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Expert opinion

The Code of Practice and Parliamentary intention concerning short term treatment orders

The Code of Practice for the Mental Health Act, 1983 "has now passed through the necessary Parliamentary procedure" but may still be subject to amendment by Parliament, and in this context it is useful to consider the expressed intention of Parliament over the last 70 years in relation to short term treatment orders and the Code's current guidance on S.2 of the Mental Health Act 1983.

The Macmillan Royal Commission of 1924–26[1] to encourage early treatment proposed the introduction of a "Provisional Treatment Order" which, while magistrates were still involved in the process of admission, was meant to spare "recoverable" patients from "full certification" for a limited period. The Mental Treatment Act 1930 modified this suggestion to allow "temporary treatment" for up to six months, without the intervention of a magistrate but on the application of the next of kin supplied with two medical certificates, for patients liable to early recovery who were incapable of expressing themselves as willing or unwilling to receive treatment ("non volitional").

The Percy Royal Commission of 1954–57[2] recorded that S.20 and S.21 of the Lunacy Act 1890 "intended for emergencies only" were also "often used in order to obtain a short period of observation and treatment in hospital 'without certification' during which the patient may recover or become willing to become a voluntary patient". The Percy Commission recommended that "it should be permissible in future for patients to be admitted compulsorily either for a period of not more than 28 days observation and preliminary treatment ... or for a longer period of treatment" and that "all distinctions of 'status' based on method of admission ... (or) on the length of time a patient has been in hospital" be abolished. The first recommendation was enacted in 1959 as "admission for observation" (S.25) which empowered the detention for up to 28 days "with or without medical treatment" of patients suffering from a "mental disorder of a nature or degree" which warranted it and only "promiscuity and other immoral conduct" were specifically excluded from being construed as mental disorder. The Memorandum on the 1959 Act[3] published under the imprimatur of the Ministry of Health stated at least one of the medical recommendations "must if practicable" be given by a doctor "already acquainted with the patient; (his) family doctor or a specialist who has known him as an out-patient or in-patient".

An Inter-Departmental Committee set up to review the 1959 Act published a consultative document in 1976[4] which drew attention to the admission under S.25 of alcoholics and addicts considered to be a danger to themselves as "suffering from any disorder or disability of mind to determine whether or not there is an underlying mental disorder". The Green Paper also noted the more frequent use of *emergency* admission for observation than had been intended and in discussing the duration of detention suggested that this should be long enough to enable a judgement of the form of mental disorder, its need for treatment, of the patient's willingness to undertake treatment voluntarily *"and to protect the patient against longer term detention for treatment"*. S.25 was now referred to as "admission for observation *and assessment*" because while evidence was taken suggesting uncertainty in some quarters concerning the power to impose treatment under S.25, the committee felt that this was indeed necessary at least "in order to deal with the emergency situation that led to admission".

A White Paper (Cmnd 7320)[5] published in September 1978 contained the government's first proposals for an amended act. Not only alcohol and drug addiction but also sexual deviancy were added to promiscuity and other immoral conduct and excluded from being construed as mental disorder. The White Paper expressed the view that powers to treat were available under S.25 but only "for what is reasonably required by way of observation" and recommended that if "developments in psychiatric practice now mean that compulsory detention in hospital often need last no longer than 28 days ... this should be clearly recognised in legislation". As "the distinction between observation and treatment did not seem sufficiently clear to warrant a separate observation order ... S.25 should explicitly provide for short term assessment and treatment" and because S.25 was to become a "treatment as well as an assessment order" the White Paper proposed that stronger safeguards against detention would be required. In the debate on the White Paper, Mrs Lynda Chalker confirmed the general view that "S.25 should specifically provide for the short term treatment of patients who go into hospital for 28 days".[6]

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In 1981 a second White Paper (Cmnd 8405)[7] noted that "admission for observation . . . is now used as a short term treatment power" making "assessment" a more suitable term "as it implies more active intervention to form a diagnosis and plan treatment" which in many cases need not extend beyond 28 days. When the Mental Health Amendment Bill was taken in the House of Lords in December 1981 Lord Elton,[8] for the government, indicated that no one should be detained longer than necessary and said quite explicitly that "the purpose of S.25 (observation) is to assess and then if appropriate treat the patient . . . (and that) the wording is being amended to make it clear that this is the case". There was subsequent discussion,[9] as to the exact phrase – "and/or treatment" or "short term treatment" (Baroness Faithfull) or "treatment if necessary" (Lord Donaldson) – that should be linked with "assessment" but finally after Lord Winstanley had asked "the noble Lord to confirm . . . (that it) does not mean that assessment has finally to be concluded before treatment can start" and been reassured, the phrase presently in the Act, "assessment followed by treatment", was adopted.

The House of Commons dealt with the Amendment Bill in a special standing committee under the Chairmanship of the Secretary of State for Health (Mr Kenneth Clarke). In evidence only the Confederation of Health Service Employees commented specifically on and welcomed the change from observation to assessment as providing "a more positive connotation with regard to the purpose of admission and the type of treatment which might then be offered".[10] Other witnesses and the subsequent debate and amendment were essentially concerned with increasing access to Tribunals, the powers of relatives, crisis intervention, protection against discrimination and community facilities. Kenneth Clarke[11] said of "assessment under the short term powers . . . It means that someone can be admitted for . . . up to 28 days because he is plainly suffering from a disorder of mind so that during those 28 days the condition can either be alleviated or accurately diagnosed." An amendment from Mr David Atkinson which proposed the banning of two admissions for assessment in any period of six months was withdrawn after the Under Secretary of State for Health Mr Geoffrey Finsberg[12] pointed out that "subsequent periods would have to be under section S.26 . . . (and) *it does not seem right to ask professional staff to use a detention power for a longer duration than they believe necessary*". The memorandum for the new Act[13] requires that of the doctors providing medical recommendations for the purposes of Part 2 "one should have if practicable had previous acquaintance with the patient".

The history of Section 2 thus shows that the intention of Parliament (with multidisciplinary professional advice) was to provide a short term treatment order, minimise the duration of detention and the use of S.3 where this was unnecessary. Admission was to be effected by professionals with knowledge of the patient, better equipped to undertake the complex diagnostic exercise prior to admission, which takes 19 pages of the Code of Practice as against less than two pages describing the use of S.2/S.3, and is needed to exclude certain behaviour as being construed as mental disorder. Power to treat was available from start to finish of the Section and it was emphasised that treatment should be based on understanding of the patient's condition.

In the Code of Practice[14], however, the "pointers" for S.2 include guidance that for a patient to be admitted on more than one occasion (without limit of time) under Section 2 his condition should have been "judged to have changed" and need "further assessment" whereas if his condition "is already known . . . and has been assessed in the recent past" by the same clinical team considering readmission, S.3 is appropriate, and categorically, that team (nor any other) should not be influenced by the fact that a proposed treatment . . . would last less than 28 days".

The Code of Practice thus fails, because of renewed legal preoccupation with the semantics of the word 'assessment', to confirm Parliament's intention with regard to S.2 which was to provide for a short term treatment order where either this was indicated or would suffice.

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