

There is no magic in a bed – The renewal of detention during a period of leave

*There is no magic in a bed – The renewal of detention during a period of leave**David Hewitt**

R (on the application of DR) v Mersey Care NHS Trust

CO/1232/2002

Administrative Court (7 August 2002) Mr. Justice Wilson.

Where medical treatment in a hospital was a significant component of a patient's treatment plan it would be lawful to renew her detention under the Mental Health Act 1983, even though there was no intention for her to become an 'in-patient'.

Introduction

Since 1986, psychiatrists have been urged to abjure the 'long leash', and to ensure that only those patients who require treatment in a hospital should be detained – or 'liable to be detained' – there. Recent cases, the present one included, may have qualified this injunction, but they do not seem to have displaced it.

Facts

The Claimant, 'D.R.', was a 44-year-old woman who was diagnosed as suffering from schizophrenia. She had first entered hospital for psychiatric care in 1991 and had been subsequently admitted to the Defendant's mental health unit on five occasions. According to Wilson J:

"[T]he pattern was of her successful treatment with medication within that climate of compulsion; but of her failure, following discharge, to take medication, born of a refusal to accept that she was ill and needed it".¹

The admission that was the subject of this case began on 12 September 2001, when D.R. was detained under section 3 of the Mental Health Act 1983 ('MHA 1983'). The authority for detention would last until 11 March 2002, unless she was discharged before that date.²

Although her mental state improved once she began to receive medication again, D.R. did not engage with hospital staff, and she became isolated within the ward. What was needed, Wilson J. concluded, was

"a mechanism [...] whereby staff could engage with her and thereby enable her to develop an

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parties in the case of IH (see below for citations)

1 Judgment, para 6

2 MHA 1983, s 20(1)

insight into her condition, which, following ultimate discharge, would lead her to continue to take medication voluntarily.”³

In October 2001, D.R.’s Responsible Medical Officer (‘RMO’) used his powers under MHA 1983, section 17 to grant her leave of absence from the hospital. In the words of Wilson J, he hoped “to end the claimant’s passage around [...] the revolving door.”⁴

The leave given to D.R. was extensive: she could go home for all but three days each week, and even on those days she would only have to be back in the hospital between 9.00 a.m. and 5.00 p.m. While on leave she would be visited by members of the ‘assertive outreach team’, who would ensure that she received her prescribed medication by injection. On 5 December 2001, having heard an application made by D.R. shortly after she was detained, the Mental Health Review Tribunal (‘MHRT’) decided not to discharge her.

There followed what Wilson J. called a “set-back”⁵ in D.R.’s treatment plan, and on 31 January 2002 she returned to the hospital, where she remained for four days and nights. On 5 February 2002, having examined D.R. in accordance with his statutory duty,⁶ the RMO completed a report in Form 30, the purpose of which was to renew her detention with effect from 11 March 2002. In his report, the RMO wrote:

“She suffers from a mental illness namely schizophrenia. She harbours numerous delusional beliefs and has recently expressed suicidal ideas to the nurses who visit her. She has no insight into her illness. She has been reluctant to take medication. She needs to be detained in hospital in order to administer medication and observe her progress by trained staff.”⁷

At the same time as completing his renewal report, the RMO also prepared a fresh treatment plan. It provided that D.R. should have leave of absence again; that members of the assertive outreach team should visit her at home each Tuesday and Thursday; and that a community psychiatric nurse should visit her every fortnight to administer her prescribed medication. Crucially, the new treatment plan also provided that D.R. should return to the hospital for occupational therapy every Friday between 9.00 a.m. and 5.00 p.m, and for the ward round every Monday morning, so that her progress could be monitored.

It will be noted that the second treatment plan envisaged D.R. having less contact with the hospital than had been provided for in the first. Previously, she was required to return for three days each week, whereas now she would only be in the hospital on a Friday, and on Monday for as long as it took to complete the ward round.

Although D.R.’s detention was renewed immediately her RMO ‘furnished’ his report to ‘the managers’ of the hospital,⁸ those managers met on 20 February 2002 to consider the report and to decide whether to use their statutory power to discharge the Claimant from detention.⁹

At the hospital managers’ review meeting, the RMO reiterated the conclusions of his report and expressed the opinion that if D.R. were to be discharged “in her current mental state, she will stop

3 *Judgment, para 8*

1983, reg 10(1)

4 *Judgment, para 5*

7 *Judgment, para 11*

5 *Ibid, para 10*

8 MHA 1983, s 20(8)

6 MHA 1983, s 20(3); *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations*

9 MHA 1983, s 23, MHA 1983 Code of Practice, para 23.7

taking the medication and her condition will rapidly deteriorate.”¹⁰ This view was supported by D.R.’s Approved Social Worker, whose report stated:

“Everybody involved with [D.R.] recognises that compliance with medication is the issue. [D.R.] has no insight into her illness and I feel masks her symptoms because she is aware we feel they indicate illness. She has promised to accept the depot injection for two years. I am not convinced she will be able to keep this promise. It may be wise to keep [D.R.] on section 3 a little longer, as this will ensure that she is treated and perhaps the revolving door cycle can be broken.”¹¹

A report written for the managers’ meeting by a nurse suggested that D.R. did not believe she was ill and that she took her medication with reluctance. As to the consequences if she were discharged, it stated:

“Compliance with treatment is an area of concern with [D.R.]. It is felt she would become non-compliant if discharged. [D.R.] would not remain as an informal patient on the ward if taken off current section. [D.R.’s] mental health state would deteriorate and she would be a risk to herself/others.”¹²

Having received these reports, and having heard from various witnesses, including D.R. herself, the managers decided not to discharge her. In the written grounds for their decision they stated:

“We are convinced the patient is suffering from a mental disorder which requires treatment. If she were not detained, we doubt her compliance. Given the recent past history and the social worker’s evidence about ‘revolving door’, we think a longer period of detention is necessary.”¹³

Her application to the Administrative Court having been initiated on 6 March 2002, D.R. was in fact discharged from detention on 11 April 2002. (The Judge said he had been assured that the second event was not linked to the first.) However, she soon stopped taking her medication, and on 9 June 2002 she was re-admitted to hospital, this time for assessment under MHA 1983, section 2.

Law

When furnishing his renewal report, D.R.’s RMO had to address the statutory conditions set out in MHA 1983, section 20(4). They require that:

- “(a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
- “(b) such treatment is likely to alleviate or prevent a deterioration of his condition; and
- “(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained.”

Of course, section 20(4) concludes:

“[I]n the case of mental illness or severe mental impairment, it shall be an alternative to the

¹⁰ *Judgment, para 13*

¹² *Ibid, para 15*

¹¹ *Ibid, para 14*

¹³ *Ibid, para 17*

condition specified in paragraph (b) above that the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation.”¹⁴

Wilson J. noted that there was judicial authority to the effect that the word ‘detained’ in MHA 1983, section 20(4)(c) should in fact be read as “liable to be detained”,¹⁵ and he concluded:

“[A]ccordingly, the conditions for renewal can be satisfied even in relation to a patient who is no longer actually detained but has been granted leave of absence under s. 17 of the Act.”¹⁶

The RMO may only furnish his report “if it appears to him” that these conditions are satisfied.¹⁷

Argument – the Claimant

On behalf of D.R., it was argued that the MHA 1983, section 20(4) conditions had not been fulfilled and therefore, that the RMO had acted unlawfully in renewing D.R.’s liability to detention and the hospital managers had acted unlawfully in sanctioning that renewal.

Counsel for D.R., Mr. Stephen Simblet, argued that a patient could only be detained, and any renewal of her detention could only be lawful, if it was planned to treat her as an ‘in-patient’. He said that the plans for his client envisaged her treatment as an ‘out-patient’.¹⁸ Mr. Simblet claimed support for this argument in the decision of McCullough J. in *R v Hallstrom and another, ex parte W*; *R v Gardner and another, ex parte L* (‘Hallstrom’ and ‘Gardner’),¹⁹ which he said had not been materially affected by the judgment of the Court of Appeal in *B v Barking Havering & Brentwood Community Healthcare NHS Trust and Dr Jason Taylor* (‘Barker’).²⁰

D.R. also ventured what the Judge described as “a late, subsidiary argument”.²¹ Her counsel noted that MHA 1983, section 23(2) gave hospital managers the discretion to discharge a patient, and to do so even if the renewal conditions were met.²² He suggested that before deciding not to exercise this discretion, the managers should have considered whether, as an alternative, D.R. might be made subject to After-care under Supervision.²³ The managers had, of course, ignored that possibility, and D.R.’s counsel argued that they had therefore acted irrationally and in breach of the ‘right to liberty’ set out in Article 5 of the European Convention on Human Rights (‘ECHR’).

Argument – the Defendant

The Defendant’s Counsel, Miss Kristina Stern, conceded that the renewal criteria would only be satisfied if the plans for a patient included a significant element of treatment in hospital. However, she contended that the terms ‘in-patient’ and ‘out-patient’ represented a gloss upon the renewal criteria that was unhelpful and not supported by MHA 1983. She too relied upon the judgment of the Court of Appeal in *Barker*, and she argued that the element of treatment in hospital contained in the plans for D.R. was significant enough to make those plans lawful.²⁴

14 MHA 1983, s 20(4)

15 *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* [1999] 1 FLR 106

16 *Judgment*, para 21

17 MHA 1983, s 20(3)

18 *Judgment*, para 5

19 [1986] 2 All ER 306

20 See note 15, above

21 *Judgment*, para 32

22 *R v Riverside Mental Health Trust, ex parte Huzzey* [1998] 43 BMLR 167

23 MHA 1983, s 25A–J

24 *Judgment*, para 5

The issue

Wilson J. sought to delve beneath what he described as “the battle-lines” in order to identify “the real issue”.²⁵ This he was eventually able to distil into a single question:

“[W]as it open to the doctor and the managers to conclude that his treatment plan for the Claimant was for ‘medical treatment in hospital’?”²⁶

If this question could be answered in the affirmative, the Defendant would succeed; if not, the Claimant, D.R., should have been discharged.

The judge set out that reasoning that had led him to this relatively simple formulation. He said:

“In my view this case is centrally an enquiry into the words ‘medical treatment in a hospital’ set out in [MHA 1983, section 20(4)] (a) and repeated, by reference, in (b) and (c). The claimant clearly suffers from mental illness so the enquiry at (a) was whether it was of a nature or degree which made it appropriate for her to receive ‘medical treatment in a hospital’. The enquiry at (b) [...] was whether ‘such’ treatment was likely to alleviate or prevent a deterioration of her condition. The enquiry at (c) was whether ‘such’ treatment could not be provided unless she continued to be liable to be detained and unless it was necessary for the health or safety of herself or (for example) her daughter.”²⁷

Decision

The managers’ test for renewal

Wilson J. did not deal with the substantive issue straight away. First, he felt it necessary to determine a preliminary point: whether, when considering the discharge of a patient such as D.R., the hospital managers must have regard to the ‘admission’ criteria contained in MHA 1983, section 3(2) or the ‘renewal’ criteria in section 20(4).

Noting that the MHA 1983 Code of Practice states, “the essential yardstick in considering a review application is whether the grounds for admission or continued detention under the Act are satisfied,”²⁸ the judge concluded:

“[W]here managers are considering whether to order discharge on expiry of the initial period of liability to detention notwithstanding the doctor’s renewal, it is the conditions for renewal set by [MHA 1983,] section 20(4) which logically they should address.”²⁹

The ECHR and the managers’ discretion to discharge

The ECHR argument put forward on behalf of D.R. was given equally short shrift. It was “a central feature”, the judge said, of the provisions for after-care under supervision that a patient could not be compelled to receive the medication that had been prescribed for her. However, in this case:

25 *Ibid.*

26 *Ibid.*, para 22

27 *Ibid.*

28 *MHA Code of Practice, Department of Health and Welsh Office, 1999, London, The Stationery Office, para 23.11*

29 *Judgment*, para 19

“[...] the doctor, the social worker and the nurse were unanimous in discerning the major problem to be that, were she to cease to be liable to be detained, [D.R.] would refuse to take the medication. Invocation of the statutory system of after-care under supervision would have represented a failure to address the major problem.”³⁰

Renewal during a period of leave

As far as the substantive issue in the case was concerned, Wilson J. began by distinguishing the facts of this case from those of *Hallstrom* and *Gardner*. He noted that:

“In neither of them did the plan which formed the basis of (in the former) the compulsory admission for treatment and (in the latter) the renewal of the authority for detention include any element of treatment in hospital.”³¹

In both cases, the Judge continued, the defendant doctors had the same plan, which was

“for the claimants to remain entirely in the community (apart, in the former, from the very first night, such being a cosmetic provision with no therapeutic purpose)”;³²

and in each case:

“[T]he motive behind the invocation of compulsory powers [...] was to be able to require (or to threaten to require) the claimants to take medication in the community, without which they were considered unlikely to do so.”³³

Wilson J. approved the *basis* of the judgment delivered by McCullough J. in *Hallstrom* and *Gardner*, but he deplored the error into which he had subsequently allowed himself to venture. As a matter of statutory construction, Wilson J. said, it was perfectly proper for McCullough J. to have held,

“[...] that the powers of admission and renewal under [MHA 1983] ss. 3 and 20 could be used in respect only of patients whose condition is believed to require detention *for treatment in a hospital*”.³⁴

As we have seen, Wilson J. believed that the plans made in *Hallstrom* and *Gardner* did not include any element of treatment in hospital. The difficulty, he said, was that McCullough J. had gone on “to reach beyond the easy conclusion that the plan for the claimants was not in any way for treatment in a hospital”.³⁵

With disapproval, Wilson J. cited³⁶ the following passage from the judgment of McCullough J:

“The phrase ‘his mental disorder ... makes it appropriate for him to receive medical treatment in a hospital’ in [MHA 1983] section 3(2)(a) also leads to the conclusion that the section is concerned with those whose mental condition requires in-patient treatment. Treatment *in a hospital* does not mean treatment *at a hospital*, as [leading counsel for the defendants], in effect, contends. If his construction were correct there would be a distinction between the patient who could appropriately be treated at home and the patient who could appropriately be treated at the out-patients’ department of a hospital. Such a distinction would be without reason.

30 *Ibid*, para 33

31 *Ibid*, para 24

32 *Ibid*.

33 *Judgment*, para 24

34 *Ibid*, para 25 [the words in italics had been those of McCullough J.]

35 *Judgment*, para 25

36 *Ibid*.

When it is remembered that the section authorises compulsory detention in a hospital it is at once clear why a distinction should be made between those whom it is appropriate to treat in a hospital, i.e. as in-patients, and those to whom it is appropriate to treat otherwise, whether at the out-patient department of the hospital or at home or elsewhere.”³⁷

Turning to *Barker*, Wilson J. noted that the treatment plan that the patient sought to overturn would have required her “to be in hospital only for two nights and the majority of two days each week”.³⁸ During this time “she was to be assessed, monitored and tested (in particular for the use of illicit drugs) and to attend occupational and art therapy”.³⁹

The Judge noted that although the word ‘in-patient’ is used in MHA 1983, section 5 it is nowhere defined. However, he stated that it “could properly be used to describe the Claimant in [*Barker*]” because it “suggests the allocation and use, albeit not at all times, of a hospital bed”.⁴⁰

In fact, when upholding the renewal of the patient’s detention, the then Master of the Rolls, Lord Woolf, had specifically described her as an “in-patient”. However, Wilson J. now held, this was not because Lord Woolf approved of McCullough J’s ‘in-patient’ / ‘out-patient’ distinction, but simply because “he held that the proposed treatment should be considered, not atomistically but as a whole”.⁴¹ As support for this proposition, the Judge cited⁴² the following passage from the judgment in *Barker*:

“It is the treatment as a whole which must be calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. As long as treatment viewed in that way involves treatment *as an in-patient* the requirements of the section can be met.”⁴³

Still on the subject of *Barker*, Wilson J. noted⁴⁴ that, in concurring with the Master of the Rolls, Thorpe L.J. had not used the word ‘in-patient’; rather, he had upheld the renewal of the patient’s detention with the following words:

“[H]er *home base* remained the hospital despite the fact that she slept many more nights out than in and despite the fact that she had a daily leave of absence for 4 hours on each of the 2 days per week when she returned to the hospital. It seems obvious to me that those 2 days of detention each week were an *essential ingredient* of the treatment [...] Her presence in the hospital each Tuesday and Wednesday was an *essential part* of the treatment package, it could only be provided in the hospital and could only be effectively provided if the appellant continued to be detained.”⁴⁵

It was this aspect of *Barker*, the Judge noted, that both parties had cited in support of their conflicting arguments. His decision suggests that it supports the Defendant’s case rather more fully. Describing it as “predictable”, Wilson J. dismissed the submission made for D.R. He ruled that the distinction that McCullough J. had drawn in *Hallstrom* and *Gardner* between ‘in-patient’ and ‘out-patient’ care had been *obiter* and also unnecessary. Further, Wilson J. said that the distinction between treatment *at* a hospital and treatment *in* a hospital was “too subtle for me”, and he added:

“When I eat at a restaurant, I eat in a restaurant.”⁴⁶

37 *Hallstrom and Gardner*, p 315c–e

38 *Judgment*, para 26

39 *Ibid.*

40 *Judgment*, para 27

41 *Ibid.*

42 *Ibid.*

43 *Barker*, para 113G [*the italics are those of Wilson J.*]

44 *Judgment*, para 27

45 *Barker*, p 118A–B and D–E [*the italics are those of Wilson J.*]

46 *Judgment*, para 29

The treatment proposed for the patient in *Barker* had “happened to be of an in-patient character,” so it was natural that Lord Woolf should describe it as such. However:

“[T]hat does not make it become the test, any more than the reference of Thorpe L.J. to a ‘home base’ renders that concept the test.”⁴⁷

Applying the decision in *Barker*, Wilson J. held that it was significant because it established that the renewal of detention could be lawful even though only part of the plan was for treatment in hospital. It would suffice “if that part of the plan was, to borrow another phrase from the judgment of Thorpe LJ, an essential ingredient”; but

“[I]t would be an impermissible – indeed an illogical – gloss upon the Act to make lawfulness depend upon a plan to put the patient at times into a hospital bed.”⁴⁸

By way of explication, the Judge added:

“There is no magic in a bed; indeed the facility for treatment at night, when the patient is in bed, must be much less than for treatment during the day.”⁴⁹

Wilson J. then set about devising his own test. He noted⁵⁰ that the statutory definition of “medical treatment” includes “rehabilitation under medical supervision”⁵¹ and that the MHA 1983 Code of Practice states that “leave of absence can be an important part of a patient’s treatment plan.”⁵² Therefore, he held:

“The question [...] is whether a significant component of the plan for the claimant was for treatment in hospital.”⁵³

He concluded that this question could be answered in the affirmative. The purpose of the leave granted to D.R:

“[...] was to preserve the claimant’s links with the community; to reduce the stress caused by hospital surroundings which she found particularly uncongenial; and to build a platform of trust between her and the clinicians upon which dialogue might be constructed and insight on her part into her illness engendered”.⁵⁴

The Judge recalled that in *Barker* the Court of Appeal had stressed the importance not merely of granting leave, but also of considering its effect upon the patient. Here, he said:

“[T]he requirement to attend hospital on Fridays between 9.00 am and 5.00 pm and on Monday mornings was also [...] a significant component of the plan. The role of occupational therapy as part of the treatment of mental illness needs no explanation. But the attendance at hospital on Monday mornings seems to me to be likely to have been even more important. Such was to be the occasion for the attempted dialogue; for monitoring; for assessment and for review.”⁵⁵

Therefore, Wilson J. held:

“[...] that a significant component of the plan for the claimant was treatment in hospital and that the conditions for renewal set by [MHA 1983,] s. 20(4) were satisfied”.⁵⁶

47 *Judgment*, para 29

48 *Ibid.*

49 *Ibid.*

50 *Ibid.*, para 30

51 MHA 1983, s 145(1)

52 MHA Code of Practice, *op cit.*, para 20.1

53 *Judgment*, para 30

54 *Ibid.*

55 *Judgment*, para 30

56 *Ibid.*, para 31

He noted that the Government’s plans to reform mental health law included provisions that would enable medical treatment for mental disorder to be imposed upon a “hospital non-resident”.⁵⁷ However, he concluded:

“Unless and until this reform is enacted, the law will remain (if my interpretation of it be sound) that the compulsory administration of medication to a patient can be secured only by making him liable to be detained or renewing such liability; that such may be achieved only if a significant component of the plan is for treatment in hospital; and that, in such an enquiry, the difference between in-patient and out-patient treatment is irrelevant.”⁵⁸

The Claimant’s application for judicial review was therefore dismissed.

Comment

Treatment in hospital must form a significant component of the care plan

The circumstances in which a patient’s detention may be renewed are now somewhat clearer. In particular, we know that that step may be taken even while a patient is on leave, provided treatment in hospital forms a “significant component” of the plan for him/her.⁵⁹

The decision in *D.R.* joins a growing body of case law on the renewal of detention under the 1983 Mental Health Act. After *Barker*, of course, there had been *R (on the application of Epsom and St. Helier NHS Trust) v The Mental Health Review Tribunal*,⁶⁰ in which the Administrative Court considered the case of a detained patient who had been on leave for some time. Sullivan J. held that:

“[I]f [...] it was proposed that the patient should be admitted to hospital for in-patient treatment in the week following the expiration of a six-month period of liability to detention, it would be absurd if the tribunal could not take that fact into account.”⁶¹

However, His Lordship concluded:

“[T]here will come a time when, even though it is certain that treatment will be required at some stage in the future, the timing of that treatment is so uncertain that it is no longer ‘appropriate’ for the patient to continue to be liable to detention.”⁶²

There was no mention of *Epsom and St. Helier* in the judgment in *D.R.*, and the two cases are easily distinguishable (chiefly because definite plans had been made for the patient in *D.R.* to return to hospital in the future). However, they both conceive of psychiatric treatment as something that may be provided elsewhere than in a hospital, and they recognise that patients may still need to be subject to the constraints of the 1983 Act when they have ceased to be confined.

Whether the rationale for the judgments in *Barker*, *Epsom and St. Helier* and *D.R.* represents a flight from *Hallstrom* and *Gardner* is, however, a different question. It is likely that these two groups of cases yielded different results simply because they were concerned with different circumstances. Lord Woolf alluded to this possibility in *Barker*, when he said:

57 See, for example: *Draft Mental Health Bill, Department of Health 2002, Cm 5538-I, cl 23(2) and (3)*; *Draft Mental Health Bill: Explanatory Notes, June 2002, Cm 5538-II, para 32*

58 *Judgment, para 34*

59 *Ibid, para 30*

60 [2001] EWHC Admin 101

61 *Epsom and St Helier, para 74*

62 *Ibid, para 62*

“It is important to note that in both [*Hallstrom* and *Gardner*] it was accepted that [the patients] did not require treatment as in-patients and the real reason for the doctors’ actions was [the patients’] refusal to take medication, which could have been taken as out-patients if they had taken it voluntarily.”⁶³

In *Hallstrom* and *Gardner*, the words in which McCullough J. dismissed the doctors’ practice distinguish it very clearly from the way patients were dealt with in subsequent cases. The judge said, speaking of section 13 of the Mental Health Act:

“The ‘detention’ there referred to cannot realistically include a purely nominal period before leave of absence is given, after which the treatment of which the patient stands in need is to begin.”⁶⁴

In *Barker* and *D.R.*, and also in *Epsom and St. Helier*, the respective claimants had spent a considerable proportion of their time under detention receiving psychiatric care in hospital.

It has been suggested that in so far as it purports to deal with a patient’s *initial* detention, the decision in this case was purely *obiter* and should not be followed.⁶⁵ However, *Hallstrom* concerned the lawfulness of detention, as opposed to renewal, and, of course, Wilson J. addressed that case in terms.

Rejecting the in-patient/out-patient distinction

It was surely right for Wilson J. to criticise the extended reasoning of McCullough J. in *Hallstrom* and *Gardner*.⁶⁶ However, the passage he cited for that purpose is questionable for at least one more reason than he mentioned.

McCullough J.’s distinction between ‘in-patient’ and ‘out-patient’ care had been made in response to the suggestion that, according to a careful construction of section 3(2)(a) of the Mental Health Act, treatment in a hospital is the same as treatment at a hospital. The judge said:

“If [that] construction were correct there would be a distinction between the patient who could appropriately be treated at home and the patient who could appropriately be treated at the out-patients’ department of a hospital. Such a distinction would be without reason.”⁶⁷

Yet, McCullough J.’s distinction was surely no less irrational. It sought to differentiate instances of precisely the same medical treatment administered in precisely the same place – namely, the hospital – and it did so merely according to the provenance of the patients who received that treatment and the degree of compulsion that could have been applied to them. It would surely be more logical to distinguish between all forms of treatment provided on hospital premises and those administered only in the community. This distinction had been advanced on behalf of the doctors in *Hallstrom* and *Gardner* (and dismissed by McCullough J.), and, having been tacitly approved in *Barker*, was left untouched by the present case.

However, not everything that Wilson J. said in criticising McCullough J. is equally acceptable. His statement “When I eat at a restaurant, I eat in a restaurant”⁶⁸ might have been made by one wholly unacquainted with ‘fast food’, the ubiquitous ‘drive-thru’, and the hurried consumption of a ‘chicken zinger’ in a rain-swept car park.

63 See Wilson J’s summary of the relevant facts, which is set out above and cited in footnotes 32–34. 31–33

64 *Hallstrom and Gardner*, pp 315j–316a

65 See, for example: R Jones, *Mental Health Act Manual*,

2003, Sweet & Maxwell, 1–046

66 *Judgment*, para 25

67 *Hallstrom and Gardner*, p 315c–d

68 *Judgment*, para 29

The continuing relevance of Hallstrom and Gardner

The judgments in *Barker* and *D.R.* each accept that McCullough J. decided *Hallstrom* and *Gardner* correctly on their facts. That is not surprising, given that, as has been already suggested, the two strands of cases are distinguishable from each other.

Certainly, there is much in the judgment of McCullough J. that still rings true. For example, having made a close analysis of sections 2 and 13 of the Mental Health Act,⁶⁹ he concludes:

“It stretches the concept of ‘admission for treatment’ too far to say that it covers admission for only so long as it is necessary to enable leave of absence to be granted, after which the necessary treatment will begin. ‘Admission for treatment’ under s. 3 is intended for those whose condition is believed to require a period of treatment as an in-patient. It may be that such patients will also be thought to require a period of out-patient treatment thereafter, but the concept of ‘admission for treatment’ has no applicability to those whom it is intended to admit and detain for a purely nominal period, during which no necessary treatment will be given.”⁷⁰

This passage does not appear to have been controverted by Lord Woolf or Wilson J. (nor by Sullivan J. in *Epsom and St. Helier*). Therefore, once ‘treatment as an in-patient’ is replaced by ‘treatment in a hospital’, it may remain an accurate statement of the law.

The managers’ test for renewal

Wilson J. decided that, when they decide whether to discharge a patient whose detention has been recently renewed, the hospital managers must apply the renewal criteria contained in section 20(4) of the Mental Health Act 1983.

This was not a surprising decision, but it does give formal approval to a distinction that can prove significant in some cases. It will apply to patients who suffer from ‘mental illness’ or ‘severe mental impairment’. In order for the detention of patients who suffer from ‘mental illness’ or ‘severe mental impairment’ to be renewed lawfully:

- (i) it must be unlikely that, if discharged, they will be able to care for themselves, to obtain the care they need, or to guard themselves against serious exploitation; or
- (ii) the proposed treatment will have to be likely to alleviate or prevent a deterioration of their condition.

Of course, neither of these requirements are applicable when such patients are first detained; whereas, in the case of patients suffering from ‘psychopathic disorder’ or ‘mental impairment’, the second requirement will apply, not only upon any renewal, but even at the point of their initial detention.⁷¹

A new definition of ‘in-patient’?

In *D.R.*, Wilson J. adopted a new definition of the troublesome term ‘in-patient’. Hitherto, in so far as it was applied to a patient with full mental capacity, it had been taken to signify “one who has understood and accepted the offer of a bed, and who has freely appeared on the ward and who has co-operated in the admission procedure”. This definition, which does not appear in Wilson J’s

⁶⁹ *Hallstrom and Gardner*, pp 315j–316b

⁷¹ MHA 1983, s 3(2)(b)

⁷⁰ *Ibid*, p 315b

judgment, was set out in the second edition of the Mental Health Act Code of Practice,⁷² and it has subsequently gained some currency.⁷³

Wilson J's formulation was somewhat different. He spoke of "the allocation *and use*, albeit not at all times, of a hospital bed".⁷⁴ This would seem to go further than the *offer and acceptance* of a bed envisaged by the Code of Practice, and it seems to require more from the putative patient than mere co-operation in the admission process. If so, and if Wilson J's definition is to be preferred, it may make it harder for patients to acquire in-patient status, and for doctors or nurses of the prescribed class to subject them to the holding powers contained in MHA 1983, section 5(2) or (4).

Is a bed necessary?

There is at least one facet of the judgment of Wilson J. in *D.R.* that might prove troublesome if it were to be misconstrued. The judge said:

"In my view it would be an impermissible – indeed an illogical – gloss upon the Act to make lawfulness depend upon a plan to put the patient at times into a hospital bed. There is no magic in a bed [...]."⁷⁵

It is necessary to treat this statement with caution. First, because it is not clear whether Wilson J. saw the existence of a bed as a test – albeit an impermissible test – of the lawfulness of a patient's original detention or merely of its renewal. Of course, the test to which he referred had been adopted by McCullough J. in *Hallstrom and Gardner*. However, the first of these cases concerned the criteria for initial admission, and the second, those for renewal. Wilson J. himself suggests that the 'in-patient' / 'out-patient' distinction – which generated that test and was, of course, the chief product of those cases – resulted from a 'gloss' upon the Mental Health Act. This was certainly how it was described by the Defendant's counsel in *D.R.*, when she wished to criticise the approach of the Claimant's counsel to the criteria for *renewal*. It seems likely, therefore, that Wilson J. intended to forswear the 'bed test' merely in so far as it could be applied to the renewal of a patient's detention, and that he did not intend his words to apply more generally, to the criteria for initial admission.

That is perhaps fortunate, for, taken on their own, his words – and in particular, the perhaps plaintive statement that "there is no magic in a bed" – might be thought to suggest that a patient may lawfully be taken into detention without a bed having first been found for him/her. Although there are some mental health professionals who would find this a deeply attractive argument, it has no basis in the judgment in this case.

In the chapter dedicated to 'Assessment', under the heading 'Individual professional responsibility – the doctor', the current Code of Practice states that:

"The doctor should:

[...]

ensure that, where there is to be an application for admission, a hospital bed will be available."⁷⁶

72 Department of Health and Welsh Office, London, HMSO, 1993, para 8.4

73 See, for example: R Jones, *Mental Health Act Manual*, 2003, Sweet & Maxwell *op cit*, 1–077. The 1993 definition does not appear, nor is any new definition

provided, in the latest edition of the Code of Practice [*op cit.*], which was published in March 1999

74 Judgment, para 27 [emphasis added]

75 *Ibid.*, para 29

76 MHA Code of Practice, *op cit*, para 2.22d

Although this statement does not go so far as to prohibit the making of an application for admission where no bed is available – or the giving of a medical recommendation in support of such an application – it should not lightly be dismissed.

However, as is discussed in the following section, the judgment of Wilson J. does point up a significant, related facet of mental health law.

The compulsory treatment of patients who have not been admitted to hospital

If medical treatment for mental disorder is to be imposed upon a ‘detained’ patient, s/he will first have to be ‘admitted’. This is because the condition of being ‘detained’ is contingent upon there having been an ‘admission’. Section 6(2) of MHA 1983 states:

“Where a patient is *admitted* [...] to the hospital specified in [the] application [...] the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act.”⁷⁷

Clearly, and as a matter of pure logic, ‘admission’ must imply the offer and acceptance – even if, to recall Wilson J’s formulation, it doesn’t strictly require the *use* – of a hospital bed. Therefore, even if it is intended immediately to grant the patient leave – albeit with hospital assessment, monitoring and review as a significant component of his/her treatment plan – it will still be necessary to find him/her a bed to call his/her own. However, medical treatment for mental disorder may be provided to needful patients who are not detained, and even though they have not been ‘admitted’ to hospital.

The providing of medical treatment for a patient’s mental disorder is governed by Part IV of MHA 1983, and in particular, by the provisions in, *inter alia*, sections 58 and 63. The patients to whom those provisions may be applied are listed in section 56. Before setting out a number of exceptions that are irrelevant for present purposes, that section states:

“(1) This Part of this Act applies to any patient *liable to be detained* under this Act.”⁷⁸

As the judgment in the present case makes clear, although all patients who are ‘detained’ under MHA 1983 may also be said to be ‘liable to be detained’, the reverse is by no means inevitably the case. In fact, this had been already hinted at in *Hallstrom and Gardner*, where McCullough J. stated:

“Ignoring the position of *a patient in respect of whom authority to detain has come into existence but who has not yet been brought under detention* and of those patients absent without leave, those ‘liable to be detained’ are, therefore, those who are detained and those who have been granted leave of absence.”⁷⁹

So, alongside patients who, having been detained, are now enjoying leave of absence, those in respect of whom an admission application has been “duly completed” are also “liable to be detained”, even though that application has not yet been accepted by the managers of the hospital in which it is hoped to detain them.

Of course, the possibility of imposing medical treatment for mental disorder upon such patients will remain for only so long as the application for their admission to hospital under MHA 1983

77 *Emphasis added*

78 *Ditto*

79 *Hallstrom and Gardner*, p 312e [*emphasis added*]; see also: R Jones, *op cit*, para 1–703

continues to be “duly completed”. Ordinarily, this will be for 14 days from the date of the later of the two examinations upon which the medical recommendations supporting the admission application are based. This is, of course, the period during which the patient may lawfully be taken and conveyed to the hospital in which s/he is to be detained,⁸⁰ and during which the managers of that hospital may lawfully admit and detain him/her.⁸¹

Developing trends?

The judgment of Wilson J. may be taken to confirm a trend that first became apparent in the cases of *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* and *R (on the application of Epsom and St. Helier NHS Trust) v The Mental Health Review Tribunal*. It now seems to be accepted, where once it might have been doubted, that it should be possible in law to subject psychiatric patients to assessment and review (at the very least) even though they no longer need to be confined in hospital. Other, perhaps more remote, exemplars of this trend might be seen in the introduction of ‘after-care under supervision’ from 1 April 1996⁸² and the judicial strengthening of conditional discharge.⁸³ If this trend has accelerated recently, that may have been in anticipation of the Government’s own proposals to permit the more assertive monitoring of psychiatric patients once they have left hospital.⁸⁴

However, any gaining of pace may equally have been influenced by the European Convention on Human Rights, which was introduced into domestic law by the 1998 Human Rights Act, and with which all public authorities have, as a result, been required to act compatibly since October 2000.⁸⁵

The emphasis of the ECHR is, of course, very much upon ‘proportionality’. Although Wilson J. does not appear to have used that word in *D.R.*, there is much in his judgment that resembles the approach of the European Court of Human Rights. For example, it will be recalled that, when considering the issue of ‘detention’ – and when it might, and might not, be said to have been imposed – the Strasbourg Court said:

“In order to determine whether circumstances involve deprivation of liberty, the starting point must be the concrete situation of the individual concerned and account must be taken of a whole range of criteria such as the type, duration, effect and manner of implementation of the measure in question. *The distinction between deprivation of and restriction upon liberty is merely one of degree, and not one of nature or substance.*”⁸⁶

If this is an instance of judicial relativism, it may betray a tendency that is evident in a number of recent domestic decisions, some of which have involved the construction of mental health law. For example, the Court of Appeal rejected the rigid ‘change of circumstances’ test that had previously determined whether a patient who had been recently discharged by a MHRT might be

80 MHA 1983, s 6(1)

81 MHA 1983, s 6(2)

82 MHA 1983, s 25A–J; see also: *Mental Health (Patients in the Community) Act 1995*, c 52; Department of Health, *Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review*, August 1993

83 *R v Secretary of State for the Home Department and the Secretary of State for Health, ex parte IH* [2002] EWCA Civ 646

84 See note 578, above

85 Human Rights Act 1998, s 6(1) (but cf s–s (2))

86 *Ashingdane v United Kingdom* (1985) Series A 93, [1985] 7 EHRR 528, para 41 [emphasis added]

lawfully re-detained.⁸⁷ Further, the Courts, influenced by the Strasbourg jurisprudence on ECHR, Article 5(4), have also rejected a single, rigid time limit for arranging MHRT hearings and deciding when that task has taken too long.⁸⁸

Although there are other cases that may exemplify this trend, their collation and analysis are beyond the scope of this paper.

Conclusion

The chief consequence of the decision of Wilson J. in *D.R. v Mersey Care NHS Trust* is to lend clarity to an aspect of mental health law that is becoming more controversial. It establishes that a patient who has received treatment in hospital may have his/her detention renewed even though s/he is on leave. Such a finding had not, of course, been ruled out by the judgment of McCullough J. in *R v Hallstrom and another, ex parte W*; *R v Gardner and another, ex parte L*.

The decision also confirms our understanding of the test that must be applied to any renewal of a patient's detention, and it offers an alternative, perhaps slightly more rigorous definition of 'in-patient' that should not be allowed to pass unremarked. The judgment of Wilson J. also demonstrates that a new Mental Health Act is unnecessary for some psychiatric patients – those who, though they have not yet been 'admitted' to hospital, are already 'liable to be detained' under a duly completed application – to be compelled to take their medicine.

Away from its particular facts and consequences, the judgment in *D.R.* may also reveal a move towards judicial relativism. If so, that is surely not inappropriate in an age in which, we are often reminded,⁸⁹ the works of John Keats and Bob Dylan are to be appreciated for their intrinsic merits, on an equal footing.

87 *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg* [2001] 3 WLR 588; see, David Hewitt, *Detention of a recently-discharged psychiatric patient*, *Journal of Mental Health Law*, February 2002, pp 50–58. *R v Ashworth Hospital Authority and others, ex parte H* : *R v* (1) *Mental Health Review Tribunal for West Midlands and North West Region* (2) *London Borough of Hammersmith and Fulham* (3) *Ealing, Hounslow and Hammersmith Health Authority, ex parte Ashworth Hospital Authority* [2002] EWCA Civ 923; see Kristina Stern and David Hewitt, *Re-admission under the Mental Health Act following discharge by a Mental*

Health Review Tribunal, Journal of Mental Health Law, July 2002, pp 169 to 178

88 *R (on the application of C) v Mental Health Review Tribunal, London South and South West Region* [2001] EWCA Civ 1110, [2002] 1 WLR 176; *R v Mental Health Review Tribunal and Secretary of State for Health, ex parte KB and 6 others* [2002] EWHC 639 (Admin); *B v Mental Health Review Tribunal and Secretary of State for the Home Department* [2002] EWHC 1553; see also: David Hewitt, *Delays have dangerous ends*, *New Law Journal*, vol 152, No 7031, May 10 2002, p 694

89 See, for example, *The Observer*, *passim*