Chapter 15

MENTAL DISORDER AT THE TIME OF SENTENCING

15.01 Introduction

Traditionally mentally disordered offenders have been exempt from ordinary penal measures either on the ground that they are not

criminally responsible for their behaviour (*i.e.* not guilty by reason of insanity (see paras. **13.02–13.05** *ante*) or they are unable to understand the course of the proceedings at the trial (*i.e.* unfit to plead or to stand trial) (see paras. **14.05–14.13** *ante*). In both instances, as already discussed, the court has no choice but to make an order admitting the person to hospital. Offenders found not guilty by reason of insanity or unfit to plead account for only a very small percentage of the total number of mentally disordered patients admitted to hospital. These traditional legal procedures were originally designed as ways of diverting the mentally disordered offender from the criminal justice system to the mental health system. Because of the narrow concept of legal insanity both in the fitness plea and the special verdict, it was difficult to excuse a mentally disordered person from criminal punishment. These traditional procedures for avoiding criminal punishment have been largely supplanted by a 'utilitarian' approach introduced by the Mental Health Act 1959 under which courts were first empowered to make hospital orders. In making a hospital order the court relinquishes control over the offender; the offender is sent to hospital as if he were admitted for treatment in pursuance of the civil provisions of Part II of the 1983 Act. Thus, he can be discharged at any time by the hospital managers, the responsible medical officer or a Mental Health Review Tribunal. A **Crown Court** can make a hospital order subject to restrictions on discharge known as a "restriction order". This means that the patient can only be discharged by, or with the consent of, the Home Secretary or by a tribunal.

A. HOSPITAL ORDER

15.02 No Causal Connection Between the Mental Disorder and the Offence

In making a hospital order, with or without restrictions, the court is not concerned with the criminal responsibility of the offender, or whether he is capable of understanding the proceedings of the trial (he usually has already been tried and convicted);[1] the only relevant considerations are his mental condition and his suitability for psychiatric treatment **at the time of sentencing**. Thus, contrary to popular belief, no causal relationship has to be established between the mental disorder and the criminal behaviour.[2] A hospital order can be made notwithstanding the fact that no such causal connection can be established and

[1] Under s. 37(3) of the 1983 Act a magistrates' court can, in certain circumstances, make a hospital order without recording a conviction. See further para. **15.05** *below*.

[2] The legal principle corresponds well with the scientific reality. It is usually difficult to establish any causal relationship between mental disorder and the commission of a crime. Mentally disordered people often have ordinary motives including greed, jealousy and need for food, sleep or shelter. See discussion and references cited in L. Gostin (1977; vol. 2) *A Human Condition*, MIND, London, pp. 6–9.

the fact that the offender is responsible for his criminal act.[1] Further, the offender's consent to a hospital order is not required.[2]

There has been a steady decline in the use of hospital orders.[3] This is partly due to the fact that courts have had some difficulty in finding hospital beds for mentally disordered offenders. There has been a conscious effort to reverse this trend: first, there is a programme of developing medium secure units in each Regional Health Authority and in Wales (see paras. **3.14–3.15** *ante*); second, sentencing courts have been given the power to require regional health authorities to provide information about hospitals that could make a bed available for an offender (see further para. **15.09** below). There are, however, several features of the 1983 Act which could make it more difficult to make a hospital order including the introduction of an express 'treatability' requirement for offenders suffering from one of the minor disorders.

15.03 Preference for a Hospital Order Over a Sentence of Imprisonment

Where sufficient medical evidence is given to satisfy the criteria and procedures of the Act and where it is consistent with public safety, the court should make a hospital order. The matter should not be left to be dealt with by the Home Secretary who has the power to transfer to hospital a person who is serving a sentence of imprisonment.[4] The only exceptions are where:

(*i*) There is a particular need to mark the gravity of the offence with punishment. Thus, in extreme cases where a particularly heinous crime has been committed, the court may impose a sentence of imprisonment even if there is sufficient medical evidence to warrant a hospital order.[5]

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[1] *R. v. Hatt* [1962] Crim. L. Rev. 647; *R. v. McBride* [1972] Crim. L. Rev. 322.

[2] The Act does not lay down a requirement of consent before a hospital order can be given, and the courts have never considered this as a relevant factor. See commentary following *R. v. Gunnee* [1972] Crim. L. Rev. 261.

[3] In 1966, 1,440 hospital orders were made, whereas in 1982 there were only 762.

[4] *R. v. Morris* (1961) 45 Cr. App. R. 185 (where punishment is not intended and the sole object of the sentence is that the offender should receive treatment for mental disorder, a hospital order ordinarily should be made; but in the circumstances of the particular case, where a bed in a **secure** hospital could not be found for a dangerous offender, the court could properly pass a sentence of imprisonment.) See *R. v. Cox* (1967) 52 Cr. App. R. 130 (hospital order substituted for sentence of imprisonment on ground that a bed in a secure hospital was made available); *R. v. James* [1961] Crim. L. Rev. 842; *R. v. Horan* [1974] Crim. L. Rev. 438.

[5] *R. v. Gunnell* (1966) 50 Cr. App. R. 242 (in a case where punishment is required it is right to send the offender to prison even though he qualifies for a hospital order and a bed is available in a secure hospital); *R. v. Harvey and Ryan* [1971] Crim. L. Rev. 664. However, it is not proper for a judge to decline a hospital order and impose a sentence of life imprisonment solely because of a worry that a mental health review tribunal may prematurely release an individual. *R. v. Fairhurst* [1996] 1 Cr. App. R (S) 242, C.A.

(*ii*) The offender presents a danger to the public and a bed cannot be found for him in a **secure** hospital.[1]

(*iii*) The offender is suffering from mental disorder for which there is no reasonable prospect of benefit from treatment.[2] (There is now a statutory requirement as to treatability which, in relation to the minor forms of mental disorder, expressly prevents the courts from making a hospital order unless there is evidence that treatment is likely to alleviate or prevent a deterioration of his condition (see para. **15.06** below)).

A hospital order is considered a remedial order designed to treat and cure the offender and is not regarded by the courts as more severe than a sentence of imprisonment of whatever length. This is so despite the fact that it may involve detention for a longer period of time than if a sentence of imprisonment were passed. Accordingly the Court of Appeal has the power, in an appropriate case, to substitute a hospital order for a sentence of imprisonment.[3]

15.03.1 *Evidence of Mental Disorder After Imposition of Prison Sentence*

In *R v. Castro*,[4] the appellant pleaded guilty to importing cocaine and was sentenced to five years imprisonment. There was no medical evidence presented at trial demonstrating that he was mentally disordered. Thereafter, he was transferred to hospital with a restriction direction (see para. **16.03** post) and later returned to prison because of a shortage of hospital beds. On appeal against sentence the Criminal Court of Appeal said it would "very seldom . . ., where mental illness is concerned, interfere with a sentence of imprisonment which was properly imposed in light of evidence which was available to the sentencing judge."

In rare cases where evidence subsequently becomes available to show the defendant was mentally disordered at the time of the offence it might be desirable for the court to make a hospital order. A major criterion for the Court of Appeal to apply in these circumstances is the degree of responsibility which the appellant has for the crime. In *Castro* "it is quite impossible to say that the man's mental illness so reduced his responsibility that an order under section 37 would be appropriate." The matter needs to be viewed not only from the perspective of the

[1] *R. v. Morris* (1961) 45 Cr. App. R. 185; *R. v. Higginbotham* (1961) 45 Cr. App. R. 379 at 386–387; *R. v. Jones*, Nov. 19, 1976, reproduced in D. A. Thomas (1983) *Current Sentencing Practice*, Sweet & Maxwell, London, para. F2.3(*b*), (*c*); *R. v. Gordon* [1981] 3 Cr. App. R. (S)352; *R. v. McFarlane* (1975) 60 Cr. App. R. 320.

[2] *R. v. Gills* [1967] Crim. L. Rev. 247; *R. v. Woolland* (1967) 51 Cr. App. R. 65; *R. v. Carr*, The Guardian, March 26, 1963; *R. v. Nicholls*, not reported, judgment given April 16, 1973. See D. A. Thomas (1979; 2nd. ed.) *Principles of Sentencing*, Heinemann, London, pp. 297–98.

[3] *R. v. Bennett* (1968) 52 Cr. App. R. 514.

[4] (1985) 81 Cr. App. R. 212, C.A.

appellant but also from the perspective of the public. If psychiatric treatment is required, then it is a matter for the Home Secretary to make a transfer direction under the Act.

Under *Castro*, then, the decision of the court as to the proper disposal of an appellant depends, in substantial part, on the degree of responsibility the appellant had for the crime. In *Castro* the evidence showed that the responsibility for the crime was not affected by mental illness. In *R. v. DeSilva*,[1] however, the Court of Appeal found that there was substantial evidence that the defendant's mental condition at the time of the offence affected his responsibility for the crime. The Court of Appeal found that the defendant's history of mental illness had not been adequately considered at trial. The court's sentence of life imprisonment was quashed and replaced with a hospital order under section 37 and a restriction order under section 41.

15.04 Who can be made the Subject of a Hospital Order?

A hospital order, if appropriate, can be made by a Crown Court in respect of any person convicted of an offence punishable with imprisonment;[2] but no hospital order can be made where the offender is convicted of murder as the sentence (life imprisonment) is fixed by law.[3] A hospital order can be made by a magistrates' court in respect of an offence punishable on summary conviction with imprisonment (s. 37(1)).[4] In dealing with a juvenile, only a juvenile court may make a hospital order.[5] If an adult magistrates' court considers that a hospital order should be made it must remit the case to the juvenile court under the Children and Young Persons Act 1933 (s. 56(1)).

15.05 Magistrates' Power to make a Hospital Order without Recording a Conviction

The magistrates' court has the power to make a hospital order without recording a conviction. The person must be suffering from a major form of mental disorder (*i.e.*, mental illness or severe mental impairment). The court must also be satisfied that the accused person did the act or made the omission charged (s. 37(3)).[6]

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[1] 15 Cr. App. R(S) 296, Court of Appeal, Criminal Division, 30 July 1993.

[2] Note that the power of a Crown Court to make a hospital order is confined to offences punishable on imprisonment rather than "any offence" as under the 1959 Act. Under section 37(1A) of the 1983 Act, the court can make a hospital order even where a minimum seven year custodial sentence is required for certain drug trafficking offences, Crime (Sentences) Act 1997, s. 3(2).

[3] Murder (Abolition of Death Penalty) Act 1965, s. 1(1). A hospital order also may not be made where a mandatory life sentence must be imposed for a second serious offence, Crime (Sentences) Act 1997, s. 2(2).

[4] This is to be construed without regard to any prohibition or restriction imposed by statute relating to the imprisonment of young offenders (s. 55(2)).

[5] Children and Young Persons Act 1969, s. 7(8).

[6] In trivial cases the magistrates may properly have recourse to the expedient of adjourning the proceedings *sine die* or of simply not proceeding. See *Barnsley v. Marsh* [1947] K.B. 672, [1947] 1 All E.R. 874.

15.05.1 *Where defendant is incompetent to consent to summary trial*

The question arises whether the magistrates' court must conduct a 'trial' before making a hospital order without recording a conviction; if the magistrates do not hear evidence in the case it would not be possible to satisfy themselves that the accused person did the act or made the omission for which he is charged. In *R. v. Lincoln (Kesteven) Justice ex parte O'Connor*,[1] an informal patient assaulted an occupational therapist at the hospital and was charged with occasioning actual bodily harm. The offence is triable either way (*i.e.* if committed by an adult, it is triable either on indictment or summarily), and the magistrates considered that summary trial was more appropriate. By sections 18 to 20 of the Magistrates' Courts Act 1980, the defendant must consent to summary trial and, in this case, he was unable to consent. The magistrates considered that they were not empowered to proceed to a trial and that they were bound to commit him to the Crown Court for the determination of the issue of fitness to plead. (The magistrates have no authority to determine the issue of unfitness to plead). Lord Lane, C.J., held that the magistrates' court does have the power to make a hospital order without convicting the accused person and that no trial is called for. The circumstances in which it is appropriate to exercise this unusual power are bound to be very rare and will usually require, as in this case, the consent of those acting for the accused if he is under a disability so that he cannot be tried.[2]

The Divisional Court was acting under the humane supposition that it was preferable to make a hospital order without recording a conviction; this would avoid the cumbersome procedure of committing the case for trial to the Crown Court where a jury would have to be empanelled to try the issue of fitness. It is suggested that the Divisional Court was wrong. The clear language of the Mental Health Act is that the magistrates' powers must be founded on their being satisfied that the defendant committed the act or omission charged; and the clear language of the Magistrates Court Act is that no trial can proceed without the consent of the accused person. The power of the magistrates under section 37(3) of the Mental Health Act was not intended to be a substitute for a finding of unfitness. The harsh consequences for the accused person (*i.e.*, a restriction order) could be dealt with by giving the magistrates power to hear the question of fitness to stand trial and, generally, by giving the courts sentencing discretion following such a finding.

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[1] [1983] 1 W.L.R. 335, [1983] 1 All E.R. 901, D.C. See M. Wasik (1983) Hospital Orders without Trial, *Just. Peace*, vol. 147, pp. 211–13.

[2] [1983] 1 W.L.R. at 338.

15.05.2 *Where defendant elects a jury trial*

In *R. v. Ramsgate Justices, ex parte Kazmarek*,[1] the defendant elected a trial by jury, and therefore could not be tried by the justices. The question arose whether the justices had the powers to call for medical reports and to make a hospital order. It was held that the magistrates did have these powers because they could make a hospital order without convicting the defendant. Therefore it was irrelevant that the justices could not have tried the defendant.

15.05.2a *Where defendant is charged with an offence triably only on indictment*

The power of the magistrates under s. 37(3) of the Mental Health Act to exercise discretion to issue a hospital order requires that the Magistrate's Court have the power to try the person concerned. In *R. v. Chippenham Magistrates' Court ex parte Thompson*[2] the defendant was charged with two offences of robbery and common assault, offences triable only on indictment. Since the Magistrate's Court would have no jurisdiction to even take a plea, there is no jurisdiction to make a hospital order under s. 37(3).

15.05.3 *Appeal*

Where a magistrates' court makes a hospital order without recording a conviction the person has the same right of appeal against the order as if it had been made on his conviction (s. 45(1)). This enables the Crown Court to deal with the whole case again as though the appeal were against conviction and sentence. The Crown Court can pass any sentence which the magistrates' court could have made if it had heard the whole case and convicted.[3] Any party may question the proceedings of the magistrates' court by way of case stated to the Divisional Court on the ground that there was an error in law or the magistrates exceeded their jurisdiction. However, on making an application for case stated the applicant loses his right of appeal against the decision to the Crown Court.[4]

An appeal by a child or young person against a hospital order made without recording a conviction may be brought by the person himself or by his parent or guardian on his behalf. This applies whether the appeal is against the order or against the finding upon which the order was made (s. 45(2)).

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[1] (1984) *The Times*, May 15, 1984.

[2] [1995] 160 J.P. 207, *The Times*, 6 December 1995, CO/3271/95 (Transcript: John Larking), Q.B.D.

[3] Courts Act 1971, s. 9(2).

[4] Magistrates' Courts Act 1980, s. 111. See *R. v. Winchester Crown Court, ex parte Lewington* [1982] 1 W.L.R. 1277.

15.06 Grounds and Procedures for making a Hospital Order

A court may authorise a person's admission to, and detention in, a hospital specified in a hospital order (s. 37(1)). Where the court makes such an order it cannot pass a sentence of imprisonment, impose a fine, make a probation order, or make a care order or supervision order under s. 7(7)(*b*) or (*c*) of the Children and Young Persons Act 1969. However, it can make any other order which the court has the power to make such as a compensation order or an order disqualifying the offender from driving (s. 37(8)). Before making a hospital order the court must be satisfied, on the written or oral evidence of two registered medical practitioners[1] (at least one of whom is approved under s. 12 (s. 54(1)) that the following conditions are met (s. 37(2)):

(*i*) **Mental disorder which makes it appropriate for offender to be detained for medical treatment**—The offender must be suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment which is of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment.[2] The order must specify the form or forms of mental disorder; and no order can be made unless the offender is described by each of the two doctors as suffering from the same form of mental disorder, whether or not he is also described as suffering from another form. If the two doctors diagnose the same from (*i.e.*, mental illness) that is sufficient. It does not matter that one psychiatrist may make a more specific diagnosis (*e.g.*, paranoid schizophenia), while the other diagnosed only mental illness.[3]

(*ii*) "**Treatability**"—If the offender is suffering from only one of the minor forms of mental disorder (*i.e.*, psychopathic disorder or mental impairment) the treatment must be likely to alleviate or prevent a deterioration in his condition. This

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[1] The Court of Appeal had advised that the trial judge should hear evidence from the doctor who will be treating the offender. *R. v. Blackwood* (1974) 59 Cr. App. R. 170. This is now a statutory requirement (s. 37(4)). In the same case the court advised that where a judge is considering making a hospital order, the defendant should, except in the rarest circumstances, be represented by counsel.

[2] The conditions for making a hospital order are similar to those for an admission for treatment under s. 3. However, there is a subtle difference in the formulation of the two provisions worth referring to. Section 3(2)(*d*) refers to a disorder of "a nature or degree which makes it appropriate to receive medical treatment in hospital". There is no reference to "detention" as in s. 37. Instead the concept of detention is introduced separately in s. 3(2)(*c*) which specifies that treatment cannot be provided unless he is detained in hospital. This was an intentional decision with the desired effect of giving courts the power to make a hospital order even where it is possible that treatment could be provided without the offender being detained in hospital, provided his mental disorder is such as to make it appropriate for him to be so detained.

[3] *R. v. Smith*, July 30, 1974, per Lawton, L.J.

incorporates the "treatability" requirement which applies to an admission for treatment under Part II of the Act. The court in making a hospital order need not consider whether persons suffering mental illness or severe mental impairment are "treatable" within the meaning of the Act; it is assumed, without having to justify it by evidence, that they can benefit from treatment. It is appropriate to bear in mind that, at the time of renewal of detention, what can be called a "viability" test is applicable.[1]

(*iii*) **Nature of the offence and antecedents of the offender**—The court must be of opinion, having regard to all of the circumstances of the case including the nature of the offence and the character and antecedents of the offender, and to other methods of dealing with him, that the most appropriate method of disposing of the case is by means of a hospital order. There are no further statutory grounds to guide the courts in making a hospital order; in particular, the concept of danger to self or others is absent from the criteria.

15.06A Specifying Hospital Units

Section 47 of the Crime (Sentences) Act 1997 amends the Mental Health Act to empower courts or the Home Secretary, when ordering an offender to hospital, to specify the unit of that hospital in which he should be detained. The power is only available where the patient is subject to restrictions on discharge.[2] The Home Secretary's consent is required to any transfer of a patient subject to detention in a named unit, whether the transfer is to another unit in the same hospital or to another hospital. The purpose of the power is to ensure that where the Home Secretary or a court concludes that a restricted patient needs to be detained under a particular level of security, the Home Secretary's consent is required before the patient can be moved.

15.07 Admission to a Hospital within twenty-eight days of the Order

The court is not empowered to make a hospital order unless it is first satisfied, on the written or oral evidence of the registered medical practitioner who would be in charge of the patient's treatment or some

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[1] For a discussion of the "treatability" and "viability" requirements see paras. **11.06.1** and **11.06.5** *ante*. It is conceivable that the new criteria will limit the powers of the court to make a hospital order. As to the possible effects on sentencing, see A. Ashworth & L. Gostin (1984) Mentally Disordered Offenders and the Sentencing Process, *Crim. L. Rev.* pp. 195–212.

[2] Thus, the power to specify a hospital unit is available only where the patient is subject to a restriction order, a restriction direction, a limitation direction or an order that he should be so treated made under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991).

other representative of the hospital managers,[1] that arrangements have been made for his admission to that hospital within twenty-eight days of the making of the order (s. 37(4)). Section 54A of the 1983 Act empowers the Secretary of State to make an order reducing the 28 day period in section 37(4). This means that the court cannot make the order until a bed is made available in an appropriate hospital.[2] Note that there is no territorial limit as to which hospital is named in the order. The offender can be admitted to any hospital, notwithstanding the fact that it is not situated in the locality where he is normally resident.[3]

The court, pending the offender's admission to hospital within the twenty-eight day period, can order his conveyance to, and detention in a place of safety (s. 37(4)).[4] If within the twenty-eight day period it appears to the Secretary of State that by reason of an emergency or other special circumstances it is not practicable for the patient to be received into the hospital specified in the order, he can give directions for his admission to another hospital (s. 37(5)). This is intended to cover the situation where the hospital specified in the order subsequently withdraws its undertaking to admit the offender. The Secretary of State, if he can obtain the agreement of another hospital to admit the offender, can substitute that hospital for the one specified in the order. If no other hospital agrees to admit the offender the hospital order will lapse after twenty-eight days and the offender is then beyond the reach of the court. There are, however, powers which can help the courts deal with this situation. The Crown Court has authority under the Crown Court Act 1971 (s. 11(2)) to vary a sentence within twenty-eight days. Home Office Circular No. 66/1980 seeks to ensure that the court is forewarned of the possible frustration of a hospital order and so has the opportunity to pass an alternative sentence within the twenty-eight day period. The Lord Chief Justice has directed that the governor of the prison which is holding the offender should be told that, if it appears that the offender might not be admitted to the hospital, he must within twenty-one days of the date of the order (or at once if it becomes

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[1] The 1959 Act was amended so that before the court can be satisfied that a hospital bed has been made available, it must receive evidence from the doctor who will be in charge of the patient's treatment (who could be one of the two doctors giving evidence under s. 37(2)(*a*)) or another representative of the managers. The reason is that in the past some hospitals had agreed to take an offender, but later refused because a restriction order was made. This provision gives the hospital authorities a formal opportunity to explain their reactions to any proposal that a restriction order should be imposed.

[2] The period of 28 days includes the date of the making of the order. *Hare v. Gocher* [1962] 2 Q.B. 641. As to the right of the managers to refuse to admit a person to hospital, see para. **3.03** *ante*.

[3] *R. v. Marsden* (1968) 52 Cr. App. R. 301.

[4] A place of safety (defined in s. 55(1)), in relation to an adult, is a police station, prison or remand centre, or a hospital willing temporarily to receive the person; and in relation to a child or young person it is a community home provided or controlled by a local authority, any police station, any hospital or surgery or any other suitable place the occupier of which is willing temporarily to receive the person (Children and Young Persons Act 1933, s. 107(11)).

apparent only after twenty-one days) report the matter to the Chief Clerk of the Court; unless otherwise directed by the Chief Clerk, he must bring the offender before the court forthwith. Magistrates' courts have re-sentencing powers, analogous to those of the Crown Court, under the Magistrates' Courts Act 1980, section 142. It is the Home Secretary's opinion that this instruction can properly be applied in cases before the magistrates' court.

Section 54A of the 1983 Act[1] empowers the Secretary of State to make an order reducing the 28 day period in section 37(4) and (5) and section 38(4). No such order has yet been made.

15.08 Difficulties in Finding a Hospital Bed

The fact that a hospital order is made, even if it is accompanied by a restriction order, does not necessarily mean that the patient will be kept under conditions of security. A court in making a hospital order can specify any hospital which agrees to make a bed available. There are a wide variety of hospitals providing varying degrees of secure accommodation which are described earlier in this text (see Chapter 3). The formal control over beds is within the powers of the managers: (see paras. **3.03** and **6.03** *ante*) the Secretary of State for Social Services in the case of special hospitals and the appropriate district health authority for regional secure units and local hospitals. If the court considers the offender to be a serious danger to the public and no bed is made available in a secure hospital, the court may have no option but to pass a sentence of imprisonment (See para. **15.03** above and note thereto.)

Courts have sometimes had difficulties in finding a hospital bed for a mentally disordered offender even if they consider it appropriate that a hospital order should be made. In practice hospital beds are under the control of the consultant psychiatrist who is considerably influenced by nursing staff on the ward. An increasing number of cases have been reported where admission of a mentally disordered offender has been barred because of the refusal of nursing staff and health service trade unions to accept difficult or potentially dangerous patients under a hospital order, particularly if there is to be a restriction order made.[2]

Judges have expressed considerable frustration at the difficulties of finding a place in a hospital for mentally disordered offenders.[3] Yet, if no appropriate hospital is willing to admit the offender, the court should not adjourn in the "pious hope" that a bed might be made available

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[1] As inserted by the Criminal Justice Act 1991, s. 27(2).

[2] For a discussion with cases cited see L. Gostin (vol. 2; 1977) *A Human Condition*, MIND, London, pp. 45–57.

[3] See *e.g. R. v. Officer* (per Lawton, L.J.) *The Times*, Feb. 20, 1976; *R. v. Brazil*, *The Times*, Oct. 29, 1975.

in future;[1] nor should an offender be given leave to appeal simply to draw attention to the problem.[2]

The Court of Appeal in *R. v. Harding*[3] has stated *obiter* that, once a hospital order is made, anyone who obstructs the exercise of that order, or counsels or procures others to do so, might be guilty of contempt of court. The Court was faced with trade union pressure not to admit the offender to a regional secure unit. It said that putting severely mentally ill people into prison was a form of cruelty and imposed great strain on the prison staff. The Court reasoned that "it was clear that it was for doctors to decide who should be admitted to a mental hospital". This is only partly true: although the consultant can give evidence on behalf of the managers, it is for the managers to decide whether a patient can be admitted; further, no hospital order can be made unless the court is first satisfied that arrangements have been made for his admission (s. 37(4)). It could not be a contempt for the managers to exercise their discretion whether or not to make arrangements for the patient's admission. Further, since no hospital order could be made, the issue of obstruction of that order does not arise. The only situation where there could be a contempt of court is where the managers have made arrangements, and a hospital order properly made, but where the order is improperly frustrated within the twenty-eight day period before the patient's admission to the hospital specified in the order.

The question arises as to the appropriate disposition where both the health and social services authority refuse to accept any responsibility for a person who has spent many years in a mental hospital and could not live in the community without disturbing others. The Court of Appeal in *R. v. Clarke*[4] said "sentences should fit crimes"; the court should not pass a prison sentence in trivial cases solely because the offender was socially inconvenient. It is not the proper function of courts to "fill the gap" by sentencing a person to imprisonment because the health and social services could not cope.

15.09 Information on Availability of Hospital Places

The House of Commons debated the issue of whether hospitals should be compelled to admit offenders who are made the subject of a hospital order by a court. This proposal was defeated[5] but a compro-

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[1] *R. v. Howard*, judgment given July 4, 1975.

[2] *R. v. Jones*, November 19, 1976, reproduced in D. A. Thomas (1983) *Current Sentencing Practice*, Sweet and Maxwell, London, para. F2.3(*b*), (*c*).

[3] *The Times*, June 15, 1983. C.A.

[4] (1975) 61 Cr. App. R. 320. See *R. v. Cornwall, The Guardian*, Oct. 7, 1976; *R. v. Eaton* [1976] Crim. L. Rev. 390.

[5] The vote was tied and the chairman cast his deciding vote against the amendment. T. Davis (June 15, 1982) *H. C. Debs.* Special Standing Committee, 13th sitting, col. 511. The amendment requiring RHAs to provide information to the courts was carried at Report Stage, K. Clarke (Oct. 18, 1982) *H. C. Debs.*, vol. 29, cols. 36–40.

mise was reached whereby a court could more readily obtain information as to the availability of suitable hospital places. By section 39 of the Act, where a court is minded to make a hospital order or interim hospital order it may request the Health Authority for the area where the person resided[1] (or any other appropriate Health Authority) to furnish information about hospitals at which arrangements could be made for the person's admission. The Health Authority is obliged to comply with the request by providing all such information which it reasonably can obtain. Section 39 obliges Health Authorities to explain to the court what facilities they provide for detained patients, including those who may require treatment under conditions of security; and it will also enable the Health Authority to advise on cases where there is some element of uncertainty as to the patient's ordinary place of residence or other factor determining the appropriate hospital within whose catchment area he falls. The intention is to provide courts with assistance but without removing the obligation in section 37(4) to be satisfied that the necessary arrangements have been made for the patient's admission. Health Authorities have been requested to make standing arrangements for meeting requests from the courts for information.[2] There should be no disputes as to which Health Authority is responsible for dealing with the court's enquiry, because any authority approached is under a statutory duty to provide information about hospitals "in its region or elsewhere".

The Code of Practice (para. 3.4) advises health authorities and the Welsh Office to appoint a named person to respond to any requesting court under section 39 or to any other proper request. The named person should provide up-to-date and full information on the range of facilities, including secure facilities.

15.10 Effect of Hospital Order

A hospital order provides sufficient authority for a constable, approved social worker or any other person directed by the court to convey the person to the hospital specified in the order within twenty-eight days of the making of the order.[3] The managers may then admit the offender and detain him (s. 40(1)). The patient is detained as if he had been admitted to hospital on the date of the hospital order in respect of an application for admission for treatment under Part II of the Act (see para. **11.06** *ante*). This means that the patient can be

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[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.I.Q.B. 21.

[2] See Home Office Circular 69/1983.

[3] As to conveyance to hospital see s. 137 and para. **21.17** *post*. Before taking the patient to hospital the person should confirm that the hospital is still willing to admit the patient. Unlike the case of an interim hospital order, the hospital, having already agreed to admit the offender, may subsequently not allow his admission; s. 40(1) does not expressly provide a power to convey the patient **from** the hospital if admission is refused.

detained for an initial period of six months which can be renewed for a further period of six months and then for periods of one year at a time. The patient is not within the reach of the court or (unless a restriction order is made) the Home Secretary. It is important to appreciate the similarities between a hospital order without restrictions and a civil admission for treatment (see Sch. 1, Pt. 1):

(*i*) **discharge**—A hospital order patient can be discharged at any time by the responsible medical officer, a Mental Health Review Tribunal or the hospital managers (ss. 23(2), 66) (see para. **17.05** *post*);

(*ii*) **transfer**—a hospital order patient can be transferred to another hospital by the managers, notwithstanding that the court specified a secure hospital in the order and the transfer is to a local hospital (s. 19) (see para. **11.18** *ante*);

(*iii*) **leave of absence**—a hospital order patient can be given a leave of absence by the responsible medical officer (s. 17). If a hospital order patient absconds or is absent from hospital without leave for a continuous period of twenty-eight days he cannot be retaken. (See para. **11.14** *ante*).

There are only two significant differences in effect between a hospital order and a civil admission for treatment: first, the nearest relative of a hospital order patient cannot order his discharge under s. 23 (Sch. 1, paras. 2, 8); second, the patient does not have the right to apply to a tribunal within six months following the hospital order being made by the court (Sch. 1, paras. 2, 9). The first occasion on which either the hospital order patient or his nearest relative can apply to a tribunal is in the period between six and twelve months of the order being made (ss. 66(1)(*f*), 69(1)). Under the 1959 Act patients were entitled to apply to the tribunal within the first six months after the hospital order was made. The reason for removing this entitlement was that the government took the view that the European Convention on Human Rights required all offender-patients (*i.e.*, patients subject to a hospital order without restrictions and those subject to restrictions) to be treated in the same way. Although it was suggested in Parliament and elsewhere that the Convention did not require national legislation to have such rigid internal consistency, the amendment withdrawing the right to apply to a tribunal within the first six months was carried.[1] The Act, however, preserves the right of patients to apply to a tribunal within the first six months if they are deemed to be made subject to a hospital order without the interposition of a court—*e.g.* restricted patients whose restrictions lapse or are removed or patients transferred from prison to hospital (see further para. **15.13** below and Chap. 16 *post*). When a patient is admitted to a hospital in pursuance of a hospital

[1] Lord Kilmarnock (Feb. 23, 1982) *H. L. Debs.*, vol. 427, cols. 863–64; L. Gostin (Jan. 28, 1982) Letter, *The Times*.

order, any previous application or hospital order ceases to have effect (s. 40(5)), unless a restriction order was in force at the time the subsequent hospital order was made (s. 41(4)). However, if the hospital order is quashed on appeal, the original application or hospital order will remain with full effect (s. 40(5)).

B. HOSPITAL ORDER WITH RESTRICTIONS ON DISCHARGE

15.11 Background: *X.v. The United Kingdom*

The Mental Health Act 1959 gave the courts power, having made a hospital order, to make a further order known as a 'restriction order'. The restriction order had the effect of preventing the patient's discharge, transfer or leave of absence unless the Home Secretary consented. Further, when a restricted patient was conditionally discharged, he was subject to recall to hospital at any time during the continuation of the restriction order. Despite the severe consequences of a restriction order, the 1959 Act did not indicate the seriousness of the offences from which the public should be protected before a restriction order could be made.

The Mental Health (Amendment) Act 1982 changed the restriction order in two fundamental ways. First, it established the requirement that a restriction order could be made only where it was necessary to protect the public **from serious harm**. There had been concern that restriction orders were imposed in cases where the history of violence, the medical evidence and the gravity of the immediate offence did not justify it.[1] The offender, because of the ostensible 'therapeutic' intent

[1] See *The Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244, HMSO, London, para. 14.24; DHSS et. al. (1978) *Review of the Mental Health Act 1959*, Cmnd. 7320, HMSO, London, paras. 5.10–5.14.

behind a restriction order,[1] received a sentence involving indefinite detention in cases where the offence was trivial. The amendment was intended to indicate more clearly the essential purpose of a restriction order, that is, to protect the public from serious harm.

The second major change in the restriction order was imposed upon the government by the European Court of Human Rights. In *X. v. the United Kingdom*[2] the applicant was conditionally discharged from Broadmoor Hospital in May 1971 and was recalled by the Home Secretary to that hospital in April, 1974, following a matrimonial dispute not involving physical violence. The applicant had at all times complied with the conditions of discharge; there was no medical recommendation sought and no verification of the wife's allegation prior to recall. Article 5(4) of the European Convention on Human Rights provides that: "Everyone who is deprived of liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful". The European Court held that section 65 of the 1959 Act (now s. 41) was in contravention of Article 5(4) of the Convention in the following respects:—

(*i*) **Frequency and scope of judicial review**—Mental illness is subject to amelioration and cure. Thus, any person detained as of "unsound mind" under Article 5(1)(*e*) must have a right to **periodic judicial review** (see para. **9.09** *ante*). Further, the review must examine not merely whether the detention is in conformity with the domestic law, but whether it is justified on its merits. The writ of *habeas corpus* is available to the patient who claims the Home Secretary is detaining him **unlawfully**. However, since the Home Secretary possessed a virtually unfettered discretion under the 1959 Act, it would be difficult to demonstrate that he acted in a way which was contrary to the Act, in bad faith or in an arbitrary manner. The European Court therefore found that the writ of *habeas corpus* did not provide a form of judicial review sufficiently wide in scope as was envisaged in Article 5(4) of the Convention.

(*ii*) **The characteristics of a court**—The word "court" in Article 5(4) does not signify a court of law of the classic kind, integrated within the judicial machinery of the country. Rather it

[1] I have argued that the restriction order should not be seen as therapeutic in intent. It is a hospital order which authorises detention for the purpose of therapy. The accompanying restriction order merely takes the decision on discharge from the doctor and places it with the Home Secretary; it is an order made purely for custodial purposes. See *A Human Condition* (1977; vol. 2) MIND, London, chap. 5.

[2] Judgment given Nov. 5, 1981. See *Winterwerp v. The Netherlands*, Judgment of the European Court of Human Rights, Oct. 24, 1979; *Weeks v. The United Kingdom*, Judgment of the European Court of Human Rights, March 2, 1987; L. Gostin (1982) Human Rights, Judicial Review and the Mentally Disordered Offender, *Crim. L. Rev.*, pp. 779–793; N. Walker (1982) X. v. the United Kingdom, *Brit. J. Criminology*, vol. 22, pp. 315–317.

> requires a body with a judicial character and which affords minimum procedural guarantees to the parties. The most important characteristic of a court is "independence of the executive and of the parties to the case." The Home Secretary could not be a 'court' within the meaning of Article 5(4). For the same reason, any body which simply advises the Home Secretary in the exercise of his powers cannot be a judicial body. The Mental Health Review Tribunal under the 1959 Act only advised the Home Secretary as to the exercise of his powers; the Home Secretary did not accept in excess of 40 per cent of all positive recommendations made by the tribunal.[1]

Under the 1983 Act the Home Secretary has the same powers that he originally possessed under the 1959 Act (ss. 41, 42). However, Mental Health Review Tribunals are also given the power to discharge restricted patients (s. 73). Either the Home Secretary or the Mental Health Review Tribunal, therefore, have jurisdiction to order an absolute or conditional discharge. The Home Secretary continues to exercise **exclusive** jurisdiction to consent to the transfer of a restricted patient to another hospital or to remove the restriction order from a patient detained in hospital. Either the tribunal or the Home Secretary have jurisdiction to remove the restriction order from a patient who has been conditionally discharged. The effect of removing the restriction order from a patient who has already been conditionally discharged is that the person is no longer subject to recall and is deemed to be absolutely discharged.

15.12 Grounds for making a Restriction Order

When a hospital order is made by a Crown Court it may make a further order (known as a "restriction order") that the offender shall be subject to special restrictions on discharge. It must appear to the court, "having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that a restriction order is necessary for the protection of the public from serious harm" (s. 41(1)). The court cannot make a restriction order unless at least one of the two registered medical practitioners whose evidence is required for the purposes of making the hospital order, has given evidence orally before the court (s. 41(2)). The Court of Appeal has also advised that the defendant should be represented by counsel.[2]

The decision whether to make a restriction order is the responsibility

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[1] See *A Human Condition* (1977; vol. 2), pp. 164–74. A rejection rate of 56% was found. J. Peay (1981) Mental Health Review Tribunals—Just or Efficacious Safeguards? *Law & Hum. Beh.*, vol. 5, p. 161.

[2] *R. v. Blackwood* (1974) 59 Cr. App. R. 170.

of the judge if he considers that the statutory criteria have been met. It is clear from the cases that the judge's decision need not be based upon any particular factor such as a past history of violence[1], the gravity of the immediate offence[2], or the medical evidence. The judge can make a restriction order notwithstanding the fact that all of the doctors giving evidence advise against it.[3] However the judge cannot disregard unanimous medical evidence if there is no evidence or sound reason for doing so.[4]

"Serious harm" refers to the potentiality of future harm to persons and, presumably, property.[5] The relevant test is not merely the degree of risk that the defendant will re-offend, but the consequence that if he did so the public would suffer serious harm.[6] A restriction order should not be imposed to mark the gravity of the offence. If the risk of re-offending is exceedingly low, a restriction order is inappropriate, even if the immediate offence was violent.[7]

The 1982 Amendment of the Mental Health Act requiring a showing of "serious harm" was clearly intended to prevent the use of restriction orders where there was no substantial danger to the public. It would be reasonable to assume that the practice direction in *Gardiner*[8] is still applicable, but with the inclusion of the amended statutory language: restriction orders should not be used in every case, "but it is very advisable that they should be made in all cases where it is thought that the protection of the public [from the serious harm] is required. Thus in, for example, the case of crimes of violence, and of more serious sexual offences, particularly if the prisoner has a record of such offences, or if there is a history of mental disorder involving violent behaviour, it is suggested that there must be compelling reasons why a restriction order should not be made". However, the extension of the *Gardiner* principle in *Toland*,[9] it is suggested, cannot survive the 1982 Amendment. The court in *Toland* indicated that a restriction order

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[1] See *R. v. Smith*, July 30, 1974, reproduced in D. A. Thomas (1983) *Current Sentencing Practice*, para. F2.4(*b*) ("The term 'antecedents' . . . is a very wide one, and is not confined to a history of previous convictions.").

[2] See *e.g. R. v. Eaton* [1976] Crim. L. Rev. 390, (1975) 119 S.J. 793 (restriction order may be made even if the immediate offence would not justify a sentence of imprisonment). It is to be doubted whether many cases of this kind would survive the 1982 amendment.

[3] *R. v. Royse* (1981) 3 Cr. App. R. (S)58. Note that the consent to a restriction order of the doctor who would be in charge of treatment is also not required. But the court must hear evidence from the doctor or another representative of the managers (s. 37(4).) This was intended to give the hospital authorities an opportunity to comment on the advisability of making a restriction order. See note 2 to para. **15.07** above.

[4] *R. v. Birch* (1989) *The Times*, May 4, 1989, C.A.

[5] It would be difficult to justify the imposition of a restriction order in cases where the only likely danger was to the offender himself. Cf. *R. v. Nadolski*, May 8, 1970, described as Mary's case in *A Human Condition* (1977; vol. 2) pp. 182–83.

[6] *R. v. Birch* (1989) *The Times*, May 4, 1989, C.A.

[7] *Ibid.*

[8] (1967) 51 Cr. App. R. 187 at 192, per Lord Parker C.J.

[9] (1973) 58 Cr. App. R. 453.

could be given notwithstanding the fact that there is no evidence of a future violent propensity if the offender is likely to abscond from hospital and thereby gain his freedom. The court described the offender as an "anti-social person" and a "pest". It would, under the new criterion, be difficult to justify a restriction order if the immediate offence were trivial and there was no history of violence. Parliament intended to prevent the courts from making restriction orders in such circumstances and arguably the courts will be unable to make such orders in some cases where they have done so in the past.[1]

In *R. v. Courtney*[2], for example, all of the medical evidence suggested that the offender would not pose a danger to others. The Court of Appeal held that the medical evidence was insufficient to make a restriction order. The evidence did not demonstrate that "if he is released in the relatively near future, he would constitute a danger to other members of the public". The case is of interest for two reasons. First, the defendant committed a violent act (strangling his wife); the offence was reduced to manslaughter by reason of diminished responsibility (see further paras **13.06–13.09** *ante*). The seriousness of the crime was overlooked because of the unanimous conclusions of the psychiatrists that he was not a danger to others. Second, the medical evidence suggested that he was suicidal and a danger to himself. The court did not explicitly discuss whether danger to self could justify a restriction order, but implicitly rejected the argument.

15.13 Duration of the Restriction Order

A Crown Court can impose a restriction order either without limit of time or during a fixed period which it can specify (s. 41(1)). If it is for a fixed term, once that term expires or otherwise ceases to have effect, the patient will still be subject to detention under a hospital order without restrictions (s. 41(5)). The used of fixed periods for restriction orders was at first fairly common. In 1961, for example, 44 per cent of all restriction orders were made for fixed periods. But later the proportion steadily declined, so that in 1966 it was only 20 per cent.[3] In 1967 in *Gardiner* Lord Parker gave the following practice direction:

> ". . . since in most cases the prognosis cannot be certain, the safer course is to make any restriction order unlimited in point of time. The only exception is where the doctors are able to assert

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[1] See, *e.g.*, *R. v. Smith* referred to in *R. v. McFarlane* (1975) 60 Cr. App. R. 320, 324 (obtaining modest amounts of money by fraudulent betting tips without past history of violence or history of mental disorder); *R. v. Eaton* [1976] Crim. L. Rev. 390 (damaging two window panes in a telephone kiosk); *R. v. Allison*, Jan. 31, 1977, reported in *Current Sentencing Practice*, Sweet and Maxwell, para. F2.4(*d*) (theft of a purse containing £4.80 from his sister).

[2] [1988] Crim. L.R. 130, C.A.

[3] See *A Human Condition* (1977; vol. 2) p. 61 (Table 1).

confidently that recovery will take place within a fixed period when a restriction order can properly be limited to that period".

Directly after Gardiner's case, the proportion of restriction orders made for fixed periods dropped to 10.2 per cent. In recent years approximately 1 per cent of such orders have been of a fixed duration. The *Gardiner* principle appears unhelpful because it is virtually impossible for doctors to predict accurately when a person will "recover" from mental disorder. Further it attempts to equate complete recovery from mental disorder with the cessation of dangerousness; often there is no causal connection between the two conditions—*e.g.* an offender may cease to be dangerous and yet continue to suffer from mental disorder or he may cease to suffer from mental disorder and still be dangerous.[1]

The period of a restriction order should not be equated with the length of the term of imprisonment which might have been imposed for the offence. A restriction order is not considered to be a punishment and its length should not be equated with the length of a tariff sentence.[2]

A restriction order continues in force unless: the order was made for a fixed period which has lapsed; the patient is absolutely discharged by the tribunal or the Home Secretary; or the Home Secretary is satisfied that a restriction order is no longer required for the protection of the public and directs that the patient shall cease to be subject to special restrictions.[3] Where a restriction order ceases to have effect and the patient has not been discharged from liability to detention in hospital, he continues to be subject to a hospital order without restrictions as if the hospital order were made on the date on which the restriction order ceased to have effect (s. 41(5)).

15.14 Power of Magistrates' Court to Commit to Crown Court for making of Restriction Order

15.14.1 *Committal in Custody*

A magistrates' court is itself not empowered to make a restriction order. In the case of a person aged fourteen or over who is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment the court may, instead of making a hospital order or other disposition, commit him in custody to the Crown Court for sentencing (*i.e.*, with a view to a hospital order with restric-

[1] See DHSS *et al.* (1978) *Review of the Mental Heath Act*, Cmnd. 7320 para. 5.27.

[2] *R. v. Haynes* (1981) 3 Cr. App. R. (S)330.

[3] A restriction order without limit of time remains in force until the Home Secretary takes an affirmative act – i.e., either a direction is made ending the restriction order, or the patient is absolutely discharged. A restriction order does not lapse by implication i.e. the Home Secretary allows the conditions under which the patient was discharged to lapse. *R. v. Secretary of State for the Home Department ex parte Didlick* (1993) 16 BMLR 71; *The Times* March 30, 1993, *the Independent* 9 April 1993. See para. **15.16** *below*.

tions being made).[1] The magistrates' court must first find that the grounds for making a hospital order are met but that "having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large", a restriction order should be made. (Note that the magistrates' court does not need to be satisfied as to the "serious harm" test, but, before making a restriction order, the Crown Court will have to apply this test).

Once the offender is committed in custody to the Crown Court, that court must inquire into the circumstances of the case and may, if the relevant statutory provisions are complied with, make a hospital order, with or without restrictions. If the Crown Court decides not to make a hospital order, it can deal with the offender in any way in which the magistrates' court could have dealt with him (s. 43(2)). The Crown Court also has the same power to remand the person to hospital for report (s. 35) or treatment (s. 36) or to make an interim hospital order (s. 38) as it would have had if the case were originally brought before it (s. 43(3)).

It is to be noted that where the magistrates' court commits an offender in custody under section 43, and if the Crown Court decides not to make a hospital order (with or without restrictions) the Crown Court can only dispose of the case in a manner in which the magistrates' court could have dealt with it; in particular the Crown Court could not inflict greater punishment than the magistrates' court has the power to inflict. That is why s. 43(4) provides that s. 38 of the Magistrates' Court Act 1980 shall also be exercisable by a magistrates' court. Section 38 of the 1980 Act enables the magistrates' court to commit an offender to the Crown Court where it is of opinion that greater punishment should be inflicted for the offence than the magistrates have power to inflict. This power is exercisable where the magistrates' court is of opinion that greater punishment should be imposed unless a hospital order with restrictions is made. The effect of s. 43(4) is that the Crown Court can make any disposal within its power including a restriction order or a sentence of imprisonment greater than is within the power of the magistrates to impose.

15.14.2 *Committal to Hospital*

Section 44 empowers the magistrates' court, instead of committing the offender to prison with a view to a restriction order being made in the Crown Court, to direct him to be admitted to a specified hospital and to be detained there until the case is disposed of by the Crown Court. The purpose is to enable a magistrates' court to deal with persons, for whom it thinks a hospital order with restrictions is clearly

[1] Instead of committing the offender in custody to the Crown Court, with a view to a restriction order being made, the magistrates can commit him to hospital for the same purpose (s. 43). See para. **15.14.2** below.

suitable, by sending them to hospital in order that they may begin receiving treatment at once and avoid having to go to prison solely in order that the hospital order may be made subject to restrictions. Before ordering the person's admission to hospital under s. 44, the magistrates' court must be satisfied, on the written or oral evidence of the doctor who would be in charge of the offender's treatment or by another representative of the hospital managers, that arrangements have been made for the admission of the offender to a specified hospital. The magistrates' court can give any directions it thinks fit for the production of the offender from the hospital to attend the court. An order under section 44 is sufficient authority for a constable, an approved social worker or any other person directed by the court to convey the patient to the hospital specified in the order (s. 40(1)). The magistrates' court can direct that the offender be detained in a place of safety for up to twenty-eight days[1] pending his admission to the hospital specified in the order (s. 37(4)); and, if within the twenty-eight day period, it appears to the Secretary of State that it is not practicable for the offender to be admitted to the specified hospital, he can direct his admission to another appropriate hospital (s. 37(5)). Once the offender is admitted to hospital he is detained there as if subject to a hospital order with restrictions without limit of time. The order continues to have effect until the case is disposed by the Crown Court. The Crown Court has the power, if it finds that it is impracticable or inappropriate to bring the offender before the court, to make a hospital order (with or without a restriction order) in his absence (s. 51(5)). The Crown Court must first be satisfied that the offender is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for the patient to be detained in hospital; and the court must be of opinion, after considering depositions and other documents, that it is proper to make such an order (s. 51(6), (7)).

15.15 Effect of a Restriction Order

The special restrictions applicable to a patient in respect of whom a restriction order is in force are as follows (s. 41(3)):

(*i*) **renewal of detention**—the provisions of Part II of the Act relating to the duration, renewal and expiration of authority for detention (see para. **11.06** *ante*) do not apply, and the

[1] The 1959 Act as originally enacted disapplied the requirement of conveyance to hospital within a period of 28 days (s. 68(3)). There was no Parliamentary intention to re-apply the 28-day period. However, there appears to have been a draftsman's oversight with the effect that there has been an effective amendment which re-applies the 28-day period. Although the reference to 28 days is omitted in respect of s. 40(1) (s. 44(3)), it is not omitted in respect of ss. 37(4) and 37(5), and the only logical conclusion to be drawn is that conveyance and admission to hospital must take place within 28 days of the making of the order.

patient remains liable to be detained until absolutely discharged. This means that the patient remains liable to detention as long as the restriction order continues in force without the need for periodic renewal of the hospital order.

(*ii*) **leave of absence**—the power of the responsible medical officer to grant a leave of absence from hospital (s. 17) (see para. **11.13** *ante*) is exercisable only with the consent of the Home Secretary. Thus, the Home Secretary cannot grant a leave of absence himself but, before leave can be granted by the responsible medical officer, the Home Secretary must consent. If leave is granted and consented to, the power to recall the patient to hospital rests with the Home Secretary as well as with the responsible medical officer. Further the power to recall the patient who is on an authorised leave of absence (s. 17), or the power to take a patient into custody who is absent without authorisation (s. 18) may be exercised at any time; the time limits referred to in sections 17 and 18 for recalling or retaking a patient to hospital are not applicable. Thus the patient may **not** obtain his discharge by absconding and staying at large for twenty-eight days (s. 18(4)), or by remaining on an authorised leave of absence for a continuous period of six months (s. 17(5)).

(*iii*) **transfer**—the power to transfer a patient to another hospital (s. 19) or into guardianship (see para. **11.18** *ante*) is exercisable only with the consent of the Home Secretary. For example, if a special hospital patient is to be transferred to a local hospital, the consent of the following persons or authorities are required: the Secretary of State for Social Services, as manager of the special hospital; the consent of the district health authority as managers of the local hospital; and the consent of the Home Secretary .

(*iv*) **discharge**—the power of the responsible medical officer or the hospital managers to order the discharge of the patient (s. 23) (see para. **11.06.7** *ante*) is exercisable only with the consent of the Home Secretary.

(*v*) **Mental Health Review Tribunal**—a restricted patient may apply to a tribunal in the period between six and twelve months from the date of the relevant hospital order; and in any subsequent period of twelve months (s. 70). Further, the Home Secretary **must** refer to a tribunal the case of any restricted patient detained in hospital whose case has not been considered by the tribunal within the previous three years (s. 71). The tribunal has the power to direct the discharge of the patient either absolutely or subject to conditions and it can defer a direction for conditional discharge (s. 73). (See paras. **18.12–18.14** *post*). The tribunal is

no longer purely an advisory body which makes recommendations to the Home Secretary, but has the power of discharge in its own right.

15.16 Powers of the Home Secretary over Restricted Patients

The Home Secretary has three major powers in respect of restricted patients which are described below: the removal of restrictions, absolute discharge, and conditional discharge. The Divisional Court in *R. v. Secretary of State for the Home Department ex parte Didlick*[1] held that a restriction order without limit of time remains in force until the Home Secretary takes an affirmative act—*i.e.*, either a direction is made ending the restriction order, or the patient is discharged absolutely. A restriction order without limit of time does not lapse by implication. In *Didlick*, a restricted patient was conditionally discharged, and, later, the Home Secretary allowed the conditions to lapse. The court ruled that by merely allowing the conditions under which the patient was discharged to lapse the Home Secretary did not bring the restriction order to an end. The patient, therefore, remained subject to recall to hospital.

15.16.1 *Removal of Restrictions*

The Home Secretary is empowered, if satisfied that a restriction order is no longer required for the protection of the public from serious harm, to direct that the restriction order will cease to have effect (s. 41(1)). Where a restriction order ceases to have effect the patient will continue to be liable to detention under a hospital order without restrictions (s. 41(5)).

15.16.2 *Absolute Discharge*

The Home Secretary is empowered, if he thinks fit, to discharge the patient absolutely. If a patient is absolutely discharged he ceases to be liable to detention under the hospital order, and the restriction order also ceases to have effect. The patient is not subject to recall to hospital (s. 42(2)). The power to absolutely discharge a restricted patient is used in only a small proportion of cases usually in respect of patients who are not detained in a special hospital.

15.16.3 *Conditional Discharge and Recall*

The Home Secretary may, if he sees fit, discharge a restricted patient subject to conditions. A conditionally discharged patient is still subject to the restriction order; the Home Secretary, at any time during

[1] (1993) 16 BMLR 71; *The Times* March 30, 1993, *The Independent* 9 April 1993, CO/0525/92 (Transcript: Marten Walsh Cherer).

the continuance in force of the restriction order, may by warrant recall the patient to any hospital specified in the warrant (s. 42(3)); the patient will then be detained as if the original hospital order with restrictions were still in effect. Usually the hospital specified is the hospital from which the patient was conditionally discharged. If he is recalled to a different hospital, the hospital order has effect as if the hospital to which he is recalled were the hospital originally specified in the order. A patient who is recalled can be taken into custody and conveyed to the hospital specified in the recall warrant by an approved social worker, an officer on the staff of the hospital, any constable or any person authorised in writing by the managers (see ss. 42(4)(*b*), 18). If the patient is subject to a restriction order of a fixed period, his liability to detention does not end if that period expires after his recall has been ordered but before he is re-admitted to hospital (s. 42(4)). If the restriction order expires or otherwise ceases to have effect while the patient is on a conditional discharge, unless he was previously recalled, he is deemed to be absolutely discharged, and the hospital order, together with the restriction order, ceases to have effect (s. 42(5)).

The primary object of a conditional discharge is that the patient will be subject to compulsory supervision in the community. If there is cause to be concerned about his health or possible dangerous behaviour, he can be recalled to the hospital with minimum formality. The supervising officer is either a probation officer or a social worker. The supervising officer will seek to ensure that the conditions of discharge are complied with. The conditions which the Home Secretary would usually impose are that the patient should live in a particular household and attend for psychiatric assessment or treatment. The supervising officer and psychiatrist usually submit periodic reports to the Home Secretary on the patient's progress and to inform the Home Secretary and the responsible medical officer in the hospital from which he was conditionally discharged if the patient's medical condition appears to be deteriorating.

The Home Secretary may allow the conditions placed on a patient's discharge to lapse. This, however, does not have the effect of removing the restriction order, and the patient will remain liable to recall to hospital.[1]

The Home Secretary's power to order the patient's recall can be exercised at his discretion and need not involve an explicit breach of the conditions. If, for example, the supervising officer considers that circumstances are such that violence may occur, he can notify the Home Secretary who will recall the patient. The circumstances in which the power of recall was exercised in *X. v. the United Kingdom* led the European Commission to find a violation of Article 5(2) of the Euro-

[1] *R. v. Secretary of State for the Home Department, ex parte Didlick* (1993) 16 BMLR 71; *The Times*, March 30, 1993; *The Independent*, 9 April 1993. CO/0525/92. (Transcript: Marten Walsh Cherer). See further para. **15.16** *above*.

pean Convention on Human Rights which requires adequate reasons to be given for a person's arrest.[1] As a result the Government introduced the following two stage procedure for informing restricted patients of the reasons for their recall:[2]

> "Stage 1—the person taking the patient 'into custody' should inform him in simple terms that he is being recalled to hospital by the Home Secretary under the Mental Health Act and that a further explanation will be given later.
>
> Stage 2—will take place as soon as possible after admission to hospital and in any event within 72 hours. The responsible medical officer or his deputy should explain to the patient the reasons for his recall. He should ensure that, so far as the patient's mental condition allows, he understands those reasons. The responsible medical officer will also be responsible for informing the patient's supervising officer in the community and a responsible member of the patient's family (or his legal adviser) of the reasons for his recall".

Patients who are conditionally discharged have new rights under the Act. First, they can apply to a tribunal for the first time to have their restriction order removed (s. 75(2)). Second, if they are recalled, the Home Secretary **must**, within a month of the return of the patient to hospital, refer the case to a tribunal (s. 75(1)).

Patients who are recalled to hospital should be given assistance in informing their legal advisor. Subject to the patient's consent, the nearest relative and/or other appropriate relatives or friends should be informed. (Code of Practice, para. 27.4).

It is not always necessary to formally recall a conditionally discharged patient who requires hospital admission. Consideration could be given to informal admission (provided the patient gives a truly voluntary consent) or compulsory admission under Part II.[3]

The powers under two parts of the Mental Health Act may be exercised simultaneously. The applicant in *Re Dlodlo*,[4] a conditionally discharged patient, was already admitted to hospital under section 3 as a

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[1] See Judgment of the European Court of Human Rights, Nov. 5, 1981, para. 16, 4 E.H.R.R. 188. In *Van der Leer v. the Netherlands*, the European Court of Human Rights (Judgment given February 21, 1990, *The Times*, March 2, 1990), reaffirmed its position that the requirement to give reasons for the decision to detain an individual extends beyond the realm of criminal law to mental health. A person confined under mental health legislation has a right to be promptly and adequately informed of the reasons.

[2] Home Office Circular No. 117/1980; DHSS Circular LASSL(80)7.

[3] In *R. v. Managers of the North West London Mental Health NHS Trust ex parte Stewart* [1996] The Times 19 July 1996, CO/1825/95, Q.B.D., it was held that "there is nothing in the [Mental Health] Act which expressly excludes the operation of Part II of the Act in the case of a restricted patient." If detention of a conditionally discharged restricted patient is necessary solely for treatment for his own health and safety, detention under section 3 is appropriate.

[4] [1996] *The Times*, 1 April 1996, CO/221/95 (Transcript: John Larking), Q.B.D.

civil patient when the Secretary of State issued a recall to the same hospital. The wider power of the Secretary of State may be exercised even if the person is already present at the hospital, if there is no section 42 order in relation to that hospital.

Even if the patient is formally recalled, he could be admitted to a different hospital with a lesser (or greater) degree of security. (Code of Practice, para. 27.2).

The power of the Home Secretary to recall a person who is no longer suffering from mental disorder was examined by the Court of Appeal in *R. v. Secretary of State for the Home Department, ex parte K.*[1] The appellant was convicted of an offence after being conditionally discharged from hospital by the tribunal.[2] Before the expiration of his prison sentence in September of 1989, the Home Secretary issued a warrant under section 42(3) of the 1983 Act recalling the appellant to hospital on the ground that he presented a danger to the public.

The appellant applied for judicial review of the Home Secretary's decision to recall him, contending that the power to recall could be exercised only on the recommendation of a medical practitioner, and that the Home Secretary could not exercise his power of recall in the absence of any objective evidence that he was suffering from a mental disorder.

The Court of Appeal held that section 42(3) does not require the Home Secretary to have medical evidence that a conditionally discharged patient is mentally disordered before issuing a warrant for his recall to hospital. The Home Secretary has wide discretion to exercise the power of recall subject to recognised public law constraints as well as the balancing of the interests of the patient against those of the public safety. Based on the facts presented, the Home Secretary had not acted unreasonably.

The Court of Appeal rejected each of the appellant's arguments. First, the appellant contended that he was not a "patient" within the meaning in section 42(3) because he was not mentally disordered. The Court of Appeal held in an earlier case involving Mr. K that the word "patient" in section 73(4) did not require a determination of mental disorder.[3] (See para. **18.13.1** *post*). The court saw no reason to construe "patient" in section 42(3) differently than in section 73(2).

Second, the appellant argued that the recall of a person to hospital who was of sound mind violated Article 5(1)(e) of the European Convention on Human Rights. Article 5(1)(e) provides that "no one

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[1] [1990] 3 All E.R. 562, CA.

[2] In an earlier case, the Court of Appeal upheld the tribunal's decision to order the conditional discharge despite the absence of evidence of mental disorder. *R. v. Merseyside Mental Health Review Tribunal ex parte K* [1990] 1 All E.R. 694, discussed at para. **18.13.1** *post*.

[3] *R. v. Merseyside Mental Health Review Tribunal ex parte K* [1990] 1 All ER 694.

shall be deprived of his liberty save in the following cases . . . (e) the lawful detention . . . of persons of unsound mind."[1] The Court of Appeal, citing *R. v. Secretary of State for the Home Department, ex parte Brind*,[2] held that since section 42(3) was plain and unambiguous on its face, the courts would not look to the European Convention on Human Rights for assistance in its interpretation.[3]

Third, the appellant argued that the Home Secretary's exercise of discretion went beyond public law constraints recognised in *Padfield*[4] and *Wednesbury*.[5] *Padfield* requires the Secretary of State to exercise his discretion only to promote the policies and objects of the legislation. The appellant argued that the policy of the Mental Health Act is that patients should be deprived of liberty only on the basis of objective evidence of mental disorder. The Court of Appeal held that the policies and objects of the Mental Health Act are broader. The Act is intended to "regulate the circumstances in which the liberty of persons who are mentally disordered may be restricted and, where there is conflict, to balance their interests against those of public safety."[6]

The appellant also argued that the Home Secretary's decisions were *Wednesbury* unreasonable. There were no changes in circumstances or evidence of mental disorder since the patient's tribunal hearing to warrant a recall to the hospital. The Court of Appeal cited a number of counterbalancing factors which made the Home Secretary's decision rational, including the patient's history of violence and the sexual nature of his repeated offences.

The Court of Appeal's decision reinforces a position taken by the courts that compulsory detention under the Mental Health Act is intended not only to treat mental disorder and rehabilitate a person in his best interests, but also to prevent future dangerous behaviour. If there is no objective evidence of mental disorder or need for treatment then the Act is being used purely for the purposes of preventive confinement, which in most other contexts, is unlawful in domestic as

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[1] See *Ashingdane v. United Kingdom* (1985) 7 E.H.R.R. 528, European Court of Human Rights; *Winterwerp v. Netherlands* (1979) 2 E.H.R.R. 387, European Court of Human Rights.

[2] [1990] 1 All E.R. 469, [1990] 2 W.L.R. 787.

[3] The European Commission of Human Rights held admissible a complaint relating to the lawfulness of recall under Articles 5 and 13 of the Convention. At issue in the case is whether: (1) a patient can be recalled if he has not broken any of the conditions of his conditional discharge; (2) a court must determine his mental condition at the time of recall; and (3) the reference to a tribunal, within the month prescribed by s. 75(1)(*a*), exceeds the time permitted under the Convention. *Roux v. United Kingdom*, App. No. 25601/94, 22 E.H.R.R.C.D. 195 (September 1996).

[4] *Padfield v. Ministry of Agriculture Fisheries and Food* [1968] 1 All E.R. 694, [1968] AC 997.

[5] *Associated Provincial Picture-Houses Ltd. v. Wednesbury Corp.* [1947] 2 All E.R. 680, [1948] 1 K.B. 223.

[6] Citing McCullogh J in *Secretary of State for the Home Department, ex parte K* [1990] 1 All E.R. 703 at 709, [1990] 1 W.L.R. 168 at 174.

well as international law. The courts implicity argue that once a person has a diagnosis of mental disorder, he is always bound to relapse. The problem with this argument is that it assumes that patients cannot fully recover and be completely free of the constraints of mental health legislation. In any event, if the person did relapse the Home Secretary could still issue a warrant for recall at that time. The Mental Health Act and the hospital system appear to be used in such cases as preventive confinement for admittedly dangerous persons. The question is whether Parliament and society wish for the mental health system to be used in this way. On 7 July 1993, the European Commission of Human Rights declared admissible an application by K. raising issues under Articles 5(1) and 5(4) of the European Convention on Human Rights.[1]

15.17 The Exercise of the Home Secretary's Powers

The Home Secretary, as we have seen, has a number of statutory powers in respect of a patient subject to a restriction order. How does he exercise these powers in practice? He may receive advice on these and other matters, in the first instance, from the responsible medical officer (R.M.O.). However, the R.M.O.'s advice is not binding. (As to the powers of tribunals to make recommendations with respect to restricted patients, see para. **15.18** below.)

The Home Secretary will not usually set in motion the formal process for examining whether to exercise his powers until he receives a positive recommendation from the R.M.O. A positive recommendation will trigger a complex decision-making process in the Home Office. This will involve, for example, private consultations with the R.M.O. and other professionals, the gathering of additional information about the social setting to which the patient may be discharged, or further assessments of his psychological or medical state.

In some cases the proposal for a change in the patient's circumstances is referred to the **Advisory Board on Restricted Patients** (see para. **15.20** below). The Board does not of itself initiate recommendations; hence it is not asked for advice until a positive recommendation is received from the R.M.O. In practice the Home Secretary's primary concern is with the protection of the public and he normally will not exercise his powers unless there is unanimity in the recommendations made by all his advisers. There is a brief examination of the various persons and bodies which advise the Home Secretary in the exercise of his powers in paras **15.18–15.20** below.

[1] Application No. 17821/91 *James Kay v. United Kingdom*, Decision of 7 July 1993.

15.17.1 *Supervision and Aftercare of Conditionally Discharged Patients*

The Home Office and Department of Health and Social Security issued in 1987 detailed *Notes for Guidance for Supervision and Aftercare of Conditionally Discharged Restricted Patients*.[1] Separate publications were issued for the multidisciplinary clinical team at the discharging hospital; supervising psychiatrists; and social supervisors (e.g. social workers and probation officers responsible for support and supervision of conditionally discharged patients in the community). The

[1] See also HN (87)5/LAC(87)3 and DHSS Circular LASSL(80)7. See also Code of Practice, paras 27.1–27.6.

Notes for Guidance were issued following a review of procedure and practice relating to the supervision of conditionally discharged restricted patients carried out by the Home Office in association with the DHSS. The Notes replace earlier guidance and will be reviewed periodically.

Many restricted patients have been in conditions of high security for long periods prior to discharge. Coping with the freedom of making everyday decisions, re-establishing family and social relationships, and finding a job are stressful. Careful aftercare and supervision are necessary both for the patient's mental health and for the protection of the public. The Notes recommend an individual plan of treatment and rehabilitation, close communication among those responsible for the patient (the hospital team, psychiatric and social supervisors and the Home Office), and personal treatment, care, monitoring and assessment of the patient in the community.

If there are good grounds for believing the person's mental health has deteriorated and that he poses a danger to himself or others, arrangements can be made for his recall to hospital. (As to the particular role of social workers in supervising restricted patients in the community, see para. **7.25A** *ante*). A sensitive balance must be achieved between obtrusive and restrictive measures unduly impeding the freedom and progress of the patient in the community, and insufficient support and attention to the real problems which occur with new-found freedom.

Given the importance to the patient and the public of aftercare and supervision, independent research on the way the new guidance is working would be valuable.

15.18 The Mental Health Review Tribunal

The tribunal's power to discharge restricted patients either absolutely or subject to conditions is exercisable independently from the Home Secretary. However, under the 1959 Act the tribunal made recommendations to the Home Secretary on a wide range of other matters—for example, transfer from a special to a local hospital; removal of the restriction order; advancement within the hospital; trial leave of absence; repatriation; and review or reference to a tribunal within twelve months.[1] The question arises whether these advisory powers survive the 1982 Amendment Act. Section 66(6) of the 1959 Act empowered the Home Secretary to refer to the tribunal "for their advice" the case of a restricted patient. No such general power to give advice is included in the 1983 Act. Moreover, section 72(3) which authorises a tribunal to recommend that a non-restricted patient should be transferred to another hospital or into guardianship, or given a leave

[1] Note that some of these recommendations are not within the power of the Home Secretary to implement (*e.g.* advancement within the hospital), and with others he can only give his consent (*e.g.* transfer or leave of absence.)

of absence, does not apply to patients subject to a restriction order (s. 72(7)).[1] From this it may be argued that tribunals are not authorised to make recommendations relating to restricted patients. However, it is the view of the Home Office and Department of Health that it was not Parliament's intention to deprive tribunals of their advisory role in cases where they did not direct discharge. On 28 October 1987 the Home Secretary announced that, if, in the course of its decision on an application to discharge a restricted patient, the tribunal recommended a transfer or a leave of absence, and the R.M.O. made a proposal based on that recommendation, the Home Secretary would take full account of the tribunal's views.[2] See further para. **18.16** *post*.

15.19 The Responsible Medical Officer

There are no figures as to the percentage of recommendations for discharge, transfer or leave of absence made by the responsible medical officer which are not accepted by the Home Secretary. However, it is clear that the Home Secretary is not bound by the R.M.O.'s advice. The circumstances of the cases of *Medway*[3] *Powell*[4] and *Kynaston*[5] all involved restricted patients whose R.M.O. had stated that the patient was not mentally disordered and should not be detained in hospital. In *Medway*'s case, the applicant argued that where the medical evidence is all one way then the pre-conditions for making a hospital order have been removed and *habeas corpus* should issue. The court granted leave for an order of *mandamus* but not habeas corpus: "You are asking us to perform the function of the Secretary of State. All we are prepared to do . . . is to grant leave to investigate whether the Secretary of State has or has not exercised his discretion". In *Medway* and *Powell* the court did not examine whether there was any sufficient evidence supporting the Home Secretary's decision, but relied principally upon the fact that he had an unfettered discretion in law. It is clear, therefore, that the Home Secretary, so long as he is not acting arbitrarily or in bad faith, can refuse to discharge a patient even if the R.M.O. and other doctors advise otherwise. However, Lawton L.J. observed *obiter* in *Kynaston* that "once the Home Secretary was satisfied that a patient was no longer suffering from mental disorder, he should be discharged without any condition. . . ." This would appear

[1] Subsection 7 of s. 72 expressly disapplies subs. 1 from the case of a restricted patient. Subs. 3 (which empowers the tribunal to make recommendations) expressly refers back to the tribunal's powers under subs. 1, and it is probable that a court would, therefore, construe the provisions as disapplying subs. 3 from the case of a restricted patient.

[2] 121 HC Official Report (6th series) written answers cols. 261–262.

[3] *R. v. Secretary of State for the Home Department, ex parte Medway* (unreported) Q.B.D., June 3, 1977.

[4] *R. v. Secretary of State for the Home Department, ex parte Powell* (unreported) Q.B.D., Dec. 21, 1978, reprinted in L. Gostin & E. Rassaby (1980) *Representing the Mentally Ill and Handicapped*, MIND, London, Appendix C.

[5] *Kynaston v. Secretary of State for Home Affairs* (1981) 73 Cr. App. R. 281, C.A. Commented upon [1982] J.S.W.L. 104 (Gunn).

to be required by Article 5(1) of the European Convention. In *Winterwerp* the European Court said that Article 5(1)(*e*) would not permit the detention of a person only because "his views or behaviour deviate from the norms prevailing in society". The lawful detention of persons of unsound mind requires the observance of three minimal conditions: except in emergency cases, the individual must be reliably found to be of unsound mind on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.[1] This concept is also reflected in section 73(1) which obliges the tribunal to order the patient's discharge (absolute or conditional) if it finds that he is not suffering from one of the specified forms of mental disorder. In practice this means, once the R.M.O. makes a recommendation to the effect that a patient is no longer suffering from mental disorder, the patient must be discharged unless there is other sufficient evidence to satisfy the Home Secretary or the tribunal that he is suffering from mental disorder within the terms of the 1983 Act.

The initiative in seeking the Home Secretary's consent to discharge, transfer or leave of absence lies with the R.M.O. and the hospital managers. While the Home Secretary may sometimes refuse or postpone his consent, he will rely on the hospital authorities to bring cases to his notice. Hospital authorities should not assume that consent will not be given before the end of the period named on a restriction order made for a limited time, since the Home Secretary has discretion to consent at any time.[2] As an additional safeguard to the restricted patient, section 41(6) obliges the R.M.O. to examine the patient and to report at least annually to the Home Secretary; each report must contain such particulars as the Home Secretary may require.

15.20 The Advisory Board on Restricted Patients

On June 28, 1972, a committee chaired by Sir Carl Aarvold was invited by the Home Secretary to advise on whether the procedures for discharge and supervision of patients subject to restrictions should be modified within the existing law.[3] (At the same time the Butler Committee was asked to examine the wider question of possible changes in the law). The Aarvold Committee recommended that exceptional cases should be identified which need special care in assessment which involve two factors: a clearly unfavourable or unpredictable psychiatric prognosis, and some indication that there is a risk of the patient harming other persons. In a case identified as needing special assessment, a recommendation by the R.M.O. for discharge (or transfer from secure

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[1] *Winterwerp v. the Netherlands*, Judgment given Oct. 24, 1979, paras. 37, 39.

[2] DHSS (1983) *Mental Health Act 1983: Memorandum*, para. 163.

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

to open conditions) should not be consented to until an independent advisory body offered a second opinion. The Advisory Board on Restricted Patients should consist of a legal chairman, a forensic psychiatrist and a representative of the social work profession who has appropriate experience.[1] Reference to the Advisory Board on Restricted Patients is made only in a comparatively small number of cases, but the number has varied over the years.[2]

The Board is an extra-statutory body and, in law, has been considered merely an appendage to the Home Secretary. Accordingly, it had been suggested that neither the Home Secretary nor the Advisory Board has a duty to act fairly: "It is difficult to see any distinction between the Home Secretary taking advice from the Aarvold Board and taking advice from a responsible officer in his own department. . . . such a body is not, in my judgment, amenable to judicial review".[3]

But that is exactly what occurred in *R. v. Secretary of State for the Home Department, ex parte Harry*.[4] In that case, a tribunal recommended the transfer of a restricted patient and, on the basis of that recommendation, the R.M.O. subsequently proposed a trial leave of absence; the Home Secretary referred the case to the Advisory Board on Restricted Patients, which declined to support either recommendation. The Court reaffirmed the Home Secretary's discretionary authority to seek further advice and information from the Advisory Board. The Home Secretary, and not the tribunal, was entrusted by Parliament to give consent to a transfer or leave of absence, and the Home Secretary, therefore, is "not only free, but bound" to seek further advice if not fully satisfied by the tribunal's findings. Nevertheless, the Home Secretary must comply with the requirements of procedural fairness in making the reference to the Board and acting on its advice. In *Harry*, the Home Secretary did not act fairly: the applicant was not furnished with the Board's report, the new information contained in the report, or a summary of the report; and the applicant was not invited to make representations to the Board or the Home Secretary.

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[1] At present, the Board consists of eight members: two lawyers (one, a judge, is chairman), two experienced forensic psychiatrists, two senior social workers, and two members with special experience of the criminal justice system.

[2] Originally, about 5 per cent of all restricted patients in special hospitals were classified as requiring special care in assessment. *A Human Condition* (1977; vol. 2) pp. 152–54. On March 1, 1978, a new method of categorising patients as requiring special care in assessment was implemented which extended the number of patients who would be subject to these special measures. Lord Harris (March 22, 1978) H.L. Debs. Cols. 1879–1881. At that time it was assumed that all restricted patients in special hospitals would be referred to the Advisory Board, although the R.M.O. could recommend that the case was sufficiently straight forward as not to merit reference to the Board. In 1997, only 13 of 2,550 recommendations for discharge, transfer, or leave were referred to the Board. *R. v. Secretary of State for the Home Department, ex parte Harry* Q.B.D. [1998] 3 All ER 360, 43 BMLR 155.

[3] *R. v. Secretary of State for the Home Department, ex parte Powell* (unreported) Q.B.D., December 21, 1978.

[4] Q.B.D. [1998] 3 All ER 360, 43 BMLR 155.

In 1998, the Home Secretary announced a change in practice when the Home Secretary seeks advice from the Advisory Boad:

> The Secretary of State accepts that the patient is entitled by reason of procedural fairness (subject to public interest immunity or some other substantial reason . . . which will normally be communicated to the patient's advisors): (1) to be told the gist of any new information before the Advisory Board on a relevant point and, in particular, . . . the gist of the report to the Advisory Board by its member who has visited the hospital; (2) to make written representations to the Advisory Board in response to such material before the Advisory Board reaches a conclusion on its advice . . .; (3) to be given a copy of the advice from the Advisory Board to the Secretary of State, and to be given an opportunity to make written representations . . . to the Secretary of State before [he] reaches his conclusions; (4) to be given reasons for the decision of the Secretary of State; and (5) to make thereafter, any further written representations to the Secretary of State, which will be considered, in it being a continuing process of review . . . of the need for, and application, of restrictions.

The court, in *Harry*, indorsed this new policy except that it emphasized that the report, in view of its importance, should be in writing. When a fundamental right is in issue, moreover, a more expansive and informative summary of the report may have to be furnished to the applicant: The detail required depends on what "fairness requires to enable the making of meaningful and focused representations." The Home Secretary must consider "whether a full and fair understanding of the gist of the report can be conveyed without production of the report itself."

15.21 Detention during Her Majesty's Pleasure

Where a serviceman has been ordered to be detained "during Her Majesty's pleasure" (*i.e.*, indefinitely), the Home Secretary may by warrant direct that he be detained in a hospital (not being a mental nursing home). Such a direction has the same effect as a hospital order with restrictions without limit of time (s. 46). Note that the Home Secretary has no criteria to follow and, in particular, need not satisfy himself that the person is suffering from one of the specific forms of mental disorder.

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C. HOSPITAL AND LIMITATION DIRECTIONS

15.21A Background and Purposes

The Crime (Sentences) Act 1997 amended the Mental Health Act 1983 to give the Crown Court the power to attach a hospital and limitation direction when imposing a sentence of imprisonment on mentally disordered offenders.[1] The intent of the hospital direction is to give higher courts greater flexibility in dealing with cases where they conclude that a prison sentence is the appropriate disposal even though there exists sufficient evidence to make a hospital order. A court could draw this conclusion either because the offender is to receive an automatic life sentence[2] or because the court believes that a hospital order, even with restrictions on discharge, will not adequately protect the public from further harm.[3]

15.21A.1 Power of Higher Courts to Direct Hospital Admission

Section 45A of the 1983 Act gives the Crown Court the power to make a hospital direction in respect of a person who is sentenced to imprisonment. The hospital direction has the effect that, instead of being detained in a prison, the offender is immediately admitted to, and detained in, such hospital as may be specified in the direction (s. 45A(3)(a)).[4] The court must also make a limitation direction that has effect as if the person were subject to restrictions on discharge from hospital under section 41 of the 1983 Act. Hospital and limitation directions are available in respct of all prison sentences passed in the

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[1] Sections 45A and 45B inserted w.e.f. 1st October 1997 by the Crime (Sentences) Act 1997, section 46, and Commencement Order No. 2, S.I. 1997, No. 2200. See Home Office Circular 39/1997.

[2] The Crime (Sentences) Act 1997, s. 2, requires the court to impose a life sentence for a second serious offence, unless the court is of the opinion that there are exceptional circumstances relating to either the offences or to the offender.

[3] The jurisprudence of the European Court of Human Rights provides another possible explanation for the introduction of hospital and limitation directions in England and Wales. The European Court of Human Rights emphasizes that the lawfulness of detention for hospital order patients is to be determined on the basis of Article 5 §1(e) of the Convention relating to persons of unsound mind to the exclusion of Article 5 §1(a) relating to persons convicted of criminal offences. Consequently, once a hospital order patient is found not to be of unsound mind, an orderly process for his discharge from hospital appears required under the Convention. See para. **18.14A.4** *post*. Hospital and limitation directions may avoid this result, since they are attached to a sentence of imprisonment. If a hospital direction patient were found not to be mentally disordered and/or not to require treatment, he would be transferred back to prison to finish his sentence, rather than being discharged into the community.

[4] If, within 28 days, it appears to the Home Secretary that by reason of an emergency or other special circumstance it is not practicable for the patient to be received into the hospital specified in the direction, he may give instructions for his admission to another hospital (s. 45A(6)(7)). (As to the power of the court or Home Secretary to specify a particular hospital unit to assure a sufficient level of security, see para. **15.06A** above.)

higher courts, except for those fixed by law.[1] Where a hospital and a limitation direction is given, it applies to all existing prison sentences passed on the offenders (s. 45A(9)).

Hospital and limitation directions do not significantly alter the requirement that courts consider evidence of mental disorder and the appropriateness of a hospital order.[2] Section 45A(1)(b) of the 1983 Act requires the court to consider making a hospital order in all cases (other than offenders sentenced to an automatic life imprisonment for a second serious offence)[3] before imposing a sentence of imprisonment (with or without attaching a hospital direction).

15.21A.2 Grounds and Procedures for Hospital and Limitation Directions

A hospital direction may be given if the court is satisfied on the evidence of two registered medical practitioners, at least one of whom has given evidence orally before the court (s. 45A(4)), that: (i) the offender is suffering from psychopathic disorder; (ii) the disorder is of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment; and (iii) that such treatment is likely to alleviate or prevent a deterioration of his condition (s. 45A(2)). A hospital and a limitation direction cannot be given unless the court is satisfied that arrangements have been made for the offender's admission to hospital within 28 days after the direction has been given.[4] The Crown Court has the same power to obtain information from health authorities (see para. **15.09** above) and to make an interim hospital order (see para. **14.16** *ante*) as it would in making a hospital order. In cases where the doctor is uncertain at the time of sentencing whether admission to hospital would be beneficial, he should consider recommending an interim hospital order.

Initially, the power to make a hospital direction is available only where the offender is suffering from psychopathic disorder. However,

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[1] This means that a hospital and limitation direction cannot be made following a conviction of murder. By virtue of s. 2(4) of the 1997 Act, an automatic life sentence made for a second serious offence is not regarded as a sentence fixed by law, so that a hospital and limitation direction can be made in respect of such offenders.

[2] Under the Criminal Justice Act 1991, s. 4, except where a mandatory life sentence applies, including one under section 2 of the 1997 Act, the court is required to consider the effect of a custodial sentence on the offender's mental disorder before passing such a sentence.

[3] The Crime (Sentences) Act 1997, s. 2, requires the court to impose a life sentence for a second serious offence, unless the court is of the opinion that there are exceptional circumstances relating to either the offences or to the offender.

[4] The court may direct that the offender is detained in a place of safety pending his admission to hospital within the 28 day period (s. 45A(5)). A "place of safety" is defined in s. 55 of the Act.

the Secretary of State may extend this to other categories of mentally disordered offender by order (s. 45A(10)(11)).[1]

15.21A.3 Effect of Hospital and Limitation Directions

A hospital direction has the effect of ordering the offender's admission to a named hospital for treatment within 28 days, as if a hospital order had been made. The patient is detained in hospital as if he were admitted under a transfer direction made under section 47 of the Act s. 45B(2)(a)). (See para. **15.10** above). The court must make a limitation direction when making a hospital direction. A limitation direction has the same effect as a restriction direction under section 49 of the Act (s. 45B(2)(a)). (See para. **16.03** *post*).

An offender who is subject to a hospital and limitation direction may serve his entire sentence in hospital if he benefits from treatment. Alternatively he may, on the recommendation of the responsible medical officer or a mental health review tribunal, be transferred to prison at any time during sentence by warrant of the Home Secretary under section 50(1) of the Act. The transfer will be considered by the Home Secretary on receipt of medical information that the patient no longer requires treatment in hospital for mental disorder. Any subsequent transfer back to hospital would be considred under section 47 of the Act.

[1] Such an order may not be made unless a draft of it has been approved by a resolution of each House of Parliament (s. 143(3)).

D. GUARDIANSHIP ORDER

15.22 Making Guardianship Orders

Guardianship orders made under the Mental Health Act are seldom used. This is unfortunate as they provide a useful alternative to detention in hospital by providing a means by which the offender can be made subject to some control, supervision and support in the community. Such orders may be particularly helpful in meeting the needs of mentally impaired offenders who could benefit from occupation, training and education in the community. In these cases a guardianship order could provide a less restrictive setting in which care and habilitation could take place. Section 27 of the Criminal Justice Act 1991 inserted a new section 39A into the Mental Health Act 1983 requiring a local social services authority to inform the court if it or any other person is willing to receive the offender into guardianship and, if so, to provide such information as it reasonably can about how the guardian's powers can be expected to be exercised.

To facilitate the making of a guardianship order local authorities are advised to appoint a named person to respond to requests from the courts for information on available services. (Code of Practice, para. 3.6)

The magistrates' court or the Crown Court has the power to place an offender under the guardianship of a local social services authority or a person approved by the authority (s. 37(1)). Where a guardianship order is made the court cannot pass a sentence of imprisonment or impose a fine or make a probation order (s. 37(8)). The criteria and procedures which govern the making of a guardianship order are almost identical as in the case of a hospital order.

15.22.1 *Who can be the subject of a guardianship order?*

The order can be made by the Crown Court following conviction for an offence punishable with imprisonment other than murder; or by a magistrates' court following conviction of an offence punishable on summary conviction with imprisonment (s. 37(1)). However, the magistrates' court can make a guardianship order without recording a conviction in respect of a person suffering from mental illness or severe mental impairment if satisfied that he did the act or omission charged (s. 37(3)).

15.22.2 *Criteria and procedures*

The court must be satisfied on the evidence of two medical practitioners (one of whom is approved under section 12 (s. 54(1)) that the person is suffering from one of the four specific categories of mental disorder of a nature or degree which warrants his reception

into guardianship. The offender must be described by each doctor as suffering from the same form of mental disorder, whether or not he is also described by either of them as suffering from another form (s. 37(7)). The court must be of opinion, having regard to all the circumstances, that a guardianship order is the most suitable disposal. The court can make a guardianship order only if the offender is aged 16 or older (s. 37(2)).

15.22.3 *Willingness of guardian*

The court cannot make a guardianship order unless it is satisfied that the local social services authority or other person approved by the authority is willing to receive the offender into guardianship. Thus the local authority cannot be compelled to receive a person into guardianship, and some authorities have been reluctant to do so (s. 37(6).

15.22.4 *Effect of Guardianship Order*

A guardianship order confers on the local authority or person named as guardian the same powers as a guardianship application under Part II of the Act (s. 40(2)). These powers are to require the patient to reside in a specified place; to attend for medical treatment, occupation, education or training; and to require access to the patient to be given at the place where the patient is residing, to any registered doctor, approved social worker or other specified person (s. 8(1)). The duration of the order and discharge of patients are also the same as under Part II with the following exception. (As to the effect of a guardianship application, see para. **11.07** *ante*.) The nearest relative of a guardianship order patient cannot discharge the patient (s. 40(4), Sch.1, Pt.I, paras. 2, 8); but the nearest relative does have the right to apply to a tribunal in respect of the patient at any time within the first year of the guardianship order, and during each subsequent period of one year (s. 40(4), Sch. 1, Pt. 1, paras. 2, 9). Where a patient is placed into guardianship under s. 37 any previous application, hospital order or guardianship order ceases to have effect. However, if the later order is subsequently quashed on appeal the previous application or order remains in effect and will validate any period of detention or guardianship under the later order (s. 40(5)).

E. MEDICAL EVIDENCE

15.23 General Requirements

Courts may make a hospital or guardianship order on the basis of written medical reports. For the purposes of Part III of the Act a written report purported to be signed by a registered medical practitioner or by a person representing the managers may be received in evidence without proof of the validity of his signature or that he has the requisite qualifications or authority. However the court can require the signatory of any such report to be called to give oral evidence (s. 54(2)). The medical reports required for a hospital or guardianship order may be adduced by either party or by the court itself. Where, in pursuance of a direction of the court, a report is tendered in evidence otherwise than by or on behalf of the subject of the report then, if that person is legally represented, a copy of the report must be given to his representatives; if that person is not legally represented, the substance of the report (not the report itself) must be disclosed to him or, where he is a minor, to his parent or guardian (s. 54(3)(*a*), (*b*)). The defence is entitled to require the doctor who has signed a medical report to be called to give oral evidence. The defence should be given the full opportunity to rebut the evidence contained in the medical report by cross examination and by calling its own medical evidence (s. 54(3)(*c*)). Where two medical reports are required for the purposes of an order made under Part III generally there is a requirement that at least one of the doctors should be approved under section 12 by the Secretary of State as having special experience in diagnosis or treatment of mental disorder (s. 54(1)) (see further para. **6.17.5** *ante*). If a court proposes to make a restriction order it is required to hear oral evidence from at least one doctor (s. 41(2)).

15.23.1 *Assessment by a doctor*

Where a doctor is asked to provide an opinion in relation to a possible admission under Part III of the Act: (*a*) he should identify himself to the person being assessed, and explain at whose request he is preparing the report, discussing the implications for confidentiality; and (*b*) he should have access to relevant social enquiry reports, medical records, and documentation regarding the alleged offence. The doctor should also seek independent sources of information about the person's previous history, psychiatric treatment, and patterns of behaviour. The doctor's report should indicate if he is not in possession of full information.

It is desirable for the doctor who has previously treated the patient to prepare the report. It is also desirable for one of the doctors preparing the report to have appropriate beds at his disposal or to take responsibility for referring the case to another doctor with access to such facilities.

The doctor preparing the report has personal responsibility. Appropriate members of the clinical team who would be caring for the patient should also be involved. The nursing member of the clinical team, in particular, should undertake a nursing assessment of the person's needs for nursing care and management. The doctor should make contact with the social worker or probation officer who is preparing a social enquiry report, especially when psychiatric treatment is suggested as a condition of a probation order.

The doctor's report should not anticipate the outcome of the judicial proceedings to establish guilt or innocence. It is sometimes appropriate to advise that a further report should be submitted after conviction and before sentencing. In any report prepared prior to conviction, the doctor may give advice on the appropriate disposal in the event that the person is convicted.

When the doctor has concluded that the person needs treatment in hospital, but there is no facility available, the task is not completed until: (*a*) a written report of the type of provision required is sent to the district health authority, which will need detailed advice in order to discharge their responsibilities; (*b*) in suitable cases contact has been made with a local NHS forensic psychiatrist. (Code of Practice, paras 3.7–3.11).

F. PSYCHIATRIC TREATMENT AS A CONDITION OF PROBATION

15.24 Probation Orders in General

Where a person aged 17 or over is convicted of an offence (other than one for which the sentence is fixed by law, such as murder), the court may, instead of sentencing him, make a probation order. The court must first be of opinion that having regard to the circumstances, including the nature of the offence and the character of the offender, that it is expedient to make a probation order. The making of a probation order means the offender will be required to be under the supervision of a probation officer for a period specified by the court of not less than six months nor more than three years.[1] A probation order may also require the offender to comply with such requirements as the court considers necessary for securing the good conduct of the offender or for preventing him from offending again.[2] The court is also specifically empowered to include the following requirements: that the offender should reside in an approved probation hostel or any other institution;[3] that the offender should present himself to specified persons at specified places or should participate in or refrain from specified activities at specified times;[4] or that the offender should attend a day centre.[5]

Before making a probation order, the court must explain to the offender in ordinary language the effect of the order and any additional requirements. It must inform him that if he fails to comply with it or commits another offence he will be liable to be sentenced for the original offence. The court cannot make a probation order unless he states his willingness to comply with its requirements.[6] Should he not understand its implications, it may be revoked on appeal.[7]

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[1] Powers of Criminal Courts Act 1973, s. 2(1). The minimum period was reduced from one year to six months by S.I. 1978 No. 478.

[2] The 1973 Act, s. 2(3). The court must not impose a requirement which introduces such a custodial or other element as will amount to the imposition of a sentence; and any discretion conferred on the probation officer must be confined within well defined limits, since it is the court alone which can define the requirements of the order. *Rodgers v. Cullen* [1982] 2 All E.R. 570, H.L.

[3] The 1973 Act, s. 2(5).

[4] The 1973 Act, s. 4A (substituted by the Criminal Justice Act 1982, s. 65(2), Sch.11). The commencement date was Jan. 31, 1983—S.I. 1982 No. 1857. For an explanation of the provisions see Home Office Circular 4/1983.

[5] The 1973 Act, s. 4B (substituted as above).

[6] The 1973 Act, s. 2(6). This provision cannot be considered as giving jurisdiction to include requirements not authorised in the Act. *Rodgers v. Cullen* [1982] 2 All E.R. 570, H.L.

[7] A probation order cannot be effectively made unless the offender is given a fair chance to decide for himself. *R. v. Marquis* [1974] 1 W.L.R. 1087, C.A.

15.25 Probation Order with a Condition of Psychiatric Treatment

The court may place the offender on probation with a requirement that he submit to treatment by or under the direction of a qualified medical practitioner with a view to the improvement of the offender's mental condition.[1] The court must first be satisfied, on the evidence of one qualified medical practitioner (approved under section 12 of the 1983 Act) that the mental condition of the offender requires and may be susceptible to treatment, but does not warrant the making of a hospital or guardianship order under Part III of the Mental Health Act.[2] The court cannot make a psychiatric probation order unless satisfied that arrangements have been made for the treatment to be given which is specified in the order.

The offender may be at liberty during his probation, so the order is used only where there is little danger that he will commit further serious offences.[3] Although the order is not usually made for particularly violent offences, the courts have on occasion used it in serious cases.[4] The court may specify any one of the following treatments: treatment as a resident in a hospital or mental nursing home (but not a special hospital); treatment as a non-resident patient at such an institution or place specified in the order; or treatment by or under the direction of a qualified medical practioner specified in the order. The court is not entitled to specify any other kind of treatment.

Where the doctor responsible for the probationer is of opinion that part of the medical treatment can be better or more conveniently given at an institution or place not specified in the order he may, with the consent of the probationer, make alternative arrangements. The doctor must give written notice to the probation officer, specifying the institution or place where treatment is to be carried out. The doctor may report to the probation officer if he considers that: the treatment should be continued beyond the period specified in the order; a different kind of treatment is needed (of a type that the court is entitled to specify); the probationer is not susceptible to treatment; no further treatment is required; or the doctor is for any reason unwilling to continue to treat the probationer. The probation officer must then apply to the court for

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[1] The court cannot amend an original probation order by adding a requirement that the offender submit to treatment for his mental condition unless the amending order is made within three months of the original order. Criminal Justice Act 1991, Sch. 2, Part IV, para. 13(2)(*a*)(ii).

[2] Powers of Criminal Court Act 1973, s. 3(3) and Sched. 1A, substituted by the Criminal Justice Act 1991, s. 9(1).

[3] *R. v. Nicholls*, [1981] 3 Cr. App. R.(s) 388; reported in *Current Sentencing Practice*, Sweet & Maxwell, London, para. F1.2(*b*); *R. v. Greedy* [1964] Crim. L. Rev. 669; *R. v. Cave* [1965] Crim. L. Rev. 448. A psychiatric probation order is inappropriate where the diagnosis is uncertain. See *R. v. Docherty* [1962] Crim. L. Rev. 851.

[4] *E.g. R. v. Hill* [1963] Crim. L. Rev. 525 (attempted murder); *R. v. James* [1965] Crim. L. Rev. 252 (indecent assault); *R. v. Hoof* [1980] 2 Cr. App. R. (S)299 (arson); *R v. Parker* (1990) *The Guardian*, February 8, 1990 (Transcript: Marten Walsh Cherer) 1 Febraury 1990, CCA (indecent assault and false imprisonment).

a variation or cancellation of the order. The probationer's agreement to the amended requirement must be obtained if the order is to be varied.[1]

A psychiatric probation order can be a useful alternative for a court to provide for the offender's treatment without the need for liability to detention. While under a psychiatric probation order, if required to reside in or attend a hospital, the probationer is an informal patient. He can refuse treatment in the same way as any other informal patient; he is not deemed to have breached the order if he reasonably refuses "to undergo any surgical, electric or other treatment".[2] A non-custodial sentence where the mentally disordered offender can receive treatment informally is to be preferred over a sentence of imprisonment or a hospital order wherever the person does not present a serious risk to the public and where he consents.

[1] The 1973 Act, Sch. 1, para. 4. No application under para. 4 may be made while an appeal against the probation order is pending. Sch. 1, para. 4A (substituted by Criminal Justice Act 1982, s. 66(3)(*b*)).

[2] The 1973 Act, s. 6(7).