear.

This section is arranged as follows—

[122] *Mental Health Act 1983: Code of Practice*, (2nd ed., 1993), para. 24.4.

- Hospital — *Statutory definitions*
  - — *Part II of the Act and private hospitals* 132
  - — *Parts III, V and VI of the Act* 133
  - — *Part IV of the Act* 134
- Secure NHS hospitals 135
- Transfers and removals between hospitals 135
- Development of hospital satellite units 137
- Problems caused by the creation of NHS trusts 139

"HOSPITAL"

Section 145(1) provides that, unless the context otherwise requires, "hospital" means any of the following —

a. any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under the National Health Service Act 1977.

b. any of the following homes or institutions which is vested in an NHS trust (**131**) or in the Secretary of State (**126**) for the purpose of his functions under the National Health Service Act 1977, including clinics, dispensaries and out-patient departments maintained in connection with them—

- a maternity home
- an institution for the reception and treatment of persons suffering from illness (including persons suffering from mental disorder)
- an institution for the reception and treatment during convalescence of persons requiring medical rehabilitation.

"HOSPITAL WITHIN THE MEANING OF PART II OF THE ACT"

The Act refers in places to a "hospital within the meaning of Part II of the Act." For the purposes of that Part of the Act, section 34(2) provides that references to a hospital are to be construed as including a mental nursing home which is registered to receive patients who are liable to be detained under the 1983 Act.[123] Perhaps confusingly, most of the references to "a hospital" in Parts III, V and VI of the Act are also to be construed as referring to "a hospital within the meaning of Part II of the Act," rather than to a hospital as defined in section 145(1), and so include mental nursing homes registered in this way.

123 "Registered" here means registered under section 23(5)(b) of the Registered Homes Act 1984. "Reception" means "taking people into a building and receiving them there." *Re Couchman, Couchman v. Eales* [1952] 1 Ch. 391, *per* Dankwerts J. at 396.

Registered Homes Act 1984

Mental nursing homes which are registered to receive detained patients are sometimes referred to in practice as "private hospitals." A mental nursing home which is not registered to receive detained patients is not a hospital for the purposes of Part II of the Act, and so cannot admit patients in pursuance of an application made under sections 2,3 or 4. Nor can its residents be detained there under section 5(2) or (4).[124] With the exception of NHS hospitals (**132**), any premises used for the reception of one or more mentally disordered patients, which provide nursing or other medical treatment (including care, habilitation and rehabilitation under medical supervision), constitute a mental nursing home,[125] and must be registered as such.[126] Where a mental nursing home is registered to receive detained patients, the particulars of the registration must be entered by the Secretary of State in a separate part of the register maintained by him,[127] and that fact specified in the certificate of registration.[128] The certificate must be kept affixed in a conspicuous place in the home.[129] It will specify the maximum number of patients who may be kept there at any one time[130] and may include conditions as to the category of persons who may be received there.[131] In certain circumstances, the Secretary of State may cancel a person's registration.[132] Where this occurs, or a person solely registered in respect of a home dies, special provisions apply if one or more residents are liable to be detained there. Notwithstanding the cancellation, the registration continues in force for a period of two months or until every patient has ceased to be liable to be detained, whichever occurs first.[133] Experience demonstrates that it cannot be assumed that even large "private hospitals" which treat detained patients are registered to receive them. The establishment's status as a hospital should always be verified, by examining the displayed certificate of registration, and an application for habeas corpus made in appropriate cases.

PARTS III , V AND VI OF THE ACT

Except where otherwise expressly provided, or where the context requires a different meaning, references to a "hospital" in Parts III (mentally disordered offenders), V (mental health review tribunals) and VI (removal and return of patients within the United Kingdom) of the Act are to be construed as referring to "a hospital within the meaning of Part II," and therefore as including mental nursing homes registered to receive detained patients. There is in fact now only one express exception. This is that the Secretary of State may not remove a person to a mental nursing home under

124 A restricted patient may, however, be conditionally discharged to an unregistered mental nursing home. Even though he is liable to be detained under the hospital order originally imposed by the court, he is not liable to be detained at the home. Similarly, section 17 leave may be granted to a patient (whether restricted or not) so as to enable him to reside at an unregistered mental nursing home. Again, he is not liable to be detained at that home, being liable to detention only at the hospital from which he has leave to be absent.

125 Registered Homes Act 1984, s.22.

126 *Ibid.*, s.23(1).

127 *Ibid.*, s.23(5)(b). In practice, the Health Authority for the area keeps and maintains the register on the Secretary of State's behalf.

128 *Ibid.*, s.23(5)(a).

129 *Ibid.*, s.23(6). Normally the certificate will be found affixed to the wall in the reception area.

130 *Ibid.*, s.29(1).

131 *Ibid.*, s.29(2). For example, that the facility is registered to receive detained patients suffering from a psychopathic disorder.

132 As to the circumstances in which a person's registration may be cancelled, see *ibid.*, s.28.

133 *Ibid.*, s.36(2).

section 46. Prior to 1 October 1997, it was also unlawful for him to transfer prisoners and other persons in custody to a mental nursing home under section 47 or 48, although he commonly did so (**381**).[134]

"HOSPITAL" FOR THE PURPOSES OF PART IV

A wider meaning still is given to the term "hospital" for the purposes of Part IV of the Act (the consent to treatment provisions). Here, any reference to a hospital "includes a mental nursing home," including therefore homes not registered to receive detained patients.[135] The wider definition is necessary because the section 57 consent procedures apply to informal patients who require psychosurgery or other forms of section 57 treatment. Some of these patients might in theory be receiving informal treatment at an unregistered mental nursing home. Such a home may also have residents who are liable to be detained for treatment but have been sent there on leave, in which case medication and ECT may only be administered if authorised under section 58.

DEFINITIONS OF A HOSPITAL

Part of the Act	Section	Definition of a hospital
General definition	145(1)	"In this Act, unless the context otherwise requires— ... 'hospital' means— (a) any health service hospital within the meaning of the National Health Service Act 1977; and (b) any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under that Act; and 'hospital within the meaning of Part II of this Act' has the meaning given in section 34."
Hospital within the meaning of Part II	34(2)	"Except where otherwise expressly provided, this Part of this Act applies in relation to a mental nursing home, being a home in respect of which the particulars of registration are for the time being entered in the separate part of the register kept for the purposes of section 23(5)(b) of the Registered Homes Act 1984 as it applies in relation to a hospital, and any reference in this Act to a hospital to which this Part of this Act applies, shall be construed accordingly."
Part III	55(5)	"Section 34(2) above shall apply for the purposes of this Part of this Act as it applies for the purposes of Part II of this Act."
Part IV	64(1)	"In this Part of this Act ... 'hospital' includes a mental nursing home."
Part V	79(6)	"In this Part of this Act, unless the context otherwise requires, 'hospital' means a hospital within the meaning of Part II of this Act."

[134] Mental Health Act 1983, s.47(1), as amended by Crime (Sentences) Act 1997, ss.49(3) and 56(2), Sched. 6.

[135] Mental Health Act 1983, s.64(1).

SECURE NHS HOSPITALS

A number of patients whose cases tribunals review are detained in high secure or medium secure hospital units. There are presently three special hospitals (High Security Hospitals) in England and Wales: Ashworth Hospital in Lancashire, Broadmoor Hospital in Berkshire, and Rampton Hospital in Nottinghamshire. Unless the context otherwise requires, section 145(1) provides that the term "special hospital" has the same meaning as in the National Health Service Act 1977, section 128 of which provides in turn that the term has the meaning given to it in section 4. That section imposes a duty on the Secretary of State for Health to—

> "provide and maintain establishments (in this Act referred to as 'special hospitals') for persons subject to detention under the Mental Health Act 1983 who in his opinion require treatment under conditions of special security on account of their dangerous, violent or criminal propensities."

Informal patients and those not requiring special security

Somewhat at variance with section 4, there are at any one time a handful of special hospital patients who are not detained there under the 1983 Act. It has also been the case that some detained special hospital patients considered suitable for transfer on clinical grounds have nevertheless remained there for a number of years for want of a less secure placement. The lawfulness of such continued detention is questionable if the delay is substantial and it is not disputed that the patient does not require detention in conditions of special security, on account of his propensities. The patient may therefore consider applying for judicial review — specifically, an order of mandamus requiring the Home Secretary to direct his transfer under section 123 — preparatory to making an application to the European Court of Human Rights.

Regional Secure Units

Although not a statutory concept, the reader should be aware that there are in excess of twenty regional secure units for the assessment, treatment and care of patients who require conditions of medium rather than high security. Special hospital patients are often referred to RSUs with a view to transfer, as the first formal stage along the pre-discharge process.

TRANSFERS AND REMOVALS BETWEEN HOSPITALS

The statutory framework concerning the movement of patients between different wards and different hospitals is as follows—

a. Applications for admission must be addressed to the managers of "the" hospital to which admission is sought.

b. A patient detained under section 5(2) may be detained in "the" hospital for 72 hours.

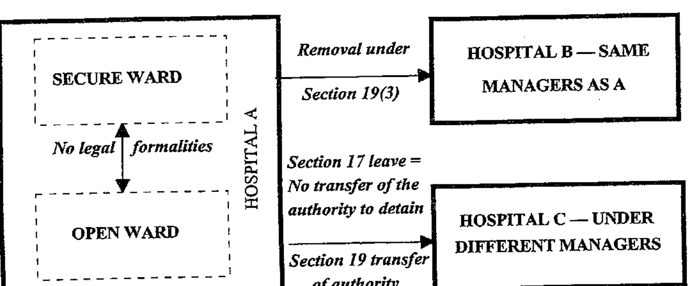
c. No legal formalities have to be observed before a patient may be moved from one ward to another ward within the same hospital. The patient continues to be detained in "the" hospital and movement within "the" hospital is not inconsistent with the existing authority for his detention.

d. Section 19(3) authorises the removal of a patient who is [illegible]ined in a hospital in pursuance of an application, order or direction to another hospital for which the same managers are responsible. Because this involves no transfer of legal responsibility for the patient's detention to different managers, and the managers are already authorised to detain him, no formal transfer document is necessary. The patient is simply deemed to have been detained from the outset at the hospital to which he is removed.[136]

e. Moving a detained patient to a differently managed hospital can be achieved in one of two ways. Firstly, by granting him leave to be absent from the hospital where he is liable to be detained and imposing a condition of leave that he resides at the second hospital.[137] However, if section 17 is used in this way, the managers of the second hospital have no authority to detain him, since the application or order only authorises his detention at the hospital specified in it. If the aim is *both* to move the patient to a different hospital, and to transfer the authority to detain him to the managers of that hospital, this can only be achieved by means of a formal transfer under section 19(1).

f. The word "transfer" in section 19 therefore denotes a transfer of the authority, and responsibility, for the patient's detention to different managers and section 19 distinguishes between the "transfer" of a patient under section 19(1) and the "removal" of a patient under section 19(3).

g. The authority to detain a patient under section 5(2) cannot be transferred to different managers under section 19, because they are not liable to be detained by virtue of an application. However, they may be removed from one hospital to another hospital for which the same managers are responsible.[138] The original reason for this limitation was that all hospitals within the same district had the same managers — the local District Health Authority — and each district had its own psychiatric facility. Consequently, the limitation caused no practical problems and ensured that the application procedures were not disrupted by the patient being moved to a different district before the section 2 or 3 application had been completed.



136 Mental Health Act 1983, s.19(2) and (3).
137 See *ibid.*, ss.17(1) and (3), 18(2).
138 See the precise wording of Mental Health Act 1983, subss. 19(1) and (3).

The way in which a hospital is defined in section 145 has important practical consequences. Many hospitals now have "rehabilitation wards" or "hospital hostels" situated in the community a number of miles from the main hospital. These are often converted guest houses with 24-hour nursing cover and a dozen or so "residents." Unless the context otherwise requires, such establishments come within the statutory definition of a hospital and so constitute in-patient facilities. Accordingly, patients seemingly discharged from hospital to local "hostels" of this kind remain in-patients. The statutory criteria for renewing their liability to detention may be satisfied and, if so, compulsory treatment continue during their residence there. It may be argued that such arrangements contravene the statutory framework because they amount to the creation of community treatment orders otherwise than by legislation. However, had such a facility not been available the patient would probably have continued to be detained on a long-stay ward at the main hospital. Either way, he continues to require continuous nursing care reinforced by some element of compulsion and his legal position is neither better nor worse. Furthermore, the more natural setting of a small satellite ward set away from the main hospital is, for rehabilitative purposes, usually more therapeutic.

Detained patients subject to restrictions

A further practical consequence of the development of hospital hostels concerns tribunal proceedings involving restricted patients. Because "discharge" in this context means discharge from hospital, and not merely discharge from liability to detention, a patient who requires further treatment in an in-patient setting cannot be discharged (**515**). If the patient's condition has improved, so that he is ready to leave the main hospital, and take up residence at a highly staffed local hostel, he can be discharged if it is managed by the local authority but not if it is managed by the local NHS trust, and so constitutes hospital premises. In the latter case, although the patient may appear to an outsider to receiving care in the community his legal status remains unchanged — it is as if he had moved wards within the main hospital. He may then live "in the community" for a number of years before eventually being conditionally discharged. While there is sometimes a meaningful distinction between "hospital hostels" and local authority hostels, if the former provide intensive nursing cover but the latter do not, the distinction is not always easy to make because of increasing co-operation between health and social services. If the trend continues and purely residential arrangements, such as group homes, constitute hospital premises then what constitutes being an in-patient is likely to become increasingly artificial.[139] Although a restricted patient who moves to a hostel may feel aggrieved that he has not been formally discharged, the Home Secretary may be equally concerned if the legal position is that his consent is not required before a restricted patient is moved from the main hospital "into the community." For, if the patient's legal status as an in-patient remains unchanged, taking up residence requires no prior discharge or transfer and, at least superficially, no leave to be absent from hospital under section 17 — in which case, nor does the move require the prior consent of the Home Secretary (**336 et seq.**). As to this, the courts may be inclined to hold—

139 As to this, the better argument is that group homes are not institutions which receive and treat patients and so, even if vested in an NHS trust, they are not hospitals for the purposes of the Act.

a. that the community ward is part of the same hospital as tha[illegible]hin which the patient is presently detained;

b. in consequence, section 19 does not apply because the patient is not being transferred or removed a different hospital;

c. similarly, the discharge provisions in sections 23, 42 and 73 do not apply because the patient is not being discharged from hospital;

d. nevertheless, moving the patient from the main hospital to the community ward involves him being absent from hospital for the time it takes to complete the journey between the two sites;

e. consequently, it is necessary to obtain the Secretary of State's consent to the patient being absent from hospital during the journey;

f. by refusing his consent to such leave of absence, the Home Secretary can prevent the patient from being moved "into the community" without his approval in this way.[140]

Commentary

The development of community-based resources since 1983 has introduced a certain tension into the statutory definition of a hospital and its practical application in the context of the detention and discharge provisions. It may be argued that arrangements of the kind outlined, involving removal to a community ward, are consistent with the way in which Parliament defined a hospital, which definition includes convalescent homes and any institution providing medical treatment. Alternatively, it may be contended that the statutory context, in relation to the detention and discharge of patients, suggests that only NHS premises at which there is always a medical practitioner on the site are hospitals — the notion of a hospital without a

140 The main objection to this argument is simply that it is contrived. No one would argue that the hospital managers' power to move an unrestricted patient to a community ward, or to remove him to a different hospital managed by them, is conditional on the responsible medical officer granting section 17 leave. At any rate, the problem will slowly be alleviated as more and more use is made of section 47 of the Crime (Sentences) Act 1997. This section came into force on 1 October 1997. It provides that a hospital order, hospital direction, or section 47 transfer direction may, if restrictions are attached, specify the hospital unit within which the patient is to be detained, *e.g.* secure unit *x* at the specified hospital. Where this power is used, any reference in the 1983 Act to a hospital (*e.g.* in sections 17(1) and 19(3)) is to be construed accordingly. The effect will be that the Home Secretary's consent is required before such a patient can lawfully have escorted leave to attend the hospital shop or be moved to an open ward on the same site, let alone moved to a community ward. At least initially, most restricted in-patients will not, of course, be detained in pursuance of an order or direction which specifies a particular unit. Consequently, the 1997 Act also provides that the managers no longer have power to remove a restricted patient to a *different* hospital under their management without the Home Secretary's consent: Mental Health Act 1983, s.19(3), as amended by Crime (Sentences) Act 1997, s.49(2), and Sched. 1, Pt. II, para. 5(c), as inserted by *ibid.*, s.49(4). The amendment does not, however, prevent the managers from moving patients whose orders do not specify a unit between wards within the *same* hospital (including therefore moving such patients to a community ward, unless the journey requires the Home Secretary's consent under section 17 or the community facility constitutes a separate hospital for these purposes). The fact that the statutory definition of a hospital — what constitutes a hospital and what constitutes a separate hospital — is not clarified in the 1997 Act necessarily does nothing to clarify the position of unrestricted patients, in particular whether small community residential units vested in an NHS trust are wards of the main hospital, etc.

doctor on site being too bro[illegible]. That it is too broad can arguably be inferred from the discharge framework for restricted patients, although many mental nursing homes which are hospitals for the purposes of the Act do not routinely have a medical practitioner on the premises. A further interpretation is simply that "community wards" and NHS hostels are separate hospitals for the purposes of the Act — in the same way that one body of managers (the District Health Authority) managed a number of hospitals at the time the statute was enacted. With the creation of NHS trusts to manage hospitals, such a trust may similarly manage a number of hospitals, the main hospital being one and a satellite hostel (not being in the same physical location) another for the purposes of the 1983 Act.

EFFECT OF THE CREATION OF NHS TRUSTS

The simple framework set out in the 1983 Act for detaining, removing and transferring patients was undermined when the National Health Service & Community Care Act 1990 created NHS trusts to manage hospitals, without in any way amending the definition of a hospital in section 145(1). Previously, all hospitals within a district had the same hospital managers, the local District Health Authority. If it was necessary to move a patient from the psychiatric ward of the local District General Hospital to a surgical ward, following a suicide attempt, the patient remained detained in the same hospital by the same managers. Consequently, no legal formalities had to be observed. Likewise, if a secure psychiatric unit was on the same site, but set apart from the District General Hospital, permitting the patients to wander the hospital grounds, or taking them to the general hospital for dental treatment, involved no legal formalities. The patient had not left the hospital where he was liable to be detained so no formal leave of absence was required. The position now is that different floors of a General Hospital may be managed by different NHS trusts. For example, the local General Hospital NHS trust may manage the first and second floors, and also those wards on the third floor which admit patients for physical conditions. The local Mental Health NHS trust may manage the open psychiatric ward on the third floor, the secure unit set apart in the General Hospital grounds, and a number of wards left on the site of the old asylum, situated some miles away. Worse still, some psychiatric wards may be shared by two Mental Health NHS trusts, both having beds on the ward. As will be seen, trying to apply the legal framework devised in 1983 for the detention, removal and transfer of patients to this new managerial system has proved difficult.

Assumptions on which the Act is based

Before analysing the problems, it is helpful to refer to a number of statutory provisions which demonstrate that the Act was drafted on the assumption that all of the wards on a single site would form a single hospital managed by a single group of managers. The Act provides that an application for admission shall be addressed to the managers of "the" hospital to which admission is sought.[141] Following admission, the application authorises "the" managers to detain the patient in accordance with the provisions of the Act. Section 37 provides that a court may authorise an offender's admission to and detention in "such" hospital as may be specified in the order.[142] Evidence must first be received, *inter alia*, from the managers of "the" hospital" that a bed is available.[143] Sections 47 and 48 similarly provide that the Secretary of State

141 Mental Health Act 1983, s.11(2).
142 *Ibid.*, s.37(1).
143 *Ibid.*, s.37(4).

may by warrant direct that certain categories of person in custody shall _ removed to and detained in "such" hospital as may be specified in the direction."[144]

Moving patients between differently managed wards

The issue that arises from reading these sections is what legal formalities must be completed (if any) before a detained patient may be moved from one ward to another in the same hospital building if those wards are separately managed? Providing the patient in each case remains detained in "the" hospital, can he be moved between differently managed wards or units within that hospital without any formal transfer of the authority for his detention or the grant of leave? If a literal interpretation of sections 17–19 is taken, such a variation involves neither the patient leaving the hospital or being "transferred to another hospital." Certainly, when each hospital was managed by the same District Health Authority, no legal formalities were necessary because such a move did not involve a change of hospital or a change of managers. Section 5(2) provides another example of the problem. The original statutory principles underlying this provision were that patients so detained need not be detained throughout the 72–hour period at the same hospital but must, if moved, continue to be detained by the same managers. However, these principles were based on the assumption that moving patients between wards or units on the same hospital site never involved a change of managers. Following the creation of NHS trusts, any opinion that section 5(2) patients can be informally moved to a ward managed by another NHS trust is consistent with the statutory premise that such patients may be informally moved between wards within the same hospital. However, it contradicts the statutory principle that authority to detain such a patient cannot be transferred to different hospital managers, informal movement between wards being permitted because of the presumption that the patient's management would remain unchanged. Conversely, the opinion that section 5(2) patients cannot be informally moved between differently managed units avoids the above inconsistency but is inconsistent with the original statutory assumption, expressed in section 145(1), that one institution equals one hospital.

The respective arguments

It can be argued that section 19 is only concerned with the transfer or removal of a patient from one institution to another. Section 19(3) provides that a patient may be removed to "any other such hospital" managed by the same trust while the transfer provisions in section 19 only apply if a patient is moved from "a hospital" to "another hospital." It was always intended that moves between wards within a single institution would be internal, informal, arrangements not subject to any legal formalities. The authority conferred by section 5(2) is that the patient may be detained for 72 hours in "the" hospital and moving him from a general to a psychiatric ward does not infringe this; he remains detained in the hospital. Against this, it must be acknowledged that Parliament foresaw none of this. The essential distinction between a transfer and a removal is that removal involves no change in the managers responsible for the patient's detention. Where it is proposed to transfer the authority to detain him from one set of people to another this must be done formally by way of a section 19 transfer entered into by both sets of managers. Furthermore, it is clear from the transfer-removal distinction that Parliament did not

[144] Mental Health Act 1983, ss.47(1) & 48(1).

intend that responsibility f patients detained under section 5(2) should be transferred between managers. Arguing that general hospitals remain one hospital for the purposes of the Act means that even patients detained in pursuance of an application or order can be moved about at random, without any need for section 17 leave or a formal transfer of responsibility. Although the idea that one institution can comprise two hospitals seems odd at first glance, it is no different from a block of flats within which each floor has a different legal owner. The idea only seems strange because for historical reasons such institutions are known by a single name. The context now requires that the term "hospital" in section 145 means *that part* of an institution which is vested in an NHS trust.

Summary

It is submitted that—

- Where two or more NHS trusts manage different parts of an institution which is a hospital for the purposes of the National Health Service Act 1977, each separately managed part is a hospital for the purposes of the admission, detention and discharge provisions in the Mental Health Act 1983.

- Accordingly, where it is proposed to move a patient from one ward or unit within the hospital grounds to another under different management, this requires the grant of leave of absence under section 17 or a formal transfer of the authority to detain the patient under section 19. In cases involving restricted patients, such a move therefore requires the consent of the Secretary of State.

- Patients detained on a general ward under section 5(2) may not be removed to a psychiatric ward under section 19(3) if that ward is separately managed. Nor can the authority to detain them be transferred to another NHS trust under section 19(1). Nor can they be granted leave of absence under section 17(1) subject to a condition that they reside on the psychiatric ward, since they have no responsible medical officer who can grant such leave. In extreme cases, their removal may be justified under common law and recourse may probably be had to section 4.

THE HOSPITAL MANAGERS

Formal responsibility for ensuring that detained patients are dealt with in accordance with the provisions of the Mental Health Act 1983 rests with the managers of the hospital or mental nursing home concerned, as defined by section 145(1). Section 118(1)(a) expressly provides that the Code of Practice prepared by the Mental Health Act Commission on behalf of the Secretary of State may include guidance for managers in relation to the admission of patients to hospitals and mental nursing homes under the Act.

THE MANAGERS

Type of hospital	Managers of the hospital
▪ Hospitals vested in an NHS trust	The trust
▪ Accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under the NHS Act 1977	The Health Authority, or Special Health Authority, responsible for the administration of the hospital
▪ Special hospitals	The Secretary of State
▪ Mental nursing homes registered under the Registered Homes Act 1984	The person or persons registered in respect of the home

STATUTORY FUNCTIONS OF THE MANAGERS

The managers' statutory functions are as follows —

- To receive applications, medical recommendations and reports furnished under Part II of the Act.[145]
- To scrutinise applications and medical recommendations furnished under Part II, to consent to their amendment, and to give notice that a recommendation appears to be insufficient to warrant the detention of the patient.[146]
- To ensure that each detained patient understands the provision under which he is detained, the effect of that provision, his rights of application to a tribunal, and the effect of the provisions referred to in section 132(2).[147]
- To detain patients in accordance with the provisions of the Act.[148]
- To discharge a patient who is liable to be detained if they deem that appropriate.[149]
- To notify the person appearing to be the nearest relative of a patient's impending discharge.[150]
- To give notice to the relevant persons of the furnishing of any report reclassifying the patient,[151] renewing his liability to detention for a further period,[152] or barring his discharge.[153]
- To refer the cases of patients to a mental health review tribunal in the circumstances specified in section 68.

145 Mental Health Act 1983, ss. 4(4)(a), 5(1)(2) and (5), 11(2), 14, 16(1) and 134(1).
146 *Ibid.*, s.15.
147 *Ibid.*, s.132.
148 *Ibid.*, ss. 6(2), 35(9)(b), 36(8), 40(1)(b), 40(3)(b).
149 *Ibid.*, ss.23(2)–(5).
150 *Ibid.*, s.133.
151 *Ibid.*, s.16(4).
152 *Ibid.*, s.20(3).
153 *Ibid.*, s.25(2).

- To authorise a perso keep a patient granted leave of absence in his custody,[154] or to take into custody and return to hospital a patient who is absent without leave.[155]
- To remove patients, if they think appropriate, from one hospital to another which is also under their management[156] or make arrangements for a patient's transfer to another hospital or into guardianship under section 19.
- To give evidence to a court that arrangements have been made for a patient's admission under Part III of the Act.[157]
- To fulfil the obligations of the responsible authority in tribunal proceedings involving patients who are liable to be detained in a hospital under their management.
- To return patients to prison in the circumstances specified in section 74(3).
- To receive requests made under section 134 for the withholding of a postal packet made under section 134, and to comply with directions of the Mental Health Act Commission concerning the release of any postal packets previously withheld by them from a patient by them.[158]
- To investigate complaints made by patients.[159]

DELEGATION OF FUNCTIONS TO OFFICERS

By section 32(3), regulations may determine the manner in which the functions of the managers under Part II of the Act are to be exercised and those regulations may specify the circumstances in which, and the conditions subject to which, any functions may be performed by officers of, or other persons acting on behalf of, the managers. The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 provide that —

- Where, under the regulations, the managers of a hospital are required to make any record or report, that function may be performed by an officer authorised by those managers to perform that function.[160]
- The managers may authorise in writing any officer or class of officers on their behalf to scrutinise medical recommendations, to consent to the amendment of an application or medical recommendation under section 15(1), and, if necessary, to give the written notice required by section 15(2).[161]

154 Mental Health Act 1983, s.17(3).
155 *Ibid.*, ss.18(1) and (2).
156 *Ibid.*, s.19(3).
157 *Ibid.*, ss.35(4), 36(3), 37(4), 38(4), 54(1).
158 *Ibid.*, s.121(8).
159 Where, after such an investigation, the complainant remains dissatisfied, he may then ask the Mental Health Act Commission to conduct a further investigation. *Ibid.*, s.120(1)(b)(i). See p.176.
160 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 3(6).
161 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 4(2).

- The managers' functions under regulation 7, in relation to the transfer of patients under section 19, may be performed by an officer authorised by them.[162]

Mental Health Act Administrators

The managers of most hospitals appoint a "Mental Health Act Administrator" to perform those functions which may be delegated to an officer. In some hospitals, the administrator may have other responsibilities and be known as the "Patients Affairs Officer" or the "Patients Services Officer." Admission documents are generally scrutinised twice, once by the administrator and once by a medical scrutineer, being a consultant appointed to undertake the task. The managers will themselves then periodically examine admission documents, often monthly or quarterly, and in that way monitor the performance of the scrutineers.

Functions which may not be delegated

The power to make an order for discharge under section 23 may not be delegated by the managers to officers, that is an employee of theirs.[163]

ORDERS FOR DISCHARGE AND MANAGERS' HEARINGS

In recent years it has become common for patients to "appeal to the managers" against their detention under the Act, sometimes in preference to making an application to a Mental Health Review Tribunal. This is because section 23 provides that an order in writing discharging a patient from detention may be made by the managers. As the managers of an NHS trust are "the trust," which is a body corporate, some mechanism must be devised which allows this power of discharge to be exercised by the trust. Section 23(4) therefore provides that three or more members of the trust, or of a committee or subcommittee of the trust,[164] may be authorised for the purpose. The persons authorised may include the chairman of the trust and non-executive directors but none of them may be employees of the trust. The three managers appointed to hear the "appeal" usually receive medical and social work reports and follow a procedure loosely based on that set out in the Mental Health Review Tribunal Rules 1983. It must, however, be emphasised that the hospital managers' "appeal hearing" does not have a statutory basis. *The Mental Health Act Commission's First Biennial Report* set out the correct position —

> "A detained patient's so-called 'appeal to the Managers' for his discharge has often caused misunderstanding in hospitals which we have visited. The leaflets which were published officially, as samples of the written information required to be given by Managers to detained patients, inform patients that they can request Managers to discharge them. This has often become called 'an appeal to the Managers,' but it is a non-statutory 'appeal' or request, not a set procedure laid down by the Act ... The Act therefore confirms their right to make an 'order' of discharge, but says nothing about the grounds for doing so, and nothing about an 'appeal' by a patient for them to do so ... The 'appeal' to the Managers should not be seen as a substitute for, but as additional to, the formal right of appeal which Parliament has provided."[165]

162 *Ibid.*, reg. 7(5).
163 Mental Health Act 1983, ss. 23 and 32(3).
164 Members of a committee or sub-committee of the trust authorised to make orders for discharge are sometimes misleadingly and erroneously referred to as the "independent managers" of the hospital.
165 *Mental Health Act Commission: First Biennial Report, 1983–85* (H.M.S.O., 1985), para. 8.13.

Mental nursing homes

A mental nursing home properly registered under the Registered Homes Act 1984 is treated as a "hospital" for most purposes of the 1983 Act **(132)**. Section 145(1) of the 1983 Act provides that, unless the context otherwise requires, the term "the managers" means "the person or persons registered in respect of the home." The managers may discharge a patient from liability to detention but any order is only valid if it has three signatories. However, the "person or persons" registered may be fewer than three individuals. The Royal Commission of 1954–57 appears to have anticipated this and also the fact that a small nursing home might not have a management committee or Board of Governors.[166] That being so, the 1959 Act provided that the registration authority and any health service body financing the patient's placement could discharge him. The purpose of doing so was to ensure that there would always be some management body (and not just some judicial body) which could order the patient's discharge. The Mental Health (Amendment) Act 1982 later extended what is now section 23(4). This subsection provides that the power to make an order of discharge may be exercised (i) by any three or more members of the body of persons having power to discharge, or (ii) by three or more members of an authorised committee or sub-committee of that "body of persons." Whether this was intended to enable a private company or a single registered person to appoint a committee or sub-committee of "independent managers" may be debated.

Disadvantages of managers' hearings

Managers hearings undoubtedly have significant disadvantages compared with the statutory tribunal process. In the first place, a panel comprised solely of lay persons is not well qualified to rigorously examine the legal and medical grounds for a patient's detention. However fair the managers strive to be, their relationship to the hospital staff giving evidence is not entirely independent. In many hospitals, obtaining free legal representation at the hearing is difficult. The hearing procedure itself is not governed by statutory instrument, or elsewhere defined, and there are no statutory discharge criteria to be applied. Consequently, some managers will direct discharge if the patient no longer satisfies the original criteria for admission; others apply the renewal criteria in section 20; others apply the tribunal discharge criteria in section 72; while yet others apply no statutory criteria, treating the issue as a matter for their discretion subject to not acting irrationally. The latter is probably the correct approach. Section 2 patients may find that they are outside the time-limits for lodging a tribunal application if they wait on the outcome of a managers' application, in the belief that they have an unanswerable case for discharge. The proportion of patients discharged by the managers is generally low, considerably lower than the proportion of patients discharged by tribunals. One hospital in England is known not to have discharged any patients during a period of eighteen years holding such appeals. Such a pattern of outcome over many years clearly represents a tremendous input in terms of professional time without any obvious corresponding benefit in terms of protecting citizens from unwarranted detention.

166 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 826.

TERMS DEFINING MEDICAL PRACTITIONERS

The 1983 Act uses various terms to describe medical practitioners and certain powers and duties may only be performed by a doctor who has been specially appointed for the purpose or who is responsible for the patient's treatment. Consultant psychiatrists undertake full responsibility for the clinical care of patients requiring specialised psychiatric treatment, heading a team or "firm" of junior doctors. There are several grades of "junior doctors" and the consultant is responsible for ensuring that they only undertake tasks which they are competent to perform.

"REGISTERED MEDICAL PRACTITIONER"

The registrar of the General Medical Council is required by the Medical Act 1983 to keep two registers of medical practitioners. The Act makes provision for three kinds of registration: full registration, limited registration and provisional registration.[167]

Significance of registration

The term "registered medical practitioner" in the Mental Health Act means a fully registered person within the meaning of the Medical Act.[168] Accordingly, only a person who is fully registered may provide a medical recommendation or report or perform the other statutory functions of a medical practitioner under the Mental Health Act.[169] A person who is not fully registered is statutorily barred from holding an appointment as a medical officer in any hospital or other place for the reception of persons suffering from mental disorder.[170]

MEDICAL PRACTITIONERS APPROVED UNDER SECTION 12(2)

The detention or guardianship of any patient whose case a tribunal may review must be founded upon the written recommendations or reports of two fully registered medical practitioners; and one of them must be furnished by a practitioner who has been approved by the Secretary of State as "having special experience in the diagnosis or treatment of mental disorder."[171] Whether or not a doctor has "special experience in the diagnosis or treatment of mental disorder" at the time he applies for accreditation is the sole criterion for approval under the section.[172] In practice, registrars and psychiatrists in higher grades may be section 12 approved, as are a few general practitioners.

167 In certain circumstances, which are specified in the Medical Act 1983, a person who has only been provisionally registered, or who has limited registration, is deemed to be a fully registered medical practitioner.

168 Interpretation Act 1978, Sched. 1.

169 Section 48 of the Medical Act 1983 also expressly provides that a certificate required by any enactment from a medical practitioner shall not be valid unless the person signing it is fully registered.

170 Medical Act 1983, s.47.

171 Mental Health Act 1983, ss.12 and 54. Guidance on the procedures to be adopted in granting such approval is contained in Department of Health Circular No. HSG (96)3. The granting of approval has been delegated to Health Authorities: National Health Service (Functions of Health Authorities and Administration Arrangements) 1996, reg.3.

172 See *R. v. Trent Regional Health Authority ex p. Somaratne* (1993) 18 B.M.L.R. 143, C.A.

"RESPONSIBLE MEDICAL OFFICER"

Informal patients and those who are liable to be detained but not liable to compulsory treatment under Part IV of the Act do not have a responsible medical officer.

Patients who are liable to be detained

Where a detained patient is liable to compulsory treatment under Part IV of the Act, the registered medical practitioner in charge of his treatment (who will usually, but not necessarily, be a consultant psychiatrist) is his "responsible medical officer."[173] Certain functions under the Act may only be performed by a patient's responsible medical officer and may not be delegated to a junior doctor on the hospital staff: the power to grant the patient leave of absence and to revoke any leave previously granted; the duty to periodically review a patient's liability to detention and the power to renew it for a further period; the power to discharge a patient under section 23 or to bar his discharge by the nearest relative; the duty to furnish periodic reports on a restricted patient to the Secretary of State; the power to authorise the administration of treatment to a capable and consenting patient under Part IV of the Act.

Patients subject to guardianship cases

In guardianship cases, the responsible medical officer is the medical officer authorised by the local social services authority to act as the patient's responsible medical officer.[174]

"APPROPRIATE MEDICAL OFFICER"

Restricted patients do not have an appropriate medical officer. The power to reclassify the form of mental disorder from which any other detained patient is recorded as suffering is exercisable by his "appropriate medical officer." Similarly, if such a patient is taken into custody after having been absent without leave for more than 28 days, it is his appropriate medical officer who must examine him in order to determine whether he should continue to be detained. However, the distinction is superfluous in practice, and can be ignored, since the Act provides that a detained patient's responsible medical officer will in all cases also be his "appropriate medical officer."

Patients subject to guardianship

Where a patient is subject to guardianship, his appropriate medical officer has other functions in addition to reclassifying the form of mental disorder recorded and reporting on patients who have been absent without leave. It is his duty to periodically determine whether the criteria for renewing the guardianship are satisfied and, where they are, he has the power to authorise the guardianship's continuance for a further period — functions performed in the case of an

173 Mental Health Act 1983, ss.34(1)(a), 55(1), 64(1).

174 Mental Health Act 1983, s.34(1)(b). The authority may appoint a registered medical practitioner to fulfil the functions of the responsible medical officer for a particular patient or appoint a particular doctor to act as the responsible medical officer in respect of all the patients under its guardianship. It may even appoint medical practitioners on an ad hoc basis to fulfil some particular function of a responsible medical officer under the Act the performance of which is due.

unrestricted detained patient by his responsible medical officer.[175] How... , in cases where a local social services authority has been appointed as a patient's guardian, the distinction is as meaningless in practice as before, since the responsible medical officer is again also the appropriate medical officer. The distinction between a responsible and an appropriate medical officer is only of any practical consequence in those rare cases where a private individual, rather than a local authority, has been appointed as the patient's guardian (*see* "nominated medical attendant").

"NOMINATED MEDICAL ATTENDANT"

Where a private guardian is appointed for a patient, that individual is required to nominate a registered medical practitioner to act as the patient's medical attendant.[176] The "nominated medical attendant" is the patient's "appropriate medical officer" but not "his responsible medical officer." As in other guardianship cases, the responsible medical officer is the doctor appointed and authorised to fulfil that role by the local social services authority.[177] As to their respective functions, it is for the appropriate medical officer/nominated medical attendant to reclassify the patient and to renew the guardianship if appropriate but the responsible medical officer who possesses the power to discharge the patient under section 23.

"MEDICAL PRACTITIONER IN CHARGE OF THE TREATMENT OF THE PATIENT"

Informal patients and detained patients who are not liable to compulsory treatment under Part IV of the Act do not have a responsible (or an appropriate) medical officer. The Act cannot therefore provide that the power conferred by section 5(2), to detain an informal patient for 72 hours, is one exercisable by the patient's responsible medical officer. Some other term or phrase is required and the Act instead states that the power may be exercised by "medical practitioner in charge of the treatment of the patient," or by his nominated deputy.

COMMUNITY RESPONSIBLE MEDICAL OFFICER (CRMO)

Where a patient is subject to after-care under supervision, the Health Authority must ensure that there is at all times a registered medical practitioner approved under section 12 in charge of the medical treatment provided for him as part of his section 117 after-care services. This doctor is called the patient's community responsible medical officer.[178] His duties include renewing the patient's liability to statutory supervision for further periods, reclassifying the form of mental disorder from which the patient is recorded as suffering, and directing that the patient shall cease to be subject to after-care under supervision.

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175 Mental Health Act 1983, s.20.

176 Section 9(2) provides that, "Regulations under this section ... shall provide for the appointment, in the case of every person subject to the guardianship of a person other than a local social services authority, of a registered medical practitioner to act as the nominated medical attendant of the patient."

177 Section 34(1)(b) states that the responsible medical officer is the registered medical practitioner authorised to act by the "local social services authority" (defined in s.145(1)) rather than the "responsible local social services authority" (defined in s.34(3)). However, this appears to be a drafting error and it may be inferred that, if the patient lives within the area of one authority and his private guardian in another, only the latter authority may authorise a doctor to act as the patient's responsible medical officer.

178 Mental Health Act 1983, s.34(1).

SECOND OPINION APPR... D DOCTORS ("SOADS")

Part IV of the Act provides that some forms of treatment for mental disorder may not be given to a detained patient who does not consent to the treatment, or who is incapable of doing so, unless a registered medical practitioner appointed for the purposes of that Part of the Act has certified that the proposed treatment should be given. Section 121(2) provides that the Mental Health Act Commission shall, on the Secretary of State's behalf, appoint registered medical practitioners to provide second opinions and certificates under Part IV and persons so appointed are conventionally known as Second Opinion Approved Doctors ("SOADs").

THE MEDICAL MEMBER OF THE TRIBUNAL

The membership of each regional Mental Health Review Tribunal comprises legal members, medical members and what are customarily known as "lay members." The medical members are registered medical practitioners appointed by the Lord Chancellor after consultation with the Secretary of State for Health.[179] At least one of the members appointed to consider an individual patient's case must be a medical member[180] who has no personal connection with the patient and has not recently treated him in a professional medical capacity.[181] Under the tribunal rules, it is the function of the medical member to examine the patient prior to the hearing and to take such other steps as he thinks necessary to form an opinion of the patient's mental condition.[182] In practice, the medical member will be a consultant psychiatrist.

NURSES AND OTHER HEALTH SERVICE PROFESSIONALS

A member of the ward nursing staff may sometimes prepare a short nursing report on a patient whose case is being reviewed by a tribunal or give oral evidence as part of the responsible authority's case. Such reports are not a formal requirement under the Mental Health Review Tribunal Rules 1983. The statutory functions of a nurse under the 1983 Act are limited.

"REGISTERED NURSE"

The United Kingdom Central Council (U.K.C.C.) maintains a professional register of nursing staff[183] which is arranged by parts, each of which is indicative of the different qualifications and kinds of training which a nurse may receive. Where the term "registered nurse" is used, it means a nurse registered in a part of the professional register.[184] The registered nurse in charge of a ward will generally be referred to in practice as the "charge nurse," "ward sister" or "ward manager."

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179 Mental Health Act 1983, s.65(2), Sched. 2, para. 1(b).

180 *Ibid.*, para. 4(b).

181 Mental Health Review Tribunal Rules 1983, r.8(2)(c).

182 *Ibid.*, r.11.

183 See Nurses, Midwives and Health Visitors Act 1979, s.10.

184 Interpretation Act 1978, Sched. 1. Nurses who were registered prior to September 1992 may elect to keep their previous title of "registered general nurse" (RGN), "registered mental nurse" (RMN), "registered mental handicap nurse" (RMHN), or registered sick children's nurse (RSCN). Prior to September 1992, a person could undertake a two year training leading to registration on the second part of the registered as an "enrolled nurse" and the term may also be encountered occasionally. Nurses registered after September 1992 are all known by the same title of "registered nurse."

Unregistered nursing staff

The nursing complement on a ward usually includes both registered nurses and unqualified nursing staff. Unregistered persons are often referred to as "nursing assistants," "health care assistants" or "nursing auxiliaries." The term "Project 2000 student" may be used to denote a person training for registration as a nurse.

"NURSES OF THE PRESCRIBED CLASS"

The six-hour power of detention conferred by section 5(4) may only be exercised by "a nurse of the prescribed class," that is a nurse registered in Part 3 of the professional register (first level nurse trained in nursing persons suffering from mental illness); Part 5 (first level nurse trained in the nursing of persons suffering from mental handicap); Part 13 (nurses qualified following a course of preparation in mental health nursing); or Part 14 (nurses qualified following a course of preparation in mental handicap nursing).

STATUTORY FUNCTIONS OF NURSES

The power in section 5(4) aside, nurses have only one other statutory function unique to them under the 1983 Act. Before a medical practitioner appointed by the Secretary of State (a "SOAD") may complete a certificate authorising the administration of treatment under Part IV of the Act, he is required to first consult a "nurse" who has been professionally concerned with the patient's treatment.[185]

PROFESSIONS SUPPLEMENTARY TO MEDICINE

Medical practitioners and nurses apart, no other professionals involved in providing medical treatment have any defined statutory powers or duties towards the patient under the 1983 Act. Their therapeutic role may, of course, be fundamental and they are occasionally called upon to furnish a tribunal with a short report. A multi-disciplinary team normally consists of a nurse, psychiatrist, social worker, occupational therapist and psychologist. The main therapists working in the treatment of mental illness are *occupational therapists* who develop and promote skills necessary for independent living; *art, music, and drama therapists* involved in the psychotherapies; *speech therapists; physiotherapists*, who influence psycho-logical health through physical approaches such as the use of relaxation, exercise and the management of disabilities; and *dieticians* offering dietary advice for anorexia or dietary neglect.

Clinical psychologists

A clinical psychologist can provide detailed assessments of a patient's cognitive functioning. They may assess suitability for an increasing range of behavioural therapies and coping techniques. It is the clinical psychologist who administers psychological tests which assess a patient's intellectual functioning, attitudes and personality traits, and undertakes counselling or behaviour modification techniques.

185 Mental Health Act 1983, ss.57(3)(b) and 58(4).

Occupational therapists

An occupational therapist assesses a patient's occupational, self-care and general living skills. This form of assessment is particularly useful for persons with chronic mental health problems and those recovering from acute illness. Previously, the occupational therapist's skills were aimed at diverting the patient's attention from his inner conflicts by arranging relaxing occupations, such as craft work. The present aim is geared more towards developing relationships within the framework of group occupational activities which will help patients to gain an understanding of their particular patterns of behaviour. For example, group discussions, readings, and psychodrama. Patients with chronic illnesses may require help in pursuits such as cooking, budgeting, and shopping, and the detention of some special hospital patients predates the introduction of decimalisation. In industrial therapy, the aim is to create a situation approximating normal working conditions. The work is often graded with the aim of gradually improving the participant's concentration.[186]

Physiotherapists

The physiotherapist deals with problems unrelated to the patient's psychiatric illness; conditions directly or indirectly caused by the patient's mental state (such as nerve lesions from severed wrists in suicide attempts); and conditions inextricably bound up with the patient's mental state (such as asthma, physical disabilities in a person with brain dysfunction, rehabilitation programmes for persons who have suffered strokes). Persons with physical handicaps will require their assistance. The physiotherapist teaches and supervises the patient through a prescribed exercise programme designed to strengthen weak muscles and prevent deformities.

SOCIAL SERVICES AUTHORITIES

Local social services authorities have responsibility for patients under guardianship, for the after-care of certain patients following their discharge from hospital, and for the appointment of approved social workers. This section is arranged as follows—

- Social services authorities— *Statutory definitions* **152**
- Social services' functions and their delegation **152**
- Community care services **154**
  - —*National Assistance Act 1948* **154**
  - —*Health Services and Public Health Act 1968* **155**
  - —*National Health Service Act 1977* **155**
  - —*Mental Health Act 1983* **155**
- Care management and care packages **156**
- Involvement of the independent sector **158**
- Financing community care services **159**

186 See M.J. Sainsbury, *Key to Psychiatry* (John Wiley & Sons, 3rd ed.)

"LOCAL SOCIAL SERVICES AUTHORITY"

Unless the context otherwise requires, the term means a council which is a local authority for the purpose of the Local Authority Social Services Act 1970.[187]

"RESPONSIBLE LOCAL SOCIAL SERVICES AUTHORITY"

The term is defined in section 34(3) and is relevant to cases involving guardianship. Where a local authority is itself acting as the patient's guardian, it is the responsible local social services authority. Where a private guardian has been appointed, the responsible local social services authority is that for the area in which the guardian — not the patient — resides. It is the responsible local social services authority to which guardianship applications and reports renewing the guardianship must be addressed and which has power to discharge the guardianship.[188]

FUNCTIONS OF SOCIAL SERVICES AUTHORITIES

Some of the most important social services functions under the 1983 Act and related legislation are summarised in the table on the following page. Under the Local Authority Social Services Act 1970, every local authority is required to establish a social services committee to deal with matters relating to the discharge by the authority of its statutory "social services functions."

Delegation of functions under Local Government Act 1972

Section 10 provides that, subject to any express provision to the contrary, an authority may discharge any of its functions through a committee or sub-committee; an or officer of the authority; another authority; jointly with one or more local authorities.[189] Under section 101(2), committees have a wide power to sub-delegate to sub-committees and officers and, similarly, sub-committees may authorise officers to fulfil functions on their behalf, *e.g.* to consider and accept guardianship applications.

Delegation of functions under Mental Health Act 1983

Section 32 provides that certain functions may be delegated in the circumstances prescribed by regulations. Where a local social services authority is required under the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 to make any record or report, that function may be performed by an officer authorised by that authority.[190] The regulations also permit the authority to authorise an officer or class of officers to consent on its behalf to the rectification of incorrect or defective guardianship applications or recommendations.[191]

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187 Mental Health Act 1983, s.145(1).

188 This fact is often not appreciated by social workers so that applications and renewal reports are furnished to the authority within whose area the patient resides even though the guardian is resident elsewhere. In such cases, any purported acceptance of the application and reception into guardianship is void *ab initio*.

189 See *The Encyclopaedia of Forms and Precedents* (Butterworths, 5th ed., 1991), Vol. 26 (39).

190 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 3(6).

191 *Ibid.*, reg. 5(2). See also Mental Health Act 1983, s.8(4).

FUNCTIONS OF SOCIAL SERVICES AUTHORITIES

	National Assistance Act 1948
ss.21–27	▪ *Provision of residential accommodation for adults suffering from mental disorder*
ss.29–30	▪ *Promoting the welfare of adults who suffer*
s.48	▪ *Providing temporary protection of property belonging to persons in hospital or accommodation provided under Part III of the Act.*
	Disabled Persons (Employment) Act 1958
s.3	▪ *Provision of facilities for enabling disabled persons to be employed or work under special conditions.*
	Health Services and Public Health Act 1968
s.45	▪ *Promotion of welfare of old people.*
	Chronically Sick and Disabled Persons Act 1970
s.2	▪ *Provision of certain welfare services.*
	National Health Service Act 1977
s.21	▪ *Prevention, care and after-care.*
	Mental Health Act 1983
Pts. II, III and IV	▪ *Welfare of the mentally disordered; guardianship of persons suffering from mental disorder; exercise of functions of nearest relative*
ss.66, 67, 69(1)	▪ *Exercise of functions of nearest relative in relation to Mental Health Review Tribunal proceedings*
s.114	▪ *Appointment of approved social workers*
s.115	▪ *Entry to and inspection of private premises*
s.116	▪ *Welfare of certain hospital patients*
s.117	▪ *After-care of detained patients*
s.130	▪ *Prosecutions under the 1983 Act*
	Registered Homes Act 1984
Pt. I	▪ *Registration of Residential Care Homes*
	National Health Service and Community Care Act 1990
s.46	▪ *Preparation of plans for community care services.*
s.47	▪ *Assessments of need for community care services.*

COMMUNITY CARE SERVICES

Community care refers to the policy of providing services and support which people affected by problems of ageing, mental illness, mental handicap, or physical or sensory disability, need in order to be able to live as independently as possible in their own homes, or in "homely" settings, in the community. is concerned with community care. More specifically, "community care services" are defined in Part III of the National Health Service and Community Care Act 1990 as being services which a local authority may provide, or arrange to be provided, under any of the following provisions[192] —

- Part III of the National Assistance Act 1948 **(687)**
- Section 45 of the Health Services and Public Health Act 1968 **(689)**
- Section 21 of and Sched. 8 to the National Health Service Act 1977 **(688)**
- Section 117 of the Mental Health Act 1983 **(413)**

National Assistance Act 1948, Part III

Part III of the National Assistance Act 1948 empowers a local authority to make arrangements for providing residential accommodation and other services for persons suffering from mental disorder.

Accommodation

Section 21 provides that a local authority may with the Secretary of State's approval, and to such extent as he directs shall, arrange the provision of residential accommodation for persons aged 18 or over who ordinarily reside in the authority's area and who, by reason of mental disorder, are in need of care and attention which is not otherwise available to them. Accommodation provided under Part III may be managed by the local authority itself, or by another local authority (with that authority's agreement), or be a nursing or residential care home managed by a voluntary organisation or other body. For the purposes of Part III, an in-patient in a hospital managed by an NHS trust is deemed to be ordinarily resident in the area in which he was ordinarily resident immediately before he was admitted as a patient to the hospital.

Promoting the welfare of persons suffering from mental disorder

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.[193] Arrangements may in particular be made for: informing persons of the services available for them under section 29; instructing them in ways of overcoming the effects of their disabilities; providing suitable work, including workshops and hostels where persons engaged in workshops may live; providing recreational facilities. By *Circular* 19/74, provision may be made under section 29 for occupational, social, cultural and recreational

192 National Health Service and Community Care Act 1990, s.46(3). For a more detailed description of the services which may be provided under these statutory provisions, see p.687 *et seq.*

193 National Assistance Act 1948, s.29.

facilities at day centres an... ..nilar establishments, and for social worker advice and support.[194] A local authority may employ as their agent any voluntary organisation or person carrying on, professionally or by way of trade or business, activities which consist of or include the provision of services for any person to whom section 29 applies, being an organisation or person appearing to the authority to be capable of providing that service.

Health Services and Public Health Act 1968, s.45

Section 45 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 old people. A local authority may employ as their agent any voluntary organisation or 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.

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

Schedule 8 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 purpose of preventing illness, for the care of persons suffering from illness, and for the after-care of persons who have been so suffering. In particular, the authority may, and where directed shall, make arrangements for the provision of centres or other facilities "for training them or keeping them suitably occupied." Section 21 provides that these services in relation to "prevention, care and after-care" are functions exercisable by local social services authorities.[195]

Mental Health Act 1983, s.117

Section 117 imposes a duty on the Health Authority and the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for patients who have been detained in hospital for treatment and who then cease to be detained and leave hospital.

Community care plans and charters

Section 46(1) of the National Health Service and Community Care Act requires local authorities to prepare and publish a plan for the provision of community care services in their area.[196] This plan must therefore make provision for section 117 after-care services. Recent Government guidance also requires that local authorities to publish a community care charter, although this requirement does not have the force of statute. Where a social circumstances report appears to make inadequate provision for a patient's after-care, a copy of the authority's community care plan and a copy of the local Community Care Charter may be obtained, in order to establish the facilities available locally, the patient's entitlement to them, and local targets for completing assessments of patients' needs for those services.

194 Social work and related services to help in the identification, diagnosis, assessment and social treatment of mental disorder and to provide social work support and other domiciliary and care services to people living in their own homes and elsewhere.

195 Health authorities have a parallel duty to provide services for this purpose, in so far as these are considered appropriate as part of the health service: National Health Service Act 1977, s.3(2)(a).

196 National Health Service and Community Care Act 1990, s.46(1).

CARE MANAGEMENT AND CARE PACKAGES

The National Health Service and Community Care Act 1990 gives local social services authorities primary responsibility for co-ordinating the assessment of community care needs. However, where, during the course of an assessment, it appears to such an authority that the provision of health or housing services may be needed, the authority must invite the relevant agencies to participate in the assessment. Departmental guidance stresses the need to ensure that social services care management for severely mentally ill people is effectively integrated with the care programme approach, the development of which is the responsibility of health authorities.[197]

TERMINOLOGY OF CARE MANAGEMENT

Assessment	The process of defining needs and determining eligibility for assistance against stated policy criteria.
Care package	A combination of services designed to meet the assessed needs of a person requiring care in the community.
Care Planning	The process of negotiation between assessor, applicant, carers and other agencies on the most appropriate ways of meeting assessed needs within available resources and incorporating them into an individual care plan.
Care Management	Any strategy for managing, co-ordinating and reviewing services for the individual in a way that provides for continuity of care and accountability to both the client and the managing agency. Previously referred to as "case management."
Care Manager	Any practitioner who undertakes all, or most, of the "core tasks" of care management. The care manager may carry a budgetary responsibility but is not involved in any direct service provision. Previously known as a "case manager."
Purchaser	The budget holder who contracts to buy a service.

Seven stages of care management

The aim of "care management" is to tailor community care services to individual need.[198] It involves assessing an individual's need for services and then, where necessary, designing and implementing a "care package" agreed with the patient, his carers, and contributing agencies. Care management consists of seven integrated stages[199] —

[197] See *Executive Letter* EL(93)119 and CI(93)35, (Department of Health, 23 December 1993), para. A8.

[198] Social Services Inspectorate, *Care Management and Assessment: Summary of Practice Guidance* (Department of Health, 1991), para. 7.

[199] Social Services Inspectorate, *Care Management and Assessment : Practitioners' Guide* (Department of Health, 1991).

- publishing informat[illegible] about the services available.
- determining the level of assessment to be carried out.
- assessing the needs of the client.
- planning a care package in light of the assessment and available resources.
- implementing that care plan
- monitoring the delivery of the care plan.
- reviewing the care plan at specified intervals, to ensure that services remain relevant to the individual's needs.

Care managers

"Care managers" act as brokers for services across the statutory and independent sectors. In theory, they should not be involved in providing services nor have any managerial responsibility for the services which they arrange. Once a person has been assessed to need services, a care plan should be drawn up. This care plan should ensure, as far as possible, that normal living is preserved or restored, primarily by providing the services within the user's home, including (where necessary) day and domiciliary care, respite care, and the provision of disability equipment and adaptations to the home. The problems and difficulties encountered in monitoring these requirements are well known — inadequate collaboration between disciplines, poor documentation, users "slipping through the net," problems associated with users who are unwilling to co-operate, and a lack of an appropriate range of services.

The assessment

Section 47(1) of the National Health Service and Community Care Act 1990 provides that where it appears to a local authority that any person for whom they may provide or arrange community care services may be in need of any such services, that authority shall carry out an assessment of the individual's needs for those services and, having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.[200]

Assessing the ability of carers

It is now also necessary to assess the ability of unpaid carers to provide care before reaching any decision about whether the patient's needs require the authority to provide community care services. The Carers (Recognition and Services) Act 1995 came into force on 1 April 1996. A carer is defined by the statute as an individual who provides or intends to provide a substantial amount of care on a regular basis for a person whose need for community care services is being assessed under section

[200] Notwithstanding that after-care provided under section 117 of the 1983 Act is a "community care service," it should be emphasised that the duty to provide such after-care for patients to whom that section applies is mandatory (**413**).

47(1)(a) of the National Health Service and Community Care Act 1990. under the 1995 Act, a carer may "request" that the local authority carries out an assessment of his ability to provide, and to continue to provide, care for the patient before it makes any decision as to whether the patient's needs call for the provision of community care services. The local authority "shall" then carry out such an assessment and shall take the results of that assessment into account before making a decision.[202] Unless the Secretary of State gives directions about the form such an assessment shall take, it shall be carried out "in such manner and take such form as the local authority consider appropriate."[203]

INVOLVEMENT OF THE INDEPENDENT SECTOR

The National Health Service and Community Care Act 1990 made a number of fundamental changes to the provision of health and social care for persons suffering from mental disorder. The underlying philosophy is to separate out the functions of purchasing and providing such care, so as to create an "internal market" in the health service and a "mixed economy of care" in relation to social services. The general position now is that any community care services which may be provided by a local authority may also be provided by an agency from the independent sector; indeed, the Government has made it clear that local authorities are expected to make maximum use of the independent sector. Just as the role of Health Authorities has become one of purchasing health services provided by NHS trusts, so local authorities are being promoted and developed as "enabling authorities" and "commissioning agencies," seeking out and purchasing community care services from a range of public and non-public providers. In some respects, the current legislation marks a return to the situation which previously existed under the Lunacy Act 1890.[204] The enabling and commissioning roles of a local authority involve it identifying the need for care among the population it serves; planning how best to meet those needs; setting an overall strategy in terms of priorities and targets; seeking out, and purchasing, the required services from a range of providers in the voluntary and private sectors, as well as the public sector (that is developing a mixed economy of care); and monitoring the quality of services which it has purchased. Because local authorities still provide some services themselves, the aim of developing a mixed economy of care is attainable only if the authority separates out its own purchasing and providing functions. Local authority staff involved in assessing an individual's needs and purchasing the required services should not also be involved in providing local authority services. For, if they were, they might not be disposed to purchase alternative, more suitable, services available in the independent sector. A new terminology has developed which reflects the underlying philosophy of the reforms so that, for example, citizens who need community care services are now referred to as "consumers."

201 Carers (Recognition and Services) Act 1995, s.1(1)(b). The person whose need for community care services is being assessed is referred to in the Act as "the relevant person" — see s.1(1)(a) — but is here referred to as the patient.

202 *Ibid.*, s.1(1).

203 *Ibid.*, s.1(4). Where a carer's needs have been assessed in this way, he cannot then have a second assessment carried out under section 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986: see s.1(5). Note also that where an individual provides, or will provide, care either as a volunteer for a voluntary organisation or by virtue of a contractual obligation, he cannot request an assessment under s.1 of his ability to provide care: see s.1(3).

204 See *e.g.* the Lunacy Act 1890, ss. 169, 243 and 269.

PROVIDERS AND THE MIXED ECONOMY OF CARE

Mixed Economy of Care — The use of independent providers (including the voluntary sector) alongside public services, to increase the available range of care options.

Agency — Any organisation, statutory or private, which provides social care, health care or housing services in the community.

THE INDEPENDENT SECTOR

Individuals, bodies or organisations not wholly maintained or controlled by a Government department or any other authority or body instituted by Special Act of Parliament or incorporated by Royal Charter. The independent sector comprises the voluntary sector and the private sector.

Voluntary sector — Voluntary organisations in which any surpluses are re-invested into the work of the organisation and managed by unpaid management committees, trustees or directors.

Private sector — Non-voluntary agencies in the independent sector.

THE PUBLIC SECTOR

Any facility maintained or controlled by a Government department or local authority or any other authority or body instituted by special Act of Parliament or incorporated by Royal Charter.

Statutory sector — Those bodies required by parliamentary statute to provide a service, principally local authorities and health authorities.

INDIVIDUALS INVOLVED IN PROVIDING SERVICES

Key worker — The practitioner involved in providing services who has most contact with the user: although the key-worker may undertake a co-ordinating function similar to that of a care manager, he remains directly involved in the services being provided.

Carers — A person who is not employed to provide the care in question by any independent or public sector body. Normally, a person who is looking after an adult with mental health problems in the home, where the latter's dependence on the carer "exceeds that implicit in normal relationships between family members.

FINANCING THE COMMUNITY CARE SERVICES

On 1 April 1993, responsibility for providing financial support to individuals entering voluntary and private sector residential and nursing home care was transferred from the Department of Social Security to local social services authorities. The local authorities are to pay for the full cost of care and retrieve from residents any Income Support, Residential Allowance and charges as appropriate. This was accompanied by changes in DSS benefits for new residents of residential care and nursing homes and by the establishment of new assessment procedures.[205] People who enter homes under the new funding structure and who need public financial support no longer have their care costs met by social security. Anyone seeking to enter an independent sector home at public expense must approach the local authority for a care and financial assessment. The local authority will then consider whether it would be appropriate, and cost effective, to keep that person in the community. Residents will be able to claim help from the normal Income Support system of personal allowances and premiums and from Housing Benefit. They will receive assistance on the same basis as that which they could obtain in their own homes.[206] Local authorities make some use of their power to "top up" for residents under pension age. Some Health Authorities also "top up" people with learning disabilities in independent sector homes who have been discharged from long-stay hospitals. The Department of Health's view is that they expect local authorities to use their bargaining power to negotiate reduced fees for residential care. Any potential for reduced fees may, however, only be achievable through "casualisation" of staff — lower wages and more part-time employment particularly in urban areas where a local labour force is more readily available.[207] There is no consensus about whether it is lawful to charge for after-care services which a local authority is under a statutory duty to provide under section 117.

APPROVED SOCIAL WORKERS

The term "approved Social Worker" means an officer of a local social services authority appointed to act as an approved social worker for the purposes of the Act.[208] No person may be so appointed unless he is approved by the authority as having appropriate competence in dealing with persons who are suffering from mental disorder.[209] Before approving a person for appointment, a local social services authority must have regard to such matters as the Secretary of State may direct."[210] Each local social services authority in England and Wales is required to appoint a sufficient number of approved social workers "for the purpose of discharging the functions conferred on them by the Act."[211]

205 Those people already receiving D.S.S. support for institutional care on 31 March 1993 will continue to do so until their placements end (the "preserved rights" arrangements).
206 *Third Report of the House of Commons' Health Committee* (H.M.S.O., 1993), paras. *8.17–8.18.*
207 *Ibid.*, Q.40.
208 Mental Health Act 1983, s.145(1).
209 *Ibid.*, s.114(2).
210 *Ibid.*, s.114(3). The Secretary of State's directions are contained in D.H.S.S. Circular No. (86)15. Provided the authority has regard to the various matters which the Secretary of State requires it to give consideration to, there is no breach of statutory duty if it then departs from that guidance. See *e.g. De Falco v. Crawley Borough Council* [1980] 1 All E.R. 913, *per* Bridge L.J. at 925.
211 Mental Health Act 1983, s.114(1).

Concept of approved socia[l w]orkers

Under the 1959 Act, mental welfare officers were authorised to apply for a patient's admission to hospital. The White Paper of 1978 recognised doubts in some quarters about their effectiveness in the admission procedures.[212] In particular, widespread concern had been expressed about the lack of specialist knowledge on the part of many social workers engaged in mental health practice.[213] The Government therefore proposed that social workers should be approved by local social services authorities in the same way that medical practitioners are "approved" under what is now section 12(2). Social workers nowadays undergo a 60-day training course prior to approval and undertake refresher training at regular intervals.

Statutory duties of an approved social worker

An approved social worker is under a duty to make an application under Part II in any case were he is satisfied that an application ought to be made in respect of a person within his authority's area and is of the opinion, having regard to any wishes expressed by the patient's relatives and other relevant circumstances, that it is necessary or proper for him to apply.[214] Before making a guardianship application or a section 3 application, he must first consult the patient's nearest relative, unless this is impracticable or would involve unreasonable delay.[215] An approved social worker owes a duty of care to the patient. That duty of care is personal and "it is the business of the duly authorised officer, rather than that of the doctor, to see that the statutory powers are not used unless the circumstances warrant it."[216]

Statutory powers of an approved social worker

The following statutory functions exercisable by social workers are reserved to social workers who are approved under the Act —

- The power to enter and inspect premises under section 115.
- The power to apply for a warrant under section 135(1).
- The conduct of assessments under sections 13 and 136.
- The making of guardianship applications and applications for admission under Part II of the Act.
- The power to take into custody a patient who is absent without leave.
- The making of applications to the county court under the 1983 Act.
- The right of access to a patient under guardianship where access is required by the guardian.

212 *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).
213 *Ibid.*, para. 3.9.
214 Mental Health Act 1983, ss.11(4), 13(1) and (5). An approved social worker may also make an application in respect of a patient outside his local authority area but is not under a duty to do so.
215 Mental Health Act 1983, s.11(4).
216 *Buxton v. Jayne* [1960] 1 W.L.R. 783, *per* Devlin L.J. at 784. See also *R. v. Barnsley* (1849) 12 Q.B. 193; *R. v. Wakefield* 48 J.P. 326.

THE SECRETARY OF STATE

Unless the contrary intention appears, the term "'Secretary of State' means one of Her Majesty's Principal Secretaries of State."[217] In practice, the Secretary of State for Health (**126**) is responsible for the National Health Service and for exercising certain powers which are not specific to restricted patients. The Home Secretary is responsible for overseeing the movement of restricted patients between hospitals and their discharge and supervision in the community.

THE HOME OFFICE

The Home Secretary's responsibilities in relation to restricted patients are discharged on a day to day basis by the Home Office's Mental Health Unit,[218] which is situated at 50 Queen Anne's Gate, London SW1H 9AT. The rationale for the current arrangement was established by the Royal Commission of 1954–1957.[219] The Committee considered that the care of people with mental health problems was a medical issue but, where a mentally disordered offender posed a particular danger to the public, his discharge should be controlled by a central authority who would have special regard to the protection of the public. The Home Secretary was the logical choice as the central authority, bearing in mind his traditional role in the area. The Home Secretary is responsible for protecting the public from unjustifiable risk and his primary concern is to ensure that the public's safety is never made subordinate to the patient's interests. When exercising his powers, the Home Secretary seeks to give precedence to public safety considerations while supporting the objectives of rehabilitation. The risk is generally that of serious harm to the person, covering offences of violence and sexual offending.

Organisation of the Mental Health Unit

Most of the day-to-day casework is dealt with at official level but Ministerial agreement is sought on most proposals for discharge, transfer or recall. It may also be sought in other circumstances, particularly where the case has attracted considerable public interest or presents particular difficulties.[220] The Head of the Division is supported by six Grade 7 officers, nine Higher Executive Officers, 18 Executive Officers, and nine Administrative Officers. Work on the files of restricted patients is divided among these staff members according to the nature of the case and the first letter of the patient's surname. Hence, one of the Grade 7 officers may have day-to-day responsibility for all patients whose surnames begin with the letters A, G, H and I, with routine work on files relating to patients whose surnames begin with the letters Ga–Go being carried out by a particular Executive Officer and/or an Administrative Officer, and so forth. The cases of patients who are subject to a restriction direction, or whose transfer to hospital under sections 47 or 48, is being organised are dealt with within the Mental Health Unit by what is known as the Prison Transfer Group.[221]

217 Interpretation Act 1978, s.5 and Sched. 1.
218 Formerly known as the Home Office's C3 Division.
219 *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).
220 In some cases, the Home Secretary is assisted by the Advisory Board on restricted patients, which is informally known as the Aarvold Board. This is a non-statutory body which advises him about the discharge, or transfer between hospitals, of restricted patients whose potential risk to public safety is thought to be particularly difficult to assess. The Board is considered further below (**165**).
221 Formerly known as the Incoming Cases Unit.

STATUTORY FUNCTIONS

The Home Secretary's main statutory and non-statutory functions are summarised below.

FUNCTIONS OF THE HOME SECRETARY

Statutory functions

- *directing the discharge of a restricted patient, whether absolutely or subject to conditions, under s.42*
- *consenting to a restricted patient being discharged under s.23 by his responsible medical officer or the hospital managers*
- *consenting to a restricted patient being granted leave of absence under s.17*
- *consenting to the transfer of a restricted patient under s.19*
- *directing the transfer of a special hospital patient under s.123*
- *recalling a conditionally discharged to hospital under s.42*
- *directing a patient's admission to a hospital other than that specified by the court in a hospital order, under s.37(5)*
- *specifying the hospital to which a patient found unfit to plead or not guilty by reason of insanity shall be admitted*
- *directing the removal to hospital for treatment of a person in custody, under ss.46–48*
- *directing the remission to prison of a patient previously removed to hospital for treatment, under ss.50, 51, 53 and 74*
- *referring to a tribunal the case of a restricted patient who has been recalled to hospital or whose case has not been considered by a tribunal for a certain period of time, under s.71*
- *removing "alien patients" under s.86 and referring their cases to a tribunal*
- *providing statements on restricted patients to tribunals*
- *considering periodic, and special oral and written reports, on detained and conditionally discharged patients and deciding or advising on appropriate courses of action*

Non-statutory functions

- *keeping under review the law and practice relating to offender patients*
- *commissioning research and providing statistics in relation to mentally disordered offenders*
- *encouraging the diversion of mentally disordered offenders from the criminal justice system or from prison*
- *servicing the Advisory Board on Restricted Patients (**165**)*

THE HOME SECRETARY AND TRIBUNAL PROCEEDINGS

Although the Home Secretary is not a party to tribunal proceedings, he has a "vital role"[222] to play by virtue of his responsibility for public safety. The focus of this involvement is to bring to the tribunal's attention relevant information on file about the patient, and to ensure that it is made aware of the Home Secretary's view about the patient's potential dangerousness and his suitability for discharge.

Home Office Statements

Where tribunal proceedings involve a restricted patient, the Home Secretary is required by the Mental Health Review Tribunal Rules 1983 to provide the tribunal with a statement on the patient. If the patient is detained, this statement has to be furnished within three weeks of the Home Office's receipt of the responsible authority's statement. In cases involving conditional discharged patients, the Home Office is responsible for obtaining reports from the supervisors and for providing a statement within six weeks of receipt by him of the notice of application (**663, 700**).

Representation

The Home Secretary may be represented at a tribunal hearing by Counsel in particularly difficult cases, where his view cannot adequately be conveyed in a written statement. This might, for example, occur where a responsible medical officer is arguing strongly for the discharge of a patient whom the Home Office believes is still highly dangerous.

Action following a tribunal's decision

If a tribunal has directed a patient's immediate discharge and he has left hospital, the Mental Health Unit will be notified of the after-care details and the conditions of discharge approved by the tribunal. According to Pickersgill, the Home Office will consider whether the detailed arrangements are satisfactory, consulting as necessary the patient's responsible medical officer or the newly appointed supervisors before reaching a decision. The Home Secretary might then vary the conditions, for example changing the condition of residence or imposing supervision conditions if the tribunal imposed none. The Home Secretary's statutory role, the recall provisions, and the need for reports on the patient to be periodically submitted, are explained to both nominated supervisors in writing. If it is felt that a tribunal has erred in law in reaching its decision, this view is usually communicated to the tribunal expressing this view and clarification sought. The Home Office may challenge the decision by way of judicial review proceedings in the High Court.[223]

Restriction direction cases

Where a tribunal notifies the Home Secretary that a serving prison who has been transferred to hospital under a restriction direction would, if subject to a restriction order, be entitled to be discharged, the Home Secretary has 90 days within which to approve the patient's discharge, if he deems that to be appropriate.

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222 The phrase used by Farquharson J. in *R. v. Nottingham Mental Health Review Tribunal, ex p. Secretary of State for the Home Department*, *The Times*, 25 March 1987.

223 A. Pickersgill, "Balancing the public and private interests" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990).

If a tribunal recommends a particular course of action to the Home Office, this is noted, specifically drawn to the responsible medical officer's attention, and considered in the context of the case's overall management.

THE AARVOLD BOARD

In cases where there seems to be a continuing risk of re-offending which is extremely difficult to predict, the Home Secretary seeks the views of the Advisory Board on Restricted Patients. The Board is a non-statutory body and its remit is fundamentally different from that of a Mental Health Review Tribunal. When considering a proposal for allowing a restricted patient greater liberty, the Board's only concern is to offer the Home Secretary advice on whether the proposal is soundly based and acceptable having regard to public safety. It is not concerned with safe-guarding the liberty of the individual.

Establishment and history

The establishment and history of the Aarvold Advisory Board has been well summarised by Egglestone.[224] The Board was established in 1973 in accordance with recommendations of the Aarvold Committee.[225] The Committee found that there was a small proportion of restricted patients in whose cases the risk of serious reoffending was particularly difficult to predict and where special care was therefore required when assessing proposals for their discharge or transfer to a less secure hospital —

> "The patients concerned could not necessarily be identified by reference to the form of their mental disorder nor even to the nature or severity of their offence; rather, in the committee's own words, the 'nature of personality deviance is probably more important than a particular psychiatric label.' Hard and fast rules could not be laid down, but sadists, some sexual offenders and some arsonists were likely to justify special assessment. Detailed selection would depend on a close examination of each individual restricted patient's case, but the common features expected to be present were a clearly unfavourable or an unpredictable psychiatric diagnosis, and an indication that there was a risk of the patient harming other persons."[226]

The Aarvold Report recommended new procedures to identify cases requiring special care in assessment and the creation of an advisory board to assist the Home Secretary in reaching decisions in such cases.

Board membership

The Board is chaired by a member of the judiciary and comprises a senior barrister, two forensic psychiatrists, a chief probation officer, a deputy director of social services and two members with special experience of the criminal justice system. The members are appointed for a three-year term and may be reappointed for a second term.

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224 F. Egglestone, "The Home Office: The advisory board on restricted patients" in *Principles and Practice of Forensic Psychiatry* (ed. R. Bluglass and P. Bowden, Churchill Livingstone, 1994).

225 *Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients subject to Special Restrictions*, Cmnd. 5191 (1973).

226 F. Egglestone, "The Home Office: The advisory board on restricted patients" in *Principles and Practice of Forensic Psychiatry* (ed. R. Bluglass and P. Bowden, Churchill Livingstone, 1994).

Selection of cases for reference to the Board

Approximately 50 cases are referred to the Board each year. The decision whether to refer a case rests with the Minister or a principal in the Home Office's Mental Health Unit. Some of the factors which are commonly influential are summarised below.

FACTORS AFFECTING REFERRAL TO THE AARVOLD BOARD

Type of offence	Offences involving serious violence, sexual offending, poisoning and arson are more likely to justify reference than other offences, particularly if there is a long history of offending.
Circumstances of the offence	Offences committed against strangers, which were random or part of a series of similar offences, may be more likely to justify referral to the Board than those committed in a family setting or where obvious stress factors triggered the offence.
Type of disorder	The Home Office considers that patients suffering from psychopathic disorder are likely to be more difficult to assess than those suffering from mental illness. Accordingly, all cases of patients suffering from psychopathic disorder should be considered for reference to the Board, as should cases where the diagnosis is unclear.
Proposal under consideration	Between 15 and 20 per cent of all transfer and discharge recommendations are put to the Board. The first move from a special hospital to another hospital will generally cause greater concern than will a move from a regional secure unit to a local hospital. Only exceptionally is the conversion of trial leave at a hospital to formal transfer referred to the Board.
Authority for the patient's detention	The cases of restricted patients detained under sections 47 and 49 are not generally considered by the Advisory Board. The risk involved in the transfer or discharge of mandatory life sentence prisoners who are to be released directly from hospital is normally assessed by the Parole Board. Discharge is generally by way of release on life licence.
Public disquiet	Some cases, although not justifying referral on other grounds, are referred to the Board because of the level of public interest in the case or the notoriety of the patient, in order to ensure that public confidence is maintained in the system.
Referrals from other agencies	Occasionally other agencies may recommend that a proposal is referred, *e.g.* the responsible medical officer, the patient's advocate, or the Board itself. However, referrals are ultimately a matter for the Mental Health Unit and the Minister.

Sources: F. Egglestone, "The Home Office: The advisory board on restricted patients" in *Principles and Practice of Forensic Psychiatry* (ed. R. Bluglass and P. Bowden, Churchill Livingstone, 1994).

How references are dealt with

The Board usually meets once a month and deals with four or five cases at each meeting. Its members are provided with dossiers about the cases to be considered. Egglestone lists the contents of the dossiers prepared for monthly meetings. They contain: full details of the index offence; the psychiatric reports prepared at the time of the trial and all subsequent key medical reports, including the responsible medical officer's formal recommendation for leave, transfer or discharge; relevant nursing or psychologists' reports; and, where discharge is recommended, social work reports on the patient's home circumstances or other arrangements for his accommodation and supervision in the community. One member interviews the patient, the responsible medical officer, and other professional staff in advance of the meeting and prepares a post-visit report for that meeting. Following the meeting, the Minister is provided with a copy of the visit report, a note of the Board's discussion of the case and its findings, and a covering submission from Mental Health Unit.

Communication of Board's findings

The Board's findings are not directly conveyed to the responsible medical officer but, if it is unable to support a proposal and the Board's advice is accepted, the reasons for rejecting the proposal are explained to him.

Information about Board recommendations

The issue of access by patients to information about advice tendered by the Board was considered in the case of *ex. p. Powell.* This case predated the Mental Health Act 1983 and some of the reasons given for the decision clearly no longer hold good. In particular, no statutory provisions equivalent to section 76 of the present Act were in force at the time **(614, 711)**.

R. v. Secretary of State for the Home Department, ex p. Powell

Unreported, 21 December 1978[227] *Q.B.D., Goff J.*

In 1967, a restriction order was imposed following the patient's conviction for causing grievous bodily harm and he was detained in a special hospital. In 1975, the responsible medical officer wrote to the Home Office expressing his opinion that the patient's case was one requiring special care in assessment for a number of reasons, including the nature of the index offence, his previous convictions, the severity and persistence of his anti-social behaviour, and his lack of progress following admission. This recommendation was accepted by the Home Office, with the effect that the patient's case would be referred to the Advisory Board if consideration was later given to his discharge. In 1977, the patient's responsible medical officer recommended to the Home Secretary that the patient be conditionally discharged. His recommendation followed a multi-disciplinary case conference which recommended that course. Accordingly, the patient's case was referred to the Advisory Board for its advice. It appeared that the Advisory Board expressed concern about the proposal that the patient be conditionally discharged. The Home Secretary concluded that the element of risk in agreeing to the patient's release was too great to be accepted and notified the responsible medical officer of his decision by letter.

[227] See L. Gostin and E. Rassaby, *Representing the mentally ill and handicapped: A Guide to Mental Health Review Tribunals*, (Quartermaine House Ltd., 1980), pp.170–174.

Application for judicial review

The patient applied for judicial review, arguing that there had been a breach of the rules of natural justice, in that he was not informed of the matters referred to the Board and therefore was deprived of any opportunity to make representations about them to the Home Secretary before he reached his decision. Although an extra-statutory body, the Aarvold Board was as amenable to judicial review as any other body if it failed to observe the rules of natural justice. Alternatively, if it failed to observe such rules, the Home Secretary's decision was susceptible to judicial review, on the basis that the Board was no more than the arm of the Secretary of State.

Goff J.

Held as follows—

a. The Advisory Board was an extra-statutory body which had no power to make any decision in the patient's case, being a purely advisory body from which the Home Secretary took advice before reaching decisions in such cases. It was difficult to see any distinction between the Home Secretary taking advice from the Board and taking similar advice from an officer in his own department. Such a body was not amenable to judicial review.

b. Insofar as the Home Secretary was concerned, the allegation that he had failed to comply with the rules of natural justice, or had acted unfairly, had to be considered with due regard to the statutory context in which the power was found, taking full account of the relevant procedures established by the Act. The Act contemplated that a patient subject to restrictions had the right to a reference to a Mental Health Review Tribunal. The purpose of the tribunal was that the Home Secretary should receive advice from it. However, although the patient was entitled to an interview, it was not contemplated that he should receive any notification from the tribunal or the Home Secretary of any matters which the tribunal then decided to bring to the Home Secretary's attention.

c. It followed that, if the Home Secretary sought advice from some extra-statutory body, such as the Aarvold Board, no criticism could be directed to the Home Secretary for proceeding in a manner similar to that in which he was entitled to proceed when making his decision after receiving advice from a tribunal. It was, moreover, very understandable that the procedure should be so limited in such cases. The Home Secretary would no doubt desire to obtain the fullest advice before reaching a decision in which he had to consider not only the liberty of the subject but also the public good. In the course of receiving the advice, he might receive opinions which, in the patient's own interest, should not be communicated to him. It might well be for that reason that the *statutory* procedure was so designed that it did not contemplate the various matters referred to in the advice being communicated to the patient before the Home Secretary made his decision. *Application dismissed.*

MENTAL H[illegible]LTH ACT COMMISSION

The function of a Mental Health Review Tribunal is to determine whether the continued use of compulsory powers is necessary or appropriate. The Mental Health Act Commission's main functions are to protect the rights of persons who are detained and to ensure the proper performance of the various powers and duties exercisable under the Act.

STATUTORY FUNCTIONS

The Mental Health Act Commission's statutory functions are[228]—

- To keep under review the exercise of the powers and the discharge of the duties conferred or imposed by the 1983 Act so far as relating to the detention of patients or to patients liable to be detained under the Act.

- To make arrangements for authorised persons to visit and interview in private patients detained under the Act in hospitals and mental nursing homes.

- To arrange for the investigation of complaints falling within its jurisdiction.

- To publish, and from time to time revise, a Code of Practice—

  a. for the guidance of registered medical practitioners, managers and staff of hospitals and mental nursing homes and approved social workers in relation to the admission of patients to hospitals and mental nursing homes under the Act; and

  b. for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.

- To publish a biennial report.

- To perform on the Secretary of State's behalf his functions in relation to the consent to treatment provisions in Part IV of the Act (appointing second-opinion doctors, regulating section 57 treatments, deciding whether patients who are incapable of consenting to treatment or who refuse treatment should be given treatment).

- To review any decision to withhold a postal packet under section 134.

Commission's statutory remit relatively narrow

As the table on the following pages illustrates, the Commission's statutory powers and duties are quite limited compared with those exercisable by the respective Commissions in Scotland and Northern Ireland.

[228] See Mental Health Act 1983, ss.118–121.

FUNCTIONS OF THE RESPECTIVE MENTAL HEALTH COMMISSIONS

Function	Whether function possessed by the Commission		
	MHAC	*MWC*	*MHCNI*
▪ General duty (i) to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests (Scotland) or (ii) to keep their care and treatment under review (Northern Ireland).	No	s.3(1) MH(S)A 1984	Art. 86(1) MH(NI)O 1986
▪ Duty to make enquiry into any case where it appears to the Commission that there may be ill-treatment, deficiency in care or treatment, or improper detention of any person who may be suffering from mental disorder.	No	s.3(2) MH(S)A 1984	Art. 86(2) MH(NI)O 1986
▪ Duty to make enquiry into any case where it appears to the Commission that the property of any person who may be suffering from mental disorder may be exposed to loss or damage, by reason of that mental disorder.			
▪ Duty to bring to the attention of the hospital managers or any local authority the facts of any case in which, in the Commission's opinion, it is desirable for them to secure the welfare of any patient suffering from mental disorder by— (a) preventing his ill-treatment; (b) remedying any deficiency in his care or treatment; (c) terminating his improper detention; (d) preventing or redressing loss or damage to his property.			
▪ Duty to give advice on any matter arising out of, or under, the relevant mental health statute which is referred to it by the Secretary of State, a Health Authority, Board, local authority or other such body.			
▪ Duty to bring to the attention of any such body any matter concerning the welfare of such persons which the Commission considers ought to be brought to their attention			
▪ Power to co-opt non-Commissioners to undertake, chair or participate in an inquiry into any possible ill-treatment, deficiency in care or treatment, or improper detention of any person who may be suffering from mental disorder.	No	s.3(8) MH(S)A 1984	Art. 86(4) MH(NI)O 1986
▪ Power to require persons to attend such an inquiry.	No	s.4(1) MH(S)A 1984	Art. 86(4) MH(NI)O 1986
▪ Power to administer oaths and examine witnesses on oath at such an enquiry.	No	s.4(4) MH(S)A 1984	
▪ Statutory provision that it is a criminal offence for a person to refuse or wilfully neglect to attend such an inquiry when served with a notice requiring them to do so.	No	s.4(5) MH(S)A 1984	
▪ Jurisdiction over patients subject to guardianship.	No	ss.3(1), 33(3), 50(2) (3) MH(S)A 1984	Art. 86(1)(2) MH(NI)O 1986
▪ Power to discharge patients subject to detention or guardianship, save for restricted patients.	No	s.3(1) MH(S)A 1984	No *See power to refer to MHRT*
▪ Power to refer to a MHRT the case of any patient who is liable to be detained or subject to guardianship.	No	*See power to discharge*	Art. 86(3), MH(NI)O 1986
▪ Power to recommend to the Secretary of State that a restricted patient should be discharged	No	s.3(3), MH(S)A 1984	No
▪ Power to apply for the appointment of a receiver/curator bonis in respect of a patient if the Commission is satisfied the person concerned is incapable, by reason of mental disorder, of managing and administering his property and affairs.	No	s.93 MH(S)A 1984	No
▪ Duty to notify the Court of Protection, or equivalent body, of any person whom it is satisfied is incapable of managing his property and affairs if Commission considers Court should exercise its powers.	No	*See duty to apply for appt of curator bonis*	s.107(3) MH(NI)O 1986
▪ Duty to notify the Commission of a patient's reception into guardianship and to forward with that notification copies of the application and medical recommendations.	No	s.41(1) MH(S)A 1984	*See* Art. 20(1) MH(NI)O 1986
▪ Statutory provision that one medical recommendation in support of a guardianship application shall be given by a SOAD or equivalent.	No	No	
▪ Duty to notify the Commission of any patient who has been absent with leave for more than 28 days and of that patient's later return.	No	s.27(5) MH(S)A 1984	Art. 15(4) MH(NI)O 1986
▪ Duty to notify the Commission of a patient's transfer.	No	s.29(2) MH(S)A 1984	Art. 25(5), 28(10) MH(NI)O 1986

Function	Whether function possessed by the Commission		
	MHAC	*MWC*	*MHCNI*
▪ Duty to notify the Commission as soon as practicable of any permanent change of address of a patient subject to guardianship and if such a patient is absent without leave.	No	Regs 6(1)(2) , Mental Health Regs 1984	*Must notify of any change of guardian*
▪ Duty to notify the Commission of a patient being detained under s.5(2), s.5(4), or equivalent.	No	s.25(4) MH(S)A 1984	Art. 7(7) MH(NI)O 1986
▪ Duty to notify the Commission without delay of a patient being detained under s.4, or equivalent.	No	s.24(5) MH(S)A 1984	
▪ Duty to notify the Commission of a patient being detained under s.2, or equivalent.	No	s.26(4) MH(S)A 1984	Art. 8(2), 9(10) MH(NI)O 1986
▪ Duty to notify the Commission of a patient being detained under s.3, or equivalent.	No	s.22(2) MH(S)A 1984	*See below — Art. 12(1)*
▪ Provision that detention under section 3, or equivalent, requires medical recommendation signed by a SOAD	No	No	Art. 12(1)
▪ Duty to notify the Commission of the renewal of the authority to detain a patient subject to s.3 or equivalent.	No	s.30(3) MH(S)A 1984	Art. 13(6) MH(NI)O 1986
▪ Provision that a second renewal of a s.3 application, or equivalent, requires medical recommendations signed by two SOADs (or equivalent).	No	No	Art. 13(3) MH(NI)O 1986
▪ Duty to send a copy of any Form 38 or 39 to the Commission.	No	s.98(3) MH(S)A 1984	Art. 64(6) MH(NI)O 1986
▪ Duty to notify the Commission of any patient who is given urgent treatment under s.62, or equivalent, and the nature of that treatment.	No	s.102(4) MH(S) A 1984	Art. 68(4) MH(NI)O 1986
▪ Duty on bodies advised to take steps by the Commission to notify the Commission of the steps taken, or to be taken, and to comply with the requirements of any notice served by the Commission.	No	*See enquiry powers*	Art. 86(6) MH(NI)O 1986

The Commission's duty to keep the operation of the Act under review is fulfilled in two main ways. Firstly, by visiting detained patients and, secondly, by investigating complaints made by them or about the way in which the Act is being used in practice. The Commission's jurisdiction to investigate complaints is conferred by section 120(1)(b) of the Act, from which it can be seen that the persons authorised may investigate two different classes of complaint.

THE COMMISSION'S COMPLAINTS JURISDICTION

120.—(1) The Secretary of State shall ... make arrangements for persons authorised by him in that behalf ...(b) to investigate—

i. any complaint made by a person in respect of a matter that occurred while he was detained under this Act in a hospital or mental nursing home and which he considers has not been satisfactorily dealt with by the managers of that hospital or mental nursing home; *and* — **Sub-para. (i) complaints**

ii. any other complaint as to the exercise of the powers or the discharge of the duties conferred or imposed by this Act in respect of a person who is or has been so detained. — **Sub-para. (ii) complaints**

The basic investigatory framework

Section 121(2)(b) provides that the Secretary of State shall direct the Commission to perform his functions under section 120[229] and the basic framework for investigating complaints may be summarised as follows —

- Section 121(2)(b) provides that the Secretary of State shall direct the Mental Health Act Commission to perform on his behalf his functions under section 120(1), which include making arrangements for authorised persons to investigate the two different types of complaint.
- The Commission shall perform these functions subject to and in accordance with such directions as the Secretary of State may give it.
- The persons authorised by the Commission to investigate a complaint only have authority to investigate matters which—

  a. fall within the terms of section 120(1)(b); and

[229] The directions are set out in the Mental Health Act Commission (Establishment And Constitution) Order 1983 (S.I. 1983 No. 892), which provides that the Commission shall perform these functions "subject to and in accordance with such directions as the Secretary of State may give to the Commission."

b. are not excluded from investigation *either* by subsection 12[illegible] (which relates to the powers and duties involving the Court of Protection) *or* under the arrangements for investigating complaints made by, or on behalf of, the Secretary of State;[230]

- where a person has authority to investigate a particular matter, he may not be required to investigate it, or to continue to investigate it, if in his opinion it is inappropriate to do so;[231]

- there is no statutory duty to furnish a report setting out the results of an investigation, unless the complaint is one which has been made by a Member of Parliament under s.120(1)(b)(ii).

An informal process

Section 120 is significant not only because of what it says but because of what it does not say. For example, it does not—

- authorise the investigation of complaints relating to informal patients or patients subject to guardianship or after-care under supervision;

- confer upon the authorised persons any judicial powers to compel persons to give evidence on oath or to produce documents;

- provide that the way in which complaints are investigated shall be subject to formal rules (in the way that a tribunal's procedure is governed by the 1983 Rules) or regulations (the 1983 regulations are silent as to the Commission's complaints functions);

- narrowly restrict the matters which may be investigated by providing time limits for making a complaint, that clinical complaints may not be investigated, or that only complaints made in writing may be investigated;

- impose any statutory duty to prepare a statement of the reasons why a decision has been taken not to investigate a particular complaint or to prepare a report of the results of an investigation (except where the complainant is an Member of Parliament);

- provide the Commission with any formal powers with which to enforce its findings and recommendations.

With regard to these omissions, it should be noted that the establishment of the Health Service Commission post-dated the establishment of the office of the Health Service

230 No specific matters have been excluded from investigation. Section 121(2)(b) provides that the Secretary of State shall direct the MHAC to perform on his behalf his functions under s.120(1). These functions include not the investigation of complaints but *making arrangements* for their investigation, while, by s.120(2), the arrangements made may exclude matters from investigation in specified circumstances. The most natural reading of these provisions is that the Commission itself may exclude matters from investigation in specified circumstances and it is unnecessary to ask the Secretary of State to specify them.

231 See Mental Health Act 1983, s.120(2).

Commissioner, who does po[illegible]s such formal investigative powers. It was envisaged that the Commission would investigate complaints which could be dealt with informally, *i.e.* investigations not requiring the use of formal powers. Paragraph 263 of the *Memorandum* on the Act states that, "The Commission does not replace or duplicate the work of other individuals and bodies who are able to help patients with their problems, for example ... the Health Service Commissioner." Unlike the Health Service Commissioner, or the Mental Welfare Commission for Scotland, the Commission has no formal powers to enforce recommendations following an investigation. The view taken by Parliament was that the expertise of its members, their eminence within their respective fields, and the quality of their investigations, would ensure that reports were given proper and adequate consideration. The Ashworth Report similarly added that the Commission's power lies in the influence it can wield in drawing to the Secretary of State's, and the public's attention, any question of non-compliance with the Act or short-fall in the quality of patient-care and treatment.

The two classes of complaint

What is now sub-paragraph 120(1)(b)(ii) was added at quite a late stage during the 1982 Bill's passage through Parliament. The inter-relationship between the two sub-paragraphs was poorly thought out at the time and their precise meaning has subsequently proved elusive. The general position is that any person, not just a detained patient, may complain that the Act is not being complied with and the Commission, being responsible for policing the statute, may immediately authorise some person to investigate that allegation. A detained patient may also complain to the hospital managers about the standard of his hospital treatment and care, since they are responsible for it. If he is not satisfied with their response, he may then ask the Commission to arrange a further, independent, investigation. But whether to complain is a matter for the person receiving the treatment and care. The complaints procedure depends upon which sub-paragraph the complaint falls within—

- Because sub-paragraph 120(1)(b)(i) commences with the words "Any complaint," and sub-paragraph 120(1)(b)(ii) with the words "Any *other* complaint," rather than vice-versa, this indicates that all complaints made by a person concerning some matter which occurred while he was detained (including those involving statutory powers and duties) must always first be referred to the hospital managers before the Commission may investigate.

- Conversely, sub-paragraph 120(1)(b)(ii) provides that the Commission never needs to refer to the managers complaints made by patients about the way in which some statutory power or duty was exercised during a period when the complainant was not detained by the managers of a hospital.[232]

- As concerns complaints made by third-parties about the way in which some statutory power or duty was exercised, there is also no obligation to refer them to the managers before investigating them.

232 For example, matters which occurred *prior* to a patient's detention in the hospital (complaints about the sectioning process, the person's detention under section 136, or the manner of his conveyance to hospital), while absent from the hospital, or after he ceased to be detained there (complaints about after-care arrangements).

Sub-paragraph (i) complaints

These complaints include both complaints about the way in which some power or duty under the Act has been exercised and a whole range of other grievances about which the Act is silent and imposes no statutory duty (for example, complaints about sexual misconduct, the quality of facilities on a ward, staff rudeness). No person has authority under section 120 to investigate a complaint which falls within sub-paragraph (i) unless the managers of the relevant hospital or mental nursing home have first had an opportunity to investigate it to the patient's satisfaction. If the patient should then be dissatisfied with the results of their inquiry, he may at that stage ask the Commission to appoint an investigator.

Sub-paragraph (ii) complaints

The Commission may investigate complaints by third parties concerning the exer-
cise of some power or duty conferred or imposed by the Act in relation to a detained
patient. The word "power" is used several times in the Act.[233] Elsewhere, as in sec-
tion 136, the word "may" is used to confer a power on some person. In other places,
as in section 63, the conferment of a power may be phrased as an exemption: "the
consent of the patient shall not be required for any medical treatment ..." Part VII
aside, the word "duty" is rarely to be found.[234] The word "shall" is used quite often,
but almost invariably to specify the procedure to be followed when exercising a
power, *e.g.*, an application *shall* be founded on written recommendations. The
statute also prohibits certain acts. For example, section 58(3) provides that no
treatment shall be given to a patient after three-months unless authorised by
statutory certificate. It is, however, more logical to think of these prohibitions as
making clear the absence of any power to do a particular act in the specified
circumstances, rather than as a statutory duty not to do the act: section 58(3) simply
limits the power to give treatment without consent conferred by section 63 to a
period of three months. Likewise with the prohibition that no section 3 application
shall be made by an approved social worker except after consulting the nearest
relative: this seems to be first-and-foremost a statement that there is no power to
make an application unless the relative has been consulted, rather than a statutory
duty of consultation. This may be playing with words but there is no duty to consult
a nearest relative when assessing a patient for admission. It is simply that the
particular power is not exercisable unless the precondition has been satisfied.[235]

Complaint "as to" the exercise of a power or duty

There is ultimately no agreement about whether clinical complaints concerning the prescription of high levels of medication, and general allegations of inadequate care, can be said to be complaints "as to" the exercise of some statutory power or duty. The Act uses the phrase "as to" many times, particularly in section headings. The words are less frequently used in the body of the statute, but most often the usage

[233] See *e.g.* sections 5(4), 8(1), 10(1)(b), 11(3), 13(5), 24(1), and 29(3)(d). There are also frequent references in Part III to a court's powers when dealing with a mentally disordered offender, and sections 72–5 set out a tribunal's powers under the Act.

[234] See sections 9(1)(b), 13(1), 13(4), 20, 68, 117, 132, 133, 140 and 141.

[235] Where there is a statutory requirement to do some act, a statutory duty may be reinforced by granting to the person with that duty those powers necessary to enable him to fulfil it. However, where the requirement is to do some act before exercising a power, this is simply circumscribing the power, saying that no power exists unless some prior step has been taken. So, in general, it is fair to say that the Act confers many statutory powers, some of which are qualified, but very few statutory duties.

here is identical to that in the section headings, the words "as to" being synonymous with "concerning" or "in respect of", rather than "relating to."[236] Whether section 120(1)(b)(ii) is capable of embracing decisions not to exercise powers, as well as the way in which powers are exercised, may also be disputed. The better view is perhaps that the sub-paragraph is only concerned with the misuse of powers and the failure to discharge duties, not with decisions not to exercise a power. Another area of doubt is whether complaints about the way in which secondary legislation is implemented may be investigated. If a very legalistic approach is adopted, the words used in sub-paragraph (ii) can be contrasted with those in section 139(1),[237] so that a complaint must concern the exercise of a power or duty found in the Act itself, rather than one which arises from regulations or rules made under it. Because the Code of Practice includes general guidance on medical treatments, guardianship and after-care under supervision, it is at any rate clear that not every failure to observe the Code will give rise to a valid concern that some statutory power or duty has been improperly exercised.[238]

Complaints about clinical decisions, etc.

Many complaints made by third parties concern clinical or quasi-clinical decisions. The third-party's complaint may be that, having regard to improvement in the patient's mental state, the responsible medical officer's decision not to discharge him, or to grant him leave of absence, is unreasonable. A relative may alternatively complain about some aspect of the patient's treatment. For example, the number of drugs being prescribed, the dosage, the quality of nursing care, a want of care, or the lack of occupational therapy. In support, it may be said that the complaints are complaints "as to" the exercise of statutory powers, because the managers have power to detain the patient for treatment and the treatment is being provided compulsorily under sections 58 and 63. If section 63 constitutes a power to give medical treatment for mental disorder, and medical treatment (as defined by section 145) extends to cover the entire care regime, there is certainly very little which lies outside the scope of the power to investigate under s.120(b)(ii). However, for the following reasons, it is submitted that such complaints do not fall within the ambit of sub-paragraph (ii)—

- A sub-paragraph (ii) complaint must be one "as to" the exercise of a power or duty granted or imposed by the Mental Health Act 1983. It is therefore pertinent to ask whether, if that statute did not exist, the act could still lawfully be done or there would still be a duty to do it. A medical practit-ioner owes all of his patients, detained and informal alike, the same duty of care when it comes to examining them, forming a diagnosis, and pre-scribing medicines and other forms of treatment. That therefore is a common law obligation, not one imposed by the statute. Nor, more specifically, is the

[236] See ss.4(4)(b), 73(1)(a) and (2), 78(4) and (5), 105(2)(4) and (5), 107(1), 118(2), and 126(2). Only relatively rarely, as in sections 24 and 76, is the phrase used in the same sentence as the word "exercise." All one can do is to note that when the words "as to" are used they are generally followed by a reference to a specific power or duty *expressly* conferred or imposed by the Act.

[237] "any act purporting to be done in pursuance of this Act, or any regulations or rules made under this Act ..."

[238] Nevertheless, one purpose of served by publishing the Code is to help to develop good practice, and also uniform practice, in the way in which statutory powers and duties are exercised across England and Wales. The Commission's duty to visit patients allows it to monitor this, and its complaints function allows it to investigate allegations that powers and duties conferred or imposed by the Act have not been exercised in the way intended by Parliament.

doctor's power to prescribe medication, in whatever dose he deems necessary in the light of the patient's condition, one conferred by the Act. Section 58 is concerned with the administration, rather than the prescription, of medication, and the responsible medical officer cannot be required to prescribe treatment which he believes to be clinically inappropriate. What would not exist in most cases if it were not for the statute would be a power to administer a course of treatment to a non-consenting, mentally competent, patient. Certainly, if the doctor was asked on what authority this was being done, he would rely on section 58 or section 63. The statutory power being exercised is therefore not the power to prescribe medicines, or medicines at a certain dosage, but the power to administer those medicines to a non-consenting patient in the circumstances set out in sections 58, 62 and 63, using reasonable force where necessary.

- It is therefore necessary to distinguish between the exercise of the power to give compulsory treatment and the exercise of the doctor's clinical judgement about whether a particular treatment should be given at all. A doctor will, or should, approach each patient's case in the same way regardless of his legal status. A mental state examination leads to the recording of symptoms and signs. These give rise to a diagnosis, which is a pointer towards the most appropriate treatment and the prognosis. At this point, no statutory power has been exercised: reaching a clinical decision does not involve exercising a statutory power. The treatment may be declined by a patient entitled to refuse it, given with the patient's consent, or administered without his consent, using reasonable force where necessary. The power granted by the Act is not one of examination, diagnosis and prescription, but one to give, without the patient's consent, that treatment deemed to be clinically appropriate. A complaint that the power to give treatment compulsorily is being exceeded is a complaint "as to" the exercise of the statutory power, *e.g.* a complaint that excessive force was used or that the treatment was not authorised under section 58. However, a complaint that the patient has been misdiagnosed as suffering from schizophrenia, and should not be prescribed antipsychotics, is not a complaint "as to" the statutory power to administer medication without consent. It is a clinical complaint about the diagnosis and prescription decision. The medical (clinical) part of the process is the treatment decision while the legal part (the power) is the administration of that treatment without consent where permitted by law. The power conferred by the Act relates to the second, not the first, process. Unless there is some allegation that the power has been exceeded or otherwise misused, such complaints are merely complaints "as to" the exercise of the doctor's clinical judgement.

- If it is true that all clinical decisions about the prescription of medication and other forms of treatment are acts as to the exercise of a statutory power or duty, it must also be true that any legal proceedings in respect of them require the High Court's leave. However, it difficult to believe that Parliament intended that section 139 should apply to all actions for negligence based on allegedly inadequate medical care and treatment.

- In one sense, every act done in respect of a detained patient is an act done in pursuance of the statute: at some level, it relates to his detention or treatment and would probably not have been done if he had not been detained. However, this is the case with many Acts of Parliament[239] and the proper interpretation of section 120(1)(b) involves establishing the essential difference between the two categories of complaint. If Parliament intended that virtually every aspect of a patient's treatment and care represents an exercise of the statutory power to detain and treat him, there would be no need for two sub-paragraphs differentiating two types of complaint. It must be the case that certain grievances are investigable under sub-paragraph (i) which are not investigable under sub-paragraph (ii). The different, and much narrower, wording of sub-paragraph (ii) suggests an intention to limit the type of complaints which third-parties may make. A natural reading of the subsection suggests that a patient's right to complain was intended to be broader than that of third-parties in one respect and narrower in another. It is wider insofar as a detained patient can clearly complain about anything which has happened during his detention: he is not limited to matters which involve the exercise of some statutory power or duty. It is narrower insofar as complaints about matters which occurred while he was detained in hospital must first be referred to the hospital managers, even if they involve an allegation that some statutory power or duty was improperly exercised.[240]

- A natural reading of the section also suggests that Parliament did not intend the Commission to investigate complaints about a patient's general care and medical treatment concerning which he himself had no grievance. There are good reasons for restricting one person's right to initiate a formal complaint about some other person's diagnosis, treatment and care. A patient who is content with his treatment might otherwise have to submit to being interviewed, and to having his records examined, at the instigation of some interfering relative. Furthermore, it would often be impossible to properly deal with a third-party's complaint that he should be given drug *x*, or less of drug *y*, without breaching the confidentiality of the doctor-patient relationship. Either the reasons for not upholding the complaint could not be communicated to the third-party, or their communication would involve disclosing to him confidential information about the patient's symptoms, diagnosis, prognosis, as well as things said by him during patient-doctor interviews.[241]

[239] For example, the case of *Burgess v. Northwich* 6 Q.B.D. 264 turned on the phrase "the exercise of any of the powers of the Act" in section 308 of the Public Health Act 1875. Lindley J. recognised that "In one sense, everything the defendants did was in exercise of the powers conferred upon them by the Public Health Act; but, by the expression 'exercise of any of the powers of this Act', in section 308, I understand new powers created by the Act."

[240] Parliament's intention here may have been to restrict the burden on the Commission to investigating complaints which cannot be resolved locally, bearing in mind that it would in any case be the managers whom the Commissioners would have to look to rectify any problems. If they were ready and willing to do so anyway then a independent investigation is unnecessary.

[241] It is sometimes said that a third-party has a personal right to complain under sub-paragraph (ii) about a deceased patient's treatment. However, if this is true, a third-party must also have the same right to complain about the treatment and care being given to a living patient, regardless of whether or not that patient himself has any complaint about it.

- The intention seems to be that everyone, including the p[illegible]t, has a common interest in ensuring that the various statutory powers and duties are properly exercised. However, it is for the patient himself to decide whether or not he has a complaint about his medical care and treatment. Before it is investigable, a complaint made under section 120(1)(b)(ii) must involve an allegation that a power conferred by the statute has been exercised improperly, that is otherwise than in accordance with the Act. A complaint concerning a clinical decision is not a complaint which is investigable under sub-paragraph (ii), while a complaint that the person in whom Parliament vested a particular power has simply exercised his discretion in the manner envisaged by Parliament (*e.g.* refusing to grant leave or to exercise his power of discharge) seems at best to disclose no case that the power has been exercised otherwise than in accordance with the statutory scheme. If it is contended by a third-party that a patient is not being detained in accordance with the provisions of the Act, that amounts to a complaint about the exercise of the statutory powers. However, if the administration of drug x to patient y has been authorised by the completion of a Form 38 or Form 39 specifying the drug, a complaint by a third-party that the medicine ought not to be prescribed, because the patient does not suffer from schizophrenia, is not a complaint as to the exercise of a statutory power, but a complaint as to the patient's diagnosis and the prescription.[242]

Whether an investigation is appropriate

In deciding whether it is appropriate to investigate a complaint made by a patient, or to continue an investigation in progress, the person authorised will usually have regard to the matters listed below—

Patients' complaints: whether appropriate to investigate

Nature of the complaint

- If established, would the matter complained of be likely to give rise to civil or criminal liability, loss of employment or disciplinary proceedings before a professional body?
- Is the complaint really a ward or hospital-based issue, such that it would be better dealt with under the Commission's visitatorial functions?

Complainant's reasons

- Why is the complainant asking the Commission to conduct a second investigation?

242 An alternative interpretation of section 120, which relies on the fact that an authorised person cannot be required to investigate a section 120(1)(b)(ii) complaint, may also be suggested. This discretion, it may be said, represents an acknowledgement that many complaints may be said at some remote level to be complaints as to the exercise of a statutory power or duty, in the sense that the act would not have been done had the patient not been detained for treatment. Where any duty to do a particular act is first-and-foremost a common law or professional duty about which the Act is silent, the person authorised may at his discretion decide that it is inappropriate to investigate the matter because it has so little to do with the operation of the statute which it is the Commission's function to keep under review.

- Is the c[illegible]plainant seeking an apology, compensation, disciplinary action against staff, conciliation, or an adjudication of a matter in dispute?
- Is the complainant attempting to use the Commission's complaints machinery in an inappropriate manner, *e.g.* as a way of obviating the usual procedures relating to pre-action discovery or as a way of gaining access to medical records?

Managers' investigation

- Was the way in which the managers' enquiry was conducted fair and impartial and consistent with established guidelines?
- To what extent were the managers' findings justified in the light of the available evidence? Did the managers obtain all the relevant evidence before arriving at their findings?
- Would a further inquiry simply duplicate what has already been said or, instead, be likely to bring to light new evidence which could materially alter the conclusions which the hospital managers themselves reached?

Alternative remedies

- Are alternative, more appropriate, courses or remedies available to the complainant (*e.g.* an action for medical negligence, professional disciplinary proceedings, an investigation by the Health Service Commissioner)?
- Would it be more appropriate to refer the case back to the managers for reconsideration (*e.g.* to obtain further evidence or to arrange for the matter to be investigated at a higher level within the hospital management before the Commission itself embarks on an investigation)?

Evidence

- What evidence has been furnished in support of the proposition that some event has taken place which the Commission should arrange to be investigated?
- Is there any evidence of a breach of the Act or of the Code of Practice?

Time factors

- Does the length of time which has elapsed since the events to which the complaint relates took place make an investigation inappropriate?

Prospect of gain

- What purpose would an investigation serve (is there any prospect of "gain" to some person, *e.g.* conciliation, an improvement in practices, or resolution through a clear adjudication of the matters in dispute)?

Resources

- Given the need to use resources carefully, and to investigate serious complaints thoroughly, is the matter sufficiently serious to warrant an external investigation?

CODE OF PRACTICE

The Health of the Nation Key Area Handbook summarises the policies which the Code of Practice recommends that health authorities, local (social services) authorities and the police develop in relation to the treatment and care of persons suffering from mental disorder.[243]

POLICIES REQUIRED UNDER THE CODE OF PRACTICE

Code para.	Policy requirement	Responsibility of —		
		H.A.	L.A.	Police
2.11c	Issue guidance to approved social workers (ASWs) about interpreters.		•	
2.14	Issue practical guidance to ASWs on procedures regarding displacement of nearest relative (s.29).		•	
2.33	Issue guidance to ASWs re request(s) from nearest relative for ASW assessment (s.13(4)).		•	
2.35	Ensure ASWs and doctors receive guidance on use of professional interpreters.	•	•	
10.1	Establish joint policy re. police power to remove person to place of safety (s.136).	•	•	•
10.19	Issue guidance to ASWs on powers of entry (s.135).		•	
11.3	Produce policy with Ambulance Service on conveyance of patients to hospitals (s.6).	•	Take lead	•
13.6	Prepare and publish policy on Guardianship (s.7).		•	
14.6	Hospital Managers' policy on providing information to patients.	•		
16.33	Hospital Managers' "Second Opinion Appointed Doctor" system.	•		
18.13	Policy on the use of restraint.	•		
18.16	Policy on the use of seclusion.	•		
18.27	Policy on the use of locked doors on "open" wards.	•		
18.29	Policy on the use of locked doors and secure areas.	•		
19.2	Policy on behaviour modification programmes.	•		
19.1	Policy on the use of "time-out"	•		
21.2	Policy on procedure re. patients absent without leave	•		
24.15	Special Hospitals policy on withholding mail	SHSA		
25.1	Policy on searching of patients and their belongings	•		
27.3	To produce procedures of aftercare with local voluntary organisations (s.117).	•	•	

243 *The Health of the Nation Key Area Handbook: Mental Illness*, (Department of Health, 2nd Ed., 1994).

PATIENTS' MAIL

Under section 134 of the Mental Health Act 1983, the Mental Health Act Commission has the function of reviewing certain decisions to withhold mail sent to or by a detained patient.

General law concerning postal services

The relevant features of the statutory scheme under the Post Office Act 1953, and related legislation, may be summarised in the following way—

- subject to exceptions, the Post Office has the exclusive privilege of conveying all letters from one place to another and of performing all the incidental services of receiving, collecting, dispatching and delivering them.[244]

- the following acts expressly authorised by statute do not infringe the exclusive privilege of the Post Office with respect to the conveyance and delivery of letters: (a) the conveyance and delivery of a letter personally by its sender[245]; (b) the sending, conveyance and delivery of a letter by means of a private friend who himself delivers it to the addressee[246]; (c) the sending, conveyance and delivery of a letter concerning the private affairs of the sender or addressee by means of a messenger sent by its sender.[247]

- the term "postal packet" includes letters, postcards, and parcels which might be sent by post, even if in fact delivered or sent by hand.[248]

- the delivery of a postal packet to a postman or to an officer of the Post Office constitutes a delivery to a post office;[249]

- the delivery of a postal packet at the premises to which it is addressed or redirected, or to the addressee's servant, agent or other authorised person, constitutes a delivery to the addressee."[250]

- a postal packet is deemed to be in the course of transmission by post from the time it is delivered to any post office to the time it is delivered to the addressee;[251]

- the Post Office will, on the application of the addressee, redirect postal packets from the original address to another address of the same addressee[252] and a postal packet delivered at the original address may be redirected to the addressee in the United Kingdom.[253]

244 Post Office Act 1953, s.3(1); Post Office Act 1969, s.23(1)(a).
245 *Ibid.*, s.3(2)(a).
246 *Ibid.*, s.3(2)(b).
247 *Ibid.*, s.3(2)(c).
248 *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (D.H.S.S., 1960), para. 269; *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S.S., 1982), p.167.
249 Post Office Act 1953, s.87(2)(b).
250 *Ibid.*, s.87(2)(c).
251 *Ibid.*, s.87(2)(a).
252 Post Office and Post Scheme 1979, Sched. 3, Item 10.
253 Post Office Act 1953, para. 32(1).

- it is generally an offence for a Post Office employee to open, d[illegible] or delay a postal packet, but this offence does not extend to opening, detaining or delaying a postal packet returned by reason that the person to whom it is directed has refused it.[254]

Mental Health Act 1983, s.134

The present law concerning the withholding of patients' post is set out in section 134. In order to appreciate its precise ambit, it is useful to be aware of the way in which the legislation in this area has developed.

Historical developments

Section 41 of the Lunacy Act 1890 required the manager of a hospital to forward unopened certain privileged correspondence, such as letters to a Judge in Lunacy. The manager was given a discretion as to whether or not to forward other letters written by a private patient, for example letters to family and acquaintances. The Commissioners could, and did, direct that every institution having a private patient display a printed notice setting forth the "right of every private patient to have any letter written by him forwarded in pursuance of the last preceding section."[255] These provisions were reviewed by the Royal Commission of 1954–57, which had this to say in its report: [256]

> "As regards the censorship of letters, we recommend that there should be no censorship of out-going letters from patients (whether subject to detention or not) except at the request of individual addressees who ask for letters addressed to themselves to be scrutinised or withheld because they find them distressing."

Mental Health Act 1959

Section 36 provided that a letter addressed to a patient could be withheld from him if the responsible medical officer considered that its receipt was likely to interfere with his treatment or cause him unnecessary distress. Correspondence so withheld was to be returned to the sender by post. A patient's outgoing mail could be withheld from the Post Office in two situations. The first of them was that the addressee had requested in writing that communications addressed to him by the patient should be withheld[257]: this exception was re-enacted in 1983 and forms part of the current law. The second situation was that it appeared to the responsible medical officer that the postal packet would be unreasonably offensive to the addressee or was defamatory of other persons (other than persons on the staff of the hospital) or was likely to prejudice the interests of the patient.[258] The second ground was not to be construed as authorising a responsible medical officer to open or examine a patient's mail unless he considered that the patient was suffering from mental disorder of a kind calculated to lead him to send communications of this kind.[259] Section 36(4), which was also not re-enacted, then went on to provide that, except as provided by the

254 Post Office Act 1953, s.58.
255 Lunacy Act 1890, s.42(1)(a).
256 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), para. 299.
257 Mental Health Act 1959, s.36(2)(a).
258 *Ibid.*, s.36(2)(b).
259 *Ibid.*, s.36(3).

section, it was unlawful to prevent or impede the delivery of mail to a detained patient, or the delivery to the Post Office of any mail addressed by him and delivered by him for dispatch. According to paragraph 270 of the *Memorandum* on the 1959 Act:

> "270. The right to withhold patients' outgoing correspondence from the post is limited to the circumstances described in paragraphs (a) and (b) of subsection (2) of section 36. The right to open correspondence in order to decide whether a letter should be withheld under paragraph (b) is specifically limited by subsection (3) to cases where the responsible medical officer (or guardian or person authorised by him) believes the patient to be suffering from disorder of a kind which is likely to lead him to send the sort of communications which may be withheld under that paragraph. Other patients' letters may not be opened. The assumption therefore is that no outgoing letters are read by hospital staff unless there are special reasons for doing so, within the terms of subsection (2), in the case of individual patients. In view of this, the Minister considers it no longer suitable that there should be general notices in the wards listing persons to whom letters must be sent unopened; the assumption is that all letters will be sent unopened unless exceptionally it is necessary to use the limited powers conferred by subsection (2)."

Review of the Mental Health Act 1959 (Cmnd. 7320)

The White Paper of 1978 recognised that it was extremely difficult to exercise effective control over distressing incoming communications in an age where patients have easy access to telephones, radios, newspapers and televisions. The Government therefore proposed to remove the power to withhold the in-coming mail of detained patients and of persons under guardianship. The White Paper then considered the situation as regards letters written by patients:

> "8.10 There are similar difficulties over out-going mail. It is not possible to intercept all correspondence which might be offensive since there are alternative methods of sending letters, such as persuading informal patients to post them. Nor is there evidence that detained patients are more likely to write abusive or distressing letters than other patients. There may however be a small number of cases where a patient's letter would be particularly distressing to its intended recipient, for example where a patient who has committed a serious crime writes to his victim or to the victim's relatives; and it seems right to attempt to exercise such control as is practicable in such cases. It is therefore proposed that it should remain possible for the hospital authorities to withhold out-going mail addressed to somebody who has specifically requested that mail addressed to him by a detained patient or a person under guardianship should not be sent to him. Such mail would be returned to the patient who would be entitled to assume that, otherwise, his mail was not being intercepted or interfered with in any way.
>
> 8.11 If detained patients are to have an unhindered right to send letters, with the exception noted in the preceding paragraph, there would no longer seem to be a need for the list in section 36(2)(b) of persons and organisations to whom patients may write without fear of interception ..."

Reform of Mental Health Legislation (Cmnd. 8405)

The White Paper of November 1981, which explained the amendments made to the 1959 Act in the recently published Bill, included the following passage:

41. The Bill also proposes other changes to the law which affect detained patients in hospital. It will considerably curtail the circumstances in which incoming or outgoing mail may be withheld, and will ensure that there is no scrutiny at all of the mail of informal patients. The Bill provides that outgoing mail from a detained patient may be withheld only if the proposed recipient has asked that this should be done with correspondence addressed to him by the patient. Incoming mail will not be opened or withheld at all except in the special hospitals, where exceptional arrangements are needed for security reasons. In the special hospitals, an officer will be authorised to withhold mail if it is necessary in the interests of the patient's safety or to protect others."

The present legislation

The present statute does not authorise interference with the correspondence of an informal in-patient. However, section 134 allows a detained patient's post to be opened, inspected or withheld from the Post Office in certain circumstances. Section 121 provides for an appeal to the Mental Health Act Commission in such cases. Part V of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, the authority for which derives from sections 121(9) an 134(8), regulates the exercise of these powers and the making and determination of applications to the Commission. The functions of the hospital managers under section 134 are discharged on their behalf by a hospital staff member appointed for the purpose — referred to in the regulations as "the person appointed."

STATUTORY GROUNDS FOR WITHHOLDING POSTAL PACKETS

	Incoming post	*Outgoing post*
▪ *Informal patients*	May not be withheld from the patient.	May not be withheld from Post Office even if addressee has made such a request.
▪ *Non-special hospital detained patients*	May not be withheld from the patient.	May be withheld from Post Office if addressee has requested this in writing.
▪ *Special hospital detained patients*	May be withheld from the patient if the managers consider that it is necessary to do so in the interests of his safety or for the protection of other persons	May be withheld from Post Office if (a) addressee has requested this in writing; or (b) the managers consider that it is likely to cause danger to some person, or is likely to cause distress to the addressee or to a person other than a member of staff at that hospital.

Incoming correspondence of detained patients

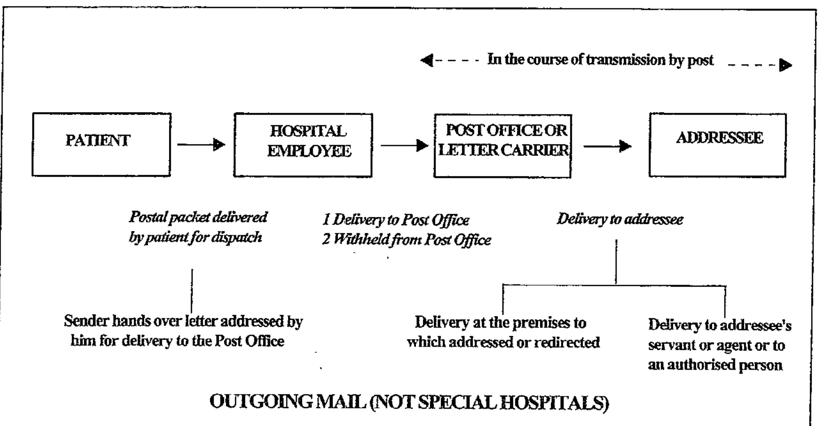
The Act does not empower the managers to withhold incoming postal packages from a detained patient who is not detained at a special hospital. In practice, some hospitals do not deliver magazines with a sexual content and the authority for this, if any exists, is presumably to be found at common law.

Incoming correspondence of patients detained in a special hospital

A postal packet addressed to a patient detained in a special hospital may be withheld from him if, in the opinion of the hospital managers, it is necessary to do so in the interests of his safety or for the protection of other persons.[260] The managers may open and inspect a postal packet for the purpose of determining whether it is, or it contains, some communication of the such a kind and in order to determine whether the packet should be withheld.[261] If a postal packet, or some item within it, is withheld from the patient, both he and the item's sender (if known) must be notified within seven days. Either, or both of them, may then require the Commission to review the decision.

Outgoing correspondence of detained patients

A postal packet "addressed to any person by a (detained) patient ... and delivered by the patient for dispatch" may be withheld from the Post Office if the addressee has requested that communications addressed to him by the patient should be withheld.[262]



Any such request must be made by a notice in writing to the hospital managers, the registered medical practitioner in charge of the treatment of the patient, or the Secretary of State.[263] In relation to this power, the hospital managers may only open a postal packet for the purpose of determining whether there is within it a written communication to a person who has given such a notice.[264] Where a postal packet, or a letter contained in it, is withheld, the hospital managers must record that fact in writing.[265] However, on the assumption that such a notice was given by the addressee, there is no need to give notice to the patient that his letter has been withheld from the Post Office and no appeals procedure.[266] Because the Post Office has a duty to deliver to the addressee mail in the course of transmission by post, the

260 Mental Health Act 1983, s.134(2).
261 *Ibid.*, s.134(4).
262 *Ibid.*, s.134(1)(a).
263 *Ibid.*, s.134(1).
264 *Ibid.*, s.134(4).
265 *Ibid.*, s.134(5).
266 There is no statutory requirement to notify the patient that a letter has been withheld or that an addressee has given notice under section 134.

1983 Act therefore provides an addressee with the means of avoiding a...essing or unwanted communications being delivered to and by the Post Office.

Outgoing correspondence of patients detained in a special hospital

A postal packet delivered by a special hospital patient for dispatch may *also* be withheld from the Post Office if the hospital managers consider that it is likely to cause danger to some person, or is likely to cause distress to the addressee or to a person other than a member of staff at that hospital.[267] The managers may open and inspect any postal packet for the purpose of determining whether there is within it a communication of such a kind and in order to determine whether the packet should be withheld.[268] If a postal packet, or some item within in, is withheld from the Post Office then the patient, but not the intended recipient, must be notified of this within seven days. The patient may then require the Commission to review the decision.

Special hospitals appeals procedure

Where a postal packet or anything contained in it is withheld *(cf. opened)* under section 134, the managers must record that fact in writing.[269] Unless the item was withheld from the Post Office at the addressee's request, the managers must, within seven days, give written notice that the item has been withheld. This notice must be served on the patient and, in the case of incoming post, the sender also (if known).[270] The notice must contain a statement of their right to apply to the Commission and of that body's powers to direct that the item not be withheld, as set out in section 121(7) and (8).[271] Within six months of the receipt of the statutory notice, the patient or sender of the postal packet may apply to the Commission for it to review the decision to withhold the postal packet (or anything contained in it). The Commission is then required to conduct such a review.[272]

Determination of the application

For the purpose of determining such an application, the Commission may direct the production of such documents, information and evidence as it may reasonably require.[273] The Commission may direct that the postal packet, or anything contained in it, shall not be withheld and the managers must comply with such a direction.[274]

267 Mental Health Act 1983, s.134(1)(b). Certain privileged correspondence, whether incoming or outgoing, cannot be withheld from the Post Office or from a special hospital patient. This comprises correspondence passing between a special hospital patient and any of the following persons or bodies: a Minister of the Crown; a Member of either House of Parliament; the Master or any other officer of the Court of Protection; any of the Lord Chancellor's Visitors; the Parliamentary Commissioner for Administration, the Health Service Commissioner for England, the Health Service Commissioner for Wales or a Local Commissioner within the meaning of Part III of the Local Government Act 1974; a Mental Health Review Tribunal; a health authority within the meaning of the National Health Service Act 1977; a local social services authority; a Community Health Council; a probation committee; the managers of the hospital in which the patient is detained; any legally qualified person instructed by the patient to act as his legal adviser; the European Commission of Human Rights or the European Court of Human Rights: MHA 1983, s.134(3).

268 *Ibid.*, s.134(4).

269 *Ibid.*, s.134(5).

270 *Ibid.*, s.135(6).

271 *Ibid.*, s.134(6).

272 *Ibid.*, s.121(7).

273 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.18(3).

274 *Ibid.*, s.121(8).

Redirecting and readdres...g mail

It is sometimes claimed that a patient's letter becomes the property of the addressee at the time it is handed to hospital staff, to be disposed of by the addressee as the latter thinks fit. This cannot be so. If a person hands a letter to his spouse to post, it remains the sender's property until it is delivered to the Post Office. So, in the English case of *R. v. Harley* (1843) 1 Car. & Kir. 89, the theft of a bank note from a letter prior to its delivery to the post office was held to be a theft from the sender of the letter, not from the addressee. Furthermore, it may not be possible to deliver some letters. Mailable matter only becomes the property of the person to whom it is addressed when it is deposited in the Post Office although, for other purposes, it may be the property of the Postmaster-General.[275] Because a letter remains the patient's property prior to its delivery to the Post Office, it can only be readdressed, or redirected, by or with the sender's consent. After posting, the Post Office may redirect it in accordance with its statutory scheme and, after delivery to the specified address, any new occupier may readdress it, if the addressee has moved. Although section 134 does not prohibit the redirection of mail, this misses the point, which is that it does not authorise such an interference with the property and rights of another person. A postal packet *"addressed ... by a patient ...* and delivered by the patient for dispatch" may only be withheld from the Post Office if the addressee has requested that communications addressed to him by the patient should be withheld.[276] To this extent, section 134 releases the managers from their general duty to deliver post to the Post Office, but it does not authorise them to readdress or redirect letters not withheld. Furthermore, no addressee has any power to authorise a third party to redirect a person's correspondence prior to its dispatch; only the Post Office may redirect a person's mail in the limited circumstances set out in the post office statutory schemes. As indicated in the White Paper of 1978, mail withheld at an addressee's request (being and remaining the patient's property) should be returned to the patient, who is otherwise entitled to assume that his mail is not being intercepted or interfered with in any way. To summarise, it is for the sender to decide to whom to address his letter and to what address to send it.

INFORMAL PATIENTS

Section 121(4) provides that the Secretary of State may direct the Commission "to keep under review the care and treatment, or any aspect of the care and treatment, in hospitals and mental nursing homes of patients who are not liable to be detained under this Act." No such direction has yet been given and, consequently, the Commission has no power to visit informal patients, or patients subject to guardianship or after-care under supervision. Nor may it investigate complaints made by or in respect of them. It is, however, noteworthy that, when the 1982 Bill was before Parliament, the Minister of Health suggested that the Commission's remit could be extended to informal patients at a particular hospital, rather than extended to all informal patients:[277]

> "The Commission could ask the Secretary of State for permission to look at some informal cases and the Secretary of State might give his consent for members of the Commission to exercise, for that hospital, the powers (in section 120(4))"

275 See *R. v. Wendland* (1970) 1 C.C.C. (2d) 382 (Can).

276 Mental Health Act 1983, s.134(1)(a).

277 The Minister of Health (Rt. Hon. Kenneth Clarke, M.P.), House of Commons Special Standing Committee, *Hansard*, 17 June 1982, col. 575.

MENTAL HEALTH REVIEW TRIBUNALS

Mental Health Review Tribunals are independent judicial bodies originally established under the Mental Health Act 1959 but now constituted under the Mental Health Act 1983. The hallmarks of a tribunal have been summarised as independence of administration; the capacity to reach a binding decision (which distinguishes them from inquiries); the fact that decisions are reached by a panel of members (often three), rather than by a single judge; a procedure similar to but simpler than that of a court; and permanent existence usually confined to a special type of case.[278] Mental Health Review Tribunals exhibit all these features and their statutory purpose is to review the cases of individuals subject to detention, guardianship or supervision under the Mental Health Act 1983. The proceedings involve "a complex equation of conflicting components all of which tend to give rise to grave public concern, namely the liberty of the subject, the protection of the public and the interests of the patient."[279]

HISTORICAL ORIGINS

The history of Mental Health Review Tribunals can be traced back to two official reports published in 1957.

Franks Report of 1957

The Franks Committee addressed the issue of administrative justice and the work of tribunals. Most statutory tribunals were regarded as specialised courts, the typical statutory tribunal exercising functions essentially judicial in character but of a specialised nature. The cardinal point in all cases was that Parliament has deliberately provided for a decision outside and independent of any Department concerned.[280] Nevertheless, the necessity for administrative justice should not lead to the creation of tribunals for their own sake when the ordinary courts could well take the decisions in question: a "decision should be entrusted to a court rather than to a tribunal in the absence of special considerations which make a tribunal more suitable."[281] It was in the context of this developing tribunal system that the decision was taken to depart from the Lunacy Act principle that decisions affecting individual liberty should be predetermined judicially, and be reviewable instead by a specialised tribunal held after the event.

Percy Report of 1957

The Percy Commission of 1954–57 reviewed the law relating to mental illness and mental deficiency and many of its recommendations were subsequently implemented in the Mental Health Act 1959.[282] Some of these provisions were later revised by the Mental Health (Amendment) Act 1982, although the underlying framework remained unchanged. The present statute is largely a consolidating Act. Prior to 1959, the order of a justice of the peace, or other judicial authority, was

278 J.F. Garner and B.L. Jones, *Administrative Law* (Butterworths, 6th ed., 1985), p.230.
279 *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, May 1995), Appendix 13.
280 *Report on Administrative Tribunals and Enquiries*, Cmnd 218 (1957), p.9.
281 *Ibid.*
282 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).

generally necessary before a person could be compulsorily admitted to hospital or received into guardianship. The Royal Commission advocated the repeal of these certification procedures. In their place, it recommended that a person's detention or reception into guardianship should be authorised if an application made by the patient's nearest relative or a specialist mental welfare officer, and supported by two medical recommendations, was accepted by the hospital to which admission was sought or, in the case of guardianship, by the social services authority concerned.[283] Because the proposed procedures did not involve any judicial body, the Commission recommended that if a patient then desired a formal review of the justification for his detention to be formally reviewed, rather than merely to apply to the hospital's own management committee or the local authority for it to exercise its power of discharge, this need should be met by the establishment of a new independent review body.[284] Their establishment would give patients opportunities to have the justification for the use of compulsion investigated by a strong independent body consisting of both medical and non-medical members.[285] The functions of such a tribunal would be to review the continuing need for compulsion.[286]

CONSTITUTION AND ADMINISTRATION

Section 3(1) of the Mental Health Act 1959 established a Mental Health Review Tribunal for each National Health Service region for the purpose of dealing with applications and references made by and in respect of patients under the provisions of that Act. Section 65(1) of the 1983 Act now provides that there shall be one tribunal for each region of England and one tribunal for Wales, the English regions being determined by order of the Secretary of State.[287]

The regions

There are currently eight National Health Service regions in England and The Mental Health Review Tribunals (Regions) Order 1996 provides for eight English tribunals, each of which covers one of these regions.[288]

283 "We consider that a sufficient consensus of medical and non-medical opinion on the need to compel a patient to accept hospital or community care would normally be provided through (an) application for the patient's admission made by a relative or mental welfare officer, ... two supporting medical recommendations, the acceptance of the patient as suitable for the form of care recommended, and the continuing power of discharge vested in the nearest relative, the hospital or local authority medical staff, the members of the hospital management committee or local authority, and the Minister of Health. To refer the application and medical recommendations to a justice of the peace before the patient's admission would not in our view provide a significant additional safeguard for the patient ..." *Ibid.*, p.148.
284 *Ibid.*, pp.48–149
285 *Ibid.*, p.12.
286 "We should make it clear that these review tribunals would not be acting as an appellate court of law to consider whether the patient's mental condition at the time when the compulsory powers were first used had been accurately diagnosed by the doctors signing the recommendations, or whether there had been sufficient justification for the use of compulsory powers at that time, nor to consider whether there was some technical flaw in the documents purporting to authorise the patient's admission ... The review tribunal's function would be to consider the patient's mental condition at the time when it considers his application, and to decide whether the type of care which has been provided by the use of compulsory powers is the most appropriate to his present needs, or whether any alternative form of care might now be more appropriate, or whether he could now be discharged from care altogether." *Ibid.*, pp.150–151.
287 Mental Health Act 1983, s.65, as amended by Health Authorities Act 1995, s.2 and Sched. 1, Pt. III, para. 107(6).
288 The Mental Health Review Tribunals (Regions) Order 1996, S.I. 1996 No. 510. The order came into force on 1 April 1996, together with the Health Authorities Act 1995.

THE MENTAL HEALTH REVIEW TRIBUNALS

Tribunal	Area	Office
South Thames	East Sussex, Kent, Surrey, West Sussex; London boroughs situated south of the River Thames.	London South Office, Hinchley Wood, Block 3, Crown Offices, Kingston-By-Pass Road, Surbiton, Surrey KT6 5QN. Tel.: 0181 398 4166. Fax 0181 339 0709.
South & West	Cornwall and the Isles of Scilly, Devon, Dorset, Gloucestershire (including the City of Bristol and the county of South Gloucestershire); Hampshire and the Isle of Wight; Somerset (including the counties of Bath and North-East Somerset and North-West Somerset); Wiltshire.	
North Thames	Essex and Hertfordshire; London boroughs situated north of the River Thames, including the Cities of London and Westminster and the Inner Temple and Middle Temple	London North Office, Canons Park, Government Buildings, Honeypot Lane, Stanmore, Middlesex HA7 1AY. Tel: 0171 972 2000. Fax 0171 972 3731.
Anglia & Oxford	Bedfordshire, Berkshire, Buckinghamshire, Cambridgeshire, Norfolk, Northamptonshire, Oxfordshire; Suffolk.	
Trent	The counties of Derbyshire (except those wards in the borough of High Peak within the North West Region), Leicestershire, Lincolnshire, North-East Lincolnshire, North Lincolnshire, Nottinghamshire and South Yorkshire.	Nottingham Office, Spur A, Block 5, Government Buildings, Chalfont Drive, Western Boulevard, Nottingham NG8 3RZ. Tel: 0115 9294222. Fax 0115 9428308.
Northern & Yorkshire	Cumbria (except the districts of Barrow-in-Furness and South Lakeland), Durham, East Riding of Yorkshire, Hartlepool, the City of Kingston-upon-Hull, Middlesborough, Northumberland, North Yorkshire, Redcar and Cleveland, Stockton-on-Tees, Tyne and Wear, West Yorkshire, York.	
North West	The counties of Cheshire, Greater Manchester, Lancashire and Merseyside; in the county of Cumbria, the districts of Barrow-in-Furness and South Lakeland; and in the county of Derbyshire, in the borough of High Peak, the wards of All Saints, Gamesley, St. Andrew's, St. Charles, St. Jane's, St. John's, Simmondley and Tintwistle.	Liverpool Office, Cressington House (3rd Floor), 249 St Mary's Road, Garston, Liverpool, Lancs L19 0NF. Tel: 0151 494 0095. Fax 0151 270133.
West Midlands	Hereford and Worcester, Shropshire, Staffordshire, Warwickshire, West Midlands.	
Wales	Wales.	MHRT for Wales, 1st Floor, Crown Buildings, Cathays Park, Cardiff CF1 3NQ. Tel: 01222 825111. Fax 01222 823117.
Special hospital cases,	*Applications and references concerning patients detained at Ashworth Hospital are dealt with by the Liverpool office; those concerning Rampton Hospital patients by the Nottingham office, and those concerning Broadmoor patients by the Hinchley Wood (London South) office.*	

Administrative support

In the exercise of their statutory functions, tribunals are independent of any government department or Health Authority. However, the 1983 Act places a duty on the Secretary of State for Health to provide each tribunal with officers and servants and such accommodation as they may require.[289] The Secretariat for the eight English tribunals is provided by the Department of Health and there are four regional offices, each of which serves two tribunals. Each office is managed by a Higher Executive Officer — known as the Clerk to the Tribunal — supported by a number of Executive Officers, Administrative Officers and Assistant Administrators. Central management responsibility for the various tribunal offices is held by the Grade 7 Principal of the Department of Health's Health Care (Administration) 5 Branch [HC(A)5]. This principal, who is also responsible for the department's forensic psychiatric services policy, oversees the tribunal budget, co-ordinates the appointment and reappointment of members, and provides executive and administrative support for meetings of the regional chairmen. The Mental Health Review Tribunal for Wales is based in Cardiff and is staffed by Welsh Office officials. Although tribunal clerks are answerable to the regional chairman for the administration of the tribunal, management responsibility for their actions lies with the Department of Health and the Welsh Office.

Financial arrangements

The Act also provides that the Secretary of State (for Health) may defray the expenses of tribunals and pay tribunal members such remuneration and allowances as he, with the consent of the Treasury, determines.[290] Payment is presently made according to daily and half-daily rates together with subsistence allowances. The legal and medical members' fees are broadly equivalent, those of the lay members being approximately 40 per cent. of the rate payable to the other members. Regional chairmen receive an additional retainer. The tribunal budget for 1994/95, excluding a small capital sum of £10,629, is given below.

COSTS OF TRIBUNALS (1994/95)

Type of expense	*England* (£)	*Wales* (£)	*Combined* (£)
Members fees and expenses	4,417,000	210,000	4,627,000
Secretariat staff costs	926,150	102,076	1,028,226
Other running costs	175,054	6,805	181,859
Total costs	5,518,204	318,881	5,837,085

Source : Mental Health Review Tribunals for England and Wales, Annual Report 1994, Department of Health, London, May 1995, p.28.

289 See Mental Health Act 1983, s.65(4).
290 Section 65(4), which is in identical terms to Mental Health Act 1959, s.3(4).

MEMBERSHIP

The Act states that the provisions of Schedule 2 shall have effect with respect to the constitution of Mental Health Review Tribunals.[291] Paragraph 1 of the schedule provides that each of the regional tribunals shall consist of a number of legally qualified members, a number of medical practitioners, and a number of other persons with suitable experience. Members may be assigned to two or more regional tribunals, in addition to which a member may occasionally sit outside his named region as the need arises.[292] Members hold office under the terms of the instrument under which they are appointed. Appointments are usually for a fixed term of three years, renewable at the discretion of the Lord Chancellor. There is an upper age limit on first appointment of 62 and an upper age limit on reappointment of 70. The duties of the regional chairmen include making recommendations on the appointment and reappointment of all tribunal members while the Council on Tribunals may make "general" recommendations to Ministers about appointments to membership. The Department of Health requests a short curriculum vitae when a member's term of appointment is due to expire. The Lord Chancellor may terminate a member's appointment and members may resign office by notice in writing to the Lord Chancellor. Any member who ceases to hold office is eligible for re-appointment. The membership of the regional tribunals as at 31 December 1994 is given below and the number of legal members includes the regional chairman. There were 432 members in all.

MEMBERSHIP OF MENTAL HEALTH REVIEW TRIBUNALS

Tribunal	*Chairman*	*Legal*	*Medical*	*Lay*
▪ *Anglia & Oxford*	Her Honour Judge Norwood	6	12	20
▪ *North West*	Mr W Greenwood	21	29	31
▪ *North Thames*	Mr M Christie	14	13	23
▪ *Northern & Yorkshire*	Mr G Scott	11	18	10
▪ *South & West*	Miss R Hare QC	15	19	22
▪ *South Thames*	His Honour Judge H Palmer	20	13	22
▪ *Trent*	Professor Sir John Wood	8	17	10
▪ *West Midlands*	Mr P Turner	11	12	12
▪ *MHRT for Wales*	His Honour Judge G Jones	9	24	10
		115	157	160

291 Mental Health Act 1983, s.65(3).
292 See Mental Health Act 1983, s.65(2), Sched. 2, para. 5.

LEGAL MEMBERS

The Act provides that each of the regional tribunals shall consist of a number of legal members appointed by the Lord Chancellor and having such legal experience as the Lord Chancellor considers suitable.[293] The Lord Chancellor's Department now advertises for, and formally interviews, prospective legal members to establish their suitability for appointment. In proceedings involving a restricted patient the legal member must be chosen from a panel of legal members approved by the Lord Chancellor to hear such cases.[294]

Administration of judicial appointments

The Lord Chancellor is assisted by the Judicial Appointments Group which has published guidance on appointments to tribunals.[295] The guidance refers to some of the factors taken into account during the recruitment process, such as the candidate's knowledge and experience of the field, his age, health, and character. For each candidate there is a correspondence file and a separate series of notes of the main facts and opinions received about him. Comments from third parties on a candidate's professional and personal suitability for judicial appointment are strictly confidential. To the extent that such information has been computerised, it is exempt from the access provisions in the Data Protection Act 1984. This is because the Lord Chancellor depends "heavily on being given frank and honest opinions about the judicial potential of candidates for office and for this reason it has always been understood that such advice is given in strict confidence."[296] No other part of the system is confidential[297] and the Lord Chancellor's Department accepts that the appointments process should where possible be open to public scrutiny.[298] While the confidentiality of information received from third parties "sometimes gives rise to anxiety that there is an undisclosed black mark against a candidate, ... this is hardly ever the case and a member of the appointments team is always willing to meet a candidate who wishes to know the position and explain it frankly."[299]

Knowledge and experience

According to the guidance, "it is an advantage for candidates to have some knowledge of a tribunal's field of law and procedure but that is not always essential ... candidates are not required to have an extensive knowledge of mental health law although experience is helpful."[300] In practice, it is quite rare for legal members to have a prior knowledge of mental health law or practice and this is perhaps the most frequent criticism of the appointments process.

Candidate's age

The only statutory requirement is that appointees have such legal experience as the Lord Chancellor considers suitable. While legal membership of most statutory tribunals is restricted by statute to solicitors or barristers who have attained a certain

293 Mental Health Act 1983, s.65(3), Sched. 2, para. 1(a).
294 *Ibid.*, s.78(4)(a); Mental Health Review Tribunal Rules 1983, r. 8(3).
295 *Judicial Appointments: The Lord Chancellor's Policies and Procedures* (H.M.S.O., 2nd ed., November 1990).
296 *Ibid.*, p.2.
297 *Ibid.*
298 *Ibid.*, p.4.
299 *Ibid.*, p.27.
300 *Ibid.*, pp.22–23.

minimum age, and have practised professionally for a prescribed number of years, no such formal requirement applies to Mental Health Review Tribunals. However, the Lord Chancellor's policy is that a nominee is "never" considered suitably experienced unless he is aged 35 years or over and has been practising for seven years or more since qualifying.

Candidate's Health

The candidate must satisfy the Lord Chancellor that his health is satisfactory. In some cases a candidate is examined by the Medical Adviser while in others he is asked to arrange for his doctor to submit a report. The guidance does not indicate what view is taken by the Lord Chancellor if a candidate has a history of mental health problems.

Character

Checks are made to confirm that candidates do not have criminal records and further checks are made with the Inland Revenue and HM Customs and Excise to ensure that there have been no past "difficulties" over the payment of tax or VAT.

Functions

The legal member's statutory function is simply to preside at hearings and, as a member of the tribunal, to hear and determine the application or reference in accordance with the law. In more practical terms, the legal member's principal functions, as set out in the job description, are[301] —

- To read the papers received from the tribunal office prior to the hearing and, if necessary, to discuss with the tribunal office the need for any additional reports or information, seeking where necessary a direction from the regional chairman.

- To preside at the hearing and to advise the other members of the tribunal on matters of law, especially with regard to the tribunal's powers and the application of the statutory criteria. As to this, the job description states that presidents "should note that no decisions are reserved to them by the rules and that each member of the tribunal is entitled to an equal voice on matters of law, procedure and substance."[302]

- To meet the other members of the tribunal approximately half an hour before the commencement of the actual hearing in order to discuss and agree preliminary matters.

- At the commencement of the actual hearing, to introduce the members of the tribunal to the patient and to the other persons present and to explain that they are independent; to explain the manner of proceeding which the tribunal proposes to adopt and, in appropriate cases, the tribunal's powers.[303]

301 See "Legal Member's Job Description" in *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), Appendix 13.

302 The alternative interpretation is that the president should determine points of law, since he is by definition presiding over the hearing and, inter alia, responsible for ensuring that it is lawfully conducted.

303 See Mental Health Review Tribunal Rules 1983, r.22(3).

- To ensure that the proceedings are conducted in a fair and impartial manner, avoiding inappropriate formality, excessive length and generally seeing that the tribunal is managed well.

- To take a note of the proceedings.

- At the conclusion of the evidence, to ensure that the tribunal members together deliberate on all relevant matters in addressing the statutory criteria and reaching the tribunal's decision. As to this, the job description states that "once the decision has been agreed the President should draft the reasons therefor, taking into account the contributions of the other members, and should record and sign the decision which has been reached."[304]

- To inform the patient how and when the decision will be communicated to him.[305]

MEDICAL MEMBERS

The Act provides that each of the regional tribunals shall consist of a number of medical members, being registered medical practitioners appointed by the Lord Chancellor after consultation with the Secretary of State for Health or the Secretary of State for Wales.[306] In practice, medical members are invariably consultant psychiatrists or retired consultants. The current practice is for prospective medical members to be interviewed by the appropriate regional chairman and the Clerk to the Tribunal. Their recommendations are then considered by the Department of Health or the Welsh Office before being forwarded to the Lord Chancellor's Department.

Functions

The medical member's principal functions, as set out in the job description, are[307] —

- To conduct a preliminary examination of the patient prior to the hearing and to take such steps as he considers necessary to form an opinion of the patient's mental condition. These steps should include reference to hospital documentation and discussions with hospital staff.[308]

- To inform the tribunal office of any potential problems arising out of the preliminary examination which might affect the hearing procedures, and if necessary refer back to the regional chairman on any matter which he believes requires a preliminary direction.

- To advise the tribunal office, at its request, with regard to the withdrawal of applications, the need for legal representation and similar matters. To inform

304 See Mental Health Review Tribunal Rules 1983, r.23(2).

305 See *ibid.*, r.24(1).

306 Mental Health Act 1983, s.65(3), Sched. 2, para. 1(b).

307 "Medical Member's Job Description" in *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), Appendix 13.

308 See Mental Health Review Tribunal Rules 1983, r.11.

the tribunal office if he discovers at the preliminary examinat... that the patient is not legally represented.[309]

- To consider the possibility of any conflict of interest arising from any former contact with the patient and to notify the tribunal office accordingly.[310]

- To report to the other members of the tribunal, when requested, of his preliminary examination and to advise and explain terminology and technicalities as necessary.

- To meet the other members of the tribunal approximately half an hour before the commencement of the actual hearing in order to discuss and agree preliminary matters (**805**).

- To put questions to each of the witnesses who give evidence at the hearing as he considers relevant. As to this, the job description states, "In particular, the medical member may consider it appropriate to question the RMO (responsible medical officer) in relation to the patient's history, progress, treatment, prognosis and future care, although he must bear in mind that the hearing is not a seminar nor a case conference. In appropriate cases he may lead the questioning of the RMO if this has been agreed beforehand with the other members of the tribunal. However, he must appreciate that he performs a dual role at the tribunal as a fact-finder and as a decision-maker and it is therefore essential that his opinion of the patient's mental condition, if it differs significantly from that of the RMO, should be made known to everyone in the course of his questioning. Thus a situation will be avoided where the members of a tribunal are acting on the basis of evidence known only to themselves, which would, of course, be a breach of a fundamental principle of natural justice and likely to invalidate the decision."

- At the conclusion of the evidence, to participate in the members' discussion so as to enable a decision to be reached, and to contribute as appropriate to the drafting of the record of the decision and of the reasons therefor.

LAY MEMBERS

The Act provides that each of the regional tribunals shall consist of a number of persons appointed by the Lord Chancellor, after consultation with the Secretary of State for Health or the Secretary of State for Wales, who have such experience in administration, such knowledge of social services or such other qualifications or experience as the Lord Chancellor considers suitable.[311] These members are known by custom as the tribunal's "lay members." The relevant regional chairman and the clerk to that tribunal interview prospective lay members and their recommendations are then considered by the Department of Health or the Welsh Office before being forwarded to the Lord Chancellor's Department.

309 See Mental Health Review Tribunal Rules 1983, rr.10 and 19.
310 See Mental Health Review Tribunal Rules 1983, r.8(2)(c).
311 Mental Health Act 1983, s.65(3), Sched. 2, para. 1(c).

Suitable experience

The general approach as to what constitutes suitable experience is summarised in the most recent annual report on the work of tribunals—

> "Lay members need reasonable familiarity with health and social services to enable them to understand why the patient is appealing, what they have experienced in hospital, and what community facilities and social supports might be available to a patient on discharge. Lay members should preferably have some interest in or experience of mental health and/or learning disability. This may have come through membership of a mental health voluntary organisation, being a hospital visitor or befriender, or from life/work experience which brings them into contact with a range of people — for example through being a magistrate, teacher, trade union official, managing a business or being involved in local government or charitable organisations. In practice 'lay' might be thought a misnomer in relation to the present Tribunal lay members who include mental health professionals, hospital administrators, social workers and nurses."[312]

Functions

The lay member's statutory function is simply to act as a member of a tribunal hearing and determining an application or reference by or in respect of a patient. The rationale for including an informed member of the general public in the decision-making process is that any consideration of whether a particular member of society is mentally disordered, and whether his detention is justified or necessary to protect other members of society, is not exclusively a question for lawyers and medical practitioners to determine alone (**1016**). The lay member therefore represents the view of the informed public, the responsible lay person, and his principal functions as set out in the job description are[313] —

- To acquire a basic understanding of the legal framework determining detention, discharge and the powers of the tribunal and some knowledge of health and social services systems.

- To read and consider any papers received from the tribunal office prior to the hearing with a view to ascertaining the main features of the patient's history and the reasons for his detention.

- To consider the possibility of any conflict of interest due to any former contact with the patient and to notify the tribunal office or, as the case may be, the other tribunal members accordingly.

- To meet the other members of the tribunal approximately half an hour before the commencement of the actual hearing in order to discuss and agree preliminary matters (**805**).

- To put such questions to each of the witnesses who give evidence at the hearing as may be relevant and, in appropriate cases, to lead the questioning

312 *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), p.10.
313 "Lay Member's Job Description" in *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), Appendix 13.

of the social worker if this has been agreed beforehand w: he other members of the tribunal.

- At the conclusion of the evidence, to participate in the members' discussion so as to enable a decision to be reached, and to contribute as appropriate to the drafting of the record of the decision and of the reasons therefor — "In reaching such a decision the lay member is entitled to an equal voice with the other members of the tribunal on all questions of law, procedure and substance."

REGIONAL CHAIRMEN

The 1983 Act provides that one of the legal members of each regional Mental Health Review Tribunal shall be appointed by the Lord Chancellor as its chairman.[314] The statutory functions of the regional chairmen are to exercise the tribunal's powers as regards the preliminary and incidental matters specified in the rules (777) and to appoint members for particular tribunal hearings. If "for any reason" the chairman is "unable to act" he may appoint another legal member to exercise his functions.[315] The chairmen meet together regularly to consider issues of policy and practice and, perhaps surprisingly given their status as independent judicial bodies, representatives from the Home Office also attend these meetings. The chairmen's various non-statutory duties include the following[316] —

- To be responsible for the administration of the regional tribunal in conjunction with the staff of the tribunal office.
- To preside at a number of hearings so as to acquire a broad experience of members and current issues.
- To provide guidance to members whenever appropriate on preliminary and incidental matters, hearing procedures, including decision making, manner of questioning of witnesses and good practice generally.
- In co-operation with the staff of the tribunal office to organise meetings, conferences and training for members.
- To interview candidates for membership, to assess their suitability and to advise the Department of Health and the Lord Chancellor's Department accordingly.

314 Mental Health Act 1983, s.65(3), Sched. 2, para. 3. Some other tribunals — such as the Social Security, Medical, Vaccine Damage, Disability Appeal and Child Support Appeal Tribunals — have a national President rather than a number of regional chairman. Mental health review tribunals have in the past been criticised, notably by Peay, for inconsistency in their interpretation of their functions, in practice, and in decision-making. At the beginning of the 1990s, the Department of Health Management Consultancy Unit Review of the MHRT Secretariat recommended discussions with the Lord Chancellor's Department concerning the appointment of a national President for MHRTs with a view to ensuring greater consistency in national policy: see His Honour Judge Holden, "Presidential System In Relation To Tribunals" in *Members' Newsheet*, Issue 9 (1992).

315 Mental Health Act 1983, ss.65(3) and 78(6) and Sched. 2, para. 4; Mental Health Review Tribunal Rules 1983, r.2(1).

316 "Role of the Regional Chairman" in *Mental Health Review Tribunals for England and Wales, Annual Report 1994* (Department of Health, 1995), Appendix 13.

- To advise the Depart t of Health and the Lord Chancellor's Department on the suitability of meɯbers for re-appointment.
- To monitor the performance and usage of members in his region by, for example, attending tribunal hearings as an observer.
- To meet other regional chairmen regularly in order to devise and agree national policies.
- As necessary to liaise with other agencies, such as health authorities and The Law Society, and provide information on practical and procedural matters.

APPOINTMENT OF MEMBERS IN A PARTICULAR CASE

The members who are to constitute a Mental Health Review Tribunal in a particular case are appointed by the chairman of the tribunal or, if for any reason he is unable to act, by another member of the tribunal appointed for the purpose by the chairman. Of the members so appointed one or more shall be appointed from the legal members; one or more shall be appointed from the medical members; and one or more shall be appointed from the lay members.[317] A member of a Mental Health Review Tribunal for one area may be appointed as one of the persons to constitute a tribunal for another area for the purposes of any proceedings or class or group of proceedings. Where this happens, he is deemed to be a member of that other Tribunal for the purposes of the proceedings for which he was appointed.[318] Where the regional chairman is included among the persons appointed, he is the president of the tribunal; and in any other case the president shall be the legal member or, if more than one of them has been appointed, such one as the chairman may nominate.[319] There is no statutory bar to the same President presiding over successive applications in respect of the same patient.[320] Notwithstanding the above, a tribunal almost invariably consists of three members, one appointed from each category, and it is exceptional for a tribunal to consist of four or more members.

Restricted cases

In any case involving a restricted patient, the president is chosen from a panel of legal members, comprising circuit judges or silk recorders, approved by the Lord Chancellor to hear such cases. For these purposes, the legal members are allocated to one of two regions, North or South. As at 31 December 1994, there were 20 legal members appointed to hear restricted cases in the Southern region, of whom five were Queen's Counsel and 15 Judges (one of whom was also a QC). There were 26 legal members appointed to hear restricted cases in the Northern Region, ten of whom were also QCs.

317 Mental Health Act 1983, s.65(3) and Sched. 2, para. 4; Mental Health Review Tribunal Rules 1983, rr.8 and 31.

318 Mental Health Act 1983, s.65(3) and Sched. 2, para. 5.

319 Mental Health Act 1983, s.65(3) and Sched. 2, para. 6.

320 See *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Mackman*, *The Times*, 2 June 1986. However, if a tribunal's decision is quashed and a new hearing directed, this will generally be before a differently constituted tribunal.

Although a Mental Health Review Tribunal is a court for most purposes, nevertheless its powers are more limited than those of most courts which are not also tribunals. Its powers are those prescribed by or under the statute and it has no inherent jurisdiction. So, for example, it has no jurisdiction to award costs against a party because neither that Act nor the tribunal rules provide for this.

Part V of the Mental Health Act 1983

Part V of the Mental Health Act 1983, which comprises sections 65 to 79, is concerned with Mental Health Review Tribunals, their constitution and powers, and certain related matters of similar importance. It is customary to note that the provisions are to be interpreted in the context of the statutory framework as a whole although this is something of a generalisation because the different Parts of the Act have their own frameworks. For example, the framework in relation to restricted patients admitted by order of the Crown Court — in respect of whom tribunals have no discretionary power of discharge or power to recommend leave or transfer — is manifestly different from that pertaining to persons admitted under Part II without any prior court order or judicial involvement. The general statutory presumption in favour of liberty therefore applies without qualification to the civil procedures, there being no judicial order authorising the citizen's detention. More generally, there is also a presumption that Acts of Parliament are not intended to derogate from the requirements of international law. This presumption has been relied upon to enable courts to have regard to the provisions of the European Convention on Human Rights as a means of restricting the operation of certain statutes.[321] As to the general rules of statutory construction—

- The literal rule states that courts are bound by the words of a statute where those words clearly govern and cover the situation before it and, in such cases, they must be applied with nothing added and nothing taken away. Recourse cannot be had to an earlier statute if the word in the Act in force is clear and unambiguous, and such references cannot be used to suggest or create an ambiguity where none exists.

- The approach to interpreting the fringe meaning of a word used in a statute is something of a legal fiction. The approach in practice tends to be to guess what meaning Parliament would have picked on had it thought of the point, and by reference also to considerations of convenience, social requirements, and accepted principles of fairness.

- The Latin maxim "*noscitur a sociis*" means that "a word may be known by the company it keeps." In construing a statutory provision, courts may look at the section as a whole, even the whole statute, and even at earlier legislation. Exceptionally, a word used twice within a single section has been interpreted as bearing two distinct meanings, *e.g.* the phrase "liable to be detained" in the 1983 Act.

321 See *e.g. ex p. Miah* [1974] 1 W.L.R. 694, *per* Lord Reid; *R. v. Home Secretary, ex p. Bhajan Singh* [1976] 1 Q.B. 207, *per* Lord Denning M.R.; *Ahmad v I.L.E.A.* [1978] Q.B. at p.48, *per* Lord Scarman.

- The "golden rule" (i[illegible]pretations necessary to avoid absurdity) allows the court to prefer a sensible meaning to an absurd if literally correct meaning, *e.g.* replacing "or" with "and," and the court may read in, ignore or alter a word in the statute being interpreted if not to do so would make the provision unintelligible, absurd, unworkable, totally unreasonable or totally irreconcilable with other provisions within the same Act. The need to apply the rule must, however, be clear-cut.

- The "mischief rule"[322] bids the courts to look at the position before the Act and the mischief that the statute was intended to remedy. The statute is then construed in such a way as to suppress the mischief and advance the remedy.

Mental Health Review Tribunal Rules 1983

The procedure for dealing with authorised applications or references is that set out in the Mental Health Review Tribunal Rules 1983 although, as with all tribunals, the rules must be applied in a way which accords with the basic principles of procedure known as the rules of natural justice or "fairness." Consequently, certain minimum standards of evidence and proof must be observed if justice is to be done.[323] The statutory authority for the rules derives from section 78 of the Act, which provides that the Lord Chancellor may make rules with respect to the making of tribunal applications and references, the proceedings of such tribunals and matters incidental or consequential thereto. Section 78(2) states that the rules may in particular provide for the matters specified in paragraphs (a) to (k) of that subsection. Paragraph (j) is drafted in general terms and empowers conferring on tribunals such ancillary powers as the Lord Chancellor thinks necessary for the purposes of exercising their statutory functions. The rules may be so framed as to apply to all applications or references or instead make different provision for different cases.[324] In particular, they may prescribe the procedure to be adopted in cases concerning restricted patients.[325] The Lord Chancellor's power to make rules is exercisable by statutory instrument[326] and such statutory instruments are subject to annulment in pursuance of a resolution of either House of Parliament.[327] The Council on Tribunals must be consulted before any such rules are made. Subject to these same conditions and limitations, the Lord Chancellor may revoke or amend the rules.[328]

322 The Rule in *Heydon's Case* (1584) 3 Co. Rep. at 7b.
323 See *e.g. R. v. Deputy Industrial Injuries Commissioner, ex p. Moore* [1965] 1 Q.B. 456.
324 Mental Health Act 1983, s.78(5).
325 *Ibid.*, s.78(4).
326 *Ibid.*, s.143(1).
327 *Ibid., s.143(2).* This form of Parliamentary control is known as the "negative procedure." The statutory instrument is laid before the House after it is made and during the following forty days is subject to being made void by a resolution of either the House of Commons or House of Lords. During this period, the document is scrutinised by a committee of both Houses called the Joint Committee on Statutory Insuments. The committee may draw Parliament's attention to certain technical defects, including defects in drafting, but not challenge the merits of or policy behind the instrument. The alternative form of Parliamentary control known as the "affirmative procedure" requires that a draft of the statutory instrument is first approved by a resolution of each House of Parliament. The affirmative procedure applies to orders made under s.68(4) or s.71(3), *i.e.* it does not extend to the tribunal rules made under s.78.
328 See Interpretation Act 1978, s.14.

Exercise and interpretation of the rules

The tribunal rules are a form of "subordinate legislation."[329] Unless a contrary intention appears, words in a statutory instrument which repeat those used in the Act from which its authority derives should be given a construction identical with that of the statute.[330] The rules are also to be construed (1) so as to be reconciled with the plain terms of the Act under which they are made and, in cases of inconsistency, the subordinate legislation must give way; (2) in accordance with the ordinary meaning of language and, as regards words specially defined, in accordance with the meaning of the definitions similarly construed; and (3) sensibly, in order to give effect to the intention so far as it can be ascertained from the words. Subject to minor exceptions, the provisions in the Interpretation Act 1978 apply "so far as applicable and unless the contrary intention appears."[331] Thus, unless the contrary intention appears, (1) expressions used in the rules have the meaning which they bear in the Act; (2) words importing the masculine gender include the feminine and vice-versa and, similarly, words in the singular include the plural and vice-versa; (3) where a power is conferred or a duty imposed by the rules, it is implied that the power may be exercised or the duty performed from time to time as occasion requires and, if imposed on the regional chairman, that it may be exercised or performed by the present holder of that office. Practice notes provided by the Department of Health for the assistance of officials concerned in the administration of a statute are inadmissible for the purpose of construing a statute and presumably also inadmissible as concerns the construction of statutory instruments.

THE SUPERVISION OF TRIBUNALS

The way in which a tribunal exercises its functions in a particular case is reviewable by the High Court while the way in which they discharge their functions generally is subject to supervision by the regional chairmen, the Council on Tribunals and the Mental Health Act Commission.

Judicial control

A tribunal's decision in any particular case is subject to judicial review by the High Court where it is alleged that its decision was reached unlawfully. Likewise, a tribunal may be required to state a point of law for determination by the High Court if its decision rests on an interpretation of some point of law which is disputed by one of the parties or, in a restricted case, by the Secretary of State.

The Council on Tribunals

Statutory tribunals are subject to supervision by the Council on Tribunals, which was originally established by the Tribunals and Inquiries Act 1958 and is now constituted under the Tribunals and Inquiries Act 1992. The Council is essentially an advisory body and it has no rule-making or decision-making powers. The general functions of the Council, as set out in section 1(1) of the Tribunals and Inquiries Act 1992, and insofar as relevant, are to keep under review the constitution and working of tribunals such as Mental Health Review Tribunals; to report from time to time on their constitution and working; and to consider and report on such particular matters

329 Interpretation Act 1978, s.21.
330 *Ibid.*, s.11.
331 *Ibid.*, s.23. Any reference to an "enactment" in the 1978 Act includes an enactment comprised in subordinate legislation.

as may be referred to it [illegible] the Lord Chancellor. It may make "general" recommendations about app[illegible]ments to membership of Mental Health Review Tribunals and the tribunal rules may only be amended by the Lord Chancellor after consultation with the Council.[332] It should be emphasised that, as with the Mental Health Act Commission, the Council's function is not to review a tribunal's decision in a particular case, or the way in which those particular proceedings were conducted or heard. These are matters entirely within the tribunal's discretion unless it is alleged that the flaws were so fundamental that the decision should be set aside, in which case it becomes a matter for the High Court.

Mental Health Act Commission

The Secretary of State for Health is under a statutory duty to keep under review the exercise of the powers and the discharge of the duties conferred or imposed by the Act so far as they relate to patients who liable to be detained under the Act.[333] The Act also provides that the statutory powers and duties which must be kept under review do not include any exercisable by the Court of Protection under Part VII, but no such exception applies to powers and duties exercised by a tribunal under Part V.[334] Thus, they must be kept under review. Moreover, the Secretary of State is further bound by statute to direct the Commission to perform on his behalf this function of keeping under review the way in which the various statutory powers and duties are discharged.[335] Consequently, the Commission has no discretion and must review the workings of tribunals, insofar as they relate to detained patients, although in practice it does so with some reluctance.

STATISTICAL INFORMATION

The number of tribunal applications has steadily increased since the 1983 Act came into force and, since 1988, the number of applications has risen by 10–15 per cent. each year. In 1984, 3558 applications were received, which figure had risen to 12,247 by 1994. The number of applications received by tribunals and the number of cases heard by them in 1994 is set out below.

NUMBER OF TRIBUNAL APPLICATIONS AND HEARINGS IN 1994

	Applications received	*Number of hearings*	*Hearings as % of applications*
Section 2 patients	3770	2228	59.1%
Other non-restricted patients	6915	3232	46.7%
Restricted patients	1562	1303	83.4%

Source : Mental Health Review Tribunals for England and Wales, Annual Report 1994, Department of Health, London, May 1995, Appendices 3 and 4.

332 Tribunals and Inquiries Act 1992, ss.5(1) and 8(1).
333 Mental Health Act 1983, s.120(1).
334 *Ibid.*, s.120(7).
335 *Ibid.*, s.121(2)(b).

The number of hearings held is always less than the number of ap tions and references received. In the case of section 2 applications, which must be heard within one week of receipt, some 40 per cent. of applications did not proceed to a hearing. In almost all of those cases this would have been because the responsible medical officer himself discharged the patient during the intervening period. In other non-restricted cases, over half of the applications did not proceed to a hearing. This partly reflects the fact that there were 11 per cent. more applications in 1994 than in 1993 and applications made towards the end of each year were not be heard until the following year. Some applications would also have been withdrawn although, balancing this, mandatory references cannot be withdrawn. It is therefore likely that about half of all non-restricted patients detained for treatment are discharged by the responsible medical officer prior to any hearing taking place. The fact that fewer cases involving patients detained for treatment proceeded to a hearing reflects the delays which occur in arranging such hearings — the time taken to hear such cases is considerably longer than the time which the average patient spends in hospital. The difference between the number of applications and hearings is significantly less in restricted cases. This reflects the fact that restricted patients continue to be liable to be detained unless discharged by a tribunal or the Secretary of State. It is not possible for the patient's responsible medical officer to unilaterally terminate the patient's liability to detention under the Act.

Number of patients discharged

The proportion of patients discharged by tribunals varies according to the authority for detention. It has been noted that in 1994 tribunals heard 2228 section 2 applications. 18.8 per cent. of patients were discharged, the remaining 81.2 per cent. of patients not being discharged. Because about 41 per cent. of the applications did not proceed to a hearing, this means that some 55–60 per cent. of patients had ceased to be detained under section 2 during the 7–10 period following the making of the application. Of the 3005 hearings involving other non-restricted patients, 15.6 per cent. were discharged while 26.1 per cent. of the 674 hearings involving restricted patients resulted in absolute or conditional discharge. Thus, a higher proportion of restricted patients were discharged than were unrestricted patients detained for treatment and this may reflect the fact that tribunals are more willing to discharge when they can do so subject to conditions.

Regional variations

From the table below it can be seen that there were significant variations between the different tribunals in terms of the proportion of patients discharged. For example, only 8.3 per cent. of section 2 cases and 7.8 per cent. of other non-restricted cases heard by the Northern and Yorkshire Mental Health Review Tribunal resulted in discharge. By contrast, 33.7 per cent. of the section 2 patients whose cases were heard by the Mental Health Review Tribunal for Wales were discharged and 40.5 per cent. of other non-restricted patients. These differences cannot be explained in terms of differences in the number of applications which proceeded to a hearing. Nor can they be explained in terms of a lower, and hence more discriminating, use of compulsory powers in the areas where the discharge rate was relatively low — both the Northern and Yorkshire and the Trent regions have relatively low rates of formal admissions per 100,000 population compared with England as a whole while North Thames has the highest. It would seem therefore that the most likely

explanation for the differenc es in the constitution or procedures of the tribunals themselves.

TRIBUNAL DISCHARGES IN 1994 BY REGION

	Section 2 hearings (% apps)	*Discharged*	*Other non-restricted hearings*	*Discharged*
North Thames	426 (59%)	22.3%	519 (38%)	13.1%
Anglia & Oxford	134 (60%)	15.7%	376 (51%)	10.1%
South Thames	352 (58%)	25.9%	383 (41%)	26.6%
South & West	215 (61%)	18.6%	349 (51%)	13.8%
Trent	183 (62%)	12.0%	214 (49%)	13.6%
Northern & Yorkshire	241 (62%)	8.3%	357 (50%)	7.8%
West Midlands	218 (49%)	24.8%	234 (40%)	14.5%
North West	364 (60%)	12.1%	425 (47%)	14.8%
Wales	95 (60%)	33.7%	148 (47%)	40.5%
Total	**2228 (59%)**	**18.8%**	**3005 (45%)**	**15.6%**

Source : Mental Health Review Tribunals for England and Wales, Annual Report 1994, Department of Health, London, May 1995, Appendices 3 and 4.

Special hospital cases

The general pattern that a higher proportion of restricted patients are discharged by tribunals than are unrestricted patients detained for treatment extends to special hospital patients except those at Broadmoor. However, not surprisingly, fewer of them in either category are discharged.

SPECIAL HOSPITAL APPLICATIONS AND HEARINGS IN 1994

	No. of hearings	*Discharged MHRT*	*% discharged*
Non-restricted patients	227	7	3.1%
Restricted patients	629	27	4.3%
Total	856	34	4.0%

Source : Mental Health Review Tribunals for England and Wales, Annual Report 1994, Department of Health, London, May 1995, Appendices 3 and 4.

It should, however, be noted that there were different patterns of outcome for the three special hospitals. Five of the seven non-restricted patients discharged by tribunals during by 1994 were detained at Broadmoor, where 61 of the 227 hearings

were held. Thus, while 8.2 per cent. of non-restricted Broadmoor ients were discharged, only one of the 74 non-restricted hearings held at Ashworm and one of the 92 hearings held at Rampton resulted in discharge. Proportionately more restricted than unrestricted patients at Rampton and Ashworth were discharged.

SPECIAL HOSPITAL PATIENTS DISCHARGED IN 1994

	% non-restricted	*% restricted*	*% discharged*
Broadmoor	8.2%	5.6%	6.4%
Ashworth	1.4%	2.1%	1.9%
Rampton	1.1%	5.5%	4.1%

Source : Mental Health Review Tribunals for England and Wales, Annual Report 1994, Department of Health, London, May 1995, Appendices 3 and 4.

4. Detention and guardianship under Part II

INTRODUCTION

The distinctive feature of compulsory admission under Part II of the Mental Health Act 1983 is that the individual is deprived of his liberty upon an application for his detention being made to the managers of a hospital rather than to a court. Similarly, reception into guardianship involves the acceptance of an application not by a court but by a local social services authority. In each case, the application may be made by the patient's nearest relative (**100**) or an approved social worker (**160**).

THE FIVE TYPES OF APPLICATION

Part II of the Act makes provision for five different kinds of application.

PART II OF THE MENTAL HEALTH ACT

Section	*Type of application*	*Purpose*
2	*Admission for assessment*	An application for a person to be detained in hospital for assessment, followed by any necessary treatment, for up to 28 days.
4	*Emergency application*	A section 2 application initially founded upon a single medical recommendation where admission is urgently necessary. Lapses after 72 hours unless the full section 2 procedures have by then been completed.
3	*Admission for treatment*	An application for a person to be detained in hospital for treatment for up to six months. The authority to detain the patient may be renewed for further periods in certain circumstances.
7	*Guardianship application*	An application for a person to be placed under the guardianship of a local social services authority or a private individual for up to six months. The guardian's authority may be renewed for further periods in certain circumstances.
25A	*Supervision application*	An application for a person detained for treatment to be subject to after-care under supervision once he ceases to be liable to be detained.