

were held. Thus, while 8.2 per cent. of non-restricted Broadmoor patients were discharged, only one of the 74 non-restricted hearings held at Ashworth 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

	% not-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.

With the possible exception of persons detained under section 4, all patients subject to compulsory powers upon the acceptance of an application may apply to a tribunal for their discharge from detention, guardianship or supervision, as the case may be. Provision is also made for the cases of detained patients to be periodically referred to a tribunal if no application has been made for a certain period of time.

Supervision applications

The provisions in the Mental Health Act 1983 concerning supervision applications were inserted by the Mental Health (Patients in the Community) Act 1995, which came into force on 1 April 1996. The new statutory procedures governing the making of supervision applications differ in many respects from those which apply to the four other kinds of application. Applications which relate to detention in hospital or reception into guardianship all adhere to a similar statutory framework — one which has its origins in the Mental Health Act 1959 and was then readopted in the 1983 statute as originally enacted. A further peculiar feature of the new supervision applications is that they cannot be made unless the patient is already liable to be detained in hospital for treatment. This is because their purpose is to provide a statutory framework for supervising in the community patients who have ceased to be liable to detention for treatment. The pre-existing authority for the patient's detention in hospital for treatment will usually be a previous application made under section 3 but it could equally be a court order or a direction given by the Secretary of State authorising his detention there. These orders and directions, made under Part III of the Act, are considered in the following chapter. Supervision application procedures therefore depart from what may be called the classical model and are initially grafted on to some prior application, order or direction authorising the individual's detention. For these two reasons, and in particular because it is crucial to keep the two different statutory frameworks distinct, they are not further considered in this chapter. They are dealt with later in the context of after-care and what follows in this chapter is exclusively concerned with the four kinds of application contained in the statute as originally enacted.

THE BASIC APPLICATION FRAMEWORK

Subject to a single caveat, the basic framework is the same for all applications authorising detention or guardianship under Part II. Detention or guardianship requires (a) the acceptance by a hospital or local social services authority (b) of an application in the prescribed form (c) made by a qualified person (the patient's nearest relative or an approved social worker) (d) which is founded upon written medical recommendations in the prescribed form (e) of two medical practitioners (f) both of whom have recently examined the patient and have no personal interest (g) and one of whom is approved as having special experience in the diagnosis or treatment of mental disorder. The exception is that in cases of urgent necessity an application for admission for assessment may initially be founded upon a single medical recommendation — this is the emergency application procedure set out in section 4. The medical evidence upon which an application must be founded, and the other legal formalities to be observed, are dealt with later (253), following consideration of the grounds of application and the main distinguishing features of each kind of application.

THE GROUNDS OF APPLICATION

Sections 2(2), 3(2), and 7(2) set out the grounds upon which an application may be made for a person's admission to hospital or reception into guardianship. The grounds, while necessarily different, conform to the same basic framework in that two questions must always be addressed. The first of the two grounds has variously been described as the "diagnostic question"<sup>1</sup> and as "the medical question."<sup>2</sup> This requires the existence of a mental disorder the nature or degree of which makes in-patient treatment appropriate or warrants the patient's reception into guardianship or detention for assessment. The second ground requires that detention or guardianship is either "necessary" or "justified" on the patient's own account (specifically his health, safety or welfare) or that of others (in order to protect them). This second ground has been described as a "mixed medical and social question"<sup>3</sup> and as having, like the first, a medical content but also incorporating ethical, social and public policy considerations.<sup>4</sup> An alternative view would be that the first ground requires the existence of a serious mental disorder while the second ground is directed towards the issue of risk — the likelihood of harm resulting if the individual is not subjected to some element of compulsion (723).

Cases of psychopathic disorder and mental impairment

A third ground of application must be satisfied in the case of section 3 applications concerning persons suffering from psychopathic disorder or mental impairment, which is that in-patient treatment is likely to alleviate or prevent a deterioration of the patient's condition. This condition has come to be known as the "treatability test" (222).

GUIDING PRINCIPLES

The Royal Commission of 1954-57<sup>5</sup> spelt out the circumstances in which it considered that the use of compulsory powers was justified. Paragraph 317 of the Commission's report states—

"We consider that the use of special compulsory powers on grounds of the patient's mental disorder is justifiable when:

- a. there is reasonable certainty that the patient is suffering from a pathological mental disorder and requires hospital or community care; and
- b. suitable care cannot be provided without the use of compulsory powers; and
- c. if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself; and

<sup>1</sup> By Forbes J. in *R. v. Mental Health Review Tribunal*, ex p. *Pickering* [1986] 1 All E.R. 99.  
<sup>2</sup> By Lawton L.J. in *R. v. Oxford Mental Health Review Tribunal*, ex p. *Secretary of State for the Home Department*; *R. v. Yorkshire Mental Health Review Tribunal*, ex p. *Same* [1986] 1 W.L.R. 1180.  
<sup>3</sup> By Lawton L.J. in *R. v. Oxford Mental Health Review Tribunal*, ex p. *Secretary of State for the Home Department* (supra).  
<sup>4</sup> By Forbes J. in *R. v. Mental Health Review Tribunal*, ex p. *Pickering* (supra).  
<sup>5</sup> *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).

d. there is also either—

- i. good prospect of benefit to the patient from the treatment proposed — an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others;
- ii. a strong need to protect others from anti-social behaviour by the patient."

### The statutory framework

The Commission's views found expression in the 1959 Act and the present statute by and large adopts the same approach. The Minister of Health explained the Government's aims in relation to the new civil procedures during the Parliamentary debate of 5th May 1959:

"We had in mind all the time to try and assemble a structure which would reflect the balance of the considerations we must have in mind. They are, firstly, the liberty of the subject, secondly, the necessity of bringing treatment to bear where treatment is required and can be beneficial to the individual and, thirdly, the consideration of the protection of the public. All though I have tried steadily to keep in mind that what we are trying to do is to erect as balanced a structure as we may which can give effect to all those things in harmony with each other."<sup>6</sup>

### MENTAL DISORDER OF THE REQUISITE NATURE OR DEGREE

The first ground of application requires that the patient is suffering from mental disorder, whether generally or from one of its specific forms, and that the nature or degree of this disorder is sufficiently serious to make in-patient treatment appropriate or to warrant his reception into guardianship or detention for assessment. An application in respect of a patient may be made on the grounds that:

- section 2  
he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period (s.2(2)(a));
- section 3  
he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital (s.3(2)(a));
- guardianship  
he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section (s.7(2)(a));

### The presence of a mental disorder

Compulsory admission for assessment requires medical evidence to the effect only that the patient is suffering from mental disorder generally, as defined in section 1(2). However, an application for a person's admission for treatment or for his reception into guardianship requires evidence that the patient suffers from at least one of the four particular forms of mental disorder set out in section 1(2).

### "Suffering from"

The term's meaning and relevance was considered during the inquiry into the circumstances surrounding the death of Georgina Robinson, an occupational therapist working at the Edith Morgan Centre at Torbay District General Hospital.<sup>7</sup> *The inquiry team referred to the case of Devon County Council v Hawkins.*<sup>8</sup> Having found that the patient was likely to suffer further epileptic seizures if he ceased taking his medication, the court in that case had held that whether a person "suffers from" epilepsy depends on the prognosis of what will occur if anti-convulsant medication is withdrawn. The Lord Chief Justice observed that it had been said with much force "that so long as it is necessary for a person to be under treatment for a disease or disability, then that person must be held to be suffering from that disease or disability. In my judgment that is in general right." By analogy, whether or not a person who has been receiving psychiatric treatment, but who presently shows no signs of mental disorder, still "suffers from" mental disorder depends on the likely effect of discontinuing treatment. The fact that an illness is asymptomatic does not demonstrate *per se* that he is not suffering from mental disorder or that any disorder from which he does suffer is not of a severe nature.

### The nature or degree of the disorder

Where there is evidence of mental disorder, the use of compulsory powers requires that it is of a "nature or degree" which either makes in-patient treatment appropriate or warrants the patient's detention for assessment or reception into guardianship ("the diagnostic question"). Practitioners and tribunals commonly confine their consideration of a patient's mental state to the degree of mental disorder present, seemingly interpreting the words "nature" and "degree" as essentially interchangeable. Accordingly, a patient is considered not to be detainable if his condition has responded to medication and is no longer acute. This approach takes no real account of the nature of the particular disorder and mistakenly equates its "degree" with its "severity." As such, there is a failure to give due weight to the chronicity of the disorder and the prognosis.

### "Degree"

The word "degree" focuses attention on the extent to which the person's mental disorder is currently active. If a patient is acutely ill, his condition characterised by obvious and gross abnormalities in his mental state, the degree of mental disorder present will generally be of a level which satisfies the first ground of application. It is noteworthy that the emergency power to detain a patient for six hours under

<sup>7</sup> *The Falling Shadow: One Patient's Mental Health Care 1978-1993* (Duckworth, 1995), pp. 153-169.

<sup>8</sup> *Devon County Council v Hawkins* [1967] 2 Q.B. 26.

section 5(4) is exercisable by a nurse only if it appears to him that the patient is suffering from mental disorder "to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital." The criteria do not refer to the nature of the patient's disorder. This reflects the fact that the purpose of the power is immediate restraint and reinforces the view that the word "degree" is directed towards the present exacerbations and manifestations of a patient's disorder, rather its nature as revealed by its longer-term consequences.

### "Nature"

Many mental disorders wax and wane because they are cyclical in nature, because the patient enjoys periods of remission — for example, during periods of low stress — or because they are intermittently alleviated by a course of treatment. A particular patient may have a long history of readmissions indicative of a severe, chronic condition which is resistant to treatment or a record of poor compliance with informal treatment following previous discharges. Although the degree of disorder may be quite low at any given time, either in absolute terms or relative to his known optimum level of functioning, the serious nature of the disorder is revealed by its historical course. Likewise, with illnesses of recent onset, the prognosis associated with the diagnosis may point strongly towards the probability of a serious, further deterioration of the patient's condition in the near future. In both instances, it may be the nature of the disorder rather than its degree which brings the patient within the first of the grounds for making an application.

### Relapsing patients

Where a patient with a chronic condition decides not to continue with medication and his condition is deteriorating, it is often said by those assessing or examining him that he is "not sectionable." By this it is usually meant that the degree of mental disorder falls below what is considered to be the threshold for detention, albeit that the rapidity of the patient's decline suggests that his disorder will soon be of such a degree. In fact, because the nature of the disorder allows such a confident prognosis to be made about its future degree in the absence of any therapeutic intervention, it is not necessary as a matter of law to wait until the condition becomes acute before compelling the patient to receive the treatment which will prevent the otherwise inevitable further decline.

### Mental Health Review Tribunals

Within the context of section 3 tribunal proceedings, a patient may have responded to treatment and be in remission by the time the hearing takes place. As such, and given the importance which attaches to a citizen's liberty in English law, the degree of mental disorder which remains may be insufficient to warrant a continuance of his liability to detention. The tribunal is not, however, obliged to discharge unless it is also satisfied that the nature of the patient's disorder, evidenced by his medical history or the outcome usually associated with such conditions, also makes liability to detention inappropriate. Similarly, where the degree of disorder apparent at the time of the hearing is quite low but the patient's recent mental state has been subject to marked fluctuations, the nature of the disorder may mean that the tribunal cannot be satisfied that the first of the grounds for discharge is made out.

### "Warrants" and "makes appropriate"

The term "warrants" was used in the 1959 Act in relation to all applications, including those for admission for treatment.<sup>9</sup> The Government considered that the word steered a "reasonably middle course between the words to which objection was taken and the alternatives suggested in Committee — 'essential', 'desirable', and the like."<sup>10</sup>

### Section 3 applications

The grounds for making an application for admission for treatment under the 1959 Act referred to the existence of a form of mental disorder of a nature or degree which "warrants the detention of the patient in a hospital for medical treatment under this section."<sup>11</sup> The 1982 Act amended the provision and a patient's mental disorder need now only be "of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital."<sup>12</sup> The previous reference to "treatment under this section" being warranted remains part of the admission criteria but is now found in section 3(2)(c), that is as part of the "health, safety of protection of others" ground. The purpose of these amendments was to separate out the two questions of whether a patient needs in-patient treatment and whether the use of section 3 is necessary in order to compel him to receive that treatment.<sup>13</sup>

### The present distinction

Admission for treatment under section 3 therefore requires instead that the patient's disorder is of a nature or degree which makes it "appropriate" for him to receive medical treatment in a hospital. In the case of section 2 and guardianship applications, it remains the case that the mental disorder from which a patient suffers must be of a nature or degree which "warrants" his detention or reception into guardianship. "Warrants" is therefore used in Part II to denote a condition the nature or degree of which is sufficiently serious to justify the use of compulsory powers, whereas "appropriate" focuses attention on whether the nature or degree of disorder makes in-patient treatment appropriate, without reference to whether compulsory treatment is indicated; if in-patient treatment is appropriate the first of the grounds is made out.

### Detention

The term was considered in the Australian case, *Paul v. Paul*,<sup>14</sup> where it was said that, "detention refers to the case of a person lawfully held against his will, one who is not free to depart when he pleases." Detention in hospital must be "warranted" under section 2 whereas the making of a section 3 application requires that the in-

<sup>9</sup> As originally drafted, the Bill referred to a patient's mental disorder, or its particular form, being of a nature or degree "which renders him suitable to be detained in hospital." (See *Hansard*, H.C. Vol. 598, col. 710). The phrase was criticised as "being redolent of the language of the cookery book, and more suited to that than to the language of a Statute" and was therefore replaced by "warrants the detention of the patient." (*Hansard*, H.C. Vol. 605, col. 268.)

<sup>10</sup> The Minister of Health, *Hansard*, H.C. Vol. 605, col. 268. A more cynical view was provided by the Member of Parliament for Oldham West: "I do not know what 'warrant' means and I doubt whether anyone else does, but, on the whole, I think that the word is not particularly objectionable. We know that anxiety neurosis is an occupational disease of Parliamentary draftsmen and that anything too specific has to be excluded for fear of judicial interpretation." (*Ibid.*, col. 272).

<sup>11</sup> Mental Health Act 1959, s.26(2)(a).

<sup>12</sup> Mental Health Act 1983, s.3(2)(a).

<sup>13</sup> *Mental Health (Amendment) Bill. Notes on Clauses. House of Commons (D.H.S., 1982)*, p.33.

<sup>14</sup> *Paul v. Paul* (1954) V.L.R. 331.

patient treatment which the patient needs cannot be provided unless he is detained under that section.<sup>15</sup>

### Hospital

The grounds of application under sections 2-4 refer to detention or treatment in a "hospital." As to the statutory meaning of this term, which includes "community wards" and private mental nursing homes which are registered to receive detained patients, see page 131.

### Assessment

The meaning of "assessment" is considered below (231).

### Medical treatment

"Medical treatment" is defined in section 145(1) and, unless the context otherwise requires, it "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision." In *Secretary of State for the Home Department v Mental Health Review Tribunal for Mersey Regional Health Authority*,<sup>16</sup> Mann J. rejected the tribunal's submission that supervision, guidance and rehabilitation which did not necessarily have to be given by nursing or medical staff or under medical supervision, because it could be given in a hostel or other suitable community provision, did not constitute medical treatment within the meaning of section 145(1).<sup>17</sup> However, it is not enough under section 3 that a patient would benefit from treatment in this broad sense. Detention under section 3 requires that in-patient medical treatment is "appropriate", necessary for the patient's health or safety or for the protection of others, and cannot be provided unless he is detained under that section.

### HEALTH, SAFETY, WELFARE AND THE PROTECTION OF OTHERS

The grounds of application include in all cases a second condition that the patient's detention or restraint is "necessary" or "justified" on his own account (specifically his health, safety or welfare) or that of others (in order to protect them from him). The criteria to be satisfied in respect of the patient are that—

- section 2 he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons (s.2(2)(b)).
- section 3 it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section (s.3(2)(c)).
- guardianship it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received (s.7(2)(b)).

<sup>15</sup> Mental Health Act 1983, s.3(2)(c).

<sup>16</sup> *Secretary of State for the Home Department v. Mental Health Review Tribunal for Mersey Regional Health Authority* [1986] 1 W.L.R. 1170.

<sup>17</sup> *Ibid.*, at 1173E.

### Historical note

During the 1959 Bill's passage through the House of Commons, the words "health or safety" were substituted for the more general phrase "in the interests of the patient",<sup>18</sup> the Government's aim being "to limit compulsory powers to cases in which it is positively necessary to override the wishes of the patient, either in the interests of his own health or safety or for the protection of others."<sup>19</sup>

### "Health"

Irrespective of whether a patient's mental disorder has any consequences for his own safety or the well-being of others, he may be detained if such a course of action is necessary for, or in the interests of, his mental or physical health.<sup>20</sup> The term is not statutorily defined in the 1983 Act or the National Health Service Act 1977. The use of the word "health" in relation to the criteria for admission to hospital, but "welfare" in the guardianship criteria, suggests that the perceived risk must be of a kind which necessitates or justifies compulsory medical intervention and not merely social work intervention. In practical terms, health may be described as the standard of physical and mental functioning necessary for a person to perform the activities which are expected of him, according to the norms of the society in which he lives; all *disabling* disease, illness and handicap must be absent (1031).

### "Welfare"

"Welfare" is also not statutorily defined and nor does the Act contain a check-list of relevant considerations of the kind found in section 1(3) of the Children's Act 1989, which stipulates that the welfare of the child shall be paramount.<sup>21</sup> Although the 1960 regulations obliged a guardian to make arrangements for the patient's general welfare,<sup>22</sup> his welfare was not originally a statutory condition of guardianship under the 1959 Act. Guardianship simply required that it was "necessary in the interests of the patient" that he should be so received.<sup>23</sup> The welfare criterion was inserted later, by sections 7(4) and 12(6) of the Mental Health (Amendment) Act 1982, the Government's reasons for amending the criteria being set out in two White Papers published at the time—

<sup>18</sup> The Lord Chancellor (Lord Kilnimit), *Hansard*, H.L. Vol. 216, col. 754.

<sup>19</sup> *Ibid.*, col. 671.

<sup>20</sup> During the Parliamentary debates on the 1959 Bill, the Lord Chancellor rejected a proposal that compulsory admission should be confined to cases where that was necessary for a patient's safety, on the grounds that "many ... who can be cured refuse treatment because their illness itself makes them incapable of appreciating the need for treatment." The Lord Chancellor (Lord Kilnimit), *Hansard*, H.L. Vol. 216, col. 754.

<sup>21</sup> The Scottish and Northern Irish mental health legislation, which post-dates our Act, also do not include a statutory definition of the term. In the context of children's legislation, the Law Commission considered that, "Welfare" is an all-encompassing word. It includes material welfare, both in the sense of adequacy of resources to provide a pleasant home and a comfortable standard of living and in the sense of adequacy of care to ensure that good health and due personal pride are maintained. However, while material considerations have their place they are secondary matters. More important are the stability and the security, the loving and understanding care and guidance, the warm and compassionate relationships, that are essential for the full development of the child's own character, personality and talents." Law Commission, *Working Paper No. 96*, para. 6.10.

<sup>22</sup> Mental Health Hospital and Guardianship Regulations 1960, reg. 6.

<sup>23</sup> Mental Health Act 1959, s.33(2)(b).

"At present an application under section 33 has to be 'necessary in the interests of the patient or for the protection of other persons. This criterion seems unnecessarily wide and the term 'patient's welfare' in place of 'patient' would help to narrow it."<sup>24</sup>

"The Bill proposes that guardianship will be required to be "in the interest of the welfare of the patient or for the protection of other persons" rather than "in the interests of the patient" as at present; this will clarify the purpose of guardianship and ensure that the power is not so wide."<sup>25</sup>

#### *The absence of any statutory definition*

As with the decision not to statutorily define "mental illness," it may be inferred that Parliament intended that practitioners and tribunals should have a broad discretion when deciding whether certain arrangements are in the interests of the patient's welfare in any given case. The reluctance to define the term probably reflects a recognition that ideas about what promotes a patient's welfare change over time. For example, while it was previously thought that the welfare of most patients was promoted by offering them asylum the underlying principle nowadays is that their welfare is better served by being part of the general community. Nevertheless, although a tribunal has a broad discretion in any particular case, it should be emphasised that any guardianship must be "necessary" in the interests of the patient's welfare (220).

#### "Safety"

During the Parliamentary debates on the 1959 Bill, the Lord Chancellor rejected a submission that compulsory admission procedures should be confined to cases where that was necessary on the ground of "safety," interpreting the word as denoting "persons who were dangerous to themselves or to others, or in danger from others."<sup>26</sup> However, sections 25(1) and 72(1)(b)(iii) distinguish between safety and dangerousness. They provide for the discharge of patients who satisfy the ordinary detention criteria — including in some cases therefore the safety criterion — but who would not, if released, be likely to act in a manner "dangerous" to themselves. The Butler Committee equated "dangerousness with a propensity to cause serious physical injury or lasting psychological harm."<sup>27</sup> Likewise, section 20 differentiates safety from exploitation and lack of care. In particular, section 20(4)(c) prohibits renewing the authority to detain a mentally ill or severely mentally impaired patient whose detention may be necessary for his own safety but whose condition is untreatable unless he would, if discharged, be unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation. The meaning of "safety" must therefore be different in some respect from the meanings which attach to the concepts of dangerousness, exploitation, and neglect.

#### *Risk of physical harm*

The concept of a person's safety clearly draws attention to a risk of physical harm to that person rather than mere ill-health, that is a general deterioration of his mental

<sup>24</sup> *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978), para. 4.14.

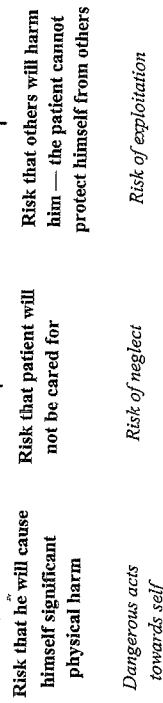
<sup>25</sup> Paragraph 44 of *Reform of Mental Health Legislation*, Cmnd. 8405 (1981), explaining the provisions in the 1982 Bill.

<sup>26</sup> The Lord Chancellor (Lord Kilmer), *Hansard*, H.L. Vol. 216, col. 754.

<sup>27</sup> *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 4.10.

health and functioning. Where a risk of physical harm exists, this may be because the patient would physically harm himself, seriously neglect himself, or there is a risk that others will harm him. If it is likely that a patient will cause himself significant physical harm if he is not detained, he may be said to be likely to act in a manner dangerous to himself. A chronically mentally ill or severely mentally impaired patient who is unable to care for himself, or to obtain the care which he needs, or who is at risk of serious exploitation, will usually require detention for his own safety as well as his health. In the case of other mentally ill patients, however, any risk to their safety if they are discharged may not relate to their ability to care for or protect themselves, for example persons suffering from a paranoid delusional disorder. Having regard to these considerations, it is submitted that the concept of a patient's safety is ultimately concerned with the existence of a risk of physical harm rather than its cause or magnitude. It is immaterial for the purposes of the admission criteria whether the risk arises because of the patient's own acts (dangerous conduct towards himself), his omissions to act (self-neglect), how others act towards him (exploiting or ill-treating him), or omit to act towards him (failing to care for him). If, however, a patient's nearest relative believes that he is fit to be discharged, the nature and magnitude of the risk is relevant to any decision about whether or not his detention may be continued — the issue in this context becomes whether he is then likely to act dangerously towards himself. Likewise, if in-patient treatment is unlikely to even prevent a patient's condition from deteriorating, he must be discharged unless his detention is necessary on account of his vulnerability — the issue in this context becomes whether he would then be neglected or exploited. Perhaps surprisingly, dangerousness is not then a statutory consideration. If this is correct, dangerous conduct and the risks of lack of care or exploitation are all particular ways in which a patient's safety may be at risk.

#### DETENTION NECESSARY OR JUSTIFIED FOR PATIENT'S SAFETY



#### "Protection of other persons"

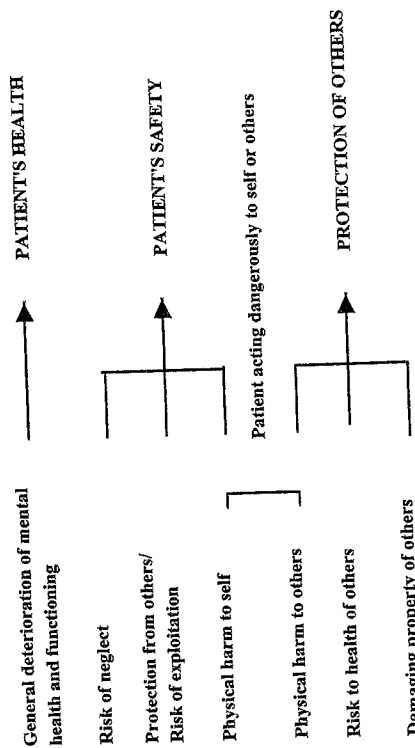
The Act distinguishes between a necessity to protect others generally and, where a patient's nearest relative is seeking his discharge, the likelihood of the patient then acting dangerously towards others.<sup>28</sup> It has been suggested that statutory references to the "protection of other persons" refer to people and not to their property.<sup>29</sup> This

<sup>28</sup> See *Mental Health Act 1983*, ss. 2, 3, 7, 20, 25 and 72.

<sup>29</sup> R. Jones, *Mental Health Act Manual* (Sweet & Maxwell, 5th ed., 1996), p.28.

seems to imply that, when deciding whether the use of compulsory powers is necessary or justified for the protection of third parties, consideration should be confined to the likelihood of the patient causing them bodily or psychological harm — in other words, harming their health or safety. However, there seems no particular reason to restrict the phrase's interpretation in this way, other than that the phrase "or their property" is not expressly added after the statutory criteria do Parliament intended such a restriction, it is surprising that the statutory criteria do not simply provide for a patient's detention where this is necessary or justified for his own health or safety or that of others. It would also be strange if a patient who persistently damaged or stole the property of some other person, on account of some delusional belief, could not be detained because there was no risk to that person's physical safety. At any rate, causing damage to a person's property will generally also cause him emotional distress so the two aspects will usually be inextricably linked. It is, however, submitted that the phrase has a more general ambit, indicating a need to protect other persons from the consequences of the patient's actions, including therefore damage to property arising as the result of the patient's mental state. As before, a distinction must be drawn between the need to protect others generally and the likelihood of the patient behaving dangerously towards them, which would appear to imply the existence of a risk of physical harm. Nevertheless, in practice, even if there is no history of physical harm to others the likelihood of such harm being caused in the future may be significant if there is a history of damage to their property. For example, if a person was admitted to hospital after damaging his neighbour's property in the belief that the latter had interfered with his thoughts or conspired against him, there will usually be a risk of future confrontations escalating into violence for as long as those beliefs persist.

#### NATURE OF RISK NECESSITATING OR JUSTIFYING DETENTION



#### "Ought to be so detained" and "necessary"

A person may not be detained simply because it can be demonstrated that he or other persons have suffered some detriment as a result of his not enjoying sound mental

health. The consequences of the patient's health or safety, or for others, if the patient is not detained must be sufficiently serious to justify his detention or to make that necessary. There must be sound evidence to support such a contention since "a man's liberty of movement is regarded so highly by the law of England that it is not to be hindered or prevented except on the surest grounds."<sup>30</sup>

#### "Ought to be so detained in the interests of" and "with a view to"

The qualifying word originally used in the 1959 Bill was "expedient," which raised the concern that a person might be detained for up to 28 days on grounds of expediency. The condition that the patient "ought to be detained in the interests of his health and safety or "with a view to" the protection of others was therefore substituted, and these qualifying words are now used in the section 2 admission criteria.<sup>31</sup> Provided that the nature or degree of the patient's disorder warrants his detention for assessment, it does not therefore matter if it is impossible to define the exact manner in which his health or safety or others will suffer if he is not detained. This is logical because the precise nature and extent of any risk to the patient and others if he does not receive treatment is one of the matters to be assessed; and the outcome of the assessment may be that any disorder from which he suffers is, if untreated, unlikely to have significant adverse consequences. The phrase "ought to be detained" means in effect that the patient's detention is "justified"<sup>32</sup> having regard to the possibility of harm to himself or others if he is not. The nature of the risk is necessarily of paramount importance. A significant risk of an insignificant decline in mental functioning would not constitute adequate justification for interfering with an individual's liberty whereas a much smaller risk of a catastrophic outcome, such as suicide, might be.

#### "Necessary"

In the case of detention under section 3, it must be "necessary" for the health or safety of the patient or for the protection of others that he receives medical treatment in a hospital and that such treatment cannot be provided unless he is detained under section 3. Similarly, guardianship requires that the patient's reception into guardianship is "necessary" in the interests of his welfare or for the protection of others. The fact that any arrangements which may be made by the prospective guardian will generally benefit the patient is therefore insufficient if his welfare can be adequately protected without the use of compulsory powers. "Necessary" is stronger than "makes appropriate" or "justifies" and indicates that the use of compulsory powers is imperative or essential and that no alternative, less restrictive, course of action will meet the needs of the situation.

#### THE GAF SCALE

The GAF scale devised by the American Psychiatric Association is a useful practical tool for assessing a patient's overall level of functioning and the extent to which his health or safety, or that of others, is at risk at any given time. The patient is rated on a 0-100 scale, with 100 representing superior functioning and 10 "persistent danger of severely hurting self or others."

<sup>30</sup> See *Ghani v Jones* [1970] 1 Q.B. 693, per Lord Denning M.R.

<sup>31</sup> See *Hansard*, H.C. Vol. 605, cols. 268-69.

<sup>32</sup> The word used in the tribunal discharge criteria in preference to "ought to be detained." See s.72(1)(a)(i).

## GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SC E)

Code	Symptoms
81-90	<b>Absent or minimal symptoms</b> (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71-80	<b>If symptoms are present, they are transient and expectable reactions to psychosocial stressors</b> (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
61-70	<b>Some mild symptoms</b> (e.g. depressed mood or mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	<b>Moderate symptoms</b> (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).
41-50	<b>Serious symptoms</b> (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
31-40	<b>Some impairment in reality testing or communication</b> (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21-30	<b>Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment</b> (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR <b>inability to function in almost all areas</b> (e.g., stays in bed all day, no job, home, or friends).
11-20	<b>Some danger of hurting self or others</b> (e.g., suicidal attempts without clear expectation of death, frequently violent, manic excitement) OR <b>occasionally fails to maintain minimal personal hygiene</b> (e.g., smears faeces) OR <b>gross impairment in communication</b> (e.g., largely incoherent or mute).
1-10	<b>Persistent danger of severely hurting self or others</b> (e.g., recurrent violence) OR <b>persistent inability to maintain minimal personal hygiene</b> OR <b>serious suicidal act with clear expectation of death.</b>

Source: *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV (American Psychiatric Association, 4th ed., 1994), p.32.*

### THE TREATABILITY CONDITION

A third ground of application — commonly referred to as the "treatability test" — must be satisfied in the case of section 3 applications which concern persons suffering from psychopathic disorder or mental impairment. This is that in-patient medical treatment is likely to alleviate or prevent a deterioration of the patient's condition. Alleviation implies that treatment is likely to enable the patient to cope more satisfactorily with his disorder or its symptoms. Medical treatment is defined in section 145(1) and, unless the context otherwise requires, the term includes nursing and also care, habilitation and rehabilitation under medical supervision.

### Historical note

Section 4(4) of the Mental Health Act 1959 defined a "psychopathic disorder" as "a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to treatment." An attempt was made in the House of Lords to remove the words "requires or" from the definition so as to ensure that the category would be confined to persons who "will really benefit from medical treatment."<sup>33</sup> The Government's position was explained by the Lord Chancellor, Viscount Kilnair, who said that the inclusion of the words allowed action to be taken in a case where the doctor hoped that a patient would respond to treatment.<sup>34</sup> In 1978, the Government set out in a White Paper its proposals for amending the 1959 Act.<sup>35</sup> It accepted that "the Act should establish a clear requirement that psychopaths should only be detained under compulsory powers where there is a good prospect of benefit from treatment." The Government proposed that the words "and requires or is susceptible to medical treatment" be omitted from the statutory definition of psychopathic disorder, since they did not define the disorder, and a "prospect of benefit from treatment" requirement incorporated instead into the criteria for compulsory admission and renewal.<sup>36</sup> The Mental Health (Amendment) Act 1982 gave effect to these proposals.

### Likelihood of initial non-cooperation and deterioration

The question of whether the treatability test is satisfied where the medical evidence indicates that admission is likely to initially bring about a deterioration of the patient's mental state, and the patient is unwilling to cooperate in the only form of treatment likely to be beneficial, was considered in *ex p. A.*

#### R. v. Canons Park Mental Health Review Tribunal, *ex p. A.*

[1994] 3 W.L.R. 630

C.A. (Nourse, Kennedy, Roch L.J.)

The evidence was that group therapy was the only form of treatment likely to alleviate or prevent deterioration of A's condition. However, it required the patient's willing co-operation in order to be likely to have this effect and the patient was unwilling to cooperate. Furthermore, there was evidence that it was likely that detention might result in a temporary deterioration of the patient's condition, due to the patient's dislike of being subjected to a controlled environment.

#### The submissions

It was submitted by counsel for the tribunal that the treatability test is concerned with the likely effect of treatment if such treatment is given, and is not concerned with the likelihood of the patient refusing such treatment. There was a known treatment which was likely to alleviate or prevent deterioration of the applicant's condition, namely group therapy. Parliament could not have intended

<sup>33</sup> *Hansard*, H.L. Vol. 217, cols. 91 and 93.

<sup>34</sup> *Ibid.*, col. 98. The Solicitor General (Sir Harry Hylton-Foster) observed that, "though there may be some kind of psychopathic disorder which is not susceptible to medical treatment, it would be a rather tougher thing to say that it is not susceptible to medical treatment in the sense of including 'nursing and ... care and training under medical supervision' which is the definition as it now stands." (*Hansard*, H.C. Vol. 598, col. 833).

<sup>35</sup> *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).

<sup>36</sup> *Ibid.*, para. 1.26.



that a patient should be deemed untreatable simply because the patient will not co-operate. That would place the key to the patient's being detained in hospital in the patient's own hands and did not accord with medical experience concerning the treatment of those with psychopathic disorders. In such cases, there might be an initial deterioration in the patient's condition. However, detention in a secure environment with nursing care and medical supervision — medical treatment within the Act — could lead to the patient gaining an insight into his condition. One of the skills of nurses and doctors in hospitals for the mentally disordered was to persuade their patients to accept treatment. A period of detention with nursing care and medical supervision was frequently a necessary prelude to treatment by way of therapy. If, during such a period, the patient was likely to gain an insight into his problem or likely to become co-operative then that in itself represented an alleviation of the condition. These submissions were generally accepted by the court.

#### Roch L.J.

The following "treatability principles" should be applied when deciding whether medical treatment as an in-patient is likely to alleviate or prevent a deterioration of the patient's condition—

- a. a patient may not be detained simply to coerce him into participating in group therapy.
- b. treatment in hospital will satisfy the treatability test although it is unlikely to alleviate the patient's condition, provided that it is likely to prevent a deterioration.
- c. treatment in hospital will satisfy the treatability test although it will not immediately alleviate or prevent deterioration in the patient's condition, provided that alleviation or stabilisation is likely in due course.
- d. the treatability test can still be met although initially there may be some deterioration in the patient's condition, due for example to the patient's initial anger at being detained.
- e. it must be remembered that medical treatment in hospital covers nursing and also includes care, habilitation and rehabilitation under medical supervision.
- f. the treatability test is satisfied if nursing care, etc., is likely to lead to an alleviation of the patient's condition in that the patient is likely to gain an insight into his problem or cease to be uncooperative in his attitude towards treatment which would potentially have a lasting benefit.

#### Kennedy L.J.

In order to satisfy the treatability test, it is not necessary to demonstrate a probability of short term gain. The fact that a patient demonstrates a fixed determination not to co-operate in the administration of psychotherapy in a group setting, which is the only form of therapy known to be beneficial, is not decisive, provided that there is a prospect that that attitude might change. If so, one is entitled to conclude that treatment over a prolonged period — consisting at first of no more than nursing care and gradual persuasion to accept group therapy but followed by group therapy itself — is likely to alleviate or prevent deterioration of the patient's condition, even if at first some deterioration cannot be avoided. Treatability is a matter of clinical judgment.

#### Summary

It can be seen that the treatability condition is satisfied if medical treatment in its broad statutory sense — which includes nursing care — is eventually likely to bring about some symptomatic relief or prevent the patient's mental health from deteriorating.<sup>37</sup> There are few (if any) conditions which are not treatable in this sense. Accordingly, if the condition was intended by Parliament to further limit the circumstances in which a citizen can be denied his liberty — by requiring a good prospect of benefit from treatment — it must be doubted whether its interpretation by the courts has had any such effect.

#### APPLICATIONS FOR ADMISSION FOR ASSESSMENT

Under the 1983 Act, and related legislation, a person may be detained in hospital for assessment under section 2 in one of three ways—

- Under Part II of the Act, a person may be admitted to hospital for assessment in pursuance of an application made under section 2 or, in an emergency, under section 4.<sup>38</sup>
- Under Part VI of the Act and under the Mental Health (Scotland) Act 1984, a person who is detained in hospital for assessment in Scotland or Northern Ireland may be removed to a hospital in England or Wales, the effect of which is that the patient is treated as if he had been admitted to that hospital under section 2 on the date of his arrival there.
- Under section 14A of the Criminal Appeal Act 1968.

However, almost all patients detained for assessment are detained following the making of an application under Part II.

#### Applications under Part II

An application for admission for assessment may be made in respect of a patient on the grounds that —

- a. "he is suffering from (213) mental disorder (051) of a nature or degree (213) which warrants (215) the detention of the patient in a hospital (131) for assessment (or for assessment followed by a medical treatment) (231) for at least a limited period (226); and
- b. he ought to be so detained in the interests of (221) his own health (217) or safety (218) or with a view to (221) the protection of other persons (219)."<sup>39</sup>

<sup>37</sup> *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X (D.H.S.S., 1987)*, para. 19.

<sup>38</sup> Emergency applications under section 4 are considered below (243).

<sup>39</sup> *Mental Health Act 1983*, s.2(2).

The somewhat clumsy phrase "for at least a limited period" is merely added to emphasise the finite nature of detention under section 2, in contrast to the admission for treatment provisions which provide for a potentially unlimited period.<sup>40</sup>

#### Removal under Part VI

Section 82(1) enables patients who are detained for assessment in Northern Ireland under Article 4 of the Mental Health (Northern Ireland) Order 1986 to be removed to a hospital in England or Wales. Where this occurs, section 82(4A) of the 1983 Act provides that the patient shall be treated as if he had been admitted to hospital in pursuance of a section 2 application made on the date of his admission to hospital in England or Wales.

#### Removal under the Mental Health (Scotland) Act 1984

The Mental Health (Scotland) Act 1984 provides that patients who are detained in pursuance of an application made on the date of their arrival under the corresponding provision in the 1983 Act.<sup>41</sup>

#### Admission orders under the 1968 Act

Where a person appeals against a verdict that he is not guilty of an offence by reason of insanity and the Court of Appeal substitutes a verdict of acquittal, the court may order that he is admitted for assessment under section 2 to such hospital as may be specified by the Secretary of State.<sup>42</sup> The court must be of the opinion, on the written or oral evidence of two registered medical practitioners, one of whom is approved under section 12, that the appellant meets the criteria for being detained under section 2.<sup>43</sup>

#### THE STATUTORY FRAMEWORK

The detention procedures under section 2 differ from those pertaining to section 3 in a number of significant ways.

#### The grounds of application

The grounds of application differ in the following respects—

<sup>40</sup> "The wording ... points the distinction between the two clauses; that in regard to the one, the treatment required may be of a short-term nature and can be done in the observation period without necessitating the rather more full-scale procedure of Clause 26, in which the application is for admission for treatment, and where there is nothing to suggest that it will be of such a short-term nature ... the words do not appear in Clause 26 because it is without limit of time in the sense that the patient must be suitable for detention." The Minister of Health (Mr. Derek Walker-Smith), *Hansard*, H.C. Vol. 605, col. 275.

<sup>41</sup> Mental Health (Scotland) Act 1984, s.77(2).

<sup>42</sup> Criminal Appeal Act 1968, ss. 12, 13(4)(b) and 14A(2). The 28-day period begins on the date of the "admission order" and the appellant must be admitted within seven days of that date, otherwise there is no authority to detain him in hospital. Pending admission, the appellant may be detained in a place of safety.

<sup>43</sup> Criminal Appeal Act 1968, s.14A(1).

The grounds of application set out in section 2(2)(a) require only that a patient suffers from mental disorder generally, as defined by section 1(2), rather than from one of the four specific forms of mental disorder. This is logical because a "specific diagnosis of the form of mental disorder ... may not be possible until the assessment has been completed."<sup>44</sup>

The mental disorder must be of a nature or degree which warrants the patient's detention in a hospital; in section 3 cases, it suffices if the mental disorder is of a nature or degree which makes in-patient treatment appropriate, irrespective of whether detention in hospital is warranted.

It is a ground of application under section 2 that the patient "ought to be so detained" in the interests of his safety or for the protection of other persons; it is not a condition that admission is "necessary" for those purposes, nor that they cannot be realised unless the patient is detained under section 2. The grounds in section 2(2)(b) are therefore "not quite so stringent" as those set out in section 3(2)(c) for section 3 admissions. The rationale is that assessment under section 2 "may be necessary to see whether the more stringent conditions for longer term admission for treatment are met."<sup>45</sup>

It is never a condition of admission under section 2 that any treatment which the patient may receive following admission is likely to alleviate or prevent a deterioration of his condition.

#### Persons assessed not to be mentally disordered

The medical practitioners providing the recommendations in support of the application must be of the opinion that the patient is suffering from mental disorder. The statutory purpose of admission for assessment is therefore not to assess whether the patient is or is not mentally disordered but to assess the mental disorder from which the doctors have certified that in their opinion he suffers. Before forming any such opinion, they must first examine the patient and they owe him a duty to take reasonable care. However, the outcome of a full hospital assessment may occasionally be that the patient does not in fact suffer from mental disorder. Nevertheless, providing the persons involved in the application process acted in good faith and with reasonable care they will be protected by section 139. An alternative way of making essentially the same point is to say that it must appear to the medical practitioners upon carefully examining the patient that he is suffering from mental disorder. Thus, Lloyd L.J. stated, in *R. v. Kirklees Metropolitan Council ex p. C (a Minor)*,<sup>47</sup> that he did not accept the argument that section 2 was "confined to cases where the patient is in fact suffering from mental disorder. Having regard to the definition of a patient in section 145 there is, in my view, power to admit a patient for assessment under section 2, if he appears to be suffering from mental disorder, on the ground that he or she is so suffering, even though it turns out on assessment that [he or] she is not. Any other construction would unnecessarily emasculate the beneficial power under section 2 and confine assessment to choice of treatment."

<sup>44</sup> *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons (D.H.S.S., 1982)*, p.25. See also *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X (D.H.S.S., 1987)*, para. 23.

<sup>45</sup> *Ibid.*

<sup>46</sup> *Ibid.*

<sup>47</sup> See *R. v. Kirklees Metropolitan Council, ex p. C (a Minor)* [1993] 2 F.L.R. 187.

It has been noted that the authority to detain a patient under section 2 expires after 28 days unless a county court application made under section 29 is pending (112). In practice, it has not been uncommon for a patient who has recently ceased to be detained under the section to be readmitted to hospital under section 2.

**R. v. Wilson, ex p. Williamson**

[1996] C.O.D. 42

Q.B.D., Tucker J.

The patient was diagnosed as suffering from paranoid schizophrenia and detained in a secure unit. He had convictions for offences against women and had been sentenced to six years imprisonment in 1988 for an offence of attempted rape. During that sentence he was transferred to a secure hospital unit for treatment, before being discharged from there at the end of 1992. Between 22 February and 1 August 1994, he received in-patient treatment as an informal patient. After a short period in the community, he was informally readmitted to hospital but decided to discharge himself on 14 October. He was prevented from doing so by being detained under section 5(2). His father, the statutory nearest relative, did not accept that compulsory admission was appropriate and refused to discuss the matter. On 17 October, the patient was detained under section 2. He applied to a tribunal but was not discharged. A Consultant Forensic Psychiatrist advised that he should remain in hospital for further treatment after the section 2 period expired on 13 November; if he not consent to remaining informally, a section 3 application should be made. Such an application would require the nearest relative's consent and the patient's detention under section 2 could only be continued if a county court application to displace the nearest relative was made before the section 2 period expired on 13 November. In the event, no such application was made. The patient remained in hospital informally but this arrangement was considered to be unsatisfactory, because the doctors believed that he was too dangerous to be allowed to leave hospital. Ms. Wilson, an approved social worker, considered making a section 3 application but the patient's father objected. The local social services authority agreed that the patient could pose a serious risk to others if he left hospital and that prompt action was necessary to prevent this. Because the patient could not be detained under section 3 unless and until a county court order had been made, and because it might take some time to obtain such an order, it was decided that a further section 2 application should be made. Accordingly, on 20 December 1994, Ms. Wilson made such an application and, later that day, the patient was transferred from the open ward where he had been to a locked ward at a different hospital. A section 29 application was eventually made to the county court on 13 January 1995, although it had not been disposed of by the time Tucker J. delivered his judgment on 5 April 1995.

**The application for judicial review**

The patient applied for judicial review of (i) the approved social worker's decision to make a second section 2 application and (ii) the hospital managers' decision to refuse to release or discharge him once the unlawfulness of the application had been pointed out. It was submitted on his behalf that section 2 provided only for a short-term period of detention for the specified purpose of assessment. The assessment contemplated by section 2 was confined to identifying the core condition. The period limited by the subsection could not be renewed, nor continued, unless a county court application had been made prior to its expiration. Section 2 was a precursor to section 3: once a decision had been taken to proceed under section 3, the need for assessment was over, the condition requiring treatment having been identified. In this case, the decision to apply under section 29, and therefore under section 3 also, had already been

**The application procedures**

As with the grounds of application, so the procedures for making an application under section 2 differ from those pertaining to section 3 in several respects—

- An approved social worker is not under a statutory duty to consult the nearest relative prior to making a section 2 application (instead, he must take such steps as are practicable to inform the nearest relative that an application is to be or has been made<sup>48</sup>).
- Although an approved social worker must have regard to any wishes expressed by a patient's relatives, a section 2 application may be made despite the objections of the nearest relative. The Government considered that the stronger provisions applicable in section 3 cases were not appropriate for admission for assessment "which is usually more urgent and lasts for no more than twenty-eight days."<sup>49</sup>
- The medical recommendations upon which a section 2 application is founded need only formally recite that the admission criteria are satisfied; the practitioners completing them are not required to state the grounds or reasons for their opinion, nor to specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.<sup>50</sup>

**The consequences of admission**

Here, too, patients detained under section 2 are in a different position from those detained following an application for admission for treatment—

- Admission in pursuance of an application under section 2 does not revoke any pre-existing guardianship application or order, nor does it revoke any outstanding supervision application.
- The authority to detain a patient which is conferred by a section 2 application is, in the normal way, limited to 28 days and may not be renewed for further periods.
- The fact that a section 2 patient is remanded in custody or committed to prison, or is absent without leave during the final week of the 28 day period, does not have the effect of extending the period for which the application remains in force.<sup>51</sup>
- A patient who is detained under section 2 has no statutory right to after-care services under section 117 but, equally therefore, no application may be made for him to be subject to after-care under supervision upon ceasing to be liable to be detained.

<sup>48</sup> The Mental Health (Amendment) Act 1982 made a number of important changes to the pre-existing legislation. The requirement, now found in s.11(3), that an approved social worker applicant take steps to inform the person appearing to be the nearest relative that a section 2 application is about to be made, or has been made, and inform him of his discharge powers was introduced.

<sup>49</sup> *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S., 1982), p.26.

<sup>50</sup> *Mental Health Act 1983*, ss.2(3) and 3(3).

<sup>51</sup> Though see p.239.

### Commentary

The Scottish courts have adopted a somewhat different approach. In *R. v. Lothian Health Board (No. 2)* [1993] S.L.T. 1021, the patient was detained under the Scottish provision corresponding to section 4 some 24 hours after the 28-day period of detention corresponding to that permitted by section 2 had expired. Section 26(7) of the Mental Health (Scotland) Act 1984 provides that such a patient shall not be "further detained" under the provisions corresponding to sections 2 and 4 "immediately after" the expiry of the 28-day period of detention. The court held that the second period of detention had not commenced "immediately after" the expiry of the first. The question was one of circumstances, having regard to the mischief that the statutory provision corresponding to section 2(4) was enacted to remove.

### THE MEANING OF "ASSESSMENT" AND ITS PURPOSE

"Assessment" is not statutorily defined. The need for, and response to, treatment of any patient under medical care is continuously being assessed in a clinical sense. Conversely, from a legal viewpoint, all detained patients are continuously receiving medical treatment because treatment includes nursing care. However, to apply these meanings to the section 2 admission criteria without qualification would be to lose sight of the different purposes of section 2 and section 3 applications. The purpose of both would then be assessment and medical treatment. This is why the Act refers to a section 2 patient's detention for assessment or for assessment "followed by" medical treatment.

### "Assessment" and "observation"

Section 25 of the 1959 Act provided for the detention for up to 28 days of a person who suffered from a mental disorder which warranted his detention in a hospital "under observation (with or without medical treatment) for at least a limited period."<sup>53</sup>

### *Mental Health (Amendment) Act 1982*

The words "observation (with or without medical treatment)" were then replaced by "assessment (or for assessment followed by medical treatment)" in the 1982 and 1983 statutes. The reason given for this at the time was that the Government preferred the word "assessment," because it implied "more active intervention to help to diagnose a patient's disorder and plan a treatment programme."<sup>54</sup> More particularly,

"Observation" is defined in the Oxford English Dictionary as 'the action or an act of observing scientifically; esp the careful watching and noting of a phenomenon in regard to its cause or effect, or of phenomena in regard to their mutual relations, these being observed as they occur in nature (and so opposed to experiment)'. 'Assessment' is a wider process ('estimation, evaluation' — OED) of which observation is only a part, and is therefore considered a more appropriate term to reflect current professional practice and to ensure that the patient's needs for treatment are ascertained and met as soon as possible."<sup>55</sup>

<sup>53</sup> Mental Health Act 1959, s.25(2)(a).

<sup>54</sup> *Reform of Mental Health Legislation*, Cmnd. 8405 (1981), para. 17.

<sup>55</sup> *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons (D.H.S.S., 1982)*, pp.23-24.

taken prior to the decision to make the second section 2 application. The first application conferred by section 2 had therefore been misused and the second application was unlawful.

### *The First Respondent's Case (Ms. Wilson)*

Although the patient's medical condition had been diagnosed, there had subsequently been a need to further assess the treatment to be given. Treatment could be provided under section 2 and an "assessment" under that section might include assessing the efficacy of treatment. It had not been necessary to make a section 3 application at the end of the initial section 2 period, nor therefore had it been necessary to apply to the county court for the nearest relative's displacement before that period expired. If the making of a second section 2 application was unlawful in the event that, as here, the patient's behaviour subsequently deteriorated and he became dangerous, there was an hiatus. In fact, that deterioration constituted a new set of circumstances which justified further assessment and a further section 2 application.

### *The Second Respondent's Case (Hospital Managers)*

Counsel for the hospital managers supported the submissions made on the First Respondent's behalf. He queried whether the concluding words of section 2(4) precluded further applications under that section, so as to prevent making a second application during the currency of the first. The matter turned on the meaning of the words used there and the meaning of the term "assessment."

### Tucker J.

The final words of subsection 2(4) excluded the possibility of a second section 2 admission being applied for during the currency of the first. They were clear words which did not give rise to any question. Section 2(4) limited the maximum period of detention under that section to 28 days unless a county court application was pending at the expiration of that period. No such county court application had been made before the section expired on 13 November 1994, and that was unfortunate. Having considered the relevant statutory provisions and the *Code of Practice*, the scheme contemplated by the legislature, and laid down in the Act, was clear. A section 2 application was only intended to be of short duration and for a limited purpose — assessment of the patient's condition with a view to ascertaining whether it was a case which would respond to treatment, and whether an application under section 3 would be appropriate. It was intended that the assessment should take place within 28 days, without any extension of time unless it was necessary for the purpose of replacing the nearest relative. Although there was nothing to suggest that section 2 was a once and for all procedure, there was also nothing in the Act which justified successive or back-to-back applications under the section of the kind which occurred here. The section 2 powers could only be used for the limited purpose for which they were intended. They could not be utilised for the purpose of further detaining a patient for assessment beyond the 28-day period or used as a stop-gap procedure. For the reasons given, the decision and the refusal were wrong in law. *Certiorari granted.*<sup>52</sup>

<sup>52</sup> The application for mandamus was withdrawn upon counsel for the hospital managers expressing their opinion that section 5(2) would not be available following the court's decision to quash the section 2 authority for the patient's detention. The reason given was that section 5(2) contemplated an in-patient who was not detained: it was "designed for the patient who had been a voluntary patient ... To invoke section 5(2), as a result of a person being an in-patient ... [when following the court's judgment] ... the patient was not a voluntary patient but happened to be [detained] there unlawfully ... would take advantage of unlawful status, and ... the hospital manager[s] would be vulnerable to another judicial review, which would effectively be saying that we were using it for improper purposes."

## The Code of Practice

Chapter 5 of the *Code of Practice* deals with the choice of section when making an application under Part II.<sup>56</sup> Paragraphs 5.2 and 5.3 list a number of section 2 and section 3 "pointers." The Code suggests that section 2 will generally be indicated where the diagnosis and prognosis of a patient's condition is unclear, there is a need to carry out an in-patient assessment in order to formulate a treatment plan; a judgement is needed as to whether the patient will accept treatment on a voluntary basis following admission; a judgement has to be made as to whether a particular treatment proposal, which can only be administered to the patient under Part IV of the Act, is likely to be effective; a patient who has already been assessed, and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and needs further assessment; a patient has not previously been admitted to hospital either compulsorily or informally. Conversely, section 3 will generally be indicated where a patient admitted in the past is considered to need compulsory admission for the treatment of a mental disorder already known to his clinical team, and which has been assessed in the recent past by that team. The Code states that decisions as to which section to invoke should not be influenced by wanting to avoid consulting the nearest relative; the fact that a proposed treatment to be administered under the Act will last less than 28 days; or the fact that a patient detained under section 2 will get quicker access to a tribunal. It is important to realise that the pointers in the Code are not a statement of the law. Rather, they represent practice guidelines as to when the use of one power may be indicated in preference to the other.

## Textbook opinion

Gostin states that the term "assessment" *in itself* "may suggest that medical procedures must be limited to those which are necessary to form a diagnosis and to devise a plan of treatment, thus excluding procedures solely for the purpose of treatment (*i.e.* alleviating or curing the patient's condition)."<sup>57</sup> Jones considers that it is unclear whether "assessment" is confined to the process involved in enabling the medical staff to identify the specific statutory form of mental disorder that the patient is suffering from or whether it could also involve the evaluation of the patient's response to treatment.<sup>58</sup>

## Judicial opinion

In the case of *ex p. Williamson* (229), Tucker J. said that section 2 had the limited purpose of assessing the patient's condition with a view to ascertaining, *firstly*, whether it was a case which would respond to treatment and, *secondly*, whether an application under section 3 would be appropriate.

## Interpretation in practice

The recent trend amongst practitioners has been to restrict the meaning of "assessment" to something approximating that given by Gostin. This has caused some practitioners to say that, in cases where a patient's medical history and his need

<sup>56</sup> *Mental Health Act 1983: Code of Practice* (Department of Health, 2nd ed., 1993).

<sup>57</sup> L. Gostin, *Mental Health Services — Law and Practice* (Shaw & Sons Ltd.), para. 11.05.5.

<sup>58</sup> R. Jones, *Mental Health Act Manual* (Sweet & Maxwell, 4th ed., 1996), p.27.

for treatment is well established, the making or continuation in force of a section 2 application is unlawful. The argument is most commonly encountered in one of three contexts.

## "Revolving-door patients" and section 29

The first situation occurs where the nearest relative of a relapsing patient, whose diagnosis and treatment regime is well-established as a result of previous admissions, refuses to consent to an admission to hospital under section 3. The situation quite often arises soon after the expiration of an earlier period of liability to detention, quickly followed by the patient refusing further treatment. A pattern of readmission and discharge develops over the years and it must be acknowledged that, following each readmission, there is generally little in the way of clinical assessment, the diagnosis and the treatment of choice being well-established. The tendency is merely to resume the same plan of treatment as before and to compel the patient to receive as an in-patient the treatment which he would not voluntarily accept as an out-patient. Where this is so, many practitioners take the view that, although detention for treatment is appropriate, the patient cannot be said to warrant detention in a hospital for assessment, and it is unlawful to make a section 2 application. Accordingly, the appropriate course of action is to first apply for the relative's displacement and, if an order is made, to then make an application under section 3.<sup>59</sup>

## "Revolving-door patients" and section 72(1)(a)(i)

The second situation arises where, in a situation similar to that just described, the nearest relative is not contactable or does not object to the patient's detention under section 2 but the patient applies to a tribunal following his admission. Under section 72(1)(a)(i), the tribunal is required to discharge him if it is satisfied that he is not, at the time of the hearing, suffering from mental disorder of a nature or degree which warrants his detention for assessment or for assessment "followed" by medical treatment. Relying on the advice in the Code, the patient's solicitor will submit that the patient must, as a matter of law, be discharged forthwith because he is detained only for treatment. His need for treatment is not being assessed.

## Tribunals and completed assessments

A similar problem may arise where a tribunal considers the case of a patient who had not previously received psychiatric care prior to being admitted for assessment. Here, there is generally no question about the propriety of using section 2 in preference to section 3 at the time of admission. However, the patient's responsible medical officer may say during his evidence that he has completed his assessment but that the patient requires further treatment before being discharged or granted leave. Based on this concession, the authorised representative will submit that the tribunal is bound to discharge the patient, because it cannot possibly be satisfied that any mental disorder from which he suffers warrants his detention for assessment, or for assessment followed by treatment, irrespective of how serious his condition may be. It is no longer a case of "assessment followed by treatment" but treatment only — specifically, the treatment indicated by the completed assessment and now in progress.

<sup>59</sup> The situation here is therefore different from that in *ex p. Williamson* (229), where the patient remained in hospital informally after the expiration of an earlier section 2 application, and so was continually receiving in-patient assessment and treatment.

### Detention under section 2 following an objection to section 3

The first question which arises from the situations described is whether, when admission under section 3 is openly acknowledged by the professionals involved to be the most appropriate form of application, the patient may nevertheless be detained under section 2 while the reasonableness of the nearest relative's objection is determined by a county court. The 1983 Act does not expressly preclude the use of section 2 as an interim measure in such circumstances. However, Parliament is presumed not to enact legislation which interferes with the liberty of the subject without making it clear that this was its intention. Unless clear statutory authority to the contrary exists, no one is to be detained in hospital without his consent.<sup>60</sup> The present edition of the *Memorandum* on the Act offers no assistance on the question and nor does the *Code of Practice*, although it may fairly be said that such a situation is not listed as a "section 2 pointer" in paragraph 5.2.

#### *The argument against section 2 being available*

It may be argued that section 29(3)(c) is intended to deal exhaustively with the situation where the nearest relative objects to a patient's admission for treatment and an approved social worker has only one of only two options: either not to make an application for admission or to apply for the nearest relative's displacement, with a view to making such an application later. Prior to any county court hearing, and a judicial finding that the nearest relative's objection is unreasonable, the patient may not be detained under Part II. Any other view means that a nearest relative who reasonably objects to a patient being again compulsorily admitted for treatment is powerless to prevent his detention. The right to object, on being consulted by an approved social worker, becomes meaningless if the social worker can simply bypass that objection by making an assessment application. The patient may be subjected to compulsory treatment for 28 days, or even longer if county court proceedings are commenced. This, it is said, cannot be correct. Although the Act does not permit the nearest relative to object to the detention for assessment of a person whose condition and need for treatment is not fully understood, its intention is to enable the nearest relative to prevent further compulsory admissions once the diagnosis, prognosis and range of possible treatments are known. At that stage, the nearest relative is presumed to be in a position to make an informed decision about the advantages and disadvantages of further treatment. That being so, any objection to further treatment is binding on the social worker concerned, at least until such time as he can demonstrate to a county court that those objections are unreasonable. Obtaining such a judicial determination need not be a prolonged affair, as was made clear in the case of *B. v. B.*<sup>61</sup> "Applications for compulsory admission to and detention in hospital for treatment often have to be made in an emergency. It is not always possible to obtain the opinions of medical practitioners approved by the Secretary of State or a local health authority. Therefore, any doctor can be called on for the purposes of supporting an application to dispense with consent in order to provide the necessary evidence for the county court."<sup>61</sup>

#### *The argument for section 2 being available*

The above argument is attractive in many ways but the history and framework of the Act in fact suggests that—

<sup>60</sup> *R. v. Hallstrom, ex p. W.*; *R. v. Gardner, ex p. L.* [1986] 1 Q.B. 1090, per McCullough J.

<sup>61</sup> *B. (A.) v. B. (L.) (Mental Health Patient)* [1980] 1 W.L.R. 116.

- the absence of a section 3 emergency procedure equivalent to section 4 means that the words "for assessment (or for assessment followed by treatment)" are not to be construed in a way which excludes patients whose need for treatment is well-established (235).

- the use of section 2 following an objection to detention under section 3 is an option which Parliament intended to be available to professionals, and one of the reasons why it gave the nearest relative no power to object to admission under section 2 (236).

- the power conferred by section 11(4) is the right to prevent a patient from being detained for a potentially indefinite period unless a county court order is first obtained; not the power to prevent detention for a finite period (236).

- the remedy which the Act gives a nearest relative who objects to a patient's detention under section 2 is the power to discharge the patient unless the responsible medical officer considers that he would then be likely to act in a manner dangerous to himself or others (237).

- Parliament intended that, unless a patient clearly requires compulsory treatment for more than 28 days, he should generally be admitted under section 2, even if he is a well-known patient whose need for treatment is well-established (238).

### The absence of a section 3 emergency procedure

The medical grounds for admission under sections 2 and 4 are the same and an emergency application is a section 2 application initially founded upon a single medical recommendation. Such an application may only be made if it is urgently necessary that the patient is admitted "for assessment (or for assessment followed by treatment)" and compliance with the usual section 2 procedures will involve undesirable delay. If there are some patients who may not be admitted under section 2, because they have previously been fully assessed, then neither may they be admitted under section 4. However, the Act does not include an equivalent emergency procedure by which a person may be detained under section 3 on the basis of a single medical recommendation. It could be that Parliament intended that chronic patients whose conditions have recently been fully assessed (for example, patients with a long history of suicide attempts, where the risk of self-harm is well-established) should not be detainable under section 4 — even if their nearest relative does not object and obtaining a second recommendation would involve undesirable delay. It is more probable, however, that Parliament intended that the single emergency procedure would be available in all cases where admission is urgently necessary. If so, Parliament must have considered that both new patients and chronic, revolving-door, patients alike may warrant detention "for assessment (or for assessment followed by treatment)" for at least a limited period." A reading of Hansard confirms this interpretation, as the following paragraph shows.

## Mental Health Act 1959, ss. 25 and 29

Section 2 derives from section 25 of the 1959 Act and section 4 from section 29. Clause 25 of the 1959 Mental Health Bill originally provided only for a patient's admission for observation, without any reference to treatment. The Government was initially concerned that if the emergency procedure was also confined to applications for observation, as some Members wished, "there might be cases which ought to be dealt with urgently under the emergency procedure but in which there was no need for observation because the nature of the illness and the need for treatment might already be clear. That was the major difficulty."<sup>62</sup> The phrase "(with or without other medical treatment)" was therefore added after the word "observation" during the Bill's passage through the House of Commons. The Minister of Health, Mr. Derek Walker-Smith, explained that observation was still "an essential object of admission under the Clause, but the Amendment makes it clear that the patient who clearly needs at least a short period of treatment can be admitted under the Clause 25 ... The Minister continued,

"The major difficulty which I had in mind is largely met by the new subsection (2) of Clause 25 ... Even in a case where it is clear what treatment will be needed, because the patient comes as an out-patient who is known, or a former in-patient, observation will generally be needed to determine whether the twenty-eight days' compulsory detention is likely to be enough. This revised wording of Clause 25 will enable a patient to be admitted with the primary object of giving the short-term treatment that is needed. The same will apply to emergency applications for observation under Clause 29."<sup>64</sup>

Sections 25 and 29 were re-enacted as sections 2 and 4 of the 1983 Act with only minor modifications, the previous references to observation with or without treatment being replaced by references to assessment or assessment followed by treatment. The reasons for this change of terminology have already been explained. On close examination, it is the significance of the phrase "followed by" rather than "assessment" which has really caused the problems encountered in practice to which reference has been made. There would be no ambiguity if section 2 instead authorised detention for assessment "with or without treatment." Nevertheless, the fact that Parliament did not use the opportunity to introduce a specific section 3 emergency procedure indicates that the original reasons given for a second emergency procedure being unnecessary were still seen as holding good. The existence of an emergency procedure providing only for detention under section 2, and the extracts from Hansard, make it difficult to argue that Parliament intended that chronic well-known patients could no longer be admitted under section 3. Indeed, contrary to what the *Code of Practice* now suggests, Parliament seems to have envisaged that, unless a patient clearly requires compulsory treatment for more than 28 days, the initial admission should be limited to that defined period.

### Limits of a nearest relative's power to prevent detention

Paragraph 133 of the *Memorandum* on the 1959 Act, issued by the D.H.S.S., stated that "an application to the county court may be made while the patient is detained for observation after admission under Section 25 or 29 — or he may be so admitted

<sup>62</sup> The Minister of Health (Mr. Derek Walker-Smith), *Hansard*, H.C. Vol. 605, col. 281.

<sup>63</sup> *Ibid.*, col. 269.

<sup>64</sup> *Ibid.*, *Hansard*, cols. 281-82.

while an application to the county court is pending."<sup>65</sup> The Government's White Paper of 1978 suggests that this option of admitting a patient under section 25 following an objection to his admission for treatment was intended to remain an option under any new legislation—

### "Safeguards in relation to section 25

....2.15 The safeguards for patients detained under section 26 are stronger than those for patients detained under section 25. For example, the Mental Welfare Officer is required to consult the nearest relative where an application is being made for detention under section 26 except where this is not practicable or would cause unreasonable delay. If the nearest relative objects to the application being made, the Mental Welfare Officer cannot proceed. However, on the application of the Mental Welfare Officer or any relative of the patient or any other person with whom the patient is living, a County Court can make an order appointing another person to act as the nearest relative in certain circumstances, for instance where it is established that the nearest relative has unreasonably objected to an application for compulsory admission. In view of the delay which can be involved in this procedure, it is not thought practicable for the patient's nearest relative to have a similar right to veto a section 25 application but it is proposed that the Mental Welfare Officer should be required to take all reasonable steps to inform the nearest relative that a section 25 application has been made and to tell him of his rights of appeal and discharge ... It is considered that the nearest relative should have the same right to discharge a section 25 patient as he does a section 26 patient, but with the same provisos....<sup>66</sup>

It seems therefore that a reason for not allowing the nearest relative a power to prevent admission under section 2 is precisely to enable the patient to be admitted under a finite, unrenounceable, "order" while the reasonableness of that relative's objection to his detention under a potentially indefinite, renewable, "order" is reviewed by the court.<sup>67</sup> It is also arguable that the fact of the nearest relative's objection, ruling out as it does the patient's immediate admission under section 3, may have the effect that detention under section 2 is then "warranted" albeit that it was not warranted prior to the making of the objection.

### The nearest relative's power to discharge

The effect of the provisions in sections 23-25 is that where a nearest relative objects to the patient's detention under section 3 and, as a result, he is admitted under section 2, that relative may discharge the patient unless the responsible medical officer considers that the patient would then be likely to act in a manner dangerous to himself or others.<sup>68</sup> This is the remedy given to the nearest relative where a

<sup>65</sup> *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (Ministry of Health, 1960).

<sup>66</sup> *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978), pp.15-16.

<sup>67</sup> Again, this interpretation is not contradicted by the decision in *ex p. Williamson* (229). The patient in that case was admitted under section 2, in the knowledge that his nearest relative objected to a section 3 application being made. The objection, there was that the patient was further detained under section 2, for a second period of 28 days, because of the local authority's failure during the first period to apply to the county court for the reasonableness of the objection to be determined.

<sup>68</sup> The making of a county court application does not prevent the patient from being discharged under section 23 before the court case is disposed of, including by the nearest relative whose displacement is being sought. See *e.g. Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (Ministry of Health, 1960), para. 131. The effect of section 29(4) is to extend beyond 28 days the period for which the managers have authority to detain the patient, not to suspend the operation of section 23. However, except in cases involving guardianship, the nearest relative's power of discharge is ineffective if the patient would, if released, be likely to act dangerously.

section 2 application is made in the circumstances described. The overall effect of the Part II provisions is therefore as follows—

- where the nearest relative objects to a patient's detention under both sections 2 and 3, and there is no likelihood that the patient would act dangerously if not detained, it will often be difficult for the approved social worker to be satisfied that a section 2 application ought to be made, and is necessary or proper.<sup>69</sup> This is because the patient's admission is likely merely to result in him being immediately discharged by the objecting nearest relative. The approved social worker may therefore decide to apply for the nearest relative's displacement and make no application for the patient's admission for the time being.
- where the nearest relative objects to a patient's detention under both sections 2 and 3, and there is evidence that the patient would act dangerously if not detained, there can be no legal or practical objection to the patient being detained under section 2 or 4 (dangerous conduct or the likelihood of it often being a reason for invoking the emergency application procedure). Any attempt to discharge the patient may be barred and he may, if necessary, be detained under section 2 until the reasonableness of the nearest relative's objection to his indefinite detention for treatment is determined by the county court.

#### *Failure to apply promptly for displacement*

In practice, a lot of disquiet arises because approved social workers who make a section 2 application following an objection to detention under section 3 do not then promptly apply to the county court for a determination of the reasonableness of the objection. Commonly, a "wait and see" strategy is adopted and a county court application is only made when the 28-day section 2 period is about to expire and further compulsory treatment proves to be unavoidable. Although this may have the benefit of avoiding unnecessary litigation and saving professional time, it also results in the section 2 period being unduly protracted, during which extended period neither the patient nor his nearest relative has any right of application to a tribunal.

#### **The statutory purpose of section 2**

The *Code of Practice* states that decisions about whether to make an application under section 2 or section 3 should not be influenced by the fact that a proposed treatment to be administered under the Act will last less than 28 days.<sup>70</sup> This reflects the current fashion of saying that section 3 applications are not more restrictive of individual liberty than section 2 applications, because the authority conferred by the former is not detention for six months, merely detention for up to six months. It is submitted, however, that such a view is wrong. The authority to detain and compulsorily treat a patient which is conferred by an assessment application is finite and non-renewable; that conferred by section 3 is renewable and potentially indefinite. Because this is so, the Act provides stronger safeguards in relation to such applications, including prohibiting them if the nearest relative objects unless a

<sup>69</sup> See *Mental Health Act 1983*, s.13(1).

<sup>70</sup> *Mental Health Act 1983: Code of Practice* (2nd ed., 1993), para. 5.4b.

county court order is first obtained. In providing these stronger safeguards, Parliament clearly did recognise that the power of detention conferred by section 3 represents a greater infringement of personal liberty. Accordingly, it also provided that a person shall not be detained under section 3 unless the in-patient treatment which he requires "cannot be provided unless he is detained under this section." In other words, section 2 should be used if the in-patient treatment can be provided under that section because no more than 28 days' compulsory treatment may be necessary. As such, a principle purpose of section 2 is to ensure that citizens are not liable to indefinite detention and compulsory treatment unless a thorough assessment indicates that there is no viable alternative. It provides an opportunity to explore less restrictive alternatives and to assess, in the light of them and the patient's response to treatment during the 28 day period, the necessity for indefinite compulsory treatment. If medical opinion is then that a prolonged and potentially indefinite period of detention is necessary, no application may be made unless the patient's nearest relative or an approved social worker concurs with this assessment of the situation and, if the former objects, unless a county court order is first obtained.

#### **The meaning of assessment**

Having regard to the above, the word "assessment" is something of a statutory term of art. The assessment involves assessing from a clinical viewpoint the patient's need for prolonged treatment and assessing from a legal viewpoint the necessity of prolonged and potentially indefinite compulsory treatment. In reaching a decision about whether any treatment which a patient requires can only be given if he is detained under section 3, it will often be necessary for an assessment to include —

- assessing whether the patient is suffering from mental disorder and, if he is, the statutory form of mental disorder from which he is suffering.
- assessing the cause of any mental disorder and identifying, where relevant, the events which triggered any recent relapse.
- assessing, that is monitoring, the patient's response to any treatment given and forming a prognosis, in order to determine whether any in-patient treatment indicated may be completed within 28 days or a prolonged period of treatment is necessary.
- identifying and assessing what other methods of treating the patient are available and, if so, whether they are appropriate.
- if a prolonged period of in-patient treatment is indicated, assessing whether it can be provided without the patient being detained under section 3.
- assessing whether detention in hospital is actually "necessary" for the patient's health or safety or for the protection of others, rather than merely justifiable with those purposes in mind.



- assessing whether, in the case of a patient found to suffer from a mental impairment or psychopathic disorder, further treatment is likely to alleviate or prevent a deterioration of his condition.
- consulting the nearest relative and ascertaining his views on the use of further compulsory powers in the context of the patient's response to treatment during the section 2 period.

It must be emphasised that because a person has previously been detained under section 3, it does not follow that prolonged liability to detention in hospital is again necessary. The relapse may be at an early stage and there may be alternative treatments or community facilities which were not previously available. The patient may historically make a good response to in-treatment and a full assessment within a hospital setting may allow effective short-term treatment to be given. In any case, the statutory issue is not whether a patient is a well known but whether he presently satisfies the more stringent criteria for detention under section 3. In particular, whether the in-patient treatment which he needs cannot be provided unless resort is had to section 3.

#### The tribunal discharge criteria

It has been noted that references in the 1959 Act to detention for "observation (with or without medical treatment)" were replaced by references to detention for "assessment (or for assessment followed by medical treatment)" in the 1982 and 1983 statutes. The new phrase also forms part of the tribunal discharge criteria. Two examples of situations in which its interpretation has been disputed and caused difficulty have been given (233). Whether a tribunal is obliged to discharge a patient once a diagnosis and prognosis have been reached and a programme of treatment been commenced was touched upon but not resolved in *R. v. Wessex Mental Health Review Tribunal, ex p. Wiltshire County Council*.<sup>71</sup> In this case, the tribunal were of the opinion that the discharge criteria were satisfied, and that a statutory duty to discharge existed, because the patient's condition was well-known and could not properly be said to require "assessment." In its application for judicial review of that decision, Wiltshire County Council contended that "no Mental Health Review Tribunal properly directing itself on the relevant law and acting reasonably could have reached the decision that the Patient should be discharged from his detention under section 2 ... The Tribunal applied an unnecessarily restrictive test when interpreting the words 'assessment' and 'assessment followed by treatment' contained in section 72(1) ..." The case was eventually determined without reference to this particular issue.

#### The statutory framework

The meaning of the phrase "for assessment (or for assessment followed by treatment)" in section 72 must be determined by reference to the statutory framework. Based on the observations which have already been made, it is submitted that this framework may be summarised in the following way—

- Where a patient is assessed not to be mentally disordered, the first of the reasons for detaining him has been fulfilled and the second also in that no treatment will follow what constitutes a completed assessment. Although section 23 does not expressly oblige a responsible medical officer to then discharge the patient, a duty to do so arises because continuing the patient's detention will not then be for a purpose authorised by the Act.
- Similarly, once a patient has been assessed not to suffer from any form of mental disorder that warrants compulsory treatment then both purposes are fulfilled, continued detention being warranted neither for assessment or treatment.
- Where, however, a patient has been assessed to suffer from a disorder which does warrant detention for treatment, his responsible medical officer is not thereby bound to discharge him simply because he has commenced the treatment indicated by his assessment of the patient's treatment needs. Nor is he obliged to recommend the making of a section 3 application merely because the focus of the detention has shifted from the first of the statutory purposes (assessment) to the second (treatment following assessment). The wording of section 2(2)(a) — "(or for assessment followed by medical treatment)" — and the consent to treatment provisions in Part IV are clearly intended to permit the giving of any treatment indicated by the assessment for the duration of the 28-day period.
- Indeed, it would arguably be improper for the responsible medical officer to complete a section 3 recommendation if the treatment assessed to be necessary might, in his opinion, be concluded within the 28-day section 2 period. This is because it is a condition of detention under section 3 that the treatment which the patient requires cannot be provided unless he is detained under that section.
- Bearing these points in mind, the issue about the ambit of section 72(1)(a)(i) becomes whether Parliament intended to impose on tribunals a duty to discharge a patient who the responsible medical officer is not obliged to discharge, simply because the first of two statutory purposes authorised by the application has been fulfilled.
- It would be remarkable if Parliament intended that whenever an assessment of a patient's condition demonstrates a need for compulsory treatment — that is that the assessment should be "followed by treatment" — a tribunal is then obliged by virtue of this positive finding of a serious mental disorder to discharge the patient. If this were correct a patient must be discharged both when he is assessed not to need compulsory treatment and when he is assessed to need such treatment.
- A patient who suffers from mental impairment or a psychopathic disorder may not be detained, nor his detention be renewed, unless his condition is treatable. However, a tribunal reviewing his case is not obliged to discharge him even if satisfied that his condition is untreatable. Nor is it obliged to discharge a mentally ill or severely mentally impaired patient whose

<sup>71</sup> *R. v. Wessex Mental Health Review Tribunal, ex p. Wiltshire County Council, Perkins v. Bath District Health Authority* (1989) 4 B.M.L.R. 145.

condition is untreatable even though there appears to be no risk of a patient being neglected or exploited upon release. Nor, because the discharge criteria are phrased as a double-negative, is it obliged to discharge any patient unless it is positively satisfied that the discharge criteria are made out. These features reflect the fact that, as a review body, it is only obliged to discharge a patient if persuaded that the two core grounds for making or renewing an application no longer subsist. It is therefore unlikely that Parliament intended, in this single instance, that a tribunal but not the responsible medical officer is obliged to discharge.

For the above reasons, it is submitted that the use of the words "followed by" in section 2 are consequential upon Parliament's preference for the word "assessment." The words emphasise that where a person is detained for 28 days, those with clinical responsibility for him should not simply passively observe his mental state but actively assess his need for treatment and then commence that treatment as soon as practicable, thereby minimising the period of detention and compulsion.

The incorporation within section 72(1)(a) of the same wording used in section 2, together with the addition of the word "then", was unfortunate and unnecessarily ambiguous. The underlying intention was to require a tribunal to consider whether it is satisfied, in the light of the evidence presented at the hearing, that the patient's condition does not, or no longer, warrants his detention for either of the statutory purposes authorised by the application, namely assessment or treatment following assessment. Insofar as the drafting is, as elsewhere in section 72, indifferent, section 72(1) should, it is submitted, be read as follows — "(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if they are satisfied (i) that he is not then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for medical treatment following assessment) for at least a limited period."

In other words, the phrase "(or for assessment followed by medical treatment)" may properly be read as meaning "(or for medical treatment following assessment)" where treatment has already been commenced before the hearing takes place.

It may be added that the "golden rule" of statutory interpretation allows the court to prefer a sensible meaning to an absurd if literally correct meaning. Similarly, 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.

## EMERGENCY APPLICATIONS

In any case of "urgent necessity," an application for admission for assessment may be made under section 4, which provides that the application shall be sufficient in the first instance if founded on one of the medical recommendations required by section 2. The grounds of the application are those set out in section 2(2). The application must include a statement that it is "of urgent necessity" for the patient to be admitted and detained under section 2 and that compliance with the usual provisions relating to such applications would involve "undesirable delay." The medical practitioner who provides the supporting recommendation must verify the statement which the applicant has made. New forms were prescribed under the 1983 Act and they require information to be given clarifying the circumstances of the emergency.

### USAGE

Approximately 10 per cent. of patients compulsorily admitted to hospital for assessment are initially admitted under section 4, on the strength of a single medical recommendation. During the period 1987-1983, the number of section 4 applications declined by 42 per cent., from 2180 to 1263 cases each year.

### HISTORICAL NOTE

Historically, Parliament has from time to time further restricted the circumstances in which a person may be admitted to hospital on the basis of one medical recommendation. Section 30 of "An Act to regulate the Care and Treatment of Insane Persons in England" (1828)<sup>72</sup> provided that a medical certificate upon which an order for the confinement of any person, other than a parish patient, was given had to be signed by two medical practitioners unless "special circumstances" prevented the patient being separately visited by two medical practitioners. Where special circumstances existed, a person could be admitted to a licensed house upon the certificate of a single medical practitioner provided the certificate was signed by a second medical practitioner within seven days of the patient's admission. Section 11 of the Lunacy Act 1890 made provision for "urgency orders." Such an order might be made by a person aged 21 or over — the patient's spouse or a relative where practicable — who had "personally seen" the patient within the previous 48 hours. A statement of various prescribed particulars had to be annexed to the application and the order was sufficient if founded upon a single medical recommendation in the prescribed form. This medical certificate was given by a medical practitioner who had "personally examined" the patient within the period of two days prior to the patient's reception and included a statement that it was "expedient" that the patient be received and detained. Once made, the order remained in force for seven days, unless at the expiry of that period a petition was before the court in which case it continued in force until the petition was disposed of. The formalities relating to the making of an emergency application under section 29 of the 1959 Act were similar to those presently in force, save that the application could be made by any relative of the patient — not just by his "nearest relative" — and the applicant had to have seen the patient within the period of 72 hours prior to making the application, compared with the 24-hour period now stipulated. In only permitting a 72-hour period of confinement, this represented a further tightening of the procedures.

<sup>72</sup> 9 Geo. IV, c.41.

## URGENT NECESSITY

In *Re Cathcart*,<sup>73</sup> Halsbury L.C. emphasised that urgency orders under the 1890 Act should only be used where instant intervention was required and, given that the statutory procedures have subsequently been further tightened, it is likely that the use of emergency applications remains confined to such cases. The *Memorandum* on the Act states that it may be necessary to admit a patient on the basis of a single medical recommendation "in exceptional circumstances."<sup>74</sup> The *Code of Practice* emphasises the need for a "genuine emergency."<sup>75</sup> This requires evidence of the existence of a significant risk of mental or physical harm to the patient or to others; and/or the danger of serious harm to property; and/or the need for physical restraint of the patient.<sup>76</sup>

## THE APPLICATION PROCEDURES

An application may not be made under section 4 unless the applicant has personally seen the patient within the previous 24 hours. Section 14, which deals with the preparation of social reports following nearest relative applications, does not apply in such cases.

## THE EFFECT OF AN EMERGENCY APPLICATION

A duly completed emergency application constitutes sufficient authority—

- for the applicant, or any person authorised by him, to take the patient and convey him to the hospital specified in the application within the period of 24 hours beginning at the time when the patient was examined by the practitioner giving the medical recommendation or the time when the application is made, whichever is the earlier;<sup>77</sup>
- for the managers of the hospital to admit the patient within that period and thereafter to detain him in accordance with the provisions of the Act.

## DURATION

The application ceases to have effect once 72 hours have elapsed since the time of admission unless by then the managers have received the second medical recommendation required by section 2 and the recommendations together comply with the usual requirements applicable in section 2 cases.<sup>78</sup> Where the necessary second recommendation is provided within this period, the patient remains liable to be detained for assessment for the remainder of the 28-day detention period which

<sup>73</sup> *Re Cathcart* [1893] 1 Ch. 466.

<sup>74</sup> *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 28.

<sup>75</sup> *Mental Health Act 1983: Code of Practice* (2nd ed., 1993), para. 6.2.

<sup>76</sup> *Ibid.*, para. 6.3.

<sup>77</sup> The Act clearly envisages that the application may be made before the medical recommendation is given, notwithstanding that it must be "founded" on the recommendation. See also Lunacy Act 1890, s.11(2); *Archbold's Lunacy and Mental Deficiency Law* (Butterworth & Co., Shaw & Sons, 5th ed., 1915), p.191.

<sup>78</sup> Apart from the necessary modification that the second recommendation may be dated later than the application: see *Mental Health Act 1983*, s.4(4)(b).

commenced with his admission. A hospital under section 4. On a practical level, it is important that the applicant obtains a copy of any second medical recommendation later furnished. If this is not done, and the second recommendation is materially defective, the patient may be detained for 28 days in pursuance of an invalid application made by him, albeit that it was in order when he submitted it.<sup>79</sup>

## APPLICATIONS FOR ADMISSION FOR TREATMENT

A person may be liable to be detained in hospital for treatment under section 3 in one of four ways—

- Under section 3, a person may be admitted to hospital for treatment in pursuance of an application for treatment.
- Under section 19, a person who is subject to guardianship may be transferred to hospital.
- Under Part VI of the Act and the Mental Health (Scotland) Act 1984, a person who is detained in hospital for treatment in Scotland or Northern Ireland may be removed to a hospital in England or Wales.
- Under the transitional provisions, a patient admitted to hospital for treatment prior to the implementation of the 1983 Act may be deemed to have been admitted in pursuance of an application made under section 3.

## Applications under section 3

An application for admission for treatment may be made in respect of a patient on the grounds that—

- a. "he is suffering from (213) mental illness (060), severe mental impairment (070), psychopathic disorder (082) or mental impairment (070) and his mental disorder is of a nature or degree (213) which makes it appropriate (215) for him to receive medical treatment (216) in a hospital (131); and
- b. in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition (222); and
- c. it is necessary (220) for the health (217) or safety (218) of the patient or for the protection of other persons (219) that he should receive such treatment and it cannot be provided unless he is detained under this section (239)."<sup>80</sup>

<sup>79</sup> For example, the second recommendation is, like the first, given by a medical practitioner who is not section 12 approved or is otherwise insufficient to warrant the patient's detention. *Mental Health Act 1983*, s.3(2).

## GUARDIANSHIP APPLICATIONS

A patient may be received into guardianship under Part II in one of three ways—

- Under section 7, an application may be made for a patient's reception into guardianship.<sup>82</sup>
- Under section 19, a patient who is liable to be detained under section 2 or 3 may be transferred into guardianship.<sup>83</sup>
- Under Part VI and the Mental Health (Scotland) Act 1984, a patient who is subject to a guardianship application in Scotland or Northern Ireland may be removed into guardianship in England or Wales.

### Guardianship applications

A guardianship application in respect of a patient may be made under section 7 on the grounds that—

- a. "he is suffering from (213) mental disorder (051), being mental illness (060), severe mental impairment (070), psychopathic disorder (082) or mental impairment (070) and his mental disorder is of a nature or degree (213) which warrants (215) his reception into guardianship under this section; and
- b. it is necessary in the interests of (220) the welfare (217) of the patient (098) or for the protection of other persons (219) that the patient should be so received."<sup>84</sup>

### Transfer into guardianship under section 19

Where a patient who is liable to be detained under section 2 or 3 is transferred into guardianship, the Act provides that the application has effect as if it were a guardianship application made and accepted on the date when the patient was originally admitted to hospital for assessment or treatment, as the case may be.<sup>85</sup> The transfer of a patient into guardianship involves few formalities. Because no fresh application is necessary, and the effect is to end the patient's liability to detention, the nearest relative's consent and fresh medical recommendations are not required, nor need the patient be interviewed by an approved social worker. If the underlying aim is to reduce the time spent by the patient in hospital, but it is realised that compulsory readmissions will periodically be necessary, further transfers to and from hospital and guardianship may be made.

<sup>82</sup> Mental Health Act 1983, ss.7(1) and (5), 11(1) and (2).

<sup>83</sup> Mental Health Act 1983, paras. 19(1)(e) and (2)(f). For the prescribed procedure and forms, see the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 7(3).

<sup>84</sup> Mental Health Act 1983, s.7(2). There is no treatability test for guardianship. It suffices that guardianship is in the interests of the patient's general welfare or for the protection of others.

<sup>85</sup> Mental Health Act 1983, s.19(2)(b). Because of an oversight, a section 2 patient who is transferred into guardianship does not have a legal classification under the Act.

### Transfer to hospital under section 19

Where a patient who is subject to a guardianship application is transferred to hospital under section 19 (283), the guardianship application takes effect as if it were a section 3 application and as if the patient had been admitted to hospital in pursuance of it on the date of his original reception into guardianship.

### Removal under Part VI

Section 82(1) enables patients who are detained for treatment in Northern Ireland under Article 12(1) or 13 of the Mental Health (Northern Ireland) Order 1986 to be removed to a hospital in England or Wales. Where this occurs, section 82(4) of the 1983 Act provides that the patient shall be treated as if he had been admitted to hospital in pursuance of a section 3 application made on the date of his admission to hospital in England or Wales.

### Removal under the Mental Health (Scotland) Act 1984

The Mental Health (Scotland) Act 1984 similarly provides that detained patients removed from Scotland to England or Wales shall be treated as if they had been detained in pursuance of an application made on the date of their arrival under the corresponding provision in the 1983 Act.<sup>81</sup>

### Patients deemed to be liable to be detained under section 3

Section 3 derives from section 26 of the Mental Health Act 1959. Patients who were originally admitted under section 26 and have remained continuously detained since then are deemed to have been admitted in pursuance of a section 3 application. In practice, it is worth carefully checking the transitional provisions since it is common to find that the first renewal report due after the new Act came into force was not furnished within the prescribed period. If this is the case, there will have been no valid authority for the patient's detention under the 1983 Act since some date shortly after it came into force.

### STATUTORY FRAMEWORK

The main differences between the grounds of application and the statutory procedures applicable under section 2 and section 3 have already been summarised (226, 228).

### DURATION

An application under section 3 authorises the managers of the hospital to detain the patient for a period of up to six months beginning with the date of his admission under section 3. The authority for the detention of the patient may be renewed if appropriate for a further period of six months and thereafter at yearly intervals in accordance with the provisions of section 20. The effect of an application under section 3 in other respects is dealt with below (273 et seq.).

<sup>81</sup> Mental Health (Scotland) Act 1984, s.77(2).

#### Removal under Part IV

Section 82(1) provides that patients subject to guardianship in Northern Ireland may be removed to in England or Wales and received into guardianship there. Where this occurs, section 82(3) provides that the patient shall be treated as if he received into guardianship in pursuance of a section 7 application made on the date he arrives at the place where he is to reside.

#### *Mental Health (Scotland) Act 1984*

The Mental Health (Scotland) Act 1984 similarly provides that a patient subject to guardianship in Scotland who is removed to England or Wales under the 1984 Act shall be treated as if he had been received into guardianship in pursuance of a section 7 application made on the date he arrives at the place where he is to reside.<sup>86</sup>

#### HISTORICAL NOTE

Although the placing of persons suffering from mental disorder under a guardian can be traced back to the middle ages,<sup>87</sup> guardianship in its present statutory form has its origins in the Mental Deficiency Act 1913<sup>88</sup> and the recommendations of the Percy Report,<sup>89</sup> most of which were later enacted in the Mental Health Act 1959.<sup>90</sup>

#### The Mental Deficiency Acts 1913 and 1927

The Mental Deficiency Act 1913 provided that "idiots" and "imbeciles" could be received into guardianship upon a parent furnishing a statement of statutory particulars concerning the patient, accompanied by a certificate signed by two medical practitioners, one of whom was required to be approved for the purpose.<sup>91</sup> Reception conferred on the guardian the powers of a father over the patient.<sup>92</sup> There was no court involvement in this procedure. However, as today, guardianship could be imposed by a criminal court in certain circumstances<sup>93</sup> and a distinctive feature of the 1913 and 1927 statutes was that such orders could also be made under a court's civil jurisdiction.<sup>94</sup> Some judicial involvement was required before guardianship could be imposed on less seriously handicapped individuals (the "feeble-minded") and persons who today might be classified as having a psychopathic disorder ("moral imbeciles").<sup>95</sup> Furthermore, as in the 1959 Act, certain age-limits applied. Mental Deficiency Rules provided for matters such as changes of residence and transfers to hospital. The legislation therefore resembled that in the 1959 Act: the abolition of the need for applications to be judicially considered aside, it is generally a myth that the civil procedures in the 1959 Act represented a clean break with the past.

<sup>86</sup> Mental Health (Scotland) Act 1984, s.77(3).

<sup>87</sup> See R. Nengebauer, "Diagnosis, Guardianship, and Residential Care of the Mentally Ill in Medieval and Early Modern England", *American Journal of Psychiatry* (1989) 146:12, 580-1584.

<sup>88</sup> Mental Deficiency Act 1913, implementing the recommendations of *The Report of the Royal Commission on the Care and Control of the Feeble-Minded*, Cd. 4202 (1908).

<sup>89</sup> *The Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957), paras. 387, 359, 400 and 411.

<sup>90</sup> Mental Health Act 1959, ss.33 and 60.

<sup>91</sup> Mental Deficiency Act 1913, s.3(1).

<sup>92</sup> *Ibid.*, s.10(2).

<sup>93</sup> *Ibid.*, ss.4(b) and 8.

<sup>94</sup> For example, upon a petition being presented under s.5(1).

<sup>95</sup> However, the endorsement of the medical certificate by a Justice of the Peace often sufficed. Mental Deficiency Act 1913, ss.2 and 3.

#### The Mental Health Act 1959

The 1959 Act extended the availability of guardianship to persons suffering from mental illness. It conferred on the guardian "to the exclusion of any other person all such powers as would be exercisable by ... him in relation to the patient if ... he were the father of the patient and the patient were under the age of fourteen years."<sup>96</sup> The guardian's duties included ensuring "that everything practicable is done for the promotion of his physical and mental health."<sup>97</sup> The use of guardianship under the Act declined markedly during the following years, partly due to doubts about the precise ambit of these paternalistic powers, but also because of increasing concern in some quarters that they were inappropriately wide.<sup>98</sup>

#### The White papers of 1978 and 1981

The Government re-examined the law relating to guardianship in the White Paper "Review of the Mental Health Act 1959."<sup>99</sup> After further consultations, it published a second white paper in November 1981,<sup>100</sup> in which it explained its proposals for revising the existing law relating to guardianship:<sup>101</sup>

"43. The guardian, who is usually but not always a local social services authority, is given the powers that a father has over a child under 14. These powers are therefore very wide, as well as somewhat ill-defined, and out of keeping, in their paternalistic approach, with modern attitudes to the care of the mentally disordered. The 1978 White Paper, in discussing guardianship powers in the Mental Health Act (in Chapter 4), suggested that further consideration was needed and put forward three possible options. One option was to retain guardianship powers in more or less their present form with some minor changes, e.g. reducing the duration of guardianship powers in line with the proposals for detention in hospital (see para. 19 above). The second option was to introduce a range of community care orders to parallel existing compulsory hospital powers (the proposal of the British Association of Social Workers). The third was to introduce new specific powers to restrict the liberty of the individual only as much as is necessary to ensure that he receives medical treatment and social support and training—the "essential powers" approach.

44. The Government has considered all the issues involved and the many comments received and has decided that the third option, which was widely supported, most closely meets current needs. The Bill therefore provides that guardianship powers should be retained but that the guardian should have only the "essential powers" rather than all the powers of the father of a child under 14 as at present. The essential powers are:—

- a. power to require the patient to live at a place specified by the guardian;
- b. power to require the patient to attend places specified by the guardian for medical treatment, occupation or training;
- c. power to ensure that a doctor, social worker or other person specified by the guardian can see the patient at his home."

<sup>96</sup> Mental Health Act 1959, s.34(1).

<sup>97</sup> Mental Health (Hospital and Guardianship) Regulations 1960, reg. 6(1).

<sup>98</sup> *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978), para. 4.8.

<sup>99</sup> *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).

<sup>100</sup> *Reform of Mental Health Legislation*, Cmnd. 8405 (1981).

<sup>101</sup> *Ibid.*, paras. 43 and 44.

## The Mental Health (Amendment) Act 1982

The essential powers outlined in paragraphs 44(a) to (c) were enacted as paragraphs 8(a)-(c) of the Mental Health (Amendment) Act 1982 and as paragraphs 8(1)(a)-(c) of the 1983 Act, the latter being in the main a consolidating statute.

### THE STATUTORY FRAMEWORK

A guardian's powers under the Act are described as "essential powers" in that they only authorise restricting the patient's liberty in the three essential ways set out in section 8.<sup>102</sup> The guardian's authority does not extend to exercising any control over the patient's property and finances, to consenting to medical treatment on his behalf,<sup>103</sup> or to any other area of his life the control of which would require the guardian to exceed these essential powers.

### A GUARDIAN'S "ESSENTIAL POWERS"

8.—(1) ... the application shall, subject to regulations made by the Secretary of State, confer on the authority or person named in the application as guardian, to the exclusion of any other person—

- (a) the power to require the patient to reside at a place specified by the authority or person named as guardian;
- (b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;
- (c) the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved social worker or other person so specified.

### Exercising the powers

A patient who absents himself from the place where he is required to reside may be compelled to return there.<sup>104</sup> However, with that single exception, a guardian's power to "require" a non-compliant patient to do any act covered by section 8 falls short of being able to enforce such lawful demands. Following the patient's reception into guardianship, there is no statutory power to convey the patient to the nominated place of residence, nor to any place he is required to attend as part of his treatment and care programme. Similarly, if the patient obstructs access to him by a authorised person, he commits no offence.<sup>105</sup> The Act therefore limits the guardian's authority to exercising certain "essential powers," none of which authorise the patient's detention

<sup>102</sup> These three powers can be remembered as the three "A"s: accommodation, attendance, access.

<sup>103</sup> See, e.g., the dicta of McCullough J. in *R. v. Hallstrom*, ex p. *W* (No. 2) [1986] 2 All E.R. 306 at 313 and of Wood J. in *T. v. T. and another* [1988] 1 All E.R. 613 at 617.

<sup>104</sup> Mental Health Act 1983, ss.18(3) and (4), 135(2).

<sup>105</sup> Mental Health Act 1983, s.129.

and most of which are widely seen as unenforceable.<sup>106</sup> Where a patient refuses to do some act lawfully required of him by his guardian, it has sometimes been speculated that the guardian may apply to the High Court for an order of mandamus directing the patient to do the required act. However, this seems unlikely given Parliament's decision not to include a statutory mechanism for enforcing demands made by the guardian.<sup>107</sup>

### Limits of a patient's essential rights

Because the liberty of a patient under guardianship is subject to less interference than that of a detained patient, the Act confers on the former correspondingly fewer forms of statutory protection. The patient enjoys the full protection of the criminal law if he is ill-treated or neglected<sup>108</sup> and, since he is not detained, he is better placed to refuse to comply with any arbitrary demands made of him. Furthermore, the exercise of a private guardian's functions are subject to an absolute right of discharge vested in the patient's nearest relative<sup>109</sup> and to supervision by the local social services authority.<sup>110</sup> The rights granted to both groups of patients are, in

<sup>106</sup> This absence of a power of conveyance is often relied upon by social workers who do not wish to make an application in a particular case, although they are invariably unable to give an example of a patient who refused to take up residence at the address stipulated by his guardian. It is important to compare the likely benefits of guardianship with the limitations of a purely informal arrangement — rather than to persistently repeat the fact that the guardian's powers are less than those of a detained hospital. Because guardianship is a form of adult care order, and many patients previously in care deteriorated when they no longer had structured support, there is sometimes a real prospect of benefit. Furthermore, if no benefit accrues, nothing has been lost. The *Code of Practice* favours a flexible, fast-track, approach to guardianship: *Mental Health Act 1983: Code of Practice* (2nd ed., 1993), para. 13.3. In theory, completing a guardianship application, and obtaining a decision concerning its acceptance, should take no longer than does the acceptance of an application for his admission to hospital. When a known patient is beginning to deteriorate, this enables guardianship to be used as a last attempt at heading off the need for compulsory readmission to hospital. If the patient is aware of this, there is a considerable incentive to comply with the community-based programme. In practice, the procedures of most local authorities are so convoluted that any decision about whether to make or accept a guardianship application can take several weeks or months.

<sup>107</sup> Where, following an application's acceptance, the patient refuses to take up residence at the nominated address, a more elegant argument would be that he is then absent from there without leave. Accordingly, he may be taken into custody and conveyed there under section 18. Insofar as material, section 18 provides as follows: "18.—(3) Where a patient who is for the time being subject to guardianship ... absents himself without the leave of the guardian from the place where he is required by the guardian to reside, he may, subject to the provisions of this section, be taken into custody and returned to that place by any officer of a local social services authority ... (6) In this Act 'absent' without leave' means absent from any ... place and liable to be taken into custody and returned under this section, and related expressions shall be construed accordingly." The counter-argument is that the use of the phrase "returned to that place" in subsection 18(3) indicates that the patient must have "resided at that place" before he can absent himself from it and be "returned to that place." Furthermore, the inclusion of an express power of conveyance in sections 6 and 40 (in relation to applications and orders for admission to hospital), and the absence of such a power in sections 8 and 40 (in relation to guardianship cases), is significant. The Act differentiates between taking and retaking a patient. In rebuttal, it may be said that the patient is absent without leave (as defined), and the effect of the omissions in sections 8 and 40 is merely that no force may be used unless the patient is unlawfully absent from where he is required to be. It would be anomalous if the power to nominate a residence for the patient is enforceable against him if he resides there for an hour but not if he refuses to take up residence. It would likewise be anomalous if a patient who is residing at the required place can refuse to take up residence at some alternative place designated for him but, if he does so for an hour (to see what it is like), he is then unlawfully absent if he returns to his previous abode.

<sup>108</sup> Mental Health Act 1983, s.127(2).

<sup>109</sup> *Ibid.*, ss.23(2)(b) and 25.

<sup>110</sup> Under paragraph 12(c) of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, a private guardian is under a duty when exercising his statutory functions "to comply with such directions as that authority may give."

theory, adequate to protect them against any arbitrary or ill-founded exercise of the compulsory powers to which they are respectively subject, and commensurate with the degree of interference with their liberty. Consequently, the statutory rights of a patient under guardianship may conveniently be referred to as his "essential rights." As regards patients subject to guardianship—

- There is no prohibition against the medical practitioners who provide the recommendations for guardianship being employed at the same hospital, even if one works under the direction of the other.<sup>111</sup>
- An approved social worker is not required to "interview" a patient before making a guardianship application, as long as he has "personally seen" that patient within the previous 14 days.<sup>112</sup>
- The nearest relative may not require that the patient be assessed by an approved social worker with a view to his reception into guardianship — he may only require an assessment with a view to his admission to hospital.<sup>113</sup>
- Provided a guardianship application is forwarded to the local social services authority within 14 days of the date of the second medical examination, there is then no particular time within which it must be accepted. In theory, the patient could be received into guardianship some months later.<sup>114</sup>
- There is no duty to notify a patient received into guardianship, or his nearest relative, of their statutory rights.<sup>115</sup>
- The appropriate medical officer is not under a statutory duty to consult one or more persons who have been professionally concerned with the patient's treatment before furnishing a report renewing the guardianship.<sup>116</sup>
- If a patient subject to guardianship does not apply to a tribunal, the Act does not require that his case is periodically referred to it for consideration.<sup>117</sup>
- A tribunal has no power to discharge a patient from guardianship on a future date or to make recommendations.<sup>118</sup>
- A tribunal may refuse to discharge a patient from guardianship notwithstanding that it is satisfied that the nature or degree of any mental disorder does not warrant guardianship.<sup>119</sup>
- The duty to provide after-care in section 117 does not extend to patients discharged from guardianship.<sup>120</sup>
- The Mental Health Act Commission's statutory remit does not extend to overseeing the welfare of patients subject to guardianship.<sup>121</sup>

<sup>111</sup> Mental Health Act 1983, ss.12(3) (4) and (7).

<sup>112</sup> *Ibid.*, ss.11(5) and 13(2).

<sup>113</sup> *Ibid.*, s.13(4).

<sup>114</sup> *Ibid.*, s.8(1) and (3).

<sup>115</sup> *Ibid.*, ss.11(3) and 132.

<sup>116</sup> *Ibid.*, s.20.

<sup>117</sup> *Ibid.*, ss.40(4) and 145(3); Sched. 1, Part I, paras. 1 and 2.

<sup>118</sup> *Ibid.*, subss. 72(3) (4) and (5).

<sup>119</sup> *Ibid.*, s.72(4).

<sup>120</sup> *Ibid.*, s.117.

<sup>121</sup> *Ibid.*, ss.120 and 121.

## DURATION

A guardianship application authorises the guardian to exercise the statutory powers for a period of up to six months beginning with the date of its acceptance. The authority may be renewed as appropriate for a further period of six months and thereafter at yearly intervals in accordance with the provisions of section 20.

## LEGAL FORMALITIES CONCERNING APPLICATIONS

The legal and procedural formalities relating to the making of applications are set out in sections 2-15 of the Act and in the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983. Where a patient is admitted to hospital or received into guardianship in pursuance of an application, there should in each case be (a) a written application; (b) supporting written medical recommendation(s); (c) a form recording receipt of a medical recommendation; (d) a form recording the patient's admission or reception into guardianship.

## THE PATIENT

A guardianship application may not be made in respect of a child who is a ward of court or under 16 years of age.<sup>122</sup> An application for the admission to hospital of a minor who is a ward of court requires the court's leave.<sup>123</sup>

## THE APPLICANT

An application under Part II may be made by an approved social worker (160), by the patient's nearest relative (100), or by the person who is exercising for the time being that relative's statutory functions (109, 111).<sup>124</sup>

### Requirement that the applicant has seen the patient

An emergency application may not be made unless the applicant has personally seen the patient within the previous 24 hours. In any other case, no application shall be made unless the applicant has personally seen the patient within the period of 14 days ending with the date of the application.<sup>125</sup>

### Applications by approved social workers

Before an approved social worker makes an application for a patient's admission to hospital, he "shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need."<sup>126</sup> No similar duty arises in the case of a guardianship application or in respect of any application made by the nearest relative. However, in all cases, an approved

<sup>122</sup> Mental Health Act 1983, ss.7(1) and 33(3).

<sup>123</sup> *Ibid.*, s.33(1).

<sup>124</sup> *Ibid.*, ss.1(1), 29(6), 32(2)(e); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 14.

<sup>125</sup> Mental Health Act 1983, s.11(5).

<sup>126</sup> Mental Health Act 1983, s.13(2).

social worker owes a duty of care to the patient and he should therefore make any necessary inquiries before applying.<sup>127</sup>

#### *Duty to consult the nearest relative*

Before making any section 3 or guardianship application, an approved social worker must consult with the person (if any) appearing to be the patient's nearest relative, unless it appears to that social worker that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay. Furthermore, no such application may be made if the nearest relative has notified that social worker, or the local social services authority which appointed him, that he objects to the application being made.<sup>128</sup>

#### *Duty to make application*

An approved social worker is under a duty to make an application in respect of a person within the area of the local social services authority which has appointed him "in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him."<sup>129</sup> No such duty arises in the case of patients outside the appointing authority's area and, similarly, a patient's nearest relative is never under a statutory duty to make an application.

#### **Applications to be in the prescribed form**

Every application must specify the qualification of the applicant to make the application.<sup>130</sup> The application must be in the form set out in Schedule 1 to the Mental Health (Hospital, Guardianship & Consent to Treatment) Regulations 1983, as amended by the Mental Health (Hospital, Guardianship & Consent to Treatment) (Amendment) Regulations 1996.<sup>131</sup>

<sup>127</sup> The 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." *Baxton 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.

<sup>128</sup> Mental Health Act 1983, s.1(4). It is not, however, necessary that the social worker is consulted after the social worker has interviewed the patient: *Re Whitehead (Mental patient: Habeas Corpus)*, *The Times*, 14 July 1997, C.A. In that case, the approved social worker consulted the nearest relative in August, when the nearest relative agreed that his son should be admitted to hospital. The patient then took steps to avoid being interviewed. This eventually occurred in October, following which, but without the nearest relative being further consulted, a section 3 application was made. The court held that a nexus had to exist between the consultation and the application that was subsequently made, and had to place the nearest relative in a position, if so minded, to object to it. Provided that was the case, the duty of consultation had been discharged and section 11(4) was not to be construed as imposing a particular chronological sequence. As to whether an approved social worker may authorise another approved social worker to undertake the consultation on his behalf, see *R. v. South Western Hospital Managers, ex p. M.* [1993] Q.B. 683 (597, 457).

<sup>129</sup> Mental Health Act 1983, s.13(1). The words "necessary" and "proper" are not coterminous. In *Re Mercury Model Aircraft Supplies* [1956] 1 W.L.R. 1153, it was said that work may be done by solicitors which is not necessary but which is none the less proper, even if due in some degree to over-caution or some other cause. It may therefore be proper to make an application but not necessary to do so, in the sense that another person, such as the nearest relative, could make it.

<sup>130</sup> Mental Health Act 1983, s.11(1).

<sup>131</sup> *Ibid.*, s.32(2)(a). The Mental Health (Hospital, Guardianship and Consent to Treatment) (Amendment) Regulations 1996, which came into force on 1 April 1996, prescribed new Forms 2 and 9 for section 2 and 3 applications made by an approved social worker. The other application forms remained unchanged. As to the position where the prescribed form is used, see *Re E (Mental Health: Habeas Corpus)*, 10 December 1996 and *Warren v. Warren* [1953] 1 W.L.R. 1268 (270).

## **PRESCRIBED FORM OF APPLICATIONS**

	Nearest relative applications	ASW applications
Section 2 application	Form 1	Form 2
Section 3 application	Form 8	Form 9
Section 4 application	Form 5	Form 6
Section 7 application	Form 17	Form 18

### **Applications to be founded upon written medical recommendations**

Except in a case where it is urgently necessary that the patient be admitted to hospital for assessment, an application shall be founded on the written recommendations of two registered medical practitioners,<sup>132</sup> signed on or before the date of the application.<sup>133</sup> The recommendations may be given either as separate recommendations or as a joint recommendation signed by both practitioners<sup>134</sup> and shall be in the form prescribed by the regulations.<sup>135</sup> Neither a guardianship application or a section 3 application is of any effect unless the patient is described by both medical practitioners as suffering from the same form of mental disorder, whether or not he is described by either of them as also suffering from another form.<sup>136</sup>

#### *Emergency applications*

An emergency application may be made founded upon a single medical recommendation, given if practicable by a doctor who has previous acquaintance with the patient.<sup>137</sup> The second recommendation required by section 2 must be furnished to the managers within the period of 72 hours from the time of the patient's admission, otherwise his liability to detention lapses.

<sup>132</sup> Mental Health Act 1983, ss.2(3), 3(3), 7(3).

<sup>133</sup> *Ibid.*, s.12(1).

<sup>134</sup> *Ibid.*, s.11(7).

<sup>135</sup> *Ibid.*, ss.2(3), 3(3), 4(3), 7(3) and 32(2)(a). The prescribed form is that set out in Schedule 1 to the Mental Health (Hospital, Guardianship & Consent to Treatment) Regulations 1983, as amended by the Mental Health (Hospital, Guardianship & Consent to Treatment) (Amendment) Regulations 1996. The 1996 Regulations, which came into force on 1 April 1996, prescribed new forms of recommendation in all cases involving admission to hospital (Forms 3, 4, 7, 10 and 11). Only the medical recommendations given in support of a guardianship application (Forms 19 and 20) remained unchanged. As to the position where the previous prescribed form is used, see *Re Z (Mental Health: Habeas Corpus)*, 10 December 1996 and *Warren v. Warren* [1953] 1 W.L.R. 1268 (270).

<sup>136</sup> Mental Health Act 1983, ss.11(6) and 15(3). Thus, the application is invalid if one recommendation describes the patient as suffering only from "mental illness" and the other only from "mental impairment," but not if the second states that the patient suffers from "mental illness and mental impairment." It would appear, however, that an application is not *per se* invalid if the application itself states that the patient is suffering from psychopathic disorder and the two medical recommendations that he is suffering only from mental illness. Because it is the form of forms of disorder recorded on the application that constitute a patient's legal classification, the responsible medical officer would no doubt reclassify the patient on admission (see s.16(1)). Judicial review might, nevertheless, still be appropriate if an approved social worker applicant had clearly failed to have regard to the relevant law and circumstances. For example, if the effect was that he should have, but could not have, had regard to the treatability test in section 3(2)(b). Or the effect was that he could not have properly interviewed the patient or been satisfied as to the appropriateness of his detention.

<sup>137</sup> Mental Health Act 1983, s.4(3).



**PRESCRIBED FORM OF RECOMMENDATIONS**

	<i>Joint recommendation</i>	<i>Separate recommendations</i>
Section 2 application	Form 3	Form 4
Section 3 application	Form 10	Form 11
Section 4 application	Not applicable	Form 7
Section 7 application	Form 19	Form 20

**Medical recommendations to be founded upon personal examinations**

Except in a case where it is urgently necessary that the patient be admitted to hospital for assessment, the recommendations shall be given by practitioners who have personally examined the patient either together or separately. Where they examined the patient separately, not more than five clear days must have elapsed between the days on which the separate examinations took place.<sup>138</sup>

**Medical recommendation(s) to include the prescribed information**

The medical recommendation upon which an emergency application is founded shall include a statement verifying that the patient's admission and detention under section 2 is urgently necessary and that compliance with the usual provisions of Part II of the Act would involve undesirable delay.<sup>139</sup> Medical recommendations provided under sections 2 and 3 shall include a statement that in the signatory's opinion the patient's condition satisfies the statutory grounds for admission under that section.<sup>140</sup> A recommendation under section 3 shall also include the grounds for the practitioner's opinion why that is so and shall specify whether other methods of dealing with the patient are available and, if so why they are not appropriate.<sup>141</sup>

**Recommendations to be given by practitioners who are individually and collectively qualified for the purpose**

At least one of the recommendations shall be given by a medical practitioner approved by the Secretary of State under section 12 as having special experience in the diagnosis or treatment of mental disorder. Unless that doctor has previous acquaintance with the patient, the other recommendation shall, if practicable, be given by a medical practitioner who has such previous acquaintance.<sup>142</sup>

<sup>138</sup> Mental Health Act 1983, s.12(1) and (7). Thus, if the first doctor examines the patient on Monday and the second at the end of that week, on Sunday, that suffices. The clear days in between (Tuesday to Saturday) do not exceed five. It is the date of the examinations which is legally important in this context, not the date on which the recommendations are completed.

<sup>139</sup> *Ibid.*, s.4(3).

<sup>140</sup> *Ibid.*, s.2(3), 3(3).

<sup>141</sup> *Ibid.*, s.3(3). A doctor examining the patient owes him a duty to exercise reasonable care: *Hall v. Semple* (1862) 3 F. & F. 337; *Everett v. Griffiths* [1921] 1 A.C. 631, H.L.; *Harnett v. Fisher* [1927] 1 K.B. 402, C.A.

<sup>142</sup> Mental Health Act 1983, s.12(2) and (7). It suffices in section 4 cases that the second recommendation, following admission, is provided by an approved doctor if the first was not.

Where the application is for the patient's admission to a mental nursing home (a "private hospital"), neither of the recommendations may be given by a medical practitioner who is on the staff of that home or by a relative of such a person.<sup>143</sup>

**Admissions to NHS facilities**

Where the application is for the patient's admission to an NHS hospital, at least one of the medical recommendations must be given by a practitioner who is not on the staff of that hospital<sup>144</sup> unless—

- compliance with this requirement would result in delay involving serious risk to the health or safety of the patient; and
- one of the practitioners giving the recommendations works at the hospital for less than half of the time which he is bound by contract to devote to work in the health service; and
- where one of those practitioners is a consultant, the other does not work (whether at the hospital or elsewhere) in a grade in which he is under that consultant's directions.<sup>145</sup>

**Other disqualified medical practitioners**

A medical recommendation may not be given by any of the following persons—

- a relative of the patient;<sup>146</sup>

<sup>143</sup> Mental Health Act 1983, ss.12(3) and 12(5)(e). However, following admission, the patient's responsible medical officer may subsequently renew the authority for the patient's detention, notwithstanding that he has a financial interest in providing medical services to the patient. The Act caters for this by providing that an NHS patient receiving treatment in a "private hospital" may be discharged by the Health Authority or NHS trust funding his treatment there, as well as by his nearest relative or a tribunal. The Act also relies on the fact that professionals with no competing interest were originally satisfied as to the existence of the grounds for admission to hospital. However, many mental nursing homes take the view that doctors who have patients at the home, but who are not employees of the company which owns or manages the home, are not on the staff of the hospital. It is usually only the medical director of the home who has such a contract. Consequently, the other doctors treating patients there may, and do, provide recommendations for each other's patients. While the distinction may have some merit in the context of employment law, the interpretation seems inappropriate in the context of a statute concerning individual liberty. A further problem arises where a detained patient is transferred from an NHS hospital to a mental nursing home and a doctor on the staff of that home provided one of the medical recommendations upon which his detention is founded. Because the application is deemed to have always specified the home as the admitting hospital, it is (at least literally) the case that the application is thereby invalidated. Furthermore, the time allowed by section 15(3) for providing a second recommendation will have expired. The situation is not as uncommon as might be thought, given that a number of practitioners at an NHS hospital may undertake private work at a local mental nursing home.

<sup>144</sup> Mental Health Act 1983, s.12(3).

<sup>145</sup> A general practitioner who is employed part-time at an NHS hospital, as opposed to a mental nursing home, is not regarded as being a practitioner on its staff.

<sup>146</sup> For these purposes, a relative is any of the following persons: husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister or sister-in-law.

- the applicant, a partner of the applicant, or a person employed as an assistant by the applicant, or by a relative of such a person;
- a partner or an assistant of the practitioner who has given the other medical recommendation, or by a relative of such a person;
- a person who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient, or by a relative of such a person.

**The application shall be addressed to and properly served on the relevant body**

Every application for admission must be addressed to the managers of the hospital to which admission is sought<sup>147</sup> and delivered to an officer of managers of the hospital authorised by them to receive it.<sup>148</sup> Similarly, every guardianship application must be addressed to the local social services authority named in the application.<sup>149</sup> However, in this case, the application may be either delivered or sent to the authority's registered or principal office by prepaid post.<sup>150</sup> It must be "forwarded" to the authority within the period of 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation in support of the application.<sup>151</sup>

**The hospital managers shall record receipt of the recommendations**

The managers of the hospital to which an application is addressed are to record, in the form set out in Form 14 of Schedule 1 to the 1983 Regulations, the receipt by them of the joint medical recommendation or, where separate recommendations were completed, their receipt of the second medical recommendation, and to attach this record to the recommendation.<sup>152</sup> In the case of guardianship applications, Form 15 is used instead.<sup>153</sup>

<sup>147</sup> Mental Health Act 1983, s.11(2). In practice, approved social workers do not always address the application to the hospital to which the patient is taken, leaving that part of the form to be completed by a hospital officer once a bed has been located for the patient. Such omissions are not new. See *Archbold's Lunacy and Mental Deficiency Practice* (Butterworth & Co., Shaw and Sons, 5th ed., 1915), pp. 175-176. Nevertheless, there is no statutory authority to take a person into custody or to convey him to a hospital until an application specifying a hospital has been duly completed. See *ibid.*, s.6(1).

<sup>148</sup> *Ibid.*, s.32(2)(b); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.3(2). "Delivered" means served personally by hand and an application for a person's detention under the Act may therefore not be sent by facsimile transmission or by post.

<sup>149</sup> Mental Health Act 1983, s.11(2).  
<sup>150</sup> *Ibid.*, s.32(2)(b); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.3(1).

<sup>151</sup> Mental Health Act 1983, s.8(1) and (3).  
<sup>152</sup> *Ibid.*, s.32(2)(a) and (c); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.4(4). A new Form 14 was prescribed by the Mental Health (Hospital, Guardianship & Consent to Treatment) (Amendment) Regulations 1996, which came into force on 1 April 1996. Previously, receipt of the recommendations was recorded on the old Form 15, and the patient's admission on the old Form 14. The two records have now been amalgamated and the revised Form 14 is to be used for both purposes in admission cases. Unfortunately, the new form is poorly drafted and a feature of many of the new forms is the draftsman's apparent inability to adhere to the statutory criteria or to the statutory framework.

<sup>153</sup> Mental Health Act 1983, s.32(2)(a) and (c); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.5(4).

**The patient must be admitted within the prescribed period**

In cases involving admission under section 2 or 3, the authority conferred by the application to take the patient into custody, convey him to the hospital named in the application, and to admit and detain him there, lapses at the expiration of fourteen days beginning with the date of the last medical examination upon which the application is founded.<sup>154</sup> Where the application is made under section 4, the patient must be admitted within the period of 24 hours beginning either at the time when the patient was examined by the practitioner giving the medical recommendation or the time when the application is made, whichever is the earlier.<sup>155</sup> No such time limits apply in the case of guardianship. Provided the application is forwarded to the local social services authority within 14 days of the most recent medical examination, there is then no particular time within which it must be accepted. In theory, the patient could be received into guardianship some months after the application was made and the recommendations completed.<sup>156</sup>

*Applications in respect of in-patients*

Where an application, or a further application, is made in respect of someone who is already an in-patient, "the patient shall be treated ... as if he had been admitted to the hospital at the time when that application was received by the managers."<sup>157</sup>

**APPLICATIONS IN RESPECT ON IN-PATIENTS**

5.—(1) An application for the admission of a patient to a hospital may be made under this Part of this Act notwithstanding that the patient is already an in-patient in that hospital or, in the case of an application for admission for treatment that the patient is for the time being liable to be detained in the hospital in pursuance of an application for admission for assessment; and where an application is so made the patient shall be treated for the purposes of this Part of this Act as if he had been admitted to the hospital at the time when that application was received by the managers.

**The admission or the acceptance of the application shall be recorded**

Where a patient is admitted to a hospital in pursuance of an application, a record of his admission shall be made by the managers of that hospital in the form set out in Form 14 to Schedule 1 of the 1983 Regulations and the record shall be attached to the application.<sup>158</sup> Where a patient is received into guardianship, a record of the

<sup>154</sup> Mental Health Act 1983, s.6(1)(a) and (2). Thus, for example, where a section 2 application relies upon two medical recommendations based upon separate medical examinations which were conducted on 1 January and 7 January, the patient must be taken, conveyed, and admitted to hospital under that application before midnight on 20 January.

<sup>155</sup> Mental Health Act 1983, s.6(1)(b) and (2).  
<sup>156</sup> See *ibid.*, s.8(1) and (3).  
<sup>157</sup> *Ibid.*, s.5(1). See p.260.

<sup>158</sup> Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.4(3). A new Form 14 was prescribed by the Mental Health (Hospital, Guardianship & Consent to Treatment) (Amendment) Regulations 1996, which came into force on 1 April 1996. This appears to assume that the date on which the "statutory documents" are received is necessarily the date of admission. The unfortunate consequence is that hospital administrators often mistakenly calculate the renewal date by reference to the day on which they received these documents, even if section 5(1) does not apply and the patient was admitted sometime before then.

acceptance of the application shall similarly be made, in the form set out in Form 21, and the record attached to the application.<sup>159</sup>

#### *Effect on previous applications*

Where a patient is admitted to hospital in pursuance of a section 2 application, any outstanding guardianship application or supervision application continues in force. Where, however, a patient is admitted to a hospital under section 3 or is received into guardianship, any pre-existing application ceases to have effect.<sup>160</sup> The effect of an application on a pre-existing order or direction made under Part III is more complicated and considered later (303).

#### *Whether applications for admission require acceptance*

A guardianship application does not take effect unless and until it is accepted by the local social services authority. It is therefore clearly no more than an application, in that it may be accepted or rejected. The position of patients already in hospital when an application is furnished lies at the opposite end of the spectrum. Section 5 provides that the patient shall be treated as if he had been admitted to the hospital at the time when the application was received, rather than accepted, by the managers. This is the case regardless of whether the patient was previously in hospital informally or in pursuance of some prior authority for his detention. The use of the phrase, "shall be treated as if he had been admitted to the hospital," implies that "admission" carries its normal, general, meaning: a patient is admitted to hospital when he becomes an in-patient but may be "treated" as having been admitted subsequently. That this is so is borne out by section 6(2) which deals with applications made in respect of patients in the community: these patients are always admitted to hospital, and never "treated" as if they had been admitted there. According to that subsection, where a person in the community is admitted to the hospital specified in an application, that application authorises the managers to detain him there. The position here is therefore intermediate between that pertaining to guardianship and that pertaining to patients already in hospital: the authority to detain the patient is expressed to arise automatically if he is admitted to hospital, but the managers can refuse to admit him. The literal effect of section 6(2) is that, while the decision whether or not to admit the patient is one for the managers, whether admission is formal or informal is, as in the case of patients already there, a matter for the persons charged with implementing the compulsory procedures — approved social workers, nearest relatives and medical practitioners. As with an individual already receiving in-patient care, liability to detention derives from the conjunction of in-patient status and the receipt by the managers of a duly made application. It may be that this is what Parliament intended and is consistent with the overall framework of the Act. Not only the initial authority, but also that authority's renewal, is automatic upon the necessary documents being furnished. If so, the managers' role is limited to admitting or discharging patients in respect of whom an application has been made: they never, in any meaningful sense, accept or approve an application, merely scrutinise it to verify that it gives them the purported authority. This then is what the Act actually says. The counter argument is that admission means admission in pursuance of the application which has been made. Sections 5 and 6 are not to be interpreted in a way which conflicts with section 131, which provides that nothing in the Act shall be construed as preventing a patient from being admitted in pursuance of arrangements made in that behalf and without any application rendering him

<sup>159</sup> Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 5(3).

<sup>160</sup> Mental Health Act 1983, s.6(4).

liable to be detained. That being so, a distinction must be drawn between the use of the word "furnished" in sections 5(2) and 20(8) and "received" in section 5(1). Accordingly, the managers may refuse to receive a duly completed application furnished to them if they consider that informal admission is more appropriate. The suggestion that, because an applicant specifies a particular hospital, and authorises his detention there, the managers of that hospital must either admit the patient formally or not at all runs counter to the whole tenor of mental health legislation since the Mental Treatment Act 1930. If the counter-argument is correct, applications for admission under the Act are genuinely applications. The managers may refuse to receive an application furnished to them in respect of an in-patient and admit informally any patient whose compulsory admission is sought, as well as refusing to admit him at all.

#### **The authority conferred by the application on the managers or guardian**

Provided an application for admission appears to be duly made and the patient is admitted to the specified hospital within the permitted period (or, if already an in-patient there, is treated by virtue of section 5 as if he had been so admitted), the application constitutes sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of the Act.<sup>161</sup> Similarly, provided a guardianship application is "duly made" and forwarded to the local social services authority within the 14-day statutory period (259), the authority's acceptance of it confers on the guardian the powers specified in section 8(1).<sup>162</sup>

#### **Notifying the patient and the nearest relative (section 132)**

Following admission, the managers must as soon as practicable take such steps as are practicable to ensure that a detained patient understands the authority for his detention and his statutory rights. The prescribed information must be given both orally and in writing.<sup>163</sup> Unless the patient objects, the managers must also, within a reasonable period following admission, take such steps as are practicable to furnish the nearest relative with a copy of the written information given to the patient.<sup>164</sup> Where this information is not provided, either because the patient was received into guardianship or because he requested otherwise, neither the managers nor the local social services authority are under any statutory duty to notify the nearest relative of the patient's admission or reception. However, an approved social worker who makes a section 2 application must take such steps as are practicable to inform the person appearing to be the nearest relative that the application is to be or has been made. Where practicable, the nearest relative must therefore be told of the application even if the patient requests otherwise. In section 3 and guardianship cases, there is no statutory duty to notify the nearest relative of the patient's admission in cases where it was not possible to consult him before making the application.<sup>165</sup> The statutory framework is therefore somewhat inconsistent as concerns a nearest relative's rights to information.

<sup>161</sup> Mental Health Act 1983, s.6(2). If the application appears to be duly made, the managers are justified in detaining the individual even if he is in fact not mentally disordered: *Norris v. Seed* (1849) 3 Exch. 782; *MacIntosh v. Smith* 4 Macq. H.L.C. 913.

<sup>162</sup> Mental Health Act 1983, s.8(1).

<sup>163</sup> *Ibid.*, s.132(1)-(3). The prescribed information is set out in section 132.

<sup>164</sup> *Ibid.*, s.132(4).

<sup>165</sup> In other words, although the nearest relative must generally be consulted about the making of a section 3 application, if the application was made without any such consultation taking place, there is no statutory duty to inform the nearest relative of the patient's admission or rights. See *ibid.*, s.11(2) and (4).

## Scrutiny of applications

The application should be scrutinised by the hospital managers or local social services authority, or by an authorised officer on their behalf. The purpose of this is to ensure that any irregularities are identified and, where permissible, rectified within period allowed under section 15, which is 14 days from the date of the patient's admission or reception (265).

## SCRUTINY OF APPLICATIONS AND IRREGULARITIES

The hospital managers or local social services authority are not required to verify the qualifications of the persons who completed the application and medical recommendations or the facts and opinions recited in them. This is because an application "which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given, or of any matter of fact or opinion" stated in it.<sup>166</sup> It is, however, necessary to scrutinise the documents to verify that they are in the required form and that the correct statutory procedures appear to have been complied with. Before the 1959 Act was in force, applications were forwarded to the Board of Control in London for scrutiny. The Percy Commission recommended that the Board should be abolished and this function performed by hospital or local health authority staff at the time of the patient's admission or reception. The Commission were of the opinion that, where the documents did not appear to be in the form required by law, the health authority should not accept them as authorising the patient's detention or guardianship. If necessary, the patient should be cared for informally, or by use of emergency procedures, while the documents were corrected or new documents prepared.<sup>167</sup>

## IMPORTANCE OF LEGAL PROPRIETY

Applications and medical recommendations having been designated as "forms" in the regulations, there is commonly a failure on the part of social workers and doctors to distinguish between the relative importance of these forms and the many other forms which they are required by their employers to complete, such as those used to record after-care information. This laxity has been reinforced by a perception that the courts do not require strict compliance with those procedures which Parliament provided must be complied with before one person has any authority to interfere with the liberty of another.<sup>168</sup> The importance of observing legal formalities was most elegantly expressed by Coleridge J. in *Re Greenwood*. The following passages

<sup>166</sup> Mental Health Act 1983, ss.6(3) and 8(3). The provision only relates to applications which appear valid on their face.

<sup>167</sup> *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmd. 169 (1957), para. 483. The Act provides that defective applications or medical recommendations may generally be rectified within 14 days of the patient's admission or reception into guardianship, in which case they are retrospectively deemed to have been in their amended form (265).

<sup>168</sup> *R. v. South Western Hospital Managers, ex p. M.* [1993] Q.B. 683 is the best example of what is perceived to be the modern judicial approach.

demonstrate the importance of applying first principles in matters concerning individual liberty, and remain among the most important known to English law.<sup>169</sup> They continue to be particularly pertinent in relation to any failure to observe the procedures set out in the body of the statute—

## The Queen v. Pinder; In re Greenwood

(1855) 1 Jur. 522.

*Court of Queen's Bench, Coleridge J.*

A medical certificate was given by a medical practitioner in which he stated that he had examined the patient on 3 October 1854, at Blackburn, in the county of Lancaster. The statute then in force prohibited the reception of any lunatic into any licensed house without the medical certificates in the form set out in the Schedule to the Act. The prescribed form required the address where the examination took place to be specified ("here insert the street and number of house").

## Coleridge J.

"This was an application, on the return to a writ of habeas corpus, for the discharge of William Greenwood from the custody of William Pinder, the occupier of a private house duly licensed for the reception of lunatics; and upon the reading of the return it was objected that the reception of him into this house and his subsequent detention there were unlawful, on account of a defect in the medical certificates under which he had been admitted; and this is the question which I have now first to determine .... The [Act] prohibits, in express terms, the reception of any lunatic into any licensed house without the medical certificates, according to the Form in Schedule (A), No. 2, annexed to the Act .... It is not agreeable to decide on a formal objection, where, under the circumstances of the particular case, the defect appears to have had no influence on the merits, and to have occasioned neither inconvenience nor injustice; and, so far as appears, that may be said in the present case. But decisions are precedents; and therefore in arriving at them, it is necessary to look at general principles rather than to the particular circumstances. Here the words are express. By the 4th section, to receive a lunatic except under an order in one form and with medical certificates under another is expressly forbidden; and to break the prohibition is an indictable offence. When from this enactment we turn to the schedules referred to, we find them full of minute particulars, manifestly framed with anxious carefulness, as if to secure some important object. It would seem dangerous to enter into a comparison of these, and to class some as material which must be observed, and some as immaterial which may be disregarded. We cannot be sure that we have the means of making the discrimination on any sound principles, or that we know the particular intention of the legislature as to the one or the other. It could hardly be contended that we could properly reject all; and yet, as they seem to have a necessary connexion one with the other, the same argument which would lead to the dispensing with one might in time be applied to another, and so lead to dispensing with the whole. This is a general observation; but I cannot help perceiving, in reference to this and preceding statutes upon the same subject, that the legislature has proceeded in them with the double object of protecting the public and lunatics, real or supposed; facilitating in many respects the reception of persons dangerous to themselves or others or of unsound mind into asylums, where they will be properly restrained and treated, yet guarding both their reception and continuance there

<sup>169</sup> Although some contemporary practitioners would deride his insistence on procedural propriety as "legalistic," it is necessary to specify how a "legalistic" approach differs from an insistence on doing only what is "legal."

## KINDS OF DOCUMENTARY IRREGULARITY

Documentary irregularities fall into three broad groups—

- those which are both incapable of retrospective correction and sufficiently serious to render invalid the patient's detention or guardianship under the Act.
- those which may be rectified within the 14-day period following admission or reception but which, if not rectified, are sufficiently serious to render the application invalid at the expiration of that period.
- errors and omissions which, even if not corrected within the statutory period, are not sufficiently serious to render the application invalid.

## DEFECTS AND ERRORS

Sections 8(4) and 15(1) of the 1983 Act provide a mechanism for rectifying applications or medical recommendations which are found to be incorrect or defective in any respect. "Defective" literally means to fail to do while "incorrect" indicates a mistake, a want of exactness, as compared with an omission.

## Applications for admission under Part II

Section 15(1) provides that if, within 14 days of a patient's admission in pursuance of an application, the application or a supporting medical recommendation is found to be in any respect incorrect or defective, it may within that period and with the hospital managers' consent be amended by the person by whom it was signed. Upon such amendment being made, the application or recommendation has effect, and is deemed to have always had effect as if it had been originally made as so amended. The managers may authorise any officer (employee) or class of officers to consent to the amendment of a document on their behalf.<sup>170</sup>

## Guardianship cases

Section 8(4) makes like provision for amending any guardianship application or supporting medical recommendation which is found to be incorrect or defective. Any amendments must be made within the 14 day period beginning with the date of the patient's reception into guardianship and require the consent of the local social services authority,<sup>171</sup> which authority may authorise in writing an officer, or class of officers, to consent on its behalf to the rectification of documents.<sup>172</sup>

<sup>170</sup> Mental Health Act 1983, s.32(3); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.4(2)(a). In practice, the Mental Health Act Administrator sometimes "tidies up" the application or medical recommendations by correcting obvious inaccuracies, having first obtained the signatory's consent by telephone. The purported justification for this is usually said to be that the administrator is acting as the signatory's "agent." This is presumably a minor drafting error and meant to read "responsible social services authority." Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 5(2).

with great, and it cannot be denied with proper, jealousy, to secure sons placed there from being improperly treated there with harshness or inconsiderateness, or detained there unnecessarily. Now, multiplied and minute forms are among the means, perhaps the necessary means, by which the desired objects are attained; they are specially a protection to the real or supposed lunatic and if neglect of any prescribed form be permitted, no one can say that some measure of that protection may not thereby be weakened or made incomplete .... If it be asked, what purpose the particular provision now in question can answer, how it is material, or what benefit can result from the statement appearing upon the face of the certificate? I think it might be enough to answer, that with such questions the Court has no concern, and that when it is clearly established that the legislature has so enacted, the only business of the Court is to give full effect to the enactment. But it seems to me that, as to the present matter it is obvious enough that it may, in a great many cases, be a guard against or lead to the detection of collusive examinations to know the exact house in which they are alleged to have taken place; and it may therefore be important that he who grants the certificate should on the face of it state that examinations are made separately, or if it be desired to know at what time of day, in whose presence, or under what circumstances it took place, it cannot be questioned that inquiry into all these particulars is made more easy by a statement on the face of the certificate on what day and in what house it took place. Nothing is more common than this mode of legislation. It should be remembered, this is not a case of the sufficiency of an equivalent phrase; if it were, different considerations might arise but here, that which the statute requires has been wholly omitted, and nothing substituted in its place.

### *Whether patient should be discharged*

I come to the conclusion, then, upon principle, that the certificate is defective in a particular which I have no right to consider is immaterial ... I was urged, however, in the commencement of the argument, at all events not to discharge the alleged lunatic; and I was reminded of what had fallen from the Court on several occasions when defects of a formal nature in orders or certificates have been urged as the ground for discharging lunatics; and I still feel that in such cases when, on the affidavits, it appears clear that the party confined is in such a state of mind that to set him at large would be dangerous either to the public or himself it becomes a duty and is within the common law jurisdiction of the Court, or a member of it, to restrain him from his liberty, until the regular and ordinary means can be resorted to of placing him under permanent legal restraint. But this arises from an obvious necessity, and cannot be extended to a case like the present. Upon the facts before me, Mr. Greenwood may be of much impaired memory, of much enfeebled intellect; it may be that he cannot prudently govern a household or manage a considerable property ... but it is quite clear that he is harmless to himself and to others. Mr. Pinder has not found it needful to restrain him at home or to prevent him from rambling alone at his free will and pleasure abroad. If, therefore, his present custody is illegal, I must determine it; and the power which I possess for the public safety or the personal safety of the individual must not be strained to continue his confinement.

*Discharge granted.*

## The ambit of sections 8(4) and 15(1)

Section 15(1) corresponds to section 32(1) of the 1959 Act, which derived from a similar provision in the Lunacy Act 1890.<sup>173</sup> Section 8(4) derives from section 34(4) of the 1959 Act, which enactment was cast in identical terms. In the case of *In Re V.E. (Mental Patient)*,<sup>174</sup> Lord Widgery C.J. described the provisions as constituting a "slip rule" permitting the correction of accidental mistakes in the form of the documents themselves. The view expressed in the *Memorandum* is that defects may be remedied as being "incorrect or defective" include, "the leaving blank of any spaces on the form which should have been filled in (other than the signature) or failure to delete one or more alternatives in places where only one can be correct."<sup>175</sup> This interpretation of the type of error caught by the subsection is repeated by Gostin,<sup>176</sup> Jones<sup>177</sup> and Hoggett.<sup>178</sup> Their common opinion is expressed by Hoggett:<sup>179</sup>

"'Incorrect' probably means 'inaccurate' in the sense of mis-stating names, dates, places or other details which had they been correctly stated would have justified the admission. It does not mean that a document which accurately reflects the facts can be rectified if those facts do not fall within the legal requirements. For example, a frequent fault is that the medical recommendations are undated or dated later than the application ... If in fact they were signed on or before the date of the application, the mistake can be rectified. But if they were signed later, then the application is invalid and the detention illegal."

'Defective' probably means 'incomplete' in the sense that all the information required in the forms has not been given. It cannot mean that forms which are complete and accurate statements of the facts can be falsified in order to provide legal justification for detention where none exists ..."

## Unauthorised amendments

The effect of an unauthorised amendment was considered in the case of *Lowe v. Fox*,<sup>180</sup> in which the petitioner<sup>181</sup> included in the statement of particulars in support of his wife's admission<sup>182</sup> the following answer to the question, "When and where previously under care and treatment?": "During the period of twenty years has been constantly under treatment." A few days after the admission had taken place the petitioner added to this answer the additional words, "for hysteria by [Dr. X]." The addition was not approved by the Commissioners in Lunacy, who at the time fulfilled the function, now performed by the hospital managers and the local social

<sup>173</sup> Lunacy Act 1890, s.34(1): "(1) If an order or certificate for the reception of a lunatic is, after such reception, found to be in any respect incorrect or defective, such order or certificate may, within fourteen days next after reception, be amended by the person who signed the same ... (3) Every order and certificate amended under this section shall take effect as if the amendment had been contained therein when it was signed."

<sup>174</sup> *Re V.E. (Mental Patient)* [1972] 1 W.L.R. 669 at 673.

<sup>175</sup> *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 54.

<sup>176</sup> L. Gostin, *Mental Health Services - Law and Practice* (Shaw & Sons Ltd.), para. 6.05.1.

<sup>177</sup> R. Jones, *Mental Health Act Manual* (Sweet & Maxwell, 5th ed., 1996), p.78.

<sup>178</sup> B. Hoggett, *Mental Health Law* (Sweet & Maxwell, 4th ed., 1996), pp.90-91.

<sup>179</sup> *Ibid.*

<sup>180</sup> *Lowe v. Fox* 12 App. Cases 206; 51 J.P. 468.

<sup>181</sup> A petitioner under the Lunacy Act 1890 fulfilled a role equivalent to that of a nearest relative applicant under current law.

<sup>182</sup> The statement of particulars may be seen as equivalent to an application under Part II.

services authority, of approval, any amendments to the admission documents. The Court held that the order was not invalidated by the entry, taking the view that the addition was merely a statement of something which had already appeared on the face of the documents.<sup>183</sup> Cast in contemporary language, the ratio is that an amendment made after admission without the sanction of the managers, but in an immaterial particular, will not invalidate the authority so as to prevent the managers of the hospital from relying on it to justify the patient's detention.<sup>184</sup> By material is meant that the grounds said to justify the patient's detention have been altered.

## Falsification of documents

Section 126(4) makes it an offence, subject to proof of mens rea, to wilfully make a false entry or statement in any application, recommendation or other document required or authorised to be made under the Act.<sup>185</sup>

## Summary

A technical defect in the form of an application or recommendation may, with the necessary consent, be amended within the prescribed period by its signatory. Unauthorised amendments may invalidate an application if material and a court should consider whether the authority is valid and sufficient without regard to unauthorised amendments to the original. Where a defect which is rectifiable under section 8 or 15 is not remedied within the period allowed, the effect of that failure depends upon the importance of the error or defect and whether even legally significant breaches render an application invalid or voidable, that is valid until set aside by a competent court.<sup>186</sup> In trivial cases, although the defect or omission may no longer be rectified after a fortnight, so that the application will never be in the correct form, nevertheless the authority conferred by the application will not be affected.

## RECOMMENDATIONS INSUFFICIENT TO WARRANT DETENTION

Subsections 15(2) and (3) provide that a fresh medical recommendation may be completed during the rectification period where it appears to the managers that one of the original recommendations, or their combined effect, is insufficient to warrant the patient's detention in pursuance of the application.

<sup>183</sup> (1) "... the judgment which we are delivering rests upon the fact that the alteration was an alteration wholly immaterial and that it is not intended to cast any doubt upon the proposition that an alteration of a document of this description in a material particular, if made at all events with the privacy and knowledge of the person who is relying upon it, would make it invalid and would preclude him from legally relying upon it." *per* Lord Herschell. (2) "If a material part of [the document] was altered so that it no longer spoke the language which it did speak when it was originally received, and upon which the detention was authorised, that vitiated the document, I think it would be a very calamitous view of the state of the law if any doubt could be entertained as to whether such a misuse of the authority given by the statute could be made with impunity. It is as well that it should be generally known that any tampering with a document of that sort would impair its validity and deprive any person professing to act under it of any protection from it." *per* Lord Halsbury, L.C.  
<sup>184</sup> See *Archbold's Lunacy and Mental Deficiency Law* (Butterworth & Co., Shaw & Sons, 5th ed., 1915).

<sup>185</sup> Subsection (1) further provides that it shall also be an offence for a person to have such a document in his custody or under his control if he knows or believes it to be false within the meaning of Part I of the Forgery and Counterfeiting Act 1981. Under the 1981 Act, a document may be "false" both by virtue of what it omits as well as what it includes. See R. Jones, *Mental Health Act Manual* (Sweet & Maxwell, 5th ed., 1996), p.333.

<sup>186</sup> See Lord Denning's judgment in *D.P.P. v. Head* [1959] A.C. 83, H.L.

### One of the medical recommendations insufficient

Section 15(2) provides that if within the period of 14 days beginning with the date of a patient's admission to hospital in pursuance of an application, it appears to the managers that "one of the two medical recommendations" on which the application is founded is insufficient to warrant the patient's detention they may, within that period, give notice in writing to that effect to the applicant.<sup>187</sup> Where such notice is given, the medical recommendation shall be disregarded,<sup>188</sup> but the application shall be deemed always to have been sufficient if—

- a. a fresh medical recommendation which complies with the relevant provisions of Part II (other than those relating to the time of signature and the interval between examinations) is furnished to the managers within that period;<sup>189</sup> and
- b. that recommendation, and the other recommendation on which the application is founded, together comply with those provisions.

Subsection (2) will be applicable where a medical recommendation does not include the information required by section 3(3) or, arguably, was furnished by a practitioner who is disqualified by section 12(5) from giving a recommendation.

### Medical recommendations taken together insufficient to warrant detention

Section 15(3) applies where the recommendations appear to comply with the Act and to warrant the patient's detention when considered separately but not when considered together. Section 15(3) provides that where the medical recommendations upon which an application for admission is founded are "taken together" insufficient to warrant the patient's detention, a notice under subsection (2) may be given in respect of "either of those recommendations." The Act also provides, however, that no such notice may be given where an application is of no effect because the two recommendations do not agree on at least one form of disorder from which the patient is suffering.<sup>190</sup> Subsection (3) will be applicable where the recommendations are collectively insufficient because—

- the two examinations upon which the recommendations are founded took place more than five clear days apart; or

<sup>187</sup> The managers may authorise any officer (employee) or class of officers to give the written notice on their behalf: Mental Health Act 1983, s.32(3); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.4(2)(b).

<sup>188</sup> On a strict reading of section 15(2), the original medical recommendation is disregarded upon the managers giving notice, regardless of whether their opinion that it is insufficient to warrant the patient's detention is accurate or not. Consequently, if a second medical recommendation is not received within the 14-day period, the patient automatically ceases to be liable to be detained, because the application is then founded on a single medical recommendation.

<sup>189</sup> Necessarily, this third recommendation will be dated later than the date of the application, and the examination upon which it is based may have taken place more than a week after that upon which the other valid medical recommendation is based. The Act recognises this and provides that as long as the two medical recommendations, both individually and collectively, comply with all the other requirements in Part II relating to medical recommendations, the application shall be deemed to have always been sufficient.

<sup>190</sup> Mental Health Act 1983, ss.11(6) and 15(2).

- neither practitioner was approved under section 12(2) of the Act; or
- both recommendations were provided by doctors on the staff of an NHS hospital although section 12(4) did not apply.

### BOTH RECOMMENDATIONS INSUFFICIENT

Where both recommendations are when considered separately insufficient to warrant the patient's detention, the position is irretrievable. Section 15 only allows one substitute recommendation to be furnished.

### Joint medical recommendation

Section 15(2) allows the managers to give notice where "one of the two medical recommendations" appears to them to be insufficient. Section 15(3) provides for giving notice in respect of "either" of the "recommendations" where they are "taken together" insufficient to warrant the patient's detention. However, section 11(7) provides that an application may be founded on a joint recommendation and subsections (2) and (3) do not seem to have been drafted with this in mind. If a joint recommendation is insufficient there is no longer even a single valid recommendation in existence and the application cannot be rectified.

### MEDICAL RECOMMENDATIONS AND GUARDIANSHIP

There is no equivalent provision whereby a substitute medical recommendation may be furnished during the 14-day period following acceptance of a guardianship application. This distinction appears to be intentional since the 1959 Act similarly made no provision for this.<sup>191</sup> This may reflect the fact that the time which a local social services authority has to scrutinise a guardianship application *before* accepting it is unlimited. At any rate, the legal position seems clear. If a medical recommendation is, whether considered separately or in conjunction with the other recommendation, insufficient then the guardianship application cannot be retrospectively validated.

### APPLICATIONS

Sections 15(2) and (3) apply only to the recommendations upon which an application is founded and not to the application itself. If an application is insufficient to warrant the patient's detention a fresh application cannot be furnished during the fortnight following patient's admission. For instance, section 15 cannot save an application which is insufficient to warrant the patient's detention because the applicant had not seen the patient within the previous 14 days.

### PRESCRIBED FORMS

A form used to make an application, or to give a recommendation, may be defective for one of three reasons—

<sup>191</sup> Because that statute was in force for 24 years, there was ample time for the omission to become apparent and to be rectified in the current legislation if this was a lacuna. Moreover, the Scottish and Northern Irish legislation does make provision for a fresh medical recommendation to be furnished in guardianship cases: Mental Health (Scotland) Act 1984, s.42(2) and (3); Mental Health (Northern Ireland) Order 1986, Art. 21(2) and (3).

- An obsolete form, which is no longer the prescribed form, has been used.
- There are defects in the prescribed forms.
- A law stationer's form, the wording of which departs from the prescribed form, has been used.

#### Use of obsolete forms

On 1 April 1996, new forms for making applications and giving recommendations were introduced.<sup>192</sup> The previous prescribed forms had been in force for more than a decade. Not all practitioners had a stock of the new forms or were aware that they were in force, because the Department of Health delayed issuing them. Consequently, a number of applications were made using the old forms during the following months. This was the point in issue in *Re E (Mental Health: Habeas Corpus)*.<sup>193</sup> The patient was admitted to hospital under section 3 on 16 June 1995. On 27 September, a tribunal refused to review the patient's detention on the basis that his detention was unauthorised and there was no authority in existence for it to review. On 9 October, a new section 3 application was completed, using the correct forms. The patient contended that he had been unlawfully detained between 16 June and 9 October and that his detention remained irregular notwithstanding the completion of a fresh application in the prescribed form. The court held that departures which were truly *de minimis* were not intended by the Act to be taken account of. Differences between forms which were *de minimis* should be ignored unless the statute expressly or by necessary implication required it to be given effect.

#### Defects in the prescribed forms

Some of the current prescribed forms do not accurately recite the statutory conditions for admission or renewal. Although it is a condition of admission for treatment, and renewal, that the patient's detention is necessary for his health or safety or for the protection of others, the new forms require the responsible medical officer to consider instead whether it is necessary "in the interests" of the patient's health or safety or "with a view to" the protection of others that he should receive treatment. The very general words, "in the interests of" and "with a view to," constitute part of the looser section 2 and guardianship criteria (221). Using the form prescribed by the regulations made under the statute therefore involves departing from the criteria prescribed by Parliament in the statute itself.

#### Defective law stationers' forms

The case of *Warren v. Warren* involved the use of a printed form the wording of which departed in one respect from the prescribed form, rather than a prescribed form the wording of which departed from the statutory criteria.<sup>194</sup> It was held that the use of the word "declare" in place of "certify" could be regarded as equivalent and sufficient, and in substitution for it (288).

<sup>192</sup> By The Mental Health (Hospital, Guardianship and Consent to Treatment) (Amendment) Regulations 1996.

<sup>193</sup> *Re E (Mental Health: Habeas Corpus)*, 10 December 1996 (unreported).

<sup>194</sup> *Warren v. Warren* [1953] 1 W.L.R. 1268.

## RECTIFICATION OF APPLICATIONS AND RECOMMENDATIONS

### Points for consideration

#### Irregularity

#### Rectification provisions

1. Do the application or recommendations contain any error or defect which the Act expressly provides cannot be rectified and shall render the application invalid?
2. Do the application or recommendations contain any error or defect which the Act implies cannot be rectified and shall render the application invalid?

1. Do the application or recommendations contain any error or defect which the Act expressly provides cannot be rectified and shall render the application invalid?
  - Medical recommendations which do not both describe the patient as suffering from at least one common form of mental disorder, e.g. one states the patient is suffering only from mental illness, the other only from mental impairment
  - Application completed by a person not qualified to complete it, e.g. not an ASW, not the nearest relative, not a person authorised to exercise that relative's functions.
  - Recommendation completed by a practitioner who is not fully registered: see Medical Act 1983, ss.47 & 48.
  - Recommendation completed by a practitioner disqualified under s.12(5).
  - Unsigned application or medical recommendation
2. Do the application or recommendations contain any error or defect which the Act implies cannot be rectified and shall render the application invalid?
  - Non-section 2 recommendations which contain insufficient grounds/reasons for the doctor's opinion that the statutory criteria are satisfied
  - If the recommendations are signed, the next step is to scrutinise each document separately, to ensure that it complies with the various statutory formalities. 3. Is the recommendation sufficient to warrant the patient's detention in pursuance of the application?

The customary view is that section 15(2) does not apply because it only allows for the rectification of applications and documents completed by a person not qualified to complete them do not constitute an application or recommendation. It is not so much that the application or recommendation is insufficient, rather the document is not an application or recommendation at all.

The conventional view is that any such application, or application which relies upon a document which is not a recommendation, is invalid and cannot be rectified under section 15. However, the point has not been determined by the courts so some caution is necessary.

Section 15(2) provides that the hospital managers may notify the applicant of their opinion that the recommendation is insufficient, in which case the recommendation is disregarded. The applicant may then arrange for a fresh medical recommendation to be furnished within the statutory 14-day period. Section 15(2) does not apply to guardianship applications and no provision is made for the provision of a substitute recommendation in such cases.

If a fresh sufficient recommendation is provided within the period allowed, the application is retrospectively validated. If not, the validity of the detention depends on the correctness of the managers' opinion that the recommendation is insufficient. In guardianship cases, the guardianship is always invalid if a recommendation is insufficient.

### Effect of an irregularity



## NATURE AND DURATION OF COMPULSORY POWERS

The authority for a patient's detention or guardianship under Part II remains in force until it is discharged or expires (285) or, more rarely, the patient is transferred from hospital into guardianship, or vice-versa (282). Prior to then, a patient may be granted leave to be absent from the hospital where he is liable to be detained (280), transferred to another hospital, or placed under the care of a different guardian (282). A detained patient may be given treatment for mental disorder without his consent in the circumstances set out in Part IV.

### TREATMENT WITHOUT CONSENT (PART IV)

Part IV of the 1983 Act, which comprises sections 56 to 64, regulates the circumstances in which a patient who is liable to be detained under the Act may be given non-consensual treatment for mental disorder.<sup>195</sup> Section 58 is concerned with the administration of ECT and medication and is the most important section in practice. In certain circumstances, treatment may only be given if it has been authorised by a registered medical practitioner appointed for the purpose by the Mental Health Act Commission, on the Secretary of State's behalf. These Second Opinion Appointed Doctors are commonly referred to as "SOADs".

### Psychosurgery and the surgical implantation of hormones

Psychosurgery (any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue) is a particularly invasive treatment and one carrying special risks. The Act therefore provides that, except in an emergency, it may not be performed on any person — including therefore informal patients and out-patients — unless the individual consents to the operation and, furthermore, his capacity to give consent, the fact that he does consent, and the likelihood of benefit have been independently verified. These special safeguards also apply to one other form of treatment, the surgical implantation of hormones for the purpose of reducing the male sex drive. As to the use made of psychosurgery and the kinds of disorder which it may be used to treat, see page 1130.

### The special procedures

Unless it constitutes urgent treatment lawfully given under section 62 (278), no person may be given any form of section 57 treatment unless<sup>196</sup>—

- a. he has consented to it, and
- b. a SOAD and two other persons appointed for the purposes of section 57 have certified in writing that he is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it; and

<sup>195</sup> Part IV is not merely concerned with compulsory treatment since, if a patient is incapable of consenting to or refusing treatment, there may be no need to compel him to receive the proposed treatment. It has been variously held that the phrase "medical treatment for mental disorder" is, in essence, not synonymous with "psychiatric treatment," insofar as it includes ancillary treatments such as force-feeding a patient who suffers from anorexia nervosa (279).  
Mental Health Act 1983, s.57(2).

<sup>196</sup>

- Effect of an irregularity*
- Rectification provisions*
- Irregularity*
- Points for consideration*
5. If the application and both medical recommendations are sufficient to warrant detention, whether considered separately or together, are any other errors or defects in the forms apparent?
  - Failure to delete one or more alternative clauses in places where only one can be correct
  - Errors in the spelling of names, addresses or places
  - Leaving blank spaces on the form which should have been completed, other than the space for signing it or for recording the doctor's reasons for believing that the statutory criteria are satisfied.
  - Both recommendations were provided by doctors on the staff of the NHS hospital to which the patient was admitted although s.12(4) did not apply.
  - More than five clear days elapsed between the days on which the doctors furnishing the two medical recommendations considered together, are the recommendations sufficient to warrant the patient's detention?
  - Neither medical practitioner is approved under s.12(2).
  - Agents may notify the applicant of their opinion and, in doing so, they shall stipulate which recommendation is sufficient to warrant the patient's detention, the next question to address is their combined effect.
  - When considered together, are the recommendations sufficient to warrant the patient's detention?
  - Both recommendations were provided by made for the provision of a substitute recommendation in such cases.
  - Sections 8(4) and 15(1) provide that an application or medical recommendation which is in any respect incorrect or defective may, with the manager's consent, be amended during the 14 days following admission or reception into guardianship.
  - Once the amendment has been made, the recommendation is deemed to have effect as if it had been originally made as so amended. If the error or defect is not corrected, the validity of detention or guardianship depends on the significance of the error or defect. If trivial, the authority is unlikely to be affected.

- c. the SOAD has further certified in writing that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given; and
- d. before certifying that the treatment should be given, the SOAD has first consulted two other persons who have been professionally concerned with the patient's medical treatment, one of whom is a nurse and the other neither a nurse nor a registered medical practitioner.

*The statutory certificate*

Certificates authorising treatment under section 57 must be in the form set out in Form 37 to the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.<sup>197</sup>

**"Excluded patients"**

Section 57 treatments aside, the provisions in Part IV of the Act only apply to treatment which is given to certain classes of patients. Another way of making the same point is that certain patients (referred to here as "excluded patients") are excluded from the operation of Part IV and so may only be given treatment to which they do not consent if its administration is justified under common law.<sup>198</sup> These patients therefore retain a citizen's usual right to refuse medication or ECT.

**EXCLUDED PATIENTS**

- Patients who are not liable to be detained in a hospital  
*Informal patients and those living in the community under guardianship, after-care under supervision or conditional discharge*
- Patients awaiting admission to hospital  
*Following the making of an application under ss.2-4 or the imposition of an order or direction under Part III.*
- Patients who are detained in a hospital under an order which lasts for 72 hours or less  
*Under section 4, 5(2), 5(4), 135 or 136.*
- Patients sent to hospital by a criminal court only so that a medical report can be prepared  
*Under section 35.*

**People detained under section 2 or for treatment**

Having regard to the list of excluded persons, it can be seen that the only patients who do come within the ambit of Part IV, and who therefore do not enjoy the usual right to refuse psychiatric treatment, are those admitted to hospital under an application, court order or direction which expressly authorises admission for

<sup>197</sup> Mental Health Act 1983, s.64(2); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 16(1)(b).  
<sup>198</sup> Mental Health Act 1983, s.56(1).

treatment. The authority conferred by a section 2 application is assessment followed by any necessary treatment while, in the other cases, the statutory purpose of the admission is expressed to be solely for the purpose of giving treatment.

**PATIENTS TO WHOM ALL THE PART IV PROCEDURES APPLY**

- Patients detained in hospital for assessment (followed by treatment)  
*Under section 2*
- Patients detained in hospital for treatment  
*Under section 3, 36, 37, 38, 44, 45A, 46-48*

**Different forms of treatment**

When considering whether a particular patient may be given compulsory treatment for mental disorder, the first step is therefore to determine whether he is a patient to whom the procedures in Part IV apply or is excluded from its provisions. If Part IV applies, the second step is to consider the nature of the treatment which it is proposed to give him because different statutory procedures apply to different kinds of treatment. Treatments which a doctor may give a Part IV patient are divided into three categories according to whether the patient's valid consent and/or independent authorisation is required.

**DIFFERENT KINDS OF TREATMENT**

- Psychosurgery  
These treatments require both the patient's verified valid consent and a certificate authorising the treatment given by a SOAD.
- Surgical implantation of hormones to reduce the male sex drive  
These treatments require either the patient's valid consent or that a certificate authorising the treatment has been given by a SOAD.
- ECT at any time  
These kinds of treatment neither require the patient's consent nor independent authorisation by a SOAD.
- Medication without the patient's consent for longer than three months  
These kinds of treatment neither require the patient's consent nor independent authorisation by a SOAD.
- Urgent treatment given under section 62  
These kinds of treatment neither require the patient's consent nor independent authorisation by a SOAD.
- Medical treatments for mental disorder which do not fall within the above classes and are given under section 63 by, or under the direction of, the responsible medical officer, including medication during the initial three month period, non-invasive treatments such as nursing care, and various ancillary treatments (such as force-feeding in the case of anorexia nervosa)

### Medication during the first three months

Sections 58 and 63 provide that a patient to whom Part IV applies may, without his consent and without any need for independent authorisation, be given medication for his mental disorder for a period of three months, provided it is given by or under the direction of his responsible medical officer. The three month period begins on the day on which the patient is first given medication for mental disorder after becoming a patient to whom Part IV applies. In other words, any medication previously given to him when he was an "excluded patient" is ignored. If the patient ceases to be a patient to whom Part IV applies before the three months have expired, the doctor's right to whom Part IV applies before the three months by definition right to administer compulsory medication for a period of three months by definition no longer applies, since it is a power conferred by Part IV. The patient, being now exempt from the provisions of Part IV, may only be given further medication without his consent if justified under common law. If, as not uncommonly happens, he later again becomes a patient to whom Part IV applies — for example, a further application is made after a short period of informal hospital treatment — the statutory three month period begins afresh with the reintroduction of the statutory scheme. Where, however, the authority for the patient's detention and compulsory treatment simply changes from one application, order or direction to which Part IV applies to another, without their being any break in the patient's status as a Part IV patient, the three month period is not recalculated but continues for whatever is left of it.

#### Examples

X has been continuously detained since 1 January and he has also been given chlorpromazine daily since then. He was detained under section 5(2) on 1 January, under section 2 on 3 January, and under section 3 on 26 January. Patients detained under section 5(2) fall outside Part IV of the Act. The treatment given on 1 and 2 January was therefore not administered under Part IV. On 3 January, the patient was therefore not administered under section 2 and given medication for mental disorder, and the three month period therefore began to run. Because he has been continuously detained since then, the three month period during which he may be given medicine without his consent or a second opinion expires at midnight on 2 April.

#### Example 2

If, in the above example, no medication was administered until 14 January, in order to allow the patient's responsible medical officer to assess his condition and the need for treatment, the three month period would have commenced on that date rather than on 3 January.

#### Example 3

If the patient was discharged from detention on 1 March, because he undertook to take medication informally but then defaulted on that agreement, so that a further section 3 application was made on 7 March, and medication given to him, the position would be as follows. Because he was an informal patient between 1 March and 6 March, he was not during that period a patient to whom Part IV applied. When he was redetained on 7 March, a new "continuous" period of detention as a Part IV patient began. He may therefore be treated without his consent or a second opinion for a period of three months beginning from then, *i.e.* until midnight on 6 June.

### Medication after three months and ECT at any time (section 58)

Once the three month statutory period has expired, further medication for mental disorder may only be administered if it is given with the patient's valid consent, or has been authorised by a SOAD, or it constitutes urgent treatment given under section 62. A consent is valid in this context if the patient understands the nature, purpose and likely effects of the proposed treatment and consents to receiving it. ECT, whether given during or after the first three months during which a person is a Part IV patient, may similarly only be administered if it is given with the patient's valid consent, or has been authorised by a SOAD, or it constitutes urgent treatment given under section 62.<sup>199</sup>

#### The statutory certificates (Forms 38 and 39)

It is not sufficient that the patient has given a general oral or written consent to ECT, or to medication administered after the initial three month period. A statutory certificate must be completed. Where a patient who is capable of giving a valid consent to treatment does consent to ECT, or to medication being given outside the initial three month period, that treatment may still only be given if his responsible medical officer has first certified that the patient understands the nature, purpose and likely effects of the proposed treatment and has consented to it. He does this by completing the relevant statutory certificate, Form 38.<sup>200</sup> Where a patient is incapable of understanding the nature, purpose and likely effects of ECT or of the medication proposed, or withholds his consent, he may then only be given that treatment if a SOAD has certified that it should nevertheless be given having regard to the likelihood of it alleviating or preventing a deterioration of the patient's condition. He authorises the treatment by completing a Form 39. Before completing that certificate, he must first consult two other persons who have been professionally concerned with the patient's medical treatment, one of whom is a nurse and the other neither a nurse nor a registered medical practitioner.<sup>201</sup>

#### Withdrawing consent to treatment

Where a patient being treated in accordance with a valid Form 38 later withdraws his consent a visit from a SOAD must be arranged so that the treatment can be authorised by him if appropriate. Prior to the completion of a Form 39, the treatment must be discontinued unless the responsible medical officer considers that its discontinuance pending a SOAD visit would cause serious suffering to the patient.<sup>202</sup>

#### Plans of treatment

A Form 38 or Form 39 may authorise a plan of treatment, such as a course of ECT or a course of specified medication.<sup>203</sup> If the patient later withdraws consent to further treatment before the course of treatment has been completed, section 62

<sup>199</sup> There are therefore two circumstances in which a Form 38 or 39 may be required in the case of a section 2 patient: (i) where ECT is being administered; (ii) where, following a county court application made under section 29, the patient has been detained under that section for more than three months.

<sup>200</sup> Mental Health Act 1983, ss.58(3)(b), 58(4), 64(2); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 16(1)(b), Sched. 1, Form 38.

<sup>201</sup> Mental Health Act 1983, ss.58(3)(b), 58(4), 64(2); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 16(1)(b), Sched. 1, Form 39.

<sup>202</sup> Mental Health Act 1983, ss.60(1) and 62(2).  
<sup>203</sup> *Ibid.*, s.59.

similarly requires the treatment to be discontinued unless the responsible medical officer considers that its discontinuance pending a SOAD visit would cause serious suffering to the patient.<sup>204</sup>

#### *Future reviews of treatment*

Where a SOAD has completed a Form 39, the responsible medical officer is periodically required to report to the Mental Health Act Commission on the progress of the patient's treatment. In the case of unrestricted patients, such a report must be furnished on the next occasion on which the responsible medical officer furnishes a report renewing the patient's detention for a further period.<sup>205</sup> Reports are made using a non-statutory form called Form MHAC/1.

### **MEDICATION AFTER 3 MONTHS AND ECT AT ANY TIME**

- Patients who are capable of consenting to the proposed treatment and consent to receiving it
- Patients who are capable of consenting to the proposed treatment but who refuse consent
- Patients who are incapable of giving a valid consent to the proposed treatment
- Patients who require the treatment urgently

The responsible medical officer or a SOAD has completed a Form 38, certifying that the patient understands the nature, purpose and likely effects of the treatment and has consented to it.

A SOAD has completed a Form 39, certifying that although the patient does not consent to the proposed treatment it should nonetheless be given having regard to the likelihood of it alleviating or preventing a deterioration of his condition.

A SOAD has completed a Form 39, certifying that although the patient is incapable of understanding the nature, purpose and likely effects of the treatment, it should nonetheless be given having regard to the likelihood of it alleviating or preventing a deterioration of his condition.

The treatment may lawfully be given, despite the lack of a Form 38 or Form 39, if it constitutes "urgent treatment" under section 62.

#### **Urgent treatment**

The usual procedural safeguards concerning psychosurgery, ECT and medication administered after the initial statutory period, do not apply if the particular treatment constitutes urgent treatment given under section 62. The need to give urgent treatment under section 62 most commonly arises when a patient requires ECT and it is not appropriate to delay the first application for the period of two or three days which it takes for a SOAD to attend the hospital. Section 62 provides that the usual section 57 and 58 procedures do apply to any treatment—

- a. which is immediately necessary to save the patient's life; *or*
- b. which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; *or*

- c. which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; *or*
- d. which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

#### *Applying section 62*

In practice, some practitioners may find it easier to approach the criteria for urgent treatment by firstly asking if the treatment is irreversible and then, secondly, whether it is hazardous.

### **URGENT TREATMENT**

- Is the proposed treatment irreversible? If so, the treatment may only be given if immediately necessary to save the patient's life.
- If not, is it hazardous? If so, the treatment may only be given if it is either immediately necessary to save the patient's life *or* immediately necessary to prevent a serious deterioration of his condition.
- If the proposed treatment is neither hazardous nor irreversible It may be given in any of the four circumstances referred to in section 62.

#### *What constitutes irreversible or hazardous treatment*

The Act does not specify that particular treatments, such as psychosurgery or ECT, shall be deemed to be irreversible or hazardous for the purposes of section 62. It merely provides that a "treatment is irreversible if it has unfavourable irreversible physical or psychological consequences and hazardous if it entails significant physical hazard."<sup>206</sup> Treatments (such as ECT) which may be hazardous for an aged patient, or a patient with some serious concurrent physical illness, will not necessarily be hazardous for a young, physically healthy, person. As to whether treatments are reversible, this is defined by reference to the consequences of the treatment rather than the procedure itself. Furthermore, only treatment which has unfavourable consequences is irreversible for these purposes. Consequently, although psychosurgery is irreversible in the sense that it involves destroying brain tissue, or the way in which such tissue functions, it does not constitute irreversible treatment in the context of section 62 unless the physical and psychological effects of the operation are both permanent and unfavourable.

#### **Section 63**

Section 63 provides that a patient's consent "shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer." In *B v. Croydon Health Authority* [1995] 1 All E.R.683, the court dismissed the argument that, whilst force-feeding

<sup>204</sup> Mental Health Act 1983, ss.60(2) and 62(2).  
<sup>205</sup> *Ibid.*, ss.61(1) and 121(2)(b).

<sup>206</sup> Mental Health Act 1983, s.62(3).

## Legal status of patients absent from hospital

The legal status of a detained patient who is absent from hospital can only be one of two things — he is either absent with leave (with his responsible medical officer's permission) or absent without leave (without that person's permission). Although patients who briefly leave the grounds to buy cigarettes at the local shop or "to pop home," sometimes with a nurse's permission, are commonly considered not to be absent from the hospital without leave, as a matter of law they are if they do not have their responsible medical officer's prior permission. Just as the statement that a person is helping the police with their enquiries is legally meaningless so too there is no intermediate legal position when it comes to being absent from hospital.

### Patients kept in custody

The fact that patients granted leave may, in the circumstances stated above, remain in custody during their absence raises the question of what being in custody means. In the first place, the patient "remains" in custody because his previous detention in the hospital is also a form of legal custody. More specifically, the patient is "in legal custody,"<sup>214</sup> and the nominated custodian is "in charge" of him.<sup>215</sup> The patient's custodian has certain duties to him, in particular to take reasonable care that the patient does not harm himself or others. As to his powers, if the patient attempts to escape from his custodian or does briefly escape, the latter then has authority to keep or take him back into his legal custody and, if on their way to some particular destination, to convey him to the stipulated place.<sup>216</sup> The position of patients granted leave to be absent from the hospital where they are liable to be detained, subject to a condition that they "reside" at another hospital but remain in custody, does, however, differ in one important respect. In contrast to patients transferred to that hospital under section 19, patients on leave there remain "liable to be detained" at the hospital from which they have leave to be absent. It is the managers of that first hospital who have authority to detain them and who remain legally responsible for them. It is to them that any reports renewing the authority for the patient's detention, and any other statutory reports, must be submitted.

### Revocation and recall

Once a responsible medical officer grants leave, he may only revoke it and recall the patient to the hospital where he is liable to be detained if it is necessary to do so in the interests of the patient's health or safety or for the protection of others.<sup>217</sup> A patient who is on leave may not be recalled to hospital after he has ceased to be liable to be detained under the Act.<sup>218</sup> This is logical because there is no longer any hospital at which he is liable to be detained and to which he can be recalled. Furthermore, the authority for his detention may not be renewed unless he requires further treatment in hospital as a detained patient, and he cannot be recalled simply as a way of bringing him within the statutory conditions for renewal.<sup>219</sup>

<sup>214</sup> Mental Health Act 1983, s.137(1).

<sup>215</sup> See *ibid.*, s.17(4).

<sup>216</sup> See *ibid.*, ss.137 and 138.

<sup>217</sup> Mental Health Act 1983, s.17(4). Any revocation of leave must be by notice in writing, served on the patient or (where applicable) on his custodian. Thus, the revocation but not the grant of leave must be in writing. Where leave is revoked but the patient does not return to hospital, he is thereafter absent without leave: *ibid.*, s.18(1)(b).

<sup>218</sup> *Ibid.*, s.17(5).

<sup>219</sup> *R. v. Hallstrom, ex p W (No. 2)* [1986] 2 All E.R. 306, per McCullough J.

may be a prerequisite to a treatment for mental disorder, or it may be treatment for that consequence of the mental disorder, it cannot be said to be treatment for the disorder. The definition of medical treatment in section 145, and the term "medical treatment ... for mental disorder" in section 63, included a range of acts ancillary to the core treatment. Treatment (in the form of nasogastric feeding) to alleviate the symptoms of mental disorder (in the form of a refusal to eat in order to inflict self-harm) was just as much a part of treatment for the disorder as that directed towards remedying its underlying cause. It therefore fell within section 63 and could be administered without the patient's consent.<sup>207</sup> The court added that it would be strange if a hospital could, without a suicidal patient's consent, give him treatment for the underlying mental illness but not without such consent treat the consequences of the suicide attempt.<sup>208</sup> *Tameside and Glossop Acute Services Trust v. C.H.* [1996] 1 F.L.R. 762 concerned a pregnant woman who believed that the doctors were trying to harm her baby, with the consequence that the baby was at significant risk. The mother-to-be was detained at the time under section 3 and, relying on section 63, Wall J gave a declaration that it would be lawful to induce labour or to perform a caesarian section. The success of the psychiatric treatment depended on the patient delivering a healthy baby and on a prompt resumption of strong antipsychotic medication and, accordingly, such interventions were part of the overall medical treatment for her mental disorder.

### Seclusion

As to whether seclusion may constitute a medical treatment given to the patient for the mental disorder from which he is suffering, see page 1168.

### LEAVE OF ABSENCE

The responsible medical officer may grant a patient leave to be absent from the hospital where he is liable to be detained, subject to such conditions as that officer considers necessary in the interests of the patient or for the protection of others,<sup>209</sup> including that he remains in custody during his absence.<sup>210</sup> Leave may be granted to enable a patient to reside at an address outside hospital or at another hospital.<sup>211</sup> Where leave is granted for a specific period, it may be further extended in the patient's absence.<sup>212</sup> A patient who absents himself from the hospital or place where he is required to reside as a condition of his leave is absent without leave for the purposes of the Act.<sup>213</sup>

<sup>207</sup> *B v. Croydon Health Authority* [1995] 1 All E.R. 683 at 687 F-G, per Hoffmann L.J.

<sup>208</sup> *Ibid.*, at 687J-688A.

<sup>209</sup> Mental Health Act 1983, s.17(1).

<sup>210</sup> *Ibid.*, s.17(3). More particularly, the subs. provides that "the patient may be kept in the custody of any officer on the staff of the hospital, or of any other person authorised in writing by the managers of the hospital, or, if the person is required ... to reside in another hospital, of any officer on the staff of that other hospital." Thus, while only the responsible medical officer can grant leave and direct that the patient shall remain in custody, if the custodian is to be some person other than an NHS employee such as a nurse — for example, a police constable or social worker — only the managers can authorise that. Furthermore, while any grant of leave need not as a matter of law be in writing any such authority given to a non-NHS employee by the managers must be.

<sup>211</sup> See *ibid.*, ss.17(3) and 18(2). A patient granted leave to reside at another hospital is not detained there but remains liable to be detained at the hospital from which he has leave to be absent. However, in appropriate cases, a condition that the patient shall remain in the custody of a nurse at the second hospital may be attached to the leave.

<sup>212</sup> *Ibid.*, s.17(2).

<sup>213</sup> *Ibid.*, s.18(1)(c) and (6).

## Transfers from guardian to hospital

Where a patient who is subject to a guardianship application is transferred to hospital, the guardianship application takes effect as if it were a section 3 application and as if the patient had been admitted to hospital in pursuance of it on the date of his original reception into guardianship.<sup>224</sup>

### Example

A patient is admitted to hospital under section 2 on 1 January. He is transferred into guardianship on 18 January. As a result, he is deemed to have been received into guardianship under section 7 on 1 January. His condition deteriorates and he is transferred back to hospital under section 19 on 1 May. The effect of the transfer is that he is deemed to have been admitted to hospital under section 3 on 1 January.

## Removals under section 19

Where a detained patient is removed under section 19(3) to a hospital under the same hospital managers, the statutory provisions relating to the duration, expiry and renewal of the authority for the patient's detention remain unaffected.<sup>225</sup>

## TERMINATION OF DETENTION OR GUARDIANSHIP

A patient may be discharged from liability to detention or guardianship under the Act. Even if a patient is not discharged, the authority for his detention or guardianship may cease to have effect for one of the reasons set out in the table on page 285.

## DISCHARGE OF PATIENTS

A patient who is liable to be detained or subject to guardianship under Part II may be discharged in the circumstances specified in sections 23 and 72.

## Orders for discharge under section 23

Section 23 provides that a patient shall cease to be liable to be detained or subject to guardianship if an order is made discharging him from detention or guardianship. An "order for discharge" must be in writing and comply with the other requirements of the section. A number of persons may make an order for discharge: the responsible medical officer,<sup>226</sup> the managers of the hospital where the patient is liable to be detained; the responsible social services authority of a patient subject to

<sup>224</sup> Mental Health Act 1983, s.19(2)(d).

<sup>225</sup> As to the distinction between transfers and removals under section 19, see p.135.

<sup>226</sup> Most orders for discharge are made by responsible medical officers. There is no prescribed form. Some hospitals have devised an in-house form. Where that is not so, it may in practice be difficult to discern any entry in the case notes which is capable of constituting an order for discharge. The exercise of the power is personal to the responsible medical officer and cannot be delegated. Orders may sometimes be signed by junior medical officers, in effect recording decisions communicated to them orally by the responsible medical officer. The legality of this is not established. Because the Act states that such orders must be in writing and made by the responsible medical officer, discharge may well only be effective if the responsible medical officer signs the order himself.

### Example

A patient is detained under section 3 on 1 January 1995. On 1 March, he is granted leave of absence subject to a condition that he resides at a different hospital. He will cease to be liable to be detained unless, prior to 30 June, the section is renewed for a further period. Since he remains an in-patient in hospital, the authority for detention may be renewed for a further period if he satisfies the renewal criteria set out in section 20(4). In particular, renewal requires that the medical treatment in hospital which it is appropriate for him to receive cannot be provided "unless he continues to be detained."<sup>220</sup>

## Patients subject to guardianship

Section 17 does not apply to guardianship cases. If a guardian agrees to the patient staying at an address other than his nominated place of abode, he simply specifies the new address as the place where the patient is required to reside for the time being.<sup>221</sup> Thus, although patients subject to guardianship may be absent without leave from their required place of residence they are never absent from there with leave granted under section 17.

## TRANSFERS AND REMOVALS UNDER SECTION 19

The transfer of a patient from one hospital to another, or from the guardianship of one person or authority to another, has no legal consequences other than to transfer the powers and duties conferred and imposed by the application from one person or body to another. The statutory provisions relating to the duration, expiry and renewal of the detention or guardianship remain unaffected.<sup>222</sup> This is not, however, the case where the transfer is from hospital to guardianship, or vice-versa.

## Transfers from hospital to guardianship

Where a patient who is liable to be detained under section 2 or 3 is transferred into guardianship, the section 2 or 3 application takes effect as if it were a guardianship application made and accepted on the date when the patient was originally admitted to hospital for assessment or treatment, as the case may be.<sup>223</sup>

<sup>220</sup> Since a patient on leave is not detained in the hospital where he is residing, the renewal criteria can only be satisfied if (a) he is first transferred (b) the word "detained" in this context is read as meaning "liable to be detained," or (c) being in the custody of an officer of the hospital where the patient is residing constitutes being detained in hospital for the purposes of s.20. The conventional view, first set out in the *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX (D.H.S.S., 1960)*, was reiterated in the Department of Health's *Health Service Guidelines HSG(96)28*. This is that the renewal criteria cannot be met if the patient has leave to reside at another hospital at the relevant time, i.e. he is absent with leave from the hospital at which there is authority to detain him and he is therefore not detained at either hospital. Furthermore, it is unlawful to return him to the first hospital purely for the purpose of renewing his liability to detention. See also page 281.

<sup>221</sup> See Mental Health Act 1983, s.8(1)(e).

<sup>222</sup> The guardianship also continues if a private guardian relinquishes his functions and, by virtue of section 10, the guardianship thereupon vests in the local social services authority. It similarly vests in the local authority if a guardian is incapacitated, dies, or is removed by the county court on the grounds that he has exercised his functions negligently or without due regard for the patient's welfare. In any such eventuality, section 19(2)(c) applies and the guardianship is treated as having commenced on its original date, but as if the substitute guardian had been named in the original authority for guardianship. The change of guardian does not affect the patient's tribunal rights nor does it act as a deemed withdrawal of any outstanding application or reference before a tribunal.

<sup>223</sup> Mental Health Act 1983, s.19(2)(b). Because of an oversight, a section 2 patient who is transferred into guardianship does not have a legal classification under the Act.

guardianship; the nearest relative.<sup>227</sup> The Secretary of State may discharge a patient who is liable to be detained in a mental nursing home, as may any NHS trust or Health Authority which is financing his assessment or treatment there.<sup>228</sup>

#### *Patients detained for 72 hours or less*

As drafted, section 23 applies only to patients who are subject to guardianship, liable to be detained under section 3, or liable to be detained "in pursuance of an application for assessment" — which, as defined by section 2(1), excludes patients detained under section 4.<sup>229</sup> Indeed, the Act appears to include no mechanism for discharging patients whose detention under the Act is authorised for a period not exceeding 72 hours, whether under sections 4, 5, 135 or 136. It may be argued that the omission in section 23 of any explicit reference to section 4 is deliberate. In essence, the purpose of the patient's detention is to allow the application process to be completed within a hospital setting because its completion outside hospital would involve unacceptable risks. The period of detention is too short to make it appropriate to prescribe any formal procedure for the patient's release, in terms of a written order of discharge or a tribunal review. The patient may simply be released by the managers at their discretion if and when it becomes clear to them that no second recommendation will be forthcoming: the fact that they are authorised to detain the patient does not mean that they must do so. The Act protects the patient during this interim period by instead providing that he may not be compulsorily treated until such time (if ever) as a second recommendation is furnished. But it is only if a second recommendation is furnished is the patient placed in exactly the same position as a person admitted under section 2. Alternatively, it may be said that an emergency application is, as section 4(1) makes clear, an application for admission for assessment and the fact that it is initially founded on a single recommendation does not alter that fact. Section 23 therefore applies. The point is further considered on page 623, in the context of a section 4 patient's right to apply to a tribunal under section 66(1)(a).

#### **Discharge by a Mental Health Review Tribunal**

A Mental Health Tribunal may, and in the circumstances specified in section 72, must discharge a patient from liability to detention or guardianship under the Act (463).

<sup>227</sup> However, an order for discharge made by the nearest relative of a patient detained under Part II is of no effect if a report barring the patient's discharge is furnished to the managers of a hospital by the patient's responsible medical officer: see Mental Health Act 1983, s.25 (610).  
*Ibid.*, s.23(3).

<sup>228</sup> Section 2(1) states that an application made under section 2 is "in this Act referred to as 'an application for admission for assessment'" while section 4(1) provides that an application made under section 4 is "in this Act referred to as 'an emergency application'". The alternative, generic, expression "an application for admission to hospital" is used where, as in section 13, a particular provision is intended to apply to all applications under sections 2, 3 and 4.

## TERMINATION OF AUTHORITY CONFERRED BY AN APPLICATION

### *I. Patient no longer subject to compulsion under the 1983 Act — now informal*

- Patient discharged from liability to detention or guardianship to a tribunal under section 23 or by a tribunal under section 72. 283
- Patient released by the High Court (*habes corpus*, judicial review) authority for his detention/guardianship. 861
- Expiration of the period of detention or guardianship 286
- Cessation due to the patient being absent without leave for a period of six months or, if his period of detention or guardianship had longer than that to run when he absented himself, at the expiration of that detention or guardianship period. 289
- Cessation due to the patient being in custody in pursuance of a court order for a period of six months or, if released before being in custody for six months, has not returned or been taken into custody under the Mental Health Act within 28 days of his release. 300
- Cessation following the patient's reclassification under section 16 as suffering only from a psychopathic disorder and/or mental impairment. 302
- Cessation upon the patient's removal outside the jurisdiction. 306

### *II. Patient remains subject to compulsion but under a different statutory provision*

- Cessation upon a subsequent application being made in respect of him under Part II of the Act 303
- Cessation upon a subsequent order or direction being made in respect of him under Part III of the Act. 304
- Patient transferred from hospital to guardianship or vice-versa 282

*Notes: Since 1 April 1996, a patient who is liable to be detained or subject to guardianship no longer ceases to be liable or subject upon being continuously absent with leave for a period of six months: see Mental Health (Patients in the Community) Act 1995, s.3(1) (300).*

## EXPIRATION OF PERIOD OF DETENTION OR GUARDIANSHIP

A patient will cease to be liable to be detained or subject to guardianship upon the expiration of the period of detention or guardianship authorised by the Act unless that authority can be, and is, renewed for a further period or a further application, order or direction is made prior to its expiration.

### Cessation at the end of the assessment period

The authority to detain a patient which is conferred by an application for assessment normally expires after 28 days. However, a patient's liability to detention under section 2 may be extended beyond 28 days if a county court application under section 29 is pending at the expiration of that period (112). The conventional view is there where a section 2 patient is absent without leave during the final week of the 28 day period the effect of this is not to extend the authorised period of detention beyond 28 days (289). Since the tribunal hearing date initially fixed in an assessment case must be a day within three weeks of the patient's admission, these expiry and extension provisions will only ever be relevant where a hearing is adjourned because the patient is absent without leave at the time it is originally scheduled to take place.

### Cessation at the end of a period of treatment or guardianship

Where a patient is detained for treatment or subject to guardianship, the authority for his detention or guardianship will expire unless periodically renewed for periods of six or twelve months at a time, in accordance with the provisions of section 20. The authority is renewed where, during the final two months of the existing period, the patient's responsible medical officer (or, in guardianship cases, his appropriate medical officer) examines him and "duly" furnishes a renewal report to the managers or authority responsible for him, stating that in his opinion the conditions for renewal are satisfied.<sup>230</sup>

### Extended detention or guardianship due to absence without leave

The normal six and twelve month periods of detention or guardianship may be extended if a patient is, or has been, absent without leave (292) or detained in custody otherwise than under the 1983 Act (300). Furthermore, if an absent patient returns or is returned to hospital within the extended period, the authority for his detention or guardianship may be retrospectively renewed in the circumstances described below (293 et seq.).

### Reasons for non-renewal

Non-renewal will generally be intentional and due to the fact that a patient's condition is no longer considered to be sufficiently serious that the conditions for renewal are satisfied. However, the authority will also expire if a renewal examination is conducted outside the statutory period; the renewal report is not "duly" furnished within those two months; it materially differs from the prescribed form; or is

<sup>230</sup> In cases involving patients who are detained for treatment, the responsible medical officer's report must be made using Form 30. In guardianship cases, the prescribed form is Form 31. Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg.10. It was held in a Scottish case that a renewal report is "furnished" to the hospital managers when it is committed to the internal mailing system operated by those managers. *Milborrow, Applicant* (1996) S.C.L.R. 315, S.L. Cl.

otherwise insufficient to constitute a valid renewal.<sup>231</sup> The rectification provisions do not apply to renewal reports. Consequently, where such a report is insufficient to renew the authority for a patient's detention or guardianship, it may not be retrospectively validated once the previous period has expired.<sup>232</sup>

### The effect of a report furnished under section 20

Section 20(8) provides that where such a renewal report is "duly" furnished, the authority for the patient's detention shall "thereby" be renewed for a further period. Unless the managers discharge the patient, they must ensure that the patient is informed that a renewal report has been furnished. It was always thought that the furnishing of a renewal report to the hospital managers instantly renewed the patient's liability for a further period: it was not necessary that the managers also consider this report, and the patient's suitability for discharge, before the existing period of detention had expired. The case of *ex p. B.* confirmed this.

### R. v. Managers of Warrington Park Hospital, ex p. B.

(1994) 22 B.M.L.R. 1 C.A. (Sir Thomas Bingham M.R., Staughton, Kennedy L.J.J.)

B. was detained under section 3. During the final two months of the first six-month period of detention, the responsible medical officer examined her and furnished a report to the managers, stating that in his opinion the conditions for renewal were satisfied. In due course, the managers met to consider the report and B's suitability for discharge but did so only after the initial six month period had expired. They decided not to discharge and recorded the section's renewal by signing the second part of the renewal report. The same pattern of events was repeated when the patient's detention next came to be renewed. The managers delayed reviewing B's case, and signing the renewal report, until after the period of detention authorised by the first renewal had expired.

### The application for judicial review

It was submitted on the patient's behalf that regulation 10 made it clear that the responsible medical officer's report was no more than a "recommendation" for renewal.<sup>233</sup> Renewal required that all of the steps referred to in section 20, which together constituted the renewal procedure, were completed before the existing period of detention expired. In B's case, the authority for her detention had

<sup>231</sup> For example, the responsible medical officer must consult one or more persons who have been professionally concerned with the patient's medical treatment before furnishing a renewal report: see Mental Health Act 1983, s.20(5). In practice, consultants rarely conduct any specific statutory consultation of this kind and the statutory renewal form (Form 30) does not require confirmation that this has been done, or information about who was consulted and when.

<sup>232</sup> See Mental Health Act 1983, ss.8(4) and 15. In *R. v. Board of Control, East Ham Corporation and Morley, ex p. Winterlood* [1938] 2 K.B. 366, C.A., the authority for the patient's detention was not renewed until after the previous period of detention had expired, the purported renewal therefore being a nullity. Where the defect is identified before the period of detention or guardianship has expired, there is of course time to furnish a fresh report in the prescribed form or to commence the whole process afresh, depending on the nature of the omission. In its annual report of 1989, the Mental Welfare Commission for Scotland noted that one-sixth of all guardianship cases terminated that year had unintentionally lapsed. *Mental Welfare Commission for Scotland: Annual Report for 1989*, para. 12.16.

<sup>233</sup> Paragraph 10(1) of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 provides that "any report for the purposes of section 20(3) (medical recommendation for renewal of authority to detain) shall be in the form set out in Part I of Form 30." Paragraph (3) states that "any renewal of authority for detention ... under section 20(8) shall be recorded by the managers of the hospital ... in the form set out in Part II of Form 30."



## CESATION DUE TO ABSENCE WITHOUT LEAVE

If an unrestricted patient is absent without leave from the hospital or place where he is required to be his liability to detention or guardianship will eventually cease if he is neither taken into custody nor returns there of his own accord.<sup>237</sup> When considering the continued liability to detention or guardianship of any patient who is, or has been, absent without leave, it is imperative to approach the matter in two distinct stages:

- 1) After what period of time does the patient cease to be liable to be detained or subject to guardianship and so also cease to be liable to be taken into custody under the Act?
- 2) If the patient is taken into custody during the permitted period, or before its expiration returns there of his own accord, what effect does this have and what legal procedures must then be carried out?

### Patients detained under section 2

Section 18 provides that a section 2 patient who is absent without leave shall "not be taken into custody" after the expiration of the period referred to in section 2(4), which (unless extended under section 29) is the usual 28 day section 2 period.<sup>238</sup>

#### *The effect of recapture or return during the permitted period*

Section 21 is expressed to apply to a patient who is absent without leave on the day on which he would "apart from this section" cease to be liable to be detained or who is absent during the preceding week. In this context, unless county court proceedings have been commenced, that means absent during the final week of the four weeks' detention authorised by section 2(4). Where section 21 applies, it provides that if such a patient is taken into custody during the time allowed by section 18 — which, in this context, means before the final week has expired — he shall not cease to be liable to be detained until the end of the period of one week beginning with the date of his return to hospital.<sup>239</sup>

#### *The effect of section 2(4)*

Notwithstanding the wording of section 21, the view universally taken in practice has always been that if a section 2 patient is absent without leave during the final week of the 28 day period the effect of this can never be to extend the authorised period of detention beyond 28 days. This is because section 2(4) provides that the authorised period of detention shall not exceed that period unless it has been extended by section 29 or the patient is subsequently detained for treatment under some other statutory provision — no other exception, such as that referred to in section 21, is mentioned in section 2(4). Furthermore, the purpose of the one week

<sup>237</sup> Section 18(5) of the 1983 Act states that, "Absent without leave" means absent from any hospital or other place and liable to be taken into custody and returned under this section, and related expressions shall be construed accordingly."

<sup>238</sup> See Mental Health Act 1983, s.18(5).

<sup>239</sup> See *ibid.*, s.21.

already expired by the time the managers reviewed her suitability for discharge, considered and endorsed the renewal "recommendation," and notified her that a report had been furnished. The hospital managers argued that the valid renewal of the authority for a patient's detention required only that the responsible medical officer had furnished a renewal report to them before that period had ended.

### Sir Thomas Bingham M.R.

There were no grounds for holding that B had at any time been unlawfully detained and the application was therefore dismissed. The court was mindful of the fact that the case concerned the liberty of the subject and of the need to ensure that procedures relating to the detention of patients were scrupulously followed. It was also highly desirable that the managers should give timely information to the patient as soon as they had the renewal report to hand and as soon as they had taken a decision as to discharge. The authority to continue to detain B arose when the responsible medical officer furnished his renewal report to the managers; it was impossible to read "thereby" as referring to anything other than the furnishing of his report. On any reasonable reading of section 20, it was not the case that the steps required of the managers also had to be taken within the final two month period. Regulation 10 required them to do no more than "record" their decision that the patient should not be discharged. If the regulations introduced any note of ambiguity that simply demonstrated that the Secretary of State had not fully understood the effect of section 20.

#### *Prescribed form defective*

A new prescribed Form 30 came into force on 1 April 1996.<sup>234</sup> This was unfortunate because the old form recited the correct statutory criteria for renewal and the only changes made to it involve a failure to accurately recite the statutory conditions for renewal. Although it is a condition of renewal that further treatment in hospital is necessary for the patient's health or safety or for the protection of others, the new form requires the responsible medical officer to certify that it is necessary "in the interests" of his health or safety or "with a view to" the protection of others that he should receive that treatment. As has been noted, "in the interests of" and "with a view to" are phrases which form part of the looser section 2 and guardianship grounds and were deliberately not incorporated in the section 3 admission and renewal criteria (221). Using the form prescribed by the regulations made under the statute therefore involves departing from the criteria prescribed by Parliament in the statute itself. Although the case of *Warren v. Warren*<sup>235</sup> involved the use of a printed form the wording of which departed in one respect from the prescribed form, rather than a prescribed form the wording of which departs from the statutory criteria, the courts must be likely to adopt a similarly practical approach to the error. In that case, Mr. Commissioner Glazebrook QC, relying on *R. v. Pinder*,<sup>236</sup> held that the use of the word "declare" in place of "certify" could be regarded as equivalent and sufficient, and in substitution for it. The issue is one of the sufficiency of the incorrect wording of the new forms. Although the errors here are more material than that in *Warren v. Warren*, the consequences of holding otherwise are unlikely to be contemplated.

<sup>234</sup> Mental Health (Hospital, Guardianship and Consent to Treatment) (Amendment) Regulations 1996, reg. 3.

<sup>235</sup> *Warren v. Warren* [1953] 1 W.L.R. 1268.

<sup>236</sup> *R. v. Pinder, Re Greenwood* (1855) 24 L.J.Q.B. 148 (263).

extension allowed by section 21 has always been explained, for example, in the *Memorandum* on the Act, in terms of giving a responsible medical officer sufficient time to renew the authority to detain a patient for treatment. The assumption has therefore been that section 21 only applies to patients who are liable to be detained for treatment. Nevertheless, the use of the phrase "apart from this section" in section 21 raises the possibility that it is intended to be a further way in which the period of detention authorised following admission under section 2 may be extended. The rationale would be to allow those involved sufficient time to examine and interview the patient and to complete any necessary section 3 application. All these consequences logically follow from a literal reading of section 21. However, a literal reading of the section would also mean that absent section 4 and section 5(2) patients who are taken into custody during the 72-hour detention periods conferred by those powers could then also be further detained for a week, which is a nonsense. In summary, section 21 cannot be read entirely literally but there is an element of ambiguity as to whether it is meant to also extend to patients detained under section 2. Either section 2(4) was meant to be exhaustive, and section 21 was drafted in the belief that that had been made clear, or the draftsman believed that the phrase "apart from this section" in section 21 made it similarly clear that this was an additional exception.

#### Unrestricted patients detained for treatment or subject to guardianship

Prior to the coming into force of the Mental Health (Patients in the Community) Act 1995, section 18 provided that where an unrestricted patient who was liable to be detained for treatment or subject to guardianship had been continuously absent without leave for a period of 28 days, he ceased to be liable to be detained or subject to guardianship. The rationale was that, if a patient could remain in the community without drawing attention to himself or obviously requiring treatment for that length of time, his condition could not be sufficiently serious to warrant detention or control.

#### The amendments made by the 1995 Act

Section 18 now provides that where such a patient absents himself without leave from the hospital or place where he is required to reside, he only ceases to be liable to be detained or subject to guardianship after he has been continuously absent for a period of six months or, if the existing period of detention or guardianship had more than six months left to run when he absented himself, upon that period expiring.<sup>240</sup> The precise period for which the application, order or direction remains in force, and during which an absent patient may be taken into custody, therefore depends upon how long his period of detention or guardianship had left to run on the day he went absent—

- As has already been noted, the authority of the hospital managers or a guardian over an unrestricted patient lapses after six months unless it is renewed for a further period of six months and thereafter for periods of one year at a time.

<sup>240</sup> Mental Health Act 1983, s.18(1) and (4), as amended by s.2(1) of the Mental Health (Patients in the Community) Act 1995.

- The first year's detention or guardianship thus consists of two six-month statutory periods. Consequently, if a patient absents himself before he has been detained for treatment or subject to guardianship for a year, there will always be less than six months of the current period of detention or guardianship left to run on the day he goes missing: even if he absents himself on the second day of one of the six month periods, there will necessarily be less than six months of that period remaining.

- Where, however, a patient has been continuously detained for treatment or subject to guardianship for more than one year the last renewal of his section will have been for a period of 12 months. If the patient then absents himself during the first half of that year, there would at that time have been more than six months of the existing period of detention or guardianship left. Conversely, if he absented himself during the second half of the year there would at that time have been less than six months of the period outstanding.

- Bearing these statutory periods in mind, the authority for the patient's detention or guardianship remains in force, and he remains liable to recapture, for six months if the period of detention or guardianship in existence when he absented himself had less than six months left to run at that time. If there were more than six months left, he remains liable for the whole of the remainder of the unexpired period.

- It is therefore the period of detention or guardianship in existence when the patient absents himself which is material. For these purposes, if a patient absents himself during the final two months of a period of detention or guardianship any renewal report furnished before he went absent is ignored.<sup>241</sup> Thus, if a patient in his second six-month of detention absents himself in December after his responsible medical officer had furnished a report renewing from 1 January the authority to detain him, this does not mean that he can be taken into custody at any time during the following year. Rather, he remains liable to be taken into custody for a period of six months commencing from the day he went missing.

- It suffices if a patient is taken into custody during the permitted period even though he is not returned to the hospital or place where he is required to be until after that period has expired. Thus, if a patient absent from a hospital in Lancashire is recaptured by police in Devon on the last day of the prescribed period but is not returned for two days, he remains liable to be detained.<sup>242</sup>

<sup>241</sup>

Mental Health Act 1983, s.18(4), as substituted by Mental Health (Patients in the Community) Act 1995, s.2(1).

<sup>242</sup>

The position is similar where a warrant is issued under section 72 of the Criminal Justice Act 1967 to arrest a hospital order patient who is absent without leave. If the patient is then held in pursuance of the warrant in some country outside the United Kingdom, Channel Islands and Isle of Man, he is deemed to have been taken into custody on the date he is apprehended in pursuance of the warrant. See Mental Health Act 1983, s.21A(4).

## PERIOD FOR WHICH PATIENTS REMAIN SUBJECT TO THE ACT

### *Class of patients*

- Patients whose period of detention or guardianship had less than six months to run on the day they went absent without leave
- Class comprises
  - Patients who were in their first or second period of detention for treatment or guardianship on the day they went absent without leave
  - Patients whose detention for treatment or guardianship was last renewed for a period of one year and who then go absent during the second six months of that period.

### *Recapture period, etc.*

Patient may be recaptured for a period of six months. The managers' authority to detain the patient or the guardian's authority lapses if the patient has not been recaptured upon the expiration of this period, and he is no longer liable to be taken into custody and returned.

Patient may be recaptured at any time during whatever remains of the existing period of detention or guardianship. If he is still at large upon the expiration of this period, the managers' or guardian's authority lapses.

- Patients whose period of detention or guardianship had more than six months to run on the day they went absent without leave
- Patients whose detention for treatment or guardianship was last renewed for a period of one year and who then go absent during the first six months of that period.

### *Examples*

The following examples illustrate the practical effect of the new provisions concerning the period during which an absent patient may be recaptured.

### *Examples*

X has been subject to guardianship for between three and four years. On 1 January, the authority for his guardianship was renewed for a further period of 12 months. On 1 February, he left his required place of residence.

Under the previous provisions, he would have ceased to be subject to guardianship after 28 days if he had not by then returned, or been returned, to his nominated place of abode. Under the new provisions, he remains liable to be taken into custody for the remainder of the current period of guardianship, that is until 31 December.

The position would be different if he had absented himself during the second half of the year, when there was less than six months of the guardianship period left. He would then have been liable to be taken into custody during the following six months, *i.e.* beyond the date by which renewal would normally be necessary.

### **Example 2**

X is detained under section 3 on 1 January. Unless the authority for his detention is renewed, he will cease to be liable to be detained after six months, on 30 June. On 1 February, after a month in hospital, he goes absent without leave. Under the previous provisions, he would have ceased to be liable to be detained after 28 days absence. Under the new section 18(4), he remains liable to be taken into custody for six months, until 31 July, even though this is beyond the date by which the section would normally need to be renewed to remain in force.

### **Effect of a patient's return during the permitted period**

It can be seen that because a patient is always liable to be taken into custody for at least six months, whereas a period of detention or guardianship often expires six months from its commencement, some provision must be made for retrospectively renewing the patient's liability under the Act. Two other points must also be addressed. Firstly, the possibility that a patient might be returned so near to the end of his period of detention or guardianship that there is insufficient time to renew it before it expires. Secondly, where a patient has been absent for a prolonged period, the possibility that he no longer needs to be detained or under guardianship. With that last point in mind, different statutory procedures apply depending upon whether or not a returned patient has been absent for more than 28 days.

### **Patients who have been absent for 28 days or less**

Where a patient is absent for 28 days or less, he would not have ceased to have been detained or subject to guardianship under the old law. In particular, there would not have been any presumption that he no longer required detention or guardianship. Consequently, the position set out in the 1983 Act as originally drafted has been retained where a patient's absence does not exceed 28 days—

- Unless the patient's return occurs during the final week of a period of detention or guardianship, or after such a period would ordinarily have expired had he not been absent, no legal consequences arise. The existing period of detention or guardianship continues in the normal way and in due course will expire unless renewed in the normal manner.
- Where, however, the patient's return takes place during the final week of a period of detention or guardianship, or occurs after the expiry of that period, section 21 provides that his liability to detention shall not cease until the expiration of one week beginning with the day of his return. This allows the patient's responsible or appropriate medical officer time to examine him and, if appropriate, to furnish a renewal report under section 20. Where a renewal report is furnished after the date on which the previous six or twelve month period of detention or guardianship would ordinarily have expired, the report is treated as if it had been furnished on the final day of that period, and future renewal and expiry dates are calculated on that basis.<sup>243</sup>

<sup>243</sup> Mental Health Act 1983 s.21A(3), as substituted by Mental Health (Patients in the Community) Act 1995, s.2(2).

### Example

A patient is detained under section 3 on 1 January. His liability to detention will ordinarily expire at midnight on 30 June unless it is renewed for a further period. The patient absents himself from hospital on 21 June and is not returned there until 11 July. Because he has not been absent for 28 days, the application remains in force and, furthermore, the initial period of detention is extended for a further week commencing on the day of his return. If, prior to midnight on 17 July, his responsible medical officer examines him and furnishes a renewal report to the managers, the authority for his detention is thereby renewed for a further period of six months, commencing on 1 July.

### Patients absent without leave for more than 28 days

Where a patient who has been absent for more than 28 days is taken into custody or returns to the required place before the recapture period has expired, two of the problems which may then arise are the same as in cases involving patients who have been absent for less than 28 days. Firstly, there may be insufficient time remaining to examine him and to furnish a renewal report. Secondly, the last day of the period of detention or guardianship which was in force when he absented himself may already have passed so that the authority for his detention or guardianship requires retrospective renewal. However, the additional consideration referred to also comes into play. Even when the patient's absence has not upset the ordinary renewal provisions because he is returned before renewal is due, the length of his absence may indicate that he no longer needs to be detained or under a guardian. While it is no longer a statutory presumption that a patient who has been absent for more than 28 days no longer requires detention or guardianship, the possibility that this is the case must still be addressed. That being so, the 1995 Act introduced a mechanism for determining whether or not such a patient still meets the statutory conditions for detention or guardianship. In all cases, the statutory criteria used to determine this issue are the ordinary renewal criteria — irrespective of whether or not renewal is actually due. Nevertheless, the Act refers to those criteria when they are used for this purpose as "the relevant conditions." The point to bear in mind is that the relevant conditions are the renewal criteria.

### Duty to examine and report on the patient

A patient who has been absent for more than 28 days may be detained for a period of one week beginning with the day of his return. During this period, his responsible medical officer is under a duty to examine him.<sup>244</sup> He must consider whether, in his opinion, the patient would satisfy the criteria for having his detention or guardianship renewed if renewal were due. As with the ordinary renewal procedure, before furnishing any report stating that a detained patient appears to satisfy the criteria, he must first consult at least one other person who has been professionally concerned with the patient's medical treatment. However, in this case, he must also consult an approved social worker. This additional requirement reflects the fact that where prolonged absence is followed by detention in hospital for treatment, reauthorising the patient's subsequent detention is factually rather similar to making

<sup>244</sup> The Act refers to the patient's appropriate medical officer but, except where a private guardian has been appointed, the responsible medical officer is also his appropriate medical officer.

a fresh application.<sup>245</sup> If, having examined the patient and consulted these other professionals, the responsible medical officer does not, during the week allowed, furnish a report stating that it appears to him that the "relevant conditions" are satisfied, the patient ceases to be liable to be detained or subject to guardianship at the expiration of that period.

### Effect of furnishing a report

If, having examined the patient and consulted the relevant persons, it does appear to the responsible medical officer that the patient satisfies the relevant conditions, he is under a statutory duty to furnish a report to this effect. The precise effect of this report depends upon exactly when it is furnished in relation to the period of detention or guardianship which was in existence when the patient absented himself. Put like this, there are three possibilities. The report might be furnished:

- *Before the renewal period* That is, at some time before the final two months of the period of detention or guardianship in force when the patient absented himself.
- *During the renewal period* That is, at some time during the final two months of that period of detention or guardianship.
- *After the renewal period* That is, at some time after that period of detention or guardianship would ordinarily have expired had the patient not been absent.

Section 3 admission on 1 Jan	Months 1,2,3,4 <i>Pre-renewal</i> Section 21B(4)	Months 5,6 <i>Renewal period</i> Section 21B(7)	Months 7,8 <i>Post-renewal</i> Section 21B(5)
1 Jan	1 May	1 July	1 Sept

### Reports furnished prior to the renewal period

Where a report is furnished on a date before the final two months of the period of detention or guardianship which was in force when the patient absented himself, that period of detention or guardianship simply continues as if the patient had never been absent. However, a right to apply to a tribunal exercisable within 28 days arises if the form of mental disorder specified in the report is different to that or those previously specified, so that it has the effect of reclassifying the patient.<sup>246</sup>

<sup>245</sup> Providing that a patient who has been absent for more than 28 days may be detained for a week following his return in order to allow a fresh application to be made would, however, leave the decision about the patient's detention to an approved social worker. A feature of the new provisions in 1995 Act is that the responsible medical officer is the key figure and approved social workers are most often merely consulted by him before exercising a particular power.

<sup>246</sup> See Mental Health Act 1983, s.66(1)(fb), as inserted by s.2(6) of the Mental Health (Patients in the Community) Act 1995.

*Example*

A patient is detained under section 3 on 1 January. His liability to detention will ordinarily expire at midnight on 30 June unless it is renewed for a further period. The responsible medical officer must examine the patient and furnish a renewal report during May or June if he is to be detained beyond that date. On 1st February he absents himself from hospital without leave. He remains absent until Monday 15 April. He has been away for more than 28 days and the new provisions apply. He will cease to be liable to be detained at midnight on Sunday 21 April unless, prior to then, his appropriate medical officer has examined him, undertaken the necessary consultations, and furnished a report to the managers stating that the "relevant conditions" are satisfied. The relevant conditions are the same as the renewal criteria. However, a renewal report is still required in May or June before the patient's liability to detention may be continued beyond 30 June.

*Report furnished during the renewal period*

Where a report is coincidentally furnished during the final two months of a period of detention or guardianship, it may state that it shall also take effect as a renewal report. This reflects the fact that the relevant conditions are the same as the renewal criteria and in each case the responsible medical officer must consult at least one other person who has been involved in the patient's medical treatment before furnishing a report. Requiring him to repeat the procedure and certify on a similar form that the renewal criteria are made out would thus be unnecessarily bureaucratic.<sup>247</sup>

*Example*

A patient is detained under section 3 on 1 January. His liability to detention will ordinarily expire at midnight on 30 June unless it is renewed for a further period. On 1 February he absents himself from hospital without leave. He remains absent during May and June so it is not possible for him to be examined with a view to renewing the detention for a further six months. On Monday 7th June — during the final two months of the initial six month period of detention — he is returned to hospital. He has been away for more than 28 days and the new provisions apply. If the appropriate medical officer furnishes a report to the managers stating that the relevant conditions are satisfied, he may also stipulate that the report shall also take effect as the renewal report which is then due. If he does this, not only does the patient's liability to detention not lapse one week after his return but it is also renewed for a further six months from 1 July.

*Report furnished after the renewal period*

With regard to patients who have been absent for 28 days or less, it has already been noted that the effect of furnishing a conventional renewal report after a period of detention or guardianship would ordinarily have expired is that the authority is retrospectively renewed. The effect is essentially the same here although, because furnishing a report stating that the relevant conditions are satisfied involves taking

<sup>247</sup> If the report does not specify that it shall have effect as a renewal report but the form of disorder specified within it is different to that previously specified, its effect is to reclassify the patient at a time other than when renewing the authority for his detention or guardianship. Accordingly, a right to apply to a tribunal within the following 28 days arises under s.66(1)(fb).

all the steps involved in a renewal, a separate conventional renewal report is not required. The report stating that the relevant conditions are satisfied automatically takes effect as a renewal report — there is no need to elect that it shall have this additional effect because, unless it does, there would be no authority for the patient's detention or guardianship after the initial one week extension expires.

*Example*

A patient is detained under section 3 on 1 January. His liability to detention will ordinarily expire at midnight on 30 June unless it is renewed for a further period. On 1 February he absents himself from hospital without leave. He remains absent during May and June so it is not possible for him to be examined with a view to renewing the detention for a further six months. On Monday 15 July, he is returned to hospital.

He has been away for more than 28 days and the new provisions apply. He will cease to be liable to be detained at midnight on Sunday 21 July unless, prior to then, his appropriate medical officer has examined him, undertaken the necessary consultations, and furnished a report to the managers stating that the relevant conditions are satisfied. If such a report is furnished during that week, its effect is to retrospectively renew the patient's detention for a further six months commencing on 1 July.

*Double renewals*

Because patients may now be absent for considerable periods of time but still remain liable to be detained, it is possible that by the time a patient is taken into custody not only will the previous authority for his detention require retrospective renewal but that retrospectively renewed further period of detention will have less than two months left to run and be due for renewal.<sup>248</sup>

*Example*

A patient is detained under section 3 on 1 January. His liability to detention will ordinarily expire at midnight on 30 June unless it is renewed for a further period. Before any renewal report is completed, the patient absents himself on 25 May. On 10 November, he is returned to hospital.

He has been away for more than 28 days and the new provisions apply. The responsible medical officer furnishes the necessary report during the week following the patient's return. This automatically retrospectively renews the authority for the patient's detention for a further six months, from 1 July until 31 December. However, the patient has been absent for so long that this period of detention is itself due for renewal since it has less than two months left. That being so, the responsible medical officer can elect that his report shall also have effect as the renewal report now due for that period. Thus, the effect of the single report is to renew the authority for the patient's detention for a period of 18 months — from 1 July until 31 December the following year.

<sup>248</sup> It is even possible that the retrospectively renewed period of detention or guardianship will itself require retrospective renewal and the Act provides for this. If in the example above the patient had absented himself on 28 June and been returned on 27 December, a report furnished on 2 January would retrospectively twice renew the authority for the patient's detention — once from 1 July and again from the following 1 January (the day before the report was furnished).

## Summary

having regard to the above, the questions which must be asked when a patient detained for treatment or subject to guardianship is absent may be rephrased:

- 1) After what period of time does the patient cease to be liable to be detained or subject to guardianship and so also cease to be liable to be taken into custody under the Act?
- 2) If he is returned during this permitted period, was he absent for more than 28 days or for 28 days or less?
- 3) If for more than 28 days and within the following week his responsible medical officer furnished a report stating that the relevant conditions were satisfied, was this furnished before, during, or after the normal renewal period.

### The 1997 Regulations and the prescribed forms

Because the authority to detain a patient who is returned after more than 28 days absence will lapse unless a report in the prescribed form is furnished during the following week, one would expect the 1996 Regulations to have prescribed such a form, thereby enabling such reports to be furnished as and when necessary. The more so since the new absence without leave provisions constituted a large part of the 1995 Act. This was not the case and it was not until some months after the Act's commencement that the Department of Health became aware that almost half the statute was effectively not in force. The Mental Health (Hospital, Guardianship and Consent to Treatment) Amendment Regulations 1997 now provide that a report furnished under section 21B(2) shall be in the form set out in Form 31A in relation to a patient who is liable to be detained and Form 31B in relation to a patient who is subject to guardianship. Departmental guidelines concerning the statutory provisions, and the completion of the new forms, is contained in *NHS Executive Letter EL (97)26*. Unfortunately, the printed copies of the new forms and the advice contained in the guidelines appear to be defective in several respects.

#### Form 31A

The form actually prescribed in the 1997 regulations is sufficient for the purpose. However, the Department of Health has added the following explanatory note at the end of the printed forms distributed to hospitals and local authorities:

**"This form should not be used for patients who on return from absence without leave have a maximum 7 days before their liability to detention expires. Such patients have their liability to detention extended by a week on return to Hospital by virtue of section 21(b). Detention may be renewed during the 7 days under section 20 using form 30."**

This cannot be correct. The statutory procedure following a patient's return after a period of absence without leave is determined by the length of his absence, not by whether the authority will expire within seven days unless renewed:

- If the patient was absent for 28 days or less, the prescribed procedure is that set out in section 21A, which involves completing the standard renewal report (Form 30) if renewal is both due and appropriate.

- If the patient has been absent for more than 28 days, the prescribed procedure is that set out in section 21B. This involves the appropriate medical officer examining the patient, consulting (*inter alia*) an approved social worker, and then completing and furnishing Form 31A, during the week following the patient's return.

- If the normal section 20 procedure is mistakenly adopted, with the effect that no approved social worker is consulted and no Form 31A is completed during the week allowed, the patient's liability to detention will expire at the end of that week.<sup>249</sup>

- However, the problem should not arise. Provided that the correct form is furnished before the end of the week (Form 31A), it automatically renews the authority for the patient's detention where that authority would otherwise have expired and, if it is due to expire shortly, the appropriate medical officer may elect that the form shall be treated as the renewal report due under section 20.

It should be emphasised that the explanatory notes at the bottom of the printed form are not part of the prescribed form, which has not itself been altered and is sufficient for the intended purpose. The solution is simply to ignore the explanatory notes and to always use Forms 31A and 31B whenever a patient is returned after more than 28 days absence without leave.

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Paragraph 4 repeats the advice as to when the standard form of renewal report (Form 30) should be completed in preference to the new forms. The additional guidance given in paragraphs 8 and 9 is somewhat misleading—

- Paragraph 9 states that a patient has no right to a tribunal if the authority for his detention or guardianship is simply restored under section 21B, rather than renewed.

<sup>249</sup> Where no report has been furnished by then, section 21B expressly provides that a patient's liability to detention or guardianship ceases at that time if it would not otherwise have expired. In the case of patients whose authority would ordinarily have expired before the week's end, because they were returned during the final week of the section or after it would ordinarily have expired, there is no need for such an express provision. No report having been furnished under section 21B, which has the effect of renewing the authority,<sup>1</sup> there is necessarily no longer any authority for the patient's detention or guardianship. <sup>1</sup> by virtue of section 21B(5) or (6).

Paragraph 8 is concerned with the effect where a section 21B report specifies a different form of mental disorder to that in the original application: "The appropriate medical officer does not then need to submit a separate reclassification report under section 16 of the Act unless the section 21B report also serves as a section 20 renewal report."

In fact, it is not necessary to furnish a classification report under section 16 where the section 21B report also serves as a section 20 renewal report. The section 21B report has "effect as a report duly furnished under section 20(3)" and "where the form of mental disorder specified in a report furnished under subsection (3) ... is a form of disorder other than that specified in the application ... the appropriate medical officer need not ... furnish a report under section 16": *Mental Health Act 1983, ss.20(9), 21B(7)*. It is because section 20(9) automatically has this effect that it is unnecessary for section 21B(8) to expressly provide that such a report shall have such an additional effect.

### CESSATION DUE TO ABSENCE WITH LEAVE

Prior to the coming into force of the Mental Health (Patients in the Community) Act 1995, if a patient has been absent with leave from the hospital where he was liable to be detained for a continuous period of six months, the authority to detain him there ceased at the expiration of that period. The position now is that a patient granted leave may not be recalled after he has ceased to be liable to be detained under the relevant application or order.<sup>250</sup> So, if a patient's liability to detention is renewed for twelve months and two months later he is granted leave, it is possible for that leave, and the patient's liability to recall, to continue for the remaining ten months of the period of liability to detention.<sup>251</sup> As to whether the responsible medical officer can renew the authority to detain a patient who is absent from hospital with his leave, see page 281.

### CESSATION DUE TO A PATIENT BEING IN CUSTODY

Section 22 applies to an unrestricted patient who, while detained for treatment or subject to guardianship, is taken into custody in pursuance of an order or sentence imposed by a court in the United Kingdom. The section does not apply to patients detained for assessment. The authority to detain such a patient lapses at the normal time, even if in custody.

#### *Custody exceeding six months*

Subsection 22(1) provides that the application, order or direction shall cease to have effect where a patient has been detained in custody for a continuous period of more than six months. Successive remands in custody are treated as constituting a single continuous period of detention.

<sup>250</sup> Mental Health Act 1983, s.18(4), as substituted by the Mental Health (Patients in the Community) Act 1995, s.2(1).

<sup>251</sup> A patient granted leave to be absent from hospital and not subsequently recalled will nevertheless be absent without leave if he subsequently ceases to reside at the place where he is required to reside by his responsible medical officer. The effect of this may then be that he then does not cease to be liable to be detained at the expiration of the period of detention which was in force at the time he absented himself.

#### *Custody not exceeding six months*

Subsection 22(2) deals with the situation where a patient is released before he has been in custody for a continuous period exceeding six months—

- The patient is treated as having absented himself without leave from the hospital or other place where he is required to be on the day of his release from prison.<sup>252</sup>
- If he is neither taken into custody under the Mental Health Act 1983, nor returns to the hospital or other place where he is required to be, within 28 days of his release, the application, order or direction ceases to have effect at the expiration of that period. Until then, it continues to have effect, whether or not it would ordinarily have expired during the patient's time in custody or during the 28 days following his release.<sup>253</sup>
- If the patient is taken into custody under the Mental Health Act 1983, or returns to the required place of his own accord, within 28 days of his release from prison then this may or may not have an effect on the renewal of his detention or guardianship under the Act.
- It could be that his detention or guardianship was not due for renewal during the period between his removal to prison and his return to the required place. Alternatively, it may be that his detention or guardianship would ordinarily have expired during that period or within a week of his return to the required place. Where this is the case, section 21 applies and, upon his return, the application, order or direction remains in force for a further week.
- This allows the patient's responsible or appropriate medical officer time to examine him and, where appropriate, to furnish a renewal report under section 20. Where such a report is furnished on a day after that on which the previous period of detention or guardianship would otherwise have expired, the report is deemed to have been furnished on the final day of that period.<sup>254</sup> Future renewal and expiry dates are calculated on that basis.

<sup>252</sup> The word "prison" is used here so as to avoid the confusion which otherwise results from referring to patients being taken into custody — in this context that could mean custody in pursuance of the court order or being taken into custody under the Mental Health Act as a patient absent without leave. However, some patients in custody in pursuance of a court order will, of course, be detained at a place other than a prison.

<sup>253</sup> As can be seen, section 22 provides an alternative to sections 35 and 36 in cases where a defendant is already liable to detention under Part II. If the court grants bail instead of remanding under section 35, the patient can simply be returned to the hospital from which he is deemed to be absent without leave. This then avoids all of the problems which arise when there are two authorities for a patient's detention.

<sup>254</sup> Mental Health Act 1983, s.21A.

### Examples

The following examples concern a patient detained under section 3 on 1st January. His liability to detention will, unless renewed, expire at midnight on 30th June. In normal circumstances, any examination for the purpose of renewal must be conducted on a day between 1 May and 30 June. Likewise, any renewal report must be furnished during the same two month period.

#### Example 1

The patient is remanded into custody by a magistrates' court on 1 March. He remains in prison until 1 May when he is released on bail, the effect of which is that he is treated as having absented himself from hospital without leave on that day. He will cease to be liable to be detained under section 3 if he is still absent from hospital without leave at midnight on 28 May. Section 21 is irrelevant since, if he is returned before then, the date of his return must necessarily occur on a day prior to the last week of his current period of detention. The application is therefore renewable in the ordinary way.

#### Example 2

The patient is, as in the first example, remanded into custody on 1 March. He remains in prison until 1 August when he is released. The effect of section 22 is that the day of his release from prison is treated as if it were 30 June, that is the last day of the six-month period of detention which commenced on 1 January, and the patient is treated as if he had absented himself on that day. If he is returned to hospital on 20 August, within 28 days of his release, the section 3 application remains in force for a further week, until midnight on 26 August. If a renewal report is furnished to the managers during that week, his section is treated as if it had been renewed in the ordinary way, that is for a further six month period beginning on 1 July.

#### Example 3

The patient is remanded into custody on 3 May and released on 1 November. He is returned to hospital on 21 November, that is within 28 days. A renewal report is furnished on 25 November. As before, this takes effect as if his detention had been renewed for a further six-month period on 1 July. A second renewal report could in theory be furnished later the same day, authorising the patient's detention for a further year from 1 January.<sup>255</sup>

### Cessation following reclassification

If a report furnished under section 16 is to the effect that a patient detained in hospital is suffering from psychopathic disorder or mental impairment, but not from mental illness or severe mental impairment, the report must also state whether, in the appropriate medical officer's opinion, further medical treatment in hospital is likely to alleviate or prevent a deterioration of the patient's condition. Where his opinion is

<sup>255</sup> It is possible for a patient not to be returned until the retrospectively renewed period has itself expired. If, in the above example, the patient is remanded into custody on 15 June, released on 9 December and returned to hospital on 4 January, a renewal report furnished on 8 January has the effect of renewing the section 3 application from 1 July until 31 December but that second period of detention has itself already expired. There being no provision for double renewals in section 22 (equivalent to that in section 21B(6)(b)), the patient is no longer liable to be detained.

that such treatment is not likely to have that effect, the authority of the managers to detain the patient ceases (056).<sup>256</sup>

### Cessation following a subsequent application under Part II of the Act

A fresh application under Part II of the Act will in certain circumstances bring to an end any previous application but not, it seems, any pre-existing order or direction made under Part III.

#### Effect of guardianship applications and section 3 applications

Reception into guardianship discharges any pre-existing application made under Part II.<sup>257</sup> Likewise, an admission under section 3 revokes any prior section 2 application, supervision application or guardianship application.<sup>258</sup>

#### Effect of applications under section 2

Where a patient is admitted for assessment under Part II, any pre-existing guardianship application or supervision application continues in force, as therefore does any tribunal application or reference relating to that guardianship. This effect is deliberate. The Act does not similarly provide that admission under section 2 revokes any pre-existing authority for the patient's detention under section 3. In practice, the situation arises where a section 3 patient who is absent without leave is admitted for assessment to a hospital which is unaware of the fact that he is already liable to be detained for treatment elsewhere.<sup>259</sup>

#### Effect of applications under Part II on Part III orders

The Act provides that a restricted patient remains liable to be detained under the accompanying hospital order or transfer direction until an order discharging him is made.<sup>260</sup> It does not expressly provide that a guardianship order or an unrestricted hospital order continues to have effect notwithstanding any subsequent application in respect of the same patient. Nor, equally, does it expressly provide the opposite, namely that such an application revokes a prior order. The situation usually arises where a patient who is absent without leave is admitted to a hospital elsewhere in England and Wales which is unaware of the existence of the previous order or direction. It also arises where a section 3 application is made in respect of a patient who is subject to a guardianship order, in preference to using the somewhat laboured transfer provisions in section 19. Although the making of an application is

<sup>256</sup> Mental Health Act 1983, s.16(2).

<sup>257</sup> *Ibid.*, ss.8(5) and 25H(5)(b).

<sup>258</sup> *Ibid.*, ss.6(4) and 25H(6)(a).

<sup>259</sup>

The three possible approaches to this problem are: (1) the second application terminates the first — the Act does not provide this; (2) the second application is ineffective because of the existence of a prior application authorising detention under section 3 — again, the Act does not provide this; (3) both applications are valid and the patient's detention under Part II in either hospital is authorised. Upon discovering that a prior application exists, the patient may be returned to the first hospital, provided that the authority to detain him there has not expired by virtue of section 18(4), because his absence has been prolonged. It is submitted that the third approach is the correct one. If so, the omission may be deliberate, and designed to ensure that the authority to detain a patient for treatment is not accidentally revoked by an application to detain him for assessment elsewhere. Similar problems do not arise when it is discovered that a treatment application has been accidentally revoked by another treatment application. The patient can simply be transferred to the original hospital under section 19, in which case the application is deemed to have always specified the hospital where there was previously authority to detain him. No further treatment application is necessary.

Mental Health Act 1983, s.41(3)(a).

<sup>260</sup>



unnecessary in normal circumstances, because section 19 can and should be used to transfer the patient from guardianship to hospital, and vice-versa, this does not help to determine the legal effect of any subsequent application.<sup>261</sup>

### Cessation due to a subsequent order or direction under Part III

The Act does not provide that all orders and directions made under Part III of the Act have the effect of revoking a pre-existing application.

### Court orders made during criminal proceedings under ss.35, 36 and 38

Where a court makes an order under section 35, 36, or 38, that order does not revoke any hospital order, guardianship order or application previously made in respect of the same patient. This is because the order does not take effect as if the patient had been detained for treatment or received into guardianship under Part II.<sup>262</sup> They are interim orders made by the court in the course of the proceedings before it.

### Court orders determining criminal proceedings (ss.37 and 37(4))

These orders dispose of the proceedings before the court and, subject to certain exceptions and modifications, they take effect as if the patient had been detained for treatment or received into guardianship under Part II of the Act.<sup>263</sup> Consequently, any previous application under Part II ceases to have effect. There is, however, a caveat to this if the hospital order or guardianship order, or the conviction on which it was made, is quashed on appeal. In such cases, the previous order or application is revived upon the order being quashed (see below).<sup>264</sup>

### Directions made by the Secretary of State under Part III (ss.47-49)

A transfer direction, with or without restrictions, revokes any previous application made under Part II. Again, subject to certain exceptions and modifications, it takes effect as if the patient had been detained for treatment under Part II.<sup>265</sup>

<sup>261</sup> The possible approaches to this problem are essentially the same as in the note above: (1) the application terminates the order unless it is one made under section 2 — the Act does not expressly provide this; (2) the application is ineffective because of the existence of a prior court order — again, the Act does not provide this; (3) both the order and the application are valid and the patient's detention in either hospital, or both his detention and guardianship, are authorised. The first interpretation is undesirable insofar as the patient's absence without leave results in the accidental termination of a court order and the acquisition by that patient's nearest relative of a power of discharge unimpaired by the court. The second and third interpretations both have the consequence that court orders are not revoked by applications, whether accidentally or otherwise, and their termination requires an order or direction for discharge or their non-renewal. However, the second interpretation has two disadvantages. Firstly, the Act does not provide that the subsequent application is ineffective and, secondly, such an inference means that the managers, although unaware of the prior authority, are liable for unlawfully detaining the patient in their hospital. The third interpretation avoids these disadvantages but does produce the anomaly that the same patient may be simultaneously liable to detention and subject to guardianship under the Act. The answer to that may simply be that this is an unfortunate consequence of the patient absents himself without leave or a misguided avoidance of section 19. It is submitted that the third interpretation is correct, at least in the case of patients who have been absent without leave. <sup>1</sup> See the precise wording of section 40(4) ("shall be treated for the purposes of the provisions of this Act mentioned in Part I of Schedule 1") and the absence of any reference to sections 2, 3, 4 and 7 in Sched. 1, Pt. 1. See Mental Health Act 1983, ss.35, 36, 38, 40, 55(4) and 145(3). <sup>262</sup> *Ibid.*, ss.40(4), 41(3), and 145(3). <sup>263</sup> *Ibid.*, s.40(5). <sup>264</sup> *Ibid.*, s.40(5). <sup>265</sup> Mental Health Act 1983, ss. 40(4), 41(3), 55(4) and 145(3).

### Section 37 order quashed on appeal

It has been noted that the effect of a hospital or guardianship order is that any previous authority for an unrestricted patient's detention or guardianship ceases to have effect. Section 40(5) attempts to deal with the situation where such an order, or the conviction on which it was made, is later quashed on appeal. It provides that any application, order or direction which was in force immediately prior to the making of the quashed order shall then be deemed not to have been revoked by it. Furthermore, section 22 shall have effect "as if during any period for which the patient was liable to be detained or subject to guardianship under the (quashed) order, he had been detained in custody as mentioned in that section." Section 22 refers in turn to sections 18 and 21 and the following examples illustrate the combined effect of sections 18, 21, 22 and 40(5).

### Examples

A patient is received into guardianship under Part II of the Act on 1 January. Unless renewed, the authority for his guardianship will lapse on 30 June. On 1 February, he is charged with burglary but granted bail. On 30 May, he is convicted by a magistrates' court, which makes a hospital order. His admission has the effect of revoking the guardianship application. On 19 September, the Crown Court quashes the conviction, the effect of which is that the quashed hospital order is now treated as not having revoked the guardianship application. Sections 21 and 22 apply. The patient is treated—

- as if he had continued to be subject to the guardianship application during the period from 30 May until 19 September (the period during which he was liable to be detained under the hospital order);
- as if he had been committed to prison on 30 May (the day on which the quashed order was imposed);
- as if he had been released from prison on the day of the successful appeal;
- as if this notional release from prison took place on the last day of the six month guardianship period which commenced on 1 January;
- as if on that day he had absented himself without leave from the place where he was required by his guardian to reside.

*The simple effect of all this is that the guardianship will lapse if the patient is not taken into custody under the 1983 Act, or does not return himself to the place where he is required to reside, within 28 days of the date on which the hospital order was quashed.*

If the patient returns or is taken into custody during the 28-day period, his appropriate medical officer has one week from the day of his return within which to furnish a renewal report under section 20(6). If he furnishes such a report during this week, the guardianship application which commenced on 1 January is treated as if it had been renewed for six months with effect from 1 July.<sup>266</sup>

<sup>266</sup> The only exception to this would be if the patient had been remanded in custody by the magistrates on or prior to 19 March and had remained in continuous custody until the hospital order was imposed on 30 May. In this example, he would then be deemed to have been in continuous custody for a period exceeding six months by the time the hospital order was quashed. The guardianship application which commenced on 1 January would therefore have lapsed. See s.22(1).

### Example 2

If the hospital order in the previous example was imposed by a Crown Court and quashed by the Court of Appeal on 15 December, the period for which the patient was subject to it, and during which he is deemed to have been continuously in custody, extends from 30 May until 15 December and so exceeds six months. Section 40(5) therefore does not save the pre-existing guardianship application because it has lapsed by virtue of section 22(1).

#### *Effect of a successful appeal on tribunal proceedings*

Where a previous application, order or direction is reactivated as a result of a successful appeal against a hospital order or a guardianship order, the effect of 40(5) is that any tribunal application or reference which was outstanding on the date the quashed order was imposed, but which was deemed withdrawn, is also reactivated. Secondly, upon the revival of the earlier authority, the hospital's managers may be required to forthwith refer the patient's case to a tribunal under section 68.

#### **Cessation due to removal outside the jurisdiction**

Where a patient who is detained or subject to guardianship in England and Wales is removed to Scotland, Northern Ireland, the Channel Islands or the Isle of Man under Part VI of the Act, the application, order or direction under which he was previously liable to be detained or subject to guardianship in England and Wales — including any restriction order or direction — ceases to have effect.<sup>267</sup>

#### *Removal to countries outside the UK, Channel Islands or Isle of Man*

An application, order or direction — other than a restriction order or direction — ceases to have effect upon a patient's removal to a hospital or other institution in a country outside the United Kingdom, Channel Islands or Isle of Man in pursuance of arrangements made under section 86.<sup>268</sup>

<sup>267</sup> Mental Health Act 1983, s.91(1).  
<sup>268</sup> *Ibid.*, s.91(2).

## 5. Orders and directions under Part III

### INTRODUCTION

Part III of the Mental Health Act 1983 comprises provisions dealing with "patients concerned in criminal proceedings or under sentence." In some cases, admission to hospital under Part III gives rise to a right of application to a tribunal. Criminal proceedings involving persons suffering from mental disorder may be viewed as comprising six distinct stages: (a) the commission of an alleged offence; (b) arrest, detention and charge; (c) pre-trial procedures, including remands, jurisdiction, mode of trial, and committals; (d) the trial process, including a defendant's fitness to plead and to stand trial; (e) sentencing and disposal; (f) the post-sentencing stage. Special legal provisions apply at each stage but Part III is mainly concerned with the formalities relating to the admission and detention of persons during or following criminal proceedings.<sup>1</sup>

### ORDERS AND DIRECTIONS UNDER PART III

The table on page 311 summarises the orders and directions which may be made under Part III, their purpose, and the ways in which a person may challenge his detention under the Act. Persons admitted to hospital under sections 35, 36 and 38 are in a fundamentally different position from persons admitted under the other orders and directions.<sup>2</sup> The Part II provisions concerning the duration, discharge and renewal of the authority for a patient's detention, and related matters such as leave and transfer, do not apply to them. The termination of a patient's detention under sections 35, 36 or 38 is a matter for the court with jurisdiction to deal with him.

### Remands and orders under sections 35, 36 and 38

Sections 35 and 36 provide that a criminal court may remand an accused person to hospital during the course of criminal proceedings, for the preparation of a report on his mental condition or for treatment. Section 38 further provides that, before sentencing an offender, the court may direct his admission to hospital in order to assist it in determining the most appropriate way of disposing of the case. In each instance, the admission is directed by the court having jurisdiction to deal with a

<sup>1</sup> *Important Note:* The Crime (Sentences) Act 1997 received the Royal Assent on 21 March 1997. Many of its provisions came into force on 1 October 1997 (1998). The final section of the chapter summarises the new laws concerning mandatory life sentences and the imposition of hospital directions and limitation directions. Less fundamental amendments of sections of the 1983 Act are referred to in the appropriate part of the text, or in footnotes.

<sup>2</sup> See e.g. the references to sections 35, 36 and 38 in sections 30(4)(a), 43(3), 80(1), 81(1), 85(1), 91(1), 123(1), 138(4) and 145(3) of the Mental Health Act 1983.