

Chapter 11

COMPULSORY ADMISSION TO HOSPITAL AND GUARDIANSHIP UNDER PART II

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A. PROCEDURE FOR HOSPITAL ADMISSION

11.01 Framework for Compulsory Admission

This chapter concerns applications for compulsory admission to hospital and guardianship under Part II of the Mental Health Act 1983. The chapter must be read as an integral part of this text; reference should also be made to the summary of procedural requirements to be found in Appendix E. The framework for compulsory admission under the Act can be viewed in stages; with each stage greater powers can be exercised over the patient. Before a duly completed application under Part II is made the approved social worker (ASW) and doctors have

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no special power to gain access to the patient for interview or examination, for example by restraining the patient or trespassing. (See para. 21.13 *post.*) If access to premises is required for this purpose then the ASW should obtain a warrant to search for and remove the patient under section 135(1). (See para. 21.16.1 *post.*)

A duly completed application for compulsory admission under Part II must be made by the nearest relative (see chap. 8) or ASW (see chap. 7) (s. 11(1)), founded upon one or two medical recommendations. The effect of a duly completed application is to give authority for the applicant, or any person authorised by him, "to take the patient and convey him to hospital" at any time within 14 days of the date the patient was last examined by a doctor giving a medical recommendation; or, in the case of an emergency application (s. 4), 24 hours from the time he was medically examined (s. 6(1)). If the patient escapes during the period when he could be conveyed to hospital, he can be retaken (ss. 137, 138). (See para. 21.17 *post.*)

It is only when the managers admit the patient to hospital that he becomes liable to be detained for the period specified in Part II—*i.e.* 72 hours (s. 4), 28 days (s. 2), or six months subject to periods of renewal (s. 3). Once a person is liable to be detained he can be retaken within a period of 28 days if he escapes (s. 138) or is absent without leave (s. 18). (See para. 21.18 *post.*) If forcible entry to premises is required to re-capture a person already liable to be conveyed or detained a warrant under section 135(2) is the appropriate procedure. (See para. 21.16.2 *post.*)

There are other methods whereby a person may be forcibly conveyed to and detained in hospital or a place of safety which do not require an application under Part II and are discussed elsewhere in this text, notably section 136 which empowers a police officer to take a mentally disordered person found in a public place to a place of safety. (See para. 12.02 *post.*)

Generally, an application under Part II cannot be made unless each of the following criteria are met:

- (i) **Mental disorder**—The person must be suffering from mental disorder or a specified form of mental disorder. This has already been discussed in chapter 9.
- (ii) **Warrants detention**—Mental disorder itself does not give grounds for compulsory admission. The mental disorder must be of a nature or degree which warrants detention in hospital. Many people who potentially could be classified as mentally disordered can, and should, remain in the community where it may be appropriate for them to receive care or treatment.
- (iii) **Health or safety or the protection of others**—The person must require detention in hospital to avoid damage to his health or

for his own safety or to protect other people. For an application for assessment the Act uses the word "ought" to be detained; and for an application for treatment the Act says it must be "necessary". Clearly the latter is stronger language and suggests that there is no reasonable alternative way in which health or safety can be assured. The word "ought" may suggest only that detention is desirable. "Health", is a broad concept and can conceivably be construed as physical or mental health.

In January 1993 the Secretary of State for Health initiated a Departmental Review of Legal Powers on the Care of Mentally Ill People in the Community, following a number of incidents involving former psychiatric in-patients. The review team was to consider whether new powers were needed to ensure their mentally ill people get the community care they need, whether the present legal powers in the 1983 Mental Health Act were being used as effectively as they could be, and what action could be taken in advance of any new legislation to ensure that they are. The team concluded that greater use could be made of section 3 to readmit patients whose mental health had begun to deteriorate even though there was not risk to the patients' or to other people's safety.¹

The revisions of the Code of Practice which accompanied the publication of the review team's report (Code of Practice, para. 2.9) are intended to "make clear" that the wording of sections 2 and 3 of the 1983 Act "allow a patient to be admitted in the interests of his or her health alone."² Paragraph 2.9 of the Code now states that those assessing patients for compulsory admission must have regard to any evidence suggesting that the patient's mental health will deteriorate, including the known history of the patient's mental disorder. Also required to be considered are the views of the patient and any relatives or close friends, especially (but not exclusively) those living with the patient, about the likely cause of his illness and the possibility of its improving. Previously the code had imposed a duty to consult only those living with the patient. This change is a clear move towards giving relatives greater say in the decision to detain. Those carrying out the assessment are to consider the impact of any future deterioration "or lack of improvement" on relatives or close friends, especially those living with the patient, including an assessment of his ability and willingness to cope. Finally assessors are to consider whether there are other

¹ Department of Health, *Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review*, Department of Health, London, August 1993, para. 3.3.

² *Id.*

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methods of coping with the expected deterioration or lack of improvement (Code of Practice, para. 2.9).

“Protection of others” includes the concept of danger to others, but it has a wider meaning. The Act does not expressly limit its scope to protection from physical harm. Arguably protection of family members from serious persistent psychological harm may be included; but it would be difficult to include protection of property. Where the patient does not pose any direct threat to the physical safety of others it is suggested that great care should be taken before making an application for compulsory admission. It would clearly be wrong, for example, if a person who was a nuisance, deviant or an embarrassment were to be subject to compulsion or where it was simply convenient for his family or the community.

In considering the “protection of other persons” it is essential to assess both the seriousness of the danger and the likelihood of it occurring. The mental health professionals making the assessment must have reliable evidence, and relevant details of the patient’s medical history and past behaviour. The Code of Practice (para. 2.8) indicates that the willingness and ability to cope with the risk by those with whom the patient lives are important factors. Certainly, persons who are particularly vulnerable to serious and likely harm are entitled to protection. It is questionable, however, whether a person should be compulsorily admitted based upon a low risk of harm simply because a family member refuses to tolerate the risk.

- (iv) **Treatability**—If the person is suffering from a minor form of mental disorder and is to be admitted for treatment, his condition must be shown to be “treatable”. This replaces the age limits for compulsory admission for treatment established in the 1959 Act.¹ (As to “treatability”, see para. 11.06.1 below)

11.02 Use of Compulsion on “Willing” Patients

The Royal Commission intended that “all forms of hospital . . . care should be available in future to patients who are content to receive them without the use of compulsory powers . . . patients should be assumed to be content to enter hospital unless they positively object”.² In addition, doctors must state in their recommendations for compul-

¹ Under s. 26 of the 1959 Act (repealed) a patient suffering from psychopathic disorder or subnormality could not be compulsorily admitted for treatment if he was aged 21 or older. If he were admitted under the age of 21 he could continue to be detained until age 25.

² *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (1957) Cmnd. 169, paras. 21, 22.

sory admission that "informal admission is not appropriate in the circumstances. . . ." (e.g. reg. 4(1)(b)(ii), Form 4).

There is nothing in the Act which expressly says that a "willing" patient cannot be compulsorily admitted. The requirement that informal admission is not "appropriate" suggests that if compulsion is to be used on a "willing" patient there must be a clear justification—e.g., that the patient has a long history of pre-mature self-discharge or that he is refusing an important treatment which could be given without his consent under Part IV if he were detained. Compulsory admission, however, cannot be used in respect of a "willing" patient simply because it is administratively convenient e.g., in accordance with a policy not to admit patients informally during nights or weekends or if the consultant is otherwise unavailable.¹

Paragraph 2.7 of the Code of Practice makes clear that willing patients should generally be admitted informally. Compulsory admission should be considered only where the patient's current mental state, together with reliable evidence of past experience, indicate a strong likelihood that the patient will leave hospital with a resulting risk to his health or the safety of others.

The Department of Health has expressly stated that no hospital should have a rule specifying times of day when only formal patients will be admitted.²

11.03 Special Provisions as to Wards of Court

Special provisions under section 33 apply to minors who are wards of court (as to which see para. 24.23 *post*):

- (i) an application for compulsory admission under Part II can be made only with the permission of the court;
- (ii) an application for admission for treatment or into guardianship can be made by an approved social worker, notwithstanding that the nearest relative has not been consulted or has objected;
- (iii) the nearest relative cannot exercise a discharge order under section 23 or apply to a Mental Health Review Tribunal under section 66.

11.03A Choice of Sections Under Part II

A professional judgment must be made as to the section under the Act that is most appropriate to the patient's case. Decisions should

¹ See E. V. Oram (Jan. 13, 1972). The Case for more Informal Admission, *Social Work Today*, 2, p. 9; R. G. Roy (Jan. 13, 1968) Problems of Compulsory Emergency Admissions, *Lancet*.

² DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, para. 272.

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not be influenced by: (a) a desire to avoid consulting the nearest relative; (b) the fact that treatment will last less than 28 days; or (c) the fact that a patient detained under section 2 will have earlier access to a Mental Health Review Tribunal than a patient detained under section 3. (Code of Practice para. 5.4).

11.03A.1 *Section 4 pointers*

Section 4 is for genuine emergencies and not for administrative convenience. A second medical opinion must be readily available.¹ Section 4 should not be used solely because a second medical opinion is unavailable, or because it is more convenient for the second doctor to examine the patient in the hospital. If a second medical opinion cannot be obtained, no application can be made unless it is a case of urgent necessity.

An emergency occurs when persons living or working with the patient are unable to cope with his mental state or behaviour. Genuine cases of crisis intervention should be supported by evidence of a significant risk of mental or physical harm to the patient or others; risk of serious harm to property; and/or the need for physical restraint of the patient.

The Code of Practice suggests procedures to follow when an application under section 4 is made and the ASW is not satisfied with the reasons for the non-availability of a second doctor. The ASW is advised to discuss the case with the doctor providing the recommendation. If it is not possible to resolve the problem, a senior officer within the local authority should take up the matter with the health authority. Despite this guidance, it is doubtful that the courts would uphold the use of section 4 other than in cases of genuine necessity given the clear language in the statute.

An appropriate second doctor should examine the patient as soon as possible after admission under section 4 to decide whether he should be detained under section 2. (Code of Practice, paras. 6.1–6.8).

11.03A.2 *Section 2 pointers*

The Code of Practice (para. 5.2) provides the following guidelines to support a decision to admit a patient under section 2 of the Act: (a) the diagnosis and prognosis are unclear; (b) in-patient assessment is needed in order to formulate a treatment plan; (c) a judgment has to be made whether the patient will accept treatment on a voluntary basis; (d) a judgment has to be made whether a particular treatment, which can only be administered under Part IV, is likely to be effective; (e) where the mental state of a patient who has previously been admitted

¹ The Managers should monitor the use of section 4 and ensure that second doctors are available to visit a patient within a reasonable time after being requested.

under the Act has changed and needs further assessment; (f) where the patient has not been previously admitted to hospital either compulsorily or informally.

11.03A.3 Section 3 pointers

The Code of Practice (para. 5.3) provides the following guidelines to support a decision to admit a patient under section 3 of the Act: (a) the patient has been admitted in the past, is considered to need compulsory admission for treatment of a mental disorder which is already known to the clinical team, and has been recently assessed by that team; (b) the patient is already admitted under section 2, is assessed as needing further treatment, and is unwilling to remain in hospital informally and to consent to treatment.

If the patient is detained under section 2 and is assessed to need treatment beyond the 28 day period, an application under section 3 should be made at the earliest opportunity and should not be delayed until the expiration of the section 2 detention. Changing a patient's detention status from section 2 to section 3 will not deprive him of a Mental Health Review Tribunal hearing if the change takes place after a valid application has been made to the Tribunal but before it has been heard. The patient's rights to apply to a Tribunal under section 66(1)(b) in the first period of detention after his change of status are unaffected.

11.04 Admission for Assessment in Cases of Emergency (s. 4)

11.04.1 Grounds and Application

In a case of "urgent necessity", an application for admission for assessment can be made; such an application is referred to as "an emergency application" (s. 4(1)). The application must be made either by an approved social worker (ASW) or by the patient's nearest relative (s. 4(2)). If it is made by an ASW he must comply with the duty to interview the patient in a suitable manner (s. 13). (See para. 7.16 *ante.*). The application must be made in the form specified in reg. 4(1)(c), addressed to the hospital managers (s. 11(2)). The application must include a statement that it is of urgent necessity for the patient to be admitted for assessment under section 2, and that compliance with the full provisions relating to section 2 would involve "undesirable delay" (s. 4(2)). The applicant must have personally seen the patient within the previous 24 hours (ss. 4(5), 11(5)). The ASW is not obliged to consult the nearest relative before making an application for assessment.

Thus, the essence of an emergency application is that the criteria for an admission for assessment are fulfilled, but, due to the patient's mental condition which requires urgent attention, there is insufficient time to obtain the second recommendation required under section 2.

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The delay involved in obtaining a second medical recommendation could depend, for example, on local geography and the adequacy of crisis intervention procedures developed by the health authority and local social services authority.

11.04.2 Medical Recommendation

An emergency application must be founded on **one** medical recommendation given, if practicable, by a doctor who has previous acquaintance with the patient—often a general practitioner. The medical recommendation must be signed on or before the date of the application. (Conceivably it could be signed after the application so long as it was on the same date. However, as the application must be **founded** upon the recommendation, it is suggested that the application should be signed only after the medical recommendation is given (see further, para. **21.13.2 post**). The recommendation cannot be given by the applicant or specified persons close to the applicant or close to the patient (s. 12(5)). If the patient is to be admitted to a private hospital or mental nursing home, the medical recommendation cannot be given from a doctor on the staff of that hospital or home (s. 12(5)(e)). The medical recommendation must verify that the case is one of urgent necessity and that obtaining a second medical recommendation required under section 2 would involve undesirable delay (s. 4(2), reg. 4(1)(d), form 7). (As to medical recommendations, see para. **11.10** below).

11.04.3 Conveyance, Admission and Detention

Once a duly completed application is made the patient must be conveyed and admitted to the hospital within 24 hours beginning with the date on which the patient was examined by the doctor providing a recommendation or the date of the application, whichever is earlier (s. 6(1)(b)). (As to conveyance to hospital, see para. **21.14.1 post**.)

11.04.4 “Conversion” into section 2

An emergency application gives the hospital managers the power to detain the patient for a period of 72 hours from the time he is admitted. An emergency application can be “converted” into an application for admission under section 2 (see para. **11.05 below**) if: (i) the second medical recommendation required by section 2 is given and received by the hospital managers within the 72 hour period; and (ii) both recommendations together comply with all of the requirements given in section 12, except the requirement in section 12(1) that the doctors must not have examined the patient more than five days of each other (s. 4(4)). (As to medical recommendations, see para. **11.10** below.) If the application is “converted” into an application for assessment the 28 day period provided for under section 2 will commence from the time of the patient’s admission to hospital under section 4.

11.04.5 *Notice to Social Services Authority of Hospitals having Arrangements for Admitting Urgent Cases*

It is the duty of every Regional Health Authority and, in Wales, every District Health Authority to give notice to every social services authority for the area of the region or district specifying the hospitals in which arrangements are made for the reception of patients who urgently require treatment for mental disorder (s. 140). This provision is intended to ensure that social workers will know which hospitals in their area are prepared to receive emergency cases either on an informal or compulsory basis.¹

11.04.6 *Consent to Treatment and Discharge*

A person who is admitted for emergency assessment is in the same position insofar as consent to treatment is concerned as an informal patient. (See para. 20.18 *post.*) The patient can be discharged at any time by the responsible medical officer or the hospital managers (s. 23(2)). However, there is no right to apply, or have the case referred, to a Mental Health Review Tribunal.

11.04.7 *Criticism of 1959 Act*

There was criticism of the excessive use of emergency applications under the 1959 Act; a high percentage of emergency applications were recorded nationally and there were marked regional variations.² The ease of application under the emergency procedures, along with its excessive use, led the DHSS³ and many commentators⁴ to discuss critically whether the statutory provisions had been subject to misuse. This criticism led to a tightening up of procedures in the Mental Health (Amendment) Act 1982: the statutory period within which the patient must be admitted to hospital was reduced from three days to 24 hours after the application; or medical recommendation, whichever is earlier (s. 6(1)(b)); the **nearest relative**, not just any relative could make an application; and the applicant must have personally seen the patient within the previous 24 hours instead of three days.

¹ DHSS (1983) *Mental Health Act 1983: Memorandum*, para. 273.

² See Enoch and Barker (April 3, 1965) *Misuse of Section 29: Fact or Fiction?* *Lancet*, vol. i, p. 760.

³ DHSS *et al.* (1976) *A Review of the Mental Health Act 1959*. HMSO, London, paras. 2.4-2.14.

⁴ Ball (Sept. 9, 1967) *Why Section 29 is Misused?* *Brit. Hosp. J.*, p. 1639; Barton and Haider (1966) *Unnecessary Compulsory Hospital Admission to a Psychiatric Hospital*, *Med. Sci. & Law*, vol. 6, p. 47; L. Gostin (vol. 1; 1975) *A Human Condition* pp. 28-31.

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11.05 Admission for Assessment (s. 2)**11.05.1 Grounds**

An application for admission for assessment (s. 2(1)) may be made on the following grounds:

- (a) the patient is suffering from mental disorder of a nature or degree which warrants his detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; **and**
- (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of others.

Note that the patient need not be suffering from a particular form of mental disorder. Any person who comes within the generic phrase "any other disorder or disability of mind" could come within the scope of section 2; for example, a mentally handicapped person (even if he could not be classified as mentally impaired because his condition is not associated with abnormally aggressive or seriously irresponsible conduct) would be eligible for admission under section 2. (As to the definition of mental disorder and its four forms, see paras. 9.01–9.04 *ante.*).

11.05.2. Application

An application for admission for assessment must be made either by an ASW or by the nearest relative. The application must state the qualification of the applicant (s. 11(1)), and must be made in the form specified in reg. 4(1)(a). The application must be addressed to the hospital managers (s. 11(2)). If it is made by an ASW he must comply with the duty in section 13 to interview the patient in a suitable manner. (See further para. 7.16 *ante.*). The applicant must have personally seen the patient within fourteen days before the date of the application (s. 11(5)). The nearest relative cannot prevent the ASW from making an application. However, before or within a reasonable time after the application is made, the ASW must take practicable steps to inform the person (if any) appearing to be the nearest relative that the application is to be or has been made and of the powers of the nearest relative to exercise a discharge order under section 23(2)(a) (s. 11(3)).

11.05.3 Medical Recommendations

An application for admission for assessment must be founded on the written recommendations of two registered medical practitioners, including in each case a statement that the criteria set out above are fulfilled (s. 2(3)). The recommendations must be in the form prescribed by reg. 4(1)(b);¹ they may be given either as separate recommendations (Form 4) or as a joint recommendation (Form 3) signed by each on or before the date of the application (ss. 11(7), 12(1)). The doctors must

¹ The Forms are set out in the 1983 regulations. Copies of the forms are available from the publishers of this text.

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have examined the patient both together or separately within five days of each other (s. 12(1)). Of the two recommendations one must be by a doctor approved by the Secretary of State for Social Services under section 12 as having special experience in the diagnosis or treatment of mental disorder. Unless the approved doctor has previous acquaintance with the patient, the other recommendation must, if practicable, be given by a doctor who has such previous acquaintance (s. 12(2)). (As to medical recommendations, see para. **11.10** below).

11.05.4 *Conveyance, Admission and Detention*

Once a duly completed application is made the patient must be conveyed and admitted to the hospital within fourteen days beginning with the date on which the patient was last examined by a doctor making a recommendation (s. 6(1)(a)). The patient is then liable to be detained for a period not exceeding 28 days from the date of admission. A patient admitted under an application for assessment cannot be detained after the expiration of 28 days unless, before it expires, a further application is made under the Act. A patient could **not** be made subject to a further period of assessment. The use of two continuous periods of assessment for 28 days each appears to be proscribed by the requirement in section 2(4) that a subsequent application, order or direction can be made only under the "following" provisions of the Act. It is also unlikely that an emergency application under section 4 could be made because it would be difficult to envisage circumstances where such an application would be of "urgent necessity".

11.05.5 *Consent to Treatment*

The term *assessment*, in itself, may suggest that medical procedures must be limited to those which are necessary to form a diagnosis and to devise a plan of treatment, thus excluding procedures solely for the purpose of treatment (*i.e.* alleviating or curing the patient's condition). However, the bracketed phrase "(or for assessment followed by medical treatment)" suggests that active treatment is authorised, at least after an initial period of assessment. The fact that active treatment is permitted under section 2 is confirmed by the inclusion of patients detained for assessment in the consent to treatment provisions of Part IV of the Act (s. 56). In most respects, therefore—apart from the period of detention—there is very little difference in effect between an admission for assessment and an admission for treatment. (As to consent to treatment, see paras. **20.17–20.28** *post*)

11.05.6 *Discharge*

The patient admitted for assessment can be discharged at any time by the RMO, by the hospital managers and, (subject to the RMO's power to bar the discharge order) by the nearest relative (s. 23). The patient (but not his nearest relative) can also apply to a Mental Health

Review Tribunal for his discharge. He can make an application at any time during the first 14 days following admission (s. 66(2)(a)). (As to the powers of the tribunal, see para. 18.08.1 *post.*)

11.06 Admission for Treatment (s. 3)

11.06.1 Grounds

An application for admission for treatment (s. 3(1)) may be made on the following grounds:

- (a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; **and**
- (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; **and**
- (c) it is necessary for his health or safety or for the protection of other persons that he should be detained for treatment.

Criterion (a): A category of mental disorder which makes it appropriate to receive medical treatment

The patient under criterion (a) must be suffering from one of the four specific categories of mental disorder. A mentally disordered person whose condition does not fall within any of the four categories, but only within the phrase "any other disorder or disability of mind", cannot be admitted under section 3. For example, a mentally handicapped person whose condition is not associated with abnormally aggressive or seriously irresponsible conduct could not be compulsorily admitted for treatment. (See discussion of mental disorder and its four specific forms at paras. 9.01–9.04 *ante.*)

The words "appropriate for him to receive medical treatment in hospital" were construed by McCulloch J in *R v. Hallstrom, ex parte W.*; *R v. Gardner, ex parte L.*¹ W. was living in a hostel but was refusing to take medication. Her general practitioner and a consultant psychiatrist signed medical recommendations under section 3, believing it was necessary for her health that she should continue to take medication while remaining in the hostel. W. was admitted to hospital for one night and thereafter granted leave of absence under section 17 (see para 11.13 below).

McCulloch J issued a judgment declaring that W. had been unlawfully admitted under section 3. "Admission for treatment is intended for those whose condition is believed to require a period of treatment as an inpatient. . . The concept of admission for treatment has no applicability to those whom it is intended to admit and detain for a

¹ [1986] 2 W.L.R. 883

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purely nominal period, during which no necessary treatment will be given.”

The language “appropriate for him to receive medical treatment in hospital” requires the doctors giving medical recommendations to have a good faith belief that the person requires treatment as an “in-patient.” If the “appropriate” treatment is at home, a hostel or as an out-patient then the person does not come within the criteria of section 3.

The word “appropriate”, as opposed to “necessary”, in the Act recognises that treatment, although more appropriately given as an in-patient, might also be given elsewhere. (For an analytical comparison with criteria for making a hospital order, see para. 15.06n. *post*). In W.’s case the doctors did not regard in-patient treatment as appropriate.

The holding in *Hallstrom* suggests that those making an application or furnishing a medical recommendation pursuant to section 3 should do so if in their best professional judgment the person requires treatment while detained as an in-patient in hospital. Compulsory admission is not appropriate where the intention is to be able to exercise control over the patient in the community. In particular, the intention of Parliament in empowering the RMO to grant a leave of absence from hospital under section 17 was to enable patients to have a trial period to assess their suitability for community living. Section 17 should not be used to circumvent the requirement in section 3 that persons should be admitted only if detention in hospital for treatment is clearly appropriate. (See further para. 11.13 below).¹

Criterion (b): The “treatability test”

Criterion (b) is the “**treatability test**” which was introduced in the Mental Health (Amendment) Act 1982. The treatability test applies only to those suffering from a minor form of mental disorder, and replaces the age limits for admission for treatment which existed under the 1959 Act. (See footnote to para. 11.01 above.) A person suffering from a minor form of mental disorder cannot be compulsorily admitted for treatment under section 2 unless the treatment is **likely** to alleviate or prevent a deterioration of his condition. “Likelihood” of benefitting from treatment suggests that the desired benefit is probable and not a mere possibility. There is no treatability requirement at the time of admission for those suffering from a major form of mental disorder; however, there is a “**viability test**” which is applicable when the authority for detention is renewed (see para. 11.06.5 below).

The new “treatability test” replaces the concept in the 1959 Act that

¹ The decision of McCulloch J that the practice of compulsorily admitting a patient to hospital and then immediately granting a leave of absence is unlawful is shared by a number of informed commentators. See Mental Health Act Commission (1985) *First Biennial Report*, H.C. 1985/586, para 8.12(d)(i); DHSS (1983) *Memorandum on the Act*, para 19; Gunn, MJ (1986) *Judicial Review of Hospital Admissions and Treatment in the Community under the Mental Health Act 1983*, *Journal of Social Welfare Law*, pp. 200-301.

a minor form of disorder must "require or be susceptible to treatment". "Requires" suggested that the person could benefit from, for example, nursing care, but there did not have to be any "cure" or prevention of deterioration of the person's condition.

The treatability test is a much more positive requirement now placed within the criteria for compulsory admission and not as part of the definition of the disorders themselves. It must be shown that it is likely that treatment will result in some change in the patient's condition—either in curing or remedying the person's condition in the sense of perceivably altering behaviour or affect or in preventing a person's condition from becoming worse. This would preclude purely custodial confinement even with a humane intention such as for asylum or protection against exploitation. The wide definition of "medical treatment" must be referred to: it "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision". It is suggested that if the patient is simply going to receive medical treatment (e.g. nursing care) this does not necessarily mean he is "treatable". The treatment must be shown to be able to effect a change in the patient's symptomatology or condition in the way contemplated by the Act.

Criterion (c): Necessary for health or safety or for the protection of others

Criterion (c) is phrased in the disjunctive. It must be "necessary" for the person's "health" or "safety" or for the "protection of others" "that he should be detained for treatment. "Safety" implies that the person himself would be subject to some harm if not detained in hospital e.g. that he would intentionally harm himself or is so gravely disabled that he could not live independently in the community. "Protection of others" implies that the person would cause some physical harm to another person if not detained. Both of these terms can be construed reasonably narrowly and add important new requirements to the criteria under section 3. The criterion of "health", however, can be broadly construed, and is somewhat repetitive. If a person is suffering from a major form of mental disorder, or a minor form which is treatable, and in-patient treatment is appropriate, it is difficult to envisage many cases where detention would not be necessary for his "health."

11.06.2 Procedures

An application for admission for treatment must be made either by an ASW or by the nearest relative. The application must state the qualification of the applicant (s. 11(1)), and must be in the form specified in reg. 4(1)(3); the application must be addressed to the hospital managers (s. 11(2)). If it is made by an ASW he must comply with the duty in section 13(2) to interview the patient in a suitable manner. (See para. 7.16 *ante*.) The applicant must have personally seen the patient within 14 days before the date of the application (s. 11(5)).

An ASW cannot make an application for admission for treatment until he has consulted with the person (if any) appearing to be the

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nearest relative, unless in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay. Consultation with the nearest relative need not take place after the ASW has seen the patient.¹ In any case where the nearest relative objects,² the ASW cannot make an application for admission for treatment (s. 11(4)). The only recourse open to the ASW in such a case is to make an application to the county court under section 29 for the appointment of an acting nearest relative. Unreasonable objection to the making of an application is one of the grounds in section 29(3) for the county court to transfer the powers of the nearest relative to an acting nearest relative. (See further para. 8.07 *ante*.)

11.06.3 *Medical Recommendations*

An application for admission for treatment must be founded on the written recommendations of two registered medical practitioners. Each practitioner must provide a statement that in his opinion the criteria for admission set out above are complied with. Each recommendation must include reasons for the doctor's opinion that criteria (a) and (b) in para. 11.06.1 above are complied with—*i.e.* why the doctor believes the person is suffering from a specific form of mental disorder; and, if it is a minor form, why the condition is treatable. The doctor must also give reasons for his opinion that criterion (c) above is complied with—*i.e.*, why detention in hospital for treatment is necessary for the health or safety of the patient or to protect others. For example, if danger to others were the ground given, was there specific recent dangerous behaviour that could be referred to? In giving his reasons the doctor must specifically say whether methods other than detention in hospital for treatment could be used and why they are not appropriate. For example, why outpatient treatment or social services provided in the community are not appropriate, or why informal admission to hospital is not appropriate (s. 3(3)).

The medical recommendations must be set out in the form prescribed in reg. 4(1)(f). The recommendations may be given either as separate recommendations (Form 11) or as a joint recommendation (Form 10) signed by each doctor on or before the date of the application (ss. 11(7), 12(1)). The doctors must have examined the patient both together or separately within five days of each other (s. 12(1)). Of the two recommendations, one must be by a doctor approved by the Secretary of State under section 12 as having special experience in the diagnosis or treatment of mental disorder. Unless the approved doctor has previous acquaintance with the patient, the other recommendation must, if practicable, be given by a doctor who has such previous acquaintance (s. 12(2)). (Astomedical recommendations, see further para. 11.10 below).

¹ *Whitbread v. Kingston and District NHS Trust and another*, *The Times* 14 July 1997 (Transcript: Smith Bernal), C.A. (Civil Division). See further para. 7.12 *ante*.)

² The nearest relative can register an objection by notifying the ASW or the local social services authority; or he can raise his objection at the time he is being consulted by the ASW.

11.06.4 *Conveyance, Admission and Detention*

Once a duly completed application is made the patient must be conveyed and admitted to hospital within 14 days beginning with the date on which the patient was last examined by a doctor making a recommendation (s. 6(1)(a)). The patient is then liable to be detained for a period not exceeding six months from the date of admission, unless the authority for detention is renewed (s. 20(1)).

11.06.5 *Renewal of Authority to Detain: The "Viability" Criterion*

The authority for detention can be renewed for a period of six months; and then for further periods of one year at a time (s. 20(2)). The renewal of authority to detain a patient is carried out in the following way. The responsible medical officer, within two months before the authority for detention is due to expire, must: (i) examine the patient and (ii) furnish a report to the hospital managers in the form specified in reg. 10(1). Before furnishing a report the RMO must consult with one or more persons who have been professionally concerned with the patient's medical treatment (s. 20(4)). It is clear from the tenor of the Parliamentary debates that the intention was that consultation should be with a non-medical member of the therapeutic team who has had specific involvement in the patient's treatment such as a nurse, social worker or occupational therapist. But, the statutory language does not appear to preclude consultation with another doctor concerned with the patient's treatment such as a registrar.

Where a renewal report is furnished, the managers must, unless they decide to discharge the patient, inform him that the authority for his detention has been renewed (s. 20(3)). The RMO can furnish such a report to the managers only if it appears to him that the following conditions are met:

- (a) the patient is suffering from one of the four specific categories of mental disorder which is of a nature or degree which makes it appropriate for him to receive medical treatment in hospital;¹
- (b) such treatment is likely to alleviate or prevent a deterioration of his condition; **and**
- (c) it is necessary for the patient's health or safety or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained.

If a patient is suffering from a minor form of mental disorder and it has become apparent since the time of admission that he is not treatable then his liability to detention cannot be renewed. However, if a patient is classified as suffering from a major form of mental disorder a "viability" criterion can be used as an alternative to the "treatability"

¹ Where the form of mental disorder in the report renewing the authority to detain is a form other than that specified in the application for admission, that application has effect as if that other form of mental disorder were specified in it. The RMO is not in these circumstances required to furnish a separate reclassification report under s. 16 (s. 20(9)). See further para. 11.06.6 below.

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criterion stated in (b) above. Thus, even if such a patient is not treatable his liability for detention can be renewed if the RMO considers that the patient, if discharged, would be unlikely to be able to care for himself, to obtain the care he needs or to guard against serious exploitation. The objective of the viability test is to prevent the discharge of a gravely mentally disabled patient who would suffer substantial harm if discharged without appropriate arrangements for his care in the community. There are some important conceptual difficulties with this criterion. There is a mandatory duty on health and social services authorities to provide after-care for patients discharged after a period of detention under section 3 (s. 117). (See further para. 4.08 *ante*.) It is to be expected, therefore, that such a person would have a right to obtain the care that he needs. Further, if the patient is untreatable and there is no realistic possibility of future therapeutic benefit in hospital, is possible exploitation in the community a sufficient reason to detain the patient for an indefinite period of time?

11.06.5A *Renewal of Authority to Detain: Temporal Limitations*

As noted in para. 11.06.5 above, the renewal of authority to detain requires certain steps to be undertaken within the period of two months ending on the day on which a patient would cease to be liable to detention (s. 20(3)). Section 20(3) of the Act does not require that all steps in the process of renewing a patient's detention occur before the expiration date of the current period of detention.¹ The two month period applies only to: (i) the examination of the patient by the RMO; and (ii) the RMO's report to the managers in the prescribed form stating that the statutory conditions for renewal of detention are satisfied. Where the report is duly furnished to the managers, the authority for detention is thereby renewed (s. 20(8)).

Section 20(3) also requires that where the RMO's report is duly furnished the managers must, unless they discharge the patient, cause him to be informed about the renewal of detention. This requires the managers to make an independent assessment about the merits of continued detention and to inform the patient accordingly. These latter steps do not need to be made prior to the expiration of the current period of detention.

In *Re B*,² the patient had originally been detained as an informal patient and then detained under section 3. Within the two month time period, the RMO filed the report in the prescribed form for renewal of authority to detain. There was correspondence regarding his report for renewal of detention in which the RMO arranged for a meeting of the managers four days after the initial authority to detain would have expired. Believing this detention was lawful, the health authority continued to detain the

¹ *R. v. Managers of Warlingham Park Hospital, ex parte B* (1994) 22 B.M.L.R. 1 (QBD.CA).

² Reported *sub nomine R. v. Managers of Warlingham Park Hospital, ex parte B* (1994) 22 B.M.L.R. 1.

patient. Six months later, the process was repeated, with the managers' meeting scheduled after the expiration of the six month period.

The Court of Appeal ruled that the two month time period applies only to the medical examination of the patient, the forming of the RMO's judgment and the furnishing of the RMO's report; it does not apply to the forming of the managers' opinion or informing the patient of the decision. Detention would be unlawful if the authorized period of detention expired without a report, duly furnished, which amounts to authorization for renewed detention. The authority was technically renewed when Formd 30 was completed by the RMO and delivered to the managers.

11.06.5B *Renewal of Authority to Detain a Patient Currently on Leave of Absence*

In order to renew a patient's authority to be detained the RMO must form the view, after careful examination, that it is "appropriate for him to receive medical treatment in hospital." (See further para. 11.06.1 above.) The ruling in *Hallstrom* suggests that if, at the time the decision to renew the authority to detain is taken, the patient is in the community on a leave of absence, then the criterion for renewal cannot be met. McCullough J said that "Parliament did not intend that the provisions for renewal should embrace those liable to be detained but not in fact detained."¹

The RMO could recall the patient to hospital specifically for the purpose of making the medical examination required for renewal of the authority to detain. Such a recall would not be lawful if the primary intention were to continue his liability for detention but still reside in the community. The RMO must have a genuine belief that recall is necessary for the patient's health or safety or for the protection of others. (See further para. 11.13.1 below.)

11.06.6 *Form of Mental Disorder and Reclassification*

The form of mental disorder under which the patient is classified clearly has important implications in relation to detention for treatment under section 3. It is more difficult to justify detention of a person suffering from a **minor disorder** (*i.e.* mental impairment or psychopathic disorder) because, both at the time of admission and renewal of the authority to detain, it must be shown that the patient is treatable. However, if the person is classified as suffering from a **major disorder** (*i.e.* mental illness or severe mental impairment), there is no "treatability" test at the time of admission and a widely framed "viability" test can be used as an alternative justification for renewal of the authority to detain.

An application for admission for treatment and any medical recommendation upon which it is founded may describe the patient as suffering from more than one form of mental disorder. However, the application is not valid unless the patient is described in each recom-

¹ [1986] 2 W.L.R. at 897-898.

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mentation as suffering from the same one of those forms of mental disorder whatever other form he may also be described as suffering (s. 12(4)). (See further para. 11.11 below.)

A power is vested in both the RMO and the MHRT, if it is felt that a patient detained for treatment is suffering from a form of mental disorder other than the form or forms specified in the application, to reclassify the person as suffering from a different form of mental disorder. The RMO can reclassify the patient by furnishing a report in the form prescribed in reg. 6 to the hospital managers (s. 16(1)). Before furnishing the report the RMO must consult one or more persons who have been professionally concerned with the patient's medical treatment (s. 16(3)). (As to consultation, see para. 11.06.5 above.) Where a report is furnished reclassifying the patient, the managers must cause the patient and the nearest relative to be informed (s. 16(4)). Either the nearest relative or the patient can apply to a Mental Health Review Tribunal within 28 days of the date on which he is informed that the report has been furnished (s. 66(1)(d), (2)(d)). Where the RMO furnishes a report to the effect that the patient is suffering from a minor disorder but not a major disorder then he must also state whether the patient's condition is treatable. If he states that treatment is not likely to alleviate or prevent a deterioration in his condition, the patient is no longer liable to be detained (s. 16(2)).

A Mental Health Review Tribunal has the power to direct the reclassification of the patient's condition in the case of any application or reference where it decides not to discharge the patient (s. 72(5)). (See paras. 18.11, 18.15 and 18.18.3.) There is no similar requirement to state whether the patients' condition is treatable. This is because the tribunal, in deciding whether to discharge the patient, must already have had regard to his treatability (s. 72(2)).

Where the RMO furnishes a report under section 20(3) renewing the authority for detention he may specify a form of disorder other than that specified in the application for admission for treatment. This has the effect of reclassifying the patient, and the RMO is not also obliged to furnish a reclassification report under section 16 (s. 20(9)). (See note to para. 11.06.5 above.)

11.06.7 *Discharge*

A patient compulsorily admitted to hospital for treatment can be discharged at any time by the RMO, the hospital managers or, subject to the power of the RMO to issue a report barring the discharge (s. 25), the nearest relative (s. 23). (See further para. 17.02 *post.*) The patient is also entitled to apply to a Mental Health Review Tribunal within the first six months of admission and during any period of renewal of detention (*i.e.* in the following six months and then during periods of one year at a time (s. 66(1)(b), (f), (2)(b), (f))). The nearest relative can apply to the tribunal within 28 days of receiving notice that the RMO has barred the discharge order (s. 66(1)(g), (2)(d)).

B. GUARDIANSHIP**11.07 Guardianship Applications****11.07.1 Introduction**

Care in the community should usually be on the basis of persuasion to accept the help and support of the health and social services authorities. However, where a person is unwilling to receive assistance which cannot be overcome by persuasion it might be feasible to place the person under guardianship. Guardianship offers a less restrictive setting than hospital in which treatment, care and support can be given.

When the 1959 Act was passed, it had been hoped that as community psychiatric services developed, guardianship would be increasingly used as a method of providing positive support for the patient. However, the use of guardianship has actually decreased over the years.¹ This may be because it came to be associated, not with positive support, but with strict powers of control over the individual. The 1959 Act gave the guardian all the powers a parent would have over a child aged fourteen or under. It was partly for this reason, and partly because of the shortage of resources, that many local authorities became reluctant to accept guardianship cases. In those cases where guardianship has been used it is usually in relation to mentally handicapped, and not mentally ill or psychopathic, patients.

Guardianship can be used as an effective way of providing the patient with treatment, care and support in a more humane and less restrictive community setting. To encourage local social services authorities to make greater use of guardianship in appropriate cases the 1982 Amendment Act gave the guardian power only to exercise limited or specific powers and not the all embracing power vested under the 1959 Act. However the problems associated with insufficient resources for community services still persist.

The Code of Practice (para. 13.1) encourages guardianship as an authoritative framework for providing services with a minimal of constraint to achieve an independent life in the community. Guardianship, therefore, must be part of a comprehensive plan for care and treatment established on the basis of multidisciplinary discussions.

11.07.1A Components of effective guardianship

The comprehensive care plan should identify the services needed including nursing care, personal and social support, medical treatment, and accommodation. Professional responsibilities under the plan should be designated. Only those guardianship powers which are

¹ See DHSS *et al.*, (1976) *A Review of the Mental Health Act 1959*, p. 28, Appendix V.

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necessary to carry out the plan should be included. If compulsory powers are not necessary, guardianship is inappropriate.

The Code of Practice (para. 13.5) sets out the planning components of effective guardianship; (a) a co-operative working relationship between the patient and guardian; (b) the guardian taking on the role of "advocate" to help obtain needed services; (c) continuing support from the local authority; (d) a residence appropriate to meeting the patient's needs for support, care, treatment, and protection; (e) availability of day care, education and training.

It is important to recognise that local authorities have overall responsibility for guardianship in the same way that health authorities have for hospital admission. Each local authority should publish a policy setting out arrangements for: (a) receiving and scrutinising applications to ensure they are lawful and sufficient; (b) monitoring guardianship (including visits to the patient) to ensure the care plan is effectively being carried out; (c) ensuring the suitability of a proposed private guardian; (d) ensuring that guardianship patients receive the same information that detained patients receive under section 32; (e) ensuring the patient is aware of his rights to apply to a tribunal and is given assistance in making an application; (f) maintaining adequate records; (g) ensuring adequate review toward the end of each period of guardianship; and discharging the guardianship (rather than letting it lapse) when it is no longer necessary.

Guardianship does not preclude a person from admission to hospital informally. Guardianship, however, should not be used to compel a patient to reside in hospital. An application for admission to hospital can be made under Part II in respect of a guardianship patient. Guardianship will remain in force if the patient is admitted under section 2 or 4, but not under section 3. (Code of Practice, para. 13.1-13.9).

11.07.2 *Grounds*

A person aged 16 or over may be received into guardianship on the grounds that (s. 7(1), (2)):

- (a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment of a nature or degree which warrants his reception into guardianship; **and**
- (b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that he should be so received.

The requirement that minors under the age of 16 cannot be placed into guardianship was introduced in the Mental Health (Amendment) Act 1982. Note that it might still be possible to make an application under the Children Act 1989 (section 31) for a care or supervision order in respect of a child under 17 who requires supervision and control in the community as a consequence of mental disorder. If the child is

married no such order can be made after he has reached his sixteenth birthday. (See further para. 24.21 *post*)

As in the case of an admission for treatment, a guardianship application can be made only if the patient is classified as suffering from one of the four specific forms of mental disorder. The application and medical recommendations can specify more than one form of mental disorder; but the application is not valid unless each recommendation describes the patient as suffering from the same one of those forms of mental disorder whatever other form he may also be described as suffering from (s. 11(6)). There is no "treatability" criterion in a guardianship application; and the concept of a person's "welfare" is used instead of his "health or safety". "Welfare" could be construed to be a wider term than "health or safety"; it could, for example, include prevention against exploitation. An admission for treatment and a guardianship application both use the phrase "protection of other persons". This refers to protection of other persons from physical harm and, arguably, from serious psychological or emotional harm, for example, from harm caused by reasonable fear of violence. However it is emphasised that mere annoyance or disturbance of other persons would be insufficient grounds to warrant a guardianship application. The very nature of guardianship suggests that it is needed to further the interests of the patient himself and not for the convenience of friends, neighbours or family.

11.07.3 *Procedures*

The procedural requirements for a guardianship application are similar to those for an application for admission for treatment. The application must be made either by an ASW or by the nearest relative (s. 11(1)) and must be in the form specified in reg. 5(1); the applicant must personally have seen the patient within 14 days of the date of the application; the application must be forwarded to the local social services authority named as guardian or to the local social services authority for the area in which the person resides (s. 11(2)).¹ A guardianship application must state the age of the patient or, if unknown, that he is believed to be aged 16 or over (s. 7(4)). The person named as guardian in the application may be either a local social services authority or any other person (including the applicant himself). If the application names a guardian other than the local social services authority, it is of no effect unless: (i) the authority accepts that person as guardian and (ii) it is accompanied by a statement (reg. 5(1)(b)) by the person of his willingness to act as guardian (s. 7(5)). The social services authority should be satisfied that the proposed guardian is

¹ Temporary absence from the place where a person lives does not affect residence, as long as there is an intention to return. *R. v. St. Leonard's Shoreditch (Inhabitants)* (1865) L.R. 1 Q.B. 21.

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capable of properly looking after the patient having regard to his special disabilities and needs.

The ASW's duty in section 13(2) to interview the patient in a suitable manner (see para. 7.16 *ante*) does not explicitly apply in the case of a guardianship application. It is suggested, however, that the social worker's duty to exercise reasonable care in making an application would require some kind of personal interview. This view is supported by the statutory obligation that the applicant must have personally seen the patient within fourteen days before the date of the application (s. 11(5)).

The requirement in section 11(4) for the ASW, if practicable, to consult the nearest relative before making an application and the prohibition against making the application if the nearest relative objects applies also to guardianship applications. (See further para. 7.12 *ante*.) If the nearest relative unreasonably objects to the making of a guardianship application the county court may appoint an acting nearest relative (s. 29(3)(c)). (See further para. 8.07 *ante*.)

A duly completed guardianship application must be forwarded to, and accepted by, the local social services authority within fourteen days of the date on which the patient was last examined by a doctor giving a recommendation (s. 8(2)). Thus, the authority must agree to the making of a guardianship application before it can have effect. The **responsible social services authority** is the authority which is itself to be the guardian; or, where the patient is to be under a private guardian, it is the local social services authority for the area in which the guardian resides (s. 34(3)). Local social services authorities have a general duty to act as guardians under the arrangements they are required to make for the care of persons suffering from mental disorder resident in their areas, and for their after-care. (See further para. 4.07 *ante*.) A guardianship application which appears to the local authority to be duly made and to be founded upon the necessary medical recommendations (see below) may be acted upon without further proof of the signature or qualification of the person making the application or recommendation, or of any fact or opinion stated in the application (s. 8(3)). Thus, if the application and recommendations appear authentic on the face of the documents they can be accepted.

11.07.4 *Medical Recommendations*

A guardianship application must be founded on the written recommendations of two registered medical practitioners. Each recommendation must include a statement that the grounds stated above are complied with. Each recommendation must include reasons for the doctor's opinion that criterion (a) in para. 11.07.2 above is complied with—*i.e.*, why the doctor believes that the person is suffering from a specific form of mental disorder which warrants reception into

guardianship. The doctor must also give a statement of reasons for his opinion that criterion (b) above is complied with—*i.e.* why guardianship is necessary for the patient's welfare or for the protection of other persons (s. 7(3)). If the general welfare of the patient were the ground given the doctor should explain exactly why guardianship would further the interests of the patient—*e.g.*, if it is to protect the patient against exploitation what evidence is there that this has taken place in the past and/or is likely to occur in the future, and how would guardianship prevent this.

The medical recommendations must be set out in the form prescribed in reg. 5(1)(c). The recommendations may be given either as separate recommendations (Form 20) or as a joint recommendation (Form 19) signed by each doctor on or before the date of the application (ss. 11(7), 12(1), (7)). The doctors must have examined the patient both together or separately within five days of each other (s. 12(1), (7)). Of the two recommendations, one must be by a doctor approved by the Secretary of State under section 12 as having special experience in the diagnosis or treatment of mental disorder. Unless the approved doctor has previous acquaintance with the patient, the other recommendation must, if practicable, be given by a doctor who has such previous acquaintance (s. 12(2), (7)). A medical recommendation for the purposes of a guardianship application cannot be given by a person with specified close relationships to the applicant, the patient or the guardian (s. 12(5), (7)). (See further para. 11.10 below.)

11.07.5 *Effect*

Where a patient is received into guardianship any previous application under Part II of the Act ceases to have effect (s. 8(5)). Where a guardianship application is duly made and accepted by the local social services authority it confers on the authority or person named as guardian, to the exclusion of any other person, the following powers (s. 8(1)):

- (a) **To require the patient to reside at a specified place**—The authority or guardian can require the patient to live, for example, in a residential establishment provided by the authority. It is an offence under section 128 to induce or knowingly to assist another person to absent himself without leave of the guardian. (See further para. 25.04 *post.*) If a patient is absent without leave from the place he is required to live he can be taken into custody and returned to that place by any officer on the staff of a local social services authority, by any constable or by any person authorised in writing by the guardian or authority (s. 18(3)). However, the patient may only be returned within 28 days of his absence without leave. A patient who is not returned or taken into custody within that period ceases to be subject to guardianship (s. 18(4)). If on the day on which the patient would other-

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wise cease to be subject to guardianship he is absent without leave, he will not cease to be subject to guardianship until the expiration of the 28 day period specified in section 18(4) or until he returns to the place he is required to live, whichever is earlier. If the patient returns within the 28 day period he can be detained for a further week beginning with the day on which he is returned (s. 21). The purpose of section 21 is to give the authorities a period of one week to enable the formalities for renewal of the guardianship to be completed.

- (b) **To require the patient to attend at specified places and times for the purpose of medical treatment, occupation, education or training**—The local social services authority or private guardian can, for example, require the patient to go to a hospital for out-patient treatment, or to attend an adult training centre or school for training or education. Although the patient can be required to attend a place for the purpose of receiving medical treatment, he cannot actually be compelled to receive the treatment without his consent. The guardianship patient is in the same position in respect of his right to consent to treatment as any informal patient (s. 56). Thus, a guardianship application could not be used as a legal justification to administer a needed psychiatric or other treatment, in the absence of consent. If, for example, an operation was needed to remove cataracts from an incompetent (perhaps non-volitional) patient, guardianship could not be used as a rationale for authorising the treatment. Other justifications would have to be explored. (See further paras. 20.16 and 20.18 *post.*)
- (c) **To require access to the patient to be given, at any place where the patient is residing, to any registered doctor, approved social worker or other specified person**—The patient or any person living with him must allow a doctor, an ASW or other person specified by the authority or guardian to enter premises where the patient is living in order to see him. A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under section 129. (See further para. 25.05 *post.*) The fact that a guardian has the power to grant access to the patient does not necessarily mean that it must grant access. In *R. v. Durham County Council ex parte H*,¹ the court refused to order a local authority to grant access to a guardianship patient by a registered doctor. The patient was opposed to being examined by a doctor on behalf of her father who was being accused of incest.

The Code of Practice (para. 13.7) states that the Act does not provide legal authority to: detain a patient physically in a specified residence

¹ CO/555/89 (Transcript: Marten Walsh Cherer) 19 July 1989.

or to remove the patient against his will; use legal force to secure his attendance at specified places; or use force to secure entry to the patient. If the patient consistently resists the exercise of the guardian's powers it can be concluded that guardianship is not the most appropriate form of care, and the guardianship should be discharged.

The powers given to guardians under the Act are "specific" or "limited". A guardianship application under the Mental Health Act does not empower the authority or guardian to exercise any control over the patient other than those listed. There are no residual powers which the guardian has over the patient even if they may appear necessary for the patient's welfare—for example, the guardian cannot interfere with any of the patient's rights or privileges not referred to in section 8(1) such as to engage in correspondence or to marry. Further, the fact that the person is under guardianship does not give the local authority any additional powers to provide services. However, the guardian should try to promote the overall welfare of the patient and take any necessary steps, in consultation with and with the consent of the patient, to further his interests.

It is an offence under section 127(2) for anyone to ill-treat or wilfully to neglect a patient subject to his guardianship or otherwise in his custody or care. (See further para. 25.03 *post.*)

11.07.6 *Duration*

A patient may be kept under guardianship for a period of not more than six months beginning with the day on which the application was accepted (s. 20(1)). The authority for guardianship may be renewed for a further period of six months, and then for periods of one year at a time (s. 20(2)). For the authority for guardianship to be renewed, the appropriate medical officer (defined para. 6.17.3 *ante*; see ss. 16(5), 20(10)) must, within two months of the time when the guardianship would expire, examine the patient and furnish a report to the guardian and, if the guardian is not a local social services authority, to that authority. Where such a report is furnished, the authority, unless they discharge the patient, must cause him to be informed (s. 20(6)). The appropriate medical officer can furnish the report only if he is of opinion that criteria identical to those used to make the original application (see para. 11.07.2 above are fulfilled (s. 20(7)). There are provisions in the Act generally (s. 16) and specifically at the time of renewal of guardianship, for the form of mental disorder to be reclassified. This is not of as great importance as in the case of patients detained in hospital for treatment because the "treatability" and "viability" criteria do not apply in guardianship cases.

11.07.7 *Discharge*

A guardianship patient can be discharged by the responsible medical officer, by the responsible social services authority, or by the

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nearest relative (s. 23(2)). It must be noted that a discharge order by the nearest relative **cannot** be barred by the responsible medical officer. The powers of discharge conferred on the local social services authority can be exercised by any three or more members of the authority authorised by them or by three or more members of a committee or sub-committee of the authority which has been authorised (s. 23(4)).

A guardianship patient can apply to a Mental Health Review Tribunal at any time during the first six months after the guardianship application is accepted (s. 66(1)(c), (2)(c)); and during any period of renewal (*i.e.* during the next six months and then during periods of one year at a time) (s. 66(1)(f), (2)(f)). There are no provisions for the automatic reference of guardianship cases to tribunals. (See further paras. **18.04.3** and **18.05 post.**) The nearest relative does not have the power to apply to a tribunal because he has an unfettered right to order the patient's discharge.

11.08 Regulations as to Guardianship

The Secretary of State for Health is empowered to make regulations for regulating the exercise of the powers of guardians; and for imposing on guardians and local social services authorities such duties as he considers necessary or expedient in the patient's interests (s. 9). The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations, S.I. 1983, No. 893, reg. 12 lays down a number of duties on private guardians (*i.e.* guardians who are not local social services authorities—see reg. 2(1)). These include, *inter alia*, the duty to appoint a registered doctor to act as the nominated medical attendant of the patient (see definition at para. **6.17.2 ante**); in exercising his statutory powers, to comply with directions given by the authority; and to furnish the local authority with specified information.

The responsible social services authority (see definition in s. 34(3)) must arrange for every patient received into guardianship under Part II to be visited at such intervals as the authority may decide, but in any case at least every three months; and at least one such visit per year must be made by a doctor approved under section 12 as having special experience in the diagnosis or treatment of mental disorder (reg. 13).

11.09 Transfer of Guardianship

There are several circumstances where the guardianship of a patient can be transferred to a local social services authority or to another person accepted by that authority:

- (i) **Death of guardian or voluntary decision to relinquish duties**—If a private guardian dies or gives notice in writing to the authority that he desires to relinquish his duties, the guardianship rests

with the local social services authority; but the authority can still transfer the patient into the guardianship of another person under regulations made under section 19 (s. 10(1)) (see below). The authority cannot prevent a private guardian from relinquishing his responsibilities if he so wishes.

- (ii) **Incapacitation**—If a private guardian is incapacitated by illness or some other cause, the functions of the guardian **may**, during his incapacity be taken by the authority or another person approved by the authority (s. 10(2)).
- (iii) **Negligent performance of functions**—If a private guardian has performed his functions negligently or contrary to the patient's welfare the county court can order the guardianship to be transferred to the authority or a person approved by the authority. Any approved social worker can apply to the county court for these purposes (s. 10(3)).¹

Section 19(1)(b) empowers the Secretary of State to regulate the circumstances in which a guardianship patient may be transferred into the guardianship of another social services authority or person. Such a transfer of guardians can take place where (reg. 8(2), Form 26): an authority for transfer is given by the guardian; the local social services authority which will be responsible when the transfer takes place has agreed and has specified a date for the transfer; and, if guardianship is to be transferred to a private person, the agreement of that person. (As to transfer from hospital into guardianship and *vice versa* see para. 11.18.3 and 11.18.5 below.)

¹ The procedure for an application to the County Court is set out in Order 49 of the County Court Rules 1981, S.I. 1981 No. 1687.

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C. GENERAL PROVISIONS AS TO APPLICATIONS AND MEDICAL RECOMMENDATIONS

11.10 Medical Recommendations

The medical recommendations required for the purposes of an application for compulsory admission to hospital under Part II of the Act must be signed on or before the date of application. The two doctors must have personally examined the patient either together or within five days of each other (s. 12(1)).¹ Of the two recommendations one must be given by a doctor approved by the Secretary of State for Social Services as having special experience in the diagnosis or treatment of mental disorder. (As to the details of approval of doctors, see para. 6.17.5 *ante*.) Unless the approved doctor has previous acquaintance with the patient, the other doctor must, if practicable, have such previous acquaintance (s. 12(2)). In practice this means that one of the two doctors is often the patient's general practitioner.

The Code of Practice (para. 2.25) strongly recommends that, in all but exceptional cases, the second recommendation should be provided by a doctor with previous acquaintance of the patient. This should be so even if the approved doctor already knows the patient.

The Act lays down specific situations where a doctor on the staff of the hospital to which the patient is to be admitted can give a medical recommendation:²

- (i) **Private patients**—no recommendation can be given from a doctor on the staff of a private hospital or mental nursing home; and no recommendation can be given by a doctor on the staff of a hospital where the patient is to be accommodated under section 65 or 66 of the National Health Service Act 1977 (which relates to accommodation for private patients (s. 12(3), (5)(e)).
- (ii) **NHS patients**—one recommendation may be given from a doctor on the staff of a Health Service hospital (s. 12(3)).

This does not preclude **both** recommendations being given from doctors on the staff of a Health Service hospital, but only if the following requirements are met: compliance with the condition that only one doctor can be on the staff would result in delay involving serious risk to the health or safety of the patient; **and** one of the doctors must work at the hospital for less than half of the time which he is

¹ Joint medical recommendation forms (Forms 3 and 10) should be used only where the patient has been jointly examined by two doctors. It is desirable that they are completed and signed by both doctors at the same time. In all other circumstances, separate recommendation forms (Forms 4 and 11) should be used. (Code of Practice, paras. 2.23–2.24.)

² A general practitioner who is employed part-time in a hospital is not regarded as on the hospital staff for the purposes of s. 12 (s. 12(6)).

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bound by contract to work in the Health Service; and where one of the doctors is a consultant, the other must not be managerially under that consultant's directions (s. 12(4)). (A junior doctor such as a registrar working as part of the consultant's team would be considered to be managerially under the consultant's directions.)

The Act also lays down prohibitions on persons giving medical recommendations where they have certain close relationships with the applicant or patient. In particular, the following persons cannot give a recommendation: the applicant; a partner or assistant of the applicant or a partner or assistant of the doctor giving the other medical recommendation; a person who may receive money for the maintenance of the patient; or by a relative of any of the foregoing persons or a relative of the other doctor giving a recommendation (s. 12(5)).

The Code of Practice (paras 4.1–4.5) emphasises that it is the personal responsibility of doctors to ensure that there is no pecuniary advantage or other conflict of interest in signing a recommendation. In particular, it is undesirable for a doctor to receive money from the patient, a relative or insurance company for his services after admission as a private patient.

The following subsections in section 12 apply to applications for guardianship under Part II (s. 12(7)):

- subs. (1)**—the recommendation must be signed on or before the date of the application by two doctors who must personally examine the patient together or at an interval of not more than five days;
- subs. (2)**—one of the two doctors must be approved and one, if practicable, must have previous acquaintance with the patient;
- subs. (5)**—a recommendation must not be given by the applicant or guardian, or by specified persons close to the applicant, guardian or patient.

11.11 Applications

An application for compulsory admission to hospital or reception into guardianship must be signed either by an ASW or the nearest relative, and must specify the qualification of the applicant (s. 11(1)). An application for admission must be addressed to the managers of the hospital to which admission is sought; and every guardianship application must be forwarded to the local social services authority named as guardian or to the authority for the area in which the guardian resides (s. 11(2)). The applicant must have personally seen the patient within 14 days (or 24 hours in the case of an emergency application under section 4) of the date of the application (s. 11(5)). An application for admission for treatment or a guardianship application (and the

recommendations upon which the application is founded) may describe the patient as suffering from one or more of the specific forms of mental disorder. However, the application is of no effect unless the patient is described in each of the recommendations as suffering from the same form of mental disorder, whether or not he is also described as suffering from another form. For example, he may validly be classified as suffering from mental illness and psychopathic disorder in one recommendation and only suffering from psychopathic disorder in the other recommendation. (In this case, if the application was for admission for treatment, the "treatability" test would apply). However, if the patient was classified as suffering from only mental impairment in one recommendation and only severe mental impairment in the other recommendation, the application would have no effect. (As to the various duties of an approved social worker to make an application, see Chapter 7.).

11.12 Rectification of Applications and Recommendations

Although the primary responsibility for ensuring that statutory forms have been completed correctly rests with those who sign those forms, the hospital managers and local social services authority should each designate an officer to scrutinise the documents.¹ (As to the role of the managers, see para. 6.04 *ante*.) There are provisions in s. 15 of the Act whereby documents relating to admission which are found to be incorrect or defective can be rectified after they have been acted upon. (See further para. 6.05 *ante*.) A similar provision for the rectification of documents relating to guardianship applications is to be found in section 8(4). If within 14 days beginning with the day on which a guardianship application has been accepted by the local services authority the application or recommendation is found to be incorrect or defective, the document may, within that period and with the authority's consent, be amended by the person by whom it was signed. Following such an amendment the document is deemed to have effect as if it were originally made as amended. It should be observed that an unsigned application cannot be rectified because it cannot be regarded as an application at all. This provision allows for the rectification of genuine mistakes—for example, the failure to state how many days have elapsed between the two medical examinations. But this does not provide authority for rectifying real breaches of the statutory procedure—for example, if the doctors in fact did not examine the patient within five days of each other.

¹ DHSS *et. al.* (1978) *Review of the Mental Health Act 1959*, Cmnd. 7320, para. 3.20.

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D. POSITION OF PATIENTS SUBJECT TO DETENTION OR GUARDIANSHIP

11.13 Leave of Absence from Hospital

11.14 The responsible medical officer (RMO) may grant to any patient who is liable to be detained in hospital under Part II of the Act leave to be absent from hospital.¹ Leave can be given subject to any conditions the RMO considers necessary in the interests of the patient or for the protection of other persons. The conditions sometimes attached are that the patient should live in a particular residence, attend for medical examination or treatment, or receive visits from a social worker. It should be noted that a patient on a leave of absence continues to be liable to be detained in hospital and can be compelled to receive treatment in accordance with Part IV of the Act (s. 56(1)). (See further para. 20.18 *post.*) Leave of absence can be given, for example, to allow the patient to attend a specific event such as a wedding or as a period of trial of the patient's suitability for discharge. Leave can be granted either indefinitely or for a specified period; if it is granted for a specified period, that period can be extended in the patient's absence (s. 17(2)). When a patient is given leave as a preliminary to discharge any necessary arrangements for finding a home, employment and for providing care and support should be made by, or in consultation with, the local social services authority.

The RMO may direct that the patient remain in custody during his leave of absence if it is necessary in the interests of the patient or for the protection of the public. The patient may be kept in the custody of any officer on the staff of the hospital or of any person authorised in writing by the hospital managers; if the patient is to reside in another hospital, the officers of the staff of that hospital can take custody over him (s. 17(3)). These kinds of arrangement would allow detained patients to have escorted leave for outings, to attend other hospitals for treatment, or to have home visits on compassionate grounds.² It could also be used for a trial period in another hospital before making a formal transfer.

A leave of absence can be an important part of a patient's plan of treatment. It is intended as a method of gradually preparing a person for discharge, but not as an alternative to discharge. If the patient is ready to leave hospital, or if the statutory criteria for detention are no longer fulfilled, he should be discharged. The leave of absence should be fully discussed with the patient and (if he consents) with his relatives and community based professionals.

¹ Section 17 applies without modification to patients subject to hospital and guardianship orders (Sch. 1, Pt. 1, para. 1); s. 17 applies with modifications to patients subject to special restrictions (Sch. 1, Pt. II, paras. 2 and 3).

² As to leave for special hospital patients see DHSS (1981) *Review of Leave Arrangements for Special Hospital Patients*.

The decision to grant leave rests with the RMO and cannot be delegated. The RMO retains responsibility for the patient's care in the community. The requirement to provide after care services applies to patients on a leave of absence. (Code of Practice, paras. 20.1–20.4).

11.13.1 *Recall to hospital*

The RMO is entitled at any time to revoke the leave of absence and recall the patient to hospital if he feels it is necessary in the interests of the patient's health or safety or for the protection of other persons. The RMO can recall the patient by giving notice in writing to the patient or to the person in charge of the patient (s. 17(4)). A patient cannot be recalled after he has ceased to be liable to be detained under Part II. He no longer is liable to be detained at the expiration of the relevant period of detention; or if he is on a leave of absence for a continuous period of twelve months without returning to hospital or being transferred to another hospital (s. 17(5)). Thus, if the patient is on a leave of absence for a continuous period of more than twelve months, his liability to detention ceases, and he cannot be recalled to hospital. If before the end of the twelve month period, the patient is absent from hospital **without leave**, he can be returned and re-admitted to hospital in accordance with the provisions of sections 18, 21, 21A and 21B. (See further paras. 11.14 and 11.16 below.)

11.13.2 *Leave of absence for patients not requiring in-patient treatment: The "long leash"*

Section 17 of the Mental Health Act has, according to the Mental Health Act Commission, been used with regularity as a means of requiring "compulsory" treatment in the community for patients on leave of absence.¹ This can occur in several ways:

- (i) Use of the power to detain under section 3, solely for the purpose of immediately granting the patient a conditional leave of absence;
- (ii) use of the power under section 17 to recall a patient on a conditional leave of absence just before the six month period of leave expires, solely for the purpose of granting another conditional leave of absence;
- (iii) use of the power under section 17 to recall a patient on a conditional leave of absence, solely for the purpose of making the required report to renew the period of detention before it expires (s. 20(3) (a)—see paras. 11.06.5, 11.06.5A above).

The Mental Health Act Commission regards each of these methods as

¹ *The First Biennial Report of the Mental Health Act Commission 1983–85*, pp. 25–27 (October 22, 1985, H.C. 586).

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“wrong in law and certainly in practice.” Use of the leave of absence provisions under section 17 should be reserved for genuine cases where it is important to assess the patient’s ability to live in the community. The imposition of a condition that the patient should have treatment during a leave of absence is probably lawful in these circumstances. If at any time during a patient’s leave of absence he no longer needs detention in hospital, he should be discharged from his liability to detention under section 3.

The view of the Mental Health Act Commission that it is unlawful to use section 17 as a “long leash”, solely for the purpose of compulsory treatment in the community, was confirmed by the Court of Appeal in *R. v. Hallstrom, ex parte W.* (see further para. 11.06.1 above). In *Hallstrom* a patient detained for treatment was granted a leave of absence under section 17; the RMO considered that it was essential for him to take his medication while living at home, but he was refusing to accept it. After examining the patient outside of the hospital, the RMO purported to renew his authority to be detained under section 20. Subsequently, the RMO, mistakenly believing his liability to be detained was due to expire, told him to return to hospital, with the intention of interrupting his leave of absence before the expiration of the six month period. He did not return to hospital.

McCullough J. held that it was unlawful to recall to hospital a patient on indefinite leave of absence when the intention was merely to prevent him from being on leave of absence for six months continuously. Section 17(4) only empowers the RMO to revoke the leave of absence and recall the patient when it is necessary for the patient’s health or safety or for the protection of other persons. If the real reason for the recall is not to bring him back to hospital for a period of in-patient treatment which is necessary for his health and safety, it is unlawful. To use the power of recall in any other way would be to contravene the intention behind the Act which is to free the patient from liability to detention if he is able to manage in the community for more than six months.

The Code of Practice (paras 20.6–20.8) points out that patients absent with leave are “liable to be detained”, and that Part IV of the Act, therefore, applies. A refusal to take medication should not be the sole reason for revoking leave. If it becomes necessary to administer treatment in the absence of consent under Part IV, the patient could be recalled to hospital.

11.13.3 *Compulsory treatment in the community and the “long leash”: Future policy*

There has been a debate in mental health over the appropriateness of introducing new legal powers to compulsorily treat patients in the community. The British Association of Social Workers (BASW) in 1977 made a constructive proposal for a “community care order”, which

would make a person subject to compulsory powers in the community.¹ The order would be made on grounds similar to an admission for treatment. That proposal was floated in the 1978 White Paper on the Act, but was not accepted.² On March 16, 1987 the Mental Health Act Commission sent a discussion paper to health and social services authorities, re-opening the debate on compulsory treatment in the community.³

The intention of BASW and others who have argued for new community based legal powers is to avoid unnecessary detention in hospital. Administration of long acting anti-psychotic medication in the community would, it is suggested, reduce the incidence of relapses and decrease the need for in-patient care.

Clinically controlled trials are necessary to assess the long-term efficacy, risks and adverse side effects of treating patients in various clinical settings. In order to evaluate the benefits and risks of mandatory community treatment, it must be compared with other cohorts who are compulsorily treated in hospital, and those who remain untreated. Whether there is a long term benefit to compulsory treatment which outweighs the long term adverse effects of medication in the community remains unestablished (see further para. 20.05.1 *post*).

MIND was one of the primary groups which opposed the initial BASW proposal. First, the benefit—risk calculus of compulsorily long-term use of major tranquillisers is not sufficiently demonstrated. Second, the principles of autonomy and self-determination in British law require a narrow focus for the exercise of compulsory powers. The use of compulsory powers in the community would be more difficult to monitor and to hold professionals accountable. Third, the use of compulsory powers in the community could widen the net of those subject to compulsion.

The Mental Health Act Commission set out a series of policy options including an expanded use of guardianship, extension of the leave of absence provisions, and a new “community treatment” order. Similar proposals have been proposed, or enacted in the United States, where there has been a similar debate. The importance of community care increases as the reliance on hospitals for mental health treatment decreases. In the ensuing debate, it is essential that the focus remains on the importance of providing adequate resources and coordination of mental health services to meet the diverse needs for housing, treatment, care and nursing in the community. The introduction of a compulsory power to treat, without a corresponding duty to provide adequate services, will not accomplish the objective of humane care of mentally disordered people in the community.

¹ *Mental Health Crisis Services – A New Philosophy*: Birmingham, BASW.

² DHSS (1979) *Review of the Mental Health Act 1959*: Cmnd, 7320, London, HMSO.

³ *Compulsory Treatment in the Community: A Discussion Paper*, December 1986.

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11.13.4 *The Mental Health (Patients in the Community) Act 1995*

In 1990 the Department of Health issued a circular to health and social services authorities promoting a care programme approach for mentally ill people who have been referred to specialist mental health services.¹ From April 1991 health authorities were required to draw up individual written care plans for all in-patients (whether detained or not who are about to be discharged from mental illness hospitals, as well as for all new patients accepted by the specialist psychiatric services. The needs of each patient for continuing care were to be systematically assessed, and appropriate arrangements made for meeting them. Each patient would be assigned a key worker whose task it would be to keep in touch with patients in the community. Review of patients' needs was to take place at regular intervals. Patients and carers were to be involved in the planning process. Social services authorities were asked to "collaborate with health authorities in introducing this approach and, as resources allow, to continue to expand social care services to patients being treated in the community."

The Mental Health (Patients in the Community) Act came into force in April 1996. It is part of a "ten point plan to reinforce the care of mentally ill people in the community." announced by in August 1993 by Virginia Bottomley, the Secretary of State for Health following an internal review by the Department of Health. The review followed two highly publicised incidents in December 1992 involving former psychiatric in-patients, Ben Silcock and Christopher Clunis. Silcock was a young schizophrenic, who jumped into the lion's enclosure at London Zoo. Although badly mauled, he survived. The whole affair was captured on amateur video and appeared on network news. In December 1992 Jonathan Zito, a young musician barely three months married, was killed by Christopher Clunis, a paranoid schizophrenic with a long history of violence. Clunis had been released from hospital three months before the attack. He had been supposed to attend Friern Barnet Hospital as a voluntary out-patient but had not turned up. The victim's widow, Jayne Zito, had been a rehabilitation manager for the mentally ill and, following Clunis' conviction had written to Virginia Bottomley deploring the failure of community care in his case, pointing to the crisis in psychiatric services, and demanding an inquiry. An inquiry was instituted by the health authorities concerned, which reported in February 1994, identifying a woeful catalogue of failure to provide adequate care for Clunis, that there had been no section 117 after care plan, and that the authorities had failed to manage or oversee provision of health and social services for him.² Since then there have been many inquiries into incidents involving former in-patients, most

¹ HC(90)23/LASSL(90)11 Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services.

² Ritchie, J H, Dick, D and Lingham, R *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, London, HMSO, 1994, 106.

notably *The Falling Shadow: One Patient's Mental Health Care 1978-1993*,¹ and *The Case of Jason Mitchell: Report of the Independent Panel of Inquiry*.²

The 1995 Act makes three major changes to the 1983 Act. First it introduces a new power of supervised discharge. Section 1 introduces ten new sections to follow section 25 of the 1983 Act which provide the framework for compulsory after-care under supervision. Section 2 extends the period during which patients who absent themselves without leave while they are liable to be detained may be retaken and returned to hospital. The period is extended to six months from the date on which he absconded or the expiry of the current period of detention, whichever is the later (see para. 11.14 below). Section 2 replaces sections 18(4) and 21 of the 1983 Act, and adds new sections 21A and 21B.

Section 3 amends section 17(5) of the 1983 Act to provide that a patient will no longer cease to be liable to be detained if he is still in the community after six months from the date when leave was granted. The limit of six months has been extended to twelve months. As the patient will be automatically discharged if he is on leave at the end of the current period of detention, this will only apply to section 3 and 37 patients who are in the third period of renewal, since detention under those provisions is for six months renewable for six months and thereafter renewable for twelve months (see para. 11.13.1 above).

The 1995 Act is accompanied by an addition to the Mental Health Act Code of Practice entitled *Guidance on Supervised Discharge (After-Care Under Supervision) and Related Provisions*. In England the Act should be read in conjunction with Health circulars HC(90)23/LASSL(90)1 (The Care Programme Approach), HSG(94)27/LASSL(94)4 (Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community) and HSG(94)5 on Supervision Registers. In Wales the Applicable Guidance is WHC(95)40 Guidance on the Care of people in the Community with a Mental Illness.³

The ten point plan included a series of shorter term measures to make greater use of existing powers. Amendments to the Mental Health Act Code of Practice were introduced in 1993 which encouraged early

¹ Blom-Cooper, L, Hally, H and Murphy, E, London, Duckworth, 1995.

² Blom-Cooper, L, Grounds, A, Guinan, P, Parker, A and Taylor, M, London, Duckworth, 1996.

³ See also Department of Health, *Building Bridges - A Guide to Arrangements for inter-Agency Working for the Care and Protection of Severely Mentally Disordered People* (1995), LASSL(96)16/HSG(96)6 *The Spectrum of Care - A Summary of Comprehensive Local Services for People with Mental Health Problems, 24 Hours Nursing Beds for People with Severe and Enduring Mental Illness, An Audit Pack for the Care Programme Approach and the Patients' Charter*, and NHS EL(97)1 *The Patients' Charter and Mental Health Services: Implementation Guidelines*.

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readmission of patients relapsing following cessation of medication. To prepare the way for supervised discharge, the Department of Health issued two further sets of guidance. The first introduced supervision registers, a form of "at risk" register for mentally disordered adults.¹ The second, issued in May 1994, provides guidance on the discharge of mentally disordered people and their continuing care in the community.² The legislative changes in the ten point plan included the lengthening to 12 months of the period during which detained patients can remain on conditional leave before they are automatically discharged. The ultimate goal of the ten point plan was the introduction of a new statutory power of "supervised discharge", for which supervision registers and the guidance on discharge would pave the way.³

11.13.5 *Early compulsory admission of patients who are relapsing*

The Department of Health's 1993 revision of the *Code of Practice on the Mental Health Act 1983* "strengthened" the guidance on assessment prior to compulsory admission. This now emphasises more strongly that a patient may be admitted under sections 2 and 3 of the 1983 Act solely in the interests of his own health, even if there is no risk to his own or other people's safety. Those doing the assessment must consider any evidence that the patient's mental health will deteriorate if he does not receive treatment, including "the known history of the individual's mental disorder." They must also consider the "reliability of such evidence", the views of the patient or relatives or friends living with the patient about his possible future deterioration, the impact that any future deterioration would have on those friends and relatives and the patient's ability to cope, and whether there are other methods of dealing with such deterioration. This in effect places much greater emphasis than the first version of the Code on the duty of those assessing a patient to consider any evidence suggesting that the patient's mental health will deteriorate if he does not receive treatment.

11.13.6 *Supervision Registers*

A central element of the ten point plan was the introduction of "supervision registers." This was achieved by Health Service Guidance HSG(94)5, issued by the NHS Management Executive. This requires the introduction of supervision registers by 1 April 1994. It informs health authorities that they are required, when purchasing mental health care services from NHS Trusts or other bodies, to include terms

¹ NHS Management Executive, Health Service Guidelines HSG(94)5 Supervision Registers.

² NHS Management Executive, Health Service Guidelines HSG(94)27.

³ Compare with the Report of the House of Commons Health Committee, "Community Supervision Orders" Fifth Report, Vol. 1, HC 667-1 (23 June 1993), xxvi.

⁴ Department of Health, *Code of Practice on the Mental Health Act 1983* (1993), para. 2.9.

in their contracts ensuring that provider units set up supervision registers which identify and provide information on mentally disordered patients in the community who are at risk. All initial assessments and follow up reviews of patients under the care programme approach are to consider whether the patient should be registered. All provider units are to be required to "incorporate the supervision register in the development of mental health information systems to support the full implementation of the Care Programme Approach." All patients of the specialist psychiatric services fall within the scope of the register.

The decision as to whether a person is to be included rests with the consultant psychiatrist in charge of the patient's care, although it should be made in consultation with the other members of the mental health team involved, including the social worker. The mechanism for making decisions about inclusion on the register is a "Care Programme review meeting", which will have to consider whether the client is suffering from serious mental illness, and whether he or she is, or is "liable to be at risk of committing serious violence or suicide, or of serious self neglect."¹ The guidance includes among the factors which might trigger such a risk, ceasing to take medication and says that "patients subject to supervised discharge . . . will be among those included in the register."² Patients, and where they wish, an advocate, relative, friend or carer, must have an opportunity to state their views and have these taken into account, for example, by attendance at the review meeting or through discussion with the relevant clinician or key worker. Wherever possible the patient's GP is to be involved in the decision.

There are three categories on the supervision register, and a patient should be assigned to no more than one of them unless there are specific reasons. The categories are: (a) significant risk of suicide; (b) significant risk of serious violence to others; or (c) significant risk of severe self-neglect.³ Where the risk is considered to be contingent on certain specified events (eg ceasing to take medication, loss of home or of a supportive relationship) the identified warning signs should be recorded.⁴ Judgements of risk should always be based on detailed evidence of the patient's psychiatric and social history and current condition, which may include evidence from any criminal justice agencies with which the patient has been involved. The evidence on which these judgements are made must be recorded in writing and should be available for the relevant professionals for the review meeting, although no mention is made in the guidance as to whether patients or their advocates would be entitled to this information, which may contain elements the veracity or accuracy of which the patient wishes to challenge.⁵

¹ HSG(94)5, Annex A, para. 4.

² *Id.*

³ *Ibid.*, para. 9.

⁴ *Ibid.*, para. 10.

⁵ *Ibid.*, para. 6.

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The guidance advises particular care where patients are being transferred from one type of care to another, or to another area.¹ It says that special hospitals and regional or medium secure units will need to ensure that all relevant information is available on patients discharged from those services into the care of local provider units so that the latter can decide whether the patient should be included on the supervision register. If a patient on a supervision register is transferred to a different provider unit, a copy of their record should, as a matter of urgency be transferred to that unit. The system manager will be accountable for ensuring that the transfer is rapid, accurate, and secure. The patient's inclusion on the receiving unit's supervision register is to be reviewed as part of the Care Programme drawn up at the new Provider unit, which will be responsible for liaising with the new Social Services Department and the GP.

Patients are to be informed orally and in writing of their inclusion on the register, "broadly" why they are on it, how the information will be used, to whom it may be disclosed, and the "mechanisms for review". An exception may be made for clinical reasons, when informing the patient would probably cause serious harm to his physical or mental health, but the guidance makes clear that this is expected to be very unlikely to apply to a patient suitable for care outside hospital. If it does apply, the decision "should not be taken lightly" and should be agreed by the mental health team including the consultant psychiatrist responsible.² The patient is to be told as soon as the risk has passed.

Care Programme Reviews of patients on the register are to take place very six months, and these should specifically consider the question of continued inclusion. The patient, or if he or she wishes, a relative, friend, advocate or carer must have a suitable opportunity to state his or her views and to have them considered. Any of the agencies or professionals involved can request a special review meeting to be held to consider withdrawal of "risk status." The patient or his chosen advocate have the right to request that the consultant remove the patient from the register, but the decision is ultimately a matter for the consultant, who, in conjunction with professional colleagues, is to consider the representations and inform the patient of the outcome and reasons for the decision. The guidance says that withdrawal will be appropriate in one of three circumstances: (a) where the patient is no longer considered to be at significant risk of serious violence, suicide, or severe self-neglect (this decision may only be taken by a review meeting); (b) where the patient's records have been transferred to another provider unit, and here there must be a written transfer agreement with the receiving unit; or (c) where the patient has died. Withdrawal from the register must not automatically entail a withdrawal of any services provided for a patient. The Guidance emphasises that "All

¹ *Ibid.*, paras 7 and 8.

² *Ibid.*, para. 12.

of the responsibilities set out in the care programme approach will continue to apply to such patients as long as they remain under the care of the specialist psychiatric services.”¹

Patients who remain dissatisfied by a decision to keep them on the register will have recourse to “the normal channels of complaint” and the right to a clinical second opinion.

Where a provider unit has lost contact with the patient the risk status should not be changed but the patient should be designated “out of contact with the unit.” Providers should make every reasonable effort to re-establish contact. The patient’s GP, social worker and other members of the care team are to be urgently notified and asked to advise and a review meeting is to be convened to which they should be invited.

The register will include the following “required contents”, listed in Appendix A of the guidance:

Part 1 Identification

- (i) Patient’s full name, including known aliases, home address including post code (or “no fixed address”), sex and date of birth.
- (ii) Patient’s current legal status in respect of the Mental Health Act (i.e. whether on leave, under guardianship or subject to supervised discharge when available)

Part 2 Nature of Risk

- (i) Category of risk and nature of specific warning indicators.
- (ii) Evidence of specific episodes of violent or self-destructive behaviour (including *relevant* criminal convictions) or severe self neglect.

Part 3 Key worker and relevant professionals

- (i) Name and contact details for patient’s key worker.
- (ii) Name and contact details of other professionals involved in the care of the patient including the consultant responsible for the care of the patient.

Part 4 Care Programme

- (i) Date of Registration
- (ii) Date of Last Review
- (iii) Date of next programmed review

¹ *Ibid.*, para. 19.

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(iv) Components of care programme

The guidance states that the patient's entry on the supervision register will be considered confidential in the same way as any other health record, but information from the register would be rapidly accessible to mental health professionals with a need to know in order to plan or provide care, and this would normally include all members of the care team, any social worker involved, and the patient's GP, who should be given a copy of the care plan. The Guidance also states that disclosures from the register to other agencies may be made either if the patient consents or without the patient's consent if disclosure can be justified in the public interest. These agencies might include the social services authorities, private sector institutions and, "in respect of mentally disordered offenders, probation or other criminal justice agencies". Where information is to be divulged to criminal justice agencies, whether it should, or even may, be divulged will depend on the nature of the information and the context in which it is sought. In *R v. Cardiff Crown Court ex parte Kellam*¹ it was held that records of patients' movements which were extracted from their medical records were "excluded material" within the meaning of section 11 of the Police and Criminal Evidence Act 1984, and therefore could not be required to be divulged to the police who were investigating a gruesome murder.²

The keeper of the record is the Board of an NHS Trust or the health authority if it directly manages the unit, and one executive member is to be identified to oversee the process. This means that if information from the register is to be disclosed to a third party, it is not for the RMO to decide, but for the Trust or the authority, "taking full account of the views of the consultant psychiatrist responsible for the care of the patient."³ The Report on the Clunis case recommends the introduction of a nationally based register of patients "subject" to section 117 where "information which leads to the ready identification of the patient may be stored and which would indicate where confidential information about the patient would be obtained."⁴ As a health record, the patient would have rights of access to it, under the Access to Health Records Act 1990 if it is manually stored, or under the Data Protection Act 1984, section 21, as modified by the Data Protection (Subject Access Modification) Health Order 1987⁵ if it is kept electronically. Under these provisions access may be withheld if disclosure would be likely to cause serious harm to the physical or mental health of the data subject or would be likely to reveal information which, on its own or in conjunction with other information, would enable another person,

¹ (1993) 16BMLR76.

² See also M. Zander, *The Police and Criminal Evidence Act 1984* (second edn) London, Sweet and Maxwell, 1990, 33-34.

³ HSG(94)5, Annex A, para. 21.

⁴ Ritchie, J H, Dick, D and Lingham, R *The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994), HMSO, 112.

⁵ S.I. 1987, No. 1903.

other than a health professional, to be identified either as a person to whom the information relates, or as the source of the information.

11.13.7 *Guidance on Discharge and Continuing Care*

The purpose of the guidance on discharge is to ensure that psychiatric patients are discharged only when they are ready to leave hospital; that any risk to the public or to patients themselves is minimal and is managed effectively; and that patients who are discharged get the support and supervision they need from the responsible agencies.¹ Referring to the risk of self harm or harm to others, and the devastating consequences of either eventuality, the Guidance particularly emphasises that those taking individual decisions about discharge (this includes Mental Health Review Tribunals, hospital managers,² and RMOs) have "a fundamental duty to consider both the safety of the patient and the protection of other people. No patient should be discharged from hospital unless and until those taking the decision are satisfied that he or she can live safely in the community, and that proper treatment, supervision, support and care are available."³ The guidance points out that certain patients with long-term, more severe disabilities and particularly those with a potential for dangerous or risk-taking behaviour need special consideration at the time of discharge and during follow-up and again stresses that discharge decisions must be fully justified:

No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions have been taken after full and proper consideration of any evidence about risk that the patient presents.⁴

Extensive information and advice are given in the guidance on the assessment of risk.⁵

The guidance restates the purpose of the Care Programme approach as being "to ensure the support of mentally ill people in the community, thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention", and says that it should be applied to all mentally ill people accepted by the specialist psychiatric services, whether or not they have been treated in hospital and whether or not they have been detained under the 1983 Act. In the case of patients who have been detained the Care Programme Approach is seen as essential to the after-care duty under

¹ NHS Management Executive, Health Service Guidelines HSG(94)27.

² Defined in the Mental Health Act 1983, s. 145(1) as amended by the Mental Health (Amendment) Act 1994.

³ NHS Management Executive, Health Service Guidelines HSG(94)27, para. 2.

⁴ *Ibid.*, para. 23.

⁵ *Ibid.*, paras 23-31.

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section 117. Authorities are told that they will need to establish mechanisms to monitor the application of the approach as a whole and to report on progress to authority members.¹

The discharge guidance sets out four essential elements of an effective care programme. Those taking discharge decisions are told they must be satisfied that these are met before the patient is discharged. They are:

- (i) *systematic assessment* of health and social care needs (including accommodation), bearing in mind both immediate and longer term requirements;
- (ii) a *care plan* agreed between the relevant professional staff, the patient, and his or her carers and recorded in writing;
- (iii) the allocation of a *key worker* whose job (with multi-disciplinary managerial and professional support) is:
 - (a) to keep in close contact with the patient;
 - (b) to monitor that the agreed programme of care is delivered; and
 - (c) to take immediate action if it is not; and
- (iv) regular review of the patient's progress and of his or her health and social care needs.²

The guidance also stresses the importance of effective record-keeping and clear arrangements for communication between members of the care team. The patient and others involved (including as necessary, the carer, health and social services staff, and the patient's GP) should be aware of the plan and have a common understanding of the following matters:

- (i) its first review date;
- (ii) information relating to any past violence or assessed risk of violence on the part of the patient;
- (iii) the name of the key worker (prominently identified in clinical notes, computer records and the care plan);
- (iv) how the key worker and other service providers can be contacted if problems arise; and
- (v) what to do if the patient fails to attend for treatment or to meet other requirements or commitments.³

Where patients have applied for a Mental Health Review Tribunal the guidance says that "it is important that the essential elements of

¹ *Ibid.*, paras 8–9.

² *Ibid.*, para. 10.

³ *Ibid.*, para. 11.

the Care Programme approach have been considered and can be put into operation if the patient is discharged, and that the key worker is made immediately aware of any conditions imposed.”¹

11.13.8 *Supervised Discharge*

The new supervision in the community power has been described as a medical form of guardianship, because instead of social services being the lead authority, applications will be made by the responsible medical officer to the health authority,² and patients subject to supervision will be under the clinical authority of a community responsible medical officer.³ However, as the Government spokeswoman Baroness Cumberledge put it in the Lords’ debates on the Act, whilst “the new power is health led [there is] . . . a firm commitment for the social services to be fully consulted and involved.”⁴ She went on to emphasise the links between the new power and section 117:

Section 117 . . . already makes clear that the provision of aftercare is a joint health and local authority responsibility. The imposition of any requirements on the patient in the community is also a joint health and local authority responsibility, as is keeping the aftercare services under review. Those provisions should avoid the risk of a health authority going ahead independently of the local social services authority and we shall also be emphasising the need for full consultation in our guidance on the operation of the new powers . . . The central principle of the Act is that supervision cannot be separated from the after care services which it exists to support.⁵

Supervision differs from guardianship in that guardianship is a “free-standing” power which can be used whether or not the person has been detained, whereas supervision is linked to a prior period of detention for treatment. In order to be eligible for this power the patient must be over 16 and liable to be detained in a hospital in pursuance of an application for admission for treatment under section 3 or under a hospital order without restrictions (section 37), or a transfer direction without restrictions (section 47 or section 48).⁶ This includes patients who are on section 17 leave. Supervised discharge takes effect when

¹ *Ibid.*, para. 19.

² Mental Health Act 1983, s. 25A(5)–(6) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

³ Defined in Mental Health Act 1983, s. 34(1) as amended by the Mental Health (Patients in the Community) Act 1995, Sch. 1, para. 4(2).

⁴ Hansard HL Debs, Vol. 564, col. 184, 11 May 1995.

⁵ *Ibid.*, cols 184 and 189.

⁶ Mental Health Act 1983, s. 25A(1) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

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the patient leaves hospital or, in the case of patients on section 17 leave, at the point when he or she is discharged from liability to detention.¹ If the patient remains in hospital on an informal basis after ceasing to be liable to be detained, the supervision application may still take effect when he leaves hospital, provided this is within six months of the application being accepted. The Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions* advises that it is preferable to avoid long delays since the patient's circumstances may change (paragraph 16).

Patients who have been admitted under section 2 of the Act may be considered for supervised discharge only if they have subsequently been detained under section 3, but this difference should not influence the choice between admission under these two sections (*Code of Practice Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions* (paragraph 15) and see the *Code of Practice* Chapter 5 for the criteria to be used in making this choice).

11.13.9 Supervisors and Community RMOs

Every patient will have a Responsible Medical Officer who applies for the supervised after-care, a Community Responsible Medical Officer, who is in charge of medical treatment in the community, and a supervisor, but there is nothing to stop all three being one and the same person.² In the Bill as originally drafted, the community RMO could be any registered medical practitioner, but after initial resistance,³ the Government accepted amendments in the Lords which will add a new section (2A) to section 117 to place a duty on the health authority "to secure that at all times while a patient is subject to after-care under supervision a person who is approved under section 12 of the 1983 Act as having special expertise in the diagnosis or treatment of mental disorder (a 'section 12 doctor') is in charge of the medical treatment provided for the patient as part of the after-care services provided for him under section 117."⁴ The Supplement to the Code of Practice (paragraph 44) says that the right person will usually be a consultant psychiatrist. The Community RMO is responsible for the patient's psychiatric treatment in the community. He also has the power to reclassify the patient as suffering from a different form of mental disorder from

¹ *Ibid.*, s. 25A(9).

² Mental Health Act 1983, s. 34(1), as inserted by the Mental Health (Patients in the Community) Act 1995, Sch. 1, para. 4(5).

³ Hansard HL Debs, Vol. 563, No. 68, col. 114, 4 April 1995.

⁴ Mental Health Act 1983, s. 117(2) inserted by the Mental Health (Patients in the Community) Act 1995, Sch. 1, para. 15(4).

that specified in the application,¹ to renew supervised discharge,² and to terminate supervised discharge.³

It is envisaged that the supervisor will be a community psychiatric nurse in most cases, although it could be the Community RMO or a social worker. The supervisor will play a "crucial role" in the success of the new power, "keeping in touch with the patient, co-ordinating the care which the patient is to receive, alerting colleagues to any modifications that may be necessary, checking that any requirements laid upon the patient are followed", and if necessary, invoking the controversial power to take and convey the patient to hospital.⁴ The Code of Practice requires that the supervisor must be a suitably qualified and experienced member of the patient's care team who has agreed to take on the role. In England this would be the key worker under the Care Programme Approach. The supervisor must be supported by a proper framework of training, accountability and clear reporting lines within his or her organisation. Close working links with the Community RMO are essential. The supervisor must maintain sufficiently close contact with the patient to be satisfied that he is receiving the agreed after-care services and is complying with the requirements, and must convene a meeting of the care team if care is not being received. He must be alive to signs of deterioration and other warning signs and must be accessible to people with whom the patient is living and listen to their concerns. He must ensure that the team reviews the care plan well before the date when it falls to be reviewed, and whenever any shortfall in the arrangements is identified.⁵

At the Report stage in the Lords, Baroness Cumberledge was asked whether the legal responsibility for doctors taken on by hospital trusts in cases of litigation will apply to supervisors, or whether they would be responsible for any failings of the social services, hospital services, GP services and others which are needed to provide treatment for the patient. She replied as follows:

While the supervisor will have professional liabilities and responsibilities along with other professionals in the care team, there will

¹ *Ibid.*, s. 25F. This is done by furnishing a report to the Health Authority on Form 4S, The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para. 57.

² *Ibid.*, s. 25G. This is done by furnishing a report to the Health Authority on Form 5S, The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, paras 58 and 59.

³ *Ibid.*, s. 25H. This is done by furnishing a report to the Health Authority on Form 6S, The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, paras 65-67.

⁴ Baroness Cumberledge, Hansard HL Debs, Vol. 563, No. 79, col. 1238, 1 May 1995.

⁵ Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para 43, 46, 48.

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be no additional liability of the kind I think my noble friend has in mind. The supervisor would of course be personally liable in cases involving, for example, serious professional negligence, indiscipline or the abuse of patients. But in general liability would fall on the bodies responsible for providing the section 117 after-care services, not the supervisor personally, just because he or she fulfils that role.¹

Paragraph 41 of the addition to the Code of Practice States that "Staff undertaking duties defined in the Act remain professionally and managerially accountable for them in the normal way." The supervisor and other professionals will be carrying out functions under the Mental Health Act 1983, and therefore will have the defence in section 139 that they cannot be liable in criminal or civil proceedings unless they have acted negligently or in bad faith.

11.13.10 *The grounds for supervision*

The link between the new power and section 117 is emphasised in the grounds which must be met for a supervision application:

- (1) The patient must be suffering from mental disorder in one of the four forms prescribed for admission under section 3: (a) mental illness; (b) severe mental impairment; (c) psychopathic disorder; (d) mental impairment;

and

- (2) there must 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;

and

- (3) his being subject to after care under supervision must be likely to help to secure that he receives the after-care services to be so provided.²

Although the concerns which have given rise to the Act relate to mentally ill people, this power will extend to people with mental impairment, severe mental impairment and psychopathic disorder.

There must be a substantial risk of serious harm to the patient's health, which includes both physical and mental health, to his safety, or to the safety of others. This means that the risk must have substance, that is be a real one. The patients for whom the legislation is designed

¹ *Id.*

² Mental Health Act 1983, s. 25A(4) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

to provide are often described as revolving door patients who relapse following cessation of medication to a degree warranting compulsory admission. A substantial risk of serious harm to mental health could be said to be present in such cases, since a history of relapse would make the risk real, and relapse would amount to serious harm to health. The inclusion in the risk criterion of substantial risk of serious exploitation was criticised during the Committee stage in the Lords as "being capable of many interpretations." Baroness Cumberledge refused to remove these words, offering as examples of what the Government had in mind the risk of patients being "lured into prostitution or exposed to the risks of drug abuse."¹ The Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions* (paragraph 14) recommends that in cases involving mentally impaired patients the RMO should always consider whether guardianship might offer a better option for the patient's after-care.

The third criterion, that the power is likely to help to secure that he receives the after-care seems intended to provide a diluted counterpart to the requirement for detention for treatment under section 3 that the treatment cannot be provided unless the patient is detained. The RMO should consider the general effectiveness of supervised discharge and reach a conclusion as to whether in the individual case it is likely to assist the care team in ensuring that the patient receives the necessary after-care services.

11.13.11 Procedure for making an application

Regulations have been introduced providing new statutory documentation in relation to supervised after-care (The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294). The procedure for employing the new power departs radically from civil admission under the 1983 Act. Instead of the applicant being an Approved Social Worker (ASW) and the doctors providing the recommendations, here the RMO applies on Form 1S to the health authority for supervision,² with one of the two recommendations coming from an ASW,³ and the other from a doctor who will be concerned with the patient's medical treatment when he or she leaves hospital.⁴ If no doctor other than the RMO will be concerned with the patient's treatment, then the medical recommendation can come from any doctor, not necessarily a section 12 doctor. If the hospital RMO is to be the Community RMO, the recommendation should come from the patient's GP. If the RMO cannot identify a doctor who will be

¹ Hansard HL Debs, Vol. 563, No. 68, col. 108, 4 April 1995.

² The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2.

³ *Ibid.*, Form 3S.

⁴ *Ibid.*, Form 2S.

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involved in the patient's community treatment, a hospital doctor may make the application, but not one who works under the direction of the RMO.

The ASW making the social work recommendation may be the patient's supervisor. The ASW and the recommending doctor should ideally see the patient together, but in any event within a week of each other. Both should examine the patient's records and consider details of the after-care services to be provided.

Before making an application, the RMO must 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 section 117, any person who the RMO believes will play a substantial part in the care of the patient after he leaves hospital but will not be professionally concerned with any of the after-care services to be provided (hereafter referred to as "the informal carer"), and, where practicable the nearest relative, unless the patient objects.¹ If the patient does object, the nearest relative may not be consulted, unless (a) the patient has a propensity to violent or dangerous behaviour towards others, and (b) the RMO considers it appropriate to inform the nearest relative.² The RMO must take the views of the people consulted into account,³ and, before making the application, must also consider the after care services to be provided for the patient under section 117 and any requirements to be imposed as part of the after care under supervision.⁴ The Department of Health Internal Review describes the consultation process as designed to produce "a comprehensive multidisciplinary approach to care." There will be a named key worker, in practice probably a community psychiatric nurse, a care programme and a clear treatment plan negotiated with the patient. Those drawing up the plan would be responsible for finding out the patient's wishes and ensuring that they are taken into account as far as practicable. The conditions of the patient's supervision will be agreed with the key worker and any other agencies and people (including relatives) involved in the patient's care. The patient's freedom of choice must not be limited "unnecessarily."⁵ The names and addresses of those consulted must be recorded on Form 1S.

Form 1S states that the conditions of the application are met. The RMO must give grounds for the diagnosis, and reasons for the conclusion that the other two criteria are met. The Community RMO, and

¹ Mental Health Act 1983, s. 25B(2) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

² *Ibid.*, s. 25A(3).

³ *Ibid.*, s. 25B(2)(c).

⁴ *Ibid.*, s. 25B(3).

⁵ Department of Health, *Report of the Internal Review of Legal Powers on the Care of Mentally Ill People in the Community*, 1993, Department of Health, para. 7.16.

the supervisor must be identified in the application, which includes signed statements from the prospective Community RMO accepting that he or she will be in charge of the patient's medical treatment, and from the prospective supervisor that he or she is to supervise the patient. The application form must also contain a statement of the requirements to be imposed on the patient, and must be accompanied by written details of the after-care services to be provided.¹

The medical recommendation will state that all the conditions required for a supervision application are met, including that the patient is suffering from one of the four prescribed forms of mental disorder. The social work recommendation will be addressed only to the other two criteria: (1) that there would be 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; and (2) that after care under supervision is likely to help to secure that he receives the after-care services to be so provided.²

On making the application, the RMO will be required to inform the patient, the informal carer, and (if he has been consulted about the making of the application) the nearest relative,³ that the application is being made, what after care services will be provided, any requirements to be imposed on the patient, and the names of the Community RMO and the supervisor.⁴

The application is addressed to the Health Authority. Before accepting a supervision application the health authority will have to consult the local social services authority with the joint duty to provide after care under s. 117.⁵ Although there is no express requirement in the Act that the health and social services authorities must reach agreement, the Government did not think this necessary because, in Baroness Cumberledge's words. "In practice the statement of services to be provided, which has to be submitted with the supervision application, will need to have been agreed with the local authority's representatives so far as the social services element is concerned."⁶ When the Health Authority accepts an application it must inform the patient, the informal carer, and (if he has been consulted about the making of the application) the nearest relative.⁷

The Health Authority's functions in receiving applications and giving information may be delegated to a body with whom the Authority has contracted to provide section 117 services. In most cases this will be a

¹ *Ibid.*, s. 25B(8).

² *Ibid.*, s. 25B(5)-(7).

³ *Ibid.*, s. 25B(10)(b).

⁴ *Ibid.*, s. 25B(9)-(10).

⁵ *Ibid.*, s. 25A(7).

⁶ Hansard HL Debs, Vol. 563, No. 68, col. 117, 4 April 1995.

⁷ Mental Health Act 1983, s. 25A(8) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

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National Health Service Trust, but it could be a private or voluntary sector provider. The Health Authority may instead delegate to any of the following bodies (a) another Health Authority; (b) a committee or sub-committee, or an officer, of the Health Authority or another Health Authority; (c) a joint committee or a joint sub-committee of the Health Authority and one or more other Health Authorities; (d) a Special Health Authority; or (e) an officer of a Special Health Authority.¹

11.13.12 Powers of the After-care Bodies

Once patients are subject to after care under supervision, the responsible after-care bodies² have power to impose requirements for the purpose of securing that they receive after-care. The Health Authority may delegate its functions to one of the bodies listed in para. 11.13.11 above and, if it does so, the local authority may delegate its functions to the same person or body.³

The conditions which may be imposed include: (a) that the patient reside at a specified place; (b) that he or she 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 he or she is residing, to the supervisor, any doctor or any approved social worker, or to any other person authorised by the supervisor.⁴

The reasons for imposing the requirements should be explained to the patient. The power to require attendance at specified places and times for the purpose of medical treatment, occupation, education or training does not include a power forcibly to treat.⁵

The terms of supervised discharge may include a power to require access to be granted to the patient at the place of residence by the supervisor, any doctor, any Approved Social Worker, or any person authorised by the supervisor. If such a term is included, these people have powers to require entry to any premises where the patient, is residing, subject to the requirement that the person seeking access must carry documentary evidence of their entitlement to enter.⁶ If the patient refuses access it would lead to a review of the case. If any other person refuses to allow access it would be an offence under section 129 of the Act. If the supervisor considers that forced entry is necessary, this may

¹ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

² The bodies which have the joint duty under s. 117, see s. 25D(2).

³ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

⁴ *Ibid.*, s. 25D(3).

⁵ Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para. 19.

⁶ Mental Health Act 1983, s. 25D inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

only be authorised by a warrant under section 135, which would need to be executed by the police.¹

The conditions of supervision are modelled on the conditions of guardianship in s. 8(1) of the 1983 Act. The major difference is that the Act introduces a power to "take and convey." The power to take and convey to a place where the patient is required to attend will only be available where the conditions of supervision include an attendance requirement. All proponents of compulsory community supervision were agreed that they do not want a power to treat forcibly in the patient's own home, concerns described by Geller as reflecting ideas of territorial propriety, that any compulsory medication would take place not in "their community", but in "our institution".² The Act provides that:

A patient subject to after-care under supervision may be taken and conveyed by, or by any person authorised by, the supervisor, to any place where the patient is required to reside or to attend for the purpose of medical treatment, occupation, education or training.³

This is in effect a power of arrest. Section 137 of the 1983 Act defines "convey" as including any other expression denoting removal from one place to another, and deems people being taken and conveyed to be in legal custody. The principal reference to the power to take and convey in relation to non-offender patients in the 1983 Act is in section 6(1), which provides that a duly completed application form shall be sufficient authority for the applicant or any person authorised by him/her to take and convey the patient to hospital. The purpose of this is to protect those acting on an application for compulsory admission against an action for wrongful imprisonment. *Winterwerp v. The Netherlands*⁴ and *X v. United Kingdom*⁵ set down the criteria for a psychiatric arrest to be lawful under Article 5 of the European Convention on Human Rights. Except in an emergency, before a person can be arrested on grounds of unsoundness of mind there must be objective expert evidence of mental disorder of a nature or degree warranting detention. A completed application with the accompanying medical recommendations would satisfy those requirements. For a psychiatric arrest to be lawful under the Convention the person must be reliably shown to be of unsound mind of a nature or degree warranting detention, entailing "the establishment of a true mental disorder before a competent author-

¹ Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para. 51.

² J. L. Geller, "The quandries of enforced community treatment and unenforceable outpatient commitment statutes" (1986), *Journal of Psychiatry and Law*, 149-158, 151.

³ *Ibid.*, s. 25D(4).

⁴ (1979) 2 EHRR 387.

⁵ (1981) 1 BMLR 98 (1982) 4 EHRR 188.

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ity on the basis of objective expertise.”¹ The evaluation may come from a general practitioner and need not necessarily come from a psychiatrist.² However, there is an exception for emergencies. In *X v. the United Kingdom* the Court stated that it could not be inferred from the *Winterwerp* judgment that the objective medical expertise must in all conceivable cases be obtained before rather than after confinement of a person on grounds of unsoundness of mind. The Court considered that where a provision of domestic law is designed, amongst other things, to authorise emergency confinement of persons capable of presenting a danger to others, it would clearly be impracticable to require thorough medical examination prior to any arrest or detention. In their view, “A wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements.”³ Where there is an emergency involving a risk that the patient will behave in a dangerous manner, the expert evaluation may take place after admission. In such circumstances the interests of the public prevail over the individual’s right to liberty to the extent of justifying an emergency confinement in the absence of the usual guarantees implied in Article 5(1)(e).⁴ Nevertheless, it must be doubtful whether detention on grounds of the person’s own health can be justified without prior medical assessment.

The Act does not specify the circumstances in which the patient may be taken and conveyed, nor does it attach conditions to the power, beyond that it is exercisable by the supervisor or any other person authorised by him or her, and that whoever is exercising it must, if asked, produce a duly authenticated document showing that he is entitled to take and convey the patient. At the Committee stage in the Lords, Baroness Cumberledge said in Committee that the power to convey “would give useful backing to the care team, for example where there is temporary reluctance to co-operate . . .” but would be “used only in times of emergency.”⁵ At the Report stage she sent out equally conflicting signals as to the circumstances in which the power would be used, refusing to accept amendments designed to subject the power to limiting criteria and procedures through a “conveyance application.” Having said that she felt it would be used in only “fairly rare cases”,⁶ but then implied that it might be used other than in emergencies with the following statement:

If a patient is on supervised discharge, the health authority would have accepted a supervision application at the outset, and . . . the

¹ See *X v. United Kingdom* 1981, para. 40; *Winterwerp* 1979, para. 39; *Luberti v. Italy* Series A, No. 75, Judgement of 23 February 1984.

² Commission Report *Schuurs v. the Netherlands*, Application No. 10518/83, p. 3, paras 5–10, 7 March 1985.

³ *X v. the United Kingdom*, para. 41 of the judgement.

⁴ *Ibid.*, para. 45.

⁵ Hansard HL Debs, Vol. 563, No. 68, cols 154 and 156, 4 April 1995.

⁶ Hansard HL Debs, Vol. 563, No. 79, col. 1252, 1 May 1995.

authorisation of a power to convey is implicit in that original acceptance. That power would be used only *under limited circumstances, but I understand it may be particularly valuable in emergencies*.¹ (emphasis added)

The Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions* (paras 48–50), specifies in more detail the circumstances in which the power may be used, and gives guidance on the mechanics of using it. The authorities must carefully consider the circumstances in which the power should be used, and the Code advises the production of a local inter-agency protocol to define the circumstances in which it may or may not be used and the records which should be kept. The Code suggests that the Supervisor may decide to use the power in the following circumstances: (a) if the patient has got into a situation where he or other people are being put at risk and he needs to be taken home urgently; or (b) if the patient is not attending for medical treatment and it is thought that this might be overcome by taking him or her to the place where treatment is to be given. In the latter case, the Code emphasises that the patient cannot be required to accept medical treatment and the power should only be used if the supervisor is satisfied that it is likely to lead to the patient co-operating with the services being provided. The supervisor should also consider whether the problem might be overcome by an adjustment to the care package, or whether it may point to a need to reassess the patient for compulsory admission.

Paragraph 50 of the Amendment to the Code emphasises that the power to take and convey, or the threat of using it should never be used to coerce a patient into accepting medication, and that where a patient has been conveyed, medical and other staff need to be satisfied that his or her consent to any subsequent treatment is genuine and not forced. “A patient who has been conveyed to a clinic and then insists on leaving cannot be kept there or given treatment against his or her will (except in circumstances allowed by common law where it may be permissible to administer treatment to deal with the immediate emergency).”

11.13.13 *Review, Modification and Transfer of After-Care*

The after care bodies have a duty under section 25E(1) to keep under review the after care services and the requirements imposed on the patient.² Where the patient “refuses or neglects to receive” any or all of the after care services provided for him (in most cases this will mean medication), or to comply with any or all of the requirements

¹ *Ibid.*, col. 1254.

² Mental Health Act 1983, s. 25E(1) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

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imposed on him, the responsible after care bodies are required by section 25E(3) to review and (where appropriate) modify the services and the requirements imposed on the patient.¹ The Health Authority and the local authority are precluded from delegating their functions under section 25E(1) and (3) insofar as they relate to review and modification of section 117 services.²

Under section 25E(4) the after-care bodies must consider whether it might be appropriate for the patient to cease to be subject to after-care under supervision, and if so, must inform the community RMO. They must also consider whether it might be appropriate for the patient to be admitted to hospital for treatment and, if they conclude that it might be, inform an approved social worker. The important aspect here is that under the Act it would be for the after-care bodies, not the community RMO or the supervisor, to bring in the ASW to consider compulsory admission. The Royal College of Psychiatrists' proposed Community Supervision Order had included a separate power of recall to hospital with less stringent criteria for admission. The Health Authority may delegate its functions under section 25E(4) to one of the bodies listed in para. 11.13.11 above and, if it does so, the local authority may delegate its functions to the same person or body.³

As part of the review which would take place in the event of non-compliance, consideration will have to be given to whether the patient's condition has deteriorated so far as to meet the criteria for compulsory admission under the 1983 Act, as interpreted in the 1993 revision of the Code of Practice.⁴ The Department of Health Review expressed concern that a recall power which did not require evidence that the patient was at the time of recall suffering from mental disorder of a nature or degree warranting detention would contravene Article 5 of the European Convention on Human Rights.

Before the after-care bodies modify the services or the requirements of the supervised after-care, they have to consult the patient, the informal carer and, where practicable, the nearest relative. If the patient objects to the nearest relative being consulted, no consultation can take place unless (a) the patient has a propensity to violent or dangerous conduct towards others, and (b) the Community RMO considers it appropriate to inform the nearest relative.⁵ They also have to inform the patient, the informal carer, and (if he has been consulted) the nearest relative if they do modify the services or the requirements.⁶ If

¹ *Ibid.*, s. 25E(2)–(3).

² The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2(5).

³ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

⁴ *Ibid.*, para. 8.14e–f.

⁵ Mental Health Act 1983, s. 25E(6)–(7) inserted by the Mental Health (Patients in the Community) Act 1995, s. 1(1).

⁶ *Ibid.*, s. 25E(8).

the Community RMO or the supervisor is changed, the patient must be informed orally and in writing, and the informal carer must also be notified. Such steps as are practicable must also be taken to inform the nearest relative unless the patient has otherwise requested.¹ The Act contains express provisions to deal with the situation where a patient under supervision moves from Scotland (where different arrangements apply) to England or Wales and vice versa. As for transfers within England and Wales, the Government considers that section 117 already allows sufficient flexibility, by simply placing a duty on the authorities where the patient is resident, regardless of whether those authorities change because of where the patient resides.² The section 117 after care form provides for the transfer of responsibility between authorities.

11.13.14 *Renewal*

After-care under supervision will last for six months, renewable for six months and thereafter for a year at a time. The procedure for renewal is that the Community RMO examines the patient within the last two months of the current period of supervision and furnishes a report to the responsible after-care bodies if the conditions for after-care under supervision are met.³ Furnishing the report has the effect of renewing the supervised after-care. There is no limit on the number of renewals.

Before furnishing a renewal report, the Community RMO must consult the patient, the supervisor, one or more persons (if there is anyone) other than the Community RMO who are professionally concerned with the patient's medical treatment, one or more persons professionally concerned with the after-care services provided, and the informal carer.⁴ Unless the patient objects, such steps as are practicable must be taken to consult the person appearing to be the nearest relative.⁵ If the patient objects to the nearest relative being consulted, no consultation can take place unless (a) the patient has a propensity to violent or dangerous conduct towards others, and (b) the Community RMO considers it appropriate to inform the nearest relative.⁶

When a renewal report is furnished under s. 25G(3) the responsible after-care bodies are obliged by section 25G(8) to inform the patient orally and in writing that the report has been furnished and of the effect of renewal of after-care under supervision, including the rights

¹ *Ibid.*, s. 25E(9)–(11).

² Hansard HL Debs, Vol. 563, No. 789, col. 1259, 1 May 1995.

³ *Ibid.*, s. 25G. This is done by furnishing a report to the Health Authority on Form 5S, The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, paras 58 and 59.

⁴ *Ibid.*, s. 25G(5).

⁵ *Ibid.*, s. 25G(5)(b).

⁶ *Ibid.*, s. 25G(6).

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of application to a MHRT which are available. They must also inform the informal carer and, if he has been consulted about the renewal, the nearest relative.

The Health Authority may delegate its functions of receiving the renewal report under section 25G(3) and of giving information under s. 25G(8) to one of the bodies listed in para. 11.13.11 above and, if it does so, the local authority may delegate its functions to the same person or body.¹

11.13.15 *Reclassification*

The Community RMO has the power to reclassify the patient as suffering from a different form of mental disorder from that specified in the application. This is done by furnishing a report to the responsible after-care bodies on Form 4S.² Before furnishing such a report the Community RMO must consult another person who is professionally concerned with the patient's medical treatment, unless no-one other than the Community RMO is so professionally concerned.³ Where a reclassification report is furnished, the responsible after care bodies are obliged by section 25F(4) to inform the patient both orally and in writing, and, unless the patient has requested otherwise, to take such steps as are practicable to inform the person appearing to be the nearest relative. The Health Authority may delegate its functions of receiving the reclassification report under section 25F(1) and of giving information under s. 25F(4) to one of the bodies listed in para. 11.13.11 above and, if it does so, the local authority may delegate its functions to the same person or body.⁴

11.13.16 *The Community RMO's Power of Discharge*

The Community RMO has the power to direct discharge by making a direction to the Health Authority or provider unit on Form 6S.⁵ Before doing so he must consult and take into account the views of the patient, the supervisor, one or more persons (if there is anyone) other than the Community RMO who are professionally concerned with the patient's medical treatment, one or more persons professionally concerned with the after-care services provided, and informal carer.

¹ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

² *Ibid.*, s. 25F. The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para. 57.

³ *Ibid.*, s. 25F(3).

⁴ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

⁵ *Ibid.*, s. 25H. The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, Sch. 2. Amendment to the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, paras 65-67.

Unless the patient objects, such steps as are practicable must be taken to consult the person appearing to be the nearest relative.¹ If the patient objects to the nearest relative being consulted, no consultation can take place unless (a) the patient has a propensity to violent or dangerous conduct towards others, and (b) the Community RMO considers it appropriate to inform the nearest relative.² The Health Authority must inform the local social services authority that supervised discharge has been terminated and should note on the form that this has been done.³ The duty to provide section 117 after-care services does not end simply because the supervision has been terminated. The duty continues until the authorities are satisfied that the after-care services are no longer needed. The responsible after-care bodies have no power themselves to terminate supervised discharge, although the patient may be discharged from supervision by a Mental Health Review Tribunal (see para. 18.08.4).⁴

If the patient is discharged, the responsible after-care bodies must inform the patient orally and in writing, and notify the informal carer. Unless the patient objects, such steps as are practicable must be taken to inform the person appearing to be the nearest relative.⁵ If the patient objects to the nearest relative being informed, no information may be given unless the nearest relative was consulted about the discharge because the Community RMO certified that (a) the patient has a propensity to violent or dangerous conduct towards others, and (b) the Community RMO considers it appropriate to inform the nearest relative.⁶ The Health Authority may delegate its function of giving information under s. 25H(6) to one of the bodies listed in para. 11.13.11 above and, if it does so, the local authority may delegate its functions to the same person or body.⁷

A patient automatically ceases to be subject to supervised after care if he or she is admitted to hospital under section 3 (but not section 2 or section 4) of the 1983 Act, or is received into guardianship.⁸ If a patient is admitted under section 2 for assessment, the obligation to comply with the requirements of supervised discharge is suspended during the detention.⁹ A person who is given a custodial sentence by a court is not required to receive after care services whilst in custody.¹⁰ If the supervised discharge is still current when the person is released

¹ *Ibid.*, s. 25H(3)(b).

² *Ibid.*, s. 25H(4).

³ Amendment of the Code of Practice *Guidance on Supervised Discharge (After Care under Supervision) and Related Provisions*, para. 65.

⁴ *Ibid.*, s. 72(4A).

⁵ *Ibid.*, s. 25H(6).

⁶ *Ibid.*, s. 25H(7).

⁷ The Mental Health (After-care under Supervision) Regulations 1996, S.I. 1996, No. 294, reg. 2.

⁸ *Ibid.*, s. 25H(5).

⁹ *Ibid.*, s. 25I(1) and (2).

¹⁰ *Ibid.*

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from prison, it will be reactivated at that point. If the person is serving a period of imprisonment amounting to six months or less or is detained under section 2, and the period of after-care under supervision would have come to an end during that period, section 25I(3) and (4) apply, so that the supervision is deemed to be extended for a further period of 28 days from the date of release from detention. This is to give the authorities time to have the patient re-examined and where appropriate renew the supervision. If the supervision is renewed it takes effect from the date when it would have been renewed had it not been for any extension.¹

11.14 Absence Without Leave²

Section 18 provides powers for retaking patients: who are absent from hospital without leave, fail to return to hospital either at the end of an authorised leave of absence or when recalled, or are absent without permission from a place they are required to live either by the conditions of their leave of absence from hospital or by their guardians (s. 18(1), (3)).³ A patient who is liable to be detained in hospital may be retaken into custody and returned to hospital or place he is required to be by an ASW, any officer on the staff of the hospital, any constable or by any person authorised in writing by the hospital managers (s. 18(1)).⁴ If the patient is required to reside in another hospital as part of the conditions of his leave of absence he can also be retaken by any officer on the staff of that hospital or by any person authorised by the managers of that hospital (s. 18(2)). A patient absent without leave while under guardianship may be taken into custody by any officer on the staff of a local social services authority, by any constable or by any person authorised in writing by the guardian or a local social services authority (s. 18(3)).

A patient who is subject to guardianship or to long term powers of detention such as under an application for treatment (s. 3) or a hospital order (s. 37) cannot be retaken if he is absent without leave for a continuous period of six months, or at the end of the current period of liability to detention, whichever is the later (s. 18(4)). This provision allows a patient to be taken into custody at any time within six months of the date on which s/he was first absent without leave, or, if later, the end of the existing authority for detention or guardianship. If the patient returns or is returned before the expiry of the six month period,

¹ *Ibid.*, s. 25I(5).

² In the Act "absent without leave" means absent from any hospital or other place and liable to be taken into custody and returned under s. 18 (s. 18(6)).

³ Section 18 is applied, with modifications, to patients under hospital orders, guardianship orders or restriction orders (Sch. 1, Pt. I, para. 2, Pt. II, para. 2) and to patients who have been sentenced to imprisonment (s. 22(2)(b)).

⁴ As to the powers of constables to forcibly enter a premises for the purpose of retaking a patient who is absent without leave, see para. 12.03.02 *post*.

but is still absent without leave on the day when his detention or guardianship would have expired or within the period of one week ending with that day, his detention is extended for one week following his return to enable a renewal report to be made (s. 21 and see para. 11.16 below). A patient who is subject to longer-term powers of detention, such as under an application for treatment (s. 3) or under a hospital order (s. 37), cannot be retaken if he is absent without leave for a continuous period of 28 days; the patient's liability to detention ceases after the expiration of the 28 day period (s. 18(4)). If the patient returns or is returned to hospital within the 28 day period he can be detained for a further one week to enable the formalities for renewing the authority to detain to be completed (s. 21(1)). (See para. 11.16 below).

The managers (or the local authority for guardianship patients) should have a clear written policy regarding the action to be taken when a patient goes absent without leave. The policy should include the duty to inform the nurse in charge and the RMO; search of the hospital grounds; circumstances when the police should be informed (see Department of Health Memorandum, para. 288); and the importance of informing the nearest relative. (Code of Practice, para. 21.1-21.3).

11.15 Patients Absent from Hospital in England and Wales

Any patient who is absent without leave or who has escaped from custody and may be retaken into custody in England and Wales under section 18 or 138 can be taken into custody and returned to England and Wales from any other part of the United Kingdom, Channel Islands or the Isle of Man (s. 88). Section 88 does not apply to guardianship patients (s. 88(4)); thus, if a patient subject to guardianship absconds from the place he is required to reside, he cannot be retaken in other parts of the United Kingdom. (See further para. 19.06.2 *post.*)

11.16 Special Provisions as to Patients Absent without Leave

Sections 21, 21A and 21B contain special provisions as to patients absent without leave. Section 21 of the 1983 Act applies where a patient returns or is returned before the expiry of the six month period, but is still absent without leave on the day when his detention or guardianship would have expired or within the period of one week ending with that day. It provides that the liability to detention or guardianship of a person who is taken into custody and returned, or who returns him or herself will not expire until the end of one week from the day on which he returns or is returned to the hospital or place where he ought to be. If the patient's liability to detention has expired and the six months during which he can be retaken has also expired before the patient returns or is returned, he or she ceases to be liable to be retaken.

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Section 21A applies where a patient who is absent without leave returns or is returned within 28 days of absconding and the period for which he is liable to be detained or subject to guardianship has been extended for one week by section 21(1) and (2). Any renewal examination and report may be made and furnished within the period as so extended. If the guardianship or detention is renewed in this way, the renewal takes effect from the day on which the previous authority would have expired, had it not been extended by operation of section 21.¹

Section 21B applies to patients who are absent without leave and return or are returned later than 28 days after absconding. If the authority for detention or guardianship expired during the absence without leave or has less than seven days to run on the date of return to the hospital or place where he ought to be, section 21 extends it for one week. If during the week following return the appropriate medical officer (the RMO of a patient who is liable to be detained or subject to local authority guardianship, or the nominated medical attendant of a patient in private guardianship) has a duty to examine him within one week of his return. If it appears that the detention or guardianship ought to be renewed, the doctor must furnish a renewal report to the hospital managers or, in the case of a guardianship patient, to the local authority. The appropriate body must then cause the patient to be informed of the renewal. Before furnishing the report in respect of a detained patient, the appropriate medical officer must consult one or more persons who have been professionally concerned with the patient's medical treatment; and an approved social worker (s. 21B(3)). If no renewal report is furnished within a week of the patient's return, he ceases to be liable to be detained or subject to guardianship, even if the previous authority has not expired (s. 21B(4)). If the authority for the patient's detention or guardianship would have expired before the end of the one week period following return and a renewal report is furnished, the detention or guardianship is renewed for the period provided for in section 20(2) (s. 21B(5)). The renewal has effect from the date when the previous authority would have expired (s. 21B(6)). If the authority for detention or guardianship would expire within the period two months of furnishing a renewal report under s. 21B(2), and a renewal report has been furnished under that provision, that report may have effect as a renewal report for the purposes of section 20. This means that the renewed detention or guardianship will run for six months or twelve months as appropriate from the date when the report was furnished, not when the previous period would have expired. The report under section 21B(2) may specify a different form of mental disorder from that which appeared in the original application, and if it does, it has the effect of both renewing the detention or guardianship

¹ Mental Health Act 1983, s. 21A.

and reclassifying the patient without any need to submit a separate reclassification report under section 16 (s. 21B(9)).

11.17 Special Provision as to Patients Sentenced to Imprisonment

If a patient who is subject to an application for treatment or guardianship is sentenced, or committed or remanded in custody, by a court in the United Kingdom for more than six months, the application ceases to have effect at the expiration of the period spent in custody (s. 22(1)). If the patient is detained in custody for less than six months and his liability to detention in hospital or guardianship would otherwise have expired, he does not cease to be liable to detention or guardianship until the day he is discharged from custody. He will then be treated as if he were absent without leave on that day (s. 22(2)). Thus, the patient can be taken into custody and returned to hospital or guardianship within 28 days of his release from custody (s. 18(3)) and the authority for detention or guardianship can be renewed (s. 21(1)).

11.18 Transfer of Patients

The Secretary of State for Social Services is empowered by section 19 to regulate the circumstances in which detained patients and guardianship patients can be transferred between hospitals or guardians or between hospital detention and guardianship (s. 19(1)). He may also regulate the conveyance to their destination of patients authorised to be transferred (s. 19(4), reg. 9).

11.18.1 *Transfers between Hospitals under Different Managers*

A detained patient may be transferred to another hospital under **different managers** subject to the following conditions:

- (i) The managers of the hospital in which the patient is liable to be detained must give authority for the transfer in Form 24, Pt. I.
- (ii) Those managers must first be satisfied that arrangements have been made for the admission of the patient to the hospital to which he is to be transferred within 28 days of the date the form is signed.
- (iii) When the patient is transferred, the managers of the hospital to which he is transferred must record his admission in Form 24, Pt. II (reg. 7(1)).

Note that the managers of **both** hospitals need to agree before a patient can be transferred. (As to the role of the managers, see para. 6.03 *ante*.) When the patient is transferred the application for admission for assessment or treatment is amended as if the patient had been originally admitted to the hospital to which he is transferred (s. 19(2)(a)). In practice, the major obstacle to arranging a transfer is

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in finding a consultant in a hospital who is prepared to make a bed available. This is particularly difficult when a transfer to or from a special hospital is desired. (see further para. 3.08.1 *ante*)

The courts are quite reluctant to interfere with the consultant psychiatrist's exercise of clinical judgement in recommending a transfer. In *R. v. Inner London Education Authority, ex parte F*¹, a consultant sought to transfer a patient aged 15 who did not want to be transferred. She applied for an interlocutory application for an order of mandamus restraining the health authority from transferring her. The court had to bear in mind that it should not deprive the doctor of his right to take such action as was dictated by his own best clinical judgement.

11.18.2 *Transfers between Hospitals under the Same Managers*

Regulation 7 discussed above does not apply to patients transferred between hospitals under the **same managers** (s. 19(3)) or transfers between and from special hospitals (s. 123(1), (2); see further para. 3.08 *ante*). Section 19(3) provides that the hospital managers may remove a detained patient to another hospital managed by the same District Health Authority or special health authority. There are no particular formal requirements for a transfer of this kind.

11.18.3 *Transfers from Hospital into Guardianship*

A detained patient may be transferred into guardianship subject to the following conditions:

- (i) the hospital managers must give their authority in Form 25, Pt. I;
- (ii) the local social services authority must agree to the transfer in Form 25, Pt. II, and must have specified a date on which the transfer is to take place;
- (iii) if the transfer is to be to a private guardian, his agreement must be recorded in Form 25, Pt. III (reg. 7(3)).

When the patient is transferred the application for admission for assessment or treatment is amended as if it were a guardianship application (s. 19(2)(b)).

11.18.4 *Transfer between Guardians*

A guardianship patient may be transferred into the guardianship of another local social services authority or person subject to the following conditions:

- (i) the guardian must give authority in Form 26, Pt. I;

¹ (1988) *The Times*, November 28, 1988, Q.B.D., Lloyd, L. J. and Auld, J.

- (ii) the transfer must be agreed by the local authority who will be responsible in Form 26, Pt. II, and that local authority must specify a date on which the transfer will take place; and
- (iii) if the transfer is to a private guardian, his agreement must be recorded in Form 26, Pt. III (reg. 8(2)).

When the patient is transferred the guardianship application is amended as if it originally specified the new guardian (s. 19(2)(c)).

11.18.5 *Transfer from Guardianship to Hospital*

A guardianship patient may be transferred to hospital by authority of the responsible social services authority in Form 27 where:

- (i) An application for admission for treatment has been made by an ASW (see para. 7.14 *ante*), complying with section 11(4) (see para. 7.16 *ante*).
- (ii) Such application is founded on two medical recommendations in accordance with s. 12 (see para. 11.10 above).
- (iii) The application is accepted by the hospital managers, and the local social services authority is satisfied that arrangements have been made for his admission within 14 days of the authority for transfer.
- (iv) The local social services authority must take such steps as are practicable to inform the nearest relative of the proposed transfer.

The hospital managers must record the transfer in Form 14 (reg. 8). When the patient is transferred, the guardianship application is amended as if it had originally been an application for admission for treatment and the patient had been admitted to that hospital (s. 19(2)(d)). When a patient is transferred from guardianship to hospital he has a right to apply to a Mental Health Review Tribunal (s. 66(1)(e)). If he does not exercise this right within six months of the transfer, the hospital managers must automatically refer his case to the Tribunal (s. 68(1)).

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