

“Hospital” Treatment Further Refined

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R (on the application of CS) v Mental Health Review Tribunal; Managers of Homerton Hospital (East London and the City Mental Health NHS Trust) (Interested Party)
Queen’s Bench Division, (Administrative Court), Pitchford J., 6 December 2004
EWHC (Admin) 2958

The decision of a Mental Health Review Tribunal under section 72(1) Mental Health Act 1983 not to discharge a patient on section 17 leave from hospital was not unlawful. The link between hospital and treatment may be “gossamer thin” but still a “significant component” to justify renewal of detention

Introduction

CS was a patient liable to be detained on leave of absence from hospital (leave).² She challenged the decision of the Tribunal which had confirmed the lawfulness of her detention following renewal³ on the grounds that she was no longer receiving hospital treatment which justified continued detention. The court, whilst restating that hospital treatment must be “a significant component” of the treatment plan to be lawful under the Mental Health Act 1983 (the Act), found that, although the Responsible Medical Officer’s (RMO) grasp on the patient was “gossamer thin”, it was a “significant component” sufficient to justify continuing detention. As a patient liable to be detained, CS could be recalled to hospital for treatment if she refused or failed to take her medication in the community which introduced an element of compulsion that she accept treatment in the community.

The Facts

CS, who had a clinical history of paranoid schizophrenia, and repeated admissions to hospital, was detained in hospital for treatment in May 2003. Her detention was renewed on 29 October 2003. On 5 November 2003 she applied for review of her detention to a Tribunal which confirmed that she should remain liable to be detained at a hearing on 2 February 2004. She had in fact been on leave since 5 November 2003.

Her treatment in hospital comprised attending ward rounds at the hospital once every 4 weeks. These were described by her RMO as an opportunity to discuss how leave was progressing, to discuss her medication and how it was suiting her and to provide her with supportive and motivational work to help her move from a hospital-based model of care to community-based care with the assertive outreach team. The latter included support for compliance with medication as part of treatment.

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² section 17 Mental Health Act (MHA) 1983
³ under section 20 MHA 1983

Further leave was negotiated at each ward round. Additionally, CS had weekly sessions with the ward psychologist. Her hospital-based care was also described by Counsel on behalf of the detaining authority, as the continued provision of a place of refuge and stability, a reference point for CS in her attempts to disengage with treatment in hospital and engage with treatment in the community. By the time the court considered her case in December 2004, CS had been discharged from detention and her care was continuing in the community without compulsion.

The issue

*...was CS's mental illness of a nature or degree which made it appropriate for her to receive treatment, a significant and justified component of which was treatment in a hospital?*⁴

CS challenged the decision of the Tribunal that she should remain liable to detention and recall (rather than directly challenging the detaining hospital following renewal), claiming its decision was disproportionate and in breach of her human rights under Article 5 ECHR, her right to liberty, as her treatment plan indicated that she was not receiving any hospital treatment. Broken down, she argued that the Tribunal failed to properly exercise its powers by:

- a) failing to order her immediate discharge, or
- b) even if it accepted the need for further phasing of her discharge incorporating a continuing element of liability to detention, by failing to name a day on which discharge should take effect, or
- c) failing to consider less restrictive (and more proportionate) options including the use of guardianship under section 7 of the Act or supervised discharge pursuant to section 25 (A–J).

Joining in East London and the City Mental Health NHS trust as an interested party, CS initially argued that the decision to renew her detention by her RMO was also unlawful because the RMO was not seeking her actual admission to hospital, but in the course of the proceedings Counsel for CS conceded that treatment in a hospital under section 3 can take place daily without overnight stays in hospital.

The Law

(1) Section 17 leave

Section 17 provides the only lawful authority for a detained patient to be absent from the detaining hospital.⁵ A person on leave remains liable to be detained and subject to consent to treatment under Part IV of the Act. The RMO can “grantleave to be absent from the hospital subject to such conditions (if any) as that officer considers necessary in the interests of the patient.”⁶ This can include a condition that the patient lives in a particular place including a care home⁷ or that the patient accepts medication or attends for medical treatment. Leave can be granted “indefinitely or on specified occasions or for any specified period”⁸ and the period may be extended. Leave can be revoked and the patient recalled to hospital by the RMO where “it appears to the RMO that it is necessary to do so in the interests of the patient's health or safety or for the protection of other persons.”⁹

4 Judgment at para 39

5 Jones, R. *Mental Health Act Manual*, 9th edition, (Sweet & Maxwell, 2004) at para. 1–172

6 section 17(1) MHA 1983

7 See note under Conditions in Jones, R. 9th edition, (Sweet & Maxwell, 2004) at para 1 – 176

8 section 17(2) MHA 1983

9 section 17(4) MHA 1983

(2) Duration of detention

A person cannot be recalled to hospital once he has ceased to be liable to be detained.¹⁰ It is unlawful for a patient to be recalled to hospital to facilitate renewal of detention under section 20 of the Act.¹¹ It will, however, be lawful if the treatment plan contains an element of hospital treatment.¹² This finding marked a departure from the position that had stood since *Hallstrom*¹³ that a patient on leave could not have his detention renewed. Developing this theme in *R (on the application of DR) v Mersey Care NHS Trust*, the lawfulness of continued detention was held to depend on

“... whether a significant component of the plan for the claimant was for treatment in hospital. It is worth noting that, by section 145(1) of the Act, the words ‘medical treatment’ include rehabilitation under medical supervision. There is no doubt, therefore, that the proposed leave of absence for the claimant is properly regarded as part of her treatment plan. As para 20.1 of the Code of Practice states, ‘leave of absence can be an important part of a patient’s treatment plan’. Its purpose 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.”¹⁴

In setting boundaries to the limits of “hospital treatment” the discharge by an MHRT of detention of a person on leave to a nursing home where it was acknowledged that hospital treatment would arise at some point in the future, but its timing was uncertain, has been held to be lawful.¹⁵

(3) The Powers of the Tribunal

Section 72(1) and (2) require the Tribunal to direct the discharge of a patient detained under section 3 if it is not satisfied that

“he is then suffering from mental illness . . . of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or that it is necessary for the health or safety of the patient . . . that he should receive such treatment¹⁶ having regard (a) to the likelihood of medical treatment alleviating or preventing a deterioration of the patient’s condition; and (b) in the case of a patient suffering from mental illness . . . to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation.”¹⁷

The Argument

The court was invited by Kristina Stern, Counsel representing both the MHRT and the Trust, to consider CS’s treatment holistically, incorporating in-patient, out-patient and community treatment, subject to constant assessment of each element. The significance of the element of

10 section 17(5) MHA 1983

11 *R (on the application of W) v Hallstrom* [1986] QB 1090, [1986] 2 All ER 306

12 section 20(4) MHA 1983; *R v Barking Havering and Brentwood Community Healthcare NHS Trust*[1999] 1 FLR 106

13 *above*, [1986] QB 1090, [1986] 2 All ER 306

14 [2002] EWHC 1810 at para 30

15 *R (on the application of Epsom and St Helier NHS Trust) v Mental Health Review Tribunal* [2001] EWHC 101(Admin)

16 Section 72(1) (i) and (ii) MHA 1983

17 Section 72(2) MHA 1983

treatment received at hospital was directly related to CS's response to the other elements and liability to be detained should be maintained whilst hospital treatment remained a significant part.

In response, it was argued by CS that what was happening was merely a method of enforcing co-operation with the outreach team. There was no in-patient treatment. Furthermore, the Tribunal's powers¹⁸, as Steven Simblet, Counsel, submitted on behalf of CS, represent "*the reverse side of the section 3 coin: in other words, if the Tribunal is not satisfied that the patient any longer satisfies the conditions for detention under section 3, then the patient must be discharged.*"¹⁹

The Decision

Pitchford J accepted that the test for continuing liability for detention was whether a significant component of the plan was for the patient to receive medical treatment in a hospital.²⁰ Finding the contention on behalf of CS that what was happening was merely a method of enforcing co-operation with the Outreach Team to be too crude an analysis, Pitchford J supported the difficult role of the RMO in managing a patient back into the community in a manner designed to avoid the revolving door syndrome:

"Viewed as a whole the course of treatment should be seen..... as a continuing responsive programme, during which the need for treatment in hospital and on leave was being constantly reassessed depending upon the circumstances, including CS's responses to AOT and the ward round. Until such time as the transition was complete, the element of treatment at hospital remained a significant part of the whole."²¹

It is clear to me that the RMO was engaged in a delicate balancing exercise by which she was, with as light a touch as she could, encouraging progress to discharge. Her purpose was to break the persistent historical cycle of admission, serious relapse and readmission. It may be that in the closing stages of the treatment in hospital her grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence."²²

Each of the challenges against the Tribunal were dismissed. On failing to order her immediate discharge, Pitchford J accepted the evidence of the RMO that :

"It is not appropriate to abruptly discharge a patient who has been subject to compulsory admission and treatment as an in-patient for a number of months. I would strongly disagree with an assertion that it is better for a patient to be discharged straight into the community without adequate phasing of care and then re-sectioned if the patient suffers a relapse. Such a statement shows little insight into modern means of engaging and treating patients with severe mental illness... To allow CS's section to lapse or bring it to an abrupt end only to re-section her would greatly upset CS and damage the relationship between her and the clinical team. It would also mean that mental health services were only able to engage once CS has suffered a significant deterioration..."²³

18 under section 72(1) and (2) MHA 1983

19 Judgment at para 29

20 *R(on the application of DR) v Mersey Care NHS Trust* [2002] EWHC 1810 at para 29; *R (on the application of CS) v MHRT* [2004] EWHC 2958 at para 45

21 Judgment at para 44

22 Judgment at para 46. It should be noted that Pitchford J ended this paragraph by stating that he was not convinced by Ms Stern's submission that "the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment of the patient at that hospital"

23 Judgment at para 46

On failing to name a day on which discharge should take effect, Pitchford J again found in favour of the medical evidence:

“That course could, as Miss Stern pointed out, have been disastrous. The RMO was not in a position to know from one day to the next what CS’s prospects in the community could ultimately be. Only upon the successful completion of the carefully laid plan of treatment could discharge be risked”.²⁴

Finally, on failing to consider less restrictive (and more proportionate) options, Pitchford J accepted the medical evidence that CS’s personality would not be amenable to supervised discharge as it was unlikely she would remain compliant with treatment. Whilst the Tribunal was not asked to consider guardianship, Pitchford J was in no doubt that guardianship was not appropriate. The new regime would have brought with it significant upheaval for CS, including a whole new group of professionals. Arguably more relevant to practice, Pitchford J agreed with Kristina Stern that “*there was no power available under either regime to require the patient to take medication*”. He further commented that “*CS’s knowledge of the RMO’s powers was a significant element in her willingness to accept the treatment plan.*”²⁵

The Court found that the Tribunal members had also addressed the issue of proportionality stating in their written decision that they had “*taken into account R (on the application of H) v Mental Health Review Tribunal North and East London Region [2001]*²⁶ and from the evidence are satisfied that detention is a proportionate response having regard to the risks on discharge.”

On the issue whether a decision to continue detention under section 72 (1) required a proportionate response under Article 5(1)(e) ECHR, Pitchford J applied the Court of Appeal’s judgment in *Nadarajah v Secretary of State for the Home Department*²⁷: A challenge to the proportionality of the Tribunal’s exercise of its powers in CS’s case would not have been made out in any event:

“the question is whether or not domestic law permits the arbitrary detention of those in the position of the claimant. It seems to me that manifestly it does not. Accordingly, there is no dimension further to s 72 of the 1983 Act which needs to be added to the statutory right to discharge and the exercise of the residual discretion. The application of the principle of proportionality to this case leads in any event, in my view, to only one conclusion: the interference with the claimant’s freedom of movement and choice were minimal in the context of the object to be achieved, namely her satisfactory return to community care.”²⁸

Comment

(a) Section 17 leave

CS reaffirms that a patient on leave at the time of a tribunal decision not to discharge the patient did not make the tribunal decision unlawful.²⁹ The cases of DR and CS have liberalised what is permissible where the patient no longer requires in-patient treatment but require an element of compulsion to give effect to their treatment plan. A hospital bed may be unnecessary³⁰ but the link

24 *Judgment at para 49*

25 *Judgment at para 48*

26 [2001] EWCA Civ 415

27 [2003] EWCA Civ 1768

28 *Judgment at para 52*

29 *above, R (on the application of CS) v MHRT [2004] EWHC 2958(Admin)*

30 *above, R (on the application of DR) v Mersey Care NHS Trust [2002]EWHC 1810 (Admin)*

between the treatment plan and hospital must be more than speculative.³¹ It must be a significant component. The degree of custodianship or actual physical control over a patient's movements as part of a treatment plan may not be determinative.³² The decision in CS supports the position promulgated in *Barker* that rehabilitation under medical supervision can include assessment or monitoring of progress of a patient on leave.³³ It can also include leave as part of a treatment plan.³⁴ The Code of Practice acknowledges that "leave of absence can be an important part of a patient's treatment plan."³⁵ As Lord Woolf MR in *Barker* commented "this appears to be just the type of treatment contemplated by the second half of the definition of treatment contained in section 145 of the Act."³⁶ Whilst adopting the test in DR, a more holistic view was taken by the court when considering treatment and rehabilitation of CS, by reference to the continuing and responsive programme. The emphasis or weight given to hospital treatment as a "significant component"³⁷ of treatment becomes more intangible when the whole of the programme is viewed in this way. How is one element of an holistic plan more significant than another? It is no doubt true, as this case shows, the exploration of the definitions of "hospital," "medical treatment," "in-patient" in the context particularly of leave is evidence of the complexity of current law.³⁸

A further conclusion to be drawn is that, whilst admission to hospital (and a bed) for treatment surely remains a necessary pre-requisite to initial detention and application of the compulsory treatment provisions of Part IV of the Act³⁹, it is no longer necessary when judging the lawfulness of renewal of detention. In this sense a different test is developing which requires only a connection between hospital and treatment. That connection can be "gossamer thin" so long as it can be shown to be a significant component of treatment. Logically, if different tests are being applied on admission compared with renewal, can this be justified in the context of an individual's human rights? Have the courts gone too far in keeping pace with clinical practice and exposed an inherent weaknesses in their decisions by discarding the requirement for in-patient treatment for renewal of detention required in *Hallstrom* and *Barker*? Only time will tell.

(b) The future for guardianship and supervised discharge?

This question is posed in the context of the *obiter* views in CS⁴⁰ and in DR.⁴¹ Both claimants failed in their arguments that a less restrictive regime than remaining "liable to be detained" should have been considered. In CS the RMO felt that her patient would not benefit from supervised discharge because she would find it difficult to comply given her personality. The judge agreed.⁴² Guardianship was also dismissed.

31 *above*, R(on the application of Epsom and St Helier NHS Trust) v MHRT [2001] EWHC 101 (Admin)

32 *Judgment at para 40*

33 *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* [1999] 1 FLR 106 at 114

34 *R (on the application of DR) v Mersey Care NHS Trust* [2002] EWHC 1810, para. 30 per Wilson J and adopted in *R(on the application of CS) v MHRT* [2004] EWHC 2958 at para. 39

35 *Mental Health Act Code of Practice revised 1999*, para. 20.1

36 *above*, *B v Barking NHS Trust* [1999] 1 FLR 106 at 112

37 *above*, *B v Barking, Havering and Brentwood Community Healthcare Trust* [1999]; *R (on the application of DR) v Mersey Care NHS Trust* [2002]

38 Hewitt, D. There is no magic in a bed – the renewal of detention during a period of leave, *Journal of Mental Health Law* July 2003, p 87

39 See *Jones R Mental Health Act Manual at para 1-042* 9th Edition, (Sweet & Maxwell, 2004)

40 *above*, *R (on the application of CS) v MHRT* [2004] EWHC 2958

41 *R (on the application of DR) v Mersey Care NHS Trust* [2002] EWHC 1081 at para 32

42 *ibid at para. 48*

Both powers fall short of permitting compulsory medical treatment in the community, unlike leave which offers a more flexible, less structured framework for a person regardless of age. They can assist in persuading the persuadable, but not the non-compliant, patient where the only available sanctions are recall or admission to hospital. Whether the threat of compulsion offers an effective carrot or stick will depend very much on the individual perceptions of what can be achieved by patient and practitioner. Claims of their coercive effect and better outcomes without damage to the therapeutic relationship are realised in some cases.⁴³ Supervised discharge can work well for a number of “difficult to engage” patients to ensure improved medication compliance⁴⁴. Whilst scrupulous about explaining that it does not permit a practitioner to force medication on a patient, it binds patient and practitioner together “*in a mutual obligation to work together with a frankly articulated statement and care plan of the rationale based on objective risks and losses.*”⁴⁵

(c) Policy Context

The focus of the Mental Health Act 1983 is compulsory treatment in hospital. Overall, numbers of admissions to hospital for mental illness have fallen⁴⁶ but use of compulsion has increased in the last 10 years by nearly 30%.⁴⁷ The key community powers are supervised discharge,⁴⁸ guardianship⁴⁹ and leave⁵⁰ (and, of course, for restricted patients, conditional discharge⁵¹). National statistics are not collated of the number of patients granted leave from hospital. The Mental Health Act Commission has suggested numbers in the region of 13,500 patients at any one time,⁵² a much greater uptake than for other powers.⁵³

The NSF set out an ambitious programme.⁵⁴ Its major components were the creation of assertive outreach teams (AOTs)⁵⁵ for “difficult to engage” people living in the community with the most complex health and social needs, crisis resolution teams (CRTs)⁵⁶ to work as an alternative to hospital admission for individuals experiencing acute crisis in their mental health and early intervention teams.⁵⁷ The NHS Plan launched specific clinical initiatives aimed at making community care work by introducing these teams.⁵⁸ Described as the two most influential policy documents in the lifetime of anyone currently working in mental health they signify

43 Bindman, Pinfold et al, *National Evaluation of Supervised Discharge and Guardianship*, September 2001

44 Franklin, Pinfold et al, *Consultant Psychiatrists’ Experiences of using Supervised Discharge*. *Psychiatric Bulletin* (2000) 24, 412–415

45 Mike Firn, Chair, *National Forum for Assertive Outreach, Evidence to the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill 2004*.

46 DH: *Hospital Activity Data*, DH Publications, London

47 Department of Health (2003) *Statistical Bulletin 2003/22*; DH: *Korner Returns*, DH Publications, London

48 Mental Health Act 1983 section 25A-J inserted by the Mental Health (Patients in the Community) Act 1995

49 Mental Health Act 1983 sections 7–10

50 Mental Health Act 1983 section 17

51 Mental Health Act 1983 sections 42(2), 73(2)

52 DMH (Memo) *Submissions by the Mental Health Act Commission to the Joint Parliamentary Scrutiny*

Committee, November 2004

53 Department of Health(2004) *Guardianship under the Mental Health Act 1983*, England, 2004

54 Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*, London DH.

55 above, see also Department of Health, (2004) 2004/0457, *National Service Framework for Mental Health – Five Years On*, p 20 reported of the 170 AOTs envisaged by 2003 more than 263 teams were in place by March 2004.

56 above, NSF for Mental Health – Five Years On, p 21 reported of the 335 teams proposed in the NHS Plan by 2004 168 were in place by March 2004

57 CRTs generally work with individuals for a few weeks whilst AOTs can work with their clients for many months and even years providing support from the management of medication to daily living skills and psychological therapies.

58 Department of Health, (2000) *NHS Plan*, London, DH

transformational change in the status of mental health in the NHS and how services are being delivered to patients.⁵⁹

In a review of the NSF five years on, Professor Louis Appleby noted the progress made as services become more responsive to the needs and wishes of the people who use them, and identified the need for action for the care of long-term mental disorders with a new model of mental health in primary care.⁶⁰ This includes new models of in-patient provision to reflect its multiple purposes – acute care, rehabilitation, crisis admission and specialist treatment and a more flexible division of responsibilities between primary and secondary care with reduction in emergency admissions through better continuing care.⁶¹ The lawfulness of continuing to detain patients liable to be detained in hospital for treatment but on leave in the community is of increasing importance given the policy shift.

Given the current rumours that the Mental Health Bill has stalled yet again⁶² where does this leave treatment in the community? Arguably, on the boundary of the hospital. The courts in *DR* and *CS* have not sanctioned compulsory treatment in the community, and arguably have gone as far as a civilised society should in compelling treatment within a hospital-based regime for the relatively small number of patients with complex needs living in the community. Compulsory treatment has been described as “deeply discriminatory.”⁶³ With neither consent nor capacity being particularly relevant factors, this is unlikely to change. Individuals will continue to be denied autonomy where treatment for mental disorder is perceived to be in their best interests. The hope is that more enlightened practice will result in fewer compulsions. The Care Programme Approach has done much to deliver a comprehensive plan of care for individual patients and improve choice. Better choice should mean less compulsion.

The challenge for practitioners will be to ensure that leave is used appropriately as part of a rehabilitative programme towards discharge and not as a method of enforcing co-operation under compulsion. Practitioners will need to show that any compulsory treatment plan is facilitating a process of careful and staged discharge from hospital to community treatment to be lawful and that the plan is not an alternative to discharge.⁶⁴

59 Chisholm, A and Ford, R *Transforming Mental Health Care: Assertive Outreach and Crisis Resolution in Practice*, The Sainsbury Centre for Mental Health/NIMHE 2004; above, DH, *NSF for Mental Health – Five Years On*, December 2004 at p66 per Professor Louis Appleby

60 DH 2004/0457 *The National Service Framework for Mental Health – Five Years On*, 20 December 2004.

61 *Ibid* at p 73

62 For example see *Guardian Newspaper* 31/10/05

63 Scott-Moncrieff, L. *Capacity Choice and Compulsion*, *Journal of Mental Health Law*, September 2004 at p146

64 above, R (*on the application of CS*) v MHRT [2004]; Mental Health Act 1983 Code of Practice revised 1999, Chapter 20.2