6. After-care and supervision applications

INTRODUCTION

Section 117 of the Mental Health Act 1983 imposes a statutory duty on Health Authorities and local social services authorities to provide after-care to patients who leave hospital having been detained there for treatment. The Mental Health (Patients in the Community) Act 1995 introduced a new power of supervised discharge. This allows an application to be made under Part II for an unrestricted patient who is liable to be detained for treatment, and therefore entitled to after-care, to be subject to "after-care under supervision" when he leaves hospital (**422**). The Act also amended the law concerning patients who are lawfully or unlawfully absent from hospital or the place where they are required to reside. Thus, the Act provides for each of the three situations in which an unrestricted patient who has been detained for treatment may be in the community — he may have leave to be absent from hospital, or he may be absent from there without leave, or he may have been discharged and no longer liable to detention.

AFTER-CARE UNDER SECTION 117

Health and social services authorities have a statutory duty under section 117 of the 1983 Act to provide after-care for patients who have been detained in hospital for treatment. More specifically, the Act provides that the duty to provide after-care under section 117 applies to persons who are detained under sections 3, 37, 45A, 47 or 48 "and then cease to be detained and *(whether or not immediately after so ceasing)* leave hospital."[1] The italicised words were inserted by the 1995 Act and they emphasise that the duty to provide after-care does not lapse because a patient who has ceased to be liable to be detained then remains in hospital for a period as an informal patient. Previously, it was sometimes argued that a patient who had been detained for treatment and then became an informal in-patient before being discharged could not be said to "then cease to be detained and leave hospital."

WHAT CONSTITUTES AFTER-CARE

The Act does not specify the extent of the statutory duty, other than that after-care services must be provided until the relevant authorities are satisfied that the patient is no longer in need of such services. What constitutes after-care and the exact nature of that duty is not defined and no regulations have been made which prescribe

[1] Mental Health Act 1983, s.117, as amended by Mental Health (Patients in the Community) Act 1995, s.1(2), Sched. 1, para. 15, and Crime (Sentences) Act 1997, s.55(1), Sched. 4, para. 12(17).

how the duties are to be performed. However, the fact that the duty is confined to persons who have required detention for treatment for a potentially indefinite period suggests that the central purpose of the after-care is to minimise, as far as practicable, the risk of relapse and the need for further in-patient treatment.

SECTION 117 : AFTER-CARE

"After Care

117.—(1) This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of *a hospital direction made under section 45A above or* a hospital order made under section 37 above, or transferred to a hospital in pursuance of a transfer direction made under section 47 or 48 above, and then cease to be detained and *(whether or not immediately after so ceasing)* leave hospital.

(2) It shall be the duty of the Health Authority and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the Health Authority and the local social services authority are satisfied that the person concerned is no longer in need of such services; *but they shall not be so satisfied in the case of a patient who is subject to after-care under supervision at any time while he remains so subject.*

(2A) It shall be the duty of the Health Authority to secure that at all times while a patient is subject to after-care under supervision—

(a) a person who is a registered medical practitioner approved for the purposes of section 12 above by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder is in charge of the medical treatment provided for the patient as part of the after-care services provided for him under this section; and

(b) a person professionally concerned with any of the after-care services so provided is supervising him with a view to securing that he receives the after-care services so provided.

(2B) Section 32 above shall apply for the purposes of this section as it applies for the purposes of Part II of this Act.

(3) In this section "the Health Authority" means the Health Authority, and "the local social services authority" means the local social services authority, for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained.

The words in italics represent insertions and amendments made by the Mental Health (Patients in the Community) Act 1995, Sched. 1, para. 15; the Health Authorities Act 1995 (which replaced previous references to a District Health Authority with references to the Health Authority); and the Crime (Sentences) Act 1997.

WHEN THE DUTY TO PROVIDE AFTER-CARE ARISES

Section 117 imposes a duty to provide after-care services for patients who are detained for treatment and then cease to be detained and leave hospital. In *ex p. Fox*, the Divisional Court rejected a submission that the duty to provide after-care only comes into existence when the patient is discharged from hospital. The duty to provide after-care services is a continuing duty in respect of any patient who may be discharged, although it is only triggered in any particular case at the moment of discharge.

R. v. Ealing District Health Authority, ex p. Fox

[1993] 1 W.L.R. 373 *Q.B.D., Otton J.*

In 1988, the patient appeared at the Central Criminal Court where he was convicted of inflicting grievous bodily harm with intent and possessing a firearm with intent to commit an indictable offence. The court was satisfied that he was suffering from mental illness and psychopathic disorder and directed that he be admitted to a special hospital in pursuance of a hospital order and a restriction order made without limit of time. On 18 July 1991, a Mental Health Review Tribunal considered his case. It directed the patient's conditional discharge but deferred the discharge until such time as it was satisfied that arrangements had been made which enabled the conditions of discharge to be satisfied. In particular, it was necessary for the Health Authority to appoint a responsible medical officer to provide psychiatric supervision for the patient in the community. In the reasons for its decision, the tribunal stated that any delay in discharging the patient would cause problems in his rehabilitation. Before coming to its decision, the tribunal did not seek the views or agreement of any doctor who might, by virtue of its decision, become responsible for providing medical treatment and supervision in the community. The doctors of the Health Authority which had the duty to provide the patient with after-care following discharge were unwilling to undertake the necessary supervision. More particularly, a forensic consultant at the regional secure unit for the area within which the tribunal decided that the patient should be discharged declined to act. He stated that; "I can only properly agree to accept the role of medical supervisor in cases where I feel the patient is amenable to continuing supervision ... I do not have this confidence and it would be wrong of me to give the appearance that I have and accept the responsibility of supervising him when I feel it to be impossible." The consultant's colleagues at that unit were of the same view. Likewise, the catchment area consultant declined to act, stating that it was important to note that at no time had he been consulted by the tribunal about taking responsibility for the patient. Based on the doctors' opinions, the Health Authority concluded that the patient should instead be supervised for at least 18 months in a regional secure unit rather than in the community. Accordingly, the Health Authority did not appoint a responsible medical officer and the patient remained in hospital. In February 1992, a consultant psychiatrist not employed by the Health Authority was instructed on the patient's behalf by his solicitor. He interviewed the patient in hospital during that month. He was willing to see the patient as an out-patient privately but, for practical reasons, could not take responsibility for how the supervision might turn out. The tribunal was due to reconsider the patient's case in March 1992 but the patient cancelled the hearing, applying instead for judicial review.

The grounds of application

The patient applied for judicial review, seeking a declaration that the Health Authority had erred in law in refusing to supply psychiatric supervision in the community for the applicant; alternatively, an order of certiorari to quash the decision of the Health Authority not to provide community psychiatric supervision; and, finally, an order of mandamus to compel the Health Authority to provide the supervision. The grounds of the application were, *inter alia*, that the Health Authority had substituted the clinical judgment of its consultant psychiatrist —that it was preferable for the applicant to be supervised in a regional secure unit— for the decision of the tribunal that he should be released into supervision in the community; that the authority had thereby prevented him from fulfilling the conditions for his release; and that the authority had failed to fulfil its duty under section 117 to provide after-care services for him. The Health Authority's case was that a tribunal has no express or implied statutory power to direct a Health Authority to provide any type of health care. If the contrary proposition were correct, a Health Authority would be under such a duty to provide community medical supervision even though a patient's condition had seriously deteriorated since the tribunal decision. There would be no need for the deferral procedure unless there was a possibility that a Health Authority might lawfully decline to provide the service contemplated by the tribunal. The effect of a deferred discharge was simply to require the Health Authority to ascertain whether the conditions could be complied with and, if the tribunal was satisfied that the necessary arrangements had been made, the discharge then took effect. Furthermore, the Health Authority was not under any duty to provide after-care to the patient by virtue of section 117: that section had not been triggered because the patient had not yet left hospital.

Otton J.

1. A conditional discharge, whether immediate or deferred, was a final order and once made the tribunal had no power to revoke it. However, section 73(7) empowered a tribunal to defer its order so that arrangements could be made which enabled the conditions of the order to be fulfilled. Although the tribunal knew that no regional secure unit was available, it was entitled to decide that conditional discharge was appropriate.

2. While it might be true that there was no express statutory power to direct a Health Authority to provide a particular type of health care to a particular person at a particular time, it did not follow that it was not in breach by refusing to treat the patient within or under its aegis. Section 117(2) was mandatory. That duty was not only a general duty but a specific duty owed to the patient to provide him with after-care services until such time as the health and local social services authorities were satisfied that he was no longer in need of them. The duty did not only come into existence when the patient was discharged from hospital. The duty to provide after-care under section 117 was a continuing duty in respect of any patient falling within section 117 who might be discharged, although the duty to any particular patient was only triggered at the moment of discharge. In the alternative, such a duty could be spelt out from the general statutory framework concerning the National Health Service, which required health authorities to provide a comprehensive range of hospital and community psychiatric services, including appropriate services to meet the needs of mentally disordered offenders.

3. As to whether the H[illegible] Authority had discharged its duty to the patient, the mere acceptance by it of the doctors' opinions was not of itself a sufficient discharge of its obligation to proceed with reasonable expedition and diligence and to give effect to the arrangements specified and required by the tribunal. The effect of a tribunal's decision was not merely to require the relevant authority to determine whether it was prepared to satisfy the conditions, so as to enable the discharge to take place. The purpose of deferral was to allow time for the Health Authority to give effect to the conditions which the tribunal had already determined.[2] If the authority's doctors did not agree with the conditions which had been imposed, and were disinclined to make the necessary arrangements, the authority could not let the matter rest there. It was under a continuing obligation to make further endeavours to provide arrangements within its own resources, or to obtain them from other Health Authorities, so as to put in place the practical arrangements enabling the patient to comply with the conditions the or, at the very least, to make inquiries of other service providers.

4. If the arrangements still could not be made, the Health Authority should not permit an impasse to continue. It should refer the matter to the Secretary of State, so that he could consider exercising his power to refer the case back to the Mental Health Review Tribunal, under section 71(1). That was also the appropriate course of action where there was a subsequent deterioration of the patient's condition.[3] There was no reason, either in principle or in practice, why a Health Authority faced with such a dilemma could not of its own initiative inform the Secretary of State of the deterioration, send him its medical reports and request him to refer the case to the tribunal afresh.

5. In summary, the authority had erred in law in that it had not fulfilled its obligations. The fact that it was not prepared to take any steps other than to obtain the views of its doctors meant that it was still in breach of its duty arising from the decision of the Mental Health Review Tribunal. As to the relief sought, it was appropriate to make an order of certiorari to quash the Health Authority's decision not to provide psychiatric supervision in the community for the patient. It was also appropriate to make a declaration in the following terms:

   (1) that the authority has erred in law in not attempting with all reasonable expedition and diligence to make arrangements so as to enable the applicant to comply with the conditions imposed by the Mental Health Review Tribunal;

   (2) that a [district] Health Authority was under a duty under section 117 of the Mental Health Act 1983 to provide after-care services when a patient leaves hospital, and acts unlawfully in failing to seek to make practical arrangements for after-care prior to that patient's discharge from hospital where such arrangements are required by a Mental Health Review Tribunal in order to enable the patient to be conditionally discharged from hospital.

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2 *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department* [1988] A.C. 120.

3 In *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department* [1988] A.C. 120 at 128, Lord Bridge said that section 73(7) "certainly enables the Secretary of State, when a deterioration in the condition of the patient is brought to his attention, to forestall the patient's discharge by exercising his power under section 71 of the Act of 1983 to refer the patient's case to the tribunal afresh."

The duty to provide after-care under section 117 does not extend to informal patients; patients detained for assessment under Part II; patients detained under any of the short-term powers of detention with a maximum duration of 72 hours or less; patients subject to guardianship, unless previously detained for treatment; Part III patients detained for treatment under sections 36 or 38; patients remanded to hos- patients detained for treatment under sections 36 or 38; pital for the preparation of a report under section 35. The rationale in the case of patients detained under section 35, 36 or 38 is that their cases have not yet been disposed of by the court. The court may later make a hospital order, in which case a statutory entitlement to after-care will arise, but equally it might deal with the offender in some other manner such as by way of a custodial sentence.

Patients detained in mental nursing homes

The Act is ambiguous with regard to patients admitted to mental nursing homes.[4] It provides that references to a "hospital" in Parts III *(mentally disordered offenders)*, V *(mental health review tribunals)* and VI *(removal and return of patients within the United Kingdom)* are to be construed as referring to "a hospital within the meaning of Part II" and therefore as including mental nursing homes which are registered to receive detained patients.[5] References to a "hospital" in Part VIII— which includes section 117 — bear instead the meaning given in section 145(1) and so exclude mental nursing homes unless the context requires a different meaning. Because this is so, certain provisions in Part VIII are expressly stated to apply both to hospitals and mental nursing homes (see ss. 116, 118 and 120) but others only to hospitals (see sections 117, 122 and 123). The question arises whether the context requires that where a section in Part VIII, such as section 117, refers only to a hospital this is nevertheless to be interpreted as referring to "a hospital within the meaning of Part II." It would seem incongruous if Parliament intended that section 117 should apply to private patients treated in an NHS hospital but not to NHS patients admitted to mental nursing homes under a contract with a Health Authority. Therefore, the absence of any reference to mental nursing homes in section 117 is probably only loose drafting. It is submitted that "hospital" in this context includes mental nursing homes, notwithstanding the definition of a hospital in section 145 and the fact that only certain sections within Part VIII of the Act are expressed to apply to mental nursing homes.

Patients detained under sections 47 and 48

The clause originally inserted in the Bill during the Third Reading in the House of Lords only provided that patients detained under what are now sections 3 and 37 had a statutory entitlement to after-care. The references to patients transferred from prison or custody were added later. Presumably, if the patient "ceases to be detained

4 The problems concerning the section's interpretation mainly arise because it was inserted during the Third Reading of the Bill, following a division in the House of Lords which the Government lost. Although the Government knew that the section was "defective in a number of respects" it did nothing to rectify those defects. See *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S.S., 1982), p.161.

5 Except where otherwise expressly provided or where the context requires a different meaning. Likewise, the references to a hospital in sections 128 (assisting patients to absent themselves without leave), 134 (correspondence of patients) and 138 (retaking of patients escaping from custody) are also to be construed according to the definition in section 34(2), and therefore encompass mental nursing homes which are registered to receive detained patients.

and leaves hospital" because , remitted to prison rather than discharged into the community no duty to provide after-care arises or, if it does, it is not triggered at that point. Some section 47 patients remitted to prison will be serving life sentences and some section 48 patients who are remitted will later be dealt with under the ordinary sentencing provisions. From one perspective, there is little merit in distinguishing between section 36 and section 48 patients since the majority of them are defendants awaiting trial in the course of criminal proceedings. The main difference in this context is that a section 48 patient may be discharged from hospital under the Mental Health Act 1983 whereas the section 36 patient may only be released by being granted bail. The implication is perhaps that if a patient is dealt with under the ordinary criminal provisions, by way of bail or custody, no duty to provide after-care arises, that duty being limited to cases where the patient "ceases to be detained and leaves hospital" through being discharged under the 1983 Act. If so, the rationale may be that the discharged patient's circumstances reflect the fact that it is more appropriate to continue to deal with him as a patient. Conversely, the grant of bail and remission to prison both imply that it is more appropriate to again deal with the individual as an ordinary offender. An intermediate view would be that the term "leaves hospital" excludes being remitted to prison but includes section 48 patients who leave hospital and take up residence in the community as a result of being granted bail. Although the position is ultimately unclear, it is submitted that the distinguishing feature of section 3, 37, 47 and 48 patients, compared with those detained under sections 35, 36 and 38, is that the former but not the latter may be discharged under the Mental Health Act 1983. Accordingly, the duty imposed by section 117 only applies to patients who cease to be detained because they are discharged under the 1983 Act and then leave hospital.

Patients granted leave of absence

It has been noted that the duty to provide after-care is triggered when a patient previously detained for treatment then ceases to be detained and (whether or not immediately after so ceasing) leaves hospital. The wording of section 117 now makes it clear that where a patient ceases to be detained but does not immediately leave hospital this does not affect his statutory entitlement. The converse situation is that where the patient leaves hospital first, under section 17 leave, and only later ceases to be "liable to be detained." The question whether leave granted prior to a patient's discharge from liability to detention triggers the duty to provide after-care was not in issue in *ex p. Fox* **(415)** and, consequently, not canvassed. It has been contended that the duty to provide after-care to patients granted leave of absence is not triggered until such time as they are also discharged from liability to detention.[6] The view of the Mental Health Act Commission is that a literal interpretation is to be preferred and the duty is triggered when a patient is granted leave, at which point he literally ceases to be detained and leaves hospital, albeit that he remains "liable to be detained." In support of the Commission's view, it may be noted that, in *R. v. Hallstrom*,[7] McCullough J. was not convinced that the word "detained" in section 117 meant in fact "liable to be detained."[8] If this is correct, the phrase "leaves"

6 By Nigel Pleming Q.C. in *R. v. Hallstrom, ex p. W.; R. v. Gardner, ex p. L.* [1986] 1 Q.B. 1090.

7 *R. v. Hallstrom, ex p. W.; R. v. Gardner, ex p. L.*, supra.

8 See also *Safford v. Safford* [1944] P.61, which concerned the meaning of the word "detained" in the context of leave granted under sections 55 and 275 of the Lunacy Act 1890. The word "detained," rather than the expression "liable to be detained," is also used in section 72(2), a usage which McCullough J. considered in *ex p. W.*: " ... in section 72(2) the only reference is a patient 'detained.' Presumably this is to be taken as covering one on leave of absence and only 'liable to be detained,' for discharge means not merely discharge from hospital but discharge from the authority to detain."

hospital" bears a different meaning in section 117 to that which it bear[illegible] section 25A. In other words, a person granted leave under section 17 has left hosp[illegible]l for the purposes of section 117 and the duty to provide after-care is triggered at this point. However, he has not left hospital for the purposes of section 25 until such time as he also ceases to be liable to be detained. It is only then that the after-care being provided under section 117 is reinforced by the statutory supervision scheme.

Duty triggered when patient leaves hospital though still liable to be detained

In favour of this construction, it may fairly be said that Parliament clearly foresaw that the period during which there exists a duty to provide after-care will commonly not correspond to any period of statutory supervision. And if, as is the case, the duty to provide after-care under section 117 may continue after any statutory supervision has been terminated so the duty to provide it may arise before any period of supervision commences. Such an interpretation ensures that detained patients who require a long period of continuous trial leave at a local social services hostel may have a statutory entitlement to such community care services. Indeed, their provision may be a necessary precondition of granting leave preparatory to eventual discharge. Furthermore, construing section 117 in this way is more consistent with the way in which it is drafted. Had the intention been to exclude patients granted leave, the wording would surely have been the reversed. As originally enacted, section 117 would instead have referred to patients who "leave hospital and then cease to be detained" rather than to patients who "then cease to be detained and leave hospital." Likewise, the duty now would apply only to patients who "leave hospital and (whether or not immediately after so leaving) then cease to be detained."

Duty triggered when patient ceases to be liable to be detained for treatment

Against the above view, it may be pointed out that leave to be absent from hospital is usually first granted for an hour only, progressing to overnight leave and then weekend leave, and building up gradually to extended leave. If leaving hospital under section 17 constitutes leaving hospital for the purposes of section 117, it is not clear whether the duty to provide after-care is continually triggered and suspended with each short additional period of absence or only triggered when leave becomes open-ended. Certainly, a social services authority will not usually be aware of each short period of leave, the grant of which is at the consultant's discretion. However, this objection, although superficially attractive, is not conclusive: the duty on the local social services authority would be to provide a patient on leave with any *necessary* after-care services. In the case of short absences, such as one hour's town leave, it is simply the case that providing social after-care services at that stage is unnecessary. Nevertheless, they must be provided when a patient requires more intensive support as the periods outside hospital become longer. A more fundamental objection is perhaps that the whole notion of after-care is directed towards a patient's situation after he has completed his medical treatment and ceased to be liable to be detained in hospital for that purpose. Thus, the National Health Service Act 1977 draws a distinction between care and after-care, authorising and in some cases requiring social services authorities to make arrangements for "the care of persons suffering from illness and for the after-care of persons who have been so suffering."[9] Moreover, the definition of medical treatment in section 145 of the 1983 Act includes rehabilitation under medical supervision. This all suggests that while

[9] See National Health Service Act 1977, Sched. 8, para. 2(1).

the patient continues to rece[illegible] medical treatment (including rehabilitation under section 3) it is treatment and care which is being provided rather than after-care. As to the drafting of section 117, if the intention was to include patients who leave hospital under section 17, any contention that section 117 includes patients on leave involves removing the phrase "cease to be detained." The section as originally enacted would simply have referred to "patients who then leave hospital" rather than to patients who "then cease to be detained and leave hospital." Excluding patients who have leave to be absent from hospital has the intended virtue that the phrase "leaves hospital" bears the same meaning in sections 25A and 117: the completion of systematic arrangements for the patient's after-care upon his ceasing to be liable to be detained leads to discharge from section and, if necessary, its simultaneous provision under statutory supervision.

Patients detained under other powers

It has already been noted that some patients previously detained for treatment may remain in hospital informally after their liability to detention has ended. However, this does not affect their entitlement to statutory after-care on leaving hospital. A variation of this situation occurs when a long-stay patient remains in hospital for a number of years after a section 3 application has ceased to have effect and, during part of that period he is detained under another provision of the Act to which no entitlement to after-care under section 117 attaches. For example, the patient may subsequently be detained under section 5(2) or under section 2 and then at a later date cease to be detained and leave hospital. This may happen where the local emergency social work team has a policy of not making section 3 applications in respect of patients not known to them. In practice, some long-stay patients spend years in hospital during which they are variously informal or subject to the whole gamut of applications and powers under Part II of the Act. Although the new words inserted by the Mental Health (Patients in the Community) Act 1995 arguably do not quite cater for this situation, it is submitted that the underlying statutory intention is clear. If a patient's condition has been sufficiently serious to warrant compulsory in-patient treatment for an indefinite period, a statutory duty to provide him with after-care arises upon his leaving hospital. This duty survives subsequent changes in his legal status during the remainder of what is a continuous period of in-patient treatment. The effect of holding otherwise would be to introduce an undesirable degree of arbitrariness into the statutory provisions. Some patients would lose their statutory entitlement because of the subsequent use of a certain kind of compulsory power when, if anything, the further use of compulsory powers merely emphasises the patient's continuing need for intensive support following eventual discharge from hospital.

Patients readmitted to hospital under section

A common further variation of the above situation is that of a patient previously detained for treatment whose after-care following discharge from hospital was insufficient to prevent a relapse of his condition, the consequence being readmission under section 2 or section 4. By way of amplification, a patient previously detained under section 3 may spend eight months at home, relapse, be urgently admitted under section 4, his detention continued under section 2, and he then apply to a tribunal for his discharge. Can the tribunal assume that the duty to provide statutory after-care survives readmission to hospital under a power which carries no

entitlement to it? If so, the mere fact of having once been detained fc atment could in theory lead to a life-long statutory commitment in the case of pa..nts with a continuing need for community psychiatric support, punctuated only by occasional readmissions to hospital. Conversely, holding otherwise means that if after-care arrangements break down, because a patient needed more intensive after-care than was being provided, the readmission may both demonstrate a need for increased after-care and terminate the patient's statutory right to any after-care. As to this point, it is submitted that the relevant health and social services authorities cannot reasonably be satisfied that the patient is no longer in need of the services which it has been their duty to provide following the previous admission: the fact of the subsequent admission under section 2 manifestly demonstrates that the patient remains in need of those services. Consequently, if a section 2 patient was entitled to statutory after-care at the time of his admission under that section he will be entitled to it when he again ceases to be detained and leaves hospital.

SECTION 117 AFTER-CARE UNDER SUPERVISION

The Mental Health (Patients in the Community) Act 1995 made several important changes to the Mental Health Act 1983. The Act amended the law concerning patients who are lawfully or unlawfully absent from hospital or the place where they are required to reside. A new power of supervised discharge allows an application to be made under Part II for an unrestricted patient who is liable to be detained for treatment to be subject to "after-care under supervision" when he leaves hospital, with a view to securing that he receives the after-care services provided for him under section 117 ..."[10] The supplement to the Code of Practice states that:

> "Supervised discharge is intended for patients whose care needs to be specially supervised in the community because of risk to themselves or others. This applies particularly to 'revolving door' patients who have shown a pattern of relapse after discharge from hospital. Relapses often follow the breakdown of arrangements for care in the community, for example when a patient stops taking medication. The legal framework which supervised discharge provides should help to prevent such failures provided that the care arrangements which it underpins have been fully agreed between the agencies concerned. Its purpose is to complement and reinforce existing arrangements under the Care Programme Approach ..."[11]

THE BASIC FRAMEWORK

The basic framework may be summarised as follows. Section 117 provides that patients who are liable to be detained for treatment have a statutory entitlement to after-care when they leave hospital. However, a proportion of patients habitually refuse to receive the after-care which is provided for them in pursuance of this duty. Provided the statutory conditions are satisfied, the responsible medical officer of an

10 Mental Health Act 1983, s.25A(1), as inserted by Mental Health (Patients in the Community) Act 1995, s.1(1).

11 *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice* (Department of Health and the Welsh Office, 1996), para. 5.

unrestricted patient who is lial ɔ be detained for treatment may now apply to the Health Authority for him to be supervised after he leaves hospital, with a view to securing that he receives the after-care services to be provided for him. Such applications are known as "supervision applications." Where such an application has made and accepted and the patient then leaves hospital, he is then "subject to after-care under supervision." Patients subject to after-care under supervision must at all times have a supervisor and a doctor in charge of their medical treatment who is approved under section 12(2) as having special experience in the diagnosis or treatment of mental disorder — what is referred to as a "community responsible medical officer." The Health Authority and the local social services authority which under section 117 have the duty to provide a supervised patient with after-care services ("the responsible after-care bodies") may under section 25D impose certain requirements on him. These requirements correspond to the essential powers of a guardian appointed under the Mental Health Act 1983 — they comprise requirements of residence, attendance and access. The patient may be required to reside at a specified place; required to attend specified places at specified times for the purpose of medical treatment, occupation, education and training; and access to him by authorised persons may be required by the responsible after-care bodies. These bodies must continue to provide after-care to the patient for as long as he remains subject to after-care under supervision. The applications process reflects the statutory purpose of supervised discharge. Before making an application, the responsible medical officer must consider the after-care services to be provided for the patient and any requirements to be imposed on him under section 25D. He must also consult certain persons, both professionals and non-professionals, and take any views which they express into account. Any application which is then made must be supported by two recommendations. It must also be accompanied by details of the after-care services and any requirements to be imposed under section 25D, and by statements from the persons who are to fulfil the functions of the supervisor and the community responsible medical officer, acknowledging that they will be undertaking those duties.

TERMINOLOGY AND SECONDARY LEGISLATION

Before dealing with the substantive provisions, it is necessary to define various new statutory terms and phrases and to make some reference to the prescribed forms. The reader should also be aware that regulations have been made which enable the responsible after-care bodies to delegate the performance of many of their functions to an NHS Trust. Consequently, although the Act refers to applications being made to, and accepted by, the relevant Health Authority, the expectation is that an NHS trust will usually perform these particular functions. Because the regulations are quite technical, and it is most important to understand the primary legislation, their consideration has been postponed until the statutory scheme has been explained (**453**). For the same reasons, the precise nature of the duty to consult the interested parties before exercising a particular statutory power, and to notify them if it is then exercised, is likewise delayed until then (**455**).

NEW TERMS

The Act introduces a number of new terms and these are summarised immediately below. The references to the section of the Act within which the term is defined are references to sections of the 1983 Act.

Supervision application

An application for a person to be supervised after he leaves hospital, with a view to securing that he receives the after-care services provided for him under section 117 (ss.25A(1) & (2), 145(1)).

After-care under supervision

If a duly made supervision application has been accepted in respect of a patient who then leaves hospital, he is "subject to after-care under supervision" (ss.25A (2), 145(1A)).

Community responsible medical officer (CRMO)

The person who is in charge of medical treatment provided for a patient subject to after-care under supervision (s.34(1)). The CRMO must be approved under s.12(2) of the Mental Health Act 1983 (s.117 (2)(a))

Supervisor

The person who is supervising a patient subject to after-care under supervision (s.34(1)). The person acting as a patient's community responsible medical officer may also be his supervisor (s.34(1A)).

Responsible after-care bodies

The bodies which have (or will have) the duty under s.117 to provide after-care services for the patient, i.e. the relevant health and local social services authorities (ss. 25D, 145(1)).

For so long as a person is subject to after-care under supervision, the responsible after-care bodies may not be satisfied that the patient no longer requires after-care services under s.117. They must therefore continue to provide such services. Furthermore, the Health Authority —not both responsible after-care bodies— shall ensure that the patient has a community responsible medical officer and a supervisor at all times (s.117 (2A)).

New statutory phrases

The 1995 Act was considerably longer than it needed to be, partly because various lengthy phrases repeatedly used in it were not also given a convenient statutory handle or title, such as the "community responsible medical officer." For the sake of brevity and convenience, the following non-statutory terms are intermittently used in the text to denote these statutory phrases.

Primary carer

A person who plays (or will play after the patient leaves hospital) a substantial part in the care of the patient but who is not professionally concerned with any of the after-care services provided (or to be provided).

Interested parties

The Act repeatedly provides that the following persons have a statutory right both to be consulted before certain statutory steps are taken and to be notified that they have been taken: the patient, his nearest relative, any primary carers. For the sake of brevity, they may be collectively referred to as the "interested parties."

Essential powers

The Act further provides that the responsible after-care bodies (**424**) may, under section 25D, impose any of the following "requirements" on a patient who is subject to after-care under supervision (or will be so subject when he leaves hospital) for the purpose of securing that he receives the section 117 after-care services provided for him —

a) that the patient reside at a specified place;

b) that the patient attend at specified places and times for the purpose of medical treatment, occupation, education, or training; and

c) that access to the patient be given, at any place where the patient is residing, to the supervisor, any registered medical practitioner or any approved social worker or to any other person authorised by the supervisor.

These powers may conveniently be referred to as "essential powers" since they are the same as the "essential powers" of a guardian under the 1983 Act (**250**). The only difference concerns their enforcement. As to this, the Act provides that a patient subject to after-care under supervision may be taken and conveyed by his supervisor, or a person authorised by the supervisor, to a place of residence or any place which he is required to attend for the purpose of medical treatment, occupation, education, or training (see s.25D(4)).

THE PRESCRIBED FORMS

Section 32 of the Mental Health Act 1983 provides that the Secretary of State may make regulations for carrying Part II of the Act into full effect. The regulations may in particular prescribe the form of any application, recommendation, report or order made or given under the Act.[12] They may further provide for requiring such bodies as may be prescribed by the regulations to keep such registers or other records as may be prescribed in respect of patients subject to after-care under supervision.[13] Regulation 3 of The Mental Health (After-care under Supervision) Regulations 1996 provide that applications and recommendations, and any statutory reports and directions made following an application's acceptance, shall be in the form set out in Schedule 1 to the regulations. The table below sets out which forms to be used for each purpose.

AFTER-CARE UNDER SUPERVISION — STATUTORY FORMS

• **Supervision application**	Form 1S	*Reg. 3(a)*
• **Medical recommendation**	Form 2S	*Reg. 3(b)*
• **Approved social worker's recommendation**	Form 3S	*Reg. 3(c)*
• **Report reclassifying the patient**	Form 4S	*Reg. 3(d)*
• **Report renewing the authority for the patient's after-care under supervision**	Form 5S	*Reg. 3(e)*
• **Report renewing the authority for the patient's after-care under supervision**	Form 5S	*Reg. 3(f)*
• **Direction ending after-care under supervision**	Form 6S	*Reg. 3(g)*

THE APPLICATION PROCEDURES

The application procedures differ from those common to other forms of application. In particular, a supervision application is made by the patient's responsible medical officer rather than by an approved social worker or his nearest relative. Only one of the two supporting recommendations is a medical recommendation, the other being provided by an approved social worker. Supervision applications are parasitic in nature in that an application, order or direction authorising a patient's detention for treatment must first exist to which a supervision application can then be attached.

12 Mental Health Act 1983, s.32(2)(a).

13 Mental Health Act 1983, s.32(2)(c), as amended by s.1(2), and Sched. 1, para. 2, of the Mental Health (Patients in the Community) Act 1995. The previous requirement that any such records or registers be kept by the hospital managers or by local social services authorities has been replaced by a general reference to the prescribed bodies. This allows the regulations to prescribe that registers and records be maintained by other bodies, such as organisations providing after-care services under a contract with a health or local social services authority.

THE PATIENT

If an unrestricted patient aged 16 or over is liable to be detained for treatment, and a duty exists to provide him with after-care under section 117 when he leaves hospital, an application may be made for him to be supervised after he leaves hospital, with a view to securing that he receives those after-care services.[14]

Patients not entitled to section 117 after-care

The 1995 Act did not modify the legal position concerning the supervision of informal patients and unrestricted patients subject to guardianship or detention under sections, 2, 3, 5, 35, 36, 38, 135 and 136.[15] That being so, it can be seen that unrestricted patients entitled to after-care are thereby also liable to statutory supervision while, conversely, patients not entitled to after-care are not liable to statutory supervision.

Wards of court

Where a supervision application has been made in respect of a ward of court, the provisions in the 1983 Act concerning after-care under supervision have effect in relation to the minor subject to any order which the court may make in the exercise of its wardship jurisdiction.[16] Although the supervision application and guardianship frameworks resemble each other in several respects, it is therefore the case that a supervision application, but not a guardianship application, may be made in respect of a ward of court.

Patients liable to be detained in Scotland

A supervision application may be made in respect of a patient subject to a community care order in Scotland who intends to leave that country in order to reside in England and Wales.[17] Section 117 and the supervision application provisions in the 1983 Act apply subject to the various modifications set out in The Mental Health (Patients in the Community) (Transfers from Scotland) Regulations 1996.[18]

THE APPLICANT

Although supervision applications are made under Part II of the Act, the application process is distinctive. A supervision application may only be made by the patient's responsible medical officer.[19] Applications must be supported by two recommendations but only one of them is given by another medical practitioner, the other being provided by an approved social worker (**160**).[20]

14 Mental Health Act 1983, ss.25A(1) and 40(4), Sched. 1, Pt. I, para. 8A., as inserted by ss.1(1) and 1(2) of, and Sched. 1, para. 6(c) to, the Mental Health (Patients in the Community) Act 1995. This is, of course, provided that the statutory criteria for making such an application are satisfied.

15 As to departmental guidelines concerning their supervision, see p.745 *et seq.*

16 Mental Health Act 1983, s.33(4), as inserted by s.1(2) of, and Sched. 1 para. 3 to, the Mental Health (Patients in the Community) Act 1995.

17 Mental Health Act 1983, s.25J(1), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

18 *Ibid.*, s.25J(2); The Mental Health (Patients in the Community) (Transfers from Scotland) Regulations 1996. As to the reverse procedure, see The Mental Health (Patients in the Community) (Transfer from England and Wales to Scotland) Regulations 1996.

19 *Ibid.*, s.25A(5), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

20 Mental Health Act 1983, s.25B(6), as inserted by s.1(1) of *ibid.*

Persons to be consulted before an application is made

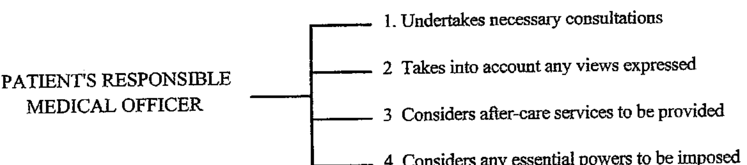
Before making a supervision application, the responsible medical officer must consult the persons referred to in the table on page 458 and take into account any views expressed by them.[21]

Matters to be considered before application is made

The responsible medical officer shall not make a supervision application unless he has considered the following matters[22]—

- **a.** the after-care services to be provided for the patient under section 117; *and*
- **b.** any "essential powers" to be imposed on him under section 25D.

There are good reasons for requiring this. The logical first step is to formulate a section 117 after-care plan in the normal way and only then to decide whether the specified services need to be reinforced by providing them under statutory supervision. Unless an after-care plan has been agreed, it will be difficult, perhaps impossible, to have a considered opinion about the grounds which must exist before an application may lawfully be made. One cannot accurately gauge a person's likely compliance with the services to be provided for him until a decision has been made about what is to be provided for him. Similarly, until a decision has been taken about what services are necessary, one cannot have a firm opinion about the precise risks which may arise if those services are not received — or whether the availability of essential powers is likely to help to ensure that the patient receives them.



Recommending that an application be made

A Mental Health Review Tribunal which does not discharge an unrestricted patient who is liable to be detained for treatment may recommend that the responsible medical officer considers whether to make a supervision application and further consider the patient's case if no such application is made.[23]

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21 Mental Health Act 1983, s.25B(2)(a)–(c), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

22 *Ibid.*, s.25B(1)(b) and (4), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

23 *Ibid.*, s.72(3A), as inserted by s.1(2) of, and para. 10(2) of Sched. 1 to, the Mental Health (Patients in the Community) Act 1995.

A supervision application may be made in respect of a patient "only" on the grounds specified in section 25(A)(4) of the 1983 Act.[24] Those grounds are set out below.

THE STATUTORY GROUNDS — SECTION 25(A)(4)

Existence of a form of mental disorder	**a.** he is suffering from one of the four forms of mental disorder specified in section 1 of the 1983 Act;
Substantial risk of serious harm	**b.** there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services to be provided for him under section 117 after he leaves hospital;
Likelihood of benefit from supervision	**c.** his being subject to after-care under supervision is likely to help to secure that he receives the after-care services to be provided under section 117.

Existence of a form of mental disorder

It suffices that the patient suffers from one of the four forms of mental disorder set out in section 1 of the Act. According to the Code of Practice, while "supervised discharge is primarily intended for severely mentally ill people it may be suitable for some people suffering from other forms of mental disorder. In the case of those suffering from mental impairment or severe mental impairment the question of potential exploitation may be particularly relevant, though the RMO should then always consider whether guardianship might offer a better option for the patient's after-care."[25]

No requirement that disorder be of particular nature or degree

In contrast to the application criteria for guardianship and admission to hospital, there is no requirement that the patient's disorder be of a particular nature or degree. The rationale for this partly derives from the fact that supervision applications may be made in respect of patients who have leave to be absent from hospital under section 17. In some cases, these patients may be in remission or even symptom free and it would be difficult to satisfy a more restrictive test. Provided that there is still evidence of an underlying form of mental disorder, and the other grounds are satisfied, the patient may be made the subject of a supervision application. This

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24 Mental Health Act 1983, s.25A(4), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

25 *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice* (Department of Health and the Welsh Office, 1996), para. 14.

reflects the fact that supervised discharge principally focuses on the risks associated with a future exacerbation of the patient's mental state rather than the present nature or degree of any disorder. That being so, the "nature and degree" qualification applicable in other cases is to some extent enshrined in the second of the supervision application grounds — albeit that the terminology of the 1995 Act fastens on to the nature or degree of the potential risk rather than the nature or degree of the disorder *per se*. Nevertheless, the first aspect (the patient's potential for dangerous behaviour) is consequential upon the second (his mental state).

Substantial risk of serious harm

The second condition requires the applicant, and the professionals providing the supporting recommendations, to consider the possible consequences if the patient does not receive the after-care services to be provided for him. A supervision application may only be made where there would be a substantial risk of serious harm to the patient's health or safety or the safety of others, or a substantial risk of the patient being seriously exploited, if he were not to receive those after-care services upon leaving hospital. A risk of serious harm does not suffice unless that risk is a substantial one. Similarly, a substantial risk of harm does not suffice unless the harm will be serious and, in the case of persons other than the patient, it is their safety, not merely their health, which will be substantially at risk. The identified substantial risk is one consequential upon failure to receive the proposed after-care services and is expressed as a future conditional. In some cases, any risk of suicide or serious harm to others may be substantial irrespective of whether the patient is receiving available after-care services. In the majority of cases, it is unlikely that this second condition will be satisfied so that most patients will, as before, receive their after-care without any formal element of supervision. Because of the need for a substantial risk of serious harm, the view expressed in the Code of Practice is that patients who meet the criteria for supervised discharge should "normally" be included in the supervision registers established in accordance with the *Health Service Guidelines* HSG(94)5 (**755**).[26]

Likelihood of benefit from supervision

If there will be a substantial risk of serious harm should the patient not receive the proposed after-care services, the third condition requires consideration to be given to the practicalities of the situation — will providing those after-care services under formal supervision be likely to help to secure that the patient receives them and so reduce the substantial risk of serious harm which has been identified?[27] This might not be the case in one of two situations. In the first place, although a failure to receive after-care would give rise to a substantial risk, the patient may be both reliable and willing to take advantage of the services being provided. Thus, the risk that the patient will not receive the after-care services arranged for him is insignificant and formal supervision is unlikely to help to provide greater security. Secondly, there is the situation where there is a real risk that the patient will reject some part of the after-care arranged for him, and there are substantial risks associated with that, but imposing formal supervision is unlikely to help to secure that he receives the services. This may be because the only part of the after-care likely to be rejected is prescribed medication; its administration to a supervised patient cannot be compelled; and the patient has made it plain that he will not accept medication voluntarily. In this context, the Code notes that "the arrangements clearly will not work without a substantial measure of agreement on the part of those responsible for them ... While the Act does not require the patient's agreement to supervised discharge it is unlikely to be effective unless the patient, and any informal carer, has understood and accepted its terms."[28]

"Likely to help secure"

Notwithstanding the above, it should be noted that the third statutory ground is satisfied if statutory supervision is likely *to help* to secure that the patient receives the after-care services. The condition is not that such supervision is likely to secure that he does. In other words, getting the patient to accept and participate in the after-care services may largely be a matter of persuasion, professional skill, and building a good therapeutic relationship. However, it suffices that the availability of the statutory powers is likely to help this process of ensuring that after-care is received. As to whether this is likely, the courts may adopt the approach outlined in *R. v. Canons Park Mental Health Review Tribunal, ex p. A* (**223**).[29] That case revolved around the question of whether compulsory admission for treatment was likely to either alleviate or prevent a deterioration of the condition of a patient suffering from a psychopathic disorder. The patient would not accept or co-operate with the only form of treatment which might have that effect. The court held that it was not necessary that treatment be immediately likely to have such a benefit, provided there was a prospect that the patient's attitude might change, so that alleviation or stabilisation was likely over time. The fact that there might initially be some deterioration in the patient's condition, due to the patient's initial anger at being detained, did not mean that her condition was unlikely to be treatable if nursing care was likely to lead to insight being gained, co-operation enlisted, and the condition alleviated in due course. Accordingly, in this context, it probably also suffices that statutory supervision is likely over time to help to secure that the patient receives the after-care services, even though some initial lack of co-operation, due to resentment or other causes, is envisaged. Similarly, the fact that a patient will not voluntarily take medication, and any substantial risks which may arise in the future stem from this, does not mean that the third of the statutory conditions is thereby not satisfied. If refusing medication is likely to lead to a deterioration in the patient's mental state and so affect his participation in other aspects of the care plan, such as attending out-patient check-ups and specified daily activities, the essential powers associated with statutory supervision may well help to secure that he receives these after-care services — even if they do not provide complete security. It is also possible that the patient's attitude to taking medication will change over time to one of grudging acceptance although the likelihood of this is frankly negligible in most cases and so something of a legal fiction.

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26 *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice* (Department of Health and the Welsh Office, 1996), para. 6.

27 In most contexts, the word "secure" is synonymous with the more natural "ensure," so that the third of the statutory tests can be read as referring to statutory supervision being likely to help to ensure that the patient receives the after-care services provided for him under section 117. To secure is to make fast or safe and the noun which corresponds to it is security. The preference for the word perhaps reflects the underlying idea that to secure after-care provides security against the substantial risks which will otherwise arise.

28 *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice* (Department of Health and the Welsh Office, 1996), paras. 23 and 24.

29 *R. v. Canons Park Mental Health Review Tribunal, ex p. A.* [1994] 3 W.L.R. 630.

Supervised discharge and conditional discharge

It has already been noted that the supervision application framework does not apply to restricted patients. This is because a separate supervisory framework for them already exists in the form of conditional discharge, and recall to hospital in the event of relapse, breach of a condition of discharge, or conduct placing the public at risk. It is important to realise the new legislation does not represent the creation of such a regime for unrestricted patients. The statutory grounds for supervision which must be considered in unrestricted cases are more specific than in restricted cases. Indeed, in the case of detained restricted patients, there are no limiting statutory criteria at all. Consequently, consideration is necessarily given to all likely risks to the patient and others and not merely substantial risks which come into being when after-care services are not received. Many restricted patients have a potential for dangerous conduct even if they receive after-care and the need to supervise them reflects this fact. The purpose of their statutory supervision is not merely to make it more likely that they will receive any key after-care arrangements incorporated as conditions of discharge. It also provides a framework for recalling patients in any of the circumstances just specified.

The chain of reasoning

When the grounds for after-care under supervision are examined by reference to the purpose of supervision in restricted cases, their purpose is more focused: to secure compliance with after-care arrangements made under section 117 in cases where non-compliance will give rise to a substantial risk of serious harm. Considered together, the three grounds for making a supervision application represent a single chain of reasoning:

1. Is the patient (still) mentally disordered?
2. If so, will there be a substantial risk of serious harm to the patient or others when he leaves hospital if he does not receive the mental health after-care services provided for him?
3. If so, will providing these services under statutory supervision be likely to help to secure that he receives them, so consequentially reducing the risk of serious harm being done?

The legislation therefore caters only for the situation where a substantial risk to the patient or others will arise if he does not receive the proposed after-care services. As to the chain of reasoning, it could have been, but is not, as follows:

1. Is the patient (still) mentally disordered?
2. If so, will there be a substantial risk of serious harm to the patient or others when he leaves hospital?
3. If so, will formally supervising him help to reduce this risk?

A broader set of statutory gr[illegible]ds along these lines would have catered for two additional situations. Firstly, t[illegible] situation where substantial risks exist even if the patient receives the after-care services provided. The risk here is essentially immediate and unconditional, rather than one which will come into being if the after-care services are not received.[30] Secondly, the situation where supervision might be useful as a long-leash, if it included a mechanism for recalling a patient to hospital in any of the circumstances applicable to restricted patients, but not in terms of helping to make compliance with after-care services any more likely.

THE SUPPORTING RECOMMENDATIONS

Supervision applications must be accompanied by two written recommendations in the prescribed form, one provided by a registered medical practitioner and the other by an approved social worker.[31] A registered medical practitioner may at any reasonable time visit a patient and examine him in private for the purpose of deciding whether to make a recommendation.[32] Similarly, an approved social worker may at any reasonable time visit and interview a patient for the same purpose although, in this case, the Act does not specify any right to a private interview.[33] For the purpose of deciding whether to make a recommendation, the visiting doctor or social worker may "require the production of an inspect any records relating to the detention of the patient in any hospital or to any after-care services provided for the patient under section 117."[34]

The medical recommendation

The Act provides that the medical recommendation shall be given by "a registered medical practitioner who will be professionally concerned with the patient's medical treatment after he leaves hospital or, if no such practitioner other than the responsible medical officer will be so concerned, of any registered medical practitioner."[35] The recommendation must include a statement that "in the opinion of the medical practitioner, having regard in particular to the patient's history, all *(three)* of the conditions for making an application are complied with."[36]

The patient's history

The reference to the patient's history is clearly directed towards the phenomenon of "revolving-door patients" and intended to focus attention on the patient's record of compliance with previous after-care arrangements. However, there is no bar on making an application in respect of a patient who has not previously been detained for treatment provided there is evidence upon which the doctor can form the opinion that the statutory grounds exist. For example, the circumstances leading up to the patient's compulsory admission to hospital may demonstrate the existence of a substantial risk of serious harm when he is not in receipt of community psychiatric

30 The presumption here must be that such patients will generally not be suitable for discharge at all, whether supervised or unsupervised.
31 Mental Health Act 1983, s.25B(6), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
32 *Ibid.*, s.25C(3), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
33 *Ibid.*, s.25C(4), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
34 *Ibid.*, s.25C(5), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
35 *Ibid.*, s.25B(6)(a), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
36 *Ibid.*, s.25B(7), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

services. Moreover, his subsequently expressed views about voluntaril[illegible]ccepting after-care may be such that the third of the statutory grounds is also satisf[illegible]

Prohibitions

Section 12, which applies to medical recommendations given in support of an application for admission or a guardianship application, does not apply to supervision applications. Apart from the prohibitions applicable to both recommendations, which are summarised below, the medical recommendation may not be given by the responsible medical officer since he is the applicant.[37] There is no requirement that it is provided by a doctor who is approved under section 12(2) of the Act as having special experience in the diagnosis or treatment of mental disorder. This is because it is presumed that the responsible medical officer will be approved under that section, although such approval is not a necessary condition of being the responsible medical officer.

Code of Practice

Although the Act does not prohibit the medical recommendation from being given by a doctor who works under the direction of the responsible medical officer, the Code of Practice discourages this. It states that the medical recommendation should normally be provided by the doctor who will be the patient's community responsible medical officer when he leaves hospital, unless the applicant himself will be undertaking that function. In the latter case, "if the RMO is unable to identify another doctor who will be involved in the patient's treatment after he or she leaves hospital the recommendation may be made by any other doctor, including a member of the hospital staff (but not one who works under the direction of the RMO)."[38] Nevertheless, if a junior member of the responsible medical officer's team will be the only other doctor concerned with patient's treatment after he leaves hospital, the Act does state that this doctor "shall" provide the recommendation, in preference to a doctor unconnected with the patient.

The social work recommendation

A recommendation provided by an approved social worker must include a statement that "in the opinion of the social worker (having regard in particular to the patient's history)" the second and third of the three grounds of application are complied with.[39] It is therefore the two medical practitioners involved in the application process — the responsible medical officer within the application itself and the doctor providing the supporting medical recommendation — who certify that the first, medical, ground exists.

Conditions and prohibitions applicable to both recommendations

Because section 12 does not apply, it is not necessary that the application and the medical recommendation are based on medical examinations which have taken place

[37] Mental Health Act 1983, s.25C(9)(a), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[38] *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice*, (Department of Health and the Welsh Office, 1996), para. 30.

[39] Mental Health Act 1983, s.25B(6)(b), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

together or, if separately, not m[illegible]an five clear days apart. Nor is it necessary that the application is made within 14 days of the date of the second recommendation. Nor is there any requirement that the application is accepted within fourteen days of it being made, which condition applies to applications for admission though not to guardianship applications. Nor is there any prohibition against the application or medical recommendation being provided by a doctor on the staff of a mental nursing home at which the patient is liable to be detained. Again, no such prohibition applies in the case of guardianship. The result is that the statutory prohibitions are confined to forbidding recommendations being given by persons with a close familial or other interest in the matter. Specifically, a recommendation may not be given[40] —

- by a "close relative" of the patient, the applicant (responsible medical officer), or the person who has provided the other recommendation; *or*
- by a person who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient or a "close relative" of such a person; *and*
- for these purposes, a person's close relatives are his spouse, parents, children and siblings and those individuals married to them.[41]

The Act does not prohibit a responsible medical officer from making an application because he is closely related to the patient or has an interest in payments made on account of the patient's maintenance or is a close relative of someone with such an interest. Secondly, on a strict reading, a person is not prohibited from providing a recommendation because he will or may have a future interest in such maintenance payments when the patient leaves hospital. However, the courts are unlikely to adopt a strict reading on that point since the statutory purpose is clear.

FORM OF THE APPLICATION

The Act provides that a supervision application must *inter alia* state the names of the persons who are to be the patient's "community responsible medical officer" and the "supervisor" when he leaves hospital, and also the names of any primary carers consulted before the application was made.

Documents in support of the application

Section 25B(9) of the 1983 Act provides that, the medical and social work recommendations apart, a supervision application must be accompanied by the documents specified in the following table.[42]

[40] Mental Health Act 1983, s.25C(9), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[41] A relative is a "close relative" if he or she is the "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" of the person concerned: *Ibid.*, s.25C(10), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[42] *Ibid.*, s.25B(9), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

STATEMENTS & DETAILS ACCOMPANYING APPLICATIONS

Community responsible medical officer's written statement	**a.** a statement in writing by the person who is to be the "community responsible medical officer" after the patient leaves hospital that "he is to be in charge of the medical treatment provided for the patient as part of the after-care services provided ... under section 117 ...";
Supervisor's written statement	**b.** a statement in writing by the person who is to be the "supervisor" after the patient leaves hospital that "he is to supervise the patient with a view to securing that he receives the after-care services so provided";
Details of after-care services	**c.** details of the after-care services to be provided for the patient under section 117;
Details of requirements under s.25D.	**d.** details of any requirements to be imposed under section 25D ("essential powers")

The application (Form 1S)

The application must be in the prescribed form. As prescribed, the application is in three parts. Part I is to be completed by the applicant who must certify that in his opinion the statutory grounds for making such an application exist. Part II consists of the statements made by the persons who will be the patient's community responsible medical officer and supervisor when he leaves hospital, acknowledging that they are to undertake these duties. Part III is completed by the Health Authority upon accepting the application. Its acceptance of the application, the fact that the local social services authority was consulted before it was accepted, and the fact that the necessary persons have been notified of its acceptance, must all be recorded here. In this respect, the application form follows the format adopted under the 1959 Act, since the application's acceptance and the patient's admission are recorded on the application rather than by completing a separate document. Although section 25B(9) specifies that a number of additional statements must "accompany" the application, it can be seen that two of these are incorporated within the application form itself. This leaves the details of the after-care services to be attached to the application, which is no doubt normally done simply by appending a copy of the after-care plan to it. The only other requirement imposed by section 25B(9) is that the application made in respect of the patient shall be accompanied by "details of any requirements to be imposed on him under section 25D," what have been referred to as the essential powers. As to this, Part I of the application includes a space to be completed by the responsible medical officer which begins, "I consider that the patient should be subject to the following requirements:– ...." Whether simply completing this part of the application satisfies the statutory requirement is considered below (**439**).

To whom the application is made

A supervision application must be addressed to the Health Authority which will have the duty under section 117 to provide the after-care services for the patient "after he leaves hospital."[43] In practice, it will normally be furnished to the NHS trust responsible for the hospital where the patient is liable to be detained (**453**).

Informing persons that an application is being made

On making an supervision application, the responsible medical officer must inform the interested parties (**425**) of the following matters: that an application is being made; the section 117 after-care services to be provided; any essential powers to be imposed on the patient under section 25D; and the names of the persons who are to be the patient's community responsible medical officer and supervisor after he leaves hospital.[44]

ACCEPTANCE OF APPLICATIONS

The local social services authority which has the corresponding duty to provide after-care must be consulted by the Health Authority before the latter accepts an application for after-care to be provided under supervision.[45] As with guardianship, there is no maximum period within which an application must be accepted.

Informing persons of an application's acceptance

Where Health Authority accepts a supervision application, it must inform the patient, both orally and in writing, that the application has been accepted and of its effect in his case, including what rights he has to apply to a Mental Health Review Tribunal.[46] Any nearest relative or primary carer consulted by the responsible medical officer before making the application must also be informed by the Health Authority of its acceptance. In the case of a nearest relative, this information must be given in writing but need not also be given orally. A primary carer must simply be "informed," so the notification may be oral or written.[47]

Whether an application can be accepted in respect of an informal patient

According to section 25A(1), a supervision application may be made in respect of a patient who is liable to be detained in hospital. This raises the possibility that the application could be accepted after the patient has ceased to be liable to be detained for treatment provided it was made while he was so liable: there is no statutory period within which an application must be accepted. The situation might arise where the patient is discharged from detention under section 3 by his nearest relative or a tribunal before the Health Authority has had sufficient time to consult the local social services authority and decide whether to accept the application. However, the wording of the statute suggests that an application may not be accepted

43 Mental Health Act 1983, s.25A(6), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
44 *Ibid.*, s.25A(10)–(11), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
45 *Ibid.*, s.25A(7), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
46 *Ibid.*, s.25A(8)(a), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.
47 *Ibid.*, s.25A(8)(b) and (c), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

after the patient has left hospital. For example, section 25A(2) states th[illegible] here an application "has been duly made and accepted ... in respect of a patient and he has left hospital, he is ... 'subject to after-care under supervision.'"[48] This implies that the acceptance of the application must precede the patient's leaving hospital, as does section 25A(7). This provides that before accepting a supervision application a Health Authority shall consult the local social services authority which "will" also have the duty to provide after-care to the patient under section 117. If an application could be accepted after the patient had left hospital, the reference would be to the social services authority which "has or will have" that duty. Furthermore, any other construction would be incompatible with the wording of section 25G(1) concerning the duration and renewal of the authority for a patient's supervision. This provides that a patient subject to after-care under supervision shall initially be so subject for the period (a) beginning when he leaves hospital; and (b) ending with the period of six months beginning with the day on which the supervision application was accepted. If a patient on section 17 leave is discharged from liability to detention under section 3 on 1 January, but a supervision application is not accepted until 8 January, any view that the application could be so accepted would mean that he was subject to after-care under supervision during the week prior to its acceptance, which is a nonsense. Section 25G(1) therefore only makes sense if the acceptance of the application must precede the patient leaving hospital. This still leaves open the possibility that a supervision application could be accepted after an in-patient had ceased to be liable to be detained if he then remained in hospital as an informal patient. He would not yet have left hospital.

DEFECTIVE APPLICATIONS AND THEIR RECTIFICATION

A supervision application is of no effect unless the form of mental disorder specified in it by the responsible medical officer (or at least one of them) is also specified in the medical recommendation.[49] Section 25C(6) provides for the rectification of incorrect or defective applications or recommendations during the 14 day period following the application's acceptance. Documents may only be amended with the Health Authority's consent and only by the person who completed the document which is considered to be incorrect or defective in some respect.[50] Where an application or recommendation is duly amended within the statutory period, it has effect as if it had been originally made or given in its amended form.[51]

Defects and errors

Section 25C(6) corresponds to sections 8(4) and 15(1) of the 1983 Act, which allow for the rectification of defective or incorrect applications and recommendations made or given in respect of an application for admission to hospital or reception into guardianship. The view expressed in the *Memorandum* is that defects which 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

[48] Mental Health Act 1983, s.25A(2), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[49] *Ibid.*, s.25C(2), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995. This provision corresponds to that set out in section 11 for other applications, with the necessary caveat that it is the (medical) application and the medical recommendation which must specify a common form of mental disorder.

[50] *Ibid.*, s.25C(6), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[51] *Ibid.*, s.25C(7); as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

delete one or more alternatives [illegible] places where only one can be correct."[52] As with guardianship applications, there is no provision equivalent to subsections 15(2) and (3), which only apply to applications for admission to hospital. These subsections provide that a fresh medical recommendation may be completed during the rectification period where it appears to the managers that one of the two original recommendations, or their combined effect, is insufficient to warrant the patient's detention in pursuance of the application. Consequently, in the case of supervision applications, if the application or a recommendation is insufficient to warrant the patient's supervision, *or* this is the combined effect of the recommendations, *or* of the application considered together with the medical recommendation, a further application or recommendation cannot be obtained during the rectification period. Consequently, the particular application cannot be retrospectively validated.[53]

IMPOSING ESSENTIAL POWERS UNDER SECTION 25D

The requirements specified in section 25D may only be imposed on a patient by both the responsible after-care bodies or by some person or body authorised to act on their behalf.[54] However, the statutory scheme is not as clear as it might be. It has been noted that the requirements which may be imposed under section 25D correspond to the essential powers of a guardian appointed under the Act. In the case of guardianship, these powers arise upon the application's acceptance and are exercisable by the guardian as the need arises.

Statutory references to the requirements

The references in the Act to these requirements are as follows. The responsible medical officer shall not make a supervision application unless he has considered any requirements "to be imposed".[55] If a supervision application is then made by him, it shall be accompanied by details of any requirements "to be imposed" on the patient.[56] On making such an application, the responsible medical officer shall inform the interested parties of the requirements "to be imposed."[57] Where "a patient is subject to after-care under supervision (or, if he has not yet left hospital, is to be so subject after he leaves hospital) "the responsible after-care bodies have power "to

[52] *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 54.

[53] As in the case of guardianship, this reflects the fact that the time which a local social services authority has to scrutinise a guardianship application before accepting it is unlimited. However, in the case of supervised discharge, it is also the case that many of the defects which sections 15(2) and (3) cater for are irrelevant, there being no requirement that the two examining doctors examined the patient not more than five clear days apart; or that at least one of them was approved under section 12(2) of the Act; or that not more than one of them was (except in an emergency) provided by doctors on the staff of the same NHS hospital. Furthermore, since supervision applications are accompanied by, rather than founded on, two supporting recommendations, and do not have to be furnished within 14 days of the second recommendation, it is arguable that (1) where a recommendation is defective, the original application can be resubmitted with fresh, valid, recommendations and (2) where an application is defective a fresh application relying on the same recommendations as before can be submitted. This assumes, of course, that the patient is still liable to be detained.

[54] If an NHS trust has been authorised to act on behalf of the Health Authority in this respect but not by the local social services authority, it will be for that NHS trust and the social services authority to decide whether to impose any of the requirements. If the NHS trust has been authorised by both authorities it can impose the requirements acting alone.

[55] Mental Health Act 1983, s.25B(1)(b) and 25B(4)(b), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[56] *Ibid.*, s.25B(9)(d), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[57] *Ibid.*, s.25B(10) and (11), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

impose" any of the requirements for the purpose of securing that he [illegible] eives the after-care services.[58] Any requirements "imposed" on a patient who is (or who is to be) subject to after-care under supervision shall be kept under review and, where appropriate, modified by the responsible after-care bodies.[59] Where the responsible after-care bodies modify any of the requirements "imposed" on the patient they must inform the interested parties of this fact.[60]

Interpretation of the provisions

Although the responsible medical officer has no power to impose requirements on the patient nevertheless he may not make an application unless he has considered any requirements "to be imposed" on him. If he then makes an application it must be accompanied by details of any requirements "to be imposed" and he must inform the interested parties of the requirements "to be imposed." However, it is only when the application has been accepted that any power to actually impose these requirements, or any others, actually arises and this power is one for the responsible after-care bodies, rather than the responsible medical officer, to exercise. The alternative construction, that the after-care authorities can impose them on a patient who is to be subject to after-care under supervision before an application for him to be so subject is made, and it is these requirements which are being referred to by the responsible medical officer in his application, seems weak. There can be no power to impose anything on the patient until an application in respect of him has been accepted. Nor can it be said that he "is to be subject to after-care under supervision" until an application for him to be subject to after-care under supervision has first been made and accepted. Moreover, the application is not accompanied by details of requirements already imposed on the patient but by requirements which are to be imposed. Bearing these points in mind, the statutory scheme appears to be as follows—

1. The responsible medical officer and the other professionals involved in the patient's case will agree an after-care plan, setting out the services to be provided for him.

2. The responsible medical officer will consider these services in the context of the statutory criteria and form a personal opinion as to whether their provision needs to be reinforced by imposing requirements on the patient under section 25D. However, before actually making any application which might have that effect, he must consult the various other professionals and non-professionals specified in the Act. Furthermore, a community responsible medical officer and a supervisor will need to be found and two supporting recommendations obtained. If the responsible medical officer does proceed, it is likely that there will be broad professional agreement about what requirements are appropriate.

3. If, after all this, the responsible medical officer makes an application, it must be accompanied by details of any requirements which, having consulted the necessary persons and taken their views into account, he considers should be imposed on the patient if the application is accepted.

4. The responsible after-care bodies will then consider whether to accept the application, having regard, *inter alia*, to the information contained within it as to the after-care services to be provided, the perceived risks and benefits, and the requirements which the applicant considers should be imposed by them on the patient if they accept the application.

5. If the Health Authority accepts the application, the responsible after-care bodies will impose any necessary requirements on the patient. These are likely to be the requirements specified in the application, since it was acceptable to them, but not necessarily so. They can be imposed prior to the patient leaving hospital provided that the application has been accepted. For example, a requirement that the patient resides at a hostel may be imposed, so that there is a power to convey him there when the authority to detain him lapses.

AFTER THE APPLICATION'S ACCEPTANCE

The Act provides for certain situations which may or will occur after the application has been accepted and the patient leaves hospital. During the period between the application's acceptance and the day he leaves hospital, the patient is someone who "is to be subject to after-care under supervision after leaving hospital."

THE COMMENCEMENT OF AFTER-CARE UNDER SUPERVISION

Where a supervision application has been accepted in respect of a patient, he becomes subject to after-care under supervision on the day he leaves hospital.[61] If someone other than the persons specified in the application is to be the patient's prospective supervisor or community responsible medical officer, the responsible after-care bodies must inform the interested parties of this change in the arrangements.

The meaning of "leaves hospital"

What constitutes leaving hospital for these purposes is defined in section 25A(9)—

> "**25A.**—(9) Where a patient in respect of whom a supervision application is made is granted leave of absence from a hospital under section 17 above (whether before or after the supervision application is made), references in—
>
> (a) this section and the following provisions of this Part of this Act; and
>
> (b) Part V of this Act,
>
> to his leaving hospital shall be construed as references to his period of leave expiring (otherwise than on his return to the hospital or transfer to another hospital)."

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58 Mental Health Act 1983, s.25D(1), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

59 *Ibid.*, s.25E(1), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

60 *Ibid.*, s.25E(8), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

61 Mental Health Act 1983, s.25A(2), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

Effect of the sub-section

The effect of the subsection is that a patient in respect of whom a supervision application has been accepted only becomes subject to after-care under supervision when he has both left hospital and ceased to be liable to be detained. More particularly—

- A supervision application may be made in respect of a patient who has leave to be absent from hospital under section 17. If so, he does not become subject to after-care under supervision until such time as he ceases to be liable to be detained.
- Similarly, where a supervision application is made in respect of a detained patient who is later granted leave of absence, he does not become subject to after-care under supervision until the day on which he also ceases to be liable to be detained.
- Where, however, a patient is still in hospital on the day he ceases to be liable to be detained, receiving further treatment there as an informal patient, he does not become subject to after-care under supervision until the day on which he does eventually leave hospital.

Who is in charge of the patient's medical treatment

Patients who are *to be* subject to after-care under supervision when they leave hospital, including informal in-patients, have a responsible medical officer but no community responsible medical officer.[62] This is because only a patient who has actually left hospital, as defined above, has a community responsible medical officer.[63] This has the important consequence that, until the patient leaves hospital, only a tribunal has authority to terminate his liability to statutory supervision or to reclassify him. During this interregnum, neither the doctor in charge of his treatment, nor any other person or body, may direct that the patient shall not be subject to supervision upon leaving hospital.

KEEPING THE ARRANGEMENTS UNDER REVIEW

The responsible after-care bodies are required to keep under review and, where appropriate modify, both the after-care services provided under section 117 and any requirements imposed on the patient.[64]

PATIENT REFUSING OR NEGLECTING TO RECEIVE AFTER-CARE

Where a patient who is subject to supervision "refuses or neglects" to receive any or all of the after-care services provided for him, or to comply with any of the

62 The definition of the responsible medical officer in section 34(1)(a) was amended by section 2(1) of, and paragraph 4(3)(b) of Schedule 1 to, the Mental Health (Patients in the Community) Act 1995. It now covers patients who remain in hospital informally following the acceptance of a supervision application. However, that doctor has no statutory functions to perform once the patient has ceased to be liable to be detained so the amendment is superfluous to this extent.

63 See *e.g.* Mental Health Act 1983, ss.25E(9) and 25H(1), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995, and s.34(1), as inserted by s.1(2) of, and Sched. 1 para 4(2) to, the 1995 Act.

64 *Ibid.*, s.25E(1), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

requirements imposed under . essential powers, the responsible after-care bodies must do four things[65]—

a. review the after-care services and any requirements imposed on the patient under section 25D.

b. consider whether it is appropriate to modify any of the after-care services provided or requirements imposed and, having consulted the interested parties (**425**) and taken their views into account, make any modifications which are appropriate.

c. consider whether it might be appropriate for the patient to cease to be subject to after-care under supervision and, if they conclude that it might be, inform the community responsible medical officer.

d. consider whether it might be appropriate for the patient to be admitted to a hospital for treatment and, if they conclude that it might be, inform an approved social worker.

Duty to notify interested persons of any modifications

The responsible after-care bodies must notify the patient and any of the interested parties who were consulted about modifying the after-care services or requirements of any modifications then made (**458**).[66]

CHANGE OF STATUTORY OFFICERS

The interested parties must be informed of any change of supervisor or community responsible medical officer (**459**). This must be done at the time when the patient leaves hospital if the community responsible medical officer or the supervisor is to be someone other than the individuals specified in the application. Similarly, the interested parties must be notified of any subsequent changes. Perhaps surprisingly, the new medical officer or supervisor is not also required to sign a statement of the kind set out in Part H of the application.

APPLICATION OF OTHER PROVISIONS IN PARTS II AND IV

The application to patients receiving after-care under supervision of the reclassification, consent to treatment, transfer, leave of absence, absence without leave, and nearest relative provisions are considered here.

Reclassification

The Act provides that the community responsible medical officer may reclassify a patient who is suffering from a form of disorder other than the form or forms specified in the application.[67] As with other kinds of application, reclassification is

65 See Mental Health Act 1983, s.25E(2)–(7); as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

66 *Ibid.*, s.25E(8), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

67 Mental Health Act 1983, s.25F, as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

automatic if a renewal report specifies a form of disorder other than tha those, specified in the application,[68] and a tribunal may also reclassify the patient.[69] Reclassification other than by a tribunal or at the time of renewal gives rise to a right of application to a Mental Health Review Tribunal (**608**). However, as with guardianship, it has no bearing on the statutory criteria which are applied when the patient is next examined with a view to renewing the authority for a further period.

Consent to treatment

The consent to treatment provisions in Part IV of the Act do not apply to patients who are only subject to after-care under supervision.[70] Accordingly, the patient cannot be given medication or ECT without his valid consent unless justified under common law. He may, however, be required to attend out-patient appointments on a regular basis.

Transfers to hospital or into guardianship

The transfer provisions in Part II do not apply to patients subject to after-care under supervision. It is thus not possible to transfer such a patient to hospital or into guardianship under section 19 and a fresh application is necessary to achieve either of those ends.

Patients moving to Scotland

The situation is governed by The Mental Health (Patients in the Community) (Transfer from England and Wales to Scotland) Regulations 1996, and involves making an application to the sheriff for a community care order.[71]

Leave of absence

The leave of absence provisions in section 17 do not apply to patients who are subject to after-care under supervision and the position is identical to that applicable in guardianship cases (**282**). If the responsible after-care authorities agree to the patient temporarily residing elsewhere, they simply specify the new address as the place where he is required to reside for the time being under section 25D.

Absence without leave

The lack of any specific provisions concerning absence without leave is considered below (**282**).

County court applications under section 29

Because the nearest relative has no power to prevent the making of a supervision application, or to discharge a patient once an application has been accepted, it will

68 Mental Health Act 1983, s.25G(9), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

69 *Ibid.*, s.72(5), as amended by s.1(2) of, and Sched. 1 para. 10(4) to, the Mental Health (Patients in the Community) Act 1995.

70 *Ibid.*, s.56(1).

71 Mental Health (Scotland) Act 1984, s.35A(1), as inserted by Mental Health (Patients in the Community) Act 1995, s.4(1), as substituted by The Mental Health (Patients in the Community) (Transfer from England and Wales to Scotland) Regulations 1996, reg. 3.

be rare for any application to b ade under section 29 for the appointment of an acting nearest relative. Such an application could only be made on one of the "no fault" grounds in section 29(3)(a) or (b) — that is, on the basis that the patient has no identifiable nearest relative or that the person entitled is incapacitated by illness. The duration of the order would need to be specified, otherwise it would normally lapse after three months. The main purpose for applying would be to ensure that there is some individual authorised to exercise any tribunal rights of application under section 66. It may also be noted that where a section 3 patient's nearest relative was previously displaced by the county court under section 29, that order ceases to have effect when the patient ceases to be liable to be detained for treatment.[72] From then onwards, the relative is entitled to be consulted about matters such as the renewal or termination of the authority, unless the usual caveat applies (**456**).

DURATION AND TERMINATION OF SUPERVISION

The Act provides that a patient who leaves hospital subject to after-care under supervision shall initially be so subject for the period of six months beginning with the day on which the supervision application was accepted (<u>not</u> the day on which he leaves hospital as defined above). The authority conferred by a supervision application remains in force until it lapses in the absence of a valid renewal, is terminated by the community responsible medical officer or a tribunal, or is revoked by virtue of the patient being admitted to hospital otherwise than as an informal patient or under section 2 or 4. It will, less commonly, also lapse if the patient has been in custody for a certain length of time. Where a person ceases to be subject to after-care under supervision, the responsible after-care bodies must inform the interested parties.

RENEWING THE AUTHORITY FOR A PATIENT'S SUPERVISION

The renewals framework is similar to that applicable in guardianship cases. The authority conferred by an application lapses after six months unless before then it is renewed for a further period of six months and therefore for further periods of one year at a time. Renewal requires that the community responsible medical officer examines the patient during the final two months of the period of supervision which is drawing to a close and furnishes a report stating that it appears to him that the conditions for renewal ("the renewal criteria") are satisfied. Such reports are furnished to the responsible after-care bodies.[73] The renewal criteria are the same as the original grounds for making a supervision application. As in the case of applications which authorise detention or guardianship, the relevant medical officer is under a statutory duty to furnish such a report if he is of the opinion that the conditions for renewal exist. Similarly, and as with other kinds of application, reclassification is automatic where a renewal report specifies a form of disorder other than that, or those, specified in the application, and a separate report reclassifying the patient need not be submitted.[74]

72 Mental Nealth Act 1983, s.30(4).

73 Not, as with the original application, to the Health Authority alone.

74 *Ibid.*, s.25G(9)–(10), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

Duty to consult and notify other professional and non-professional c[illegible]s

Before furnishing a renewal report, the community responsible medical officer must consult and take into account the views of the following persons: the patient; his supervisor; unless no other person is professionally concerned with the patient's medical treatment, one or more persons who are so concerned; one or more persons who are professionally concerned with the after-care services (other than medical treatment) provided under section 117; any person believed to be a primary carer; and the patient's nearest relative unless the statutory caveat applies (**456**).[75] Where a renewal report is furnished, the responsible after-care bodies must inform the interested parties (the patient and any primary carer or nearest relative consulted before the report was furnished) of that fact.[76]

When the first six month period commences

The initial six month period commences from the day on which the supervision application is accepted, albeit that the patient does not actually become subject to after-care under supervision until he leaves hospital. Consequently, by the time the patient leaves hospital, the authority for his supervision will often have less than six months left to run and may require renewal soon after he leaves. It will be remembered that, in this context, leaving hospital means that the patient has both left hospital and ceased to be liable to be detained there.

Example

X is detained under section 3. The authority for his detention was renewed on 1 January for a period of six months. On 1 February a supervision application in respect of him was accepted by the local NHS trust on behalf of the Health Authority. On 1 April he was discharged from liability to detention under section 3 and left hospital. He therefore became subject to after-care under supervision on that day. The authority for his supervision will lapse after four months, at midnight on 31 July, unless before then it is renewed for a further period of six months.

Patients who do not leave within six months of the application's acceptance

It is quite possible that a patient does not leave hospital in the statutory sense during the six month period following the application's acceptance. The question arises whether the authority for his supervision may be renewed before he has become subject to after-care under supervision. Having regard to the renewal process set out in section 25G, it would appear not. This is because subsection (1) provides for renewing the authority to supervise a patient who is, rather than who is to be, subject to after-care under supervision; and subsection (2) refers to renewing the authority of a patient "already" subject to after-care under supervision for a second period of six months. Furthermore, unless and until the patient has ceased to be liable to be detained and is subject to after-care under supervision, it will be impossible to conduct the consultations which are necessary before a renewal report can be furnished.

[75] Mental Health Act 1983, s.25G(5), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

[76] *Ibid.*, s.25F(8), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

In particular, no one will be [illegible]essionally concerned with the after-care services provided under section 117 (as opposed to those to be provided). Indeed, the patient does not yet have a supervisor or even a community responsible medical officer who could furnish such a report.

Examples

X is detained under section 3. The authority for his detention was renewed on 1 January for a period of 12 months. On 1 February a supervision application in respect of him was accepted by the local NHS trust on behalf of the Health Authority. The authority for him to be subject to after-care under supervision when he leaves hospital will cease at midnight on 31 July unless it is renewed for a further period of six months. Accordingly, if he is still in hospital or is still liable to be detained, on that date, the authority conferred by the supervision application will lapse. A further application will then be necessary.

On 1 March, the patient was granted extended leave of absence under section 17. This does not constitute leaving hospital for the purposes of the supervision provisions and the patient does not become subject to after-care under supervision on that date. The leave of absence granted under section 17 may continue for the remainder of the 12 month period of liability to detention which began on 1 January: until 31 December. However, if it continues beyond 31 July then, unless a fresh supervision application is made, there will be no authority to supervise the patient upon his eventually "leaving" hospital. Renewal of the supervision application accepted on 1 February is not possible, since the patient has not yet become subject to after-care under supervision.

Example 2

If the patient in the above example was not granted leave of absence but, following the supervision application's acceptance, he was discharged from liability to detention under section 3 on 1 April, and he then remained in hospital as an informal patient, the position would be as follows. The authority conferred by the supervision application would lapse unless he had left hospital by midnight on 31 July. So, for example, if he remained in hospital as an informal patient until 15 August, there would by then be no authority to supervise him.

Delaying acceptance of the application

Having regard to the above, Health Authorities will no doubt consider delaying acceptance of an application until immediately before the patient is ready to leave hospital. However, they will need to balance this consideration against the possibility of the patient being unexpectedly discharged from liability to detention before then by his nearest relative, a tribunal, or by the managers of the NHS trust. The Act does not preclude accepting an application made many months previously, nor therefore one based on examinations and consultations conducted many months previously. However, it remains to be seen whether any such acceptance might be judicially reviewable if there was evidence before the Health Authority of a subsequent material change in the patient's condition, or a change in the opinions of those previously consulted, which it took no account of before accepting the application.

Absence without leave

If a patient who is subject to after-care under supervision absents himself from the place where he is required to reside by the responsible after-care bodies, he is as a matter of logic absent from there without leave. However, section 18, which provides that a patient does not cease to be liable to be detained or subject to guardianship until he has been absent for at least six months, does not apply to supervised patients. Nor does any person appear to be authorised to take him into custody under section 18 or 138.[77] Nor do sections 21 and 21A apply. They provide for the retrospective renewal of the authority conferred by an application where an absent patient is returned after the date on which the authority for his detention or guardianship would ordinarily have expired. Accordingly, if it is impossible to renew the authority for a patient's supervision for a further period, because he is absent during the final two months of the period of supervision which was in force when he went absent, he ceases to be so subject at the expiration of that period. Whether these omissions are deliberate, or instead represent a significant oversight on the draftsman's part, is unclear.

Examples

X was detained under section 3 on 1 January. On 1 February a supervision application in respect of him was accepted by the local NHS trust on behalf of the Health Authority. On 1 March he ceased to be liable to be detained and left hospital, taking up residence at a local hostel in accordance with a requirement imposed on him by the responsible after-care bodies. The authority for his supervision, including authority to require him to reside there, will cease at midnight on 31 July unless it is renewed for a further period of six months. This requires that the community responsible medical officer examines him during June or July and furnishes a report renewing the authority for a further six-month period. X absents himself from the hostel on 15 May, not being located or returning there until 10 August. The authority conferred by the supervision application has lapsed. He can longer be required to reside there unless a guardianship application is made.

Example 2

X was detained under section 3 on 1 January. The authority to detain him will ordinarily expire at midnight on 30 June unless renewed for a further period. On 1 February a supervision application in respect of him was accepted by the local NHS trust on behalf of the Health Authority. The authority for him to be subject to after-care under supervision when he eventually leaves hospital will cease at midnight on 31 July unless it is renewed for a further period of six months. On 15 April he absents himself from hospital without leave. Although the authority for his detention can be renewed if he is taken into custody at any time before midnight on 14 October (**292**), the authority for his subsequent supervision will lapse if he is not returned by 31 July. A fresh supervision application will therefore be necessary if he is taken into custody and returned to hospital during the period from 1 August until 14 October.

77 Although not specifically an absence without leave provision, s.25D(4) could be used by the supervisor, or by a person authorised by him, such as a police constable, to take and convey an absent patient to the required place. However, it does not appear that a police constable may take an absent supervised patient into custody unless authorised to do so by the supervisor.

Effect of a subsequent application or order under the 1983 Act

The authority conferred by a supervision application is revoked if the patient is admitted to hospital for treatment under section 3, *or* in pursuance of a hospital order or transfer direction, *or* he is received into guardianship in pursuance of a guardianship application or order.[78] The interested parties must be informed that the patient has ceased to be so subject (**459**).[79] Admission as an informal patient, or under section 2 or 4, does not have the effect of terminating the after-care under supervision, nor does admission under sections 35, 36 or 38.

Detention under section 2

While a patient who is subject to after-care under supervision is detained under section 2 he is not required during this period to receive any after-care services provided for him under section 117 or to comply with any requirements previously imposed on him under section 25D.[80] If the patient would ordinarily have ceased to be subject to after-care under supervision during the period he is detained under section 2, or during the 28 day period beginning with the day he ceases to be detained under that provision, he does not cease to be so subject until 28 days have expired from the time he ceased to be detained under section 2.[81] Any renewal report furnished during this extended period is valid and, where necessary, may have retrospective effect.

Example

On 1 January a supervision application made in respect of X, a patient detained under section 3, was accepted by the local NHS trust on behalf of the Health Authority. On 1 March he ceased to be liable to be detained and left hospital, at which point he became subject to after-care under supervision. The authority for his supervision was renewed for a further period of six months commencing on 1 July. This authority will ordinarily expire on 31 December unless before then it is renewed for a further period of twelve months. Renewal requires that the community responsible medical officer examines him during November or December and furnishes a report renewing the authority.

On 25 November, and before any such report has been furnished, X is admitted to hospital under section 2. He is discharged from liability to detention under section 2 on 18 December. His community responsible medical officer then has 28 days — until midnight on 14 January — within which to examine the patient, consult the necessary persons, and furnish a report renewing the authority for the patient's supervision. Thus, if he furnishes such a report on 8 January, it has retrospective effect and the authority for the patient's supervision is thereby renewed for a period of 12 months beginning on 1 January. If no report has been furnished by midnight on 14 January, the patient ceases to be subject to after-care under supervision at that time.

78 Mental Health Act 1983, ss.25H(5), 40(4), 55(4), 145(3), Sched. 1 Pt. I para. 1, as inserted by s.1(1) and (2) of, and Sched. 1 para. 6(a) to, the Mental Health (Patients in the Community) Act 1995.

79 *Ibid.*, s.25H(6), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995.

80 *Ibid.*, s.25I(1)(b) and (2), as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995. The same presumably applies to patients admitted under sections 4, 35, 36 and 38.

81 *Ibid.*, s.25I(3)–(5), as inserted by Mental Health (Patients in the Community) Act 1995, s.1(1).

Patients taken into custody (prison)

The authority to supervise a patient may similarly be extended, and retrospectively renewed, if he is taken into custody in pursuance of a sentence or order passed by a court within the United Kingdom, including an order remanding him in custody. If the patient is released from custody before he has been in custody for a period of six months and during that period, or within 28 days of his release, he would ordinarily have ceased to be subject to supervision because of a failure to renew the authority for a further period, he nevertheless continues to be subject to after-care under supervision for a period of 28 days beginning with the date of his release from custody. Any renewal report which is furnished during this extended period has effect as if it had been furnished during the final two months of the period of supervision which was in force when the patient was taken into custody.[82]

Example

X was detained under section 3 on 1 January. On 1 February, a supervision application in respect of him was accepted by the local NHS trust on behalf of the Health Authority. On 1 March he ceased to be liable to be detained and left hospital, thereby becoming subject to after-care under supervision. The authority for his supervision will ordinarily cease at midnight on 31 July unless it is renewed for a further period of six months.

On 1 April he is charged with burglary and remanded in custody. He is released after five months, on 1 September. He remains subject to supervision for a further 28 days, until midnight on 28 September. If no renewal report is furnished before then he ceases to be subject to after-care under supervision at that point. If, however, a renewal report is furnished during that period it has retrospective effect. Thus, a report furnished on 14 September will renew the authority for the patient's supervision for a period of six months commencing on 1 August.[83]

DIRECTING THAT THE AUTHORITY CEASE TO HAVE EFFECT

Although many of the provisions which apply to patients subject to after-care under supervision mirror the pre-existing guardianship provisions, the discharge powers differ. Following the acceptance of a supervision application, the authority to supervise the patient is not dischargeable by the responsible medical officer; the managers of the hospital at which he is liable to be detained or residing; the Health Authority; the local social services authority; the nearest relative; the Secretary of State. Thus, neither the patient's nearest relative nor the responsible after-care bodies have power to terminate the supervision. Apart from the patient's community responsible medical officer, only a tribunal may direct that a patient subject to after-care under supervision shall cease to be so subject. Moreover, until the patient leaves hospital and the supervision actually commences, *only* a tribunal may

[82] Mental Health Act 1983, s.25I, as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995. Note that, in contrast to section 22, a patient whose supervision was last renewed for a period of 12 months does not automatically cease to be subject to after-care under supervision by virtue only of the fact that he has been in custody for more than six months.

[83] It may briefly be noted that section 25I does not provide for double renewals or for double retrospective renewals of the kind found in section 21B6(b) and (7). See p.297 for an illustration of the point.

terminate his liability to supervision. Furthermore, until then, the Secretary of State has no power to refer his case to a tribunal. And, once the patient has left hospital, if the responsible after-care bodies review the after-care arrangements and any requirements imposed on him, and conclude that statutory supervision is no longer justified, their only available course of action is to notify the community responsible medical officer of their opinion (**442**).

Direction by the community responsible medical officer

The responsible community medical officer may at any time direct that a patient subject to after-care under supervision shall cease to be so subject.[84] Such a direction is equivalent to an order for discharge under section 23 in respect of a patient who is liable to be detained or subject to guardianship. However, before giving any such direction, the community responsible medical officer must first consult the same classes of professional and non-professional persons as must be consulted before a supervision application is renewed for a further period and take their views into account (**459**).[85] Where a direction terminating the statutory supervision is given, the responsible after-care bodies (not the community responsible medical officer) must inform the interested parties of this fact (**459**).[86] There should therefore be written evidence of the fact that a direction has been given, although the Act does not expressly provide that such a direction itself must be in writing.

Discharge by a Mental Health Review Tribunal

Following the application's acceptance, the patient's rights to apply to a tribunal, and the tribunal's powers, are similar to those in cases involving guardianship. And, as with guardianship cases, there is no duty to periodically refer the patient's case to a tribunal if no application has been made for a certain period of time.

Rights of application

The patient's rights of application correspond to those of a patient subject to guardianship. However, the nearest relative's rights are more limited that those of the nearest relative of a patient subject to a guardianship order. As can be seen from the table on the following page, the patient may in many cases prevent his nearest relative from acquiring a right to make an application to a tribunal in respect of him. To this extent, and quite uniquely in the overall context of the Act, the nearest relative's rights are rights subject to the patient's discretion, rather than absolute rights vesting in the relative by virtue of his relationship to the patient.

Tribunal's powers

Where a tribunal considers the case of an in-patient in respect of whom a supervision application has been accepted, the tribunal must direct that the application shall cease to have effect if they are satisfied that the grounds for making such an application "are not complied with" (**508**). If not satisfied as to this, the tribunal may still revoke the application at its discretion (as in guardianship cases) and, where it does not direct that the application shall cease to have effect, reclassify the patient.

[84] Mental Health Act 1983, s.25H(1), as inserted by Mental Health (Patients in the Community) Act 1995, s.1(1).

[85] *Ibid.*, s.25H(2)–(4), as inserted by Mental Health (Patients in the Community) Act 1995, s.1(1).

[86] *Ibid.*, s.25H(6) as inserted by s.1(1) of the Mental Health (Patients in the Community) Act 1995. It appears to be assumed that the CRMO will notify these bodies that he has directed that the patient shall cease to be subject to after-care under supervision.

Where a patient has left hospital, and so is receiving after-care under supervision, the position is essentially the same, except that the duty to revoke the application arises if the tribunal are satisfied that the criteria for renewing supervision applications are not complied with. However, apart from minor and inconsequential modifications, the renewal criteria are the same as the original grounds for making a supervision application.

TRIBUNAL RIGHTS OF APPLICATION

Right of application	*Who may apply*	*When they may apply*
• **Following the acceptance of a supervision application made under s.25A (s.66(1)(ga).**	*The patient or, subject to the note below, his nearest relative*	During the six-month period beginning with the date of the application's acceptance.
• **Following the furnishing of a report under s.25F reclassifying the patient (s.66(1)(gb)**	*The patient or, subject to the note below, his nearest relative*	During the 28 day period beginning with the day on which the applicant is informed the report has been furnished.
• **Following the furnishing of a report under s.25G renewing the authority for the patient's supervision for a further period (s.66(1)(gc)**	*The patient or, subject to the note below, his nearest relative*	During the additional six or twelve month period of supervision authorised by the report.

Notes concerning the nearest relative: In each case above, the nearest relative only has a right to make an application if he has been, or was entitled to be, informed under the Act of the application's acceptance or, as the case may be, that a report renewing the authority or reclassifying the patient has been furnished. If the patient requests that the nearest relative not be informed of his reclassification, the nearest relative is not entitled to be informed. If the patient requests that the nearest relative not be consulted about whether a supervision application should be made or renewed, that relative will not be consulted unless the patient has a propensity to violent or dangerous behaviour and the medical officer in charge of his treatment considers that consultation is appropriate. Unless this caveat applies, the nearest relative is not entitled to be consulted unless he is also one of the patient's primary carers (456). If the nearest relative is not entitled to be consulted about whether an application should be made, or the authority renewed, then neither is he entitled to be informed that such an application or authority has been made or renewed. Consequently, he has no right to apply to a tribunal upon the application being accepted or the authority conferred by it renewed.

MENTAL HEALTH ACT COMMISSION

Patients subject to after-care under supervision do not fall within the Commission's remit. However, patients in respect of whom a supervision application has been accepted, but who remain liable to be detained, will come within the Commission's jurisdiction for so long as they remain liable to be detained for treatment. The Act provides that the Code of Practice shall include guidance on after-care under supervision.

DELEGATION AND CONSULTATION

This final section of the chapter deals with two important but technical areas, the delegation of statutory functions and the extent of the duty to consult various interested parties before exercising some statutory power.

DELEGATION OF FUNCTIONS

As has been noted, section 32 of the 1983 Act provides that the Secretary of State may make regulations for carrying Part II of the Act into full effect. The regulations may in particular determine the manner in which the functions under Part II of the hospital managers, local social services authorities, Health Authorities and National Health Service Trusts are to be exercised. They may also specify the circumstances in which, and the conditions subject to which, "any such functions" may be performed by officers of, or other persons acting on behalf of, those managers and authorities.[87]

The Mental Health (After-care under Supervision) Regulations 1996

The Mental Health (After-care under Supervision) Regulations 1996 have been made under section 32 and they came into force on 1 April 1996.[88] They provide that functions under what are referred to as the "relevant provisions" may in the circumstances prescribed be performed by some other body or person on behalf of a Health Authority or local social services authority.[89] The "relevant provisions" are those set out in Schedule 1 to the regulations.[90]

SCHEDULE 1 Regulation 2(1)

PROVISIONS OF THE ACT CONFERRING FUNCTIONS ON HEALTH AUTHORITIES AND LOCAL SOCIAL SERVICES AUTHORITIES

(1) Provision of the Act	*(2) Subject matter*
Section 25A(6), (7) and (8)	Supervision applications— acceptance etc.
Section 25C(6)	Supervision applications—consent to amendment
Section 25D(1)	Imposition of requirements
Section 25E(1), (3), (4), (6), (8) and (11)	Review and modification of requirements imposed
Section 25F(1) and (4)	Receipt of reclassification report
Section 25G(3) and (8)	Receipt of renewal report and notification
Section 25H(6)	Ending of after-care under supervision and notification

87 Mental Health Act 1983, s.32(3).
88 The Mental Health (After-care under Supervision) Regulations 1996 (1996 No. 294).
89 *Ibid.*, reg. 2.
90 *Ibid.*, reg. 2(1).

Functions the performance of which cannot be delegated

Regulation 2 expressly provides that nothing in the regulations shall permit a Health Authority or local social services authority to authorise a person or body to exercise the relevant functions under section 25E(1) and (3) of the 1983 Act so far as they relate to review and modification of after-care services provided (or to be provided) to a patient under section 117.[91] What this means is that the health and local social services authorities must themselves review and where necessary modify the after-care services being provided under section 117. They may, however, in the circumstances prescribed by the regulations, authorise another body or a person not employed by them to undertake the process of reviewing and modifying any essential powers previously imposed under section 25D. Thus, the regulations separate out the processes of reviewing and modifying the after-care services comprised in the after-care plan (which may not be delegated) and of reviewing and modifying the way in which the new statutory powers are being exercised to secure the receipt of those services (which may be delegated).

Who may be authorised to perform one of the relevant provisions

Subject to the above caveat, the regulations authorise the making by a health or local social services authority of the following arrangements with regard to the performance of those functions referred to in the "relevant provisions" —

1. A Health Authority may "make arrangements" for its functions under the relevant provisions to be exercised on its behalf by an officer of that authority or by a committee or sub-committee of that authority.[92]

2. A Health Authority may "make arrangements" for its functions under the relevant provisions to be exercised on its behalf by another Health Authority; or by an officer, committee or sub-committee of another Health Authority, including a Special Health Authority; or for their exercise by a joint committee or joint sub-committee of the Health Authority and another Health Authority.[93]

3. A Health Authority which "makes an arrangement" with an individual, an NHS trust, or some other person or body such as a voluntary organisation, for the provision of psychiatric and related services to the patient may also "authorise that person or body to perform on its behalf its functions under the relevant provisions" in respect of him.[94]

91 The Mental Health (After-care under Supervision) Regulations 1996, reg. 2(5).
92 The Mental Health (After-care under Supervision) Regulations 1996, reg. 2(3); National Health Service Act 1977, s.16, as substituted by s.2(1) of, and Sched. 1 para. 7 to, the Health Authorities Act 1995. The term "an officer" means an employee.
93 The Mental Health (After-care under Supervision) Regulations 1996, reg. 2(3); National Health Service Act 1977, s.16, as substituted by s.2(1) of, and Sched. 1 para. 7 to, the Health Authorities Act 1995. A Health Authority does not appear to have authority to make arrangements for its functions under the relevant provisions to be exercised by a joint-committee of the Health Authority and a local social services authority.
94 The Mental Health (After-care under Supervision) Regulations 1996, reg. 2(2); National Health Service and Community Care Act 1990, s.4; National Health Service Act 1977, s.23.

4. Where the Health Aut... ity has authorised or arranged for its statutory functions under the relevant provisions to be exercised by some other some person or body, the local social services authority with the corresponding duty under section 117 to provide the patient with after-care services "may authorise the same person or body to perform all of" its functions under the relevant provisions in respect of him."[95]

Summary

The intention behind the regulations is to enable statutory powers and duties which specifically relate to the element of statutory supervision in a patient's after-care plan, rather than to the provision or delivery of those services, to be exercised on behalf of the responsible after-care bodies by some agreed person or body. While Health Authorities will no doubt routinely delegate the exercise of these functions to NHS trusts from which they have purchased health services, it must be emphasised that a local social services authority is not obliged to follow suit — it is merely lawful for it to do so. Indeed, many social services authorities may wish to retain joint control with the NHS trust in relation to the way in which any essential powers under section 25D are imposed and modified.

DUTIES TO CONSULT AND NOTIFY OTHER PERSONS

When contrasted with applications for guardianship under Part II, a noteworthy feature of the statutory framework for after-care under supervision is that many powers are solely vested in the responsible medical officer or, once the patient leaves hospital, the community responsible medical officer. The acceptance of an application does not require the consent of the patient's statutory nearest relative or the local social services authority and they have no power to later terminate the authority. In part compensation for this, the Act imposes an extensive range of duties on those doctors (and others) to consult various interested parties before exercising any statutory power, to take their views into account, and to notify them of any statutory steps which are then taken. These duties are set out on page 458.

The basic framework

The basic framework may be summarised in the following way—

- Where a statutory power is one for the medical practitioner in charge of the patient's treatment to exercise and involves the authority for after-care under supervision (making an application, furnishing a renewal report, terminating the supervision), he must consult a range of professionals and non-professionals (the interested parties) involved in the case before exercising it.

- Where the exercise of a statutory power is vested in both responsible after-care bodies (modifying the after-care services or any essential powers imposed under section 25E), the statute only imposes a duty to consult relevant non-professionals (the interested parties). Such collective professional decisions mean that the professionals involved are doing the consulting rather than being consulted.

95 The Mental Health (After-care under Supervision) Regulations 1996, reg. 2(4).

- Upon a statutory power being exercised, whether by the docto[illegible] [illegible]charge of the patient's treatment or by the after-care bodies, the duty is to inform the relevant non-professionals (the interested parties) of this fact, it being assumed that persons professionally involved will be notified as a matter of course. The basic rule of thumb is that if an interested party was consulted before the particular step was taken he must also be informed if it is then taken.[96]

The nearest relative's right to be consulted and kept informed

The general rule is that, unless the nearest relative is also a primary carer, he generally need not be consulted about some proposed statutory step if the patient objects to that. However, if the doctor in charge of the patient's treatment is of the opinion that he has a propensity for violent or dangerous behaviour towards others and, by virtue of this, it is appropriate to consult the relative about the step in question then that person may be consulted.

When the caveat does not apply

The caveat represents a recognition that the relative may be a potential victim of the feared behaviour and so should be consulted and kept informed about the supervisory process. However, it does not apply in two situations. The patient's right to "request" that his nearest relative is not informed of any reclassification is not qualified in this way. Consequently, the relative's right to apply to a tribunal following reclassification becomes one exercisable only with the patient's consent. This represents a departure from the position in respect of detained patients and those subject to guardianship. Here, the nearest relative's right to be told of any reclassification, and to then apply to a tribunal, is a personal one: it is his right and not one for the patient to grant. The second exception is that where the patient's community responsible medical officer or supervisor changes, the Act simply provides that the nearest relative shall be informed of this unless the patient has requested otherwise. Accordingly, if the caveat would apply on the facts, the absurd position is reached that patient cannot prevent the nearest relative from being informed of who is to be the community responsible medical officer and supervisor when the application is made, but can prevent him being told that they are no longer performing those duties. This must be a drafting error so that, under the "golden rule" of statutory construction, the caveat may be read as applying here also.

Whether doctors must personally undertake statutory consultations

The Code of Practice states that the responsible medical officer and, by implication, the community responsible medical officer is not obliged to personally undertake all consultations but the responsibility should be delegated only with his express agreement.[97] No authority is given for this statement and, indeed, the Act does not itself authorise delegating the statutory duty to another person, such as a junior

[96] Strictly speaking, if it was not practicable to consult the nearest relative about some proposed step before the event it is not then necessary to notify him that it has been taken after the event, even though that would be practicable.

[97] *Mental Health (Patients in the Community) Act 1995: Guidance on Supervised Discharge (After-care under supervision) and related provisions. Supplement to the Code of Practice* (Department of Health and the Welsh Office, 1996), para. 5.

doctor or administrator.[98] In the a[illegible]nce of an express provision of the kind found in section 5(3), the customary view has always been that a responsible medical officer may not delegate the performance of his statutory functions. For example, he must personally examine the patient and furnish statutory reports required under section 20 and 58, and only he within the medical team has authority to discharge a patient or grant him leave of absence under section 17. Likewise, he must personally consult another person professionally involved in the patient's medical treatment before furnishing a renewal report or a report reclassifying him. In the absence of any express provision to the effect that the duties vested in him may be undertaken by another individual not specified by Parliament, it must therefore be assumed that the same principles apply. Accordingly, the responsible medical officer must, likewise, personally consult his professional colleagues before making a supervision application, renewing it, or terminating it. Otherwise the personal exercise of the powers vested in him by Parliament becomes divorced from the personal duties imposed on him by Parliament, by which the exercise of those powers is kept in check. And, if he must conduct professional consultations personally, there appears to be no logical reason why the non-professionals are only entitled to be consulted vicariously. Indeed, the extensive nature of the duty to consult others reflects the concentration of several powers in a single pair of hands, counter-balances this, and compensates persons such as the nearest relative for their relatively limited statutory rights. Often, these rights consist *only* of this right to be consulted by the person who is contemplating exercising one of his powers. While the need to conduct a series of consultations is time-consuming — and the understandable unpopularity of the prospect with some consultants appears to have been the motivation for the advice in the Code — there is nevertheless nothing in the Act to support such a view. It involves reading every reference to the medical officers in charge of a patient's treatment as referring not in fact to them but to them or any authorised person: that is not what the Act says. Indeed, if professional convenience is allowed to dictate such an interpretation, the ambit of many other protective provisions would be thrown into doubt, with significant consequences for the liberty of the subject. Approved social workers might claim that their corresponding statutory duty to consult the nearest relative before making an application is satisfied if vicariously performed. And a similar latitude might be claimed in respect of consulting others before renewing a patient's detention, reclassifying him, or authorising compulsory treatment under section 58. Better therefore to emphasise that the law requires consultants who are over-worked to distinguish between their statutory and non-statutory duties, when deciding what duties may properly be delegated to junior members of their team.[99]

[98] Nor do the regulations provide for such a delegation of his statutory functions. Indeed, it is noteworthy that while section 34(2)(e) and (3) allow for the performance by a third party of the statutory functions of nearest relatives, and the delegation of functions vested in the hospital managers, local social services authorities, and NHS trusts, no such provision is made in respect of the responsible medical officer's functions.

[99] Support for a counter-argument derives from dicta of Laws J. in *R. v. South Western Hospital Managers, ex p. M.* [1994] All E.R. 161 at 175–176, where His Lordship said that an approved social worker's duty to consult the nearest relative before making a section 3 application could be performed vicariously. Since part of that decision has since been overruled, there are difficulties with other parts of it (**593**), and no reasons were given for the opinion expressed there, it is submitted that the conventional view about an approved social worker's duties being personal should be adhered to until the courts firmly decide otherwise.

CONSULTATION AND NOTIFICATION OF INTERESTED PARTIES

Provision	Subject matter	The duty to consult or notify
S.25B(1)–(3)	• **Consultation prior to making an application**	The RMO shall consult the patient; one or more persons who have been professionally concerned with the patient's medical treatment in hospital; one or more persons who will be professionally concerned with the after-care services to be provided under s117; any person whom he believes will be a primary carer after the patient leaves hospital; where practicable , the person (if any) appearing to be the nearest relative unless the patient has requested otherwise. and neither of the following caveats apply. The first caveat is that the patient has a propensity to violent or dangerous behaviour towards others and the RMO considers it is appropriate to take such steps as are practicable to consult that relative about making an application. The second caveat is that the nearest relative will also be a primary carer and so, despite the patient's wishes, is entitled to be consulted in that capacity.
S.25B(10)–(11)	• **Notification that an application has been made, etc.**	The RMO shall inform the following persons that he had made an application: the patient (orally and in writing); any nearest relative (in writing) and primary carer (not specified) consulted before it was made. The persons notified shall also be informed of the after-care services to be provided for the patient, of any essential powers to be imposed on him; and of the persons who are to be his CRMO and supervisor.
S.25A(7)	• **Consultation before an application is accepted**	Before accepting an application, the Health Authority must also consult the local social services authority which constitutes the other responsible after-care body.
S.25A(8)	• **Notification of the application's acceptance**	The Health Authority shall inform the patient (orally and in writing), any person whom the RMO stated in the application was consulted before it was made as a primary carer (not specified) or nearest relative (in writing). The patient must also be informed orally and in writing of the application's effect, including his rights of application to a Mental Health Review Tribunal. Strictly speaking, there is no similar statutory duty to inform the local social services authority of the application's acceptance.
S.25E(1)–(7)	• **Consultation about modifying the after-care services or essential powers**	The responsible after-care bodies must first consult the following persons about the proposed modifications: the patient; any person whom they believe is a primary carer; where practicable, the person (if any) appearing to be the nearest relative unless, subject to the same caveats as before, the patient has requested otherwise. The first caveat in this context is that the patient has a propensity to violent or dangerous behaviour towards others and the RMO (or the person who is to be the CRMO) considers that it is appropriate to take such steps as are practicable to consult that relative about the modifications.
S.25E(8)	• **Notification of modifications to the after-care services or essential powers**	The responsible after-care bodies shall inform the following persons of the modifications: the patient (orally and in writing); a... nearest relative (in writing) and primary carer consulted before they were made.

Provision	Subject matter	The duty to consult or notify
S.25E(9)–(11)	• **Notification of change of CRMO or supervisor**	Where at the time the patient ceases to be liable to be detained a person other than those named in the application becomes the CRMO or supervisor, or at a later date some other person assumes one or both of those roles, the responsible after-care bodies shall notify the following persons of the name of the person assuming the role: the patient (orally and in writing); any person whom the bodies believe is a primary carer; where practicable the person (if any) appearing to be the nearest relative unless the patient has requested otherwise (in writing). The first caveat previously referred to does not apply in this case.
S.25F(1)–(3)	• **Consultation prior to any reclassification**	Unless no other person is professionally concerned with the patient's medical treatment, the CRMO shall before furnishing a report reclassifying a patient consult one or more persons who is so concerned.
S.25F(4)	• **Notification of reclassification**	Where a report reclassifying a patient is furnished, the responsible after-care bodies shall notify the following persons of this fact: the patient (orally and in writing); where practicable, the person (if any) appearing to be the nearest relative unless the patient has requested otherwise (in writing). Both of the caveats previously referred to do not apply and there is no duty to inform a person believed to be a primary carer since he has no right to a tribunal following reclassification.
S.25G(1)–(7)	• **Consultation prior to furnishing a renewal report**	Before considering whether the statutory grounds exist for renewing the authority conferred by a supervision application, the CRMO shall consult the following persons: the patient; the supervisor; unless no other person is professionally concerned wi[th] the patient's medical treatment, one or more persons who is so concerned; one or more persons who are professionally concerne[d] with the section 117 after-care services (other than medical treatment); any person whom the CRMO believes is a primary carer; where practicable the person (if any) appearing to be the nearest relative unless, subject to the same two caveats as before, the patient has requested otherwise. The caveat is that the patient has a propensity to violent or dangerous behaviour towards others and the RMO considers that it is appropriate to take such steps as are practicable to consult that relative about renewing the authority.
S.25G(8)	• **Notification of renewal of the authority**	Where the CRMO furnishes a renewal report, the responsible after-care bodies shall notify the following persons of this fact: the patient (orally and in writing); any nearest relative (in writing) and primary carer (not specified) consulted before it was made. The patient shall also be informed of the also be informed orally and in writing of the renewal report's effect, including his rights of application to a Mental Health Review Tribunal.
S.25H(1)–(5)	• **Consultation about the ending of after-care under supervision**	The CRMO shall not direct that a patient shall cease to be subject to after-care under supervision unless he has first consulted the same classes of persons who must be consulted prior to any renewal and has taken any views expressed by them into account. The caveats concerning the need to consult the nearest relative similarly apply.
S25H(6)–(7)	• **Notification of the ending, cessation or expiration of after-care under supervision**	Where the CRMO directs that a patient shall cease to be subject to after-care under supervision, or the patient ceases to be so subject for any other reason, the responsible after-care bodies shall notify the same persons of this fact as must be notified of any report renewing the authority for a further period. That is to say the patient (orally and in writing); any nearest relative (in writing) or primary carer consulted before it was made.

A tribunal's powers