7. A tribunal's powers in unrestricted cases

INTRODUCTION

This chapter deals with a tribunal's powers in respect of unrestricted patients. These patients comprise —

For a brief summary and comparison of a tribunal's powers in these cases, see the introduction. As to whether a tribunal may have regard to irregularities in the authority for the patient's detention, guardianship or supervision, see page 574.

PATIENTS DETAINED UNDER SECTION 2

A tribunal's powers when dealing with the case of a patient who is liable to be detained for assessment are specified in section 72, the relevant parts of which are set out on the following page.

SUMMARY OF POWERS

A tribunal must discharge a section 2 patient whom it considers satisfies the statutory criteria for being discharged set out in section 72(1)(a) — "mandatory discharge." Where the mandatory discharge criteria are not satisfied, it may still discharge the patient at its discretion if it considers that is appropriate having regard to all the circumstances of the case — "discretionary discharge." A tribunal which discharges a patient may direct that the discharge take effect on a specified future date, rather than forthwith, regardless of whether discharge is mandatory or discretionary. A tribunal which does not discharge may, with a view to facilitating a patient's discharge on some future date, recommend that he be granted leave of absence, transferred to another hospital, or transferred into guardianship. In the

event that its recommendation is not complied with, the tribunal may further consider the case. In summary, a tribunal is obliged to discharge if the relevant statutory criteria are satisfied, may in other cases discharge at its discretion and, where it does not discharge, may make certain statutory recommendations with a view to facilitating discharge in the future.

POWERS OF TRIBUNALS IN SECTION 2 CASES

Discretionary discharge

72.—(1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and

Mandatory discharge

(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if they are satisfied—

(i) that he is not then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or
(ii) that his detention as aforesaid is not justified in the interests of his own health or safety or with a view to the protection of other persons.

Future discharge

(3) A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction;

Recommendations

and where a tribunal do not direct the discharge of a patient under that subsection the tribunal may—

(a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and
(b) further consider his case in the event of any such recommendation not being complied with.

References

(6) Subsections (1) to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a tribunal by or in respect of a patient.

TERMINOLOGY

As to the meaning of the words used in the admission and discharge criteria, see "discharge" **(466)**; "patient" **(098)**; "liable to be detained" and "detained" **(467, 585)**; "satisfied" **(567)**; "then" **(466)**; "suffering from" **(213)**; "mental disorder" **(051)**; "nature or degree" **(213)**; "warrants" **(215)**; "detention" **(215)**; "hospital" **(131)**; "assessment" **(231)**; "treatment" **(216)**; "for at least a limited period" **(226)**; "ought to be so" and "justified in the interests of"" **(221, 227, 466)**; "health" **(217)**; "safety" **(218)**; "protection of other persons" **(219)**. By way of summary—

- A person whose symptoms are merely controlled by medication still "suffers from" mental disorder. Furthermore, the fact that a person is in remission, and there are no longer any obvious symptoms or signs of mental disorder, is not proof that the underlying disorder is not of a severe nature.

- The words "nature" and "degree" are not interchangeable. The word "degree" focuses attention on the present manifestations of any mental disorder which exists. The word "nature" focuses attention on precisely that: the characteristics of the patient's condition, its historical course and chronicity, and the prognosis associated with any diagnosis made. A condition may be severe because it is acute (of a severe degree) or because it is chronic or progressive and difficult to treat (of a severe nature).

- "Warrants" denotes a condition the nature or degree of which is sufficiently serious to require the use of the particular compulsory power. The "the unsoundness of mind, whose presence is essential to justify a compulsory order, manifestly means more than mental illness which qualifies a person to be a voluntary patient ... in ordinary language "certifiable" is perhaps more likely to be used to express the same idea."[1]

- "Detention" refers to the case of a person lawfully held against his will, one who is not free to depart when he pleases.

- "Assessment" involves assessing from a clinical viewpoint the patient's need for prolonged treatment and assessing from a legal viewpoint the necessity of prolonged and potentially indefinite compulsory treatment.

- "Medical treatment," unless the context otherwise requires, "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision."[2]

- "Health" may be described as the standard of physical and mental functioning necessary for a person to perform the activities which are expected of him, according to the norms of the society in which he lives; all *disabling* disease, illness and handicap must be absent.

- "Safety" denotes freedom from physical harm. A patient's safety may be at risk because of his own acts (dangerous conduct towards himself), his omissions to act (self-neglect), how others act towards him (exploiting or ill-treating him), or omit to act towards him (failing to care for him).

- The expression "protection of other persons" indicates a need to protect other persons from the consequences of the patient's actions, including psychological injury and damage to property resulting from his mental state.

- "Justified in the interests of" means that the patient "ought to be detained"[3] because of the possibility of harm to himself or others if he is not.

1 *Buxton v. Jayne* [1960] 2 All E.R. 688 at 697, *per* Devlin L.J.
2 Mental Health Act 1983, s.145(1).
3 The expression used in the section 2 admission criteria.

The discharge criteria closely correspond to the original grounds for admission under section 2 or 4. The expression "ought to be detained" in section 2(2)(b) is, however, replaced in section 72(1)(a)(ii) by a reference to the patient's detention being "justified." In both cases, the contrast is between that which is necessary (detention under section 3) and that which ought to be done and can be justified (detention under section 2). The other difference is the addition of the word "then" in the discharge criteria, the effect of which is that a tribunal must discharge a patient if it is satisfied that there are no grounds for detention under section 2 at the time of the hearing — the tribunal is not reviewing whether such grounds existed at the time of the patient's admission to hospital. The word should not, however, be interpreted so literally as to mean that a tribunal must therefore disregard the history of the patient's condition or recent fluctuations in his mental state. These are relevant because they define the nature of his present condition. The point generally arises where there is good evidence that a patient who presents very well at the hearing was floridly ill a day or two previously. This may indicate a qualitative improvement in his mental health but it may also be evidence merely that his mental state fluctuates markedly over short periods of time. Likewise, the fact that a person behaved violently towards a nurse a week before the hearing may, in the absence of evidence that circumstances have materially changed, be an indication that detention continues to be justified with a view to protecting others.

The meaning of "discharge"

In assessment cases, "discharge" means to discharge the patient from his liability to detention under section 2, not discharge from hospital (**571**). Consequently, a tribunal must discharge a patient who requires in-patient assessment or in-patient treatment if it is satisfied that his condition does not warrant detention for either of these purposes or that his detention in hospital is not justified with a view to his health or safety or the protection of others.

Completed "assessments"

Section 72(1)(a)(i) requires a tribunal to "discharge" a patient detained under section 2 if they are satisfied that he is not "then" suffering from mental disorder "or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by a medical treatment) for at least a limited period." The extent of this obligation has caused considerable debate, leading some tribunals to conclude that a duty to discharge arises if the assessment of a patient's need for treatment has been concluded prior to the hearing. The meaning of "assessment" in this context has already been considered in some detail (**231**). By way of summary, it has been submitted that where a patient is assessed not to be mentally disordered, the first of the reasons for detaining him has been fulfilled and the second also in that no treatment will follow what constitutes a completed assessment. Similarly, both statutory purposes have been fulfilled once a patient has been assessed not to suffer from any form of mental disorder which warrants compulsory treatment, continued detention being warranted neither for assessment or treatment. Where, however, a patient has been assessed to suffer from a disorder which does warrant detention for treatment, neither his responsible medical officer nor a tribunal is thereby bound to discharge him simply because the former has commenced

the treatment which the patient has been assessed to need. It would be remarkable if Parliament intended that whenever an assessment of a patient's condition demonstrates a need for compulsory treatment — that is that the assessment should be "followed by treatment" — a tribunal is then obliged to discharge the patient by virtue of this positive finding of a serious mental disorder. If this were correct a patient must be discharged both when he is assessed not to need compulsory treatment and when he is assessed to need such treatment. Insofar as the drafting is indifferent, the phrase "(or for assessment followed by medical treatment)" may properly be read as meaning "(or for medical treatment following assessment)" where treatment has already been commenced before the hearing. Accordingly, section 72(1)(a)(i) should be read as follows —

> *"(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if they are satisfied (i) that he is not then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for medical treatment following assessment) for at least a limited period."*

Patients not requiring in-patient assessment or treatment

Section 72 requires a tribunal to discharge a patient who is "liable to be detained" under section 2 if it is satisfied either that his mental disorder is not of a kind which warrants his "detention in a hospital ..." or that "his detention as aforesaid" is not justified for one of the permitted purposes. In contrast, a tribunal is only obliged to discharge a section 3 patient where satisfied that his mental disorder is not of a kind which makes it appropriate for him to be "liable to be detained in a hospital ..." As McCullough J. noted in *ex p. W,*[4] those "liable to be detained" are those who are detained and those who have leave to be absent from hospital. Consequently, a tribunal is not obliged to discharge a section 3 patient merely because he is not presently receiving in-patient treatment — the issue is whether his condition makes it appropriate for him to remain liable to detention. The question arises whether the use in the section 2 discharge criteria of the word "detained" in preference to "liable to be detained" is simply loose drafting or is intended to require tribunals to discharge patients who do not presently require in-patient assessment or in-patient treatment.

The argument that "detained" means "liable to be detained"

Section 72(3) provides that a tribunal which does not "discharge" a section 2 patient may recommend that he be granted leave of absence, with a view to facilitating his "discharge" on a future date. This suggests that a tribunal is not invariably under a duty to discharge a section 2 patient who does not presently need to be detained in hospital. Otherwise, the fact that a tribunal considers leave appropriate would oblige it to discharge and the option of recommending leave as a way of facilitating discharge would not exist. The "assessment" includes assessing whether any treatment assessed to be necessary can be given outside hospital, and the words "detained" and "detention" in section 72(1)(a) mean "liable to be detained" and "liable to detention" respectively.[5]

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4 *R. v. Hallstrom, ex p. W. ; R. v. Gardner, ex p. L.* [1986] 2 All E.R. 306.

5 The word "detained" in mental health legislation has often been interpreted as including persons who have leave to be absent from hospital. See *e.g. Safford v. Safford* [1944] P.61. The word "detained" is also used in section 72(2), a usage which was considered in *ex p. W.* : "Presumably this is to be taken as covering one on leave of absence and only 'liable to be detained,' for discharge means not merely discharge from hospital but discharge from the authority to detain."

The argument that "detained" means "detained"

The counter-argument is simply that the draftsman's use of the word "detained" in relation to the section 2 criteria for discharge, and "liable to be detained" in relation to the section 3 criteria, must be deliberate. Section 72(1)(a) and (b) both commence with a common initial reference to patients who are liable to be detained. In both cases, the phrase does not form part of the criteria for discharge. Its purpose is to emphasise that a patient must be liable to be detained, in the sense that his detention is legally authorised, before he can be discharged by a tribunal. The Act then goes on to use the word "detention" twice in the discharge criteria for section 2 patients but not at all in the criteria which determine whether a section 3 patient must be discharged. This is because there is no obligation to discharge a patient previously detained for treatment if his condition justifies no more than a period of trial leave outside hospital. However, in section 2 cases, the purpose of the admission is more specific. It is to detain a person in order to assess his need for in-patient treatment and to provide any in-patient treatment assessed to be necessary. If, on a proper assessment of the patient's mental state, a tribunal is satisfied that his condition does not presently warrant detention in hospital, or that his detention there is not justified for his health or safety or to protect others, the limited purpose of the admission has been completed. In other more finely-balanced cases, the phrasing of the discharge criteria as a double-negative comes into play. If a tribunal is *not* satisfied that a section 2 patient's detention is unwarranted or unjustified, it is not obliged to discharge him. In this case, it may recommend that he be granted leave, which may help to facilitate his future discharge by establishing whether further detention and treatment in hospital is unwarranted or unjustified. Nevertheless, it does not follow from the fact that a tribunal may recommend (some) leave in finely balanced cases, where the patient cannot overcome the double-negative, that it need not discharge a patient if it *is* satisfied that his condition does not presently warrant detention, or it is satisfied that his detention there is not presently justified.

Summary

The argument is finely balanced. However, it is submitted that a tribunal must discharge a section 2 patient if it is satisfied that the nature or degree of his mental disorder is not at present so serious that detention in hospital is warranted, either for assessment or treatment. Likewise, if it is satisfied that detention in hospital is not presently justified for one of the three statutory purposes. This will generally be the case if open-ended, "extended", leave has been granted, unless the tribunal's opinion is that this leave is inappropriate in the light of the patient's condition.

DISCHARGE ON A FUTURE DATE

Section 72(3) not only empowers a tribunal to postpone the discharge of a patient whom it has discharged at its discretion, but also to delay the discharge of a patient who is entitled to be discharged. A tribunal's power to defer making a direction for a restricted patient's conditional discharge should not be confused with this power to direct that an unrestricted patient shall be discharged on a specified future date. In the former case, the patient's discharge may never be directed. In the latter case, the tribunal's direction that the patient be discharged is complete and in force the moment it is made: it is not provisional upon future events.[6]

[6] In *Grant v. The Mental Health Review Tribunal for the Trent Region; R. v. The Mersey Mental Health Review Tribunal, ex p. O'Hara, The Times*, 26 April 1986 (**549**), McNeill J. observed that the power is one "wholly different" to deferred discharge under section 73(7).

Postponing mandatory discharge

Because of the tribunal's finding that there were no longer any statutory grounds for the patient's detention, it was previously sometimes argued that a mandatory discharge could not be postponed under section 72(3): once it had been established that there were no legal grounds for detaining him, he had to be immediately set at liberty.[7] This was always a somewhat weak argument. The paramount rule of statutory construction is that "every statute is to be expounded according to its manifest and expressed intention"[8] and all other rules of interpretation are subordinate to it.[9] As Crane pointed out, since section 72(3) clearly shows that the legislature intended to allow a discharge to be postponed for a specified period of time, section 72(1) must be interpreted in this light. If there was any ambiguity about section 72(3), it needed to be pointed out.[10] That a tribunal which is under a duty to direct a patient's discharge may direct that he be discharged on a future date, rather than forthwith, was recently confirmed in *R. v. South Thames Mental Health Review Tribunal, ex p. P.* The case is also quite interesting as an example of the operation of section 72(1)(b)(iii) (**491**) and of rule 18, which allows two tribunal applications concerning the same patient to be joined (**637**).

R. v. Mental Health Review Tribunal for North Thames Region, ex p. P

CO/1467/96, 20 May 1997 — *Q.B.D., Harrison J.*

On 29 April 1996, a tribunal considered two applications made in respect of the same patient, who was detained under section 3. One of them she had herself made and the other had been made by the statutory nearest relative under section 66(1)(g), following the issue of a report barring discharge. The tribunal received two written reports from the responsible medical officer's senior house officer. These indicated that the patient's medication had been increased following a relapse and that the administration of compulsory ECT under section 58 would need to be considered during the following fortnight if her depression did not respond. The tribunal heard evidence from the patient's new responsible medical officer, who stated his opinion that it was necessary to detain her in the interests of her health and safety, but not in order to protect others. To the best of his knowledge, she had never tried to harm herself and had not admitted to any suicidal ideation or intent. He was, however, concerned that she would, if discharged, further withdraw, refuse medication and harm herself. A nursing report confirmed that the patient had at no time been an actual or potential danger to herself or to others, and that she was compliant with medication. The patient's evidence was that, if discharged, she would return to live with her mother and would take her medication, attend out-patient appointments and see a social worker. She was, however, opposed to receiving ECT. Her mother, who was the nearest relative, indicated that she would like her daughter to be discharged so that she could come home as soon as possible.

[7] In *R. v. Oxford Mental Health Review Tribunal, ex p. Stoddard* (January 1994, unreported), a tribunal directed that a patient who satisfied the criteria for mandatory discharge be discharged in four months' time. This was in order to enable a care assessment to be carried out and a care plan put in place. In the opinion of Treasury Counsel, the power to postpone discharge was only available where the patient was being discharged under the tribunal's discretionary power. Moreover, any other construction might contravene Article 5(1) of the European Convention on Human Rights. The application for judicial review was therefore conceded by the tribunal.

[8] *Attorney-General for Canada v. Hallett & Carey Ltd.* [1952] A.C. 427 at 449, *per* Lord Radcliffe.

[9] *Prince Ernest of Hanover v. Attorney-General* [1956] Ch. 188 at 201, *per* Evershed M.R.

[10] M. Crane, "Discharge under MHA 1983" in *LAG Bulletin*, November 1995.

The tribunal's decision in respect of the patient's application

In relation to the patient's application, the tribunal did not direct her discharge. Expressing their findings as a double negative, they were not satisfied as to existence of the grounds for mandatory discharge. As to their discretionary power of discharge, the patient's depression was unlikely to lift spontaneously and to return her to the community would be doing her a great disservice.

The tribunal's decision in respect of the nearest relative's application

In relation to the nearest relative's application, the tribunal directed that the patient be discharged on 20 May 1996. As to the additional ground for mandatory discharge in such cases, set out in section 72(1)(b)(iii), the tribunal was satisfied that the patient would not, if released, be likely to act in a manner dangerous to other persons or to herself: "Accordingly, the mother's application must succeed but we postpone discharge pursuant to section 72(3) until 20 May so that the patient may receive such further treatment as the RMO thinks appropriate, which may include ECT."

The application for judicial review

On 8 May 1996, Popplewell J. granted the patient leave to apply for judicial review and he further granted an interim injunction restraining the responsible medical officer from administering ECT pending the hearing of the application. The issue was whether a tribunal which has a duty to discharge a patient under section 72(1)(b) may, under section 72(3), direct that that discharge shall take place on a future date. On the patient's behalf, it was submitted that the power of postponement was only available when a tribunal exercised its discretionary power of discharge. If a patient was entitled to be discharged, any deferral of that discharge was inconsistent with the duty to discharge which had arisen.

Harrison J.

Section 72(3) provided that a tribunal which discharged a patient under section 72(1) could direct that this discharge take place on a future date specified in its direction. A direction to discharge under section 72(1) could be a discretionary discharge or a mandatory discharge and section 72(3) did not in any way confine the power to cases of discretionary discharge under section 72(l). There was no ambiguity and, if Parliament had intended the power to apply only to such cases, it could and would have said so. The argument advanced on the patient's behalf involved reading the word "forthwith" into section 72(1)(b) and also some limiting phrase, such as "when exercising the discretionary power to direct the discharge of a patient," into section 72(3).The way section 72 operated was that a tribunal had, first of all, to apply the statutory criteria for discharge and decide whether it was obliged to discharge the patient (mandatory discharge) and then, secondly, if it was not obliged to do so decide whether to discharge the patient at its discretion (discretionary discharge). Having decided that it either had to or would direct the patient's discharge, it thirdly had to consider whether that discharge should be immediate or whether it should —pursuant to section 72(3)— be on a future date specified in the direction.

Purpose of the deferment

The legislation did not specify the circumstances in which, or the purposes for which, deferment of discharge could or should he directed. There was force in the point that one would not normally expect to delay a discharge if the patient was entitled to it. It was of paramount importance that the power to defer discharge should not be used so as to circumvent the obligation to discharge if the statutory criteria in section 72(1)(a) or (b) were met. If there was such a misuse of the power, the remedy of judicial review would be available. As to the

present case, the application judicial review had been based on the proposition that there was no power to defer discharge if a duty to discharge existed. However, during the course of argument, the patient's counsel had raised the question of whether, if such a power existed, it might have here been exercised for an unlawful purpose. In particular, the power had, it was said, been exercised in order to enable her to receive compulsory treatment, rather than for some purpose connected with the statutory issue raised by section 72(1)(b)(iii), *i.e.* whether she would, if released, be likely to act in a manner dangerous to other persons or to herself. That was an argument worthy of serious consideration. However, the judicial review hearing was taking placed on the day set by the tribunal for the patient's discharged and she would no longer be detained when the parties were in a position to fully argue the point. It was therefore not practicable to determine it. Although the point could not be decided, and it would not be right for the court to express any concluded view on this aspect of the case, His Lordship harboured grave reservations about whether the exercise of the power in this case was lawful.

Summary

On a proper construction of section 72(3), a tribunal had power to direct the discharge of a patient on a future date in circumstances where there was a mandatory duty to discharge the patient under section 72(1)(b)(iii). It followed that the application must be dismissed. *Application dismissed and interim injunction discharged.*

Postponement must be for purpose of discharge

In *ex p. P.*, the issue of precisely when the power of postponement might not be available was raised but not resolved. It is submitted that the position is as follows.

1. Provided that a tribunal has sufficient information to determine the patient's current suitability for discharge, it must determine whether or not it is satisfied that he is presently entitled to be discharged. It may not adjourn the hearing to see if his condition improves, with a view to discharge at a later reconvened hearing.[11] Nor may it may defer a restricted patient's discharge under section 73(7) in the hope that he may be suitable for discharge by the time the conditions of discharge are met.[12] Nor therefore may it direct, under section 72(3), that a patient shall be discharged on a specified future date in the hope or expectation that his mental state will by then have improved sufficiently for discharge to be mandatory or appropriate.

2. It follows that a direction that a patient shall only be discharged after further compulsory in-patient treatment is given is incompatible with a finding that he is not presently suffering from a mental disorder which warrants further detention for treatment or which makes it appropriate for him to remain liable to such treatment. It is similarly incompatible with a finding that further treatment in hospital is unnecessary for the patient's health or safety or to protect others.[13]

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11 *R. v. Nottingham Mental Health Review Tribunal, ex p. Secretary of State for the Home Department, R. v. Northern Mental Health Review Tribunal, ex p. Secretary of State for the Home Department*, *The Times*, 25 March 1987, Q.B.D.; *The Times*, 15 September 1988, C.A.

12 See *e.g.*, *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department* [1988] 1 A.C. 120.

13 This was, of course, not the case in *ex p. P.* since the tribunal refused the patient's application.

3. However, in some cases, a tribunal's finding that the patient is entitled to be discharged rests on the evidence which it has received about the arrangements which can be made for him outside hospital. As to this, Lord Bridge stated in the Oxford case that a tribunal "may perfectly properly be satisfied that hospital detention is no longer necessary provided that [a restricted patient] can be placed in a suitable hostel and required to submit to treatment as an out-patient by a suitable psychiatrist. These are matters to be secured by imposing appropriate conditions."[14]

4. In unrestricted cases, a tribunal may similarly decide that it is under a duty to discharge the patient because arrangements can be made for his treatment and care outside hospital which, once made, mean that continued liability to detention in hospital is unwarranted, inappropriate, or unnecessary having regard to his present mental condition. If it is the case that it is only when those arrangements have been made that further liability to detention is inappropriate, unjustified, or unnecessary, the date of discharge may be postponed. So, for example, if it will take a fortnight to make these arrangements, postponing the discharge for that period is not incompatible with the tribunal's finding that the patient is entitled to be discharged: those arrangements constitute the basis of his entitlement.

5. The power to direct a patient's discharge on a future date is quite different from that set out in section 72(3), which enables a tribunal to defer giving a direction that the patient shall be discharged. The fact that a discharge date must be specified indicates that the power is intended to be used where a tribunal which has sufficient information to make a decision is satisfied that arrangements can be made which entitle the patient to be discharged or which make discretionary discharge appropriate.

6. In *ex p. P.*, the postponement was unlawful having regard to the statutory framework relating to applications under section 66(1)(g). This is that the nearest relative has a right to discharge the patient unless the responsible medical officer bars that discharge under section 25, on the ground that the patient is likely to behave dangerously if released, and a tribunal is not satisfied that that is not the case. The nearest relative's right to order the patient's discharge in such circumstances cannot be barred under section 25, or postponed under section 72, on the lesser ground that further detention and treatment is necessary for the patient's health.

Postponing discharge to enable section 3 application to be made

In *ex p. Wiltshire County Council*, Nigel Pleming Q.C. submitted that a tribunal cannot direct a section 2 patient's discharge on a future date merely so as to give the relevant professionals an opportunity to decide whether to make a further application authorising his detention under section 3.[15] The point was not conceded or

[14] *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department* [1988] 1 A.C. 120, at 127.

[15] "Mr. Pleming is also prepared to concede that a Mental Health Review Tribunal cannot defer discharge under section 72(3) of the Act in order to allow the authorities to decide whether there is some basis for his detention other than that which he is currently detained. That concession is not accepted by the County Council and, that being so, it would be wrong for us to endorse Mr. Pleming's concession without further argument." *R. v. Wessex Mental Health Review Tribunal, ex p. Wiltshire County Council* (1989) 4 B.M.L.R. 145., *per* Lord Donaldson M.R.

ruled upon. Nevertheless, the function of tribunals is to review the justification for compulsory powers. Their powers do not include a power to authorised a patient's detention pending the completion of an application under Part II — a sort of judicial section 5(2). Furthermore, the statutory purpose of the power of postponement is to bring about the patient's discharge from liability to detention, not to prolong the period for which he may be detained. The problem should, in any case, not arise if the mandatory discharge grounds in section 72(1)(a) are properly construed. In other words, the tribunal in *ex p. Wiltshire County Council* was wrong in its opinion that it was obliged to discharge the patient from liability to detention under section 2 because he was no longer being assessed in some restrictive sense. Had they not discharged, there would have been no need to resort to such a device as a way of enabling him to be further detained while a new application was made.

Further application prior to the patient's discharge

In *ex p. M*, the patient's case was heard by a tribunal on 14 December 1992. The tribunal was satisfied that she was not suffering from mental disorder of a nature or degree which warranted her detention in a hospital for assessment and so directed her discharge. However, the tribunal directed that the discharge be deferred until 17 December in order that social services could make arrangements for a suitable support programme. During the period between the tribunal's direction and the date on which it was to come into effect, the patient was detained under section 3. Laws J. said that he could see no basis for construing the statute so as to produce the result that the duty and discretion of the approved social worker to make the section 3 application were to any extent impliedly limited or abrogated by the existence of an earlier tribunal decision to discharge (**593**).

Future discharge and section 29 applications

A point considered, but not determined, in *ex p. Wiltshire County Council* was whether the making of a county court application, under section 29, during the period between the date on which the tribunal directed the patient's discharge and the date fixed by it for his discharge has the effect of extending the section 2 period and overriding the tribunal's outstanding direction for the patient's discharge.[16] The answer must be that it does not. A tribunal cannot postpone a patient's discharge until midnight on the 28th day because this would be equivalent to a direction that he not be discharged, that the existing authority for his detention be allowed to run its full course. It must therefore specify a date prior to the authority's expiration, whereas section 29(4) only has effect if the patient is still detained under section 2 at the moment immediately before the usual 28-day period expires.[17]

STATUTORY RECOMMENDATIONS

A tribunal which does not direct the discharge an unrestricted patient who is liable to be detained in hospital may, with a view to facilitating his discharge on a future date,

[16] *R. v. Wessex Mental Health Review Tribunal, ex p. Wiltshire County Council; Perkins v. Bath District Health Authority* (1989) 4 B.M.L.R. 145.

[17] Section 29(4) provides that the usual 28-day section 2 period shall be extended "if, immediately before the *expiration* of the period for which a patient is liable to be detained by virtue of an application for admission for assessment," an application under section 29(3)(c) or (d) is pending. That the period referred to is the 28-day period is clear from the use of the word "expiration" and the fact that the 1959 Act included an identical provision, albeit that tribunals had no power to discharge such patients.

recommend that he be granted leave of absence, or transferred to another hospital, or into guardianship.[18] It may further consider his case in the event that such a recommendation is not being complied with.[19] The power to make these recommendations also applies to unrestricted patients who are liable to be detained for treatment. Indeed, because the treatment which a section 2 patient requires is usually still being assessed, it is relatively rare for tribunals to make statutory recommendations about their future care or treatment. Moreover, the short duration of section 2 applications means that it will generally not be feasible for a tribunal to further consider the case if its recommendation is not being complied with.

Recommendations and the 1983 Rules

Although the Act provides that a tribunal "may" further consider a patient's case if its recommendation is not being complied with, the rules provide that a tribunal "shall" specify the period at the expiration of which it "will" further consider the patient's case if its recommendation is not complied with.[20] The rules then state that if, after making appropriate inquiries of the responsible authority, it appears to the tribunal that its recommendation has not been complied with, it may reconvene the proceedings after giving the parties the required notice.[21] Notwithstanding the rules, it is clear from the statute that a tribunal is not obliged to further consider the case at the expiration of any period stipulated under the rules.

Recommending leave of absence

A tribunal may recommend that a patient be granted leave of absence with a view to facilitating his discharge on a future date. It is then up to the responsible medical officer to decide whether suitable arrangements can be made for the patient's absence from hospital and what conditions of leave should be imposed. Leave is most often granted so that a patient can reside, or spend time, outside hospital. However, it may also be granted to enable a patient to reside at a hospital other than that in which he is liable to be detained. This is usually done as a step preparatory to formal transfer, although the power may also be used if treatment is required at a general hospital. Two points may be noted. Firstly, the actual grant of leave and the imposition of any conditions of leave, such as a condition of residence or a condition that the patient remains in custody during his absence, are matters for the responsible medical officer. Similarly, whether the patient should be in the custody of a person other than a hospital employee is a matter for the hospital managers. All a tribunal may do is to recommend leave generally. Secondly, the purpose of recommending leave must be to facilitate the patient's discharge on a future date, rather than to enable him to undergo an operation or to attend some function.

Recommending transfer to another hospital

A tribunal which does not discharge a patient may recommend that he be transferred to another hospital with a view to facilitating his discharge on a future date. Thus, as Mann J. observed in *Secretary of State for the Home Department v Mental Health Review Tribunal for Mersey Regional Health Authority*, provision is made

18 Mental Health Act 1983, s.72(3)(a).
19 *Ibid.*, s.72(3)(b).
20 Mental Health Review Tribunal Rules 1983, r.24(4) and 33.
21 *Ibid., rr.25(2) and 33.*

for the achievement of an in[illegible]n regime preparatory to discharge.[22] In assessment cases, the power may be used to recommend a patient's transfer to a unit with special expertise in assessing and treating conditions of the kind from which he is suspected to suffer. In other cases, the power may be used to recommend a patient's transfer from a high or medium secure unit to his local catchment area hospital. It may, of course, be the case that the nominated hospital is unable to accommodate the patient so that the recommendation cannot be implemented. Because the recommendation may only be made with a view to facilitating the patient's future discharge, it is unlawful for a tribunal to recommend transfer from a local hospital to a special hospital because of concerns for the public's safety. Notwithstanding this, it has been known for such recommendations to be made with that purpose in mind.

Recommending transfer into guardianship

Where a section 2 patient is transferred into guardianship, he is treated as if he had been received into guardianship in pursuance of a guardianship application accepted on the date of his admission to hospital under section 2. However, patients detained for assessment are not recorded as suffering from a particular form of mental disorder and no provision is made for a form of mental disorder to be recorded at the time of transfer. Following transfer, such patients also have no right to apply to a tribunal until the next period of guardianship has commenced, which in section 2 cases will necessarily not be for at least five months.

The rationale of recommendations for transfer into guardianship

The effect of a transfer into guardianship is necessarily that the patient ceases to be liable to be detained for treatment. Consequently, it might be argued that if the tribunal's opinion was that the nature or degree of the patient's condition warranted guardianship, rather than continued liability to detention in hospital, it was in fact under a legal duty to discharge him. However, the criteria for discharge in section 72 are essentially relative, rather than absolute. Whether a tribunal is satisfied that a patient's detention is no longer warranted or appropriate often depends upon what alternative arrangements exist or can be made. Similarly, whether further in-patient treatment is justified or necessary for the patient's health or safety, or to protect others, can often only be determined by reference to the availability of a structured package of care in the community. If there is a viable alternative, the risk of early relapse or non-compliance with treatment may be slight but not otherwise. Furthermore, on a technical point, a transfer under section 19 does not involve the patient being discharged: the effect of the recommendation is to facilitate his future discharge from the authority conferred by the application or order being reviewed.

Whether the tribunal can discharge on reconvening

Where a tribunal's recommendation is not being complied with, and it reconvenes the proceedings, whether it can then direct the patient's discharge was recently considered in the unreported case of *Mental Health Review Tribunal v. J.J.H.* Before considering that case, it is worthwhile briefly summarising the historical origins of the power and the main arguments for and against a power to reconsider the original decision not to direct discharge.

22 *Secretary of State for the Home Department v Mental Health Review Tribunal for Mersey Regional Health Authority* [1986] 1 W.L.R. 1170.

Historical origins of the power

Under the Mental Health Act 1959, a tribunal had no statutory power to make recommendations. It could only discharge or not discharge a patient and, if the latter, reclassify him in appropriate cases. Paragraph 6.5 of the Government's 1978 White Paper[23] dealt with the proposals, set out in an earlier consultative document,[24] for extending the powers of tribunals in unrestricted cases—

> "There has been general endorsement of the Consultative Document's proposals for extending the powers of Tribunals to enable them to order delayed discharge (for up to three months) and to recommend trial leave, transfer to another hospital or conditional discharge. The distinction between ordering and recommending is an important one and takes account of the need for the agreement of others, *e.g.* the receiving hospital or social services department. It is proposed to adopt the suggestion that a Tribunal should be informed if any of their recommendations are not accepted and why, and that, if not implemented within a specified time, the Tribunal should be able to make an alternative finding. Recommendations by Tribunals for trial leave and transfer to another hospital do not entail legislative change. The Act does not however make express provision for the conditional discharge of unrestricted patients from hospital ... The purpose of conditional discharge would generally be to ensure that on discharge the patient remained resident in a particular place or continued to undertake some specified form of treatment. "

Mental Health (Amendment) Act 1982

In accordance with these proposals, the 1982 Act made provision for statutory recommendations and discharge on a future date. The idea of recommending conditional discharge in unrestricted cases was, however, rejected and replaced by a power to recommend transfer into guardianship.[25] Initially, Parliament envisaged that the power to make recommendations would be set out in the Mental Health Review Tribunal Rules but in the event the power was placed on a statutory footing.[26]

"Further consider the patient's case"

Although the White Paper of 1978 envisaged that tribunals would be able to make an alternative finding, the proposals set out there did not reach the statute book in their envisaged form. The matter is one of statutory intent and the rules cannot be used to construe the statute.[27] The question is whether the words "further consider the patient's case" can properly be interpreted as meaning or including "further consider its decision" or "further consider the patient's case and make any decision which it may make under section 72(1)." The case law concerning restricted patients indicates that a tribunal's decision as to whether or not to discharge is a final

23 *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978).

24 *A Review of the Mental Health Act 1959* (D.H.S.S., 1976), paras. 8.12–8.17.

25 See *e.g. Hansard*, H.L. Vol. 426, col.783, *per* Lord Sandys, who said with regard to the non-implementation of recommendations: "The Committee may say that recommendations are all very well, but recommendations are not always implemented, so that the tribunal's wishes may not be put into effect. But we intend to provide for this eventuality also by setting down in the rules that if the tribunal's recommendations are not implemented within a certain period — say three months — then the tribunal should reconvene to consider why this is and whether another course of action now seems preferable."

26 See e.g. *Hansard*, H.L. Vol. 426, col. 784.

27 In any case, rule 25(2) is poorly drafted and of little assistance. It refers to giving notice of the reconvened hearing to the Secretary of State although a tribunal has no power to make such recommendations in restricted cases. To this extent, the rule would appear to be ultra vires: *R. v. The Mersey Mental Health Review Tribunal, ex p. O'Hara, The Times*, 26 April 1986 (549).

decision, one which cannot later be reconsidered if arrangements cannot be made fulfilling the conditions imposed.[28] Against this, the powers of tribunals in unrestricted cases are clearly far wider and allow for the exercise of discretion. More particularly, whilst section 73(7) does not provide that a tribunal may reconsider the patient's case if satisfactory arrangements are not made, section 72(3) expressly confers a discretionary power to further consider the patient's case.

Arguments concerning a power of discharge upon reconvening

The main arguments in favour of a power of discharge upon reconvening are as follows: (1) the ambit of the words is deliberately as broad as possible, leaving the issue of how to proceed to the tribunal's discretion; (2) the natural meaning of to further consider someone's case is that the body concerned should review his overall circumstances, including his mental condition and whether compulsory powers are still required; (3) if Parliament had intended that tribunals should have no power to discharge, it would have made that explicit, since the words used in the statute clearly make that interpretation possible; (4) though not strictly relevant, there is some evidence that Parliament intended that tribunals should have the option of reaching an alternative finding; (5) it is clearly unsatisfactory, and hence probably not what Parliament intended, that a tribunal which further considers a patient's case should have no power to discharge him at the end of the reconvened hearing if it is of the opinion that he is entitled to be, or should be, discharged; (6) the *Oxford case* can be distinguished because of the absence in section 73(7) of any power to further consider a restricted patient's case and the absence of any discretion in restricted cases; (7) the use of the words "further consider" in preference to "reconsider" indicates that the tribunal is not reconsidering its earlier decision but may at its discretion make a further decision; (8) the words "further consider his *case*" should be read together with the words "the tribunal may in any *case* direct that the patient be discharged" in section 72(1); (9) accordingly, a tribunal which reconvenes can further consider discharge but cannot be required to further consider it. The main arguments against a power of discharge are: (1) Parliament cannot have intended that patients may have a further opportunity to be discharged if a tribunal's recommendation is not complied with but not if it is complied with; (2) section 72(3) provides that the power to make a recommendation facilitating future discharge arises only where a tribunal "do not direct the discharge of a patient" under section 72(1); thus, the tribunal has already determined the patient's application to be discharged; (3) had Parliament intended to empower tribunals to discharge a patient in such circumstances, it would have made this explicit by the use of some phrase such as "further consider the patient's case, including its decision not to discharge him"; (4) the purpose of a recommendation is to facilitate future discharge if it is complied with, not discharge if it is not complied with; (5) the words "further consider the patient's case" mean to consider why its recommendation is not being complied with and to take or encourage any action which may lead to existing obstacles to its implementation being overcome.

Mental Health Review Tribunal v. J.J.H.

Although not all of these arguments were referred to in *Mental Health Review Tribunal v. J.J.H.*, and the historical origins of the power appear not to have been considered, the court held that a tribunal which further considers a patient's case under section 72(3) has precisely the same powers as it had at the original hearing.

28 *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department*, [1988] 1 A.C. 120.

Mental Health Review Tribunal v. J.J.H.

CO/3946/96, 10 July 1997 — *Q.B.D., Kay J.*

The patient was detained under section 3. On 9 July 1996, his application was heard by a tribunal. Having not directed his discharge, the tribunal recommended his transfer to another hospital. The recommendation was not complied with and the question arose as to what were its powers at the reconvened hearing. The tribunal reluctantly concluded that it had no power to reconsider its original decision; all it could do was to consider the reasons for the failure to comply with its recommendation. The patient challenged the ruling.

Kay J.

There was no authority on the point and it was therefore necessary to apply the normal rules of statutory interpretation. On the face of it, the use of the words "his case" in section 72(3)(b) suggested that the tribunal could consider the whole matter again. "His case" must mean his application for discharge: that was the case that had been considered and therefore the case that was to be further considered. If it had been Parliament's intention to restrict the tribunal's further consideration of the case to the recommendations made by it, the subsection could very readily have been worded "further consider such recommendation." Bearing in mind that the subection dealt with the liberty of the subject, it would require some very compelling reason to read it in a way that was unfavourable to the patient. Three main arguments had been advanced against the interpretation suggested by him: (1) It was contended that the wording of the subsection contradicted such a straightforward interpretation. The first clause of subsection 72(3) required a tribunal to make a decision as to the patient's release on a future date. It was only when that direction was ruled out that the question of whether a recommendation should be made arose. Hence, the further consideration involved considering the case in the light of a decision already made, namely that he was not entitled to be, and should not be, discharged. The only further consideration allowed was the making of some other recommendation. With regard to this argument, there seemed to be no justification for reading the subsection in this restricted way. It seemed clear that Parliament, having regard to the patient's rights, wished to put in place a meaningful safeguard for the situation where a tribunal's recommendations were not followed. (2) It was then said that to interpret the subsection as giving power to make any of the decisions permitted at the original hearing placed such a patient in a more favourable position than one in respect of whom a tribunal's recommendation had been complied with. That was in a sense true but it was not a reason to interpret the provision in a way that placed him at a disadvantage vis-à-vis a patient whose recommendation had been given effect. (3) The final argument was that the patient's interpretation left uncertainty as to when the tribunal's decision became final. That could not be so. When the tribunal's recommendation was implemented, the decision became final. If the recommendation was not followed, and the matter came back before the tribunal for further consideration, it would become final either then or when any alternative recommendation made by it was implemented. If there was a dispute as to whether or not the recommendation had been implemented, the tribunal would first of all resolve that issue. There was, in any case, a real sense in which such a decision was never final because the patient was entitled to periodically apply for his discharge. The only question was whether following one hearing his eligibility to be discharged should not be further considered unless and until fresh proceedings were commenced. For the reasons given, a tribunal had the same powers when it further considered a patient's case under section 72(3) as it had at the original hearing, and subject to the same statutory criteria and principles. *Tribunal's decision quashed.*

UNRESTRICTED PATIENTS DETAINED FOR TREATMENT

Where a tribunal determines the case of an unrestricted patient who is liable to be detained in hospital for treatment, its powers are specified in section 72, the relevant parts of which are set out in the table on pages 481–482. Unrestricted patients liable to be detained for treatment are detained under one of the following sections: 3, 37 (hospital orders), 47 or 48 (transfer directions).

SUMMARY OF POWERS

The majority of patients detained in hospital for treatment are not subject to special restrictions. Whatever the original authority for such a patient's detention, the Act provides that tribunals shall apply the same discharge criteria and have the same powers in all cases involving unrestricted patients detained for treatment. A tribunal's powers are similar to those in respect of patients detained for assessment, so that the cases of all unrestricted in-patients are dealt with in a comparable way. In particular, a tribunal is required to discharge a patient who satisfies the statutory criteria for being discharged set out in section 72(1)(b), may at its discretion discharge a patient where this is not so and, if it does not discharge, may make the same kinds of recommendations as in a section 2 case. Discharge may, as before, either be forthwith or on a specific future date. There are, however, three important differences. When deciding whether to exercise its discretionary power of discharge, a tribunal must have regard to certain statutory matters set out in section 72(2). Furthermore, a tribunal which does not discharge may recommend that a supervision application be made; and it may also direct that the form of mental disorder from which the patient is recorded as suffering on the authority for his detention be amended, so as to show that he is suffering from some other form. A similar power of reclassification would be superfluous in section 2 cases because all patients detained for assessment are classified as suffering from "mental disorder" generally, rather than from one or more of its particular forms.

STATUTORY FRAMEWORK

The statutory criteria which determine whether a tribunal must discharge a patient who is liable to be detained for treatment do not correspond to the criteria which regulate their admission to hospital and any renewal of the authority to detain them. The respective criteria are set out in the table on page 483 and the differences illustrate the relatively limited nature of a tribunal's functions. In particular, a tribunal is not bound to discharge such a patient merely because it is satisfied that his condition is not treatable in the statutory sense and takes the view that, as matters presently stand, the criteria for later renewing the authority for his detention are not satisfied. Likewise, a tribunal is not bound to discharge a mentally ill or severely mentally impaired patient merely because it is satisfied that his condition is not treatable and he would not be vulnerable if discharged (**492**).

Historical development of powers

The present statutory framework is also exposed by considering a tribunal's powers under the previous statute and the amendments made to it. Under the Mental Health Act 1959, a tribunal had a like duty to discharge if satisfied as to the statutory cri-

teria and it could discharge at its discretion where this was not the case. There were, however, no issues which, as a matter of law, it had to have regard to before exercising its discretion to discharge. Moreover, a tribunal which discharged a patient could not discharge him on a future date and, if it did not discharge, it had no power to make any statutory recommendations of the kind which it may now make, although it could reclassify. The discharge grounds were set out in section 123 of that Act and they were materially different to the present criteria in relation to the two universal grounds for mandatory discharge—

Mental Health Act 1959	*Mental Health Act 1983*
123.—(1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and shall so direct if they are satisfied—	**72.** —(1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and (b) the tribunal shall direct the discharge of a patient ... if they are satisfied—
(a) that he is not then suffering from mental illness, psychopathic disorder, subnormality or severe subnormality; or	(i) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
(b) that it is not necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should continue to be liable to be detained;	(ii) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment;

As can be seen—

- Under the 1959 Act, unless a tribunal was satisfied that the patient was not mentally disordered, it was only obliged to discharge him if it was satisfied that it was unnecessary in the interests of his health or safety, or for the protection of others, that he "should continue to be liable to be detained. "
- The previous reference in the second ground as to whether or not it is necessary for the patient to continue to be liable to be detained has been replaced by a reference to whether or not it necessary for his health, etc., that he should receive "such treatment." Different views are taken about whether the reference to "such treatment" in section 72(1)(b)(ii) is a reference to the necessity of treatment in a hospital as a detained patient or simply a reference to the necessity of treatment in a hospital (**488**).
- Conversely, a reference to the patient's detainability has been added to the first ground, which now requires a tribunal to consider whether it appropriate that the patient should remain liable to be detained in a hospital for medical treatment.

Discretionary discharge

/

Mandatory discharge

Criteria applicable in all cases

72. —(1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if they are satisfied—

(i) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or

Additional criteria where a nearest relative applies following a report barring discharge

(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself.

Matters which a tribunal must have regard to in determining whether to exercise its discretionary power of discharge

(2) In determining whether to direct the discharge of a patient detained otherwise than under section 2 above in a case not falling within paragraph (b) of subsection (1) above, the tribunal shall have regard—

"Treatability test"

(a) to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and

"Vulnerability test"

(b) in the case of a patient suffering from mental illness or severe mental impairment, to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation.

Future discharge

(3) A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction;

Recommendations with a view to facilitating discharge	and where a tribunal do not direct the discharge of a patient under that subsection the tribunal may— (a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and (b) further consider his case in the event of any such recommendation not being complied with.
Other recommendations	(3A) Where, in the case of an application to a tribunal by or in respect of a patient who is liable to be detained in pursuance of an application for admission for treatment or by virtue of an order or direction for his admission or removal to hospital under Part III of this Act, the tribunal do not direct the discharge of the patient under subsection (1) above, the tribunal may— (a) recommend that the responsible medical officer consider whether to make a supervision application in respect of the patient; and (b) further consider his case in the event of no such application being made.
Reclassification	(5) Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the tribunal do not direct that the patient be discharged ... the tribunal may, if satisfied that the patient is suffering from a form of mental disorder other than the form specified in the application, order or direction relating to him direct that that application, order or direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate.
References	(6) Subsections (1) to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a tribunal by or in respect of a patient.

STATUTORY CRITERIA FOR ADMISSION, RENEWAL AND DISCHARGE CONTRASTED

Grounds for detention under section 3	*Grounds for renewal — s.3,37,47, 48 patients*	*Tribunal criteria for discharge — s.3,37,47, 48 patients*
An application may be made in respect of a patient on the grounds that—	It appears to the responsible medical officer that—	The tribunal shall direct the discharge of a patient if they are satisfied—
▪ he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital;	▪ the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital;	▪ that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment;
—and—	*—and—*	*—or—*
▪ it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.	▪ it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained;	▪ that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment
—and—	*—and either—*	*In determining whether to exercise its discretionary power of discharge a tribunal shall have regard—*
▪ in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition.	▪ such treatment is likely to alleviate or prevent a deterioration of his condition	▪ to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and
	—or—	*—and—*
	▪ in the case of mental illness or severe mental impairment, the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation.	▪ in the case of a patient suffering from mental illness or severe mental impairment, to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation.

TERMINOLOGY

For the meaning of the words used in the admission and discharge criteria, see—"discharge" (**485**) and "released" (**491**); "patient" (**098**); "detention," "detained" and "liable to be detained" (**215, 487, 585**); "satisfied" (**567**); "then" (**466**); "suffering from" (**213**); "mental illness" (**060**); "psychopathic disorder" (**082**); "severe mental impairment" (**070**); "mental impairment" (**070**); "nature or degree" (**213**); "appropriate" (**490**); "hospital" (**131**); "medical treatment" (**216**); "necessary" (**221, 485**); "health" (**217**); "safety" (**218**); "protection of other persons" (**219**); "dangerous" (**218**). By way of summary—

- A person whose symptoms are merely controlled by medication still "suffers from" mental disorder. Furthermore, the fact that a person is in remission, and there are no longer any obvious symptoms or signs of mental disorder, is not proof that the underlying disorder is not of a severe nature.

- The words "nature" and "degree" are not interchangeable. The word "degree" focuses attention on the present manifestations of any mental disorder which exists. The word "nature" focuses attention on precisely that: the characteristics of the patient's condition, its historical course and chronicity, and the prognosis associated with any diagnosis made. A condition may be severe because it is acute (of a severe degree) or because it is chronic or progressive and difficult to treat (of a severe nature).

- "Appropriate" in the context of the section 3 admission criteria refers to a person whose condition makes in-patient treatment appropriate, irrespective of whether detention is necessary for that purpose. However, the test in section 72(1)(b)(i) is whether liability to detention in hospital for treatment is appropriate. The "the unsoundness of mind, whose presence is essential to justify a compulsory order, manifestly means more than mental illness which qualifies a person to be a voluntary patient ... in ordinary language "certifiable" is perhaps more likely to be used to express the same idea."[29]

- Patients who are "liable to be detained" for treatment are those who are detained in hospital and those who have leave to be absent from hospital under section 17. Accordingly, a tribunal is not obliged by virtue of section 72(1)(b)(i) to discharge a patient who has leave to reside at home or in a hostel, or who it considers should be granted leave of absence, unless it is also satisfied that it is inappropriate for him to remain liable to be detained in a hospital for further medical treatment.

- "Medical treatment," unless the context otherwise requires, "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision."[30]

- "Health" may be described as the standard of physical and mental functioning necessary for a person to perform the activities which are expected of him, according to the norms of the society in which he lives; all *disabling* disease, illness and handicap must be absent.

[29] *Buxton v. Jayne* [1960] 2 All E.R. 688 at 697, *per* Devlin L.J.

[30] Mental Health Act 1983, s.145(1).

- "Safety" denotes freedom from physical harm and a patient's safety may be at risk because of his own acts (dangerous conduct towards himself), his omissions to act (self-neglect), how others act towards him (exploiting or ill-treating him), or omit to act towards him (failing to care for him).

- The expression "protection of other persons" indicates a need to protect other persons from the consequences of the patient's actions, including psychological injury and damage to property resulting from his mental state.

- "Necessary" is stronger than the phrase "justified in the interests of" which is used in relation to section 2. Many things which are not necessary may nevertheless be justified.

THE CRITERIA FOR MANDATORY DISCHARGE

The customary view is that discharge in relation to unrestricted patients means merely discharge from liability to detention for treatment while, in relation to restricted patients, it means discharge both from hospital and from liability to detention for the time being (**571**). Accordingly, a tribunal is under a duty to discharge an unrestricted patient who requires further treatment in hospital if it is satisfied that it is not appropriate for him to be liable to be detained there for that treatment. In other words, it is appropriate for him to receive any further in-patient treatment as an informal patient.

The two common discharge grounds

In all cases, a tribunal must discharge a patient if it is satisfied that he is entitled to be discharged on one of two grounds—

- The first of them, which is set out in section 72(1)(b)(i) and is sometimes referred to as the "diagnostic question," requires the tribunal to consider whether the patient is suffering from a mental disorder the nature or degree of which makes it appropriate for him to be liable to be detained for in-patient treatment.

- The second ground, which is set out in section 72(1)(b)(ii), requires considering whether such treatment is "necessary" for the patient's own health or safety or to protect others. The criteria which comprise the second ground are therefore directed towards the issue of risk: the likelihood of undesirable consequences if the individual does not receive necessary medical treatment. The risks may consist of a likelihood of significant deterioration in his health, a risk to his physical safety, or a risk to others.

The combined effect of the two grounds is that a tribunal must terminate a patient's liability to detention in a hospital for treatment if it is satisfied that it is unnecessary for his health or safety or to protect others that he receives further in-patient treatment *or* it is satisfied that it is no longer appropriate for him to be liable to be detained in a hospital in order to receive treatment there.

THE NATURE OR DEGREE OF DISORDER AND SECTION 72(1)(b)(i)

The nature or degree of mental disorder which makes admission, removal or renewal appropriate is different from that which determines whether a tribunal is bound to discharge a patient under section 72(1)(b)(i).

Section 3 patients and section 72(1)(b)(i)

The admission grounds and the renewal criteria require only that the patient's condition is such that in-patient medical treatment is appropriate.[31] Accordingly, the first of the statutory grounds for detention or renewal exists if this is so regardless of whether detention for in-patient treatment is also appropriate. The issue of whether the patient's detention is necessary forms part of the second universal ground for making an application or renewing the authority conferred by it — this requires both that in-patient treatment is necessary for the patient's health or safety or for protection of others and that it cannot be provided unless he is detained.

Admission and renewal criteria	*Tribunal discharge criteria*
• The patient is suffering from a form of mental disorder the nature or degree of which makes it appropriate for him to receive medical treatment in a hospital.	• The patient is not suffering from a form of mental disorder the nature or degree of which makes it appropriate for him to be liable to be detained in a hospital for medical treatment.

The reasons why the admission and renewal grounds separate out the two issues of the appropriateness of in-patient treatment and the necessity for detention have already been explained (**215**). However, in this context, the important point is that the tribunal discharge criteria do not adhere to the same format: a patient must be discharged if the nature or degree of his condition makes it inappropriate that he should remain liable to be detained for further in-patient treatment. The issue is the appropriateness of liability to detention rather than actual detention. It does not suffice that in-patient treatment is appropriate but, equally, it is not essential that a patient presently requires in-patient treatment if it is nevertheless appropriate that he should remain liable to be detained for further in-patient treatment. That being so—

1. Even if further in-patient treatment is appropriate, a tribunal must discharge a patient under the first ground if it is satisfied that his condition no longer makes it appropriate for him to be liable to be detained for that purpose.

2. Conversely, a tribunal is not obliged to discharge a patient who has extended leave to be absent from hospital unless it is satisfied that his condition makes it inappropriate for him to be liable to be detained for further in-patient treatment. This is so even though it is necessarily of the opinion that he could not currently be admitted afresh under section 3 and nor could the authority to detain him be renewed if renewal was due.

31 See Mental Health Act 1983, ss.3(2)(a) and 20(4)(a).

Part III patients and section 72(1)(b)(i)

In contrast to the first ground for detention under section 3, admission for treatment under sections 37, 47 and 48 requires that the court or the Secretary of State is satisfied that the patient is suffering from a form of mental disorder the nature or degree of which makes it appropriate for him to be "detained" in a hospital for medical treatment. This reflects the absence in Part III of any requirement that the patient's admission for treatment is necessary for his health or safety or to protect others and it cannot be provided unless he is detained. However, following admission, the same renewal and tribunal discharge criteria apply to all unrestricted patients who have been detained for treatment. In the case of Part III patients, the first of the grounds for renewal is less stringent than the original admission ground. This is because renewal is possible provided his condition makes further in-patient treatment appropriate, regardless of whether continued detention in hospital is appropriate. As to a tribunal's duties, it has already been noted that a tribunal must discharge an in-patient whom it is satisfied no longer needs to be liable to be detained. Conversely, it need not discharge a patient who is no longer in hospital unless satisfied that it is inappropriate for him to remain liable to detention for further in-patient treatment. With regard to section 48 patients, while removal requires that their condition necessitates urgent treatment, whether or not this remains the case is irrelevant insofar as the renewal and tribunal discharge criteria are concerned.

Whether and when liability to detention is appropriate

The use of a "liability to detention" test takes account of three possible situations encountered in practice. Firstly, it may not be appropriate to continue to detain or to compulsorily treat some in-patients. Secondly, it may be appropriate for some in-patients who have been seriously ill to initially leave hospital on a trial basis and to be liable to recall during the current period of detention if further in-patient treatment is indicated. Thirdly, it may similarly be appropriate for some patients already no longer in hospital to remain liable to recall for further in-patient treatment because of the risk of relapse.

Patients who are receiving in-patient treatment

Although it is sometimes said that the test set out in section 72(1)(b)(i) is whether it is appropriate to physically detain the patient in hospital, this is something of a simplification. The existence of an authority to detain a patient not only empowers the managers to detain him in the hospital, using restraint if necessary. It also has the necessary consequence that the patient may only leave the ward or hospital with permission and, where necessary, only then with an escort or subject to conditions. The administration of treatment without his consent is also authorised. Accordingly, it may be appropriate for an in-patient to remain "liable to be detained" even though he would not otherwise immediately leave hospital. For example, because he might otherwise refuse prescribed medication; intermittently absent himself in a way that undermines the treatment programme or puts himself or others at risk; or intermittently require restraint. This is, of course, provided that in-patient treatment is necessary for his health or safety or to protect others. Bearing these points in mind, the responsible medical officer should always be asked to clarify why a power of detention is appropriate: is it because the patient may need to be restrained; that

he requires a period of trial leave before it can be established that further detention for treatment is inappropriate; or that he would otherwise discharge himself from hospital, refuse necessary treatment, or intermittently absent himself?

Patients who have extended leave of absence

As to patients who are not receiving in-patient treatment at the time of their tribunal hearing, different considerations apply. Whether the patient would deviate from his prescribed medication if free to do so is not strictly the issue. The statutory test is not whether it is appropriate to compel him to take medication at home but whether his condition makes it appropriate for him to be liable to detention in a hospital for further medical treatment *there*. Furthermore, some degree of non-compliance may not be likely to give rise to any need for further treatment in hospital, in which case the purpose served by the admission has been completed.

THE RISK GROUND AND SECTION 72(1)(b)(ii)

Section 72(1)(b)(ii) provides that a tribunal shall discharge a patient if it is satisfied that it is not necessary for his health or safety or to protect others "that he should receive such treatment." In the *Oxford case*, Lord Bridge said in passing that this phrase "must here mean treatment under detention."[32] Consequently, in practice, the phrase is often taken by tribunals to refer back to sub-paragraph (i) and to mean that it is unnecessary for the patient to remain liable to be detained in a hospital for medical treatment. However, that is not actually what section 72 says and textbook opinion on the point varies. Jones' note reads as follows: "Compare with the criterion set out in para. (a)(ii). The patient will not gain his discharge if he satisfies the tribunal that treatment under detention is not necessary: he must show that medical treatment is not necessary."[33] Similarly, Gostin and Fennell comment: "Thus if the tribunal is not satisfied that the patient does not need in-patient care in the interests of his own health, it is not required to discharge him even if satisfied that detention is not necessary for his safety or for the protection of others."[34] However, Gostin writing on his own states: "Criterion (ii) is set in the disjunctive. Thus, the patient need not be discharged if detention is necessary for his health or safety or the protection of others."[35] The *Memorandum* on the Act is of no assistance, completely confusing the two grounds for discharge.[36] It is submitted that Jones' interpretation, and that of Gostin and Fennell collectively, is the correct one. The phrasing of section 72(1)(b)(ii) materially differs from that used in section 123(1)(b) of the 1959 Act, and in sections 3(2)(c), 20(4)(c) and 72(1)(a)(ii) of the 1983 Act, and the omission from section 72(1)(b)(ii) of any reference to the necessity of detention must be deliberate. The correct approach is to decide first of all whether further in-patient treatment is unnecessary. If it is, it cannot possibly be appropriate for an individual to remain liable to detention in a hospital when further treatment there is unnecessary. If, however, the tribunal is not satisfied that further in-patient treatment is unnecessary, the issue becomes whether it is nevertheless satisfied that the patient's condition is not of a nature or degree which makes it appropriate for him to remain liable to detention in hospital for the purpose of giving him any in-patient treatment which is or may be necessary.

32 *Campbell v. Secretary of State for the Home Department* [1988] 1 A.C. 120, at 127.
33 R. Jones, *Mental Health Act Manual* (Sweet & Maxwell, 5th ed., 1996), p.256.
34 L. Gostin and P. Fennell, *Mental Health: Tribunal Procedure* (Longman, 2nd ed., 1992), p.88.
35 L. Gostin, *Mental Health Services — Law and Practice* (Shaw & Sons), para. 18.08.2.
36 *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X* (D.H.S.S., 1987), para. 214.

Patients detained under section 3 and section 72(1)(b)(ii)

It is a condition of admission under section 3, and of any renewal, that it is necessary for the patient's health or safety or for the protection of others that he receives in-patient treatment and "it cannot be provided unless he is detained under this section" or, in the case of renewal, "continues to be detained." The tribunal discharge criteria are, however, different. They require a tribunal to discharge only if they are satisfied "that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment."

Admission and renewal criteria	*Tribunal discharge criteria*
• The patient's mental condition makes it appropriate for him to receive medical treatment in a hospital.	• The patient is not suffering from a form of mental disorder the nature or degree of which makes it appropriate for him to be liable to be detained in a hospital for medical treatment.
• ... such treatment is likely to alleviate or prevent a deterioration of his condition.	
• It is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment *and it cannot be provided unless he is detained under this section/continues to be detained.*	• It is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment.

It can be seen that the additional admission and renewal condition, that "such treatment" cannot be provided unless the patient continues to be detained, is omitted from the tribunal discharge criteria. Equally, it is not replaced by a requirement that such treatment cannot be provided unless he continues to be *liable to be detained.* The reason given for this at the time was that a tribunal might otherwise be obliged to discharge a patient because necessary in-patient treatment could be provided without him being liable to be detained.[37] The change also ensured that the two issues of the need for in-patient treatment and the need for compulsion remained separate (**215**).

Whether further in-patient treatment is or may be necessary

Section 72(1)(b)(ii) is therefore concerned with the issue of whether further in-patient treatment is or may be necessary for one of the statutory purposes, the references to "such treatment" in sections 3, 20 and 72 being references to the necessity of medical treatment in hospital, rather than the necessity of *compulsory* in-patient or out-patient treatment.[38] Unless a tribunal is satisfied that further in-patient treatment is unnecessary, it has not been demonstrated that the purpose of the patient's admission, which was for him to receive necessary in-patient treatment, has been fulfilled. Even if he is not presently in hospital, in order to establish if he can now cope or be treated outside hospital, whether this trial absence will prove to be permanent or temporary, and whether a tribunal can be satisfied that further in-patient treatment is no longer necessary, may often be unclear. Whether it is appropriate for the patient to be continued to be liable to be detained for medical treatment in a hospital is a separate matter, to be considered under sub-paragraph (i).

37 See *Mental Health (Amendment) Bill: Notes on Clauses, House of Commons* (D.H.S.S., 1982), p.150.
38 See also the different form of words used in section 72(1)(a)(ii) in relation to section 2 patients.

The significance of the distinction

The effect of the omission in section 72(1)(b)(ii) is that the appropriateness of in-patient treatment constitutes the first ground for admission and renewal, while the necessity for compulsion forms part of the second universal ground, but the position is reversed when it comes to the tribunal discharge criteria. The reversal is significant for two reasons—

1. Firstly, while compulsory admission and renewal requires that the in-patient treatment considered to be necessary cannot be provided unless the patient is detained — in other words detention is also necessary — a tribunal is not required to consider if this is in fact the case. If it is not satisfied that further in-patient treatment is unnecessary, it is only obliged to discharge the patient if it is satisfied that it is inappropriate for him to remain liable to be detained for that purpose. Whether a tribunal considers that liability to detention is "appropriate" is a much looser and more subjective test than considering whether further in-patient treatment cannot be provided unless the patient remains liable to be detained. What is appropriate in any particular situation involves balancing several, often competing, considerations. The issue is therefore whether the patient's health or safety or the need to protect others necessitates further in-patient treatment, rather than whether those considerations necessitate his further detention: the issue there is not whether his continued liability to detention is unnecessary but whether it is inappropriate in all the circumstances.

2. The second consequence relates to the fact that tribunals sometimes deal with cases involving patients on extended leave in terms of whether compulsory out-patient treatment is necessary for the patient's health or safety or to protect others. However, a tribunal must discharge a patient under paragraph (b)(ii) if it is satisfied that further in-patient treatment is unnecessary for one of the permitted purposes. This is so however convenient or beneficial it is to be able to enforce out-patient treatment, in particular medication, during what remains of the current period of detention. The statutory test is whether further in-patient treatment is or may be necessary, not whether the patient should be liable to compulsory treatment in the community. Of course, the two issues will be factually related if it is likely that the patient will immediately cease medication and relapse if discharged, so that further in-patient treatment is necessary. However, that is often not the case.[39]

[39] Again, section 72 accords with the statutory framework. Admission and renewal require that in-patient treatment or further in-patient treatment is necessary. If further in-patient treatment may be necessary during the current period of detention then a further renewal is a possibility and a tribunal is not required to discharge the patient. If further treatment in hospital does then prove to be necessary, the authority to detain him may be renewed. If, however, a tribunal is satisfied that further in-patient treatment will not be necessary, the purpose served by section 3, which was to admit the patient to hospital for medical treatment, has been served. Thereafter, one is simply allowing the section to continue as a community treatment order.

Part III patients and section 72(1)(b)(ii)

It is not a ground of admission for treatment under Part III that it is necessary for the patient's health or safety, or to protect others, that he receives in-patient treatment and it cannot be provided unless he is detained under that section. Section 37 requires instead that the court is of the opinion that a hospital order is the most appropriate way of disposing of the case, having regard to all the circumstances including the nature of the offence, the character and antecedents of the offender, and the other available methods of dealing with him. Transfer directions under sections 47 and 48 require that the Secretary of State is of the opinion that it is expedient to direct the person's removal to hospital for treatment, having regard to the public interest and all the circumstances. However, following admission, the same renewal and tribunal discharge criteria apply to all unrestricted patients detained for treatment. Consideration must then be given to whether in-patient treatment *is* necessary for the patient's health or safety or to protect others and, in the case of renewal, to whether it can be provided without the patient being detained. Whether the patient's presence in hospital is in the public interest, and the other matters referred to in original criteria for making such orders and directions, are irrelevant except insofar as they are evidence of the appropriateness of the patient's detention.

Summary

A tribunal must terminate a patient's liability to detention in a hospital for in-patient treatment if it is satisfied that it is unnecessary for his health or safety or to protect others that he receives further in-patient treatment or it is satisfied that it is no longer appropriate for him to be liable to detention in a hospital in order to receive treatment there.

NEAREST RELATIVE APPLICATIONS AND S.72(1)(b)(iii)

Where a tribunal application is made under section 66(1)(g) — that is by the nearest relative following the issue of a report barring him from ordering a section 3 patient's discharge — the criteria for mandatory discharge include a third ground. In such cases, a tribunal must also discharge the patient where satisfied that "the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself." This ground therefore corresponds to the statutory ground upon which the patient's discharge was barred (**610**). The Act therefore distinguishes between detention which is necessary or justified for the patient's own health or safety, or to protect others, and the likelihood of dangerous behaviour. What constitutes dangerous conduct has already been considered (**218**) and it may simply be noted here that the Butler Committee equated "dangerousness with a propensity to cause serious physical injury or lasting psychological harm."[40]

"If released"

As to why section 72(1)(b)(iii) refers to the patient being dangerous "if released," rather than dangerous "if discharged," the reason for the substitution is not readily apparent.[41] The ground upon which an order barring discharge may be made, which

[40] *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 4.10.

[41] The word "release" is only used in three other places in the Mental Health Act 1983: ss. 50(1), 51(4), and Sched. 5, para. 35(1). Its use was more common in the 1959 Act, the usage there ("released from the hospital") corresponding to that in Sched. 5, para. 35(1).

is the act giving rise to the tribunal, is that the responsible medical officer believes that the patient would "if discharged" be likely to act in a dangerous manner. Logically, the tribunal are considering the same question, namely whether it is satisfied that this is not the case: Is the patient likely to act in a dangerous manner if the tribunal directs his discharge, that is releases him? Unless it can be said that the tribunal must discharge such a patient if he is no longer in hospital — release meaning release from hospital — there would seem to be no significance in the use of the word in preference to "discharge."

DISCRETIONARY DISCHARGE AND SECTION 72(2)

Another significant difference between the admission and renewal criteria on the one hand, and the tribunal discharge criteria on the other, concerns what are by custom known as the patient's treatability and vulnerability. The authority to detain a patient may only be renewed for a further period if it appears to the responsible medical officer *either*—

a. that medical treatment in a hospital is likely to alleviate or prevent a deterioration of his condition; *or*

b. that a mentally ill or severely mentally impaired patient would, if discharged, be unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation.

However, while these two conditions form part of the mandatory renewal criteria — that is, the patient cannot be further detained unless one of them appears to be satisfied — they are excluded from the tribunal grounds for mandatory discharge. Instead, they are matters which a tribunal must have regard to when it decides whether to exercise its discretion to discharge a patient who does not satisfy the (correspondingly narrower) grounds for mandatory discharge in section 72(1)(b).[42]

Mandatory conditions for renewal	*Discretionary discharge by a tribunal*
MHA 1983, s.20(3)	*MHA 1983, s.72(2)*
The authority to detain a patient may only be renewed for a further period if it appears to the responsible medical officer either—	In determining whether to discharge a patient who does not satisfy the discharge grounds set out s.72(1)(b), a tribunal shall have regard—
▪ that medical treatment in a hospital is likely to alleviate or prevent a deterioration of his condition; or	▪ to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and
▪ that a patient suffering from mental illness or severe mental impairment would, if discharged, be unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation	▪ in the case of a patient suffering from mental illness or severe mental impairment, to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation.

[42] That this is so was confirmed in *R. v. Canons Park Mental Health Review Tribunal, ex p. A* [1994] 3 W.L.R. 630 (223).

Patients suffering only from psychopathic disorder or mental impairment

Insofar as tribunals are concerned, a person who suffers only from mental impairment or psychopathic disorder may not be compulsorily admitted to hospital for treatment unless in-patient treatment is likely to alleviate or prevent a deterioration of his condition ("the treatability test"). Nor may the authority for his detention be renewed for a further period unless it appears to his responsible medical officer that further in-patient treatment is likely to confer such a benefit.[43] Whether and when treatment may be said to be likely to alleviate or prevent a deterioration of a patient's condition was considered by the Court of Appeal in the case of *ex p. A* (223). While the treatability test forms part of the mandatory conditions for admission or renewal, it does not form part of the statutory criteria for mandatory discharge by a tribunal. Instead, it is a matter which must be taken into account by a tribunal when deciding whether or not to exercise its discretionary power of discharge. Accordingly, a tribunal is not bound to discharge such a patient merely because it is satisfied that his condition is not treatable in the statutory sense and takes the view that, as matters presently stand, the criteria for later renewing the authority for his detention are not satisfied. Consequently, if the tribunal decides not to exercise its discretion in favour of discharge, the patient's responsible medical officer may later renew the authority for a further period if he disagrees with the tribunal's assessment of the patient's treatability — and this may have been part of his evidence to the tribunal. Indeed, he will be under a duty to furnish a renewal report if this is his opinion and the other conditions are satisfied. Thus, if the patient is not entitled to be discharged on some other ground, the tribunal can decline to interfere with the responsible medical officer's opinion concerning the patient's treatability and lawfully allow the patient's liability to detention to continue.[44]

Patients suffering from mental illness or severe mental impairment

It has been noted that where the responsible medical officer's opinion is that a patient suffers only from psychopathic disorder or mental impairment, he may only renew the authority for his detention if it appears to him that medical treatment in hospital is likely to alleviate or prevent a deterioration of the patient's condition ("the treatability test"). Where, however, his opinion is that the patient suffers from mental illness or severe mental impairment, renewal is permissible on the alternative ground that he would, if discharged, be unlikely to be able to care for himself, to obtain the care which he needs, or to guard himself against serious exploitation ("the vulnerability test"). The grounds for renewing the detention of a patient who suffers from mental illness or severe mental impairment are therefore somewhat broader. As to the circumstances in which a tribunal must discharge a patient, the position is similar to that just outlined. While the treatability and vulnerability tests form part of the mandatory conditions for renewing the authority to detain a person who suffers

[43] See Mental Health Act 1983, s.20(4).

[44] The point may be particularly relevant where a patient is reclassified by his responsible medical officer under section 16 with the effect that he is then recorded as suffering only from psychopathic disorder or mental impairment. The authority to detain him immediately ceases unless that doctor is of the opinion that his condition is treatable in the statutory sense. If he considers that the patient's condition is treatable, the patient remains liable to be detained but may apply to a tribunal. If the tribunal which then reviews the patient's case disagrees, being of the opinion that his condition is not in fact treatable, it is nevertheless not obliged by virtue of this finding to direct the patient's discharge. The right to a tribunal following reclassification is thus fundamentally different from that which arises following the issue of a barring report, where the tribunal must discharge if it is satisfied that the grounds for barring discharge do not apply.

from mental illness or severe mental impairment, they are not part of the statutory criteria for mandatory discharge. Instead, they are matters which must be taken into account when a tribunal decides whether to exercise its discretionary power of discharge. Accordingly, a tribunal is not bound to discharge a mentally ill or severely mentally impaired patient merely because it is satisfied that his condition is not treatable and he would not be vulnerable if discharged. And, as before, if a tribunal decides not to exercise its discretion in favour of discharge, and the patient's responsible medical officer disagrees with its assessment of the patient's treatability or vulnerability, he will later be under a duty to furnish a renewal report if this remains his opinion and the other conditions are satisfied.

Summary

While the above considerations define when a tribunal is under an obligation to discharge, they do not represent the whole picture. When a tribunal is considering whether to exercise its discretion to discharge a section 2 patient, there are no matters which it must have regard to as a matter of law. That being so, the purpose of section 72(2) is clearly to require a tribunal to address the issue of whether the patient's detention could be continued if renewal was due — whether he is still detainable in that loose sense. If the tribunal is of the opinion that further in-patient treatment will be of no benefit, and the patient will not be vulnerable if discharged, it is clearly required to carefully consider what possible justification there might be in permitting his detention in hospital for further treatment. The tribunal's view as to the patient's treatability and vulnerability also has some bearing on both of the grounds for mandatory discharge — that is, whether liability to detention is still appropriate and whether in-patient treatment is necessary for the patient's health or safety or to protect others. Why ineffective in-patient treatment is necessary needs to be spelt out.[45]

DISCHARGE ON A FUTURE DATE

Where a tribunal discharges a patient, section 72(3) provides that it may direct his discharge on a future date specified in the direction. As to whether a tribunal is obliged to discharge forthwith a patient who satisfies the statutory criteria for discharge, and who is therefore legally entitled to be discharged, see page 469. It has been known for a tribunal to direct that a patient shall be discharged on a date after the end of the current period of detention. In some cases, this is because the tribunal's decision that the patient must or should be discharged is founded on a finding that adequate alternative arrangements can be made for the patient's treatment and care outside hospital but these arrangements will not be concluded prior to the expiration of the period of detention which is drawing to a close. One argument would be that the tribunal's finding is essentially that the patient's detention under the existing authority is not unwarranted and should be allowed to run its full course. Accordingly, its finding necessarily leads to a decision not to discharge the patient. Whether the detention continues beyond then is a matter for the responsible medical officer.

[45] Most often, the reasons will be that (1) it is necessary that the patient receives nursing and care in hospital in order to protect other people, and (2) it is appropriate for him to be liable to be detained there for such treatment because his untreatable mental disorder is of a severe nature and degree, manifesting itself from time to time in violent conduct.

RECOMMENDATIONS TO FACILITATE DISCHARGE

If a tribunal does not direct that a patient shall be discharged, the natural next question is whether there are any other powers it may exercise short of discharging the patient. In this respect, a tribunal's power to make recommendations under section 72(3) with a view to facilitating a patient's future discharge, is the same as in section 2 cases (**474**). The tribunal may recommend that the patient be granted leave of absence, transferred to another hospital, or transferred into guardianship. If its recommendation is not being complied with, it may further consider the patient's case. The limits of the power to make recommendations, and whether a tribunal which reconvenes may then direct the patient's discharge, have already been considered (**476**). However, two further points may be noted. Firstly, the authority to detain a patient who is liable to be detained for treatment will lapse if he is granted extended leave of absence and is not recalled to hospital prior to the expiration of the current period of detention (**281**). Secondly, a patient who is transferred into guardianship is treated as if he had been received into guardianship on the date of his original admission to hospital under section 3 or, as the case may be, the date on which the hospital order was made. One effect of this is that the authority for his guardianship will immediately be due for renewal if, at the time of transfer, the existing authority for his detention was due to expire within two months.

OTHER RECOMMENDATIONS

Subsection 72(3A) was inserted into the 1983 Act by the Mental Health (Patients in the Community) Act 1995. It empowers a tribunal which does not discharge a patient who is liable to be detained for treatment to recommend that his responsible medical officer considers whether to make a supervision application in respect of him. The tribunal may later further consider the patient's case in the event that no supervision application is made.

Whether recommendation must be with a view to facilitating discharge

It seems quite probable that the new power will in due course be the subject of an application for judicial review. The essence of the application is likely to be that a recommendation under section 72(3A) may only be made in the same circumstances in which a recommendation may be made under section 72(3), namely with a view to facilitating the patient's discharge on a future date. In support of this contention, the argument may be forwarded that the statutory function of a tribunal is to review whether compulsory powers are necessary and it is never involved in the process of imposing compulsory powers. With the coming into force of the Mental Health Act 1959, patients could henceforth be detained for treatment without the need for any judicial order. Tribunals were therefore constituted which would enable patients who were detained to have the need for compulsory powers independently reviewed. Parliament cannot have intended that these judicial bodies — set up to protect the liberty of the subject and with the sole function of reviewing whether there were grounds for using compulsory powers — would also be involved in the process of imposing additional compulsory powers by recommending that a further application be made. Any departure from the principle that a patient may apply to a tribunal safe in the knowledge that, if his application is refused, he will not at any rate be in a worse position would require clear evidence that this was Parliament's intention. To hold otherwise would seriously undermine the very raison d'être of the tribunal system. Patients would then be disinclined to exercise their right to a

review, because of a fear that the tribunal might not only not lift existing compulsory powers but also recommend the use of further powers upon eventual discharge. Recommending that a fresh application be made is qualitatively different in this respect from recommending transfer into guardianship. In the latter case, the existing application becomes a guardianship application and the patient is only subject to guardianship for whatever remains of the period of detention previously authorised. There is no further application and he does not thereby become liable to compulsory powers for any greater period of time.

The statutory framework

Upon first reading the new provision, the purpose of inserting a whole new subsection after section 72(3) appears simply to be to clarify that a tribunal may only recommend that a supervision application be considered if the patient is liable to be detained for treatment. This reflects the fact that an application, order or direction authorising detention for treatment must first exist before a supervision application may be made. Because section 72(3) also applies to patients detained under section 2, a reference to a supervision application being made in some cases but not others could not easily have been added to the existing list of recommendations without making it so lengthy as to be virtually unreadable. However, this point does not cater for the fact that section 72(3A) does not similarly qualify the circumstances in which such a recommendation may be made by including the same words, "with a view to facilitating his discharge on a future date." That phrase could, as with section 72(3), easily have been added after the words "the tribunal may ..." but was not. It must be presumed that the omission was deliberate since the likelihood of any draftsman missing such an obvious point, when deliberating over whether to simply amend section 72(3) or to construct a new subsection along similar lines, must be virtually nil. It would clearly be illogical for a tribunal to recommend that a supervision application be considered unless it was of the opinion that there were grounds for making such an application. From the tribunal's viewpoint, the first of the statutory grounds will necessarily exist in every case where it makes the recommendation because it would otherwise have directed the patient's discharge. The second ground requires that there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services provided under section 117 after he leaves hospital. The final ground is that providing those after-care services under supervision is likely to help to secure that the patient receives them. Given its opinion that a supervision application should be considered, the tribunal's reasons for not discharging the patient are likely to include a belief that there will be a substantial risk of serious harm if the patient leaves hospital and does not receive necessary after-care. Hence, the patient is not suitable for discharge and, by implication, will not be suitable for as long as this remains the case. However, the making of a supervision application would be likely to help to secure that he receives those services, thereby reducing those substantial risks, and so making discharge more likely. In many cases therefore, the effect of making of a supervision application will necessarily be to facilitate the patient's discharge. Furthermore, it may be contended that recommending that an application is made is not qualitatively different from recommending a patient's transfer into guardianship. In both cases, the underlying purpose is to hasten the end of his liability to detention in hospital by encouraging the bringing into being of a statutory scheme for the patient's supervision and care outside hospital. While all this may often be the case, so that

the tribunal's main purpose in making the recommendation will be to facilitate discharge, by making it a more realistic option, it will not always be so straightforward. It is only a matter of time before a tribunal recommends that a supervision application be considered with the primary purpose of protecting the public from serious harm. For example, the patient may be on leave, and his current period of detention drawing to a close at the time of the hearing, so that he will soon cease to be liable to be detained. The responsible medical officer may not consider that recall is presently justified but nevertheless wish him to remain on leave for what remains of the existing period. In this situation, a tribunal which considers that the patient will probably not co-operate with after-care or take medication once he can no longer be compelled to do so, and believes that he will then relapse and there be a substantial risk of serious harm to others, may wish to recommend that a supervision application be made. This will not advance discharge because the patient will shortly cease to be liable to be detained anyway and that will not, of course, be the purpose behind the recommendation. In other cases, the responsible medical officer may indicate that he himself plans to discharge the patient in a few weeks time and the tribunal be similarly concerned by this prospect. It has a different view as to the patient's likely compliance and potential dangerousness. In yet other cases, it may simply be clear from the reasons for the tribunal's decision that it considers that the conditions for an application are satisfied and it would be prudent to make such an application, in order to ensure that a statutory scheme is in place when the patient is eventually released. However, again, it may be obvious that the primary concern is to ensure that the public are protected if the patient is discharged, for example by his nearest relative, rather than to facilitate his discharge. Virtually all that can usefully be said with regard to these situations is to repeat the fact that the likelihood of any draftsman forgetting to insert the words "with a view to facilitating discharge" in section 72(3A), when deciding whether to amend section 72(3) or to construct a new sub-section along similar lines, must be virtually nil. The omission must therefore be deliberate and reflect the intention behind the Mental Health (Patients in the Community) Act 1995. This was not to introduce additional safeguards in response to public concern that the liberty of detained patients was being unjustifiably infringed. Rather, it was to respond to their concerns that the existing safeguards against serious harm resulting from patients being in the community were insufficient. As to this, a person who has been detained for treatment may later be in the community in one of three ways — upon ceasing to be liable to be detained, upon being granted leave to be absent from hospital, upon being absent from hospital without leave — and the Act tightened the existing framework, and extended the element of control over patients in all three of these areas. Empowering a tribunal which considers that not only is the patient not suitable for discharge, but also that his discharge will lead to a substantial risk of serious harm, to recommend that the new power of supervised discharge be considered is therefore not inconsistent with the overall aims of the Act which created this new power. In the alternative, because any recommendation will often serve more than one purpose, both protecting the patient and others from serious harm and so also facilitating his discharge, the omission of the words is simply designed to avoid endless challenges based on the contention that the *primary* purpose behind the recommendation was not to facilitate discharge. Either way, even if the new power is ill-considered, it is submitted that Parliament's intention is clear. A recommendation is not invalid because it is made with a view to some purpose other than facilitating the patient's discharge.

Recommendation that consideration be given to the matter

It has been noted that a tribunal may further consider the patient's case in the event that no supervision application is made. If the responsible medical officer notifies the tribunal that he has considered but rejected making a supervision application then, even though he has complied with its recommendation, the tribunal may nevertheless still further consider the case. This is, of course, provided that the patient remains liable to be detained. If he is no longer so liable, the time for making a supervision application has passed and the tribunal application will in any case be deemed to have been withdrawn.

Power of supervised discharge already considered

Where the responsible medical officer indicates in his evidence that he has already considered and ruled out the need for a supervision application, whether the tribunal may still make the recommendation has not been decided. Strictly speaking, it would then be asking him not to consider the matter but to reconsider the decision which he has made. However, this may be too literal an approach for two reasons. Firstly, most consultants will have previously considered the matter in the limited and literal sense that they have reflected upon whether there are grounds for making an application. If "consider" in this context meant only that, it would virtually never be possible for a recommendation to be made under section 72(3A). Consequently, it is more likely that the word in this context means to consider making an application having first taken the various steps which must be taken before making an application may be considered. These preparatory steps involve consulting the various professional and non-professional persons referred to in section 25B, taking their views into account, and considering both the after-care services to be provided and any essential requirements which should be imposed under section 25D. Secondly, the contention that some general prior deliberation of the matter rules out the recommendation does not take account of the fact that the making of any recommendation entitles a tribunal to later reconvene to examine the reasons why the particular step has not been taken. The person or authority which has not carried the recommendation into effect can then be obliged to furnish the tribunal with an account of the reasons for not taking the recommended course of action. Thus, whether or not the matter has been previously considered in some general way, the purpose served by any recommendation is that the particular matter must be systematically considered, and the tribunal given reasons if the recommendation is rejected after proper consideration. Unless this view is taken, there would be little point in providing that a tribunal can further consider the case at that point. The intention therefore appears to be to require the responsible medical officer to consult the relevant persons, to consider the statutory issues, to then form an opinion about whether an application should be made, and to notify the tribunal of his view. The tribunal may then itself further consider the matter, reconvening if it finds the reasoning unconvincing or it wishes to further explore the issue.

RECLASSIFICATION

Apart from making recommendations, a tribunal has one other power in respect of patients whom it does not discharge. Section 72(5) provides that a tribunal which does not discharge a patient may in the circumstances specified direct that the authority for his detention shall be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate.

72.—(5) Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the tribunal do not direct that the patient be discharged *or, if he is (or is to be) subject to after-care under supervision, that he cease to be so subject (or not become so subject)*, the tribunal may, if satisfied that the patient is suffering from a form of mental disorder other than the form specified in the application, order or direction relating to him, direct that that application, order or direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate.

(6) Subsections (1) to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a tribunal by or in respect of a patient.

Issues arising from section 72(5)

Several questions naturally arise from any consideration of the subsection—

1. What is the purpose served by reclassification?
2. What are the legal consequences of reclassification?
3. Does the giving of a direction reclassifying the patient ever have the effect that the patient must be immediately discharged?
4. If a tribunal is satisfied that a patient's classification is erroneous, why is a direction reclassifying him not mandatory?
5. Is the power of reclassification merely one of substitution?
6. Does the power extends to restricted cases?[46]

In order to make sense of these questions, it is necessary to first summarise the legislative history.

Mental Health Act 1959

The 1959 Act provided that an application, other than one for observation, could describe the patient as suffering from more than one form of mental disorder."[47] Similarly, an order or direction was required to specify the form "or forms" of disorder from which the patient was found to be suffering.[48] The responsible medical officer could reclassify an unrestricted patient who appeared to him to be suffering from "a form" of disorder other than "the form or forms" specified in the authority.[49] A tribunal which did not discharge an unrestricted patient had the same power to reclassify a patient whom it did not discharge as now conferred by section 72(5).

[46] Consideration of this last question is postponed until later (551).
[47] Mental Health Act 1959, s.26(4), 33(5).
[48] *Ibid.*, ss.60(5), 72(5), 73(3).
[49] *Ibid.*, ss. 38(1), 63(3), 147(4), Third Sched.

It could, if satisfied that he was suffering from "a form" of disorder other than "the form" specified, direct that the authority be amended by substituting for "the form" specified such "other form" as appeared to it to be appropriate.[50] In contrast to the present position, reclassification could never be effected through the furnishing of a renewal report, no doubt because the renewal criteria did not refer to the form of disorder from which the patient was then suffering.[51] Consequently, the original classification stood unless and until the responsible medical officer or a tribunal exercised their discretionary power of reclassification. As to why reclassification might be desirable, the form of disorder recorded could have a bearing on whether the compulsory powers had effect after the patient reached the age of 25. What was important in this respect was whether the patient suffered only from a minor (psychopathic disorder or subnormality) or a major (mental illness or severe subnormality) form of disorder.

Patients subject to guardianship

The ordinary renewal criteria were the same in all cases and made no reference to the form of disorder recorded, or its nature or degree.[52] However, where a guardianship application was in force, the patient ceased to be subject to guardianship when he attained the age of 25 if he was recorded as suffering only from a minor disorder.[53] If the effect of reclassifying a patient aged under 25 was that he was now recorded as suffering from a major disorder, the application became capable of having effect after he reached that age. Conversely, if the effect was that the patient was recorded as now suffering only from a minor disorder, he immediately ceased to be subject to guardianship if aged over 25, otherwise the authority ceased when he reached that age. Different rules applied to patients subject to a guardianship order: such orders did not cease to have effect upon the patient attaining that age, regardless of the form of disorder specified in it.[54] Reclassification by the responsible medical officer gave rise to a right to apply to a tribunal in all cases. This was so notwithstanding even though it necessarily had no bearing on renewal, nor any legal consequences at all if the patient was subject to a guardianship order.

Unrestricted patients detained for treatment

The renewal criteria were, as with guardianship, the same in all cases, making no reference to the form of disorder from which a patient was recorded as suffering or its nature or degree. If the effect of amending an application was that a patient aged under 25 was then recorded as suffering only from a minor disorder, he ceased to be liable to be detained on attaining that age unless, during the two months prior to that birthday, the responsible medical officer furnished a report stating that he would, if released, be likely to act in a manner dangerous to himself or others. Where reclassification was in the other direction, so that an application no longer recorded that a patient under 25 years of age was suffering only from a minor disorder, the consequence was to render him liable to be detained after he reached that age, regardless of whether he was dangerous. Reclassification gave rise to a right to apply to a tribunal in all cases, notwithstanding that it had no bearing on the likelihood of renewal nor, in hospital order cases, any legal consequences for the order's duration.

50 Mental Health Act 1959, s.123(3).
51 *Ibid.*, s.43.
52 *Ibid.*, s.43(4).
53 *Ibid.*, s.44(1).
54 *Ibid.*, s.63(3)(b).

Summary of the old provision

The significance of a patient's classification, and thus of reclassification, under the 1959 Act may be summarised as follows: (1) it was irrelevant for renewal purposes; (2) it had no bearing on the duration of a hospital order, guardianship order or transfer direction; (3) it might have a bearing on the duration of a guardianship application or an application for admission for treatment, but not necessarily so. Notwithstanding points (1)–(3), (4) all unrestricted patients could be reclassified by their responsible medical officer or a tribunal; (5) reclassification was, however, discretionary; (6) where a patient was reclassified by his responsible medical officer, that gave rise in all cases to a right to apply to a tribunal; (7) there was no power to reclassify restricted patients.

Mental Health Act 1983

The conditions for renewing the authority for a patient's detention or guardianship now require the patient's medical officer to give his opinion of the form of disorder from which the patient appears to be suffering, and the renewal criteria differ according to the form specified. The careless references to the form or forms of disorder recorded have been carried over into the present legislation. An application, other than one made under section 2, may describe the patient as suffering from "more than one of the ... (four) forms of mental disorder ..."[55] Likewise, an order or direction made under Part III shall specify the "form or forms" of disorder from which the patient is found to be suffering.[56] Where the responsible medical officer furnishes a renewal report and "the form" of disorder specified therein is a form "other than that" previously specified, the authority "shall have effect as if that other form of mental disorder were specified in it ..."[57] Similarly, if at any other time it appears to the patient's responsible medical officer that the patient is suffering from a form of disorder other than "the form or forms" specified, he may furnish a report to that effect, whereupon the application, order or direction shall have effect "as if that other form of mental disorder were specified in it."[58] As can be seen the drafting is inconsistent. The Act provides that the authority for a patient's detention or guardianship may specify more than one form of disorder and the power to reclassify under section 16 clearly contemplates and deals with the possibility. However, the drafting of sections 20 and 72 are materially different insofar as they contemplate a single form of disorder being recorded, whether as the original classification or following an earlier reclassification. Furthermore, while the power in section 72 is expressed as one of substitution, that given to the responsible medical officer is one of adding a further form to that or those specified, although section 16(2) then partly contradicts this by suggesting that the power there is one of substitution.

55 Mental Health Act 1983, s.11(6).
56 *Ibid.*, ss.37(7), 47(4), 48(3).
57 *Ibid.*, ss.20(9), 40(4), 55(4), 145(3), Sched. 1, Pt. I, para. 6(b). Strictly speaking, it is the appropriate medical officer who furnishes such reports. However, the responsible medical officer will also be the patient's appropriate medical officer in all cases except those where a private guardian has been appointed under the Act.
58 Mental Health Act 1983, ss.16(1), 40(4), 55(4), 145(3), Sched. 1, Pt. I, para. 3. However, section 16(2) immediately contradicts section 16(1), because it is clear that, following such a reclassification, the patient may no longer be recorded as suffering from any major form of mental disorder. Thus, the responsible medical officer may also remove a form of disorder from the pre-existing classification.

The purpose served by reclassification

Reclassification under the 1959 Act frequently had important legal consequences in terms of the duration of the compulsory powers. Following the abolition of the age-limits, and given that it is the form of disorder from which the patient is found to be suffering at the time of renewal which is determinative, it is a largely pointless exercise nowadays as far as tribunals are concerned. The rationale behind providing a tribunal right of application in *all* cases can be summarised in the following way (**053, 608**). Where during the course of a period of detention, a patient's mental state, or his responsible medical officer's assessment of it, is so materially different from that upon which the current period of detention was authorised as to require legal reclassification, the continuance of the detention for the remainder of the authorised period should always be susceptible to independent review. Similarly where a patient is subject to guardianship or after-care under supervision.

The legal consequences of reclassification

The legal consequences of reclassification by a responsible medical officer are that it may necessitate the patient's immediate discharge and, in other cases, a right to apply to a tribunal arises (**302, 608**). Subject to the decision in *Re. V.E.*, the legal consequences of reclassification by a tribunal are now negligible.

Whether reclassifying ever obliges the tribunal to discharge

In *Re V.E. (mental health patient),*[59] the application for the patient's admission to hospital for treatment stated that she was suffering from mental illness. E applied to a tribunal for her discharge. The tribunal did not discharge but concluded that her condition had been wrongly diagnosed and directed under section 123(3) of the 1959 Act — which sub-section is repeated in the 1983 Act as section 72(5) — that the application for her admission be amended so as to substitute "psychopathic disorder" for "mental illness." Under the 1959 Act, an application for treatment could not be made in respect of a patient aged over 21 if she suffered only from that form of disorder. The patient was aged 40. The question arose whether the tribunal's direction that the patient be reclassified was incompatible with its direction that she not be discharged. Did its reclassification have the effect that she must be discharged on the ground that, as a person over 21 suffering from psychopathic disorder, no application could be made for her detention under the 1959 Act? The Court of Appeal held that the application remained throughout the only authority for the patient's compulsory detention. Consequently, if an amendment of the application so altered its averments that they no longer alleged circumstances which would justify detention, the patient had to be discharged. Accordingly, since the amended application alleged no more than psychopathic disorder in a patient aged 40, her continued detention could not be justified under the Act and she was entitled to be discharged. In any event (*per* Lord Widgery C.J.), she was entitled to discharge by reason of the fact that on a proper diagnosis she had never qualified for detention at all. Under the present statute, there is only one circumstance in which precisely the same legal situation may arise. That is where a tribunal do not discharge an unrestricted patient detained under section 48 but reclassify the form of mental disorder recorded to psychopathic disorder or mental impairment. A transfer direction cannot be made under section 48 in respect of a person suffering only from

[59] *Re V.E. (mental health patient)* [1973] 1 Q.B. 452 (577).

such a "minor" form of mental d[illegible]der and, hence, according to *Re V.E.*, the patient must be immediately discharged.

Why directing reclassification is not mandatory

The power to reclassify conferred by section 72(5) is permissive rather than obligatory and section 16(1) provides that the responsible medical officer has a similar discretion. As drafted, neither a tribunal nor a responsible medical officer would seem to be obliged to effect reclassification, even though satisfied that the present classification is incorrect. So, for example, a tribunal which does not discharge a patient recorded as suffering from mental illness, because it is satisfied that that he suffers from a serious psychopathic disorder, is not obliged to reclassify him. The original reasons for conferring such a discretion may well have been twofold. Firstly, because reclassification had no legal consequences in terms of renewal, and often no bearing at all on the duration of the powers, it was left to the tribunal's discretion whether to reclassify if no purpose would be served by doing so.[60] Secondly, a discretion not to reclassify avoided a tribunal being obliged to discharge a patient aged over 25 because it was of the opinion that he suffered only from a minor disorder (see *Re V.E.*, **577**). Similarly, the fact that the power remains discretionary may reflect the fact that reclassification rarely fulfils any useful legal purpose and, when it does, a tribunal might prefer not to exercise the power.

Whether the power is one of substitution only

Section 72(5) is more restrictively drafted than sections 16 and 20 insofar as it explicitly provides that the tribunal's power *is* one of substitution — it may substitute for the form of disorder specified such other form as appears to the tribunal to be appropriate. As drafted, the provision does not extend to many situations in which a tribunal might be minded to alter a patient's formal classification. For example, a tribunal may wish to delete one of two forms of disorder recorded without substituting another form for it. Conversely, it might wish to add a form of mental disorder to that already specified, rather than in substitution for it. Thus, in *ex p. Hinsley*, which was not proceeded with for reasons unknown, the patient sought judicial review of the tribunal's decision to add a further form of mental disorder to the original classification. The question arises whether the power is one of substitution only or also empowers a tribunal to add or delete a form of disorder which it is satisfied is incorrect. One view is simply to acknowledge that the drafting is inconsistent and to take a practical approach. This is that Parliament must have intended that both a tribunal and the responsible medical officer may adjust a patient's classification in whatever way is necessary in order to ensure that it accurately reflects their opinion concerning the legal basis of his detention. The alternative approach is that Parliament must have had some reason for formulating the tribunal's power in such a distinctive and limited way. For example, where a patient's detention as authorised solely on the ground of mental illness, the lawfulness of his continued detention might be open to challenge if a tribunal had found that he was not mentally ill and could not substitute an alternative form of disorder for that recorded in the application. In that situation, a tribunal which found him to be suffering from some other form of disorder might wish to make a single substitution, so as to ensure that his further detention was authorised. Ultimately, the very precise terms of section 72(5) make it difficult to argue that there is any ambiguity in the drafting, only an unnecessary limitation spelt out at some length.

[60] See *Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX* (D.H.S.S., 1960), para. 90.

PATIENTS SUBJECT TO GUARDIANSHIP

A tribunal's discharge powers when reviewing the case of a patient subject to guardianship are set out in section 72(4) of the Act.

PATIENTS SUBJECT TO GUARDIANSHIP

Discretionary discharge

72.—(4) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is subject to guardianship under this Act, the tribunal may in any case direct that the patient be discharged,

and shall so direct if they are satisfied—

Mandatory discharge

(a) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; or

(b) that it is not necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under such guardianship.

Reclassification

(5) Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the tribunal do not direct that the patient be discharged, the tribunal may, if satisfied that the patient is suffering from a form of mental disorder other than the form specified in the application, order or direction relating to him direct that that application, order or direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate.

References

(6) Subsections [(4)] to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a tribunal by or in respect of a patient.

TERMINOLOGY

For the meaning of the words used in the criteria for reception and discharge, see—"discharge" (**571**); "patient" (**098**); "subject to guardianship" (**250**); "satisfied" (**567**); "then" (**466**); "suffering from" (**213**); "mental illness" (**060, 068**); "psychopathic disorder" (**082**); "severe mental impairment" (**070**); "mental impairment" (**070**); "necessary in the interests of" (**221, 485**); "welfare" (**217**); "protection of other persons" (**219**). For a short summary of the meaning of many of these terms, see page 484. "Welfare" is not statutorily defined. While any arrangement which is necessary for a patient's health and safety may also be said to be necessary in the interests of his welfare, the latter has a wider ambit and includes matters such as social functioning, education, training and the other matters referred to in section 8.

SUMMARY OF POWERS

Section 72(4) provides that a tribunal shall discharge a patient from guardianship if the criteria set out there are satisfied. As in other unrestricted cases, a tribunal also possesses a discretionary power to discharge a patient whom it does not consider satisfies the criteria for mandatory discharge. Because a guardianship application or order specifies the form of disorder from which the patient has been found to suffer, a tribunal has the same power to reclassify a patient whom it does not discharge from guardianship as it does an unrestricted patient detained for treatment. There the similarities end. A tribunal has no power to direct a patient's discharge from guardianship on a specified future date so that any discharge must take effect forthwith. Moreover, a tribunal which does not discharge a patient from guardianship has no power to make statutory recommendations with a view to facilitating his future discharge from guardianship. In part, this is because the recommendations which a tribunal may make when reviewing a patient's liability to detention would be irrelevant or inappropriate in guardianship cases. Recommending leave of absence would be otiose because a guardianship patient cannot be granted leave of absence. Similarly, recommending transfer to hospital would contravene the statutory premise that a tribunal's functions in unrestricted cases are limited to discharging patients or facilitating their discharge. Except in so far as recently provided for by the 1995 Act, a tribunal has no power to further restrict a person's freedom.

THE CRITERIA FOR MANDATORY DISCHARGE

The main point to note in relation to the criteria for mandatory discharge is the absence of any "nature or degree" test. Under section 72(4)(a), a tribunal is not obliged to discharge a patient unless it is satisfied that he is no longer suffering from a form of mental disorder.[61] This is so notwithstanding that it is satisfied that he is not then suffering from a form of disorder which is of a nature or degree warranting guardianship. For two reasons, it is not possible to argue that this is a drafting error. Firstly, there is similarly no "nature or degree" test in relation to conditionally discharged patients and those subject to after-care under supervision. The position is therefore the same for all patients subject to powers of supervision in the community whose cases a tribunal may consider (**068**). Secondly, the current position repeats that set out in section 123(2)(a) of the Mental Health Act 1959. That Act was in force for 23 years. If this was a lacuna, there was ample time for it to become apparent and for the omission to be remedied in the present legislation.

DISCRETIONARY DISCHARGE

There are no matters which a tribunal must have regard to as a matter of law before determining whether to exercise its discretionary power of discharge.

RECLASSIFICATION

As to the power of reclassification conferred by section 72(5), see page 499. It has already been noted that where a section 2 patient is transferred into guardianship he does not have a classification under the Act. Unless the pragmatic view is taken that

[61] As to whether a very mild disorder of mind can constitute mental illness for the purposes of section 72, see p.68.

a patient may be classified, and not merely reclassified, under section 20(72(5), there is little that can be done about this.

CASE LAW

In *ex p. E*,[62] the guardianship application was invalid and the patient was being detained at the place where she was required to reside by the local authority. The patient applied for habeas corpus, for judicial review of the guardianship application, and for judicial review of the tribunal's decision that she not be discharged from the guardian's authority over her. In the event, the local authority itself discharged the guardianship several months later, a matter of days before the applications were due to be heard.

SUPERVISION APPLICATION CASES

A tribunal's discharge powers when reviewing the case of a patient who is, or who is to be, subject to after-care under supervision are set out in section 72(4A) of the Act.

SUMMARY OF POWERS

Where a tribunal reviews the case of a patient who is, or who is to be, subject to after-care under supervision, its range of powers are the same as in guardianship cases. The tribunal must direct that the patient shall cease to be subject to after-care under supervision, or liable to supervision upon leaving hospital, if it is satisfied that the relevant statutory criteria are not complied with. Where this is not the case, it may still at its discretion direct that the patient shall cease to be subject to after-care under supervision or not become subject to it upon leaving hospital. A tribunal which does not direct that the patient shall cease to be subject or liable to supervision may reclassify the form of disorder from which he is recorded as suffering. As with guardianship, it has no power to make any statutory recommendations with a view to facilitating a patient's discharge from statutory supervision at a later date.

TERMINOLOGY

As to the meaning of the words used in the application and discharge criteria, see "patient" **(098)**; "after-care under supervision" **(422)**; "leaves hospital"; **(441)**; "complied with" **(508)**; "satisfied" **(567)**; "suffering from **(213)**; "mental illness" **(060)**; "psychopathic disorder" **(082)**; "severe mental impairment" **(070)**; "mental impairment" **(070)**; "substantial risk of serious harm" **(430)**; "health" **(217)**; "safety" **(218)**; "serious exploitation" **(219)**; "after-care services under section 117" **(413)**; "likely to help to secure" **(431)**.

[62] *R. v. South East Thames Mental Health Review Tribunal, ex p. E*, CO/1096/89 (unreported). See also p.581.

Discretionary discharge

72.—(4A) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is subject to after-care under supervision (or, if he has not yet left hospital, is to be so subject after he leaves hospital), the tribunal may in any case direct that the patient shall cease to be so subject (or not become so subject),

Mandatory discharge

and shall so direct if they are satisfied—

Patients not yet subject to after-care under supervision

(a) in a case where the patient has not yet left hospital, that the conditions set out in section 25A(4) above are not complied with; or

> "25A(4). A supervision application may be made in respect of a patient only on the grounds that—
>
> (a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment;
> (b) there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services to be provided for him under section 117 below after he leaves hospital; and
> (c) his being subject to after-care under supervision is likely to help to secure that he receives the after-care services to be so provided."

Patients subject to after-care under supervision

(b) in any other case, that the conditions set out in section 25G(4) above are not complied with.

> "25G(4) The conditions [for renewal] referred to in subsection (3) above are that —
>
> (a) the patient is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment;
> (b) ; and there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services provided for him under section 117 below
> (c) his being subject to after-care under supervision is likely to help to secure that he receives the after-care services so provided."

Reclassification

(5) Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the tribunal do not direct that ... if he is (or is to be) subject to after-care under supervision, that he cease to be so subject (or not become so subject), the tribunal may, if satisfied that the patient is suffering from a form of mental disorder other than the form specified in the application ... relating to him direct that that application ... be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate.

References

(6) Subsections [(4A)] to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a tribunal by or in respect of a patient.

WHEN PATIENT BECOMES SUBJECT TO SUPERVISION

By way of summary as to when a patient becomes subject to after-care under supervision—

- Where a supervision application is accepted, the patient is then "to be subject" to after-care under supervision "after he leaves hospital." For these purposes, a patient does not leave hospital, and so does not become subject to after-care under supervision, until he has *both* ceased to be liable to be detained for treatment (*i.e.* his liability to detention has been discharged or has lapsed) *and* has left hospital in the conventional sense that he has ceased to be an in-patient.

- By way of amplification, two situations will be commonly encountered. Firstly, a supervision application may be accepted in respect of a patient who is then discharged from detention under section 3 or 37 but who remains in hospital for a further period as an informal patient. He has not left hospital and does not become subject to after-care under supervision until he actually leaves hospital. Secondly, a supervision application may be accepted in respect of a patient who has leave to be absent from hospital or who is subsequently granted such leave. He has not left hospital for these purposes, and does not become subject to after-care under supervision, until such time as he also ceases to be liable to be detained for treatment. In both cases, the patient has not yet left hospital in the statutory sense and the tribunal criteria to be applied are those in section 72(4A)(a).

- In the case of patients who have not yet left hospital, no person or body other than a tribunal has power to "terminate" the supervision application.

THE MANDATORY CRITERIA

Where a patient is not yet subject to after-care under supervision, the tribunal must consider whether it is satisfied that, as matters now stand, a supervision application could not be made because it is satisfied that one or more of the three grounds for making such an application do not apply. In the case of patients who are subject to after-care under supervision, it must decide whether it is satisfied that one or more of the conditions which must exist before the authority for a patient's supervision can be renewed do not exist as matters presently stand.[63]

"Satisfied that the conditions are not complied with"

The use of the words "complied with" might at first sight seem to require a tribunal to review whether the conditions for making the supervision application, or for renewing it, were complied with at the time when the application was accepted or last renewed. That this is not so is clear if one considers the position of a patient who, having ceased to be liable to be detained, immediately returns home two

[63] If a tribunal applied the wrong criteria, it is arguable that the High Court might not set aside their decision solely on this ground because the criteria in section 25A(4) and 25G(4) are virtually identical. On the other hand, it might be said that the tribunal's grasp of the patient's legal position was so tenuous that it must be doubtful whether the decision it reached was correctly arrived at.

months after the supervision application's acceptance. Even though the authority conferred by the application has not yet been renewed, so that it is impossible for a tribunal to retrospectively consider whether there had been grounds for renewal, the discharge criteria to be applied by the tribunal are the renewal conditions set out in section 25G(4) — not the grounds in section 25A(4) upon which the application had been made. Thus, the tribunal is not reviewing whether the authority for the patient's current period of supervision was validly made or renewed. It must instead adopt the customary approach of looking at matters as they stand at the time of the hearing. The use of the phrase "are complied with," rather than "were complied with," in paragraphs (a) and (b) of section 72(4A) confirms this.

Supervised patients subsequently readmitted to hospital

Where a patient who is not receiving in-patient treatment ceases to be liable to be detained for treatment he thereupon becomes subject to after-care under supervision. If he is later readmitted to hospital as an informal patient, or under section 2 or 4, he nevertheless remains subject to after-care under supervision. However, he has still left hospital for the purposes of section 72(4A) and the criteria to be applied by a tribunal which then hears his case in hospital are the renewal conditions set out in section 72(4A)(b).

No requirement that disorder be of particular nature or degree

It suffices for the purposes of making or renewing a supervision application that the patient suffers from one of the four statutory forms of mental disorder. There is no requirement that this disorder be of a particular nature or degree.[64] This reflects the fact that supervised discharge principally focuses on the risks associated with a future exacerbation of the patient's mental state rather than the present nature or degree of any disorder. That being so, a "nature or degree" qualification is to some extent enshrined in the second of the supervision application grounds, albeit that the Act fastens on to the nature and degree of the potential risks rather than the nature or degree of the patient's disorder *per se*. Nevertheless, the first aspect (his potential for dangerous behaviour) is consequential upon the second (his mental state). See page 429.

Substantial risk of serious harm

The second condition requires the tribunal to consider the possible consequences if the patient does not receive the after-care services which are being provided, or will be provided, for him. Insofar as words can define anything, the test could not be more stringent. In terms of making a supervision application or renewing the authority, a risk of serious harm does not suffice unless that risk is a substantial one. Similarly, a substantial risk of harm does not suffice unless the harm will be serious and, in the case of persons other than the patient, it is their safety rather than merely their health which will be substantially at risk. Likewise, a tribunal must terminate the patient's liability to statutory supervision if it is satisfied that any risk of serious harm is insubstantial, or that any harm which is substantially likely does not amount to serious harm; or any serious harm to others would involve serious harm to their health rather than to their safety. The second ground is expressed as a future

[64] As to whether a very mild disorder of mind can constitute mental illness for the purposes of section 72, see p.68.

conditional so that a supervision application may only be made where there will be a substantial risk of serious harm *if* the patient were not to receive the after-care services provided for him. In some cases, a substantial risk of suicide, or of serious harm to others, may exist regardless of whether the patient receives those services. In practice, the courts may take the view that if there will or may be a substantial risk of serious harm if the patient does not receive after-care, it is irrelevant that such a risk currently exists even though he is receiving after-care.

Likelihood of benefit from supervision

If there will or may be a substantial risk of serious harm should the patient not receive the proposed after-care services, the third condition requires consideration to be given to the practicalities of the situation — will providing those after-care services under formal supervision be likely to help to secure that the patient receives them and so reduce the substantial risk of serious harm which has been identified? As to the third ground and, in particular, the phrase "likely to help secure," see page 430 *et seq.*

DISCRETIONARY DISCHARGE

There are no matters which a tribunal must have regard to as a matter of law before determining whether to exercise its discretionary power of discharge.

RECLASSIFICATION

As to the power of reclassification conferred by section 72(5), see page 499. For two reasons, reclassification has no legal consequences in terms of the likelihood of renewal. Firstly, the renewal criteria are the same whatever the form of mental disorder which the patient suffers from. Secondly, whether or not a patient is suffering from a particular form of disorder at the time a renewal report is furnished is a matter for the patient's community responsible medical officer to determine; he is not bound by any previous reclassification (**057**).

8. A tribunal's powers in restricted cases

INTRODUCTION

This chapter deals with a tribunal's powers in respect of restricted patients. These patients comprise —

- Patients who are liable to be detained for treatment in pursuance of a hospital order and a restriction order, under sections 37 and 41 or section 46. **511**
- Patients who are liable to be detained for treatment in pursuance of a transfer direction and a restriction direction, made under sections 47 and 49 or 48 and 49, or a hospital direction and a limitation direction imposed under section 45A. **555**
- Patients who are subject to a restriction order or a restriction direction but have been conditionally discharged from hospital by a tribunal or by the Secretary of State. **560**

DETENTION SUBJECT TO A RESTRICTION ORDER

A tribunal's powers when dealing with the case of a patient who is liable to be detained in hospital and subject to a restriction order are set out in section 73 of the Act. Section 72 does not apply except insofar as the criteria for discharge set out in section 72(1)(b) are incorporated within section 73.[1]

SUMMARY OF POWERS

The essence of a restriction order is that the usual powers by which a patient who is liable to be detained for treatment in pursuance of a hospital order may be discharged or granted greater freedom are restricted. This principle extends to tribunals so that its usual powers either do not apply or only in a restricted way. The single superficial similarity is that a tribunal must discharge a patient who satisfies

[1] Mental Health Act 1983, s.72(7); *Grant v. The Mental Health Review Tribunal for the Trent Region; R. v. The Mersey Mental Health Review Tribunal ex p. O'Hara, The Times*, 26 April 1986 (**549**).