The Mental Health (Northern Ireland) Order 1986

A Guide

Department of Health and Social Services

1986

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THE MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986

A Guide

Introduction

1 This Guide to the Mental Health (Northern Ireland) Order 1986 is intended for the staff of Health and Social Services Boards and others who may be involved in the procedures for the compulsory admission of mentally disordered people to hospital and their detention therein or for their reception into guardianship. It is for guidance only and cannot be taken as an authoritative interpretation of the law as set out in the Order or in Regulations made under the Order. While it explains the purpose and effect of most of the provisions of the Order and Regulations it is not comprehensive and it may therefore, at times, be necessary to refer to the legislation itself, or to seek advice from other sources. It does not deal with Part VII of the Order which is about the registration of private hospitals, nor with Part VIII which covers the management of the property and affairs of patients and the Office of Care and Protection, nor with offences other than those covered by Part X which are concerned with the sexual abuse of patients.

Commencement of the Order and Regulations

2 The Order comes into operation on 31 July 1986, except for a very few provisions. The main exceptions are:

i. the provisions relating to the establishment, membership and constitution of the Mental Health Commission for Northern Ireland which was set up on 1 May 1986 so that it could make the necessary arrangements to appoint Part II and Part IV doctors*, and be in a position to carry out its functions as soon as the main provisions of the Order took effect;

ii. Article 111 which provides for a code of practice - the preparation of a code of practice will not start until some practical experience of the Order in operation has been gained;

iii. Article 115 which relates to the appointment of approved social workers - this provision will be brought in at a later date when suitable arrangements for their training and appointment are in place;

iv. Article 116 which empowers Health and Social Services Boards to receive and hold money and valuables up to a maximum amount on behalf of patients - this provision will be activated when it has been decided what is an appropriate amount.

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* Throughout the Guide, the terms "Part II doctor" and "Part IV doctor" are used to refer to a doctor, normally a consultant psychiatrist, appointed by the Mental Health Commission for the purposes of Part II (compulsory admission to hospital and guardianship) and Part IV (consent to treatment) of the Order respectively.

The Order should be read in conjunction with the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 which also come into operation on 31 July 1986.

Prescribed forms and other documentation

3 The Order authorises the Department of Health and Social Services to prescribe certain forms required under the compulsory powers and this is done in the Schedule to the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986. A list and copies of the prescribed forms have been included as Appendix 1 to the Guide for ease of reference. The Department has also prepared a series of non-prescribed specimen forms, leaflets and letters to provide Boards with model documentation for administrative purposes under the Order. Copies of these have already been sent to Boards under cover of the Department's letter of 3 April 1986 to General Managers. Unless otherwise stated, all references to numbered forms are references to prescribed forms.

References

4 The Order is divided into eleven parts and seven Schedules. The Guide generally follows the sequence in which provisions appear in the Order. Except where specified, references to Parts, Articles and Schedules in this Guide are references to the Parts, Articles and Schedules of the Mental Health (Northern Ireland) Order 1986 and references to Regulations are references to the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986. References to the 1961 Act or the previous legislation are references to the Mental Health Act (Northern Ireland) 1961.

Interpretation

5 Certain expressions are used throughout the Order, either as convenient abbreviations or as having a particular meaning in relation to particular Parts or Articles of the Order. Article 2(2) defines these or gives the provisions of the Order in which they are defined. The following interpretations are particularly important:-

Approved Social Worker is an officer of the Board appointed under Article 115 to carry out certain functions under the Order. Until Article 115 is brought into operation, the functions of approved social workers will be undertaken by designated social workers; that is social workers designated by Health and Social Services Boards for the purposes of the Order under paragraph 26 of Schedule 6. This arrangement is similar to the arrangement under the 1961 Act.

Board means a Health and Social Services Board.

The Commission means the Mental Health Commission for Northern Ireland.

The Department means the Department of Health and Social Services.

Hospital means any hospital, institution or special accommodation vested in the Department. Legally, any such hospital may admit and detain patients under the procedures laid down in the Order. In practice, however, admissions and detentions will only take place at psychiatric or mental handicap hospitals or those general hospitals which have psychiatric or mental handicap units.

Medical treatment is broadly defined to include nursing and also care and training under medical supervision.

Nearest relative: the terms "relative" and "nearest relative" are defined in Article 32 (see paragraphs 110-116).

Patient means a person suffering or appearing to be suffering from mental disorder. However, in Part VIII of the Order, "patient" has a different meaning, ie a person whom the High Court is satisfied is incapable of managing and administering his or her property and affairs by reason of mental disorder.

Responsible Board means -

(a) in relation to a patient who is in, or is liable to be detained in, a hospital, the Board administering that hospital;

(b) in relation to a patient who is the subject of a guardianship application or is subject to guardianship under the Order, the Board for the area in which that patient resides.

Responsible medical officer means -

(a) in relation to a patient liable to be detained in hospital under the Order, the medical practitioner appointed for the purposes of Part II by the Commission who is in charge of the assessment or treatment of the patient;

(b) in relation to a patient subject to guardianship under the Order, any medical practitioner appointed for the purposes of Part II by the Commission who may be authorised to act as the responsible medical officer by the responsible Board;

(c) in relation to any other patient, the medical practitioner appointed for the purposes of Part II by the Commission who is in charge of the treatment of the patient.

The Review Tribunal or the Tribunal means the Mental Health Review Tribunal for Northern Ireland.

Application of the Order - mental disorder

6 The Order makes provision for the detention, guardianship, care and treatment of patients suffering from mental disorder and for the management of the property and affairs of such patients. Mental disorder is a generic term that is used throughout the Order to refer

to everyone to whom the Order as a whole applies. It is defined in Article 3(1) as "mental illness, mental handicap and any other disorder or disability of mind" and it covers all forms of mental ill-health and disability, except those conditions which are specifically excluded by Article 3(2) (see paragraph 14). It is employed for the purposes of those aspects of the Order which have a general application, for example the short-term compulsory powers (admission for assessment, the doctors' 48 hour holding power under Article 7(2), the nurses' 6 hour holding power under Article 7(3) and the police's powers of removal to a place of safety under Articles 129 and 130), access to the Mental Health Commission, and the right to voluntary use of services under Article 127(1). Article 127(1) makes it clear that nothing in the Order is to be construed as preventing a person who needs treatment for mental disorder from being admitted to any hospital for that treatment as a voluntary patient, or from remaining in hospital as a voluntary patient after the authority for his or her detention has come to an end. It reflects two of the key principles of the Order that people suffering from mental disorder should as far as possible be treated in the same way as those suffering from physical disorder and that compulsion should be used only if there is no other way to ensure that they receive the care and treatment which they need.

7 However, for the purposes of the long-term compulsory powers (detention for treatment and reception into guardianship) and for most other purposes, it is not enough for a person to be suffering from mental disorder as defined in Article 3(1). The person must be suffering from at least one of 3 of the 4 specific categories of mental disorder set out in Article 3(1). The 3 categories are: mental illness, severe mental handicap and severe mental impairment. These, together with mental handicap, are defined in Article 3(1).

Definitions of mental illness, mental handicap, severe mental handicap and severe mental impairment

8 The definitions in Article 3(1) are not intended to be medical classifications. They are purely legal definitions to be used for the purposes of the legislation.

9 Mental illness means a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons. A mentally ill person may be subject to any of the compulsory powers in the Order provided the other requirements of the Order are satisfied.

10 Mental handicap is defined as a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning. It replaces the term "arrested or incomplete development of mind" used in the 1961 Act. Both terms refer to broadly the same group of people but mental handicap reflects current medical perceptions of the nature of the disability by emphasising the importance of social functioning, such as the ability to eat, control one's bodily functions, learn new skills, recognise common hazards or exercise reasonable judgement and foresight. The lack of these abilities is as much a part of mental handicap as low

intelligence and their inclusion as essential elements in the definition ensures that an intellectually dull but otherwise normal person is outside the scope of the Order.

11 Severe mental handicap corresponds exactly to the "special care" sub-category in the 1961 Act, which it replaces. It is defined in the same way as mental handicap except that it includes severe instead of significant impairment of intelligence and social functioning. The distinction between the 2 categories is thus one of degree and it is entirely a matter for clinical judgement as to whether a person exhibits "significant" or "severe" impairment of intelligence and social functioning.

12 Severe mental impairment is an additional sub-category of mental handicap for which there was no equivalent in the 1961 Act. To qualify for inclusion in this category a person must not only suffer from severe mental handicap but his handicap must be associated with "abnormally aggressive or seriously irresponsible conduct". The purpose of this sub-category is to limit the application of the long-term powers of compulsory detention (detention for treatment) on the mentally handicapped to those whose handicap is severe and who exhibit abnormally aggressive or seriously irresponsible behaviour. Its introduction ensures that mental handicap can never by itself be sufficient ground for long-term detention in hospital, and clearly distinguishes that small group of mentally handicapped people who need to be detained from the majority who do not.

13 The consequences of the Order for a mentally handicapped person are thus determined by the category into which his handicap falls. For example a person who is suffering from mental handicap may be admitted for assessment, detained for 48 hours under the doctors' holding power, held for 6 hours under the nurses' holding power or removed to a place of safety for 48 hours (the short-term compulsory powers) but he may not be detained for treatment or placed under guardianship (the long-term compulsory powers) unless he is classified as severely mentally impaired or severely mentally handicapped respectively.

Exclusions from the definition of mental disorder

14 Article 3(2) excludes personality disorder, promiscuity or other immoral conduct, sexual deviancy and dependence on alcohol or drugs from the definition of mental disorder. This means that it will not be possible to exercise powers of compulsion on the grounds of any of these conditions alone, unless the condition co-exists or is associated with a mental disorder and all the other relevant criteria are satisfied. This does not mean that people suffering from these conditions will no longer be able to get treatment, for example, at existing facilities for the treatment of alcohol or drug dependence at psychiatric hospitals or units. On the contrary, they will continue to be able to obtain treatment on a voluntary basis as at present.

PART II - COMPULSORY ADMISSION TO HOSPITAL OR RECEPTION INTO GUARDIANSHIP

Admission For Assessment

Introduction

15 Part II of the Order deals with the circumstances in which, and the procedures through which, mentally disordered people can be compulsorily taken into and detained in hospital or received into guardianship. It does not deal with patients referred through the courts or transferred from prisons or other institutions (see paragraphs 123-177) or with patients transferred from other parts of the United Kingdom (see paragraphs 257-259).

Admission to hospital for assessment

16 Unlike the 1961 Act which had 2 ways by which a mentally disordered person could be compulsorily admitted to hospital - the "normal" procedure (section 12) and the "emergency" procedure (section 15) - there is only one procedure under the Order. Central to this procedure is the requirement that all patients who are compulsorily admitted to hospital will be held initially for a period of assessment of up to 14 days before being admitted for treatment (see paragraphs 46 and 47). Patients will be examined on admission or within 48 hours by a consultant psychiatrist (the responsible medical officer or a Part II doctor*) and before they can be detained for treatment they must be examined by a consultant psychiatrist on 2 more occasions.

17 The purpose of the assessment period is to ensure that the patient's mental condition is thoroughly investigated and his need for compulsory care and treatment fully established by the persons who are best equipped to do so before he can be detained on a long term basis. It should be clearly understood that, subject to the consent to treatment provisions in paragraphs 178-196, a patient detained for assessment may be given treatment other than the assessment procedures. Indeed, it is expected that treatment given during the assessment period will enable many patients to be discharged within that period, while others may be able to stay in hospital as voluntary patients. Only those who meet the necessary conditions can be detained on a long term basis for further treatment.

Application for admission for assessment

18 An application for admission for assessment may be made either by the patient's nearest relative or by an approved social worker (see paragraphs 119-122 which deal with the duty of an approved social worker to make applications). Applications must be made on a prescribed form; Form 1 is used where the application is made by the nearest relative and Form 2 if the approved social worker is the applicant. Specimens of the prescribed forms are shown in Appendix 1. No application can be made unless the applicant has seen the patient within the previous 2 days and unless it is founded on and accompanied

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*See the footnote on page 1 for an explanation of the term "Part II doctor".

by a medical recommendation (see paragraph 21). Although the application form and medical recommendation are addressed to the responsible Board, they will in practice normally be taken with the patient to the receiving hospital in the case of an immediate admission or, in other cases, may be taken or sent direct to that hospital ahead of the patient. The doctor giving the medical recommendation (usually the patient's general practitioner) will decide which hospital should be named in the application. If there is any difficulty in having a patient admitted to that hospital the Board administering it has power under Article 28(3)* to require it to admit the patient.

Consulting the nearest relative

19 Where an approved social worker is making the application, he must, unless it is not reasonably practicable to do so or would involve unreasonable delay, consult the nearest relative. If the nearest relative objects to the application, the approved social worker may consult another approved social worker. If after this consultation he is satisfied that the application should go ahead then he is free to proceed, provided he records the nearest relative's objection on the application form. This provision enables the approved social worker to make an application against the wishes of the nearest relative without having to get an order from the county court for the appointment of an acting nearest relative under Article 36 (see paragraphs 114-116). Where the approved social worker has been unable to consult the nearest relative before making the application he must inform him of it as soon as practicable.

Social work report

20 Where the approved social worker makes the application he will have satisfied himself that in all the circumstances, admission for assessment is the most appropriate way of meeting the patient's needs. However, if the application is made by the nearest relative no social worker may have been involved before it is made. In this type of case Article 5(6) requires the responsible Board to arrange for a social worker, who need not be an approved social worker, to interview the patient and provide the responsible medical officer with a report on his social circumstances. The report will deal with such matters as the past history of the patient's mental disorder, his present condition and the social, familial and personal factors bearing on it, the wishes of the patient and his relatives, and medical opinion. The social worker making the report will need to consult those professionally involved in the case (for example, the doctor or a community psychiatric nurse) and will consider other options for giving the patient the care and treatment he needs, such as guardianship, admission as a voluntary patient, day care, out-patient treatment, community psychiatric nursing support, primary health care support and support from friends, relatives and voluntary organisations. The social worker's report must be done as soon as practicable as it should be available to the responsible medical officer

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* The power under Article 28(3) to require admission to a hospital is conferred on the Department but has been delegated to Boards by the Functions of Health and Social Services Boards (No.1) Direction (Northern Ireland) 1973 as amended by the Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1986.

as early as possible during the assessment period.

Medical recommendation

21 The medical recommendation which will accompany an application for assessment must be made on Form 3, and will normally be given by the patient's own general practitioner. If he is not available, the person making the application must try and get a recommendation from a doctor who knows the patient personally. Should he be unable to do so, he must give his reasons on the application form. Only in cases of urgent necessity is a doctor on the staff of the receiving hospital allowed to give the medical recommendation. Close relatives, business partners and others (see Schedule 1 to the Order) are NOT permitted to give the medical recommendation.

22 The doctor must have examined the patient not more than 2 days before he signs the recommendation and must state that in his opinion the patient is suffering from mental disorder of a nature or degree which warrants his detention in hospital for assessment (or for assessment followed by medical treatment), and that failure to detain him would create a substantial likelihood of serious physical harm to himself or to others. Both these criteria must be met. A specific diagnosis of the form of mental disorder is not required, as part of the purpose of the "assessment" is to determine this. However, the words " of a nature or degree which warrants his detention in hospital" are intended to restrict the use of admission for assessment to patients who are thought to be suffering from a form of mental disorder which would justify detention for treatment.

Grounds and evidence for medical opinion

23 The statements in the medical recommendation governing the criteria for admission for assessment are statements of opinion, and must be supported by statements of the grounds for the diagnosis, and evidence that there is a substantial likelihood of serious physical harm to the patient or to others. Form 3 provides for these statements which, in the case of the diagnosis, should include a clinical description of the patient's mental condition and should indicate why the patient cannot suitably be cared for outside hospital, or be treated in a day-hospital, or as an out-patient, or be admitted as a voluntary patient. The interpretation to be placed on the term "a substantial likelihood of serious physical harm" is contained in Article 2(4) and the doctor's statement must, therefore, include evidence for at least one of the following:-

(i) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself;

(ii) that the patient's judgement is so affected that he is, or would soon be, unable to protect himself against serious physical harm and that reasonable provisions for his protection is not available in the community;

(iii) that the patient has behaved violently towards other persons;

(iv) that the patient has so behaved himself that other persons were placed in reasonable fear of serious physical harm to themselves.

24 It will be for the doctor to decide whether the evidence for one or more of the above is sufficient to warrant admission for assessment, but clearly a mentally disordered person who was simply making a nuisance of himself or indulging in anti-social behaviour would not meet the criteria. On the other hand, it is clear from paragraph 23(ii) that it is not necessary to wait until the patient has actually injured himself before admitting him to hospital.

Transport to hospital

25 A properly completed application for assessment accompanied by the appropriate medical recommendation constitutes sufficient authority for the compulsory removal of a patient to the hospital named in the application and his detention there. The most appropriate means of conveying the patient to hospital will depend very greatly on the circumstances of the case and it will be for the applicant and the doctors arranging for the patient's admission to make the most suitable arrangements. The onus to take the patient to hospital rests with the applicant and in many cases he, or a person authorised by him, will be able to do so without further assistance. However, in cases of difficulty, the applicant is entitled under Article 8(1)(b) to ask the Board to take and convey the patient to hospital. These are most likely to arise in emergency situations and it will be the Board's responsibility to arrange both for the transport and for the care of the patient prior to or during removal, including medical and nursing escorts if required. Where there is likely to be, or is, exceptional difficulty because of resistance on the part of the patient or his relatives, it may be appropriate to seek the co-operation of the police in securing the patient's removal (see paragraphs 247-251).

Time limit for getting the patient to hospital

26 The authority to admit the patient to hospital and detain him there expires if he is not admitted within 2 days beginning with the date on which the medical recommendation was signed. In exceptional circumstances this period of 2 days can be extended up to 14 days (Article 8(1)) but only if the applicant gets a certificate in the prescribed form (Form 4) from a Part II doctor stipulating the number of days to which it can be extended and giving reasons for the extension. This could arise if, for example, there were problems locating the patient or if, being violent, he shut himself in and more time was needed to deal with the situation.

Escape on the way to hospital

27 Article 131 of the Order has the effect that a patient who is being conveyed to hospital in pursuance of a properly completed application is deemed to be in legal custody while being so conveyed. Any person

authorised to convey the patient has for that purpose all the powers, authorities, protection and privileges of a constable. These rights include the use of reasonable force to overcome an attempt to escape, or to call for assistance from a third party. In the event of a patient escaping on the way to hospital, Article 132 allows him to be retaken by the person in whose custody he was when he escaped, by a constable, or by an approved social worker. He must be retaken within the 2 day period or, as the case may be, the extended period up to 14 days allowed for his removal - see previous paragraph. Otherwise a fresh application will have to be made to authorise his removal to hospital.

On arrival at hospital

28 Immediately after he is admitted to hospital the patient must be examined by the responsible medical officer, a Part II doctor or any other doctor on the staff of the hospital. However, if a doctor on the staff of the hospital gave the medical recommendation on which the application for admission was founded, that same doctor is not permitted to examine the patient following admission. As soon as the medical examination has been carried out, the doctor must send a report using Form 7, to the Board stating that in his opinion the patient should be detained for assessment. This report is of particular significance because the date on which it is furnished to the Board will count as the patient's date of admission for the purposes of Part II. If the medical examination was carried out by the responsible medical officer or a Part II doctor the patient can be detained for 7 days but if any other doctor did the examination he can only be held for 48 hours, during which time he must be examined again by the responsible medical officer, or, if that is not practicable, by a Part II doctor. In these circumstances Form 8 must be completed and the patient may then be held for 7 days beginning with the date of admission.

29 Where during this 7 day period, the patient is examined again by the responsible medical officer or a Part II doctor and a report on Form 9 is sent to the Board, he may be held for a further 7 days (that is, for 14 days in all), at the end of which he must be discharged unless he is detained for treatment under Article 12 (see paragraph 46). The medical reports contained in Forms 7, 8 and 9 constitute the authority to detain the patient and if they are not furnished to the Board at the appropriate times the patient will not be liable to be detained.

Duty to notify the Commission

30 The Board has an obligation under Article 8(2)(b) to send a copy of the application for assessment and the medical recommendation on which it is founded to the Commission as soon as the patient is admitted to hospital. Copies of the medical reports completed following admission and for extension of the assessment period (Forms 7, 8 and 9) must also be sent to the Commission as soon as they are received by the Board. (Article 9(10)).

Application for assessment in respect of patients already in hospital

31 Article 7(1) permits an "application for admission for assessment" to be made in respect of patients who are already in hospital as voluntary patients. The procedure to be followed will be the same as if the patient were being admitted for assessment from outside hospital. This will ensure that where possible the nearest relative, a social worker and a general practitioner will be involved in all cases where compulsory detention is being considered. Where any doctor on the staff of the hospital concerned feels that an application for assessment ought to be made, he has power under Article 7(2) to restrain a voluntary patient from leaving the hospital for 48 hours by furnishing a report on Form 5 to the Board. This will allow time to have an application form and medical recommendation completed as detailed in paragraphs 18 to 24. A copy of Form 5 must be sent immediately to the Commission by the Board. The doctor's holding power can be used to detain an in-patient in any hospital, including a general hospital, even though the patient is not being treated for mental disorder at the time. If at the end of 48 hours a properly completed application for admission for assessment has not been made the patient cannot be detained further against his will.

The nurses' holding power (Article 7(3))

32 A first level nurse trained in nursing people suffering from mental illness or mental handicap - ie a nurse registered in Part 3 or Part 5 of the professional register* (see Regulation 3) - may detain a voluntary patient who is already being treated for mental disorder as an in-patient, for up to 6 hours, if it appears to him that:-

(a) an application for assessment ought to be made in respect of the patient; and

(b) it is not practicable to secure the immediate attendance of a medical practitioner for the purpose of furnishing a report to detain the patient for 48 hours as outlined in paragraph 31.

33 The holding power starts after the nurse has recorded his opinion on the prescribed form (Form 6) and ends either 6 hours later, or on the earlier arrival of a doctor on the staff of the hospital who may make a report under Article 7(2). The doctor is free to make such a report or to decide not to detain the patient further (which may, for example, include persuading him to stay voluntarily). The nurse making the record on Form 6 must deliver it to the Board as soon as possible after it is made. The nurse's holding power cannot be renewed after the 6 hour period has elapsed nor can it be used to detain patients who are only receiving treatment for physical illness. A copy of the record made by the nurse (Form 6) - and a copy of the doctor's report detaining the patient for 48 hours (Form 5) - must be sent immediately to the Commission by the Board.

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* The professional register refers to the register prepared and maintained under section 10 of the Nurses, Midwives and Health Visitors Act 1979.

Scrutiny and rectification of documents

34 An error or a defect in an application for assessment, the medical recommendation on which it is based, or a medical report given under Article 9, may mean that the authority for the detention of the patient is open to challenge and could be found to be invalid. Article 11 of the Order contains certain provisions under which documents which are found to be incorrect, defective or insufficient may be rectified after they have been acted on, and under which patients may continue to be detained for a limited period while an error capable of being rectified is corrected.

35 Those who sign applications, medical recommendations or reports should take care to see that they comply with the requirements of the Order and are in the proper form. Boards should make arrangements to have the admission documents carefully scrutinised as soon as the patient has been admitted, or, if he is already in hospital, as soon as the documents are received. Medical reports under Article 9 which constitute the authority for detaining the patient for assessment should also be examined as soon as they are received.

36 The Mental Health Commission receives copies of the above mentioned documents and although it does not have an explicit statutory duty to scrutinise them it does have a duty to ensure that no patient is improperly detained. The Commission will therefore draw attention to any defect which it observes and will require appropriate action to be taken. The responsible Board is required to notify the Commission immediately of any amendments made to admission documents or medical reports and immediately forward to it copies of any fresh medical recommendations or reports which may have been furnished.

37 The faults which should be looked for fall into three categories:

(i) those which invalidate the application completely and cannot be rectified;

(ii) those which may be capable of amendment under Article 11(1); and

(iii) those which make a medical recommendation or report insufficient to detain the patient, but which may be capable of rectification by the substitution of a fresh medical recommendation or report under Article 11(2).

38 Documents cannot be rectified under Article 11 unless they can be properly regarded as applications or medical recommendations or reports within the meaning of the Order. A document purporting to be an application, medical recommendation or medical report cannot be regarded as such if it is signed by a person who is not empowered under the Order to do so or if it is not signed at all. The first check to be made therefore is that each document is signed; that the application appears to be signed by the patient's nearest relative or the acting nearest relative or by an approved social worker; that the medical recommendation is signed by a practitioner who is not excluded under Article 6(d); and that medical reports under Article 9(3), (6) or

(8) are signed by doctors empowered to do so. Unless there is any reason to believe that they are inaccurate, the scrutinising officers may accept at their face value the statements made on the documents; for example, they need not check that a doctor who has stated that he is a registered medical practitioner is so registered, nor that a person who states that he is the patient's nearest relative, is in fact the nearest relative within the meaning of the Order.

39 If a fault of this kind is discovered in the documents there is no proper authority for the patient's detention unless steps are taken for a new application to be made based on a medical recommendation which complies with Article 6. If the patient is already in hospital he may be detained while a new application is being made, but only if a doctor on the staff of the hospital issues a report under Article 7(2) (see paragraph 31).

Errors which may be amended under Article 11

40 Article 11(1) allows an application, medical recommendation or medical report which is found in any other respect incorrect or defective to be amended by the person who signed it, with the consent of the responsible Board, within 14 days from the date of the patient's admission. Faults which may be capable of amendment under this Article include the leaving of blank spaces on the form which should have been filled in (other than the signature), or failure to delete one or more alternatives in places where only one can be correct. The patient's forenames and surname should agree in all places where they appear in the application, the supporting medical recommendation and medical reports.

41 If the officer scrutinising any document finds any errors of this sort he should return the document to the person who signed it for amendment. When the amended document is returned to the Board it should again be scrutinised to check that it is now in the proper form. If this is all done within a period of 14 days starting with the date on which the patient was admitted (or the date when the application was received by the responsible Board if the patient was already in hospital when it was made) the documents are deemed to have had effect as though originally made as amended.

Time limits

42 Another point which should be checked as soon as the documents are first received is whether the time limits mentioned in Article 5(2), 6(a), 8(1), 9(1), 9(5) and 9(8) have been complied with. These limits are:

(a) the date on which the applicant last saw the patient must not be more than 2 days before the date on which the application is made - Article 5(2);

(b) the date of the medical examination of the patient by the doctor giving the medical recommendation must not be more than 2 days before the date on which he signs the recommendation - Article 6(a);

(c) the patient's admission to hospital must take place within 2 days beginning with the date on which the medical recommendation was signed. Where Form 4 has been completed extending the period for admission (which can be up to 14 days) the admission must take place within the number of days specified in that form, beginning with the date on which the medical recommendation was signed - Article 8(1);

(d) the patient must be medically examined immediately after he is admitted to hospital (the report of this examination (Form 7) will usually be signed on the same day as the patient is admitted to hospital but may, if the admission takes place shortly before midnight, be signed on the following day) - Article 9(1);

(e) the medical examination by the responsible medical officer or a Part II doctor to extend the assessment period from 48 hours to 7 days, the report of which is furnished to the responsible Board on Form 8, must be carried out no later than 48 hours from the time at which the report of the medical examination immediately after the patient's admission to hospital (Form 7) is signed - Article 9(5);

(f) the date of the medical report for the extension of the assessment period for a further 7 days (Form 9) must not be later than 7 days inclusive after the patient's date of admission (ie the date on which Form 7 is signed) - Article 9(8).

43 If the dates entered on the application, medical recommendation or medical report do not conform with these time limits, the persons who signed them should be asked whether the dates or times entered are correct. If they are not correct, and the correct dates and times do conform with the limits, the entry on the forms may be amended under Article 11(1). If the time limits have, in fact, not been complied with, the application is invalid unless the error is capable of being rectified by the substitution of new forms under Article 11(2).

Faulty medical recommendations and reports

44 In addition to scrutiny for errors or defects of a technical nature described in the previous paragraphs, medical recommendations and reports should be scrutinized by a doctor at the hospital appointed for this purpose by the Board. He will make sure that the clinical details entered on these forms, including statements and reasons given to support opinions expressed, meet the requirements of the Order and are sufficient to warrant the patient's detention for assessment. To do so he will probably wish to consult the doctor who made the recommendation or report before coming to a decision that they are insufficient. Where they are found to be defective the Board must notify the applicant (nearest relative or approved social worker) of this fact in writing. It would be advisable also at the same time to inform the doctor who gave the recommendation or report. The applicant should be advised that if a fresh recommendation or report is furnished to the Board within 14 days from the patient's admission the application for assessment will be regarded as in order. In some cases it may be suitable for the fresh medical recommendation to be given by a doctor

on the staff of the hospital provided he did not also give the medical report immediately after the patient's admission.

Disregard of assessment period

45 Article 10 is an entirely new provision and is unique to Northern Ireland. It enables any periods for which a patient has been detained for assessment and which have not been immediately followed by a period of detention for treatment to be disregarded for certain purposes, that is, treated as if they had never occurred. Thus, except in the case of court and certain other proceedings of a judicial nature, a person has the right to decline to answer questions about any such periods without prejudice to himself. Any legal or contractual obligations to disclose information to any person does not apply to such periods. In the occupational and employment fields, such periods or the failure to disclose information about such periods is not a legitimate ground for unfavourable treatment. In addition any disqualification, disability, prohibition or other penalty of a legal or statutory nature attaching to liability to be detained, other than under the Order itself; does not apply to such periods.

Detention for treatment

46 During the second 7 days of the assessment period the patient must be examined by a Part II doctor to decide whether it is necessary to detain him for treatment beyond that period. It may be that during the assessment period the patient's condition has improved to the extent that he is now prepared to remain in hospital as a voluntary patient or to receive treatment as an out-patient etc. However, if as a result of the examination, the doctor is satisfied the patient should be further detained on the grounds that he is suffering from mental illness or severe mental impairment, that he is very likely to cause serious physical harm to himself or others, and that no other methods of dealing with the patient are available or are appropriate, he must furnish a report to that effect to the Board using Form 10. The patient may then be detained for up to 6 months, beginning with the date of admission, so that he can receive the treatment he needs. The grounds for detention to be stated on Form 10 are the same as for admission (see paragraphs 22 and 23) except that the general diagnosis of mental disorder is no longer sufficient and it must be clearly stated that the patient suffers from either mental illness or severe mental impairment or, exceptionally, from both.

47 The doctor who decides whether or not the patient should be detained for treatment must not be the one who gave the medical recommendation on which the application for assessment was founded nor any of the persons listed in Schedule 1 to the Order. This excludes certain relatives, business associates and others closely involved with the patient who might have ulterior motives for having him detained. The Board will scrutinise the medical report on Form 10 to ensure that it constitutes proper authority to detain the patient and will then arrange to send a copy to the Commission immediately.

Renewal of authority for detention

48 Under the Order the periods for which detention for treatment can be renewed after the initial 6 months period are half those under the 1961 Act, and now stand at 6 months in the first instance, and, thereafter, 1 year at a time. If within a month of the end of the initial 6 month period of detention, the responsible medical officer examines the patient and furnishes a report on Form 11 to the Board confirming that in his opinion the criteria for detention continue to be met and giving the necessary particulars and evidence to support his opinion as set out in Article 12(1), then the patient can be detained for a further 6 months. It is not necessary that the form of mental disorder from which the patient is suffering at this stage is the same as that stated on Form 10 when he was first detained for treatment.

49 Within 2 months of the end of the second 6 months period of detention the authority to detain can be renewed again but this time for a full year. This is seen as a very important stage in the detention and treatment of a patient and extra safeguards are built into the system to ensure that his interests are fully protected. The patient and his nearest relative must be informed at least 14 days before the patient is to be medically examined and the examination itself must be carried out by 2 Part II doctors, one of whom must not be on the staff of the hospital where the patient is detained and must not previously have been involved in giving a medical recommendation or report on the patient. A completely fresh medical opinion will therefore be brought to bear at this stage. The medical report which will have the effect of detaining the patient for up to a year must be jointly completed and signed by the 2 doctors concerned and will be made on Form 12.

50 If at the end of this year, which in practice will be 2 years from the date on which the patient was admitted to hospital, the patient is to be further detained, he will be examined by the responsible medical officer who will complete Form 11 stating that the conditions for detention as set out in Article 12(1) are still satisfied. Thereafter detention can be renewed in the same way for a year at a time, with the medical examination in each case taking place within 2 months of the end of the previous period of detention. Each time the authority is renewed the patient and the nearest relative must be informed and copies of the medical reports which have been accepted by the Board as a basis for continued detention must be sent to the Commission.

Discharge of patient from detention

51 Article 14 sets out who may discharge a patient from compulsory detention in hospital and the circumstances in which this may or must be done. Discharge in accordance with the provisions of this Article means discharge from detention and it is in this technical sense that it is used in this Guide. It does not mean that the patient must leave hospital and, indeed, Article 127(1) makes it plain that nothing in the Order is to prevent a patient remaining in hospital for treatment on a voluntary basis after he has ceased to be subject to detention there.

52 Patients in hospital for assessment or detained for treatment may be discharged at any time by the responsible medical officer, the responsible Board or the nearest relative. Furthermore, the responsible medical officer has a duty to discharge a patient if he is satisfied that the criteria for detention are no longer satisfied, that is:

a. that the patient is no longer suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; or

b. that, having regard to the care which would be available for the patient if he were discharged, the discharge would not create a substantial likelihood of serious physical harm to himself or other persons.

53 A patient cannot be discharged unless the person empowered to discharge him makes an order in writing for this purpose. There is no prescribed form of notice, but sample forms have been drawn up by the Department and may be adapted for use if appropriate (see paragraph 3). However, a written statement that the patient is hereby discharged from detention under the Order will in practice be sufficient if signed by a person empowered under the Order to order discharge or by a person authorised to do so on behalf of the responsible Board.

54 The responsible medical officer, as the person in clinical charge of the patient, will normally be responsible for any action required by a change in his condition and will therefore usually be the one who exercises the power to discharge. The Board will rarely exercise its power to discharge since the medical opinion to enable it to do so would normally come from the responsible medical officer who himself has this power. Nonetheless, the Board has the authority to do so and this should enable it to act quickly if, for example, it has reason to believe that the responsible medical officer is not acting in the patient's best interests.

55 The nearest relative's power to order discharge is subject to the restrictions set out in Article 14(4). If he wishes to exercise this power the nearest relative must give 72 hours notice in writing to the Board concerned. The 72 hours runs from the time the notice is received by the Board and arrangements should therefore be made to record the time of receipt of the notice. Where any part of the 72 hour period falls on a Sunday the period of notice is automatically extended to 96 hours. It is essential that the receipt of such a notice is brought to the attention of the responsible medical officer as soon as possible, since he has power to bar discharge by the nearest relative in certain circumstances. Boards should therefore ensure that suitable arrangements are in place in each hospital for this purpose, particularly at weekends or during holidays.

56 If the responsible medical officer makes a report to the responsible Board, within the 72 hour period mentioned above, to the effect that the criteria for detention still apply or that he is not satisfied that the patient, if discharged, would receive proper care, the discharge by the nearest relative will not be allowed and the nearest relative may not make another order for discharge for a period of 6 months beginning with the date of the report. Where possible the responsible medical officer should

endeavour to see the nearest relative to explain the circumstances in which the report was made. In any event the Board must inform the nearest relative and forward a copy of the report to the Commission. The nearest relative then has a right to apply to the Mental Health Review Tribunal, within 28 days from the date on which he is so informed, for the patient's discharge (see paragraph 199).

57 If the patient is discharged under Article 14 by the responsible medical officer, the nearest relative or the responsible Board, the Board must immediately notify the Commission.

58 The nearest relative may authorise a doctor of his choice to visit and examine the patient in private for the purpose of advising him as to the exercise of his power to discharge the patient. The doctor so authorised also has a right to require the production of and inspect any records relating to the detention or treatment of the patient.

Leave of absence from hospital

59 Article 15(1) allows the responsible medical officer to grant a patient leave to be absent from the hospital in which he is liable to be detained. The responsible medical officer may impose any conditions on the leave he thinks necessary in the interest of the patient or for the protection of other people; for example, he may require the patient to live in a specified place or under the care of a specified person, or may require the patient to accept visits from doctors, nurses or social workers or attend at a day hospital or out-patient clinic. Leave of absence can be given either for a temporary absence or on a specific occasion, after which the patient is expected to return to hospital, or as a period of trial of the patient's suitability for discharge. Leave can be extended in the absence of the patient (Article 15(2)).

60 Article 15(3) states explicitly that the responsible medical officer may direct that the patient must remain in custody during his leave if it is necessary in the interests of the patient or for the protection of other persons. The patient may be kept in the custody of an officer of the Board or of any other person authorised in writing by the Board. These kinds of arrangements would allow detained patients to have escorted leave for outings, to attend other hospitals for treatment, or to have home visits on compassionate grounds. So long as a patient is still liable to be detained in hospital, the responsible medical officer remains responsible for his care and treatment and must see that appropriate arrangements are made for his supervision while absent on leave. It is particularly important when the patient is sent on leave as a trial for discharge that such matters as somewhere for him to live and a job or day centre placement are arranged before he leaves hospital. These arrangements will normally be made by the appropriate social work department and after discussion with the nearest relative where practicable. Where appropriate, support from the community psychiatric nursing service should be arranged.

Recall from leave

61 If leave of absence is granted for a specified period the patient should be given to understand that, unless the period of leave is extended, he will be expected to return to the hospital at the end of the period without notice of recall. For longer periods of absence, Boards may wish to make arrangements to remind the patient when he is due to return. If the patient does not return at the appointed time he may be taken into custody and returned to hospital under the provisions of Article 29 (see paragraphs 107-109).

62 Under Article 15(5) the responsible medical officer may recall a patient before the end of the period for which he was originally granted leave. This would arise where the responsible medical officer considered it to be necessary in the interests of the patient's health or safety or for the protection of other persons or because the patient was not receiving proper care. Where a patient is to be recalled, notice in writing revoking the leave of absence must be given to the patient or to the person in charge of him. A patient may not be recalled from leave after he has ceased to be liable to be detained under Part II of the Order.

Notification of Mental Health Commission

63 The Board is required under Article 15(4) to notify the Mental Health Commission if the responsible medical officer grants a patient a period of leave of absence - or extension of leave of absence - which in total exceeds 28 days. The notification must advise the Commission of the address at which the patient will reside while on leave. The Commission must also be informed of the return of the patient to hospital following recall from leave or the expiry of a period of leave. Sample forms of notification have been prepared for these purposes by the Department (see paragraph 3). The Order requires the Commission to be notified at the latest within 14 days of the granting of the leave or extension of leave, or the return of the patient, as the case may be. The purpose of these arrangements is to enable the Commission to carry out its statutory duty to visit detained patients. It is not necessary for the Commission to be informed if the patient's absence is for less than 28 days.

Patients' correspondence

64 Article 16 provides powers for the incoming and outgoing mail of detained patients to be inspected and withheld in certain circumstances. The term "postal packet" is used in Articles 16 and 17 and has the same meaning as in the Post Office Act 1953, that is, "a letter, postcard, reply postcard, newspaper, printed packet or parcel and every packet or article transmissible by post (which) includes a telegram".

Correspondence of patients in ordinary psychiatric or mental handicap hospitals or units

65 The Order places no restrictions whatsoever on the correspondence of voluntary patients. Furthermore, there are no restrictions on the incoming correspondence of patients detained in ordinary psychiatric or mental handicap hospitals or units. The only restriction on outgoing mail

in such hospitals or units is the power to withhold from the Post Office a postal packet addressed by a detained patient if the person to whom it is addressed has requested that he receives no correspondence from that patient (Article 16(1)(a)). Such a request must be in writing and can be made to either the responsible Board or the responsible medical officer.

66 Where such a request has been made the ability of staff to intercept correspondence will depend on the circumstances of the patient's detention. For example, if the patient has been granted leave to be absent from the hospital for any period in each day or week, then he may use public postal facilities. Only where the patient is under constant supervision and is obliged to deliver his mail to staff for despatch will it be possible to ensure that such a request is complied with. The Order gives the responsible Board the power to comply with a request that communications be withheld but it does not place the Board under a duty to exercise any particular degree of vigilance to ensure that the patient does not succeed in any attempt to communicate with the person concerned. Generally, where it is possible to monitor a patient's outgoing mail, and a request under Article 16(1)(a) has been made, it will be sufficient to look at the address to which the patient's letters are being sent, and to withhold any addressed to the person who has made the request. It is not likely that these powers will have to be used often; and where they do have to be used, interception at ward level is likely to be most appropriate.

67 Where a postal packet is withheld from the Post Office as described above, the responsible Board has to record that fact in writing. It is suggested that this record should include the name of the patient concerned, the nature of the postal packet, the date on which it was withheld and the reason for withholding it (that is, that the addressee has requested that communications addressed to him by the patient should be withheld). This record, together with the postal packet, should be kept with the patient's records. An explanation should be given to the patient, and the postal packet should be returned to him if he so requests; this also should be noted on the record.

Correspondence of patients in secure accommodation

68 The remaining provisions of Article 16 and all of Article 17 refer only to the correspondence of patients detained in special accommodation, that is accommodation for patients who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities. Since there is no such accommodation in Northern Ireland, these provisions have no practical application for Boards at this stage. Patients requiring treatment in special accommodation are transferred to special hospitals in England or to state hospitals in Scotland where they come under the corresponding provisions in the Mental Health Act 1983 or the Mental Health (Scotland) Act 1984, as the case may be.

Guardianship

General

69 Unlike the 1961 Act which gave guardians the wide general powers of a

father over a child of 14 years of age, the Order limits guardians' powers to those which are essential for the purpose of ensuring that patients receive the medical treatment, social support and training they require. In almost all cases it should be possible for patients for whom care in the community is appropriate to receive that care without being subject to the control of guardianship. However, in a small minority of cases guardianship enables a relative or social worker to help a mentally disordered person to manage in his own home or in other accommodation in the community, where the alternative would be admission to hospital. The guardian may be the Board in whose area the patient resides or an individual approved by that Board, such as a relative of the patient.

Children under 16

70 Children under 16 years of age can no longer be received into guardianship. Instead they will be dealt with under the powers contained in the Children and Young Persons Act (Northern Ireland) 1968 which are considered to be more appropriate than guardianship for young people in this age group. Under the provisions of section 103 of the Children and Young Persons Act (Northern Ireland) 1968, Boards have a duty, in the interests and welfare of a child (under 18), to take him into care in appropriate circumstances, and can in cases of persistent neglect apply to the court for a parental rights order. Additionally, Boards have a duty under section 94 of that Act to bring before the court any child who is lacking care, protection or guidance which is likely to cause him unnecessary suffering or seriously to affect his health or development. The court has a range of options for dealing with such cases, including, for example, the child's committal to the care of a fit person, the making of a supervision order in respect of the child or the ordering of his parent or guardian to enter into a recognizance to exercise proper care. Although mental disorder itself is not a ground for taking a child into care or making a care or supervision order, these options and powers together with the alternative of admission to hospital are sufficient to ensure that mentally disordered children receive the care and protection they need. Guardianship is of course an additional option in respect of a young person between 16 and 18 years of age.

The grounds for guardianship

71 There are two grounds for guardianship: the medical ground and the welfare ground. A guardianship application may be made on the grounds that a person is suffering from mental illness or severe mental handicap of a nature of degree which warrants his reception into guardianship (the medical ground) and it is necessary in the interests of the welfare of the patient that he should be so received (the welfare ground). An application must be accompanied by 2 medical recommendations stating that the medical ground is met and a recommendation by an approved social worker stating that the welfare ground is met.

72 The purpose of guardianship is, therefore, primarily to ensure that the patient receives the care and protection he needs rather than medical treatment, although the guardian does have the power to require the patient to attend for medical treatment (but not to make him accept it). In giving his recommendation the approved social worker must be satisfied

that without the supervision of a guardian the patient is, for example, likely to suffer neglect or to be at risk of exploitation. Equally, there is little point considering guardianship if there is a likelihood that the patient will be unwilling to co-operate or abide by the conditions imposed by the Order. In each case it is for the approved social worker, in the exercise of his professional judgement, to determine whether guardianship is justified in the light of the benefit the patient may derive from the exercise of the limited supervisory powers of the guardian.

Powers of a guardian

73 The intention is that the 3 new specific powers of a guardian (Article 22(1)) should restrict the liberty of the individual only so far as it is necessary to ensure that he receives the medical treatment, social support and training he needs. The first power is to require the patient to live at the place specified by the Board or person named as guardian. This may be used to discourage the patient from sleeping rough or living with people who may exploit or mistreat him, or to ensure that he resides in a particular hostel or other facility. The second power enables the guardian to require the patient to attend specified places at specified times for medical treatment, occupation, education or training. These might include a day centre, an adult training centre, a hospital, a day-hospital, surgery or clinic. The third power enables the guardian to require access to the patient to be given at the place where the patient is living, to any doctor, approved social worker, or other person specified by the guardian. This power could be used, for example, to ensure that the patient did not neglect himself.

Applications for guardianship

74 An application for guardianship may be made by the nearest relative or by an approved social worker, and the applicant must have seen the patient within 14 days prior to the making of the application. The application must be made on a prescribed form : Form 13 is for use by the nearest relative and Form 14 for use by the approved social worker. Part II of these forms provides for a statement by the person chosen as guardian (other than the Board) that he is willing to act in this capacity. The applicant is allowed to name himself as guardian (Article 18(5)) but he may instead name another person such as a relative or family friend. The completed application form and accompanying medical and social work recommendations must be forwarded to and be accepted by the responsible Board otherwise the application will have no effect. It follows therefore that the Board must accept the nominee as a suitable person to act as guardian. A guardianship application cannot be made by the same approved social worker as gave the social work recommendation on which it is founded.

75 Before making an application the approved social worker must consult the nearest relative unless this is not reasonably practicable or would involve unreasonable delay. If the nearest relative objects to the application, the approved social worker, if he wishes to proceed, either must apply for an order under Article 36 transferring the functions of the nearest relative to another person (see paragraphs 114-116) or must consult a second approved social worker. The person consulted must not be the same approved social worker who gave the social work recommendation on

which the application is founded. This means that in this particular type of case 3 different approved social workers are involved in the application. If following the consultation with the second approved social worker, the applicant is satisfied that the application should be made, he can proceed with it provided he records the nearest relative's objection on the application form. Thus this information will be available to the responsible Board when it comes to consider whether or not the application should be accepted. If the approved social worker is unable to consult the nearest relative before the patient is received into guardianship he must inform him as soon as practicable afterwards.

The medical recommendations

76 The medical recommendations must be in the prescribed form and may be given either separately or jointly. Form 15 or Form 16 should be used as appropriate for this purpose. Each doctor must examine the patient within 2 days prior to signing the recommendation and, where the doctors examine the patient separately, the 2 examinations must not be more than 7 days apart. This means that the earlier of the 2 examinations can never take place more than 14 days before the application is sent to the Board. One of the doctors must be a Part II doctor who will in practice be a consultant psychiatrist and will have special knowledge of the patient's condition, and the other should, if practicable be the patient's own general practitioner or a doctor who knows him. This could be a hospital doctor who has previously been involved in treating the patient or another general practitioner. The aim is to ensure that the decision to place the patient in guardianship is taken in the light of full and recent evidence as to his mental condition, given, as far as possible, by doctors who have been in the past, and may be in the future, clinically responsible for him.

77 The statements as to the form of mental disorder which constitute the medical ground for reception into guardianship (see paragraph 71) are statements of opinion. The grounds on which these opinions are based must be given and should include a full description of the patient's clinical condition. As the two forms of mental disorder are not necessarily mutually exclusive, it is possible for either of the medical recommendations to state that the patient is suffering from both mental illness and severe mental handicap. However, unless both medical recommendations agree in specifying at least one form of mental disorder in common, a guardianship application will be of no effect.

The approved social worker's recommendation

78 Although the Order is less specific about the timing of the approved social worker's recommendation, the intention is that the decision to place the patient in guardianship is taken in the light of full and recent knowledge of his social circumstances. The recommendation must be given on a prescribed form (Form 17) and must include:

(i) a statement that in the opinion of the approved social worker it is necessary in the interests of the welfare of the patient that he should be received into guardianship;

(ii) a statement of the grounds for that opinion giving reasons why the patient cannot be appropriately cared for without powers of guardianship;

(iii) a statement as to whether the approved social worker is related to the patient or has any pecuniary interest in his reception into guardianship. Although the Order does not specify when the approved social worker's recommendations should be signed, it is essential that this is done before the date of the application, and within - at most - two weeks prior to that date.

Receipt of application by the Board

79 A guardianship application must be forwarded to the Board not more than 7 days after the patient's last medical examination for the purposes of the application. Once the application has been accepted by the Board the powers of guardianship take effect immediately and the patient may be kept under guardianship for a period of 6 months. Any previous application for guardianship or liability to be detained lapses when the patient is placed under guardianship. The Board is required to send a copy of the application form and the recommendations on which it is founded to the Commission immediately the patient is received into guardianship.

Rectification of applications and recommendations

80 Article 21 contains provisions which allow guardianship applications and supporting recommendations to be rectified within 14 days of the application being accepted by the Board. It is essential therefore that Boards make arrangements for the immediate scrutiny of such documents as soon as they are received. The errors to be looked for and the procedures for rectifying them are broadly the same as in the case of an admission for assessment (see paragraphs 34-44). Although an insufficient recommendation may normally be substituted by a fresh one even in cases where the 2 medical recommendations taken together are insufficient, a new document may not be substituted where the application has been invalidated under Article 18(7) because the two medical practitioners do not agree as to the form of the patient's mental disorder.

Renewal of authority for guardianship

81 The authority for guardianship may be renewed at the end of the initial 6 months period for a further 6 months and subsequently for consecutive periods of 1 year. The medical and welfare grounds for renewal are the same as those required for making an application (see paragraph 71). The procedure for renewal remains the same, regardless of the duration of the authority sought. The responsible medical officer must, within the period of 2 months before the expiry of the authority for guardianship, either examine the patient himself or obtain a report on the condition of the patient from another doctor (this is most likely to be the patient's own general practitioner). If the responsible medical officer is satisfied that the medical ground for guardianship continues to be satisfied, he must give to an approved social worker named by the Board a report on the prescribed form (Form 18) to that effect, together with the other doctor's report if he has obtained one. The approved social worker must then

consider whether the welfare ground for guardianship continues to apply. If he is satisfied that it does, he must send to the Board a report on the prescribed form (Form 19) to that effect, along with the responsible medical officer's report and any second medical report that he may have obtained. When these reports have been received by the Board, the authority for guardianship is renewed for the appropriate period. Each time the authority is renewed the Board must inform the patient, the nearest relative and the guardian, and must send copies of the reports on which the renewal is founded to the Commission.

Discharge from guardianship

82 A patient may be discharged from guardianship under Article 24 by the responsible medical officer, an approved social worker authorised for this purpose by the Board, or by the nearest relative. The responsible medical officer must discharge the patient if he is satisfied that the medical ground for guardianship is no longer satisfied and the authorised social worker must discharge him if the welfare ground no longer applies. To be valid, an order for discharge must be in writing. There is no prescribed form for this purpose but the Department has prepared a specimen form which may be adapted for use (see paragraph 3). In practice, a written statement that the patient is hereby discharged from guardianship under the Order will be sufficient if signed by a person empowered to discharge him.

83 If the nearest relative wishes to exercise his right to discharge the patient he must give at least 72 hours notice to the responsible Board. Where any part of the 72 hour period falls on a Sunday the period of notice is automatically extended to 96 hours. If during this period of notice the responsible medical officer makes a written report to the Board stating that the medical ground for guardianship continues to apply AND an authorised social worker reports to the Board in writing that the welfare ground still applies, the discharge will not be allowed. In these circumstances the Board must forward a copy of each report to the Commission, and also must inform the nearest relative that the discharge has been barred and that he will not be able to make another order for discharge for 6 months from the date of the later of the two reports by the responsible medical officer and the authorised social worker. The nearest relative then has a right of appeal to the Mental Health Review Tribunal, within 28 days of being so informed by the Board, to seek the patient's discharge (see paragraph 199).

84 If the patient is discharged by the responsible medical officer, an authorised social worker or the nearest relative, the Board must immediately inform the Commission and the patient's guardian, if other than the Board.

85 A doctor authorised by or on behalf of the nearest relative may at any reasonable time visit the patient and examine him in private, for the purpose of advising the nearest relative as to the exercise of his powers to discharge the patient.

Transfer of guardianship

86 Articles 25 and 28(5)(a) provide for the transfer of a patient from the guardianship of one person to another without a break in the authority for guardianship and without the need for a fresh application. This may arise in a variety of circumstances; for example, if the guardian dies, becomes incapacitated, wishes to relinquish his functions or is found to be performing his functions negligently.

87 Where a guardian dies or gives notice in writing to the Board that he is no longer willing to act as guardian, the guardianship of the patient will immediately vest in the Board. The Board then has the option of acting as guardian itself or of transferring the patient into the guardianship of another person under Article 28(5). Needless to say the Board will take the necessary steps to ensure that any new guardian is a suitable person for the purpose and that he is willing to act in that capacity. His consent should be obtained in writing. Before arranging a transfer under Article 28(5), the Board must, if practicable, inform the patient's nearest relative and the guardian, if other than the Board, who is being replaced.

88 Where the guardian is temporarily incapable of acting, because of illness or for any other reason, the Board itself may temporarily act as guardian or approve another person for the purpose. This makes it unnecessary to operate the full procedure for transfer of guardianship where the guardian's incapacity is clearly not going to be permanent.

89 If a Board is satisfied that a guardian has been negligent in carrying out his duties or failed to act in the interests of the welfare of the patient, and the guardian is unwilling to agree to the transfer of the guardianship functions to another person, the Board may apply to the county court for an order transferring the guardianship to the Board or to any other person approved by the Board. The Board must notify the Commission immediately of any transfer of guardianship either temporary or permanent.

Care and treatment of patients under guardianship

90 Regulations 4 and 5 set out the duties, other than those inherent in the powers set out in paragraph 73, of a private guardian (ie a guardian other than a Board) and the Board in relation to a patient under guardianship and the relationship between the Board and the guardian. The principal duty placed on the Board by Regulation 5 is the exercise of general supervision over every patient received into guardianship. This duty commences with the choice of a suitable person to act as guardian. Once the guardian has been approved, the Board will be able to exercise effective control over him by virtue of Regulation 4 which gives it power to issue directions with which he must comply, and by requiring him to furnish it with any reports or information about the patient which it may require. The guardian must also ensure that the patient is registered with a general medical practitioner and notify the Board of the doctor's name and address. In addition he must notify the Board in writing about such matters as any change in his own address or that of the patient, if the patient dies, if he is absent without leave or returns from such absence.

91 The Board's main contact with the patient and his guardian, however, will be through visits by staff rather than through written notifications. Regulation 5 requires the Board to arrange for every patient under guardianship to be visited at least once every 3 months and one such visit each year must be by a Part II doctor. This is regarded as the minimum number of visits to be made and more frequent visits may be desirable in the majority of cases. The Board's other responsibility under Regulation 5 is to notify the Commission in writing of permanent changes in the address of the patient or guardian, of the termination of guardianship either by the death of the patient or otherwise and of any absence of the patient without leave or his return following such an absence.

General provisions relating to detention in hospital or guardianship.

Duty of Board to give information to patients and nearest relatives

92 Article 27 places a duty on the responsible Board to provide certain information to patients detained in hospital or subject to guardianship and to their nearest relatives. Article 27(1) requires the Board to take such steps as are practicable to ensure that the patient understands:

(a) under which provision of the Order he is being detained or subject to guardianship and the effect of that provision; and

(b) his right to apply to the Mental Health Reveiw Tribunal (if applicable).

93 This information must be given as soon as practicable after the commencement of the patient's detention in hospital or his reception into guardianship, or after any renewal of the authority for detention or guardianship, and must be given both orally and in writing. In practice this will mean that the patient will have to be told immediately if he is detained for 48 hours or less. It is important that the patient should be made aware of the legal aid scheme (see paragraphs 214 and 215) when he is being told about his right to apply to the Tribunal.

94 When the responsible medical officer, nurse or social worker is giving information to the patient he should be as helpful as possible, and try to explain to the patient any points he does not appear to understand. Some patients will not be able to comprehend what they are told, but the law requires that the attempt should be made, and in the case of the short-term powers there may be little time to wait and see if a patient's powers of understanding improve.

95 Article 27(2) places a further duty on the Board to take such steps as are practicable to ensure that a patient detained in hospital or subject to guardianship understands the effect, so far as they apply to him, of Articles 14, 24 and 71(4) of the Order which deal with the power of the responsible medical officer, an authorised social worker, the responsible Board and the nearest relative to discharge him; and that he understands that he may make representations to the Commission. The Board must also take steps to ensure that a detained patient understands the effects, so far as they apply to him, of

Articles 16 and 17 which deal with patients' correspondence, Article 111 which deals with the Code of Practice, and Part IV which deals with consent to treatment; and that the patient's nearest relative is furnished with a written statement of his rights and powers under the Order.

96 The information to be given to the patient under Article 27(2)(a) and (b) must be given both orally and in writing, and the information to be given in writing to the nearest relative under Article 27(2)(c) must be given in writing. In addition, the information must be given as soon as practicable after the patient's detention or guardianship begins. It should be noted that Article 27(5) requires that the patient's nearest relative should also be given a copy of any written information given to the patient, but this requirement is subject to the patient's wishes; in other words, if the patient expressly requests that such information should not be given to the nearest relative then the Board should not do so. Specimen leaflets have been prepared by the Department for the purpose of informing patients and nearest relatives of their rights which Boards can adapt for use (see paragraph 3).

97 An oral explanation is required because this will often be the best way of helping the patient to understand his position. The person who explains the patient's rights to him should answer all reasonable questions and should take account of the patient's intelligence as well as any physical disability which inhibits the patient's ability to communicate. Indeed it may be necessary for example to call upon the services of persons trained in working with the deaf, if the patient's hearing is impaired. In the case of the longer term powers a period of time may be allowed to elapse before the patient is given this information if, at the start of detention, his condition is so bad that it is felt he will not understand it, but it is important that this delay is not prolonged to the extent that it conflicts with the requirements of the Order to inform "as soon as practicable".

98 When a patient is discharged from detention, or the authority for his detention expires, this fact should be made clear to him whether he wishes to leave hospital or stay on as a voluntary patient. The nearest relative, and in guardianship cases, the guardian must also be informed, as soon as practicable, when liability to detention or guardianship ceases. Where a patient subject to detention in hospital is to be discharged from hospital, otherwise than by virtue of an order for discharge by his nearest relative, the Board is required under Article 117 to take such steps as are practicable to inform the nearest relative. The information must, if practicable, be given 7 days before the date of discharge. This requirement is subject to the wishes of both the patient and his nearest relative and does not apply if either of them does not want it. In many cases it may not be possible to give 7 days notice and the words "if practicable" should therefore be interpreted in the spirit of the provision and the nearest relative should be given as much notice as possible.

Transfer of patients

99 Article 28 permits the responsible Board to arrange for the transfer of a detained patient from one hospital to another; for the transfer of a

detained patient into guardianship; and for the transfer of a patient subject to guardianship from the guardianship of one person into that of another (see paragraphs 86 to 89). A patient subject to guardianship cannot be transferred to detention in hospital. A transfer may be arranged for a variety of reasons, for example, the responsible medical officer may consider that another hospital could provide treatment more suitable to the patient's needs, or the nearest relative or other relatives of the patient may request it to facilitate visiting.

Transfer between hospitals

100 However the suggestion for the transfer of a patient to another hospital originates, it will normally be for the responsible medical officer in the original hospital to ensure that a suitable vacancy exists in the receiving hospital, and that the doctor who will be acting as responsible medical officer of the patient once he reaches that hospital, has full information about the patient's condition and the statutory provisions to which he is subject. Once these preliminary arrangements have been satisfactorily completed the responsible Board must, if practicable, inform the nearest relative of the proposed transfer before it takes place (Article 28(9)). If the transfer is to a hospital in another Board's area the written agreement of the receiving Board should be quickly obtained. Where the transfer is from one hospital to another in the same Board's area it is essential that the names and designations of those who arranged the transfer be recorded in writing and kept with other documents relating to the patient's detention. Otherwise there may be no correspondence or papers to indicate that the appropriate persons arranged and agreed to the transfer.

101 The transfer should then go ahead with the minimum of delay making sure that the patient's records precede or accompany him to his new destination. In addition, the responsible Board should notify the Commission of the transfer, immediately it takes place. Transfer to a different hospital will not affect the patient's legal status or position in any way. He will be treated in all respects, including the documentation completed in relation to his admission to, and detention in, hospital, as if he had always been in the new hospital. The authority to detain and the power of discharge are of course transferred to the responsible medical officer at the new hospital and to the new responsible Board (if applicable) from the time the patient is admitted to the receiving hospital.

Transfer from hospital to guardianship

102 The question of transferring a patient from detention in hospital to guardianship is most likely to arise after a patient has already been on leave of absence from hospital. In such cases if, after a suitable period on trial in the community, it is still not clear that a patient has recovered to the extent that would justify complete discharge from all compulsory powers, but it is not likely to be necessary to recall him to hospital, the patient may be transferred to guardianship to provide the necessary statutory basis for long-term care under compulsory powers in the community.

103 As with transfers between hospitals, the initiative for transfer from hospital to guardianship will usually originate with the responsible medical officer. He is likely to involve an approved social worker at a very early stage who will give advice on the patient's suitability for guardianship from a welfare point of view. The nearest relative may be consulted also at an early stage but in any case the Board is required to notify him before any transfer takes place (Article 28(9)). If the guardian is to be a person other than the Board, the guardian's consent should be obtained in writing. The Board's agreement to the transfer should also be recorded in writing. If the transfer is to another Board's area the agreement of that Board should also be obtained in writing. These records will ensure that the authority of the guardian over the patient and the powers and duties of the responsible Board may not subsequently be questioned.

104 The removal of the patient to the place where the guardian wishes him to live should be arranged as soon as possible after the above records have been made. The authority of the guardian will date from the day on which the patient reaches his new residence (or, if the patient is already there on leave, from the date on which the procedure for authorising the transfer is completed).

105 Where a patient is transferred from detention in hospital to guardianship the provisions of Part II of the Order apply to him as if the application for assessment by virtue of which he was admitted to hospital were a guardianship application. The transfer does not affect the duration of the patient's detention which will expire at the same time as it would have expired if the patient had remained in hospital. Both the medical and welfare grounds for guardianship will of course have to continue to be met if the patient is to remain in guardianship or if the authority for guardianship is to be renewed. As with transfers between hospitals the responsible Board is required under Article 28(10) to notify the Mental Health Commission of the transfer of a patient from hospital to guardianship or from one guardian to another, immediately the transfer takes place.

Admission to hospital of patients under guardianship

106 Because the grounds for detention in hospital are so different from those required for guardianship, there is no provision in the Order for the transfer of patients in guardianship to detention in hospital. Consequently the normal procedure for admission for assessment must be followed in this type of case. Guardianship can remain in force during the assessment period but does not do so if the patient is detained for treatment (Article 12(3)). If a patient under guardianship requires treatment in hospital and there is no need to detain him then he may be admitted as a voluntary patient while still remaining in guardianship.

Absence without leave

107 Article 29 provides powers for retaking patients who are absent without leave from hospital, or from the place where they are required to live (by their guardian or by the conditions of authorised leave of absence) or who fail to return from leave either at the end of leave or when

recalled. A patient who is liable to be detained in hospital may be retaken by any officer on the staff of the hospital in which he is liable to be detained, by any constable, by any approved social worker or by any other person who is authorised in writing to do so by the responsible Board. A patient who is absent without leave while under guardianship may be taken into custody by any constable, any approved social worker or any person authorised in writing by the guardian or the responsible Board.

Time limits for retaking patients absent without leave

108 If a patient remains absent without leave for 28 days he cannot be retaken and ceases to be liable to detention (Article 29(3)). A fresh application for admission for assessment or guardianship would have to be made if compulsory powers were still appropriate. Article 29(4) provides that a patient cannot be retaken if the period of his detention under any of the following short-term powers has expired: detention of an in-patient by a doctor for 48 hours (Article 7(2)), or by a nurse for 6 hours (Article 7(3)), admission for assessment for up to 48 hours, 7 days or 14 days (Article 9(4), (7) and (8)).

Special provisions as to patients absent without leave

109 Article 30 provides that where a patient is absent without leave, he remains liable to be detained or subject to guardianship until the expiry of the period during which he can be taken into custody mentioned in paragraph 108 or the day on which he returns or is returned, whichever is the earlier. If he does return within this time and less than 7 days is left before the authority for his detention or guardianship would expire, his detention or guardianship is extended until the end of 7 days from the date of his return. This allows time for the completion of the renewal procedure if it is appropriate, and where detention or guardianship is renewed the renewal takes effect from the day on which it would have expired apart from Article 30.

The nearest relative

110 The Order confers various functions on the patient's nearest relative such as making applications for admission, exercising the right to discharge the patient and making applications to the Tribunal. These and other rights and powers of the nearest relative are mentioned in more detail as they arise throughout the Guide. It is open to the nearest relative of a patient who is detained or subject to guardianship to authorise under Article 35 some other person to perform his functions under the Order. If he wishes to do so he must get the written agreement of the person who is willing to act in this capacity and must forward a notice to the responsible Board using the prescribed form (Form 20) formally assigning his functions as nearest relative.

111 The definition of nearest relative in Article 32 differs in some respects from that in the 1961 Act. For example, the father no longer automatically takes precedence over the mother, but other things being equal the elder of the two will take precedence. Care should therefore be taken to establish who the nearest relative is before, for example, an application for assessment or guardianship is made. To assist those

involved some notes of guidance have been included on the reverse of the respective application forms (Form 1 and Form 13).

112 A list in order of precedence of the persons who are entitled to be regarded for the purposes of the Order as the patient's relative is contained in Article 32(1). The nearest relative is then defined as the first person listed who is caring for the patient, or, if the patient is already in hospital, was caring for the patient before admission. For example, if a patient is being cared for by a grandchild, that grandchild would be the nearest relative within the meaning of the Order even though a son or daughter was still alive. The definition is, however, subject to the remaining provisions of Article 32 which cover a wide variety of special circumstances, as follows:

(i) if the patient has relatives but none is or was caring for him, then the nearest relative is simply the first person listed;

(ii) where there are two or more persons in one category, the elder or eldest is preferred;

(iii) an illegitimate person is treated as the legitimate child of his mother;

(iv) to determine relationship a half-blood is treated as a whole-blood but within the same category of relative, a whole-blood is preferred to half-blood;

(v) where the person who would otherwise be the nearest relative, is under 18 years of age, that person is disregarded unless he or s is the spouse or parent of the patient;

(vi) where a marriage is broken up, and the person who would otherwis be the nearest relative of the patient by virtue of his being hi or her spouse is no longer living with the patient, that person disregarded;

(vii) where a person who would otherwise be the nearest relative ordinarily lives outside the United Kingdom, the Channel Islands the Isle of Man or the Republic of Ireland, that person is disregarded unless the patient also ordinarily lives abroad;

(viii) for the purposes of the Order, the term "spouse" includes a pers who is living with the patient as though they were married, or - if the patient is already in hospital - had been so living with him or her before admission, and has or had been so living for n less than 6 months;

(ix) a person with whom the patient ordinarily resides and has been s resident for at least 5 years but who is not a relative and canno be regarded as a "spouse" in the terms of (viii) above is treated as the nearest relative within the meaning of the Order if he or she is caring for the patient.

113 Article 33 deals with cases where children are taken into care, and provides that the Board or the person exercising parental rights in such a case is deemed to be the nearest relative within the meaning of the Order, except where the child is married. If the Board has assumed parental rights in respect of one parent only, the other parent remains as the child's nearest relative. If the child is married, the spouse becomes the nearest relative. Article 34 deals with cases where children are under guardianship or in the custody of one parent and provides that the person having guardianship or custody of the patient shall be deemed to be the nearest relative for the purposes of the Order.

Appointment by county court of acting nearest relative

114 In some cases a patient may not have a nearest relative within the meaning of the Order, or the person who is the nearest relative may be incapable of acting because of illness or mental disorder (see paragraph 115). Accordingly the Order contains provision in Article 36 whereby a county court may make an order directing that the functions of the nearest relative may be carried out by another person (approved by the court) or by the responsible Board. An application for such an order may be made by any relative of the patient, any other person with whom the patient lives or last lived before entering hospital, or by an approved social worker.

115 There are four grounds on which an application to appoint a nearest relative may be made:

(a) that the patient has no nearest relative within the meaning of the Order, or that it is not reasonably practicable to ascertain whether he has such a relative, or who that relative is;

(b) that the nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness;

(c) that the nearest relative unreasonably objects to the making of an application for assessment or a guardianship application in respect of the patient; or

(d) that the nearest relative has exercised without due regard for the welfare of the patient or the interests of the public, his power to discharge the patient from hospital or guardianship, or is likely to do so.

116 In a case where there is no nearest relative there is no obligation to make an order to appoint one, but this may be done if someone comes forward who wishes to perform the function. An order made on the grounds of (a) or (b) above may specify a period for which it is to remain in force, unless previously discharged. One example of a way in which a court might use this power would be to specify that the order should cease on the date when the eldest child of the patient reached 18, so that he could then take on the role of nearest relative. With regard to grounds (c) and (d) above it will be for the approved social worker who wishes to make the application, in consultation with professional colleagues, including doctors who may be prepared to give

medical recommendations, to consider whether he should apply to the court for an order.

Discharging or varying a court order for the appointment of an acting nearest relative

117 A county court has power under Article 37 to discharge or vary an order appointing a nearest relative. An application to discharge such an order may be made by the person who was appointed by the court to act as nearest relative under Article 36. It can also be made by the nearest relative in cases where the order was made because a nearest relative could not be identified or was unable to act or where the nearest relative at the time the order was made was no longer the nearest relative. An application to vary an order may be made by an approved social worker or by the person appointed by the court to act as nearest relative. The person to be substituted as nearest relative in these circumstances must have indicated his willingness to do so and must satisfy the court that he is a fit person to act. If the person appointed by the court to act as nearest relative dies, any relative of the patient is empowered under Article 37(3) to apply to the court to discharge or vary the order and until the court does so nobody is entitled to act as nearest relative.

118 Article 37(4) specifies the duration of an order which has not previously been discharged. Such an order lasts either for the period specified under Article 36(4) (see paragraph 116) or until the patient is discharged from hospital or guardianship if he was so detained or subject at the time the order was made or became so within the following 3 months. If the patient is not detained in hospital or subject to guardianship within the 3 month period following the making of the court order, it ceases to have effect at the end of that period. A transfer between hospital and guardianship or between hospitals or guardians does not affect the duration of the order.

Duty of approved social worker to make applications for admission or guardianship

119 Article 40 imposes a duty on an approved social worker to make an application for assessment or a guardianship application in any case where he considers an application ought to be made and where, after taking into account the views of the relatives and any other relevant circumstances, he thinks it necessary and proper to do so. This does not affect the provisions as to consultation with nearest relatives (see paragraphs 19 and 75) but subject to those provisions, and the powers of the nearest relatives, it places on approved social workers a duty to act when necessary, particularly if relatives are unable or unwilling to do so. The nearest relative may often prefer that the approved social worker should sign an application, because, for example, of fear of reprisals from the patient following discharge at a future date.

120 Before making an application in the circumstances described above, the approved social worker is required under Article 40(2) to interview the patient "in a suitable manner": in other words he must take account of any physical or mental disabilities the patient may have such as hearing or linguistic difficulties. He must also satisfy himself that,

in all the circumstances of the case, detention in hospital or guardianship, as the case may be, is the most appropriate way of providing the care and treatment the patient needs. In doing so he will take account of matters such as those mentioned in paragraph 20 which deals with social work reports.

121 An approved social worker is allowed by Article 40(3) to make an application for admission or guardianship outside the area of the Board by which he has been appointed. This provision is new and will give the required flexibility where, for example, a patient is admitted as a voluntary patient to hospital outside the Board area in which he lives and subsequently needs to be detained. An approved social worker from his home area who is familiar with his case and would be the most suitable person to make an application could do so. In addition some psychiatric hospitals have catchment areas which cross Board boundaries and it might therefore be helpful in some cases if the approved social worker is able to make an application outside his own area.

122 Article 40(4) enables the nearest relative to require a Board in whose area the patient lives to direct an approved social worker to make an application for the patient's admission to hospital or guardianship. The approved social worker is required to consider the matter as soon as practicable and if after due consideration he decides not to proceed with an application he must inform the nearest relative of his reasons in writing.

PART III - POWERS OF THE COURTS AND SECRETARY OF STATE

Introduction

123 Part III deals with the circumstances in which patients may be admitted to and detained in hospital or received into guardianship on the order of a court, or may be transferred to hospital from penal institutions on the direction of the Secretary of State. In addition to the existing powers of the courts to make hospital and guardianship orders (Article 44), the Order gives the courts 3 new powers: remands to hospital for a medical report; remands to hospital for treatment and interim hospital orders (Articles 42, 43 and 45).

Remand to hospital for report on mental condition

124 Article 42 empowers the courts to order the remand to hospital of an accused person for the preparation of a report on his mental condition. This provides an alternative to remanding the accused person in custody for a medical report, in circumstances where it would not be practicable to obtain the report if he were remanded on bail (for instance because he might decide to break a condition of bail that he should reside at a hospital and the hospital would then be unable to prevent him discharging himself).

125 This power applies to the following categories of persons:-

a. where the power is being exercised by the Crown Court, to any person who is awaiting trial before the court for an offence punishable with imprisonment or who is at any stage of such a trial prior to sentence (other than a person convicted of murder);

b. where the power is being exercised by a court of summary jurisdiction, to any person -

   i. convicted of an offence punishable on summary conviction with imprisonment; or

   ii. charged with such an offence if the court is satisfied that he did the act or made the omission charged or he has consented to the exercise of the power.

126 The power may be exercised only if:-

a. the court is satisfied on the oral evidence of a Part II doctor* that there is reason to suspect that the accused person is suffering from mental illness or severe mental impairment;

b. the court is of the opinion that it would be impracticable for a report on his mental condition to be made if he were remanded on bail; and

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* See the footnote on page 1 for an explanation of the term "Part II doctor".

c. an opportunity has been given to the Department (see paragraph 147) to make representations to the court concerning the remand.

127 Remand is in the first instance for up to 28 days, after which the accused person may be further remanded for periods of up to 28 days, but only;

a. if it appears to the court, on the written or oral evidence of the medical practitioner responsible for making the report, that this is necessary for completing the assessment; and

b. up to a maximum total period of 12 weeks.

The power of further remanding the accused person may be exercised by the court in his absence if he is legally represented and his representative is given the opportunity to be heard. The court may terminate the remand at any time, and the accused person is entitled to obtain a separate medical report from a medical practitioner of his own choice and at his own expense and to apply to the court on the basis of it for his remand to be terminated.

128 The effect of the remand is, first, to direct a constable (or any other person chosen by the court) to convey the accused person to the hospital designated by the Department* to receive him and, second, to entrust responsibility for his detention and reappearance in court to the Board administering the hospital. If the accused person absconds, he may be arrested without warrant by any constable and is then to be brought before the court that remanded him, which may decide on some alternative approach to his case.

Remand to hospital for treatment

129 Article 43 empowers the Crown Court to order the remand to hospital of an accused person for treatment. This provides an alternative to the Secretary of State's power under Article 54 to transfer unsentenced prisoners to hospital in an emergency. The power applies to a person who is in custody awaiting trial before the court for an offence punishable with imprisonment (other than murder) or who is in custody at any stage of such a trial prior to sentence.

130 The power may be exercised only if the court is satisfied:-

a. on the oral evidence of a Part II doctor and on the written or oral evidence of one other medical practitioner, that the accused is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; and

b. that an opportunity has been given to the Department (see paragraph 147) to make representations to the court concerning the remand.

131 Paragraphs 127 and 128 also apply to remands to hospital for treatment under Article 43, with the difference that since the purpose of the remand is the accused person's treatment rather than the preparation of a report on him, further remands depend simply on written or oral evidence from the responsible medical officer that a further remand is warranted

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* This function has been delegated to Boards.

(but the patient can still apply for the remand to be terminated on the basis of a medical report he has obtained himself).

Interim hospital orders

132 To assist the courts and the hospitals in determining whether it is appropriate to make a hospital order in respect of an offender, Article 45 empowers the courts to make an interim hospital order so that the offender's response in hospital can be evaluated without any irrevocable commitment on either side to this method of dealing with the offender if it should prove unsuitable. The power applies to the same categories of person as do hospital orders (see paragraph 136) but a court of summary jurisdiction cannot make an interim hospital order in respect of an unconvicted person.

133 The power may be exercised only if:-

a. the court is satisfied, on the oral evidence of a Part II doctor and on the written or oral evidence of one other medical practitioner:

i. that the offender is suffering from mental illness or severe mental impairment; and

ii. that there is reason to suppose that the mental disorder is such that it may warrant a hospital order being made in his case; and

b. that an opportunity has been given to the Department (see paragraph 147) to make representations to the court concerning the making of such an order.

134 An interim hospital order may be made in the first instance for a period of up to 12 weeks and may be renewed for further periods of up to 28 days to a maximum total period of 6 months. Both the power of renewal and the power to convert an interim hospital order into a hospital order may be exercised by the court in the absence of the offender if he is legally represented and his representative is given the opportunity to be heard. The court may also terminate the interim hospital order after considering the written or oral evidence of the responsible medical officer, if it decides to deal with the offender in some other way.

135 The effect of an interim hospital order is first, to direct a constable (or any other person chosen by the court) to convey the offender to the hospital designated by the Department* to receive him and, second, to entrust responsibility for his detention and reappearance in court to the Board administering the hospital. If the offender absconds, he may be arrested without warrant by any constable and is then to be brought before the court that made the order which may decide on an alternative way of dealing with him.

Hospital and guardianship orders

136 Article 44 empowers courts to make a hospital or guardianship order in respect of certain categories of offender:

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* This function has been delegated to Boards.

a. where the power is being exercised by the Crown Court, in respect of any person convicted before that court for an offence punishable with imprisonment (other than murder); and

b. where the power is being exercised by a court of summary jurisdiction; (i) in respect of any person convicted by that court of an offence punishable on summary conviction with imprisonment, and (ii) in respect of any person charged before that court with such an offence who would, if convicted, be liable to be made subject to a hospital or guardianship order as a person suffering from mental illness or severe mental impairment, if the court is satisfied that he did the act or made the omission charged.

137 The power to make a hospital order may be exercised if:-

a. the court is satisfied on the oral evidence of a Part II doctor and on the written or oral evidence of one other medical practitioner:-

i. that the offender is suffering from mental illness or severe mental impairment;

ii. that the offender's mental disorder is of a nature or degree which warrants his detention in a hospital for medical treatment; and

b. an opportunity has been given to the Department (see paragraph 147) to make representations to the court concerning the making of such an order; and

c. the offender is described by each of the medical practitioners whose evidence is taken into account as suffering from the same form of mental disorder; and

d. the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that a hospital order is the most suitable method of dealing with the case.

138 The power to make a guardianship order may be exercised if:-

a. the court is satisfied on the oral evidence of a Part II doctor and on the written or oral evidence of one other medical practitioner that the offender is suffering from mental illness or severe mental handicap which warrants his reception into guardianship;

b. the court is satisfied, on the written or oral evidence of an approved social worker, that it is in the interests of the welfare of the offender that he should be received into guardianship; and

c. the offender has attained the age of 16 years; and

d. the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender and to the other available methods of dealing with

him, that a guardianship order is the most suitable method of dealing with the case.

139 Where a patient is admitted to hospital under a hospital order or placed under guardianship by a guardianship order, any previous application for admission or guardianship and any previous hospital or guardianship order still in existence 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 under the later order.

140 The court may not, at the same time as making a hospital or guardianship order in respect of ar offender, pass a sentence of imprisonment or impose a fine or make a probation order (in this context "sentence of imprisonment" includes any sentence or order for detention, including an order under section 74(1) (a) or (e) of the Children and Young Persons Act (NI) 1968); but the court may otherwise make any other order which it has the power to do.

Restriction orders

141 Article 47 empowers the courts, when making a hospital order, to make in addition a restriction order. Orders restricting discharge may be made under Article 47 only when a hospital order is also made, not when a guardianship order is made.

142 The requirement for the making of a restriction order is that it appears to the court, having regard to:-

i. the nature of the offence; and

ii. the antecedents of the offender; and

iii. 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.

Medical evidence

143 On all occasions in which a remand for report, remand for treatment, interim hospital order, hospital order, guardianship order or restriction order is to be made, the oral evidence of a Part II doctor is required. On most occasions the written or oral evidence of one other medical practitioner is also required. Medical reports should normally be submitted in writing to the court in advance of the hearing and the doctors should be prepared to give oral evidence if required.

Arrangements for reports on defendants in custody

144 When the remand or committal for trial is in custody, the medical officer of the prison or remand centre will normally ask the Board for the area in which the prison or centre is situated to arrange for a doctor, usually from the staff of the local hospital, to visit and examine the patient. The doctor called in to examine the patient must be a Part II doctor.

Need for separate medical reports from each doctor

145 Each of the 2 doctors must make a separate report to the court - though one may, if he wishes, merely express agreement with the views and recommendations of the other. The immediate object of the reports is to give the court the medical evidence on which it may, if it thinks fit, found a hospital or guardianship order, or to inform the court that in the opinion of the reporting doctors the grounds for such an order do not exist. After making the examination and before preparing their reports the 2 doctors should confer together on whether the conditions specified in Article 44(2) are satisfied. If they do not consider detention in hospital or guardianship necessary they should say so and may indicate for the assistance of the court any other form of care or treatment, which, if the court did not impose a sentence involving detention, they would consider useful. If the doctors recommend a hospital order they should indicate in their reports, in order to help the court to decide whether to make a restriction order, whether they consider the offender's mental condition to be such that, if he is at large, there is a risk of his committing offences of serious harm to the public. The doctors' reports should be sent to the court before the date on which the offender is due to appear.

146 The Order requires 2 reports before a hospital order is made, but there is no limit to the number of doctors who may examine the patient (the defence may, for example, commission further reports) and there is nothing to prevent 2 reports being furnished to the court even if other doctors have disagreed on the need for hospital treatment. It is, however, desirable that the court should be aware of any difference of view.

Opportunity for the Department to be heard in court

147 The Department of Health and Social Services has been given the right under the Order to make representations in any court where the making of an order for remand for a report or treatment, an interim hospital order, a hospital order or a restriction order is under consideration. In practice this function has been delegated to Boards. The Board will therefore be notified in writing, by the Chief Clerk in respect of Crown Courts and the Clerk of Petty Sessions in respect of courts of summary jurisdiction, of the date and time of hearing of any case where the outcome is likely to be an order committing a patient to hospital. In addition, it is expected that the consultant intending to advise the court that a patient should be sent to hospital will have discussed and agreed this course of action with his colleagues in the proposed receiving hospital. At the same time he will have discussed the admission with the Board's Chief Administrative Medical Officer to ensure that the prospective responsible Board and its representative at the court can be made aware of the position as soon as possible. In this way it is hoped to avoid any problems but where objections or difficulties do arise they can be fully aired and considered by the court. The final decision as to the making of such orders will however still rest with the court.

Place of safety pending admission to hospital

148 If the hospital can admit the patient within 28 days of the court's sitting, but not immediately, the court may make a hospital order and also make an order under Article 46(4) for the patient to be detained in a place of safety while awaiting admission to hospital. "Place of safety" in Part III of the Order is defined as any Royal Ulster Constabulary station or any prison or any hospital of which the administering Board is willing temporarily to receive him.

149 If an order is made for a patient's detention in a place of safety under Article 46(4), he may be detained there for not more than 28 days. There are no provisions for discharge or leave of absence. If the patient escapes, Article 132 allows him to be retaken by the person who had his custody immediately before his escape or by a constable or an approved social worker, or by any officer on the staff of the hospital to which he is due to be admitted, or any person authorised in writing by the responsible Board. If the hospital order was not accompanied by a restriction order, he may not be retaken after the time limits described in Article 29(3). (If the hospital order was accompanied by a restriction order, he may be retaken without limit of time. Article 56(4) provides in effect that time ceases to run while ex-prisoner patients (who represent the majority of patients subject to restrictions of fixed duration) are at large; or they remain liable to recapture indefinitely.) If he is retaken, the time during which he was absent does not count towards the 28 days for which he may be detained in a place of safety.

Rights of appeal against conviction and sentence

150 All patients admitted to hospital on a hospital order will have certain rights of appeal either to the Court of Appeal or the county court. A leaflet describing the rights of appeal and the appeal procedures should be made available to the patient at the hospital concerned so that if he wishes to appeal he will be aware of the procedure to be followed. The specimen leaflets prepared by the Department can be used for this purpose (see paragraph 3). If a patient appeals from the decision of a court of summary jurisdiction to a county court he must be present in court when his appeal is heard. On the day of hearing, of which the hospital authorities will be notified by the county court, he should be taken to the court with an escort.

151 If the patient appeals to the Court of Appeal, he will not necessarily have to appear before the court, but if the court wishes him to be present he should similarly be taken with an escort. If he is subject to a restriction order, the Northern Ireland Office should be notified as soon as it is known the court wishes him to be present; the Secretary of State will then issue a direction under Article 48(5) authorising his production before the court. If any patient who is required to appear before the court is, in the opinion of the responsible medical officer, unfit to appear, the county court or the Master of the Court of Appeal should be notified immediately. If on appeal the patient's conviction is quashed or another sentence is substituted for the hospital order the authority for his detention in hospital lapses automatically (but see paragraph 139).

Effect of a hospital order without restrictions or of a guardianship order

152 The effect of a hospital order is, first, to confer authority on a constable, an approved social worker or any other person directed by the court to convey the patient to the hospital designated by the Department* within 28 days and, second, to confer authority on the Board administering the hospital to admit the patient within that period and to detain him. The effect of a guardianship order is to confer on the Board or person named on the order the same powers as a guardianship application made and accepted under Part II of the Order.

153 A patient admitted to hospital under a hospital order without restriction or placed under guardianship by a guardianship order is treated essentially the same as a patient admitted to hospital or placed under guardianship under Part II of the Order. The necessary modifications to the provisions of Part II are made in Part I of Schedule 2 to the Order. The major difference between a Part III patient and one admitted under Part II is that the power of the patient's nearest relative to discharge him from hospital or guardianship does not apply to Part III patients.

Effect of a hospital order with a restriction order

154 When a patient is admitted to hospital on a hospital order accompanied by a restriction order he is subject to the special restrictions and modifications set out in Articles 47 and 48 of the Order.

155 The patient may not be given leave of absence or be transferred to another hospital or to guardianship or be discharged except with the Secretary of State's consent, although a restricted patient can also apply to be discharged by the Mental Health Review Tribunal (see paragraph 198). Requests for consent to leave of absence, transfer or discharge should be sent to the Northern Ireland Office by the responsible medical officer. When consent to transfer is given, the document in which consent is given should be attached to the authority for transfer and sent with it to the receiving hospital, a copy being kept by the hospital which the patient is leaving.

156 The authority for detention does not expire while the restriction order is in force. It does not, for example, expire if a patient absents himself without leave and is not returned to hospital within the periods mentioned in Article 29; the patient may be returned to the hospital under that Article at any time so long as the restriction order is in force.

157 It is, however, the duty of the responsible medical officer to keep continually under review the suitability for discharge of all patients who are subject to restriction on discharge, as of all other patients, and under Article 47(5) he is obliged to report at least annually to the Secretary of State on each restricted patient in his care.

158 The Secretary of State is given powers under Article 48(2) to discharge patients subject to restriction orders. If the Secretary of State (or the Mental Health Review Tribunal) discharges a patient the discharge may be conditional or absolute. A patient who is conditionally discharged may be recalled to hospital by the Secretary of State at any time during

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* This function has been delegated to Boards.

the currency of the restriction order. The conditions which the Secretary of State would normally think it appropriate to attach to a conditional discharge are that the patient should live in a particular area and be under the supervision of a consultant psychiatrist and a responsible person (usually a social worker) who would undertake to submit reports to the Secretary of State on the patient's progress from time to time and to inform the Secretary of State if the patient's mental condition appeared to be deteriorating.

159 If a patient subject to a restriction order is absent from the hospital without leave the Northern Ireland Office should be informed at once and also told when he returns. The local police should also be notified (see paragraphs 247-251).

160 A restriction order ceases to have effect at the end of any period named in the order by the court or may be brought to an end at any time by the direction of the Secretary of State under Article 48(1). When this happens, Article 47(4) provides that the patient is to be treated as though he had been admitted to hospital in pursuance of a hospital order without a restriction order made on the date on which the restriction order ceased to have effect.

Transfer to hospital of prisoners

161 Articles 53-59 make provisions for the transfer on the direction of the Secretary of State from penal institutions to hospitals of people suffering from mental disorder. Different considerations apply to sentenced prisoners from those which apply to unsentenced prisoners because of the need ultimately to bring the latter before a court or to resolve in some other way the proceedings in which they are involved. There are further distinctions between different categories of unsentenced prisoners. Articles 53, 55 and 56 apply to sentenced prisoners: Articles 54, 55, 57, 58 and 59 apply to the various categories of unsentenced prisoners.

Sentenced prisoners

162 The power to transfer sentenced prisoners applies to any person serving a sentence of imprisonment or other form of detention. The power may be exercised only if:-

a. the Secretary of State is satisfied by written reports from at least 2 medical practitioners, one of whom must be a Part II doctor:

   i. that the person is suffering from mental illness or severe mental impairment; and
   ii. that the mental disorder is of a nature or degree which warrants the prisoner's detention in hospital for medical treatment; and

b. both medical reports describe the prisoner as suffering from the same form or one of the same forms of disorder; and

c. the Secretary of State is of the opinion, having regard to the public interest and all the circumstances, that it is expedient to direct the prisoner's transfer.

If transfer to a hospital is recommended, the Northern Ireland Office will, if satisfied that it is right to do so, issue a transfer direction - ie a warrant directing the patient's transfer.

Sentenced prisoners - transfer directions with or without restriction directions

163 A transfer direction has the same effect as a hospital order made by a court without an order restricting discharge (see paragraphs 152 and 153). The direction is valid for 14 days, after which a fresh direction will be necessary if the patient has not been admitted to hospital.

164 When giving a transfer direction in respect of a sentenced prisoner, the Secretary of State has discretion also to give a restriction direction under Article 55. This direction has the same effect as a restriction order made by the court (see paragraphs 154-160).

165 A restriction direction ceases to have effect on the date when the prisoner's sentence would have ended if he had remained in prison. Under Article 56(3) this date is calculated taking into account any remission of sentence to which the prisoner would have been entitled if he had not been transferred. Hospitals will be notified at the time of transfer of the date on which restrictions will expire, but if a patient has been absent without leave before that date the period of absence does not count towards the period of sentence. If any such patient is absent without leave the hospital should inform the Northern Ireland Office of the absence and when he returns to the hospital. The Northern Ireland Office will then advise the hospital of the effect on the period of restriction.

166 Where both a transfer direction and a restriction direction are in force, the Secretary of State may direct the patient's return to prison (or another penal institution) or discharge him from the hospital on the same terms on which he could be released from prison. Before he can return a patient to prison the Secretary of State must first be notifed by the responsible medical officer, the Review Tribunal or any Part II doctor that the patient no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital to which he has been transferred. The responsible medical officer should notify the Northern Ireland Office at once in writing if he considers that a patient meets these criteria. If the Secretary of State decides that a patient should be returned to a prison or other institution he will issue a warrant directing the patient's removal from the hospital under Article 56 of the Order.

167 The restriction on discharge on any patient transferred under Article 53 may be terminated at any time by the Secretary of State. When this is done or when the period of restriction indicated in the transfer direction expires, the position of the patient and his nearest relative will be as described in paragraph 153. The patient may also be discharged from hospital with the consent of the Secretary of State and

in certain circumstances by the Mental Health Review Tribunal (see paragraphs 207 and 208).

Other prisoners

168 The power to transfer prisoners other than those covered by Article 53 applies to:-

a. all other persons detained in a prison or remand centre including:

b. persons remanded in custody by a magistrates court;

c. civil prisoners other than those covered by Article 53; and

d. persons detained under the Immigration Act 1971.

169 The power may be exercised only if the Secretary of State is satisfied by reports similar to those required by Article 53 that:-

a. the person is suffering from mental illness or severe mental impairment; and

b. the mental disorder from which the person is suffering is of a nature or degree which warrants his detention in hospital for medical treatment; and

c. the person is in urgent need of such treatment.

170 As with transfer directions given under Article 53, both reports must describe the prisoner as suffering from the same form or at least one of the same forms of mental disorder and the direction is valid for 14 days. The effect of the direction is the same (see paragraph 163). When giving a transfer direction in respect of a prisoner in categories (a) and (b) of paragraph 168 the Secretary of State MUST also give a restriction order, and when giving a transfer direction in respect of a prisoner in categories (c) and (d) he MAY give a restriction direction.

171 The consequence of a transfer direction given in respect of a prisoner in category (a) of paragraph 168 are as follows. (In such cases there will invariably be a restriction direction as well, as explained in the previous paragraph.) The transfer direction will cease to have effect when the patient's case has been fully dealt with by the appropriate court. Alternatively, if meanwhile the Secretary of State is notified by the responsible medical officer, the Review Tribunal or any Part II doctor that:-

i. the patient no longer requires treatment in hospital for mental disorder; or

ii. no effective treatment for his disorder can be given in the hospital to which he has been transferred,

the Secretary of State may direct the patient's return to prison (or other penal institution).

172 Another alternative is that the court may order the patient to be returned to prison or released on bail if satisfied on the written or oral evidence of the responsible medical officer as to either of the conditions in (i) or (ii) above.

Finally if:-

a. it appears to the court that it is impracticable or inappropriate to bring the patient before it; and

b. the court is satisfied on the oral evidence of 2 Part II doctors that the patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; and

c. the court is of the opinion that it is proper to make such an order,

the court may make a hospital order (with or without a restriction order) in the patient's absence and, in the case of a person awaiting trial, without convicting him.

173 The consequences of a transfer direction given in respect of a prisoner in category (b) of paragraph 168 are as follows. (In these cases too there will invariably be a restriction order as explained in paragraph 170.) The transfer direction will cease to have effect on the expiration of the period of remand to which the prisoner was subject unless he is then committed in custody to the Crown Court or otherwise dealt with. The prisoner may be further remanded without being brought before the court, but only if he has appeared before the court in the previous six months; and if the prisoner is further remanded in custody the transfer direction will continue in effect. Alternatively, the magistrate's court may terminate the transfer direction, if satisfied on the written or oral evidence of the responsible medical officer, that the patient no longer requires treatment in hospital for mental disorder or that no effective treatment can be given in the hospital to which he has been transferred. The magistrate's court may conduct committal proceedings in the absence of the patient, if satisfied on the written or oral evidence of the responsible medical officer that the patient is unfit to take part in the proceedings and if the patient is legally represented; and if the patient is committed to the Crown Court and the magistrate's court has not terminated the transfer direction on the grounds that the patient no longer requires treatment etc, the provisions of Article 57 (see paragraph 171) will apply.

174 The consequences of a transfer direction given in respect of a prisoner in categories (c) or (d) of paragraph 168 are as follows. In all cases the direction will cease to have effect on the expiry of the period during which the prisoner would have been liable to be detained. However, in cases where a restriction direction has been given as well as a transfer direction, the Secretary of State may direct the patient's return to prison if he is notified by the responsible medical officer, the Review Tribunal or any Part II doctor that the patient no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital to which he has been transferred.

Detention during Her Majesty's pleasure

175 Article 52 of the Order applies in the comparatively unusual circumstances where a serviceman is found to be not guilty by reason of insanity or unfit to stand trial by a court martial and ordered to be detained "during Her Majesty's pleasure" ie indefinitely. It gives the Secretary of State power to direct the detention of such a person in hospital as if subject to a hospital order with restrictions.

Unfitness to be tried and finding of insanity

176 Articles 49 and 50 make provision for persons who are unfit to be tried or who are found by the court to be not guilty on grounds of insanity. In the event of either of these findings the court must make an order under Article 49(6) or Article 50(2) the effect of which is that the person will be detained as if he were subject to a hospital order together with a restriction order made without limit of time.

177 Because a patient admitted to hospital under Article 49 will not have been tried he may, if he recovers sufficiently, be remitted to prison by warrant of the Secretary of State for this purpose. The general principle observed is that a person who has been accused of an offence ought, if possible, to be brought to trial so that he may have the opportunity of having his guilt or innocence determined by a court. Since orders under Articles 49 and 50 have the like effect of a hospital order with restrictions on discharge, patients subject to such orders have the same rights of appeal to the Review Tribunal as do other Part III patients.

PART IV - CONSENT TO TREATMENT

Introduction

178 Part IV of the Order (Articles 62-69) is concerned with the treatment of mentally disordered people, both with and without their consent. However, the provisions apply only to treatment for mental disorder, and the treatment must be "medical treatment" as defined in the Order, ie treatment, including nursing, care and training under medical supervision. They do not apply to treatment for a physical disorder (for example, an appendectomy), or for social purposes (for example, a non-therapeutic sterilisation). Such treatment is outside the scope of the Order and is governed by the rules of common law. In very broad terms, these rules allow patients to be given treatment but only where they have given express consent, or to prevent them doing harm to themselves or to other people or to property, or in cases of necessity (the best example of this is the case of an unconscious road accident victim).

179 The Order provides for 2 distinct categories of treatment, each with its own level of procedural safeguards.

(i) The first category covers the most serious forms of treatment and requires both the patient's consent and a second medical opinion (paragraphs 181-184). These requirements must be observed in every case where it is proposed to give a form of treatment which falls into this category, whether or not the patient is liable to be detained. In other words, they apply not only to patients who are liable to be detained under the Order (including patients admitted for assessment and patients listed in paragraph 180) but to anyone suffering from mental disorder (including voluntary patients and people who are subject to guardianship).

(ii) The second category covers other serious forms of treatment and requires either the patient's consent or a second medical opinion (paragraphs 185-187). With the exception of the patients listed in paragraph 180, treatments in this category may be given to patients who are liable to be detained under the Order (including patients admitted for assessment) with or without their consent, but only if the requirements for consent or a second opinion are complied with. These safeguards do not apply to patients listed in paragraph 180 or to people who are not liable to be detained under the Order (including voluntary patients and people who are subject to guardianship). Treatments in the second category can only be given to such patients in accordance with the principles of common law, that is with the patient's consent or in certain emergency situations (see paragraph 178).

In certain circumstances (see paragraphs 193 and 194), the safeguards provided for both these categories of treatment can be set aside if the treatment is required urgently, and in the case of treatments in the first category, they can be dispensed with, whether or not the patient is liable to be detained. All other forms of treatment for mental disorder not falling within either of the 2 categories, such as nursing care, occupational therapy etc, can be given to detained patients (except those listed in paragraph 180 but including patients admitted for assessment)

without their consent or a second opinion, provided the treatment is given by the responsible medical officer or under his direction. The Order does not give any statutory authority to impose these treatments upon any other people (for example, voluntary patients and people subject to guardianship), and, as a result, if such treatments are necessary, the common law has to be relied upon for the authority to do so.

180 Although certain patients are liable to be detained under the Order, the consent to treatment provisions do not apply to them, except to the extent that the provisions relating to forms of treatment in the first category (treatments requiring consent and a second opinion) apply to them. These are:

a. in-patients detained for up to 48 hours on a doctor's report (Article 7(2)) or for up to 6 hours under the nurses' holding power (Article 7(3));

b. accused patients remanded to hospital for a report on their mental condition (Article 42);

c. offenders admitted to hospital as a place of safety under a direction made by the court for up to 28 days following the making of a hospital order (Article 46(4));

d. persons suffering from or believed to be suffering from mental disorder and removed to a place of safety by a warrant made under Article 129 or found in a public place and removed to a place of safety under Article 130 for up to 48 hours;

e. a restricted patient who has been conditionally discharged under Article 48(2), 78 or 79 and has not been recalled to hospital;

Such patients are in the same position as voluntary patients with regards treatment.

Treatment requiring consent and a second opinion

181 Only one treatment - psychosurgery (any surgical operation for destroying the functioning of brain tissue) - is specified on the face of the Order as a form of treatment requiring consent and a second opinion (Article 63). This Article also provides that other forms of treatment can be specified in Regulations and, accordingly, Regulation 6(1) specifies "the surgical implantation of hormones for the purpose of reducing male sexual drive". There is also provision in Article 111(2) which enables the Department to specify additional forms of treatment in the Code of Practice. Treatments specified as above can only be given if the patient has given his consent and 3 independent people appointed by the Mental Health Commission, one of whom must be a medical practitioner, have certified that the patient understands the treatment and has consented to it.

Obtaining and validating consent

182 Where it is proposed to give any of these most serious forms of treatment the responsible medical officer should in the first instance seek the

patient's consent in the normal way. He should explain to the patient in simple terms the nature, purpose and likely effects of the treatment. If the patient is not considered to be capable of giving valid consent or if he does not give his consent the treatment cannot be given. If the patient consents to the treatment and appears to have understood the explanation given to him, the responsible medical officer should contact the Mental Health Commission. The Commission will send a Part IV doctor* who may be a medical commissioner, and two other appointed persons, who are not doctors (and who will probably be non-medical commissioners), to consider the validity of the consent. They must be allowed to interview, or, in the case of the doctor, examine, the patient, in private if they wish, and the doctor may also require the production of and inspect any records relating to the treatment of the patient.

Obtaining a second opinion

183 If the Part IV doctor and the two appointed persons agree that the consent is valid, they will jointly issue a certificate (Form 21, Part 1) to the effect that the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it. This certificate is not a substitute for a standard consent form, which should be obtained. The Part IV doctor has also to consider whether the treatment is appropriate, and, if he is satisfied as to this, will issue a certificate (Form 21, Part II) to the effect that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, it should be given.

Need to consult others concerned in the patient's treatment

184 Before he issues this certificate, the Part IV doctor is required to consult such person or persons as appear to him to be principally concerned with the patient's treatment. This will, of course, include the responsible medical officer himself, and should invariably include the nurse in charge of the patient's ward or other nurse who has been caring for the patient. It should also include any other professional (psychologist, social worker, occupational therapist etc.) involved in the patient's treatment who may reasonably be expected to have an informed view on the suitability of the proposed treatment. The responsible medical officer should provide the Part IV doctor with the relevant documents and the names of other professionals involved in the case. Arrangements should then be made for the Part IV doctor to see the professionals he wishes to see. The original of Form 21, the two parts of which constitute the authority for proceeding with the treatment, should be retained with the patient's records and a copy sent immediately to the Mental Health Commission.

Treatment requiring consent or a second opinion

185 Two forms of treatment have been specified for the purposes of Article 64. These treatments can be given where the patient has consented or a Part IV doctor has certified that either the patient is not capable of giving his consent or that the patient should receive the treatment even though he has

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* See the footnote on page 1 for an explanation of the term "Part IV doctor."

not consented to it. Article 64 itself specifies the administration of medicine for mental disorder if 3 months or more have elapsed since medicine was first given during that particular period of detention and Regulation 6(2) specifies electroconvulsive therapy. There is no provision to have any treatments for the purposes of Article 64 specified in the Code of Practice.

186 It should be noted that during each period of detention that

(i) a course of medication for mental disorder can be given to a patient for up to 3 months without consent and without the need to consult or to obtain an independent medical opinion;

(ii) the 3 month period will run from the day after medicine was first administered as a form of treatment for mental disorder regardless of whether there was an interval during which no medicine was given.

Procedure for obtaining consent or a second opinion

187 If a patient is considered to be capable of giving valid consent to a form of treatment which comes under Article 64, and which the responsible medical officer has proposed and explained to the patient, the responsible medical officer or a Part IV doctor must certify in writing that the patient is capable of understanding the nature, purpose, and likely effect of the treatment and has consented to it. Form 22 must be used for this purpose, whether or not a standard consent form has also been completed. The original of Form 22 should be retained with the patient's records and a copy sent immediately to the Mental Health Commission. If the patient does not consent to a treatment to which Article 64 applies or is considered to be incapable of giving valid consent, and the responsible medical officer, having considered the alternatives, continues in the opinion that the patient needs that particular form of treatment, he should contact the Mental Health Commission. The Commission will arrange for a Part IV doctor to examine the patient, to consult with those who appear to be principally concerned with the patient's medical treatment and to give a second opinion as described in paragraph 184. The Part IV doctor must use Form 23 for this purpose, and when certifying that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given, will also certify either that the patient is not capable of understanding the nature, purpose and likely effect of the treatment or that the patient has not consented to that treatment. Form 23 should be retained with the patient's records and a copy sent immediately to the Commission. In the case of the administration of medicine, the responsible medical officer may, instead of contacting the Commission for a Part IV doctor, himself obtain the second opinion from a Part II doctor* who must carry out the requirements of the Order in the same way as a Part IV doctor. The Part II doctor can be a doctor on the staff of the hospital in which the patient is detained but obviously could not be the responsible medical officer himself (and, indeed, the Order expressly forbids this).

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* See the footnote on page 1 for an explanation of the term "Part II doctor"

Plans of treatment

188 Article 65 states that any consent or certificate obtained for the purposes of Article 63 or 64 may relate to a plan of treatment which may involve one or more of the treatments specified under the same Article and may include a timescale for their administration. For example, electro-convulsive therapy is usually given as a planned series of treatments rather than an individual treatment. If a plan of treatment is being considered by a Part IV doctor (or a Part II doctor giving a second opinion), he will consider the whole plan and will accept or reject it as a whole. However it is expected that there will in each case be scope for discussion between the responsible medical officer and the second opinion doctor about details of the plan, so that a generally sound plan need not be rejected because of a minor disagreement. An outline of the plan will appear on the certificate, and the plan will of course be described in detail in the patient's medical records.

Withdrawal of consent

189 Article 66 entitles a patient to withdraw his consent to any treatment or plan of treatment under Article 63 or 64. Where a patient withdraws his consent the remainder of the treatment must be considered as a separate treatment. This means that if the patient withdraws his consent to an Article 63 treatment it must not be given or, if a plan of treatment is in progress, the treatment must cease immediately unless one of the criteria for urgent treatment described in paragraphs 193 and 194 is met. If a patient withdraws consent to a treatment or plan of treatment specified for the purposes of Article 64, the responsible medical officer must stop the treatment - unless the circumstances are such that it can be given as urgent treatment - until the requirements of that Article relating to a non-consenting patient can be complied with.

Review of treatment: reporting to the Mental Health Commission

190 Where a patient is given treatment under Article 63 or 64, the responsible medical officer must report to the Mental Health Commission on the treatment and on the patient's condition:

a. when the authority to detain the patient is being renewed under Article 13 of the Order; and

b. at any other time the Commission requires him to do so.

191 In the case of a patient subject to a restriction order or direction the report must be made:

a. six months after the date of the restriction order or direction if the treatment was given in that period;

b. if the treatment is given more than six months after the date of the restriction order or direction, the next time the responsible medical officer makes a report to the Secretary of State under Article 47(5) (paragraph 157);

c. at any time the Commission requires him to do so.

192 The Commission may, in effect, at any time direct that a form of treatment should cease to be given by giving notice to the responsible medical officer that the certificate authorising the treatment shall not apply to the patient after a specified date. If the responsible medical officer wishes to continue treatment after that date he will again have to go through the procedure set out above (paragraphs 181-188) unless the grounds for urgent treatment described in paragraphs 193-195 are met.

Urgent treatment

193 Article 68 describes the circumstances in which treatments specified for the purposes of Articles 63 and 64 may be given without the patient's consent, or without a certificate, to a patient who is not capable of giving valid consent. Any treatment may be given which is immediately necessary to save the patient's life. Treatments for mental disorder will of course seldom come into this category. Treatment for physical disorder is not covered by the Order, and doctors should follow their usual policy; for example, if a brain tumour is incidentally causing mental disorder, surgery to remove it would not come under Article 63, since it would not be primarily a form of treatment for the incidental mental disorder.

194 Other urgent treatments which may be given are:

i. a treatment which is not irreversible and is immediately necessary to prevent a serious deterioration in the patient's condition (a treatment is considered to be irreversible if it has unfavourable irreversible or psychological consequences);

ii. a treatment which is not irreversible or hazardous and is immediately necessary to alleviate serious suffering by the patient (a treatment is considered to be hazardous if it entails significant physical hazard); or

iii. a treatment which is not irreversible or hazardous, is immediately necessary, and represents the minimum interference necessary to prevent the patient behaving violently or being a danger to himself or others.

Urgent treatment within the meaning of Article 68 must cease as soon as the crisis which led to its being given has been successfully resolved.

195 A course of treatment or a plan of treatment may be continued where the patient has withdrawn his consent, or where the Mental Health Commission has given notice invalidating a certificate of consent (paragraph 192), if the responsible medical officer considers that discontinuing the treatment abruptly would cause serious suffering to the patient. In all such cases treatment may be continued only until the provisions of Article 63 or 64, as the case may be, can be complied with. Treatment must cease as soon as its cessation will no longer cause serious suffering.

196 Where urgent treatment is given or treatment is continued in the circumstances described in the previous paragraphs, the responsible medical

officer is required to notify the Mental Health Commission immediately as to:

a. the nature of the treatment given to the patient; and

b. - which of paragraphs (a) to (d) of Article 68(1) applied in relation to the patient - in other words, the circumstances which made it necessary to give the treatment.

PART V - THE MENTAL HEALTH REVIEW TRIBUNAL

Introduction

197 The Mental Health Review Tribunal is an independent body set up under Article 70 of, and Schedule 3 to, the Order. Its function is to provide mentally disordered patients with a safeguard against unjustified detention in hospital or control under guardianship by means of a review of their cases from both the medical and non-medical view points. There are two ways in which a patient's case may come to be considered by the Tribunal:

(i) **by application**; which is usually made by the patient himself but which may in certain circumstances be made by his nearest relative;

(ii) **by referral**; which can be either discretionary or mandatory (see paragraphs 200 and 201).

The address of the Tribunal is given in Appendix 2

Right to apply - patient

198 Patients detained in hospital or subject to guardianship have a right to apply to the Tribunal on the following occasions:

Non-offender patients:

(a) once during the first 6 months of detention or guardianship. The application may be made at any time beginning with the date of admission to hospital for assessment or acceptance of the guardianship application;

(b) once during the 6 month period beginning with the date of the first renewal of the authority for detention or guardianship;

(c) once during each subsequent 12 month period for which detention or guardianship is renewed.

Unrestricted offender patients: the same as for non-offender patients, with the date of the hospital order or transfer direction counting as the date of admission to hospital or acceptance into guardianship.

Restricted patients: once in the 6 months period beginning with the date of the hospital order or transfer direction, once in the period of 6 months following that initial 6 month period, and once in each subsequent 12 month period of detention in hospital.

Conditionally discharged patients: if not recalled to hospital, once in the first 12 month period following conditional discharge and annually thereafter; if recalled to hospital, the Secretary of State must refer

such cases to the Tribunal within one month of their return to hospital (see paragraph 201).

Right to apply - nearest relative

199 The nearest relative of a patient detained in hospital or subject to guardianship may apply to the Tribunal on the occasions set out below:

Non-offender patients:

(a) once within the first 28 days from the date on which the nearest relative is informed that his order for the patient's discharge from detention or guardianship has been barred by the responsible medical officer under Article 14(4) or by the responsible medical officer and an authorised social worker under Article 24(4);

(b) where the nearest relative is barred from acting as such by a county court order under Article 36 he may apply to the Tribunal once in the first 12 months following the date of the court order and once in each 12 month period for the duration of that order.

Unrestricted offender patients: to compensate for the absence of a right to order the patient's discharge, the nearest relative has a right to apply to the Tribunal once during the first 12 month period of detention in hospital or reception into guardianship and every 12 months thereafter.

Discretionary referrals

200 The case of a patient liable to be detained in hospital or subject to guardianship under the Order **may** be referred to the Tribunal on the following occasions:

Non-offender patients and unrestricted offender patients; at any time by the Attorney General, the Department or the Master (Care and Protection).

Restricted patients; at any time by the Secretary of State.

All detained patients or persons subject to guardianship; the Mental Health Commission has power under Article 86(3)(a) to refer the case of any person who is liable to be detained or who is subject to guardianship under the Order to the Tribunal at any time.

A case referred in any of the above circumstances must be considered at a properly constituted hearing of the Tribunal.

Mandatory referrals

201 Patients subject to detention in hospital or guardianship must be referred to the Tribunal in the following circumstances:

Non-offender and unrestricted offender patients: by the responsible Board, if the patient's case has not been considered by the Tribunal for 2 years (1 year if the patient is under 16 years of age). The case does

not have to be referred to the Tribunal as soon as the 2 year period has elapsed but at the next renewal of the authority for the patient's detention or guardianship.

Restricted patients: by the Secretary of State, if the patient's case has not been considered by the Tribunal for 2 years.

Conditionally discharged patients: if such a patient is recalled to hospital, the Secretary of State must refer his case to the Tribunal within one month of his return to hospital.

References by the Secretary of State must be considered at a properly constituted hearing of the Tribunal. However hearings in the case of references by Boards are held at the discretion of the Tribunal.

Powers of the Tribunal

202 When the Tribunal comes to consider any particular case it has a range of powers which largely depend on the status of the patient whose case is being decided. The powers applicable in relation to the various categories of patient are set out in paragraphs 203-209.

Non-offender and unrestricted offender patients(Article 77)

203 The powers available to the Tribunal in relation to these patients are as follows:

(i) the patient **may** be discharged at the discretion of the Tribunal;

(ii) the Tribunal has a **duty** to discharge the patient if it is satisfied that one or more of the criteria for detention in hospital or remaining in guardianship, as the case may be, no longer applies. Where the case being considered is one in which the patient's discharge by his nearest relative was barred by the responsible medical officer under Article 14(4) the Tribunal must be satisfied that the patient would, if discharged, receive proper care;

(iii) the Tribunal has power to direct the delayed discharge of the patient at a specified date. It might exercise this option where time is needed to make alternative arrangements for the care of the patient;

(iv) the Tribunal can recommend that these patients should have leave of absence, be transferred to another hospital or transferred from hospital into guardianship. If the Tribunal's recommendation is not complied with, it may reconsider the case.

Patients subject to restriction orders (Article 78)

204 The Tribunal has no discretionary powers to discharge these patients, neither can it direct delayed discharge (except in cases of conditional discharge) nor recommend leave of absence, transfer to another hospital or into guardianship, and although the Tribunal may discharge restriction

order patients the Secretary of State retains his discretionary powers to discharge and to terminate restrictions.

205 The powers available to the Tribunal in relation to restriction order patients are:-

(i) it must direct the absolute discharge of these patients if it is satisfied that one or more of the criteria for continued detention in hospital is not met and that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment;

(ii) if satisfied that it is appropriate for the patient to remain liable to be recalled for further treatment, the Tribunal must direct a conditional discharge;

(iii) the Tribunal may defer a decision to conditionally discharge a patient until it is satisfied suitable arrangements have been made for this purpose. In practice this will mean that the Tribunal will require the responsible Board to submit proposals for the patient's accommodation, supervision and aftercare, for its approval.

206 Conditionally discharged patients may be recalled to hospital by the Secretary of State at any time. They must comply with any conditions imposed by the Tribunal at the time of discharge or by the Secretary of State thereafter. The Secretary of State may at any time alter the conditions whether imposed by him or the Tribunal. Where a restriction order is removed or expires after the patient is conditionally discharged he is then treated as absolutely discharged.

Patients subject to restriction directions (Article 79)

207 Patients subject to a restriction direction given by the Secretary of State (see paragraph 164) are liable to resume serving their prison sentence or to be brought before a court to stand trial if they no longer require treatment in hospital. The Tribunal cannot therefore authorise discharge in the normal way. Instead it has to notify the Secretary of State if it finds that the patient would be entitled to be conditionally or absolutely discharged had he been subject to a hospital order with restrictions. If the Tribunal notifies the Secretary of State that the patient would be entitled to a conditional discharge, it may at the same time recommend that if the patient cannot be discharged he should continue to be detained in hospital rather than be returned to prison.

208 In the case of a sentenced prisoner, it may be that the Secretary of State is able to agree to the discharge. The Secretary of State has 90 days from the date of notification of the Tribunal's finding in which to give notice that the patient may be discharged: if he does not do so, the patient must be returned to prison unless the Tribunal has made a recommendation that in these circumstances he should remain in hospital.

209 In the case of a patient who was originally a remand prisoner or other prisoner transferred to hospital under Article 54(2) (civil prisoners and persons detained under the Immigration Act 1971, etc) the

Secretary of State has no discretion. Unless the Tribunal has made a recommendation that the patient be detained in hospital he must return the patient to prison.

How to apply

210 Applications to the Tribunal must be made in writing, signed by the applicant or any person authorised by him to do so on his behalf and addressed to the Tribunal. Although there is no prescribed form of application a suitable form can be supplied to the applicant on request by either the Secretary to the Tribunal or the responsible Board which should arrange for hospitals in which patients are detained and local social services offices to hold stocks of these forms. Board staff should give patients and their relatives any help required to fill in the forms.

211 In each case only one application can be made in the period specified. This application can be made at any time during the period. An application which is withdrawn before it can be determined does not count for this purpose. However the agreement of the Tribunal is required if an application is to be withdrawn. This is to ensure that withdrawal is not the result of improper influence or has not been decided on without due consideration.

Tribunal rules

212 The Lord Chancellor has made Rules under Article 83 which provide for a code of procedure to be followed in proceedings before the Tribunal - the Mental Health Review Tribunal (Northern Ireland) Rules 1986. These impose certain duties on the responsible Board: for example the Tribunal will send a copy of each application to the Board and ask it to submit a statement giving certain information including a medical report by the responsible medical officer. The Board should inform the Tribunal immediately if the patient has no right to apply, for example if he is not subject to detention under the Order and is free to leave hospital. In all other cases the Board should forward its statement as soon as possible, and in any case within three weeks, and the Tribunal will then arrange a hearing in accordance with the Rules. Where the applicant is a restricted patient detained in hospital the Secretary of State will also provide a statement. Where the applicant is a conditionally discharged patient, the Secretary of State will provide the whole statement. The responsible Board or the Secretary of State may ask, giving supporting reasons, that part of the statement is withheld from the patient (see Rules 6(4) and 12).

213 The Tribunal has power under the Rules to obtain any information it deems necessary, including the power to subpoena witnesses. The medical member of the Tribunal will in all cases be required to examine the patient or take such steps as he considers necessary to form an opinion of the patient's mental condition. It should be noted that the patient or the applicant has also got a right to have a doctor of their choice carry out an independent medical examination of the patient. This examination may be carried out in private and the doctor involved may require any records relating to the patient's detention or treatment in hospital to be produced for his inspection. Such an independent medical examination may

be carried out either for the purpose of advising whether an application to the Tribunal should be made in the first instance or, in the case of a reference to the Tribunal, for the purposes of furnishing information for the purpose of the reference. However, restricted patients do not have a right to independent medical advice for the purposes of a reference by the Secretary of State.

Legal aid and assistance

214 Legal assistance under the Green Form Scheme is available to help patients and other applicants with limited financial resources to prepare their cases. This assistance covers all the work done by a solicitor in preparing the case, including paying for an independent medical report, where this is considered necessary by the solicitor. Patients may also be provided with legal representation at the hearing under the Assistance By Way of Representation (ABWOR) Scheme. Before assistance of any kind may be given under the Green Form Scheme, the patient must undergo a simple assessment of resources carried out by his solicitor to ensure that he qualifies on financial grounds. The solicitor must also apply to the Legal Aid Department for approval to assist by way of representation in the proceedings.

215 Green forms may be obtained from any solicitor undertaking legal aid work. The Legal Aid Solicitors List and leaflets on eligibility for legal aid are available from the Legal Aid Department at the address given in Appendix 2. In addition Health and Social Services Boards, and any member of hospital staff, including social workers, may obtain advice on Legal Aid and the availability of solicitors from that Department to assist those patients who have no access to solicitors or other legal advice.

216 The responsible Board may be represented at a Tribunal hearing by any officer they authorise for this purpose. This will normally be the responsible medical officer who should be ready to answer any questions the Tribunal may have about the patient's suitability for discharge and his home circumstances. Other people, in particular social workers, may be brought as witnesses when necessary. It is not usually necessary for the responsible Board to be legally represented.

217 Tribunal hearings are usually held at the hospital in which the patient is detained. Boards are asked to ensure that suitable rooms are made available for the Tribunal and anyone attending as a witness.

PART VI - THE MENTAL HEALTH COMMISSION

Introduction

218 Part VI of, and Schedule 4 to, the Order provide for the establishment of the Mental Health Commission for Northern Ireland, an independent, multi-disciplinary body with investigative, inspectorial and advisory functions whose role is to protect the rights and welfare of mentally disordered people and to safeguard staff involved in their care and treatment. The Commission's role is not confined to patients detained in hospital: on the contrary, its jurisdiction extends to voluntary patients, people subject to guardianship, patients in nursing homes or residential accommodation and anyone suffering, or even appearing to suffer, from mental disorder.

Role of the Commission

219 The Commission's primary function is to keep under review the care and treatment of people who are mentally disordered. This expressly includes the duty to keep under review the exercise of the powers and the discharge of the duties conferred or imposed on any person or body by the Order. Its role can therefore be seen as twofold; a protective role in relation to all mentally disordered people, and a monitoring role in relation to the operation of the Order. It has been given a wide range of duties and powers in the Order to enable it to carry out this role. Among these are duties of a general nature to bring any matters concerning the welfare of mentally disordered persons to the attention of the appropriate authority (Board, Department, Secretary of State etc.) where it considers this should be done, and a duty to give advice to any statutory body on matters arising out of the Order, if it is asked to do so. The Department has power to extend the role of the Commission by giving it additional functions.

Specific duties and powers

220 The Commission has a specific duty to investigate any case where there appears to it to be ill-treatment, or deficiency in the care or treatment of a patient, improper detention in hospital or reception into guardianship or actual or potential loss or damage of a patient's property. If need be, it has power to hold a formal enquiry to establish the facts of a case. Where, following a full investigation, the Commission is satisfied that remedial action needs to be taken, it must bring the facts to the attention of the appropriate authority. This might be the Department, the Secretary of State, a Board, a guardian or any other person having care of a mentally disordered person. Although the Commission does not have the power to enforce compliance with its recommendations or advice, it can, where it considers that it is necessary to do so, require the relevant authority or person to make a formal response within a specified period, explaining what action has been taken to remedy the situation or why no action has been taken. This power is discretionary because a formal reply would not be necessary or even desirable in every case.

221 The Commission has a statutory duty to visit and interview in private patients liable to be detained in hospital under the Order. This includes

patients on leave of absence or conditionally discharged patients. The timing and frequency of such visits is not specified and is entirely at the discretion of the Commission. However, hospitals can expect to be visited at least once a year. In practice some short term patients may not therefore receive a visit during their stay in hospital. It is expected that the Commission will normally give notice of its intention to visit a hospital but it does not have to, and on occasions may prefer to visit unannounced.

222 In addition to the above statutory duty the Commission has power, at any reasonable time, to visit, interview and medically examine in private any mentally disordered person whether he is in hospital, subject to guardianship, or in a nursing home or any form of residential accommodation. Of course only medically qualified commissioners, or doctors employed by the Commission for the purpose, can medically examine patients. The doctor can require the production of and inspect medical records relating to the detention or treatment of the patient. In addition, any non-medical member of the Commission or any person authorised by it for a particular purpose can require the production of and inspect records of a non-medical nature which relate to a patient's detention or treatment. The right to inspect records extends to those of ex-patients whose complaints can also be investigated.

223 To further assist the Commission to do its job effectively, any of its members or any person authorised by it for a specific purpose must be offered all facilities necessary to enable them to carry out their tasks. Hospital and other Board staff must therefore co-operate fully with the Commission as indeed must anyone else caring for a mentally disordered person subject to guardianship, or in a nursing home, home for persons in need or a voluntary home. To refuse access to patients or records or to obstruct an authorised person in any way in carrying out his functions under the Order is an offence under Article 125. Furthermore, the Department and Boards must provide the Commission with whatever information it requires, and Boards must forward to it copies of all prescribed forms as soon as they are completed or notify it of the procedure involved.

Other functions

224 Other functions of the Commission which are dealt with in greater detail elsewhere in the Guide are:-

i. the appointment of Part II doctors, that is the doctors, normally consultant psychiatrists, who provide the medical reports required for the purposes of compulsory detention in hospital or reception into guardianship under Part II (see paragraphs 28, 29, 46 and 49), whose oral evidence is required for the purposes of remands to hospital, hospital orders and guardianship orders under Part III (see paragraphs 126, 130, 133 and 137), on whose reports the Secretary of State may transfer prisoners to hospital under Part III (see paragraphs 162, 166, 171, 172 and 174), and who, in cases where it is proposed to administer drugs without consent, can provide the second opinion for the purposes of Part IV of the Order (see paragraph 187);

ii. the appointment of doctors and other persons to verify consent to treatment, and doctors to provide an independent second opinion under Part IV of the Order (see paragraphs 182-187);

iii. to review periodically the imposition of treatment which requires consent and/or a second opinion (see paragraphs 190-192) and to monitor the administration of urgent treatments (see paragraph 196);

iv. when requested to do so, to review a decision to withhold a postal packet; it can compel the production of items withheld for this purpose;

v. in relation to patients' property, it has a duty in certain circumstances to notify the Office of Care and Protection of any person who is incapable of managing his affairs (see paragraph 233); it can also allow Boards to hold money or valuables for a patient in excess of the amount allowed by the Department (see paragraph 234).

Reports

225 The different types of report which may emanate from the Commission are specified in paragraph 8 of Schedule 4 to the Order. These are described below.

i. The Commission is required to publish a report on its activities at regular intervals. The Department will give directions as to the form and frequency of these reports. It is expected however that the initial report will be made after 2 years and thereafter there will be an annual report. Copies of these reports must be sent to the Head of the Department (in practice, the Department) who is required to lay copies before the Northern Ireland Assembly.

ii. The Commission is free to publish such other reports on any of its activities as it thinks fit. The publication of reports could in certain circumstances be used to put pressure on bodies/persons to take remedial action where standards have been found wanting.

iii. Finally, if the Department makes a request in writing, the Commission must provide it with a report on any of the Commission's activities.

Overlap with other bodies

226 It is not intended that the Commission should replace or duplicate the work of other individuals or bodies who may be able to help patients with their problems; for example Boards' staff, voluntary organisations, public representatives or the Commissioner for Complaints. Neither is it intended that it should in any way interfere with the Boards' existing machinery for monitoring the care and treatment of patients. Indeed, if the Commission considered that it was appropriate to do so, it would try to ensure that a

mentally disordered person received help from the most appropriate person or body while at the same time reserving the right to take up any matters where the patient feels his grievance has not been resolved satisfactorily. Patients can still refer complaints to the Commissioner for Complaints, and, indeed, the Commission itself is subject to investigation by the Commissioner for Complaints - mainly because of its role as a potential employer of staff.

227 The Commission's functions are quite separate from the Mental Health Review Tribunal or the Hospital Advisory Service. The Tribunal remains the only body with power to discharge patients from compulsory detention or guardianship while the function of the Hospital Advisory Service is to provide information and objective advice about the overall standards of care provided in long stay hospitals.

Membership

228 The Chairman and members of the Commission are appointed by the Department after consultation with concerned bodies or persons. There will be a vice-chairman who will be elected annually by the members themselves. The Order does not place any limits on the size of the Commission but in practice it will have about 12 part-time members. In addition the Commission has power, if the need arises, to appoint people who are not members of the Commission to carry out specific tasks on its behalf. It can therefore avail of expertise which may not be available within the Commission itself or use this power to acquire the services of additional people should it be necessary to cope with its workload.

229 Apart from the chairman, who must have legal qualifications, there are no qualifications laid down for Commission members. However, the intention is that it should reflect the main professional disciplines involved in mental health care (medicine, nursing, social work and paramedical). It will also have a significant lay element. Because of the small numbers involved it will not be possible to represent all the caring professions at all times. In any case, members are not there to represent the interests of their respective professions but as individuals and will be chosen for their experience and knowledge of the special problems with which the Commission will be concerned.

230 Members may be appointed for up to 4 years and will be eligible for re-appointment. The Commission has a full-time secretariat which is independent of the Department and Boards, and can be contacted at the address shown in Appendix 2.

MISCELLANEOUS

Patients' property

231 Most people who suffer from mental disorder are quite capable of looking after their own property and affairs. The law recognises this fact and assumes that a person is capable until the contrary is proved. There is therefore no category of patient whose property affairs are automatically taken out of his hands.

232 However, patients who are incapable of managing their property and affairs by reason of mental disorder, whether liable to be detained in hospital or not, may have them placed under the jurisdiction of the High Court. This jurisdiction is administered by the Office of Care and Protection under the direction of the Master of Care and Protection. Most of the legislation dealing with patients' property and affairs is contained in Part VIII of the Order. This sets out the powers under which the Office of Care and Protection may assume responsibility for managing the property and affairs of patients, and the procedures for their exercise. The Office of Care and Protection whose address is given in Appendix 2 will provide information and advice on these powers and procedures.

233 Particular attention should be paid to Article 107 which places a duty on Boards to notify the Office of Care and Protection of any person within their areas whose affairs they think should be looked after by the Office. It will be for Boards to judge which cases should be notified but obviously if a person has no property there will be no need to do so. Notification must be on the prescribed form, copies of which can be obtained from the Office of Care and Protection. A similar duty to notify the Office of Care and Protection is placed on persons carrying on nursing homes or homes for persons in need in respect of people within their care, and on the Mental Health Commission in respect of any person.

Board's power to administer small amounts

234 Article 116 permits Boards to hold and administer money and valuables on behalf of patients in Board accommodation, whom they consider to be incapable by reason of mental disorder of managing their own property or affairs. This power applies only to possessions up to a maximum total value to be decided by the Department. Separate guidance on this matter will be issued by the Department and until then the provision remains inactive. If Boards wish to exercise power in respect of valuables or money in excess of the sum set by the Department they must get permission from the Commission. If, in any case, a controller has already been appointed by the Office of Care and Protection , the Board cannot become involved in administering the patient's affairs. On the other hand, if the Board is looking after a patient's property in accordance with Article 116 it may not be necessary for the Office of Care and Protection to appoint a controller.

235 Where a Board is administering property on behalf of a patient it can spend the money or dispose of valuables provided this is done for the patient's benefit. It will be for the Board to take advice and to consider the needs and wishes of the patient so as to ensure that his best interests are being served. Boards are specifically required under Article 116(3) to have regard to the sentimental value that any article may have for the patient in deciding whether or not it should be disposed of.

Pay, pensions, etc of patients

236 Article 128 enables government departments and other public bodies to pay direct to an institution or person caring for a mentally disordered person, his wages, pension or other payment due in respect of present or past employment. This would apply to the wages etc. of civil servants, members of the security forces, employees of Health and Social Services Boards, Education and Library Boards, the Northern Ireland Housing Executive, District Councils etc.

237 It will be for the paying authority to decide how much of the amount due should be paid to the institution or person caring for the patient. Any sums which remain can be paid to members of the patient's family, or to other persons for whom the patient might be expected to provide were he not mentally disordered, or to reimburse people who have paid his debts or helped to maintain him or his family. This facility can only be used if the paying authority is satisfied, after considering medical evidence, that the person to whom the money is due is unfit because of mental disorder to manage his affairs, and where a controller has **not** been appointed by the Office of Care and Protection.

Other legislation on patients' property

238 Boards are obliged under Article 38 of the Health and Personal Social Services (Northern Ireland) Order 1972 to take all reasonable steps to prevent or mitigate the loss or damage of property of patients admitted to hospital or residential accommodation or placed under guardianship who are unable to do so themselves. For the purpose of this duty, Boards have a power of entry and may deal with the property in any way which is necessary to mitigate or prevent loss or damage.

239 There is also provision in social security legislation which allows the Department to appoint suitable people to receive social security benefits and supplementary benefits on behalf of persons who are "unable to act". The appointee in these circumstances could be a hospital administrator or officer in charge of a residential home, who will have his duties fully explained to him by the paying authority concerned.

Code of Practice

240 Article 111 requires the Department to prepare, publish and from time to time revise, a Code of Practice. The Code must include:-

a. guidance in relation to the admission of mentally disordered patients to hospital or their reception into guardianship;

b. guidance in relation to the medical treatment of patients suffering from mental disorder.

Article 111(2) provides that the Code shall specify forms of medical treatment which give rise to special concern and should therefore only be given with the patient's consent and a second opinion (see paragraphs 181-184). The forms of treatment specified in the Code will be in addition to any specified in the Regulations (Regulation 6) and should be treated in the same way as treatment given under Article 63.

241 Work on the preparation of the Code will not start until some practical experience of the Order in operation has been gained. The Department is

required under Article 111(3) to consult the Commission and other concerned bodies before preparing the Code or making any alterations to it. The need to alter the Code might arise, for example, as a result of developments in professional practice or where it has come to the attention of the Commission or the Department that guidance on a particular issue is needed. The Code does not have the force of law except in relation to treatments of special concern, but everyone involved in the care of mentally disordered patients, including treatment in the community, should have regard to it whenever it is relevant. Failure to do so could be used as evidence of negligence or bad practice.

242 Once the Code of Practice, or any alteration to it, has been prepared the Department is required under Article 111(4) to lay copies before the Northern Ireland Assembly. The Assembly can reject the Code or any part of it, whereupon a revised version has to be prepared. Once the Code is approved by the Assembly it will be published.

Approved social workers

243 Health and Social Services Boards are required under Article 115(1) to appoint a sufficient number of approved social workers to carry out the functions given to them under the Order. Article 115(2) provides that nobody can be appointed as an approved social worker unless a Board has approved him as having appropriate competence in dealing with people who are suffering from mental disorder. In appointing approved social workers Boards must have regard to whatever directions are issued by the Department. These directions are the subject of separate guidance from the Department and are not dealt with in this Guide. Until arrangements for the training and appointment of approved social workers are in place their functions under the Order will be carried out by social workers designated by the Board for the purposes of the Order under paragraph 26 of Schedule 6.

Sexual offences against patients

244 There are two distinct types of protection against sexual exploitation afforded to mentally disordered people. The first is given by Article 122 and deals with the protection of women who are severely mentally handicapped. Under this Article, it is an offence for anyone to have unlawful sexual intercourse (sex outside marriage) with, or to sexually exploit in a number of other ways, such females. Severely mentally handicapped males are protected against homosexual acts by Article 3(3) of the Homosexual Offences (Northern Ireland) Order 1982, as amended by Schedule 5 to the Order, which provides that a severely mentally handicapped male cannot validily consent to such an act.

245 The second type of sexual protection is given under Article 123 and covers the protection of mentally disordered persons of both sexes but only against sexual acts by persons who have positions of special responsibility towards them. Under this provision, it is an offence for a male who is employed in a hospital or nursing home or who is a member of the Board responsible for administering the hospital or is in charge of a nursing home, to have unlawful sexual intercourse with a female, whether detained or not, who is receiving in-patient treatment there for mental disorder. It is also an offence for such males to have unlawful sexual intercourse in the hospital or nursing home premises with a female who is receiving treatment there as an out-patient. It is an offence for a man to have unlawful sexual intercourse with a mentally disordered female who is subject to his guardianship or who is in his custody or care. Similarly, it is an offence for a man who is a member of a Health and Social Services

Board to have sexual intercourse with a female who is in the Board's guardianship, custody or care. Mentally disordered males are given exactly the same protection under Article 123 as women, except that the protection is restricted to homosexual offences.

246 Where there is reason to believe that an offence has been committed under Article 122 or 123 the Royal Ulster Constabulary should be informed as soon as possible. The police will then decide on the right course of action, in consultation with professional staff involved in the patient's care. If a member of the Board or Board's staff or any other person who has care or custody of a patient is believed to be involved in such an offence, the Board should immediately send a report to the Department giving brief details of the case and the action it is proposed to take.

Assistance from the police to retake or remove patients

247 Police constables are included among the people authorised to retake patients who are absent without leave from the hospital where they are liable to be detained or from the place where they are required by their guardian to live (Article 29). They are also included among the people authorised by Article 132 to retake patients who escape while being conveyed from one place to another, or who escape from a place of safety or custody under the Order.

248 Calls on the police to assist in the retaking of patients should be kept to a minimum, but the police should always be informed at once of the escape or absence without leave of a patient who is considered dangerous or who is subject to restriction on discharge under Part III of the Order. There may be other cases where, although it is not necessary to seek help from the police in retaking a patient, his history makes it desirable that the police should be informed that he is absent without leave in the area. Whenever the police are asked to assist in retaking a patient they must be informed of the time limit on the power to retake him.

249 Article 129 provides that in certain circumstances a justice of the peace may issue a warrant authorising any constable named therein, accompanied by a medical practitioner, to enter premises, by force if necessary, for the purpose of removing a mentally disordered person to a place of safety for up to 48 hours, or to take or retake a patient who has escaped or who is absent without leave. In the circumstances described in Article 129(4), a justice of the peace may issue a warrant authorising a constable to remove a patient to hospital where an application for assessment has been made and the applicant has requested the Board to remove him but it has failed to do so.

250 A place of safety is defined as any hospital, of which the administering Board is willing temporarily to receive persons who may be taken there under the Order, any police station or any other suitable place the occupier of which is willing temporarily to receive such persons. Boards have already designated certain hospitals as places of safety for the purposes of the 1961 Act and notified the Department accordingly. The hospitals concerned are listed in Appendix 3. These should continue to be used and the Department informed of any amendments as and when they arise. Patients should be kept in places of safety for as short a time as possible while other arrangements are made for their care. This is particularly so

in the case of a police station which should be used as a place of safety only when no other suitable place is available. Patients retaken under Article 129(2) will normally be returned directly to the hospital or other place from which they are absent or have escaped.

251 Police constables also have power under Article 130 to remove to a place of safety a person whom they find in a public place who appears to be suffering from mental disorder and to be in immediate need of care and control in his own interests or for the protection of others. The person can then be detained for 48 hours so that he can be examined by a doctor and interviewed by an approved social worker who should make suitable arrangements for his placement as soon as possible. The policeman who removed the person has a duty under Article 130(3) to inform, where practicable, the nearest relative and a responsible person residing with the removed person.

Protection for acts done in pursuance of the Order

252 Article 133 affords protection from legal proceedings for people who perform functions purporting to be done under the Order, unless they have acted in bad faith or without reasonable care. Criminal proceedings against staff require the consent of the Director of Public Prosecutions and civil proceedings require the consent of the High Court. It is not now necessary, as it was under the 1961 Act, that the High Court be satisfied that there is a prima facie case for the contention that the person to be proceeded against acted in bad faith or without reasonable care. Nevertheless, the Director of Public Prosecutions and the High Court, in granting consent or leave to proceed will apply their own rules which require grounds to be demonstrated. Article 133 does not apply to proceedings brought against the Department or a Board.

Patients removed to or from Northern Ireland

253 The authority to move patients detained in hospital or subject to guardianship between Northern Ireland and England and Wales or Scotland is contained in Part VI of the Mental Health Act 1983 or Part VII of the Mental Health (Scotland) Act 1984 respectively as amended by the Mental Health (Northern Ireland Consequential Amendments) Order 1986. Patients being moved under these provisions remain under detention or guardianship while being moved and become subject to the provisions of the mental health legislation of the receiving country as soon as they arrive there. Part VI of the Mental Health Act 1983 and Part VII of the Mental Health (Scotland) Act 1984 also contain provisions under which a patient absent without leave from a hospital in one part of the United Kingdom may be taken into custody elsewhere in the United Kingdom and returned to the hospital where they should be; and powers under which foreign mentally ill in-patients may be repatriated.

Removal from Northern Ireland

254 There is no high security accommodation in Northern Ireland. Consequently, one of the reasons why detained patients may occasionally be transferred to Great Britain is to receive treatment under conditions of special security, on account of their dangerous, violent or criminal propensities.

255 Other reasons for transfer may be at the patients own request or that of his family or friends. All transfers under section 82 of the Mental Health Act 1983 or section 81 of the Mental Health (Scotland) Act 1984 must be authorised by the Department, or, if the patient is subject to restrictions on his discharge, by the Secretary of State. In either case directions may be given for the conveyance of the patient. Preliminary enquiries about arrangements for the care and treatment of the patient in the other country should be made before any approach is made to the Department for a transfer. It would be useful at this stage to know:

i. the patient's status and background;

ii. why it is necessary to transfer the patient, and how the move is expected to benefit him;

iii. which hospital is to receive the patient, and the name of the doctor who has agreed to be the new responsible medical officer; and

iv. whether the patient's relatives have been consulted, who is the nearest relative, and what are their views on the proposed transfer.

256 A proposal to remove a patient from Northern Ireland should be put in writing to the Department. If appropriate, the Department will then liaise with the Northern Ireland Office before making an approach to the Department of Health and Social Security in London or the Scottish Home and Health Department. Once the Secretary of State or the Department authorises the transfer of a patient from Northern Ireland they are required under Article 134(6) to give the Commission and the patient's nearest relative at least 7 days notice of the transfer before the patient is removed. The patient should not be moved until a copy of the transfer direction has been received from the Department. This document should accompany the patient to his destination where it will constitute the continuing authority for his detention or guardianship.

Transfers to Northern Ireland

257 Most detained patients transferred to Northern Ireland are returning following treatment in secure accommodation, because their condition has improved to the extent that they can now be cared for in an ordinary psychiatric hospital or the community. In many cases preliminary consultations will already have taken place between staff at the receiving hospital and their opposite numbers at the hospital where the patient is being detained, before a formal approach for transfer is made to the Department by the Department of Health and Social Security or the Scottish Home and Health Department.

258 Once it has been agreed to transfer the patient, written authority for his removal will be given by the appropriate authority at the patient's place of origin and will either precede him or accompany him on transfer. This authority should be kept with the patient's records as it constitutes the power for his continued detention or guardianship in Northern Ireland because the application or order under which he was originally detained ceases to have effect on his removal from the jurisdiction in which it

was made. The patient on arrival in Northern Ireland should be treated as if he had been admitted to hospital or received into guardianship here under the provisions of the Order equivalent to the provision of the Mental Health Act 1983 or the Mental Health (Scotland) Act 1984 under which he was originally detained or received.

259 Because the definitions of mental disorder and related expressions in the Order are different from those in the Great Britain Acts, Article 134 provides for the reclassification of the patient's mental disorder following his transfer to Northern Ireland. The responsible medical officer is required to examine the patient and make a report in the prescribed form (Form 24) to the Board within 28 days of the patient's admission to hospital stating the form of mental disorder from which the patient is suffering. The responsible Board is required to notify the Commission immediately a patient is transferred to detention in hospital or guardianship in Northern Ireland and to send a copy of the report by the responsible medical officer (Form 24) to the Commission as soon as practicable.

Detention of Members of Parliament and Members of the House of Lords

260 Section 141 of the Mental Health Act 1983 is among the provisions of that Act which apply to Northern Ireland. Under that section, when a member of the House of Commons is authorised to be detained on the grounds that he is suffering from mental illness the following bodies or persons all have a duty to inform the Speaker of the House of Commons at the Palace of Westminster, London SW1, that the detention of the MP has been authorised:

a. the court, authority or person who made the order or application for detention;

b. the registered medical practitioners making medical recommendations;

c. the managers of the hospital or other place where the MP is detained.

Section 141 does not apply to any MP who is detained on the ground that he is suffering from any form of mental disorder other than mental illness.

261 There is no similar provision in the 1983 Act in relation to members of the House of Lords but House of Lords Standing Order 77 requires a court or authority ordering the imprisonment or restraint of a member of the House of Lords to give written notice to the Clerk of the Parliaments. Where a member of the House of Lords is detained under the Order, the responsible Board should inform the Clerk of Parliaments, House of Lords, SW1 in writing of the Article of the Order under which that member is detained and the date of his detention.

262 The Clerk should also be informed when the member of the House of Lords is discharged or is given leave of absence, or if he absents himself without leave. Where a member of the House of Lords is sent from a court or transferred from prison, the court or prison will have informed the Clerk of the Parliaments but when that member is discharged or given leave of absence, or if he absents himself from the hospital without leave, it will be for the responsible Board to inform the Clerk. Similarly the responsible Board should inform the speaker of the Northern Ireland

Assembly when a member of that body is detained on the grounds that he is suffering from mental illness.

APPENDIX 1

LIST AND SPECIMENS OF PRESCRIBED FORMS

Prescribed Forms

1. Application by nearest relative for admission for assessment (Article 4).

2. Application by an approved social worker for admission for assessment (Article 4).

3. Medical recommendation for admission for assessment (Articles 4 and 6).

4. Medical certificate to extend time limit for conveying patient to hospital (Article 8(1)).

5. Medical practitioner's report on hospital in-patient not liable to be detained (Article 7(2)).

6. Nurse's record in respect of hospital in-patient not liable to be detained (Article 7(3)).

7. Report of medical examination immediately after admission for assessment (Article 9(3)).

8. Medical report to extend assessment period from 48 hours to 7 days (Article 9(6)).

9. Medical report to extend assessment period for a further 7 days (Article 9(8)).

10. Medical report for detention for treatment (Article 12).

11. Report by responsible medical officer for renewal of authority for detention for 6 months or one year (Article 13(2) and (5)).

12. Joint medical report for first renewal of authority for detention for one year (Article 13(3)).

13. Guardianship application by nearest relative (Article 18).

14. Guardianship application by approved social worker (Article 18).

15. Joint medical recommendation for reception into guardianship (Articles 18 and 20).

16. Medical recommendation for reception into guardianship (Articles 18 and 20).

17. Recommendation by an approved social worker for reception into guardianship (Article 18).

18. Report by responsible medical officer for renewal of authority for guardianship (Article 23(2)(a)).

19. Report by approved social worker for renewal of authority for guardianship (Article 23(2)(b)).

20. Assignment of functions by nearest relative (Article 35).

21. Certificate of consent to treatment and second opinion (Article 63).

22. Certificate of consent to treatment (Article 64(3)(a)).

23. Certificate of second opinion (Article 64(3)(b)).

24. Medical report on patient removed to Northern Ireland (Article 134(1)).