Community care: duties towards mentally ill people and their families

David Fish

In two articles, David Fish provides information to practitioners in mental health law about the duties of local authority social services departments and approved social workers and explains when it may be possible to challenge their decisions. This first article concentrates on duties under the NHS and Community Care Act 1990 (1990 Act), the Mental Health Act (MHA) 1983 and certain delegated legislation. The second article will look in more detail at the role of the approved social worker, the use of guardianship by local authorities, local authorities' powers of entry and displacement of the nearest relative.

Principles behind the 1990 Act

The key objectives of the Act are:[1]

1 To promote the development of domiciliary day and respite services to enable people to live in their own homes whenever feasible and sensible.
2 To make proper assessment of need and good care management the corner-stone of high quality care.
3 To ensure that service providers make practical support for carers high priority.
4 To secure better value for taxpayers' money by introducing a new funding structure for social care.

Every local authority with a social services responsibility is required to prepare and publish a plan for the provision of community care services. Practitioners would be well advised to obtain a copy from their local social services department (SSD). In its plan, the SSD should identify the care needs of the local population, taking into account such factors as age distribution, problems associated with living in inner city or rural areas, special needs of ethnic minorities and the number of homeless or transient people likely to require care. Most SSD plans will have to take account of an increasing elderly population with a higher incidence of dementia and the gradual closure of traditional mental hospitals which have caused institutionalisation for many mentally ill patients.

The plan should also describe how the care needs of individuals approaching the local authority for assistance will be assessed. The SSD must work out a procedure for assessing needs and a care plan for each individual. The care plan should refer to the services to be provided, eg, accommodation, community care workers' support, use of guardianship or placement on the supervision register.

SSD assessment procedures will be based on a multi-agency approach and should include:

- identification of the people to whom the procedures apply
- trigger criteria for multi-agency assessments (MAAs)
- priorities
- initiating an MAA
- the role of the service user and carer in the assessment process
- roles of professionals in MAAs
- co-ordination
- implementing the personal service plan
- resolving disputes
- hospital discharge etc.

SSDs are required to work closely with health authorities, both in the overall community care plan and each individual's plan. The government set up a task force to assist this process. Some SSDs have provision for an MAA to be initiated by a member of the public, but usually the initiator will be the approved social worker or health authority personnel.

The role of the lawyer

Practitioners who are acting for mentally ill patients or are consulted by family members should be aware of the local authority's duties. They must obtain the local SSD community care plan to ensure that patients have been properly assessed for services and are receiving the services that they and their family require.

SSDs are always subject to budget controls but the lawyer for a patient should try to ensure that the drive for economy does not result in an inadequate service plan or none at all. Decisions of the local authority and health authority either not to provide a community care plan for a patient or not to provide services may be subject to judicial review.[2]

Mental health review tribunals

Community care plans for patients who have applied to a mental health review tribunal (MHRT) may make the difference between discharge or continued detention. Lawyers acting for patients should make enquiries to ascertain whether MAAs have been or are to be carried out before the MHRT hearing.

The Department of Health (DoH) guidance states that, where a patient has applied for an MHRT, it is important that the essential elements of the care programme approach have been considered and can be put into operation if the patient is discharged and that the key worker (see below) is immediately made aware of any conditions imposed.[3]

Section 117 after-care

The duties of the local authority under the 1990 Act should be seen in the context of the additional duty imposed on the SSD under MHA 1983 s117. Health authorities and local authorities have a statutory duty under s117 to provide after-care services for patients in all categories of mental disorder who have been detained in hospital under MHA 1983 s3, 37, 47 or 48.

After-care under s117 should be provided in accordance with the care programme approach.[4] The DoH has issued further guidance to SSDs in the preparation of an after-care form to record s117 services provided.[5]

At an MHRT, the approved social worker and health professionals should be able to give evidence about the MAA of the patient and s117 services provided. In cases of clear failure to carry out duties it is possible to issue a witness summons to the director of social services.

Supervision registers

The supervision register concept follows on from the community care programme approach generally and is a particular reaction of the government to recent high-profile cases in which mentally ill patients living in the community either used extreme violence towards others or showed signs of severe self-neglect. Guidance to SSDs and health authorities was issued on 1 April 1994.[6]

Certain events, eg, pre-discharge meetings or MHRTs, should trigger a decision by the SSD to include or not to include a patient on the supervision register under one or more of the following categories:

- significant risk of suicide
- significant risk of violence to others
- significant risk of severe self-neglect.

Inclusion of a patient on the supervision register may in certain cases be used to persuade an MHRT that, although a patient may continue to suffer mental disorder, it is not necessary for the health and safety of the patient or for the protection of other persons that s/he should receive treatment in hospital. On the other hand, the mere fact that a patient is regarded as likely to fit the criteria for inclusion on the register may sway the minds of panel members against discharge.

The register should include details of the patient's current legal status, the nature of any risk and specific warning indicators, details of the key worker – usually the approved social worker or community psychiatric nurse – and details of the care programme.

If a practitioner believes that it would benefit a mentally ill client to be

included on the register, then representations should be made to the team manager of the adult services team at the SSD district office to assess whether there are any proposals for such a decision to be considered.

If a decision is made not to place the client on the register and this is unacceptable to the practitioner and the patient, consideration can be given to whether an application for judicial review is possible. The patient has a legal right of access to the relevant part of the register.[7]

David Fish is a solicitor in Walsall, a former solicitor to Staffordshire Social Services Department, and a member of the Law Society's Children Panel. An application for membership of the MHRT Panel is pending.

1 DoH *Community care in the next decade and beyond: policy guidance* November 1990, HMSO.
2 See Richard Gordon's article in August 1993 *Legal Action* 8 and series on judicial review by Stephen Cragg and Lee Bridges, October, November and December 1994 *Legal Action*.
3 Health Service Guidance HSG(92)27.
4 Described in detail in Health and Local Authority Circular HC(90)23/LASSL(90)11 *Care programme approach for people with a mental illness referred to the specialist psychiatric services.*
5 Letter to local authorities, dated 7 July 1994, from Steve Denford, Health Care (Admin) Division, DoH. See also the Ritchie Inquiry, which made over 75 individual recommendations relating to s117 after-care and other mental health issues.
6 HSG (94)5 *Introduction of supervision registers for mentally ill people.*
7 Ibid Annex A para 22.

IMMIGRATION

Recent developments in immigration law

Rick Scannell, Jawaid Luqmani and Chris Randall

This series appears every four months, in March, July and November. The authors welcome comments, case notes and transcripts.

POLITICS AND LEGISLATION

Proposed legislation

Benefit curbs

On 11 October 1995, during the Tory Party conference, social security secretary Peter Lilley announced plans to curb benefit entitlements for asylum-seekers and other persons from abroad. At the time of writing, draft regulations were not available. The DSS press release stated that:

> asylum-seekers who make no claim until after they have arrived in the UK would not be entitled to benefits. And asylum-seekers who claim at their point of entry to the UK would cease to be eligible for benefits if their claim is refused by the asylum division of the Home Office rather than, as now, from the time their appeal is rejected.

In justifying the change, the press release refers to the fact that 70% of asylum-seekers do not claim at the border but arrive in some other capacity (visitors, tourists or students) on the understanding that they will maintain themselves. The press release then points out that a subsequent application for asylum prolongs their stay and gives them access to benefits. It also refers to the escalation of asylum applications and states that this is partly because of the availability of benefits (although no justification is given for this statement). The proportion of applicants found to have a valid claim for refugee status is quoted as having fallen from 32% in 1984 to 4% in 1994.

Peter Lilley also sought to mitigate the change by stating that:

> an exception would be made, however, should the Home Secretary declare that a significant upheaval has occurred in a country, where that upheaval occurs after the national arrived in the United Kingdom.

Practitioners may be cynical about the number of times the Home Secretary is likely to make such a declaration. The statement also ignores the possibility that an individual's situation in his/her country of origin may change dramatically for the worse without there being an upheaval or change in the circumstances in the country itself.

The press release states that, for those who *do* claim at the port, entitlement will be restricted to income support, housing benefit and council tax benefit and will end immediately if the Home Office refuses the asylum claim. Clearly, a government under financial pressure may reflect that pressure in its asylum determination policies.

A significant question which remains unanswered in these changes is whether asylum-seekers will still be allowed to work after their applications have been outstanding for six months. A change in this discretionary policy, in conjunction with the implementation of the above proposals, would be devastating to all in-country applicants, and to any port applicants who are refused.

The press release announces transitional arrangements for asylum applicants already in receipt of benefits on 11 October 1995. They will retain benefit until there is a negative decision in their case. In cases in which there is a negative decision after 11 October but before the regulations come into force, benefits will cease as soon as practicable after the latter date. Applicants already in the UK who claim benefits between 12 October and the date the regulations come into force will be treated in a similar way. Those granted refugee status or exceptional leave to remain (ELR) would be unaffected.

The notes to the press release refer to the small number of appeals which were allowed by the immigration appellate authorities (4%) and the low initial recognition rate (4%), although it does not mention grants of ELR. It refers to the increase in the number of asylum applicants from 1992 to 1994, and compares 1992 with the number of applicants in 1984:

> 1994: 42,000 applicants;
> 1993: 28,000 applicants;
> 1992: 32,300 applicants
> (all including dependants)
> 1984: 2,900 applicants (excluding dependants).

The press release does not reveal that in 1991 the number of applicants was higher than in 1994!

In addition, the press release suggests that benefit rules will also be changed in non-asylum cases where undertakings have been given by sponsors. It points out that in 1992 3,450 applications for sponsorship were accepted, of which 3,050 were from people already in the UK. About half breached the undertakings. However, the press release is unclear about the changes that will be made in this respect.

Consultation and other measures

In a letter to the Immigration Law Practitioners' Association (ILPA), the social security minister suggested that the regulations are planned to take effect on 8 January 1996. A consultation process is currently under way.

The letter also states that Home Secretary Michael Howard has indicated on a number of occasions that he is considering further measures, including legislation to improve the effectiveness of asylum procedures. However, Michael Howard's speech to the Tory conference was silent on this matter. One document, which was in circulation at the Tory Party conference, identifies three main measures for an asylum and immigration bill: the designation of selected countries as unlikely to produce genuine applicants; appeals against removal to a safe third country to be exercisable only after removal; and more effective appeal arrangements in the Immigration and Asylum Appeals Act 1993. There is also reference to the short pilot procedure which has brought down the period in which initial decisions are made (see 'Asylum' on p22).

As immigration practitioners ponder the effect of these proposals, they may wonder what incentive there is for the Home Office to provide more resources either for their appeals preparation sections, or for the Lord Chancellor's Department to provide funds for more immigration courts. Lack of funds for applicants will effectively have the desired effect of reducing the number of appeals.

from the right to a fair hearing is the principle of 'equality of arms'. This entails a litigant having a reasonable opportunity of presenting her/his case to the court under conditions which do not place a person under a substantial disadvantage vis-a-vis an opponent.

We do not know how the discretion of district judges under CCR Order 19 r3 will be exercised, but the European Court may in a suitable case provide a more sympathetic response than the domestic forum.

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1 County Court (Amendment No 3) Rules 1995 SI No 2838.
2 *Daly v Ford Motor Company* (1992) 13 February; [1992] CLY 3438, Coventry District Registry.
3 *Afzal v Ford Motor Co Ltd* [1994] 4 All ER 720, CA.
4 *Joyce v Liverpool City Council* (1995) 27 HLR 548, where this approach was tacitly accepted by the Court of Appeal.
5 CCR 1981 Order 19 r3(2).
6 No 3 Rules 1995 (note 1) r4.
7 *Afzal* (note 3) at p733.
8 Ibid at p734.
9 Ibid at p733.
10 Ibid at p734.
11 CCR Order 19 r4(2).
12 RSC 1965 Order 1 r4(1); see also *Paterson v Chadwick* [1974] 2 All ER 772, QBD.
13 *NLJ* 2 February 1996 p118.
14 Powers of Criminal Courts Act 1973 s35.
15 EPA 1990 s82(12).
16 Legal Aid Act 1988 s2(2)–(4).
17 County Court Fees Order 1982 SI No 1706 article 4.
18 Civil Legal Aid (General) Regulations 1989 SI No 339 regs 85, 103.
19 A 32 (1979).

Community care: duties towards mentally ill people and their families: II

David Fish

This is the second article concerning the duties of local authorities towards mentally ill people. The first article (November 1995 Legal Action *20) looked at duties under the National Health Service and Community Care Act 1990 regarding assessment, the Mental Health Act (MHA) 1983 and certain delegated legislation. This article looks at the role of the approved social worker (ASW), the use of guardianship by local authorities, the displacement of the nearest relative under MHA 1983 s29 and local authorities' powers of entry under s135 of that Act.*

Approved social workers

MHA 1983 s114(1) imposes on each local social services authority a duty to appoint 'a sufficient number of approved social workers for the purpose of discharging the functions conferred on them' by the Act. A circular issued in 1986 by the Department of Health and Social Security (as it then was) contained directions for the appointment of ASWs.[1] The new arrangements were designed to ensure that all ASWs received appropriate and adequate training for the statutory duties that they are required to perform.

The circular also set out what it considered to be the ASW's role. Paragraph 14 provides:

> Approved social workers should have a wider role than reacting to requests for admission to hospital, making the necessary arrangements and ensuring compliance with the law. They should have the specialist knowledge and skills to make appropriate decisions in respect of both clients and their relatives and to gain the confidence of colleagues in the health services with whom they are required to collaborate. They must be familiar with the day-to-day working of an integrated mental health service and be able to assess what other services may be required and know how to mobilise them ... Their role is to prevent the necessity for compulsory admission to hospital as well as to make application where they decide this is appropriate.

Liability

Under MHA 1983 s114 ASWs carry out their duties personally and on the face of it have personal liability. However, this should be read in conjunction with s139(1), which states that:

> No person shall be liable, whether on the ground of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VII of this Act, unless the act was done in bad faith or without reasonable care.

In other words, the section protects the ASW from a negligence action in the vast majority of cases.

Acting in bad faith or without reasonable care has been judicially considered in *Richardson v London County Council*.[2] It seems to be a question of fact, with the burden of proof lying on the applicant to prove bad faith or negligence. It was also stated that the predecessor to this section offered protection even when the person proceeded against acted either without jurisdiction or misconstrued the Act, as long as the misconstruction was one which the Act was reasonably capable of bearing. Although a mistake about the law comes within the scope of this section, it is arguable that professional people who have functions placed on them by an Act are under an obligation to acquire knowledge about the law they are operating. The person seeking a remedy for an alleged mistake of law would be obliged to apply for judicial review of the decision.[3]

The more recently decided case of *M and Another v Newham London Borough Council*[4] seems to limit further the ability of persons to sue a council or its employees for breach of statutory duties. This case concerned the duties of local authorities in performing their public law functions relating to the care of children in need. It was held that an action for breach of statutory duty or common-law negligence could not be maintained by a child against the local authority in respect of acts or omissions which the authority was allegedly responsible for in the exercise of its functions as a social services authority. Some of the principles in this case could be applied to ASWs in the field of mental health.

In summary, provided social workers act in good faith, an action in negligence is unlikely to be successful.

Use of guardianship

A guardianship order can be made in civil proceedings under MHA 1983 s7 or in criminal proceedings under s37.

Under s7(2), a guardianship application may be made in respect of a patient on the grounds that:

> (a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental

impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section; and
(b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.

If this definition is read with that of mental disorder contained in MHA 1983 s1, it is clear that it is not possible for a person with learning difficulties whose behaviour is not associated with abnormally aggressive or seriously irresponsible conduct to be made subject to guardianship.

Two medical reports are required for an application in support, one usually by the person's general practitioner and the other by an approved psychiatrist.

In the majority of cases the local authority becomes the guardian, but other people can be made guardians if the local authority approves.

Guardian's powers

The effect of a guardianship order is that the guardian has the following powers (s8(1)):

- to require the patient to reside at a place specified by the guardian, eg, Part III accommodation provided by the local authority under the National Assistance Act 1948;
- to require him/her to attend at places and times specified for treatment, occupation, education and training; this might include day centres or sheltered workshops;
- to ensure that access to the patient by an ASW or doctor is given, even if the patient is in a hostel or privately rented accommodation.

It is important to stress that there is no power to ensure that medication is taken by the person concerned.

Guardianship has the effect of covering a person with a protective umbrella. It is aimed at those people with mental disorders who do not require treatment in hospital, either informally or formally, but nevertheless need close supervision and some control in the community. These include people who are able to cope, provided they take medication regularly, and those who neglect themselves to the point of seriously endangering their health. It mainly relates to those who are mentally impaired. It is initially granted for six months but is renewable from year to year.

Drawbacks

Some local authorities use guardianship often, but many do not use it at all. Several reasons have been put forward why it has not been used more frequently.

- It is costly to resource. It resembles a supervision order under the Children Act 1989, with the same difficulties concerning provision of adequate supervision.
- There is some uncertainty among local authorities and social workers over the extent of their powers.
- Local authorities have a right to refuse to be guardian when an application is made by another person, subject to making a reasoned decision.
- A guardianship order cannot compel a person to live in local authority accommodation.

Increased use?

There needs to be a re-examination of guardianship's merits by social work professionals if it is going to be used more frequently.

There has been consultation and discussion regarding the use of a community supervision order or community treatment order which would give the power to enforce treatment of mentally ill patients outside hospital. This has not found favour with many working in the field of mental health.[5]

Examples of where guardianship might be used effectively include:

- *An elderly woman suffering from senile dementia, who is living at home, does not wish to go into hospital and is likely to deteriorate if she does. There is little support from relatives and she requires constant supervision to ensure that she takes medication.* Provided that she falls within the definition of mental disorder in MHA 1983 s1, guardianship under s7 could be useful to avoid the need for hospital admission.
- *A young man suffering from mental disorder, who will neglect himself if not closely supervised and if medication is not taken.* Guardianship could ensure that he is cared for appropriately in a hostel or at home, rather than in hospital.
- *The nearest relative objects to plans for care in a hostel, lodgings or attendance at a day centre, but the patient is either unable to disagree or wishes to follow the local authority's plans.* Guardianship might be useful, provided that a successful application could be made to displace the nearest relative under MHA 1983 s29 (see below).
- *A near relative or other person is causing positive harm by visiting a person in lodgings or in a hostel.* A guardianship order could prevent this happening.
- *A social worker is concerned at allegations of sexual abuse by a relative against a young woman with learning difficulties or mental impairment living within the family. The police might be reluctant to intervene and the evidence would not stand up in court.* An application to displace the nearest relative and then introduce guardianship could be used, since it is arguable that allowing oneself to be abused is seriously irresponsible conduct.[6]
- *A carer, because of either his/her own advancing age or ill health, is worried about continuing to look after a dependent relative suffering from a mental disorder.* Guardianship might be used to take the pressure off the carer and to make constructive plans for care of the relative in the community in the longer term. As more traditional mental hospitals close and more patients are discharged to carers, this is an increasingly serious problem for local authorities and for central government alike.

Supervision

The Mental Health (Patients in the Community) Act 1995, which came into force on 1 April 1996, makes provision for a responsible medical officer to apply to a health authority for a patient who is being discharged to be placed under supervision, the supervisor usually being a community psychiatric nurse.

There are similarities between guardianship and supervised discharge; for example, both contain a provision which may require the patient to live in or attend a certain place but no provision to enforce the taking of medication. It will be interesting to see if supervised discharge is used any more widely than guardianship.[7]

Displacement of nearest relative

If the nearest relative objects to guardianship and thinks it an inappropriate order for the person concerned, then it will be necessary to make an application under MHA 1983 s29 to displace the nearest relative. 'Nearest relative' is defined in s26.

Section 29(1) provides:

The county court may upon application ... direct that the functions of the nearest relative of the patient ... shall, during the continuance in force of the order, be exercisable by the applicant, or by any other person specified in the application, being a person who, in the opinion of the court, is a proper person to act as the patient's nearest relative and is willing to do so.

The section lists those who may make such applications, but in the main they are made by ASWs.

The grounds for such an application are set out s29(3):

(a) that the patient has no nearest relative within the meaning of this Act, 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 of the patient unreasonably objects to the making of an application for admission for treatment or a guardianship application in respect of the patient; or
(d) that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient from hospital or guardianship under this Part of this Act, or is likely to do so.

It should be remembered that, where a patient is detained for assessment under MHA 1983 s2, the detention continues lawfully until an application under s29 has been determined and for a further period of seven days thereafter.

A problem arises where an ASW thinks it appropriate for the patient to be detained under s3 and the nearest relative does not consent. This is all very well where the detention is moving from s2 to s3 and a s29 application is pending. It is far less straightforward if detention for treatment is

applied for under s3 with no previous reference under s2 or, for example, where the detention is progressing from initial temporary detention under s5(2) (doctor's holding power).

There is guidance within the code of practice[8] to indicate those situations in which s2 detention for assessment is appropriate and those when s3 detention for treatment is appropriate.

If there is no consent from the nearest relative and it is inappropriate to detain for assessment, perhaps because of frequent recent admissions for assessment under s2, there may be no power to detain a patient pending the determination of the s29 application. A s29 application cannot be made ex parte, and it can take some time for such an application to be determined by the court. If there is grave risk to the patient and/or the public, then the code of practice may have to be overridden. This is likely to be a point for heated debate among mental health professionals.

The code of practice and MHA 1983 ss11(4) and 13(1) impose a duty on an ASW to consult with the nearest relative. If the nearest relative is also suffering from a mental disorder and it is not possible to consult constructively, then an application may be necessary under s29 to displace him/her, in view of the provisions of s11(4).

Making the application

These applications are fairly rare and there is only limited guidance within the *County Court Practice*.

Great attention is required by the legal department of the local authority to ensure that the most appropriate procedure is followed. There is generally no point in an interim hearing because it causes delay and, once service of the application has been effected on the nearest relative, then the case should be listed for an urgent hearing. The approved ASW will have to give evidence in support of the application, supported by a psychiatric report and oral evidence from the psychiatrist if the report cannot be agreed.

Many s29 applications are based on the ground that the nearest relative unreasonably objects to admission for treatment or guardianship. The case of *W v L*[9] involved consideration of what was unreasonable objection. In this case it was held that the test under MHA 1959 s52(3)(c), as it then was, was an objective one. Lawton LJ said that, since mental illness was not defined in the Act and the words had no special medical or legal meaning, they should be given their ordinary meaning and should be construed in the way ordinary sensible people would construe them. In this particular case the ordinary sensible person, on being informed of the patient's behaviour, would have said that the patient was obviously mentally ill.

In *Re B*[10] an application was made by Liverpool City Council for the nearest relative of a patient to be displaced under s29 on the ground that he unreasonably objected to the making of a guardianship application. The issue was raised whether in deciding the matter the court had to be satisfied that the grounds for guardianship were also established. It was held that the test to be applied is what a reasonable person would do in the circumstances. The reasonableness must be judged in relation to the criteria for a guardianship acceptance. If there is acceptable evidence of a relevant mental disorder of the appropriate degree and the welfare of the patient requires admission to guardianship, then an order for displacement would be made. It is not necessary for the court to be satisfied that the application for guardianship would be successful.

Richard Jones[11] submits that the correct approach is outlined in the case of *N v S*,[12] in which the judge said:

> The court must not substitute its own view for the view of the nearest relative ... and I accept that there is a band of decisions within which no court should seek to replace the nearest relative's judgment with its own.

He believes that a reasonable nearest relative is entitled to consider all the circumstances of the case and not just the medical recommendations. It should be remembered that the nearest relative retains one crucial right, to apply to a mental health review tribunal on behalf of the patient.

Powers of entry

The definition of mental illness in *W v L* can be used by an ASW to make an application under MHA 1983 s135(1) to the magistrates for a warrant authorising a constable to enter premises if there is reasonable cause to suspect that a person believed to be suffering from mental disorder

> (a) has been or is being ill-treated or neglected or kept otherwise than under proper control ... or
> (b) being unable to care for himself, is living alone in any such place.

Magistrates tend to adopt a fairly common-sense approach to these applications. If an elderly person has not been seen to follow his/her usual routine for some weeks and, even with no obvious psychiatric history, has been seen to be acting bizarrely and against his/her own interests, then such an application for a warrant may be successful.

Conclusion

Applications made by a local authority under MHA 1983 are fairly rare and mental health practitioners may be unfamiliar with the law and the procedure. It is hoped that this article will improve the ability of those on the mental health review tribunal panel to deal with such cases.

David Fish is a solicitor in Walsall, a former solicitor to Staffordshire Social Services Department and a member of the Law Society's Children Panel. An application for membership of the MHRT panel is pending.

1 DHSS Circular no 86(15) dated 24 November 1986.
2 [1957] 1 WLR 751.
3 On judicial review see the series of articles by Stephen Cragg and Lee Bridges in October, November and December 1994 *Legal Action*.
4 (1994) *Times* 3 March, CA.
5 See article by Jonathan McLeod in *Law Society's Gazette* 13 January 1993 p11 and news item 20 January 1993 p5. The article indicated that one existing alternative to a new supervisory order would be greater use of guardianship.
6 An example was provided by Peter Edwards at a recent training course organised by North West Law Conferences for solicitors working within local authorities.
7 See DoH guidance in HSG (96)11, 15 February 1996.
8 Department of Health and Welsh Office, Mental Health Act 1983 Code of Practice (1993) paras 6-048ff.
9 [1973] 3 WLR 859, CA, decided under MHA 1959 s52.
10 (1985) 29 November, Liverpool County Court, unreported.
11 Richard Jones, *The Mental Health Act Manual* (Sweet & Maxwell 4th edition 1994).
12 (1983) 1 January, Croydon County Court, unreported.