

## Chapter 18

### MENTAL HEALTH REVIEW TRIBUNALS

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#### A. STRUCTURE AND ADMINISTRATION

##### 18.01 Constitution

Mental Health Review Tribunals (MHRTs) are independent bodies reviewing the justification for a patient's detention. They were originally established under the 1959 Act, and continue under the 1983 Act. A tribunal must be established for each of four regions (North London and East Region, Trent and Northern and Yorkshire Region, South London and South and West Region, and West Midlands and North West Region) and for Wales (s. 65(1)).<sup>1</sup> The tribunal's jurisdic-

<sup>1</sup> Mental Health Review Tribunals (Regions) Order 1998, S.I. No. 1460.

tion may be exercised by three or more of its members (s. 65(3)). At least one of the members must be a lawyer, one a doctor and one neither a lawyer nor a doctor (s. 65(2), Sch. 2, para. 4). In practice, a tribunal usually consists of three members. A tribunal member is precluded from serving on a particular case if he is a member or officer of the responsible authority<sup>1</sup> or if he has recently treated the patient or has some other close knowledge of or connection with him (Mental Health Review Tribunal Rules 1983, S.I. 1983 No. 942, r. 8(2); for the Rules see Appendix B; any further reference to Rules in this chapter are to the MHRT Rules).

Since the Mental Health Act 1983 came into force an increasing number of requests for statistics relating to the work of tribunals have been made to the DHSS. The DHSS now publishes statistics, which are updated at six monthly intervals.<sup>2</sup>

### 18.01.1 *The Lord Chancellor*

The Lord Chancellor appoints chairmen and members of MHRTs (s. 65(2), Sch. 2) and makes rules as to their procedures (s. 78).

### 18.01.2 *Council on Tribunals*

The Council on Tribunals is established by the Tribunal and Inquiries Act 1971. Its overall function is to review the construction and working of tribunals and statutory inquiries. The Council must be consulted when procedural rules are made or amended and may investigate complaints about the tribunal procedures. While it has no power to enforce its recommendations, its opinion is highly regarded. The Council makes an annual report which is laid before Parliament.

## 18.02 Members

### 18.02.1 *Legal Members*

The legal members are appointed by the Lord Chancellor and are persons he considers to have suitable legal experience (Sch. 2, para. 1). The legal member appointed to hear a particular case is the president of that tribunal (Sch. 2, para. 6) and has wide discretion in the conduct of proceedings under the Rules. In the case of restricted patients the legal member must be chosen from a panel of legal members who have been approved by the Lord Chancellor to hear such cases (r. 8(3)). The intention of this provision is to ensure that persons

<sup>1</sup> The "responsible authority" is defined in r. 2(1) of the MHRT Rules 1983 to mean: (a) in relation to a patient liable to be detained in hospital or mental nursing home, the managers as defined in s. 145(1) (see para. 6.01 *ante*); (b) in relation to a guardianship patient, the responsible social services authority as defined in s. 34(3) (see para. 11.07.3 *ante*).

<sup>2</sup> DHSS (August 1985) *The Mental Health Review Tribunals for England: Statistics for Mental Health Review Tribunals*. See also, Birmingham DF (March 1987) *Mental Health Review Tribunals: A Case for Delayed Discharge Bull. of the Royal Coll. of Psychiatrists*, vol. II, pp. 96-97.

presiding over tribunals in cases of patients who may pose a serious danger to the public have "substantial experience in the criminal courts", such as a Circuit Judge or recorder.<sup>1</sup>

The Lord Chancellor must appoint one legal member to be chairman in each region for which the tribunal is established and for Wales (Sch. 2, para. 3). The chairman (or another tribunal member whom he may nominate) is responsible for appointing the tribunal members to hear a particular case (Sch. 2, para. 4). He is empowered to deal with matters which are preliminary or incidental to the hearing and may take steps to ensure that the case is given prompt consideration (rr. 5, 13).

### 18.02.2 *Medical members*

The medical members are registered doctors appointed by the Lord Chancellor after consultation with the Secretary of State for Social Services (Sch. 2, para. 1). The medical member has a duty to examine the patient prior to the proceedings and to form an opinion about the patient's mental condition (r. 11). (As to disclosure of medical member's report to patient's representative, see para. 18-25.1 below.)

### 18.02.3 *Other members*

The other tribunal members are appointed by the Lord Chancellor after consultation with the Secretary of State for Social Services. They are persons with experience in administration, social services or persons with other qualifications or experience which is considered suitable (Sch. 2, para. 1).

## B. APPLICATIONS AND REFERENCES

### 18.03 *Patients who have Access to the Tribunal*

The MHRT has no jurisdiction over informal patients. Further, the following categories of detained patient cannot apply or have their case referred to a tribunal: patients detained for 72 hours or less (ss. 4, 5, 135, 136); patients remanded to hospital for report (s. 35) or remanded for treatment (s. 36); and patients under an interim hospital order (s. 38). Patients detained other than under the foregoing provisions, and any guardianship patients, can have their case reviewed by a tribunal. A patient's case can come before a tribunal in any of the following ways: the patient or his nearest relative can make application during specified periods; the Secretary of State for Social Services or, in the case of restricted patients, the Home Secretary can refer a case to a tribunal at any time; if a case is not reviewed (*i.e.* by application or reference) by a tribunal within a certain period of time, it is referred automatically.

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<sup>1</sup> Belstead (Jan. 25, 1982) *H. L. Debs.*, vol. 426, col. 761.

**18.04 Applications**

There are many circumstances in which a patient or his nearest relative can apply to a MHRT, and Tables 1 and 2 give a comprehensive account of when applications can be made in respect of patients detained under Part II or III of the Act. The most important periods of eligibility are briefly set out in the following paragraphs. Note that only one application may be made during each specified period (s. 77(2)).

**TABLE 1**  
**Patients Admitted Under Part II of the Act**

<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<i>Admission for assessment</i> (28 days: s. 2) (para. <b>11.05</b> <i>ante</i> ).	Within 14 days of admission (s. 66(1)(a), (2)(a)).	Within 12 months of an order under s. 29 appointing an acting nearest relative (para. <b>8.05</b> <i>ante</i> ) and during any subsequent 12 month period while the order is in force (s. 66(1)(h), (2)(g)).	
<i>Admission for treatment</i> (6 months followed by renewal period of 6 months and then for 12 month periods thereafter: s. 3) (para. <b>11.06</b> <i>ante</i> ).	Within 6 months of admission (s. 66(1)(b), (2)(b)) and during each subsequent renewal period, <i>i.e.</i> the 6 months immediately following and then each subsequent 12 month period (para. <b>11.06.5</b> <i>ante</i> ) (s. 66(1)(f), (2)(f), 20(2)).	Within 28 days of receiving notification that an order for discharge has been barred under s. 25 (para. <b>17.02.3</b> <i>ante</i> ) (s. 66(1)(g), (2)(d)).	At the expiry of the first 6 months if no application or reference is made within that period (s. 68(1)). At renewal of detention if three years (1 year for a child under 16 years) has elapsed since case was last considered by a tribunal (s. 68(2)).

<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<i>Admission for treatment (continued)</i>	Within 28 days of receiving notification of reclassification of mental disorder* under s. 16 (paras. <b>9.06</b> and <b>11.06.6 ante</b> ) (s. 66(1)(d), (2)(d)).	Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (paras. <b>9.06</b> and <b>11.06.6 ante</b> ) (ss. 66(1)(d), (2)(d)).  Within 12 months of an order under s. 29 appointing an acting nearest relative (para. <b>8.05 ante</b> ) and during any subsequent 12 month period while the order is in force (s. 66(1)(h), (2)(g)).	
<i>Transfer from guardianship to hospital (6 months followed by renewal period of 6 months and then for 12 month periods thereafter: s. 19) (para. <b>11.18.5 ante</b>).</i>	Within 6 months of transfer (s. 66(1)(e), (2)(e)) and during the same periods as a patient admitted for treatment. Renewal periods are calculated from date of acceptance of guardianship application (s. 19(2)(d)).	Same as if patient had been admitted for treatment (s. 19(2)(d)).	At the expiry of the first 6 months from the date of transfer if no application or reference is made within that period (s. 68(1)). At renewal of detention if three years (1 year for a person under 16 years) has elapsed since case was last considered by tribunal (s. 68(2)). Renewal periods are calculated from date of acceptance of guardianship application (s. 19(2)(d)).

\* An application may be made by the patient or the nearest relative, but not both (s. 66(1)(i)).

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<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<p><i>Reception into guardianship</i> (6 months followed by renewal period of 6 months and then for 12 month periods thereafter: s. 7) (para. <b>11.07 ante</b>).</p>	<p>Within 6 months of reception into guardianship (s. 66(1)(c), (2)(c), and during each subsequent renewal period, <i>i.e.</i> the 6 months immediately following and each subsequent 12 month period (ss. 66(f), (2)(f), 20(2)).</p>	<p>Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (para. <b>9.06 ante</b>) (s. 66(1)(d), (2)(d)).</p>	
	<p>Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (s. 66(1)(d), (2)(d)).</p>	<p>Within 12 months of an order under s. 29 appointing an acting nearest relative (para. <b>8.05 ante</b>) and during any subsequent 12 month period while the order is in force (s. 66(1)(h), (2)(g)).</p>	
<p><i>Reception into after-care under supervision</i> (six months followed by renewal period of six months and then for twelve month periods thereafter s. 25A)</p>	<p>Within the first six months following acceptance of the supervision application (s. 66(1)(ga) and (2)(c)) and during each subsequent renewal period, <i>i.e.</i> the six months immediately following and each subsequent twelve month period (s. 66(1)(gc) and 66(2)(fa)).</p> <p>Within 28 days of receiving notification of a reclassification report under s. 25F (s. 66(1)(gb) and s. 66(2)(d)).</p>	<p>If the nearest relative was consulted or was entitled to be consulted about the application or its renewal, within the first six months following acceptance of the supervision application (s. 66(1)(ga) and (i) and (2)(c)) and during each subsequent renewal period, <i>i.e.</i> the six months immediately following and each subsequent twelve month period (s. 66(1)(gc) and (i) and s. 66(2)(fa)). If the nearest relative was informed or was entitled to be informed about the application, within 28 days of receiving notification of a reclassification report under s. 25F (s. 66(1)(gb) and (i) and s. 66(2)(d)).</p>	<p>The Secretary of State may at any time refer the case of a patient who is subject to supervised after-care to the MHRT (s. 67(1)).</p>

**TABLE 2**  
**Patients admitted under Part III of the Act**

<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<p><i>Hospital Order:</i> (6 months followed by renewal period of 6 months and then for 12 month periods thereafter: s. 37) (paras. <b>15.02–15.10 ante</b>).</p>	<p>Between 6 and 12 months from the order and during each subsequent renewal period, <i>i.e.</i> each subsequent 12 month period (para. <b>15.10 ante</b>) (ss. 66(1)(f), (2)(f), 40(4), Sch. 1, Pt. I, paras. 2, 6, 9).</p> <p>Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (paras. <b>9.06, 11.06.6, 15.10 ante</b>) (ss. 66(1)(d), (2)(d), 40(4), Sch. 1, Pt. I, paras. 2, 3).</p>	<p>Between 6 and 12 months from the order and during each subsequent 12 month period (s. 69(1)(a)).</p> <p>Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (paras. <b>9.06, 11.06.6, 15.10 ante</b>) (ss. 66(1)(d), (2)(d), 40(4), Sch. 1, Pt. I, paras. 2, 3).</p>	<p>At renewal of detention if 3 years (1 year for a child under 16 years) has elapsed since case was last considered by a tribunal (s. 68(2)).</p>
<p><i>Guardianship order</i> (6 months followed by renewal periods of 6 months and then for 12 month periods thereafter: s. 37) (para. <b>15.22 ante</b>).</p>	<p>Within 6 months of the order (s. 69(1)(b) and during each subsequent renewal period, <i>i.e.</i> the 6 months immediately following and each subsequent 12 month period (ss. 66(1)(f), (2)(f), 40(4), Sch. 1, Pt. I, paras. 2, 6, 9).</p>	<p>Within 12 months of the order and during each subsequent 12 month period (s. 69(1)(b)).</p>	

<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<i>Guardianship order (continued)</i>	Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (paras. 9.06 and 15.22.4 ante) (ss. 66(1)(d), (2)(d), 40(4), Sch. 1, Pt. I, paras. 2, 3).	Within 28 days of receiving notification of reclassification of mental disorder under s. 16 (paras. 9.06 and 15.22.4 ante) (ss. 66(1)(d), (2)(d), 40(4), Sch. 1, Pt. I, paras. 2, 3).	
<i>Hospital order with restrictions (normally without limit of time: s. 41) (paras. 15.11–15.20 ante).</i>	Between 6 and 12 months after the order and during each subsequent 12 month period (s. 70).		When 3 years has elapsed since case was last considered by a tribunal (s. 71(2)).
<i>Recall to hospital (s. 42(3)) (para. 15.16.3 ante).</i>	Between 6 and 12 months after recall to hospital and during subsequent 12 month period (ss. 70, 75(1)(b)).		Within 1 month of return to hospital (s. 75(1)(b)), then as for hospital order with restriction.
<i>Criminal Procedure (Insanity) Act 1964 (s. 5): special verdict (paras. 13.03 and 13.05 ante); unfitness to plead (para. 14.11 ante).</i>	Within 6 months of the order (s. 69(2)(a)), then as for hospital order with restrictions.		At expiry of 6 months if no application is made during that period (s. 71(5)), then as for hospital order with restriction.
<i>Conditional discharge (s. 42(2)) (paras. 15.16.3 and 15.18 ante).</i>	Between 12 months and 2 years after conditional discharge and during each subsequent 2 year period (s. 75(2)).		
<i>Transfer from prison to hospital (ss. 47(3), 48(3)) (paras. 16.01–16.03 ante).</i>	Within 6 months of date of direction (s. 69(2)), then as for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restrictions, whichever applies.



<i>Category of admission</i>	<i>Application by patient</i>	<i>Application by nearest relative</i>	<i>Automatic reference</i>
<i>Cessation of restriction order (s. 41(5)) (para. 15.13 ante).</i>	Within 6 months of date of order or direction (s. 69(2)), then as for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restriction, whichever applies.	As for hospital order with or without restrictions, whichever applies.
<i>Transfer from hospital in Northern Ireland, Channel Islands or Isle of Man (ss. 82(2), 85(2)) (paras. 19.03.2 and 19.04.3 ante).</i>	Within 6 months of date of order or direction (s. 69(2)), then as for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restriction, whichever applies.	As for hospital order with or without restrictions, whichever applies.
<i>Transfer from hospital in Scotland (s. 73(2) Mental Health (Scotland) Act 1960)</i>	Within 6 months of date of order or direction (s. 69(2)), then as for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restriction, whichever applies.	As for hospital order with or without restrictions, whichever applies.
<i>Detention during Her Majesty's pleasure of a serviceman (s. 46(3)) (para. 15.21 ante).</i>	Within 6 months of date of order or direction (s. 69(2)), then as for hospital order with or without restrictions, whichever applies.	As for hospital order with or without restriction, whichever applies.	As for hospital order with or without restrictions, whichever applies.
<i>Reception orders under the Lunacy Act 1890, temporary patients under Mental Treatment Act 1930, detention or guardianship under Mental Deficiency Act 1913 (Sched. 5.)</i>	Within current period of treatment (Sched. 5, para. 31(2)) and during each subsequent renewal period, <i>i.e.</i> each subsequent 2 year period (Sched. 5, para. 33, s. 66(1)(f)).	As for admission for treatment or reception into guardianship under Part II except for patients detained under ss. 6, 8(1) or 9 of Mental Deficiency Act whose nearest relative may apply during any 12 month period (Sched. 5, para. 34).	As for admission for treatment or reception into guardianship under Part II (Sched. 5, para. 34).

**18.04.1 Admission for assessment (s. 2)**

The **patient** can apply within the first fourteen days of admission (s. 66(1)(a), (2)(a)). The Mental Health (Amendment) Act 1982 provided for assessment (previously observation) patients to have the right to apply to a MHRT for the first time.

**18.04.2 Admission for treatment (s. 3)**

The **patient** can apply within the first six months of admission (s. 66(1)(b), (2)(b)) and during each period of renewal, *i.e.* within the next six months and then for periods of one year at a time (ss. 66(1)(f), (2)(f), 20(2)). The **nearest relative** can apply only after his power to discharge the patient has been barred by the responsible medical officer (see further para. 17.02.3 *ante*). He can apply within 28 days after he has been informed that the RMO has issued the report barring his discharge (s. 66(1)(g), (2)(d)).

**18.04.2A Change of detention status from section 2 to section 3**

What should happen in the case of a patient admitted under section 2 who applies to a tribunal and, while the application is pending, the patient is detained under section 3?<sup>1</sup> The question is important because a patient is permitted only one application to the tribunal per period of detention. The court in *R. v. South Thames Mental Health Review Tribunal ex parte M<sup>2</sup>* held that if, at the time of the hearing, the patient is detained under section 3, the tribunal should consider discharge criteria relevant to a section 3 patient, even though the application was pursuant to section 2. If the tribunal mistakenly applies criteria relevant to a section 2 application, this does not prevent the patient from making a separate application challenging her continued detention under section 3. Although this effectively means that the patient has two opportunities to challenge her detention, there is nothing in the Mental Health Act that takes away the right of a section 3 patient to make an application to the tribunal.

**18.04.3 Reception into guardianship (s. 7)**

The **patient** can apply within the first six months of reception into guardianship (s. 66(1)(c), (2)(c)), and during each period of renewal, *i.e.*, within the next six months and then for periods of one year at a time (ss. 66(f), (2)(f), 20(2)). The **nearest relative** does not have the right to apply to a tribunal because he can order a patient's discharge at any time and his discharge order cannot be barred by the RMO.

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<sup>1</sup> See Code of Practice, para. 5.3.

<sup>2</sup> CO/2700/97 (3 September 1997) (Transcript: Smith Bernal).

**18.04.3a** *Reception into after care under supervision* (s. 25A)

The **patient** can apply once during the six months following acceptance of the application for supervised discharge (s. 66(1)(ga) and (2)(c)) and once during each subsequent renewal period, *i.e.* the six months immediately following and each subsequent twelve month period (s. 66(1)(gc) and 66(2)(fa)). The **patient** may also apply within 28 days of receiving notification of a reclassification report under s. 25F (s. 66(1)(gb) and s. 66(2)(d)).

The **nearest relative** can apply, if he was consulted or was entitled to be consulted about the application or its renewal, within the first six months following acceptance of the supervision application (s. 66(1)(ga) and (i) and (2)(c)) and during each subsequent renewal period, *i.e.* the six months immediately following and each subsequent twelve month period (s. 66(1)(gc) and (i) and s. 66(2)(fa)).

If the nearest relative was informed or was entitled to be informed about the application, within 28 days of receiving notification of a reclassification report under s. 25F (s. 66(1)(gb) and (i) and s. 66(2)(d)).

**18.04.4** *Hospital order without restrictions* (s. 37)

The **patient or his nearest relative** can apply in the period between six and twelve months after the making of the order and in any subsequent period of one year (ss. 66(1)(f), (2)(f), 40(4), Sch. 1, Pt. I, paras. 2, 6, 9). A patient who is subject to a hospital order by virtue of the expiration or removal of a restriction order (s. 41(5); see further paras. 15.13 and 15.16.1 *ante*), is entitled to apply to a tribunal within the *first* six months of the hospital order (s. 69(2)) (for an explanation see para. 18.04.7 below).

**18.04.5** *Restriction order or restriction direction*

With certain exceptions (see para. 18.04.7 below), the **patient** can apply in the period between six and twelve months of the order, and in any subsequent period of twelve months (s. 70). The **nearest relative cannot apply** to a tribunal. If a restricted patient is conditionally discharged and is recalled to hospital (see further para. 15.16.3 *ante*), he can apply between six and twelve months after the recall and in any subsequent twelve month period (ss. 70, 75(1)(b)). (Note that his case **must be referred** to the tribunal within one month of his return to hospital (s. 75(1)(b)); see para. 18.05 below).

A conditionally discharged patient who is not recalled to hospital has the right for the first time to apply to a tribunal in the period between the expiration of twelve months and the expiration of two years begin-

ning with the date on which he was conditionally discharged; he can also apply in any subsequent period of two years (s. 75(2)).<sup>1</sup>

#### 18.04.6 *Guardianship order* (s. 37)

The **patient** can apply within the first six months of the order (s. 69(1)(b)), and during each renewal period, *i.e.* within the next six months and each subsequent twelve month period (ss. 66(1)(f), (2)(f), 40(4), Sch. 1, Pt. I, paras. 2, 6, 9). The nearest relative can apply within the first twelve months of the order and in any subsequent twelve month period (s. 69(1)(b)).

#### 18.04.7 *Hospital order patients who can apply within the first six months of the order*

Under the 1959 Act the patient could apply to a tribunal within the **first** six months of the making of a hospital order without restrictions. A restricted patient did not have the right of application but could have his case referred to a tribunal during the **second** six months after the restriction order or direction was made. In response to *X. v. the United Kingdom* (see paras. 13.04.1 and 15.11 *ante*), the government gave restricted patients the right of application in the **second** six months after the order or direction was made. They considered that they were bound by Article 14 of the European Convention of Human Rights to be internally consistent in the Act and, therefore, decided to remove the right of hospital order patients to apply to a tribunal during the **first** six months after the order was made. Article 14 states that the "enjoyment of rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground". The government's interpretation of Article 14 (*i.e.* requiring rigid internal consistency in domestic legislation) is open to serious doubt.

A further reason given for the change is that hospital order patients already have a judicial determination of the need for hospital detention at the time the hospital order is made. Where there is no such judicial determination, the patient can apply to a tribunal within the **first** six months of the order or direction. Thus, in each of the following cases the patient can apply to a tribunal within six months of the order or direction and within each period of renewal (s. 69(2)): where an order is made under section 5(1) of the Criminal Procedure (Insanity) Act 1964 (see the special verdict and fitness to plead, paras. 13.05.2 and 14.11 *ante*); where a restriction order ceases to have effect while the relevant hospital order remains in force (s. 41(5), see para. 15.13 *ante*);

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<sup>1</sup> The date on which a patient is considered conditionally discharged is the date of actual release from detention in hospital, not the date on which the tribunal made the decision that deferred the discharge until the necessary community arrangements were in place. *R. v. Cannons Park Mental Health Review Tribunal ex parte Martins* [1995] 26 BMLR 134, Q.B.D.

persons detained under H.M. Pleasure (s. 46(3); see para. 15.21 *ante*); and persons transferred from prison to hospital (ss. 47(3), 48(3); see paras. 16.01–16.03 *ante*).

#### 18.04.8 *Withdrawal of application*

An applicant may withdraw his application at any stage of the proceedings provided the tribunal agrees (r. 19(1)). Where the tribunal authorises the withdrawal the applicant does not lose his right of application during that period and thus may re-apply to the tribunal (s. 77(2)). An application which has been withdrawn is disregarded for the purposes of assessing whether the patient's case should be referred automatically to the tribunal (see para. 18.05 below). Where an application is withdrawn after the expiry of a period to which automatic reference applies, the patient's case must be referred to the tribunal as soon as possible after the withdrawal (ss. 68(5), 71(6)).

#### 18.05 Automatic References

The Act places a duty on the hospital managers or the Home Secretary to refer a case to the tribunal at the end of specified periods if no application or reference is made in respect of the case during that time. There was no provision for automatic reference under the 1959 Act. Patients had to initiate applications to the tribunal with the result that only a small proportion of eligible patients did so; some patients did not know of their rights and some were too ill or withdrawn to exercise them. Consequently some patients were detained for considerable periods without any independent assessment of the need for their detention. The 1983 Act tries to resolve this in two ways. First, hospital managers have a duty to inform patients and nearest relatives of their rights to apply to the tribunal (s. 132; see paras. 6.07–6.08 *ante*). Secondly, the provisions for automatic reference ensure that in cases where the patient does not apply to the tribunal of his own accord his case will nevertheless be considered by the tribunal at periodic intervals.

The hospital managers are responsible for automatic reference of non-restricted patients; the Home Secretary is responsible for automatic reference of restricted patients. It may be noted from Tables 1 and 2 (see para. 18.04 above) that a patient detained for treatment (s. 3) has a right of reference after the first six months while a patient detained under Part III of the Act has no such right. The reason is that, unlike a patient admitted for treatment, a patient detained under Part III of the Act has already, through the sentencing court, had an independent assessment of the appropriateness of his admission.

Patients detained under a restriction order by virtue of section 5(1) of the Criminal Procedure (Insanity) Act 1964 are special cases for the reasons given in paragraph 18.04.7 above. Thus, unlike other restricted patients, such patients have a right of application to the tribunal during

the first six months of detention; if no application is made during that period the patient's case must be referred to the tribunal by the Home Secretary.

Restricted patients who are recalled to hospital following a conditional discharge do not have the opportunity of an independent assessment of the justification for recalling them, prior to their return. While they themselves cannot apply to the tribunal in the first six months after recall, their cases must be referred to the tribunal by the Home Secretary within a month of their return to hospital.

It sometimes occurs that a patient who is automatically referred to a MHRT may not have a desire to be discharged. The tribunal, nonetheless, has a duty to consider his case, and it must discharge the patient from liability to detention if the statutory criteria are fulfilled. However, in practice, the patient is not obliged to appear before the tribunal if he does not wish to do so. Further, (except perhaps in a special hospital, see para. 3.04.1 *ante*) the patient may, in conjunction with the hospital authorities, decide to remain in hospital on an informal basis.

### **18.06 References by the Secretary of State at his Discretion**

Section 67(1) gives the Secretary of State for Health unfettered discretion to refer to a tribunal the case of any patient liable to detention, subject to guardianship or subject to supervised after care under Part II of the Act. Section 40(4) extends this provision to patients detained under a hospital order without restrictions or subject to a guardianship order made by a court. Section 71(1) gives the same discretionary power to the Home Secretary with respect to restricted patients.

The Secretary of State may exercise his discretion to refer a case to a tribunal at any time and for any reason. In practice a case may be referred to a tribunal under these provisions if the patient's condition has suddenly improved, his circumstances have changed, or if the patient unintentionally forfeited a right of application in a particular period.

## **C. POWERS IN RESPECT OF UNRESTRICTED PATIENTS**

### **18.07 Introduction**

The function of a MHRT for both restricted and unrestricted patients is to review the justification for the patient's detention or guardianship at the time of the hearing. Accordingly, the tribunal has

no power to determine whether the original admission was lawful<sup>1</sup> (see *habeas corpus*, para. 17.07 *ante*), and it has no power to hear complaints, for example about the effects of a particular treatment or consent to treatment or about restraint used on the hospital wards. These matters can be discussed only insofar as they may relate to the tribunal's actual powers under the Act. The tribunal's powers are exercised in accordance with the statutory criteria which are set out below. In hearing the case of an **unrestricted patient** its powers are limited to discharge, delayed discharge, recommendation for transfer or leave of absence and reclassification.<sup>2</sup> In hearing the case of a **restricted patient** its powers are limited to absolute discharge, conditional discharge and reclassification. In practice tribunals sometimes make recommendations for transfer, leave of absence and removal of restrictions; but there is no clear statutory basis for such recommendations.

Tribunals have an obligation to follow the relevant statutory criteria for discharge, and must give adequate reasons for their decisions. They cannot legally render decisions that are arbitrary, without any evidence to support them. However, tribunals have wide discretion to render decisions that may appear to be against the weight of evidence.<sup>3</sup>

## 18.08 Discharge

### 18.08.1 Admission for assessment (s. 2)

The tribunal **may** direct a patient to be discharged on any grounds (s. 72(1)). This gives the tribunal a general discretion to discharge a patient which is not fettered by specific statutory criteria. The tribunal **must** discharge a patient if satisfied (s. 72(1)(a)):

- (a) he is not then suffering from mental disorder or mental disorder of a nature or degree which warrants his detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; **or**
- (b) his detention is not justified in the interests of his own health or safety or with a view to the protection of others.

The above criteria for discharge correspond with the criteria for admission (see discussion at paras. 11.01 and 11.05.1 *ante*).

The tribunal should state affirmatively that it is satisfied that the criteria in section 72(1)(a) are met before ordering the patient's dis-

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<sup>1</sup> See *R. v. Hallstrom & another ex parte Waldron* [1986] 1 Q.B. 824, [1985] 3 All E.R. 775, at 846, per Ackner LJ (the tribunal "has no power to consider the validity of admission which gave rise to the liability to be detained"); *R. v. Mental Health Review Tribunal ex parte Cooper*, CO/786/89 (Transcript: Marten Walsh Cherer) 14 Feb. 1990, Rose J.

<sup>2</sup> In assessment applications the tribunal's powers are limited to ordering discharge.

<sup>3</sup> *R. v. Trent Mental Health Review Tribunal, ex parte Ryan*, CO/445/91 (Transcript: Marten Walsh Cherer) 4 October 1991, Q.B.D. Nolan, LJ.

charge. In *Perkins v. Bath District Health Authority; R. v. Wessex Medical Health Review Tribunal ex parte Wiltshire*,<sup>1</sup> the Court of Appeal held that a tribunal erred when it decided to order discharge because it was “not satisfied that this patient is suffering from mental disorder of a nature or degree which warrants detention in hospital for assessment for at least a limited period.” Lord Donaldson said that “clearly [the tribunal] has to be satisfied, and should state that they are satisfied that he is not then suffering from mental disorder. That is not the same thing as saying the Tribunal is not satisfied that he is so suffering.”

**18.08.2 Admission for treatment (s. 3) or hospital order patients (s. 37): Mandatory duty to discharge**

As with patients admitted for assessment, patients admitted for treatment or under a hospital order may be discharged by the tribunal under its general discretion which is not subject to any specific statutory criteria (s. 72(1)). The tribunal has a mandatory duty to discharge if it is satisfied (s. 72(1)(b)):

- (a) the patient is not then suffering from one of the four specific forms of mental disorder (*i.e.* mental illness, severe mental impairment, mental impairment or psychopathic disorder) of a nature or degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment; **or**
- (b) it is not necessary for his health or safety or the protection of others that he should receive such treatment; **or**
- (c) in the case of an application under s. 66(1)(g) by a nearest relative following the barring of a discharge order, that the patient if released would not be likely to act in a manner dangerous to himself or others.

The tribunal, therefore, has a mandatory duty to discharge the patient if *any* of the three statutory criteria are satisfied: an “appropriateness” test, a “health or safety” test or, in the case of a discharge order by the nearest relative, a “dangerousness” test.<sup>2</sup>

(i) *The “appropriateness” test*

Under criterion (i) the patient cannot be detained unless he is suffering from a specific form of mental disorder and not simply “any other disorder or disability of mind” (see para. 9.01 ante). For example, a mentally handicapped person whose condition is no longer associated

<sup>1</sup> (1989) 4 BMLR 145; *The Times*, 29 August 1989 (Transcript: Association), CA. As to the facts of this case, see para. 18.09 below.

<sup>2</sup> However, a mandatory discharge may not necessarily be immediate, the tribunal may defer the discharge of the patient to a future date. *R. v. Mental Health Review Tribunal for North Thames Region, ex parte Pierce*, 20 May 1996, CO/1467/96 (Transcript: Smith Bernal). See also 18.09 post.



with “abnormally aggressive or seriously irresponsible conduct” cannot be classified as mentally impaired and must be discharged.

A critical question arises under section 72(1)(b)(i): is the tribunal obliged to discharge a patient suffering from a minor form of mental disorder (*i.e.*, psychopathic disorder or mental impairment) if it finds that medical treatment is not likely to alleviate or prevent a deterioration of his condition? The treatability test is applied when the patient with a minor form of mental disorder is admitted and detained (s. 3(2)(b)), reclassified (s. 16(2)), or when the period of his detention is renewed (s. 20(4)).<sup>1</sup> Logically, the tribunal would also be obliged to discharge patients who were not susceptible to treatment. Otherwise, patients could be detained even though they would not have been subject to compulsory admission under the same clinical circumstances.

Despite the logical incongruity among the criteria for detention, the Court of Appeal in *R. v. Canons Park Mental Health Review Tribunal ex parte A*,<sup>2</sup> held that section 72(1)(b) did not require a Mental Health Review Tribunal to have regard to the treatability test in exercising its mandatory power to discharge patients. The tribunal only had to consider the appropriateness and safety tests that are expressly referred to in section 72(1)(b)(i) and (ii). (As explained in para. 18.08.2A below, the tribunal does have the duty to consider the treatability test in the exercise of its *discretionary* power to discharge.)

In *Canons Park*, the applicant, who suffered from borderline personality disorder, was denied a discharge by the Mental Health Review Tribunal because she needed medical supervision for the protection of herself and others, even though her condition was not being alleviated by medical treatment. The only appropriate treatment for her disorder was group therapy, and she refused to cooperate. In ruling that the “treatability” test must be applied only at the discretionary stage, Kennedy LJ reasoned that the function of the tribunal is different from that of the doctors at the time of admission, reclassification, or renewal. If Parliament had intended to require the tribunal to discharge patients who are not susceptible to treatment it would have said so, “but I find it difficult to see how it could have done so without transferring the onus of proof and thus putting the tribunal in the same position as the responsible medical officer.”

Does the construction of the Mental Health Act to allow detention of non-treatable persons violate the European Convention on Human Rights and what are the implications for mental health policy? Kennedy LJ found no ambiguity or uncertainty in section 72(1)(b), so he saw no reason to resolve a doubt by resorting to the principles of the European

<sup>1</sup> As to the use of the “viability” test for persons with mental illness or severe mental impairment at the time of renewal of detention, see para. 11.06.5 *ante*.

<sup>2</sup> [1994] 2 All ER 659, 3 WLR 630, 18 BMLR 94, 16 February 1994.

Convention on Human Rights.<sup>1</sup> The European Court of Human Rights in *X. v. the United Kingdom*<sup>2</sup> held that every patient detained under mental health legislation has the right to a hearing by a judicial body on the *merits* of the case. It is not enough for the tribunal to review the *pro forma* lawfulness of the detention under domestic law. The question arises whether the concept of treatability is so central to the merits of the case, that it must be a determinative or conclusive factor in the tribunal's decision. Put another way, could a person who was of unsound mind, but not susceptible to psychiatric treatment, be compulsorily detained in a mental hospital consistent with Article 5(1) and (4) of the Convention? This is a question which the European Court of Human Rights has yet to decide.

What are the implications for mental health policy if persons who are not susceptible to treatment are subject to detention? A principal justification for detention of persons with mental disorder in the absence of a criminal conviction is that the person can receive beneficial treatment. Further, mental hospitals and mental health professionals receive National Health Service resources to provide treatment. The use of the mental health system for custodial confinement without a reasonable prospect of benefit from treatment raises concerns about the ethical justification for compulsory detention and the prudent use of scarce health resources.

(ii) *The "health" or "safety" test*

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.

(iii) *The "dangerousness" test*

Criterion (iii) arises only in relation to patients admitted for treatment whose nearest relative has unsuccessfully sought to exercise a discharge order (see para. 17.02.3 *ante*). It is an exacting standard which should require some evidence of dangerous behaviour which would result in physical injury. The terms "health", "safety" and "protection" in criterion (ii) potentially encompass a wider range of actions which do not necessarily amount to physical harm, for example causing disruption, verbal abuse, exploitation or damaging property.

**18.08.2A** *Admission for treatment (s. 3) or hospital order patients (s. 37): Discretionary power to discharge*

Where the criteria for mandatory discharge discussed in section 18.09.2 above are not met the tribunal may nevertheless discharge

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<sup>1</sup> Citing, *Brind v. Secretary of State for the Home Department* [1991] 1 All ER 729, [1991] 1 AC 696 for the proposition that courts should only invoke the assistance of the Convention in cases of ambiguity in the statute.

<sup>2</sup> (1981) 1 BMLR 98, 4 EHRR 188.

on any other grounds. In exercising this general discretion the tribunal must have regard to the following criteria (s. 72(2)):

- (a) the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and
- (b) in the case of mental illness or severe mental impairment, the likelihood that if discharged he will be able to care for himself, obtain the care he needs of guard against serious exploitation.

Criterion (a) is the treatability test (see para. 11.06.1 *ante*). The treatability test for a person suffering from a major form of mental disorder (*i.e.*, mental illness or severe mental impairment) is not applicable at the point of admission but what can be called a "viability" test applies at the time of renewal (see para. 11.06.05 *ante*); this viability test is reflected in criterion (b). As noted in para. 18.08.2 above, the tribunal is not **obliged** to discharge a non-treatable patient; but it may consider the treatability of the mental disorder. Nevertheless treatability is an important factor in the exercise of the tribunal's discretionary judgment especially in respect of the minor disorders (*i.e.*, mental impairment or psychopathic disorder). In the case of patients suffering from mental illness and severe mental impairment the tribunal must weigh treatability against the patient's ability to meet his own needs and to prevent serious exploitation.

In *R. v. Canons Park Mental Health Review Tribunal ex parte A*,<sup>1</sup> the Court of Appeal examined the standard to be used by the tribunal in the exercise of its discretionary power to discharge, and clarified the meaning of "treatability." The tribunal, in exercising its discretion, should consider whether it is satisfied that treatment is *unlikely* to alleviate or prevent a deterioration of the patient's mental disorder, not whether treatment is *likely* to have such an effect. Roch LJ reasoned that this approach is consistent with the proper weight that should be given to the views of the RMO who has greatest knowledge of the patient. If the tribunal wishes to direct the discharge of a patient contrary to the advice of the RMO it ought to identify which of the matters set out in section 72(1) it was satisfied did not exist and give reasons for that decision. While the reasoning offered by Roch LJ is understandable, there is nothing in the Act to suggest that the views of the RMO are more considered or hold more weight than those of the tribunal. The language in section 72(2)(a), if read consistently with parallel provisions of the Act, appear to ask the tribunal to inquire whether treatment is *likely* to alleviate or prevent a deterioration of the patient's condition.

The Court of Appeal further held that, for the purposes of the treatability test, medical treatment should not be construed narrowly. The tribunal found that the only form of treatment likely to alleviate

<sup>1</sup> [1994] 2 All ER 659, 3 WLR 630, 18 BMLR 94, 16 February 1994.

or prevent a deterioration in the patient's condition was group therapy, that the patient was unwilling to cooperate in that treatment, but that continued detention and care might lead her to cooperate in time. In such circumstances the treatability test was satisfied, since Parliament could not have intended that a patient was untreatable simply because she refused to cooperate with suitable treatment.

Roch LJ suggested that the treatability test is satisfied if treatment is likely to prevent a deterioration, even if it is unlikely to alleviate the patient's condition. The test is also satisfied if treatment is likely to alleviate or stabilize the patient's condition in due course—*i.e.*, if the treatment envisaged is likely eventually to alleviate or prevent a deterioration of the patient's condition. The tribunal, however, should direct discharge if the patient's detention is simply an attempt to coerce consent to treatment.

Undoubtedly, nursing, care, habilitation and rehabilitation are all part of the spectrum of treatment envisaged under the Act (s. 145). However, simply because a patient receives some or all of those services does not mean that he or she is "treatable." That would render the term meaningless because virtually everyone in hospital receives those services. Treatability when used in the context of compulsory detention must mean something more. The logical meaning would go to the question of *benefit* to the patient—*viz.*, whether it eased the patient's symptomatology and improved his capacity for independent living or, minimally, prevented a deterioration of his condition.

### 18.08.3 *Guardianship patients* (s. 7 or 37)

The tribunal has a general discretion to discharge a patient subject to guardianship (s. 72(4)). It **must** discharge the patient if it is satisfied (s. 72(4)):

- (a) he is not then suffering from one of the four forms of mental disorder; or
- (b) it is not necessary in the interests of his welfare or the protection of others that he should remain under guardianship.

Unlike patients detained in hospital there is no specification in criterion (a) as to the nature or degree of the mental disorder. In criterion (b) the concept of the guardianship patient's "welfare" is wider than "health and safety" used for hospital patients. "Welfare" potentially could include possible exploitation and an ability to handle his personal affairs and to make decisions.

### 18.08.4 *Patients Subject to Supervised Discharge*

As with non-restricted detained patients, tribunals have a general discretion to discharge patients from supervised after-care in any

case. They come under a duty to discharge only if the patient satisfies them that the conditions for an application or renewal of supervised after-care are **not** met.<sup>1</sup> Thus unless a supervisee can persuade the MHRT to exercise its discretion to discharge, the burden is on him or her to satisfy them:

- (a) that he is not suffering from mental disorder being mental illness, severe mental impairment, psychopathic disorder or mental impairment; *or*
- (b) that there would not 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 s. 117 below; *or*
- (c) that his being subject to after care under supervision is not likely help to secure that he receives the after care services to be so provided.<sup>2</sup>

As with guardianship patients, there is no specification as to the nature or degree of the mental disorder in criterion (a).

This burden will be hard to discharge. The patient will find it difficult to satisfy the tribunal that he or she is not suffering from mental disorder if he or she has a history of relapse following cessation of medication. This will be a matter on which the patient will wish to seek independent psychiatric opinion, but the tribunal is likely to find that even though the overt symptoms of illness are not manifest at the time of the hearing, the patient is still suffering from mental disorder the symptoms of which are kept in check by the medication. If the medical authorities state that the patient would be at risk if he or she did not continue to accept the after care services, it will be difficult for the patient to show that there would be not be a substantial risk of serious harm to his or her own health or safety or of serious exploitation without the requirement to accept after care. What the decision will often boil down to is whether the MHRT accepts the doctor's assertion that without medication a patient who has relapsed in the past following cessation of medication will relapse again. Recurrence of illness justifying re-admission would be serious harm to mental health, and the fact that the patient had relapsed before would be evidence that the risk is substantial or, in other words, real. It can confidently predicted that discharges "as of right" will be few. It will be difficult for a patient who has remained stable in the community whilst taking medication to convince a tribunal that this is not because of the medication when the RMO says that it is, and that the supervised discharge is helping to secure that the patient receives the after-care services.

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<sup>1</sup> Mental Health Act 1983, s. 72(A) inserted by Mental Health (Patients in the Community) Act 1995, Sch. 1, para. 10(3).

<sup>2</sup> *Id.*, and s. 25A(4).

### 18.09 Delayed Discharge

Where a tribunal is considering the case of a detained patient it may direct that he is discharged on a future date which it must specify (s. 72(3)). The tribunal must, within seven days of the hearing, communicate its decision to the patient (r. 24(1); see para. 18.24 below). If it decides to make a delayed discharge order it must, at that time, specify a particular date on which the discharge takes effect. Having made a decision to delay a discharge the tribunal cannot, prior to the specified date, change the order (*cf.* deferred conditional discharge at para. 18.14.1 below). The provisions for delayed discharge do not apply to patients subject to guardianship.

The 1959 Act contained no provision for delaying a discharge; where the tribunal decided to direct the patient's discharge it communicated its decision to the patient within seven days of the hearing, and the discharge took effect immediately. The result was that patients were discharged before arrangements could be made for their accommodation or care in the community. The power to delay a discharge under the 1983 Act should most frequently be used in cases where there is no satisfactory accommodation for the patient outside the hospital and where support from the social services needs to be arranged.

The Act does not explicitly limit the period for which an order for discharge may be delayed, but it is presumed that the delay would have to be a reasonable one and related to a valid objective such as the availability of after-care. A tribunal could not specify a date for discharge after that on which the authority for a patient's detention expires.

Intriguing questions concerning delayed discharge were raised, but not decided, in *Perkins v. Bath District Health Authority; R. v. Wessex Mental Health Review Tribunal ex parte Wiltshire County Council*.<sup>1</sup> On 23 May 1989 the tribunal ordered the discharge of a patient admitted for assessment, but the discharge was delayed until 27 May. The authority for detention under section 2 would have expired on 3 June. On 26 May the County Council applied to the County Court for an order under section 29 replacing the nearest relative on the ground that he was unreasonably objecting to an admission for treatment (s. 29(3)(b)). The patient argued that once the tribunal found he was no longer suffering from mental disorder of a nature or degree which warrants detention for assessment, it had no power to delay the discharge; and, since that patient was not technically subject to section 2, his detention could not be extended under section 29(4) (see para. 8.05 *ante*). The patient withdrew these claims after the nearest relative agreed to make an application under section 3. But the question still remains whether section 29(4) extends the period during which section

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<sup>1</sup> (1989) 4 BMLR 145; *The Times*, 29 August 1989 (Transcript: Association), CA. See further para. 18.08.1 above.

2 applies regardless of an order by the Tribunal or whether it is subject to any such order. The better view is that once a tribunal makes a binding order to discharge the patient, he should be discharged and a fresh application under section 3 ought to be made if appropriate.

Lord Donaldson was sympathetic to the patient's position that a tribunal cannot delay discharge under section 72(3) in order "to allow the authorities to decide whether there is some basis for his detention other than that under which he is currently detained." Even though the Court did not rule on this point, it emphasizes the importance of valid reasons for a tribunal's decision to delay discharge.

Lord Donaldson also felt that the interaction between sections 66 (application to tribunal) and 29 (appointment by court of an acting nearest relative) deserves re-consideration by Parliament. A patient has fourteen days within which to apply to a tribunal for discharge under section 2. A patient might decide not to make an application in reliance on a maximum period of detention of 28 days. If he did, the patient might be overlooking the fact that under section 29(4) the period of detention under section 2 is extended by operation of law until the conclusion of the County Court proceedings; this could result in a quite considerable extension of the twenty-eight day period. Lord Donaldson was troubled by the following question: The fourteen day period having expired and the twenty-eight day period having become extended by operation of law, should it then be open to a patient to apply for a tribunal? Parliament did not make express provision for applying for a tribunal during the extended period while County Court proceedings take place. Yet, as Lord Donaldson implies, a patient's liberty is deprived during that period, without recourse to a full and fair review of the necessity for detention.

**18.09.1** *Delayed discharge in cases where there is a mandatory duty to discharge*

The question as to whether a delayed discharge can be made when the tribunal has a mandatory duty to discharge under 72(1)(b) was raised in *R. v. Mental Health Review Tribunal for North Thames Region, ex parte Pierce*.<sup>1</sup> On 29 April 1996 the tribunal considered an application by the patient's mother for the discharge of her daughter from hospital where she had been detained under section 3. The tribunal decided that the patient should be discharged from liability to be detained with effect from 20 May 1996. The patient argued that since there was a mandatory duty to discharge under 72(1)(b)(iii) it was improper for the tribunal to direct the discharge on a future date.

The court held that, under a proper construction of section 72(3) a tribunal has the authority to direct the discharge of a patient at a future

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<sup>1</sup> (1996) CO/1467/96 (Transcript: Smith Bernal), Q.B.D.

date, even in cases where the tribunal is under a mandatory duty to discharge the patient under section 72(1)(b)(iii). (See para. 18.08.2 above). Section 72(3) does not confine the power to delay discharge only to cases of discretionary discharge. The court found that tribunals first must decide whether to order the patient's discharge. Given its findings of fact, the tribunal's power to discharge may be either discretionary or mandatory. "Having decided that it either has to, or will, direct a discharge, it then has to consider whether the discharge should be immediate or whether it should be at a future date specified in the direction pursuant to section 72(3)."

*Ex parte Pierce* raises an interesting question since, if the tribunal has a mandatory duty to discharge, the conditions that warrant detention under the Act are absent and, theoretically, restraint of liberty is no longer justified. The case raises another important question which the court did not address, but felt was worthy of serious consideration. Assuming it is appropriate to delay discharge for certain purposes (e.g., until appropriate aftercare arrangements are in place), are there other purposes (e.g., the administration of compulsory medical treatment) for which delayed discharge would be unlawful? Tribunals, in practice, do delay discharge in cases of mandatory discharge to allow time for arrangements for accommodation or for psychiatric aftercare in the community. In *ex parte Pierce*, the tribunal delayed discharge explicitly to permit the patient to undergo electroconvulsive therapy prior to discharge. Arguably, once the tribunal has decided that it has a mandatory duty to discharge the patient, it no longer possesses the power to delay his confinement solely, or primarily, for the purposes of compulsory treatment. Patient's who are not liable to detention could not lawfully receive electroconvulsive therapy or other medical treatments without their consent.

### 18.10 Recommendation for Transfer or Leave of Absence

Where a tribunal decides not to discharge a detained patient it may recommend that he is granted leave of absence (see para. 11.13 ante), or transferred to another hospital (see para. 11.18.1 ante) or into guardianship (see para. 11.18.3 ante) (s. 72(3)(a)) or (in the case of a patient liable to be detained under section 3) that the RMO apply for compulsory supervision in the community (see para. 11.13.8 et seq ante) (s. 72(3A)). It should be emphasised that tribunals do not have the power to direct transfer or leave of absence but can only make recommendations to that effect. Under the 1959 Act tribunals could only discharge a non-restricted patient or reclassify the category of mental disorder; they held no advisory powers in respect of transfers or leave of absence. The 1983 Act expanded the tribunal's advisory powers so as to enable them to deal more flexibly with the patient's needs; in particular, it was recognised that many patients require a



period of gradual rehabilitation in which transfer to more open conditions or periods of supervised leave may be important elements.

Under section 72(3)(b) the tribunal may further consider a patient's case in the event that any recommendation it makes under section 72(3)(a) is not complied with. Under Rule 24(4) the tribunal's decision must specify the period at the expiration of which the tribunal will consider the case further in the event of those recommendations not being complied with.

At the time the case is further considered, the tribunal is vested with all of the powers that it had at the time it first considered the application. The tribunal is not limited only to a re-examination of its initial recommendations; the tribunal may order immediate discharge or future discharge if it finds either option appropriate.<sup>1</sup>

### 18.11 Reclassification

Where the tribunal does not discharge the patient but is satisfied that he is suffering from a form of mental disorder different from the one specified in the documents relating to detention, it may direct that the form of mental disorder is amended accordingly (s. 72(5); as to reclassification, see para. 11.06.6 *ante*).

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<sup>1</sup> *Mental Health Review Tribunal v. Hempstock*, CO/3946/96, 10 July 1997, Q.B.D.

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## D. POWERS IN RESPECT OF RESTRICTED PATIENTS

### 18.12 Introduction

The 1983 Act significantly extends the powers of MHRTs in respect of patients subject to a restriction order. Under the 1959 Act they could only advise the Home Secretary as to the exercise of powers by him. The final decision rested with the Home Secretary who could accept or reject the MHRT's advice on any grounds and without giving reasons; the tribunal's advice to the Home Secretary was in confidence and was effectively immune from challenge in the courts. The 1983 Act brings the law into conformity with the decision of the European Court of Human Rights in *X. v. the United Kingdom*. Tribunals now have binding authority to discharge a patient subject to a **restriction order**. (As to the tribunal's power in cases where the patient is subject to a **restriction direction** see para. 18.17 below). This power runs concurrently with that of the Home Secretary who retains the power to dis-

charge a restricted patient absolutely or subject to conditions, recall the patient or remove a restriction order. (See further para. 15.16 *ante*).

### 18.13 Absolute Discharge

The tribunal's general discretion to discharge a patient on any grounds does not apply in relation to restricted patients (*cf.* para. 18.08.1 above). The tribunal must assess the relevant statutory criteria and can only discharge the patient if the criteria are satisfied (s. 73(1)). The tribunal **must** give a direction for absolute discharge if it is satisfied:

- (a) that the patient is not then suffering from one of the four forms of mental disorder which makes it appropriate for him to be detained in hospital for medical treatment; or
- (b) it is not necessary for the patient's health or safety or the protection of others that he should receive such treatment; **and**
- (c) it is not appropriate that the patient remains liable to be recalled to hospital for further treatment.

Criteria (a) and (b) are the same as for patients admitted for treatment or under a hospital order (see para. 18.08.2 above). Note that under criterion (a) a restricted patient must be discharged (either absolutely or conditionally) if he is not suffering from one of the specific forms of mental disorder, even if he remains dangerous. This is probably in response to indications by the domestic courts<sup>1</sup> and the European Court of Human Rights<sup>2</sup> that only patients who are mentally disordered can be detained under mental health legislation. (See further para. 9.09 *ante*). Criteria (a) and (b) are phrased in the disjunctive so that the patient must be discharged if either are satisfied. If criterion (c) is fulfilled the patient must be absolutely discharged; if it is not satisfied he must be conditionally discharged. (As to the distinction between absolute and conditional discharge see para. 15.16 *ante*; for a discussion of criterion (c), see paras. 18.13.1 and 18.14 below).

In contrast to non-restricted patients (see para. 18.08.2 above), there is no provision requiring a tribunal to have regard to the treatability of a restricted patient, irrespective of the classification of mental disorder. (The requirement for tribunals to have regard to the treatability of non-restricted patients in section 75(2) is linked exclusively to the tribunal's discretionary powers of discharge under section 72(1). Since these discretionary powers do not extend to restricted patients, neither does

<sup>1</sup> *Kynaston v. Secretary of State for Home Affairs* (1981) 73 Cr. App. R. 281, C.A. The Court of Appeal, however, has upheld the decision of a tribunal to order a **conditional** discharge, and the decision of the Home Secretary to recall the patient to hospital in the absence of any objective evidence of mental disorder. *R. v. Merseyside Mental Health Review Tribunal ex parte K* [1990] 1 All E.R. 694; *R. v. Secretary of State for the Home Department ex parte K* [1990] 3 All E.R. 562. See paras 15.16.3 *ante*, and 18.13.1 below.

<sup>2</sup> *Winterwerp v. the Netherlands*, European Court of Human Rights, Judgment given Oct. 24, 1979, paras. 37–39.

the requirement to have regard to treatability.) It is curious that this should be so as the court, in making the hospital order with restrictions, must apply the treatability test to the minor disorders; this seriously undermines the importance of treatability as a major factor in influencing the detention of restricted patients.

### 18.13.1 Discharge of "patient" not suffering from mental disorder

Does the tribunal have a duty to grant an absolute discharge if it finds that the "patient" is not mentally disordered? In *R. v. Merseyside Mental Health Review Tribunal ex parte K*.<sup>1</sup> a tribunal said the patient was not mentally disordered, but found under section 73(1)(b) that it was appropriate for him to remain liable to be recalled to hospital for further treatment. The tribunal granted a conditional, as opposed to an absolute, discharge. The applicant claimed that he should be absolutely discharged. He should not be subject to the Mental Health Act because he was not mentally disordered: the preamble of the Act refers to "mentally disordered persons"; it has effect with respect to the "reception, care and treatment of mentally disordered patients" (s. 1); and a "patient" means "a person suffering or appearing to be suffering from mental disorder" (s. 145). A conditional discharge under section 73(2) must pre-suppose possible recall to hospital for "further treatment", but if the person is not mentally disordered there is nothing to treat.

The Queen's Bench Divisional Court held that a restricted patient who was not mentally disordered remained a "patient" under the Act for the purposes of section 73(2) and could, therefore, be conditionally discharged so that he remained liable to recall to hospital. Any other conclusion would be untenable because: "If at the date of the decision the tribunal was wholly satisfied that the person concerned was not suffering from mental disorder but there was substantial expert evidence that he was liable to relapse, nevertheless the tribunal would be obliged to let him loose." Section 73 specifically provided for conditional discharge where the tribunal found that he should remain liable to recall. "It was clear that in section 72 and associated sections the context did require another meaning of the word 'patient'."<sup>2</sup>

The Court of Appeal agreed with the interpretation of the Act formulated by the Divisional Court.<sup>3</sup> Lord Justice Butler-Sloss first considered

<sup>1</sup> [1990] 1 All E.R. 694; *The Times*, June 15, 1989; *The Independent*, June 8, 1989.

<sup>2</sup> *R. v. Mental Health Review Tribunal, ex parte Kay* (1988) *The Times*, May 25, 1988, D.C.

<sup>3</sup> *R. v. Merseyside Mental Health Review Tribunal ex parte K* [1990] 1 All E.R. 694, C.A. Lord Justice Kerr joined in the decision of Butler-Sloss LJ. Sir Denys Buckley wrote his own concurring opinion dismissing the appeal on much more narrow grounds. He did not find it necessary to consider how the word "patient" should be construed, since the 1986 tribunal decision merely suspended the operation of the conditions on discharge set in 1985 while the applicant was in prison. The 1986 tribunal decision was not subject to judicial review on the question put forward in the appeal.

the propriety of a tribunal granting a conditional discharge after it found as a matter of fact that the applicant was not mentally disordered. The tribunal under section 72(1) must direct the discharge of the patient if satisfied he is not *then* suffering from mental disorder. But in the case of a restricted patient section 73 applies. The tribunal cannot absolutely discharge a restricted patient unless it finds that, under section 73(1)(b), it is not appropriate for him to remain liable to be recalled to hospital for further treatment. Thus, even if the tribunal finds the patient is not mentally disordered, it must direct a conditional discharge unless satisfied that it is not appropriate to recall the patient. Lord Justice Butler-Sloss concluded that it is clear the tribunal had the statutory power to make an order for a conditional discharge.

The Lord Justice next considered whether the applicant who was not mentally disordered was a "patient" within the meaning of the Mental Health Act.

"At the time the offender is detained under a hospital order he is a patient within the interpretation in s. 145. By s. 41(3)(a) a restricted patient continues to be detained until discharged under s. 73 and in my judgement remains a patient until he is discharged absolutely, if at all, by the tribunal. Any other interpretation of the word 'patient' makes a nonsense of the framework of the Act and the hoped-for progression to discharge of the treatable patient, treatability being a prerequisite of his original admission."

Lord Justice Butler-Sloss observed that the power to order a conditional discharge is designed both to support the patient in the community and to protect the public. It is an important discretionary power vested in the tribunal, and not lightly to be set aside in the absence of clear words.

### *Commentary*

The power to supervise mentally disordered patients in the community is of undoubted importance, since it can provide a network of treatment, care, and support after a long period of detention in an institution. But the very purpose of mental health legislation is to have control over, and to treat, mentally disordered persons. That purpose is made clear from the preamble to the Act, the scope of the Act (s. 1), and the definition of "patient" (s. 145(1)), all of which refer to the mentally disordered person as the proper subject of the Act's powers. A hospital order can only be made in respect of mentally disordered offenders who are treatable and the conditional discharge provisions contemplate recall only for "further treatment" (s. 73(1)(b)). Once the purposes for detention (treatment of mentally disordered persons) are no longer applicable, a person should no longer be subject to the Act. These provisions do appear clear, particularly in light of the rule of statutory interpretation which requires strict construction of an Act of Parliament which affects personal liberty. Certainly, the definition of

medical treatment under the Act is quite broad: it "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision." But this must mean medical treatment of mentally disordered persons. Otherwise, anyone who was cared for in the community for any medical condition would come within the broad definition of "treatment."

Arguably, Article 5(1)(e) of the European Convention on Human Rights would prohibit the restraint of liberty of persons who are not currently of "unsound mind" because of the possibility that they may become mentally ill in the future. (See further paras. 9.09 and 13.04.1 *ante*). The "lawful detention" of persons under Article 5(1)(e) requires a reliable showing that the person is of unsound mind on the basis of objective medical expertise. Further, the European Court of Human Rights recognised that mental disorder is subject to amelioration and cure.<sup>1</sup> Once the person is "cured" and is no longer of unsound mind, the logic of the European Court's decision suggests that restraint under Mental Health legislation is no longer compatible with the Convention. The only major argument on the other side is that patients who are conditionally discharged are not formally subject to detention in hospital, and that any restraint on their liberty may be justified by their own benefit in receiving care and support in the community, and the continuing protection of the public.<sup>2</sup>

#### 18.13.1A *Discharge of a patient who poses no danger to the public*

The question arose in *R. v. Mental Health Review Tribunal ex parte Cooper*<sup>3</sup> as to whether a tribunal properly exercised its discretion in ordering a **conditional** discharge after it determined that the patient did not pose a danger to the public. Rose J held that, where a tribunal determined that the criterion in section 73(1)(c) was not fulfilled, then it not only had discretion to make the discharge conditional, but it was required to do so. Thus, once a tribunal determines that it is appropriate for the patient to be liable to recall to hospital for further treatment, it must make its discharge order subject to conditions and it does not have the power to order an absolute discharge.

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<sup>1</sup> *Winterwerp Case* Judgment of the European Court of Human Rights, 2 E.H.R.R. 387 (1979). See further para. 15.11 *ante*.

<sup>2</sup> The Court of Appeal addressed these arguments in a later case involving the same patient. *R. v. Secretary of State for the Home Department, ex parte K* [1990] 3 All E.R. 562. The Court cited *R. v. Secretary of State for the Home Department ex parte Brind* [1990] 1 All E.R. 469 for the proposition that where an English statute is plain and unambiguous it is not open to the courts to look to the European Convention on Human Rights for assistance in its interpretation. See para. 15.16.3 *ante*.

<sup>3</sup> CO/786/89 (Transcript: Marten Walsh Cherer) 14 February 1990.

### 18.13.2 *Detention Without Treatment*

In this paragraph it is pointed out that there is no “treatability” criterion in relation to Tribunal discharge decisions for restricted patients. The issue came before the Divisional Court by way of an application for judicial review in *R v. Mersey Mental Health Review Tribunal ex parte Dillon*.<sup>1</sup> Mr. Dillon, a restricted patient at Park Lane Hospital was determined by his RMO “no longer to be suffering from any mental disorder” and, in particular, was no longer suffering from psychopathic disorder. The Hospital was still concerned that he posed a threat to the public safety.

The Tribunal refused to order the patient’s discharge, and said:

“We do not accept the views of [the RMO] that the applicant is no longer suffering from psychopathic disorder.”

This was based upon his past behaviour.<sup>2</sup> The Tribunal reasons stated that “the patient is suffering from psychopathic disorder of a nature and degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment and that it is necessary for the protection of other persons that he should receive such treatment.”

The Court observed that “medical treatment” is defined in section 145 as including nursing, care, habilitation, and rehabilitation (see para. 20.02 *post*). The applicant was receiving this level of medical treatment at Park Lane. Lord Justice Russell held that “there is no requirement that the medical treatment envisaged in sections 72 and 73 should be such medical treatment as might have the effect of alleviating or improving the condition of the patient.”

The Court further discussed a passage in the tribunal’s decision under the heading “other comments”:

“The Tribunal sympathises with those responsible for the care of the applicant in that they find themselves unable to adopt any form of treatment of the applicant, other than containment in conditions of high security. Unhappily, the index offense and the applicant’s subsequent conduct has led the Tribunal to the conclusion that such containment is the only course open in the case of one from the community who needs to be protected.”

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<sup>1</sup> *The Times*. April 13, 1987. Full unpublished decision, co/1381/87, 19th March 1987.

<sup>2</sup> The only evidence that Mr. Dillon was mentally disordered appeared to be his past sexual behaviour and the fact that he carried a photograph of a young boy dressed in swimming trunks. The court reported no medical evidence indicating he had psychopathic disorder, although the tribunal composition included a medical member. Can this decision be reconciled with *R. v. Mental Health Review Tribunal ex parte Clatworthy*? In *Clatworthy* the court held that where the only evidence of psychopathic disorder is sexual offending, he is not mentally disordered within the meaning of the Act. (See para 9.01 ante.) Is psychopathic disorder now so problematic that it should be removed from the Act? See Taylor, P. J. (Dec., 1986) Psychopaths and their Treatment, *Journal of the Royal Society of Medicine*, Vol. 79, pp. 693-95.



Russell, L.J. while regretting the Tribunal language, did not believe it flawed the decision. Otton, J. suggested the "comments must be seen in context. They were not used by way of explanation or enlargement of the Tribunal's decision, but simply in recognition of the difficulty which the applicant's case presented for the hospital authorities."

Tribunals must strike a balance between giving full reasoned decisions and avoiding dicta which clouds the basis of their decision.

*R. v. South East Thames Mental Health Review Tribunal, ex parte Ryan*.<sup>1</sup> is consistent with the holding in *Dillon*. William Ryan's R.M.O. recommended his discharge because he was not in need of medical treatment. Watkins, LJ defined care as "the homely art of making people comfortable and providing for their well-being". He noted that under section 14 of the Act "Parliament has deliberately . . . provided that treatment and care shall not be different, but that treatment shall include care, nursing, habilitation and rehabilitation under medical supervision". Given the court's expansive interpretation, it would appear that the hospital milieu itself qualifies as "medical treatment". The essence of the Tribunal's decision, said Watkins, LJ, is that Mr. Ryan "still needs to be kept and cared for in the setting of a mental hospital".

#### 18.14 Conditional Discharge

Where the tribunal considers that either criterion (a) or criterion (b) or both are satisfied but that criterion (c) is not satisfied, it must direct the conditional discharge of the patient (s. 73(2)). Even if the patient is found not to be mentally disordered the tribunal must order a conditional, rather than an absolute, discharge if criterion (c) is not fulfilled. See para. 18.13.1 above.

The patient must abide by any conditions laid down by the tribunal or subsequently imposed by the Home Secretary. A patient who is conditionally discharged may be recalled to hospital by the Home Secretary (s. 73(4)). The Home Secretary may also vary any condition which has been imposed either by the tribunal or by himself (s. 73(5)). The tribunal is not obliged to lay down any specific conditions when it makes its order for conditional discharge. However, in practice it is unlikely that a patient will be conditionally discharged without conditions being imposed either by the tribunal or by the Home Secretary.

##### 18.14.1 *Tribunal must be satisfied that patient should be released from the hospital before directing a conditional discharge*

In two cases brought by the Home Secretary under the case stated procedure (s. 78(8), see para 18.25 below), Mann, J. examined the

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<sup>1</sup> QBD, CO/98/87, 30 June 1987. See further para 18.24 below.

meaning of a conditional discharge by a tribunal.<sup>1</sup> In the case of patient G., the tribunal found that he was no longer suffering from mental illness, but was suffering from severe mental impairment requiring supervision and guidance on personal hygiene and social rehabilitation. The tribunal, deciding that such treatment was not “medical treatment” under section 145(1), ordered a discharge on condition that he continue to reside in hospital. (See further para 18.14A.2 below).

Mann, J. held that mental health review tribunals have a mandatory duty to discharge a patient conditionally if satisfied that section 73(2) applies; “discharge” means release from hospital, and not that he should remain in the same or another hospital. Accordingly, a condition of discharge that a patient reside in a hospital is inconsistent with the mandatory duty to discharge a patient conditionally. The tribunal’s finding that patient G. needed supervision and training was, in fact, a finding that he needed medical treatment as defined by section 145(1). The tribunal wrongly decided that the criteria for conditional discharge were met because it did not believe that the patient should be released from hospital.

#### 18.14A Deferred Direction for Conditional Discharge

The tribunal may defer a direction for conditional discharge until arrangements for the patient’s care are made to its satisfaction (s. 73(7)). Two observations need to be made about a deferred direction. First, it can only be made in respect of a conditional discharge. If the criteria for an absolute discharge are met, the discharge order must be made within seven days of the hearing (r. 24(1)). Second, the power to defer a conditional discharge of a restricted patient differs significantly from the tribunal’s power to delay a discharge in the case of a non-restricted patient (see para. 18.09 above). When the tribunal delays the discharge of a non-restricted patient it makes an order for discharge which is to take effect at a specified date in the future; discharge must be effected on or by that date irrespective of whether arrangements for the patient’s care have been completed. On the other hand when the tribunal makes a deferred direction for conditional discharge, the discharge will take effect only after arrangements have been made to its satisfaction.

It has been decided by the House of Lords that when a deferred direction is made, the tribunal has no power to go back on the decision (see para. 18.14A.1 and 18.14A.2 below). The tribunal only has the further discretion to determine whether satisfactory arrangements for the conditional discharge have been made. These “arrangements” are purely for the purpose of effectuating the conditional discharge. In practice, the hospital should make all reasonable and good faith efforts to arrange for accommodation in a hostel or home; psychiatric and/or

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<sup>1</sup> *Secretary of State for the Home Department v. Mental Health Review Tribunal for Mersey Regional Health Authority (Patient S); Same v. Mental Health Review Tribunal for Wales (Patient G.)* [1986] 1 W.L.R. 1170, Mann, J.

social support; and supervision. If the tribunal is not satisfied that appropriate arrangements have been made the order for conditional discharge does not take effect. If no decision has been made before the patient's case next comes before a tribunal for its consideration, the tribunal must deal with the fresh application or reference; no decision can be given on the earlier one (s. 73(7)).

Following the passage of the 1983 Act tribunals often directed a deferment to a fixed date. They would then re-convene on that date to decide if satisfactory arrangements had been made. Lord Bridge, in *dicta*, in *Campbell v. Secretary of State for the Home Department*<sup>1</sup> said that there is no authority in the Act or Rules to defer a conditional discharge to a fixed date. He argued that "it is impossible for a tribunal in making a deferred direction for conditional discharge to predict how long it will take to make the necessary arrangements". The person responsible for making the arrangements should proceed with "all reasonable expedition" and should inform the tribunal when it is thought that satisfactory arrangements have been made.

The problem with this position, however, is that the time taken to make arrangements is almost completely out of the tribunal's hands, and arrangements for aftercare may be unnecessarily thwarted or delayed.

**18.14A.1** *A tribunal has no power to re-consider a deferred direction for conditional discharge*

In *R. v. Oxford Regional Mental Health Review Tribunal, ex parte Secretary of State*<sup>2</sup> the Court of Appeal heard two cases together, deciding that tribunals have no power to reconsider a deferred direction for conditional discharge. In the first case, involving a Broadmoor patient, Mr. Campbell, the Home Secretary was not given notice of a tribunal hearing. The tribunal made a deferred direction for conditional discharge. Woolf J. refused an application for judicial review by the Home Secretary, because the Home Secretary could be heard when the tribunal reconsidered the direction. Since the Home Secretary would have the opportunity to be heard at that time, before a final decision was made, Woolf J. found no breach of natural justice. In the second case, a tribunal made a conditional discharge with the express proviso that if the necessary arrangements were not made within six months, it would reconsider whether the direction could be perfected without any specific arrangements. The Home Secretary's application for judicial review was refused by Kennedy J. on the ground that the tribunal had power to review the initial decision.

The Court of Appeal noted that an order for conditional discharge is mandatory once the tribunal is satisfied that the criteria of section

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<sup>1</sup> [1987] 2 W.L.R. 522, H.L.

<sup>2</sup> [1986] 1 W.L.R. 1180; [1986] 3 All E.R. 238, C.A.

73(2) are fulfilled. Once a deferred direction is made, it is final. The deferred direction does not mean that the decision for conditional discharge can be reviewed afresh. The order can be deferred only for the necessary arrangements for the patient's discharge to be made. The tribunal's discretion, once the deferred direction is made, is limited to reviewing whether arrangements have been made to its satisfaction; the tribunal may not re-examine the condition of the patient or his suitability for a conditional discharge.

Accordingly, the Home Secretary's applications were granted since, in the first case (of Mr. Campbell), the order was made without notice and, in the second case, the tribunal erred in stating that it had a power to re-consider the case.

The House of Lords in *Campbell v. Secretary of State for the Home Department*<sup>1</sup> affirmed the Court of Appeal decision. Lord Bridge concluded that the tribunal is not empowered to re-consider its determination under section 73(1)(a), (2) that discharge under certain conditions is appropriate. The tribunal can only assess whether the appropriate aftercare had been arranged and, if so, it must direct the patient's conditional discharge. This conclusion follows from the language in section 73(7) – "such arrangements as appear to the tribunal to be necessary for that purpose". The "purpose" must be to enable the patient to comply with the conditions the tribunal has already decided to impose.

Must the Tribunal, then, conditionally discharge a patient whose condition has seriously deteriorated since it first considered the case and made a deferred direction? The answer is apparently yes, once the tribunal decides that the necessary aftercare arrangements have been made to its satisfaction. But Lord Bridge said, in *dicta*, that it is always open to the tribunal to avoid coming to any decision on the adequacy of the aftercare arrangements, in which case, under the second part of subsection (7), the whole case comes to the tribunal afresh on a subsequent application or reference. Lord Bridge said further that the Home Secretary could forestall the patient's conditional discharge by exercising his power under section 71 to refer the patient's case to the tribunal.<sup>2</sup> Lord Bridge has interpreted the language of subsection (7) and section 71 quite literally. However, it is by no means clear that Parliament intended that the tribunal's duty to conditionally discharge (where satisfactory aftercare arrangements are made) should be so easily circumvented.

To reiterate, the import of *Campbell v. Secretary of State for the Home Department* is that the tribunal, having made a deferred direction, cannot look backward to reconsider whether a conditional discharge was appropriate. The only discretion of the tribunal is to look at the arrangements that have been made to determine whether they

<sup>1</sup> [1988] 1 A.C. 120; [1987] 3 W.L.R. 522; [1987] 3 All E.R. 8, H.L.

<sup>2</sup> See further paras. 4.08.5 ante and 18.14A.2 below.

are satisfactory. For these purposes only, the tribunal may, but it is **not** to be obliged to, receive further evidence or hold a further hearing (r. 25(1)).

#### 18.14A.2 *Duty to provide aftercare for conditionally discharged patients*

Once the Mental Health Review Tribunal makes an order for conditional discharge, which under the doctrine of *Campbell* is a final order which cannot be revoked and is not dependent for its effect on the fulfillment of conditions in the order,<sup>1</sup> the health and social services authorities are under a continuing duty to provide the patient with after care services. The authorities must provide after care services until they are satisfied that they are no longer needed.

Otton, J in *R. v. Ealing District Health Authority, ex parte Fox*<sup>2</sup> held that the duty to provide after care services arises either under section 117 of the Mental Health Act 1983<sup>3</sup> or under the general statutory framework which requires the health authority to provide a comprehensive range of hospital, psychiatric, and community services to meet the needs of mentally disordered persons.<sup>4</sup>

In the *Fox* case, a tribunal directed a conditional discharge of a restricted patient under section 73(2) and (7) of the 1983 Act, but deferred the discharge until it was satisfied about arrangements for the provision of after care services by the health authority into whose area the patient was to be released. To fulfil the condition, the health authority had to appoint a responsible medical officer to provide psychiatric supervision for the patient in the community. The doctors of the health authority opposed plans for the patient's release due to his deteriorating mental health and were unwilling to undertake the necessary supervision. Accordingly, the health authority did not appoint a responsible medical officer and the patient remained in hospital.

The court found that the authority erred in law in not using reasonable expedition and diligence to make after care arrangements to enable the patient to comply with the conditions imposed by the tribunal. Section 117 places a mandatory duty on the district health authority to provide after care services when the patient leaves hospital. The authority acted unlawfully in failing to make practical arrangements for after care prior to the patient's discharge from hospital where such arrangements were required by the tribunal.<sup>5</sup>

Alternatively, the court found a duty to provide after care arose from

<sup>1</sup> See para. 18.14A.1.

<sup>2</sup> [1993] 1 WLR 373, 11 BMLR 59.

<sup>3</sup> See further para 4.08 *ante*.

<sup>4</sup> See further para. 2.04.1 *ante*.

<sup>5</sup> See para. 4.08 *ante*.

the general statutory framework of the National Health Service Act and regulations. This requires health authorities to provide a comprehensive range of hospital and community psychiatric services to meet the needs of mentally disordered offenders.<sup>1</sup>

**18.14A.3** *A tribunal cannot defer a conditional discharge until arrangements are made for admission to another hospital*

In *Secretary of State for the Home Department v. Mental Health Review Tribunal for Mersey Regional Health Authority*<sup>2</sup> the tribunal made an order for conditional discharge of patient S. under section 73(2). However, it deferred the direction under section 73(7) until arrangements could be made for his admission to another hospital so that he could be rehabilitated for his eventual discharge into the community. In effect, the tribunal sought to use its powers of deferred discharge to secure the patient's transfer from a special to a local hospital for a period before his discharge. This is based upon the sound mental health practice of allowing a patient to move gradually from conditions of higher to lower security before being discharged into the community.<sup>3</sup> The tribunal argued that the word "arrangements" in section 73(7) was susceptible to wide interpretation and could include the imposition of an interim form of hospital care prior to a direction of conditional discharge.

Mann J held that, *a fortiori*, a tribunal cannot defer a discharge under section 73(7) for arrangements to be made for transfer to another hospital, as the only permissible deferment of a conditional discharge is for arrangements to be made for the patient to live in the community. This follows from the fact that tribunals have a mandatory duty to discharge a patient conditionally if satisfied that section 73(2) applies, and that "discharge" means release from hospital, and not transfer to another hospital.

**18.14A.4** *Continued detention after a conditional discharge violates the European Convention on Human Rights*

In *Johnson v. United Kingdom*,<sup>4</sup> the applicant sought a ruling from the European Court of Human Rights that his continued detention in hospital, under a deferred direction of conditional discharge, after a Mental Health Review Tribunal finding that he no longer suffered from mental illness, was a violation of his rights under Article 5 §1 of the European Convention on Human Rights. The Court unanimously

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<sup>1</sup> See National Health Service Act 1977, s. 3(1); National Health Service Functions (Directions to Authorities and Administrative Arrangements) Regulations 1991 (S.I. 1991, No. 554. See para. 2.04.1 *ante*.

<sup>2</sup> [1986] 1 W.L.R. 1170, Mann J.

<sup>3</sup> See Gostin, L. (1986) *Institutions Observed: Towards a New Concept of Secure Provision in Mental Health*, London, Kings Fund.

<sup>4</sup> Case No. 119/1996/738/937, Judgment 24 October 1997.

determined that, although the tribunal made a lawful order, the applicant's detention for an additional three-and-one-half-years after the initial direction of conditional discharge was a violation of his rights.

The applicant was convicted in 1984 for assault and given a hospital order with restrictions on discharge. In 1989, a tribunal found that the applicant no longer suffered from mental illness, but that he still should be subject to recall to hospital. The tribunal ordered a conditional discharge, the conditions being that the applicant remain under psychiatric supervision and reside in a supervised hostel. The tribunal deferred the discharge until appropriate after-care arrangements could be made. A suitable hostel could not be found, and Johnson remained in hospital for an additional three-and-one-half-years after the conditional discharge. In 1993, a tribunal ordered the applicant's absolute discharge.

The Court followed its established jurisprudence by observing that, even though the applicant had been convicted of an offence, he was in a mental hospital. Consequently, his detention would have to be justified under Article 5 §1(e) as a person of unsound mind. Further, even though the applicant's detention was substantively and procedurally lawful under domestic law, it is still necessary to determine the lawfulness of detention under the Convention.<sup>1</sup>

The Court found that, simply because an expert authority determined the applicant was no longer suffering from mental disorder, it does not require his immediate and unconditional release into the community. Such a rigid approach would constrain the exercise of judgment whether "the interests of the patient and the community into which he is to be released would in fact be best served" by an immediate and unconditional discharge.<sup>2</sup> The Court acknowledge that a responsible authority should be able to "retain some measure of supervision over the progress of the person once he is released into the community and . . . to make his discharge subject to conditions."

The Court held that, while the deferral of the conditional discharge was justified in principle, the lack of safeguards to ensure that the applicant's release was not unreasonably delayed constituted a violation of Article 5 §1 of the Convention. The violation arose because the applicant did not have the ability to petition the tribunal during the time between the annual reviews allowed under the Mental Health Act 1983. In addition, under the Act, there was no provision to seek judicial review of the terms of the conditional discharge. The "onus was on the authorities to secure a hostel willing to admit the applicant." Therefore, despite the fact that a good part of the difficulty in obtaining a suitable

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<sup>1</sup> A person cannot be detained as a person of "unsound mind" unless three minimum conditions are met: firstly, he is reliably shown to be of unsound mind; secondly, the mental disorder must be a kind or degree warranting compulsory confinement; and thirdly, the validity of continued confinement depends upon the persistence of such a disorder. *Luberti v. Italy*, Judgment 23 February 1984, Series A, no. 75, pp. 12-13, §27.

<sup>2</sup> *Luberti v. Italy*, Judgment 23 February 1984, Series A, no. 75, pp. 12-13, §27.

community placement was the refusal of the applicant to cooperate with the process of finding appropriate accommodations, the unreasonable delay in his discharge did result in a violation of Article 5 §1 of the Convention.

### 18.15 Reclassification

Where a tribunal does not discharge a patient but is satisfied that the patient is suffering from a form of disorder different from the one specified on the forms relating to his detention, it may direct that the form of mental disorder is amended accordingly (s. 72(5), (6)).

The application of section 72(5) (power of reclassification in respect of non-restricted patients; see para. 18.11 above) to restricted patients was probably unintentional. While reclassification may have important consequences for the subsequent detention of a non-restricted patient it has no legal consequences for the restricted patient, and the fact that neither the RMO nor the Secretary of State has the power to reclassify a restricted patient support the argument that granting that power to tribunals was unintentional. Indeed the Home Office argues that because reclassification has no relevance to restricted patients, section 72(5) does not apply to such patients. In a few cases tribunals have made use of the power to reclassify restricted patients against Home Office advice.<sup>1</sup> Clarification of this point of law by the High Court by way of the case stated procedure under section 78(8) would be useful (see para. 18.25 below.)

### 18.16 Recommendations for Transfer, Leave of Absence and Removal of Restrictions

Section 72(3), which authorises a tribunal to recommend that a non-restricted patient should be transferred to another hospital or into guardianship or given leave of absence (see para. 18.10 above), probably does not apply to patients subject to a restriction order. This is because section 72(3) applies only where a tribunal has considered the case of a patient under the provisions of section 72(1). However, the relevant provisions of 72(1) (which concern the discharge of patients) do not apply to restricted patients (s. 72(7)); it follows that section 72(3) cannot apply to such patients. Thus, there is no apparent statutory basis for a tribunal to recommend transfer or leave of absence in the case of restricted patients. Nevertheless, the Home Office and DHSS

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<sup>1</sup> However, the use of this power by the Mental Health Review Tribunals to reclassify patients has been accepted by the courts as "the appropriate vehicle for dealing with the reclassification of patients detained in a mental hospital, whether under compulsory detention by way of order of the Court or otherwise." In order to reclassify a patient, tribunals are required to consider anew all relevant legal matters that have to be considered under the Mental Health Act. *R. v. South Thames West Mental Health Review Tribunal ex parte Demetri*, 12 June 1996 (Transcript: Smith Bernal), C.A.



take the view that Parliament did not intend to deprive tribunals of their advisory power (see discussion at para. 15.18 *ante*).

The issue came before Mr. Justice McNeil in *Grant v. Mental Health Review Tribunal*.<sup>1</sup> Mr Justice McNeil held that Parliament did not intend to give tribunals the power to recommend the transfer of unrestricted patients. Parliament's intent was "to repose wider powers on a tribunal dealing with an unrestricted patient and to limit the power of a tribunal in directing the conditional discharge of a restricted patient by enacting specific powers in the Secretary of State to 'supervise' such a patient who was conditionally discharged."

Note that if tribunals do decide to make recommendations<sup>2</sup> their advice is not binding. Even if, in light of the tribunal's advice, the hospital managers agree to a transfer or the RMO agrees to a leave of absence, neither power can be exercised without the Home Secretary's consent in the case of restricted patients (see further para. 15.16 *ante*).

### 18.17 Patients Subject to a Restriction Direction

#### 18.17.1 *Absolute discharge of sentenced prisoners who have been transferred to hospital*

Where a patient has been transferred from prison to hospital under a limitation direction or restriction direction the tribunal is not empowered to order his discharge. A person who is transferred from prison to hospital under section 47 (see chap. 16) is technically, still subject to a sentence of imprisonment and thus any final decision regarding his discharge must be taken by the Home Secretary.<sup>3</sup> The tribunal's role is limited to notifying the Home Secretary whether the patient would be entitled to be absolutely or conditionally discharged had he been subject to a restriction order (s. 74(1)). Thus, the tribunal must consider the same statutory criteria that apply to a patient subject to a restriction order (see paras. 18.12 and 18.13 above). If the Home Secretary is notified that the patient would be entitled to be absolutely discharged he may, within ninety days, consent to the discharge and the tribunal must accordingly discharge him (s. 72(2)). If at the end of the ninety-day period, the Home Secretary has not given his consent, the hospital managers must transfer the patient back to a prison or

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<sup>1</sup> (1986) *The Times*, April 26, 1986.

<sup>2</sup> The advisory functions of tribunals could be supported by two possible arguments. First, the court might be persuaded, in light of the clear language of subs. 7 (which does not refer to subs. 3), not to have regard to the sentence before the semi-colon in subs. 3. It is arguable that where the tribunal decide not to exercise its power to direct discharge it is not, in fact, acting in pursuance of subs. 1. Second, it could be argued that the tribunal do not need any express statutory authority to give informal advice. (But why, it may be argued, was it necessary expressly to give tribunals the power to make recommendations in unrestricted cases under s. 72(3)?)

<sup>3</sup> The court in *R. v. Secretary of State for the Home Department ex parte S (Stroud)* *The Times* 19 August 1992, discussed the Home Secretary's current practice of discharging life sentence prisoners who have been transferred to hospital. See para. 16.04 *ante*.

other institution in which he might have been detained if he had not been removed to hospital. (In practice, the Home Secretary will consult the Directorate of the Prison Medical Service as to the most appropriate prison before issuing a warrant.) The patient would then serve the remainder of his sentence or be dealt with as if he had not been transferred to hospital (s. 74(3)). This is a logical result for, if the person is entitled to an absolute discharge, there is no case for continuing to detain him in hospital. The issue becomes whether the person is dangerous and requires further detention in prison to complete his sentence or whether he can be released. This is a matter for the Home Secretary.

**18.17.2** *Conditional discharge of sentenced prisoners who have been transferred to hospital*

Where the tribunal notifies the Home Secretary that the patient would be entitled to be conditionally discharged it may add a recommendation that the patient should remain in hospital if his discharge is not approved (s. 74(1)(b)). As with absolute discharge, if, within ninety days, the Home Secretary gives his consent the tribunal must conditionally discharge the patient (s. 74(2); it may defer the direction for discharge in the same way as for patients subject to a restriction order (ss. 74(6), 73(7); see para. 18.14.1 above)). If the Home Secretary does not give his consent and the tribunal has not recommended that the patient should remain in hospital, then the hospital managers must return him to prison or to the institution from where he came (s. 74(3)). If the tribunal has recommended that the patient should remain in hospital if not discharged then he may not be returned to prison. This is also a logical result. For the patient who is entitled to conditional discharge but is not so discharged there is a choice to be made: whether he would benefit from further hospital care as opposed to prison confinement. The MHRT assists the Home Secretary in this choice by making the appropriate recommendation.

**18.17.3** *Discharge of unsentenced prisoners who have been transferred to hospital*

Prisoners **not** serving a sentence of imprisonment who are transferred to hospital under section 48 (see paras. 14.02–14.04 *ante*), are an exception to the above. In such cases neither the tribunal nor the Home Secretary has the power to discharge the patient. As in the case of other persons under a restriction direction, the tribunal must assess the statutory criteria that apply to patients subject to a restriction order and must inform the Home Secretary whether the patient would be entitled to absolute or conditional discharge; if entitled to conditional discharge the tribunal may add a recommendation that the patient should remain in hospital if not discharged. Where the Home Secretary is informed that the patient is entitled to absolute or conditional

discharge, and no further recommendation is made, the Home Secretary must issue a warrant remitting the patient back to a prison or other institution in which he might have been detained (s. 74(4)). This is because, in the case of section 48 patients, the issue which remains once treatment in hospital is no longer necessary is less one of dangerousness than that the person remains unconvicted and within the jurisdiction of the court.

#### **18.17.4 *Reclassification***

As in the case of patients subject to a restriction order, the tribunal may reclassify the form of disorder from which the patient is suffering (s. 72(5)). The application of this section to restricted patients was probably unintentional and tribunals are unlikely to use this power. This is explained further in para. 18.15. above.

#### **18.17.5 *Advising the Home Secretary***

The tribunal may choose to make recommendations as to the transfer, leave of absence or removal of restrictions in respect of patients subject to a restriction direction in the same way as for patients subject to a restriction order (see para. 18.16 above). There is no specific statutory power to make such recommendations.

There are, however, specific statutory powers for tribunals to give advice to the Home Secretary on other matters. When an offender is transferred to hospital with a restriction direction the Home Secretary has a general discretion to transfer him back to prison at any time during the period of his sentence (taking into account periods of remission). There is provision in section 50(1) of the Act for the RMO, any other registered medical practitioner or a MHRT to inform the Home Secretary if the person no longer requires treatment or if no effective treatment can be given to him in the hospital. After receiving such advice the Home Secretary can direct that the patient be sent back to prison or other institution (s. 50(1)(a)) or he can discharge him on licence or under supervision (see further para. 16.03 *ante*).

There is similar provision for persons on remand, civil prisoners and others detained under section 48, except that such persons can only be sent back to the prison or other institution in which they were originally detained, the Home Secretary does not have the power to release them (s. 51(3); see further para. 14.03 *ante*).

#### **18.18 *Conditionally Discharged Patients***

The Act gives conditionally discharged patients the right to apply to tribunals; such patients did not have a right to a tribunal hearing under the 1959 Act. (As to conditional discharge see para. 15.16.3 *ante*). The tribunal has the following powers.

**18.18.1**

## MENTAL HEALTH REVIEW TRIBUNALS

**18.18.1** *Change of conditions*

The tribunal may vary any condition by which the patient must abide or impose a new condition (s. 75(3)(a)). Thus, the tribunal may change a condition in accordance with a change in the patient's circumstances or remove a condition if it is no longer necessary.

**18.18.2** *Cessation of restriction order or direction*

The tribunal may direct that the restriction order or direction be lifted (s. 75(3)(b)). The patient will cease to be liable to detention under the hospital order, hospital direction or transfer direction (s. 75(3)) and will not be subject to recall to hospital.

**18.18.3** *Reclassification*

As with other restricted patients the tribunal has the power to reclassify the form of disorder from which the patient is suffering (s. 72(5)). This power is unlikely to be used for reasons discussed previously in para. 18.15 above.

## E. PROCEDURES

### 18.19 Introduction

It is not the intention here to review the procedure relating to MHRTs in detail. The complete text of the Mental Health Review Tribunal Rules 1983, S.I. 1983 No. 942 is to be found in Appendix B; and a full discussion is contained elsewhere.<sup>1</sup> It should be noted that the distinction under the old Rules of having formal and informal hearings has been removed. There are different procedural requirements for applications made by patients detained for assessment than for other cases because of the speed with which the tribunal must operate. There follows a brief discussion of the most important procedural requirements.

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<sup>1</sup> See L. Gostin and P. Fennell (1992) *Mental Health: Tribunal Procedure*, (2nd Edn) Longman, London.

### 18.20 Application and Notice

Part II of the Rules are concerned with preliminary matters. An application must be made in writing by the applicant or by a person authorised by him for this purpose (r. 3(1)); it may also be made by the applicant's representative (r. 10(4)). The application must be sent to the relevant tribunal office—the relevant tribunal is the one responsible for the area in which the hospital is situated or, in guardianship cases, the area where the patient resides (s. 77(3), (4)). The five Tribunal Offices are:

<p><b>Tribunal Office for North East Thames, North West Thames, and East Anglia</b> Government Buildings Canons Park Honeypot Lane Stanmore Middlesex HA7 1AY (071) 972 2000</p> <p><b>Tribunal Office for South East Thames, South West Thames, South Western and Wessex</b> Spur B, Block 3 Crown Buildings Kingston Bypass Road Surbiton Surrey KT6 5QN (081) 390 4166</p>	<p><b>Mersey Tribunal Office</b> 3d Floor Cressington House 249 St. Mary's Road Garston Liverpool L19 0NF (051) 494 0095</p> <p><b>Nottingham Tribunal Office</b> Spur A, Block 5 Government Buildings Chalfont Dr. Western Boulevard Nottingham NG8 3RZ (0602) 294222/3</p> <p><b>Welsh Tribunal Office</b> 2d Floor, New Crown Buildings Cathays Park Cardiff CN1 34Q (0222) 8225798</p>
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There are three different forms of notice that the tribunal is required to give:

- (i) **notice of the application** to the responsible authority (defined in r. 2(1) and note to para. 18.01 above), the patient (if he is not the applicant) and, in the case of a restricted patient, the Home Secretary (r. 4(1));
- (ii) **notice of the proceedings** (r. 7) must be sent to interested persons specified in r. 7 after the statements from the responsible authority and Home Secretary are received;
- (iii) **Notice of the hearing** must be given at least 14 days before the hearing to all the parties, their representatives and, in the case of a restricted patient, the Home Secretary (r. 20).

The importance of giving notice to all parties was underscored in *Campbell v. Secretary of State for the Home Department*<sup>1</sup> In that case

<sup>1</sup> [1987] 3 W.L.R. 522 H.L.

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(ADDITIONAL APPENDIX)

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**ERRATUM:** In para 18.20 the telephone number of the Tribunal Office for South East Thames, South West Thames, South Western and Wessex should read (0181) 398 4166 NOT (081) 390 4166

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the Home Secretary had not received notice of the hearing of a restricted patient. The Home Secretary had lost his right to make any representation, which was "a breach of the most fundamental rule of natural justice, in that . . . a vitally interested party was denied a hearing". Failure to give notice would require a complete rehearing *de novo*.

Lawton L.J., in the Court of Appeal decision in *Campbell*<sup>1</sup> advised tribunals in all future cases that, before starting to hear any application of a restricted patient, when the Home Secretary is not represented, they should inquire and note, whether he has been given notice of the application and when.

### 18.20A Adjournment

A Mental Health Review Tribunal has the power to adjourn a hearing for the purpose of obtaining further information or for such other purposes as it thinks appropriate (r. 16(1)).

In *R. v. Mental Health Review Tribunal, ex parte Cleeland*, the court had to determine whether a tribunal's refusal to adjourn the proceedings prevented the applicant from submitting evidence which would have materially affected the tribunal's decision.<sup>2</sup> The applicant, who had been transferred to Moss Side Hospital from prison, sought to call two prison doctors to testify that he did not suffer from a mental illness. The doctor could not be located in time for the hearing and the tribunal refused to adjourn for this purpose. Popplewell J held that it was appropriate for the tribunal to refuse adjournment because if the evidence sought had been available it would not have changed the tribunal's decision. The tribunal had accepted the applicant's contention that the doctor, if called, would have testified that they had examined the applicant and had not found evidence of mental illness. Even if this evidence had been presented the tribunal still would not have discharged the patient.

#### 18.20A.1 Adjournment to monitor the applicant's progress

If a tribunal requires further information as to the present state of mental health of a patient, that is a purpose for which it can properly exercise its power of adjournment under rule 16. The question arose on two appeals from Farquharson J<sup>3</sup> whether the tribunal has the power to adjourn for the purpose of monitoring the patient's mental

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<sup>1</sup> *R. v. Mental Health Review Tribunal, ex parte Secretary of State* [1986] 1 W.L.R. 1180 at 1189 C.A.

<sup>2</sup> *R. v. Mental Health Review Tribunal ex parte Cleeland* [1989] C0/819/88, Popplewell J. Appeal dismissed by Court of Appeal (Transcript Association) 28 June 1989.

<sup>3</sup> *R. v. Mental Health Review Tribunal, ex parte Secretary of State for the Home Department* (1987) *The Times* March 25, 1987.

state in order to give him the opportunity to improve or an opportunity to see if an improvement already made is sustained.<sup>1</sup>

The second limb of Rule 16 allows an adjournment "for such other purposes as [the tribunal] may think necessary". The Court of Appeal observed that a judicial function would not of itself preclude the possibility of an adjournment to see whether the conditions for discharge which are not then satisfied will be satisfied at some future date. However, the Court of Appeal held that the Mental Health Act does not give tribunals any such power. The tribunal has no general supervisory function over the progress of a restricted patient. That is the function of the Home Secretary. Where the tribunal is satisfied that the criteria for discharge or conditional discharge are not fulfilled at the time of the hearing it has no power to adjourn the proceedings in order to give the patient the opportunity to improve or an opportunity to see if an improvement already made is sustained. The power to adjourn is primarily for the specific purpose of obtaining information.

The tribunal, therefore, has to consider the mental state of the patient at the time of the hearing. It is not entitled to adjourn to see whether his mental state will alter or improve.

### 18.21 Representation and Finance

Any party to the proceedings may be represented (r. 10(1)). If Rule 10(1) is read with the definition of "party" in Rule 2, it becomes apparent that the Home Secretary does not have a right to be represented at the hearing of a restricted patient, although it is possible that a Home Office representative might be called to appear under Rule 14(1).

If a party is financially eligible he can receive public funding for a solicitor to help him prepare his case under the Legal Advice and Assistance Scheme (the "Green Form"); this does not provide funding for the actual representation before the tribunal.<sup>2</sup> Public funding for the representative at the tribunal hearing is available only to the applicant or, in reference cases, to the patient. On 1 December 1982 "Assistance by Way of Representation" (part of the Legal Aid Scheme) was extended to representation before MHRTs. The Law Society has established a panel of solicitors with experience in MHRT work which assists applicants in finding a suitable representative.<sup>3</sup> The responsibility for

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<sup>1</sup> *R. v. Nottingham Mental Health Review Tribunal ex parte Secretary of State for the Home Department*; *R. v. Trent Mental Health Review Tribunal ex parte Secretary of State for the Home Department* (1988) *The Times* October 12, 1988, C. A.

<sup>2</sup> Legal Aid Act 1974, ss. 1-5; No. 1898, regs. 1-15, 22-28.

<sup>3</sup> *Law Society's Gazette* Jan. 19, 1983. See, Extending "Assistance by Way of Representation" to the Mental Health Review Tribunal: Note for Guidance, (Nov. 24, 1982) *Guardian Gazette*.

administering legal aid has been transferred from the Law Society to the Legal Aid Board which was established by the Legal Aid Act 1988.<sup>1</sup>

A representative may be any person except a patient liable to be detained or subject to guardianship under the Act or any person receiving treatment for mental disorder at the same hospital or mental nursing home as the patient (r. 10(1)).

The European Commission and Court of Human Rights have repeatedly emphasised the need for effective legal representation as part of the "special procedural guarantees" required in mental health cases.<sup>2</sup> Further, in *Airey v. Republic of Ireland*<sup>3</sup> the European Court considered that the right of a person to appear in the High Court without representation would not be "effective in the sense of whether she was able to present her case properly and satisfactorily". The Court concluded that public representation was required so that her rights under the European Convention were not "theoretical or illusory", but "practical and effective". These cases suggest that where a patient has expressed clearly a desire to be represented, and he is prevented from being represented either because the tribunal does not ensure that someone is appointed and/or he cannot afford representation, a claim under Article 5(4) of the Convention conceivably could arise.<sup>4</sup>

## 18.22 Information for the Tribunal

The tribunal will have before it the following written information.

### 18.22.1 *The responsible authority's statement*

The responsible authority's statement contains, insofar as it is known to the authority, certain factual details about the patient (*e.g.* name, age, date of admission) which are specified in Sch. 1, Pt. A. of the Rules; an up-to-date medical report (Sch. 1, Pt. B. of the Rules); and, insofar as it is reasonably practicable to provide, an up-to-date social circumstances report (Sch. 1, Pt. B. of the Rules; see further para. 7.24 *ante*). The responsible authority's statement must be sent to the tribunal within three weeks of receiving notice of the application in all cases except for assessment applications and applications in respect

<sup>1</sup> Legal Advice and Assistance Regulations 1989, S.I. 1989, No. 340.

<sup>2</sup> *Winterwerp v. the Netherlands*, European Court of Human Rights, Judgment given Oct. 24, 1979, paras. 60–61, 101–102; *X. v. Belgium*, European Commission of Human Rights, Application No. 6859/74, 3 *Decisions and Reports* 13. See also application nos. 3/51/67 and 4625/70.

<sup>3</sup> Judgment given, Oct. 9, 1979, para. 24.

<sup>4</sup> The case which precipitated the reform of the law to allow public financing of representation at MHRTs was *Collins v the United Kingdom*, app. no. 9729/82 (withdrawn due to change in the law). Mr. Collins was a patient at Broadmoor Hospital whose solicitor would not represent him at the tribunal hearing because there was no legal aid to pay for a representative. The Commission found his case admissible. (See further para. 1.11.2 *ante*.)

of conditionally discharged patients; in the case of a restricted patient a copy must also be sent to the Home Secretary (r. 6(1)).

#### 18.22.2 *The Home Secretary's statement*

In the case of restricted patients other than those who have been conditionally discharged, the Home Secretary must, within three weeks of receiving the responsible authority's statement, provide the tribunal with a statement containing any further information relevant to the application (r. 6(2)).

#### 18.22.3 *Statement relating to conditionally discharged patients*

In the case of a conditionally discharged patient it is the Home Secretary, not the responsible authority, who must provide the tribunal with the requisite information. The information is specified in Sch. 1, Pts. C. and D. of the Rules.

#### 18.22.4 *Further documents received by the tribunal and distributed under Rule 12*

There are often a number of further documents received by the tribunal after the submission by the responsible authority and the Home Secretary of statements under Rule 6 (see preceding paras.). These may be up-dated reports which fill the gap between the submission of statements and the hearing itself or there may be special reports provided by an independent psychiatrist at the request of the patient's representative. Rule 12 provides that every document which is relevant to the application must be copied to the applicant, the responsible authority and, in the case of a restricted patient, the Home Secretary, and that any of those persons may submit written comments thereon to the tribunal. Where a further written report is submitted a day or two before the hearing, it sometimes makes it impossible for the tribunal to fulfill its obligation under Rule 12. In these circumstances the tribunal may have to adjourn the hearing until the applicant, the responsible authority and the Home Secretary have had an opportunity to submit written comments to the tribunal.

#### 18.22.5 *Disclosure of information*

Rule 6(4) authorises the responsible authority and the Home Secretary to set aside any part of their statements which they consider should not be disclosed to the applicant or patient on the grounds that disclosure "would adversely affect the health or welfare of the patient or others". However, the final decision as to whether documents should be disclosed lies with the tribunal (r. 12). The tribunal is **required** to disclose in full every document to the applicant's representative so long as the representative is a barrister or solicitor, a doctor, or other person

whom the tribunal considers to be suitable by virtue of his experience or professional qualification (r. 12(1), (3)). As to disclosure of the medical member's report, see para. 18.25.1 below).

### 18.23 Conduct of the Proceedings

Unless the patient requests otherwise the tribunal sits in private. It must sit in public if the patient requests it and MHRT is satisfied that a public hearing would not be contrary to the patient's interests (r. 21(1)). The publication of information relating to proceedings before a MHRT sitting in private is a contempt of court. (Administration of Justice Act 1960, s. 12(1)(b)). See further para. 18.23A below.

The tribunal has a general discretion to conduct the proceedings in the manner it considers suitable (r. 22(1)). In practice the tribunal always interviews the patient (without the presence of any other person if requested) unless he positively objects (see r. 22(2)).<sup>1</sup> Unless they are excluded from the hearing, the applicant, the patient and the responsible authority have the right to give evidence, hear each other's evidence and put questions to each other, and to call and question any witness (r. 22(4)).<sup>2</sup> If the applicant or patient is excluded from the hearing his authorised representative is entitled to remain throughout (r. 21(4)). After the evidence is given, the applicant and, where he is not the applicant, the patient can address the tribunal (r. 22(5)).

#### 18.23.1 *A speedy and just determination*

The speed with which tribunals hear cases was raised before the European Commission of Human Rights in *Barclay-Maguire v the United Kingdom*.<sup>3</sup> In that case the applicant waited some four months from the date of the application before he was given a hearing. The case was pending before the Commission during the time the tribunal Rules of Procedure were being reformed. It resulted in Rule 13 which gives the MHRT a general discretion to give such directions as it thinks fit to ensure "the speedy and just determination of the application".

The Council on Tribunals in its annual report for 1984-85 said that the Lord Chancellor's Department and the Department of Health had overcome the problem of delays in bringing cases before Mental Health Review Tribunals. However, in the Council's Report for 1985-86, it reported that serious problems of delay were re-occurring. The matter had been referred from the Mental Health Act Commission, which

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<sup>1</sup> A patient might object, for example, if his case is automatically referred to the tribunal but he has no desire to be discharged. See para. 18.05 above.

<sup>2</sup> The tribunal has a duty to proceed fairly. Applicants, therefore, must be given the opportunity to cross examine the R.M.O. about the factual basis of his report and to present the applicant's own evidence on that topic. *R. v. Mental Health Review Tribunal for Merseyside, ex parte Kelly*, Q.B.D. 39 BMLR 114, 22 April 1997 (holding that a tribunal acted contrary to the rules of natural justice when it refused to allow cross examination of the R.M.O. with regard to the applicant's behaviour prior to recall to hospital).

<sup>3</sup> App. no. 9117/80. Decision as to admissibility, Dec. 9, 1981. (Case withdrawn following change in the law.)

reported one case where there was a delay of five months. The problem had occurred mostly because judges with previous commitments had to cancel or reschedule tribunal hearings. The Lord Chancellor has given assurances that he would give priority to mental health cases in finding replacements for judges.

The European Court of Human Rights returned to the question of a speedy review in *Van der Leer v. the Netherlands*.<sup>1</sup> The Court said that in guaranteeing to persons detained a right to institute proceedings, Article 5(4) of the Convention also proclaimed their right to a speedy decision terminating their deprivation of liberty if it proved unlawful. In *Van der Leer* the proceedings lasted five months. Given the other deprivations of human rights in that case, and absent any justification for the delay, the Court found a violation of Article 5(4). (See further para 9.09.4 *ante*).

### 18.23A Prejudicial Publicity

The Council on Tribunals expressed concern in its annual report for 1985–86, H.C. 42, about prejudicial publicity given to a Tribunal case. A restricted patient was supported by his RMO, but opposed by the Home Secretary, in an application to a tribunal. Several days before the hearing a newspaper featured the case quoting an unnamed Minister saying, “P’s release would terrify me.”

The Council stressed the importance of Tribunals making decisions on the evidence before them and that they should not be influenced, or thought to be influenced, by comments made elsewhere—for example in Parliament or the press. The Home Office said that it would be its practice in future, other than in exceptional circumstances, not to make any substantive comment during the four weeks preceding a hearing. The Council asked the Home Office to monitor this arrangement for two years, at the end of which the Council would review it—particularly with regard to whether the four week period is long enough.

In *Attorney General v. Associated Newspapers Group*<sup>2</sup> the Attorney General applied for an order that two newspapers were guilty of contempt of court because prejudicial articles which appeared shortly before a tribunal was due to hear an application had “tended to interfere with the course of justice in particular legal proceedings”.<sup>3</sup> The newspapers criticised the responsible medical officer for recommending the patient’s discharge from a special hospital. The issue arose whether the proceedings of a Mental Health Review Tribunal were proceedings before a “court” within the meaning of section 19 of the Contempt of Court Act 1981.

The Court held that a Mental Health Review Tribunal was not a “court” for the purposes of the 1981 Act and, therefore, articles

<sup>1</sup> Judgment given Feb. 21, 1990, *The Times*, March 2, 1990.

<sup>2</sup> [1989] 1 All E.R. 604, [1989] 1 WLR 322.

<sup>3</sup> Contempt of Court Act 1981, s. 1.

published prior to or during the hearing of such a tribunal were not a contempt of court. Mann LJ relied upon the words of Lord Salmon in *A-G v. BBC*<sup>1</sup> that “public policy requires that most of the principles of contempt of court, shall not apply to valuation courts and the host of other modern tribunals”. Application of contempt of court principles, said Lord Salmon, would unnecessarily contract freedom of speech and press. There was no appeal from that decision.

A strong argument can be made, however, that a Mental Health Review Tribunal is much different from valuation courts or other modern tribunals which normally concern disputes over some proprietary interest. Mental Health Review Tribunals act judicially and take binding decisions affecting human liberty.

The patient made a subsequent application to a tribunal. Several newspapers, believing they were not now in danger of being held in contempt, published a series of sensational articles, protesting about the possible release of the patient. The tribunal hearing was postponed and the patient sought a declaration and injunctions designed to prevent the newspapers from publishing any information relating to the tribunal application. The newspapers said they had no intention of publishing information relating to the evidence before the tribunal or the identity of witnesses, representatives, or members of the tribunal. They claimed, however, the right to publish the fact that the patient was applying for discharge, the date of the hearing, and the effect of the decision of the tribunal. The trial judge held that Rule 21(5) of the Mental Health Review Tribunal Rules 1983 did not confer a private right of action or remedy, and refused the injunction. The Court of Appeal held that a tribunal was a court for the purposes of section 19 of the Contempt of Court Act 1981 (overruling *A-G v. Associated Newspapers Group*), that the patient had standing, and he was entitled to an injunction prohibiting the newspapers from publishing the date of the hearing and the actual decision, but not the fact that he had applied for his discharge or the result.<sup>2</sup>

Several questions arose in an appeal to the House of Lords.<sup>3</sup> (i) Was the publication of information about the application prohibited by law, particularly by Rule 21(5) of the Mental Health Review Tribunal Rules 1983? (ii) Would publication be a contempt, having regard to section 12(1)(b) of the Administration of Justice Act 1960? (iii) Is a Mental Health Review Tribunal a “court” within the meaning of section 19 of the Contempt of Court Act 1981? (iv) Does Rule 21(5) confer on a patient a right of action or the right to bring proceedings for declaratory or injunctive relief restraining publication of information about his application to the tribunal?

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<sup>1</sup> [1980] 3 All E.R. 161 at 168–169, [1981] AC 303, 342.

<sup>2</sup> [1990] 1 All E.R. 335, [1990] 2 WLR 494.

<sup>3</sup> *Pickering v. Liverpool Daily Post and Echo Newspapers* [1991] 2 AC 370, [1991] 1 All E.R. 622, [1991] 2 WLR 513, HL.

Rule 21(5) of the 1983 Rules provides that: "Except in so far as the tribunal may direct, information about proceedings before the tribunal and the names of any persons concerned in the proceedings shall not be made public." The House of Lords held that the boundaries of privacy afforded by law protected the substance of the matters considered by the tribunal. This protects the evidence and arguments put forward to the tribunal including the patient's mental condition, the reasons for the decision, and the conditions, if any, imposed by the tribunal.

The law of privacy does *not* protect against: (i) publication of the fact that the tribunal had sat, is sitting, or will sit to consider the case at a certain date, time, and place; (ii) publication of the name of the patient;<sup>1</sup> and (iii) publication of the decision of the tribunal that the patient is, or is not, discharged absolutely or conditionally. The House of Lords reasoned that this information does not represent a disclosure about the proceedings which ought to be kept secret, and it would not be a contempt to publish it. Thus, the newspapers were free to publish the information which they claimed to be entitled to publish.

Section 12(1)(b) of the Administration of Justice Act 1960 provides that publication of information relating to proceedings before any court sitting in private is not of itself a contempt of court except, *inter alia*, where the proceedings were before a Mental Health Review Tribunal. It appears that publication of information relating to the proceedings of a tribunal is, *prima facie*, a contempt of court. Lord Bridge of Harwich observed that the proceedings before a Mental Health Review Tribunal "require for their just and effective conduct the same cloak of privacy as the common law had always drawn around proceedings in [wardship and mental health]."<sup>2</sup>

The specific inclusion of Mental Health Review Tribunals in section 12(1)(b) shows that Parliament clearly intended that the tribunal should be a court to which the law of contempt applies. Accordingly, the House of Lords affirmed the decision of the Court of Appeal that a tribunal is a "court" for the purposes of liability for contempt of court under section 19 of the Contempt of Court Act 1981. The tribunal is akin to a court because it exercises the "judicial power of the state."

These statutory provisions suggest that the cloak of privacy which protect the proceedings of the tribunal, backed by the sanction of the law of contempt, is not lifted unless the tribunal so directs. The Tribunal Rules contain no sanction for an unauthorised breach of privacy. The only sanction thought necessary was afforded by the law of contempt. The House of Lords declined to construe rule 21(5) as giving a cause

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<sup>1</sup> The House of Lords reasoned that the name of a patient is not "information about proceedings before a tribunal and the names of persons concerned in the proceedings" since r 21 only applies to proceedings at the hearing.

<sup>2</sup> See *Scott v. Scott* [1913] AC 417 at 437-438, Viscount Haldane LC.



of action for breach of a statutory duty to a patient in respect of the unauthorised publication of information about the proceedings of the tribunal. The House of Lords concluded that breach of the right to privacy in the Tribunal Rules would not cause members of the class for whose protection the prohibition was imposed personal injury, property damage or economic loss. Although the publication of unauthorised information about the proceedings might in one sense be adverse to the patient's interest, it was incapable of causing him loss or injury of a kind for which the law awarded damages.<sup>1</sup>

### 18.23B Duty of Confidence on Independent Medical Experts

Increasingly, patients and their representatives are making use of independent medical and after care reports. These reports can assist the tribunal in making very difficult assessments about the patient's medical condition, propensity for dangerousness, and care available in the community.

The question arises as to the duties of independent experts to maintain confidentiality of the information they receive and the reports that they prepare. The Court of Appeal in *W. v. Egdell*<sup>1</sup> held that an independent psychiatrist is entitled to disclose his report to the hospital and the Home Office even though the patient did not want it disclosed. The duty of confidence in such cases is discussed in detail at paras. 20.30–20.33 *post*).

### 18.24 Decision

The decision of a Mental Health Review Tribunal must be made by a majority vote; in the event of an equality of votes, the president has the casting vote (r. 23(1)). The decision must be recorded in writing signed by the president (r. 23(2)). The decision may be given immediately, but *must* be given within seven days of the hearing (r. 24(1)).

#### 18.24.1 Reasons for the Decision

Reasons for the tribunal decision must be given (r. 23(2)). The reasons, in law, must be proper and adequate:

“ . . . Parliament having provided that reasons shall be given . . . must be read as meaning that proper, adequate reasons must be given; the reasons that are set out . . . must be reasons which are not only intelligible, but also can reasonably be said to deal with the substantial points that have been raised.”<sup>3</sup>

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<sup>1</sup> Citing, *Cutler v. Wandsworth Stadium Ltd* [1949] 1 All E.R. 544.

<sup>1</sup> [1990] 1 All E.R. 835.

<sup>3</sup> *Re Poyser and Mills's Arbitration* [1963] 1 All E.R. 612 at 66, Megaw J, quoted with approval in *Bone v. Mental Health Review Tribunal* [1985] 3 All E.R. 330, Nolan J.

In practice, the quantity and quality of reasons given by tribunals have been extremely variable. Frequently the reasons given merely set out the statutory matters of which the tribunal must be satisfied. But the essence of the duty to act judicially is that full and careful reasons must be given as to why it is so satisfied.

Where the reasons given are inadequate there are strong grounds for a case to be brought by way of case stated to establish what are proper reasons under rule 23(2); or, preferably, for judicial review, which will allow a broader consideration of the issues and more comprehensive relief (see para 18.25 below). Since the passage of the 1983 Act and Tribunal Rules of Procedure, several cases have been brought under both of the foregoing procedures which have underscored and amplified the requirement to give proper and adequate reasons.

In *Bone v. Mental Health Review Tribunal*<sup>1</sup> the tribunal was asked to state a case under section 78(8) of the Act. The tribunal's reasons consisted essentially of re-iterating the statutory criteria for discharge by a tribunal. Nolan J said that the reasons must not only be intelligible but must deal with the points that have been raised.<sup>2</sup> The overriding test must always be: "is the tribunal providing both parties with the materials which will enable them to know that the tribunal has made no error of law in reaching its finding of fact."<sup>3</sup>

In *R. v. Mental Health Review Tribunal, ex parte Clatworthy*<sup>4</sup> all the medical opinion put before the tribunal stated that the only evidence that the applicant was suffering from psychopathic disorder was the fact that he was sexually deviant. Mr Justice Mann said that as section 1(3) states that a person cannot be dealt with as suffering from mental disorder by reason only of sexual deviancy (see para. 9.01 *ante*), it followed that he should have been discharged. The tribunal did not order the discharge and, in giving reasons, it recited the statutory criteria for discharge under section 72(1). The tribunal added: "he shows sexual deviancy but he also has features of psychopathic disorder". The Court said that the reasons "are a bare traverse of a circumstance in which discharge should be contemplated." They were insufficient to allow the applicant to know why the detailed case advanced on his behalf had not been accepted. Potentially the error of law was irrationality.

In both *Bone* and *Clatworthy* the Court set aside the decision of the tribunal and suggested that a fresh application for discharge should be

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<sup>1</sup> [1985] 3 All E.R. 330, Nolan J.

<sup>2</sup> See *Re Poyser and Mills Arbitration* [1964] 2 Q.B. 467, 478.

<sup>3</sup> *Alexander Machinery (Dudley) Ltd. v. Crabtree* [1974] I.C.R. 120, 122.

<sup>4</sup> [1985] 3 All E.R. 699. Mann J stated the critical question as follows: "Standing back and looking at these reasons, . . . would the applicant . . . know why the case advanced in detail on his behalf had not been accepted?" [1985] 3 All ER at 704. Quoted with approval by Nolan LJ in *R. v. Trent Mental Health Review Tribunal ex parte Ryan*, CO/445/91 (Transcript: Marten Walsh Cherer) 4 October 1991.

made; and that the application merited a prompt re-hearing, preferably before a differently constituted tribunal.

The tribunal in *R. v. Mental Health Review Tribunal, ex parte Pickering*<sup>1</sup> sought to amplify its decision beyond a mere re-statement of the statutory criteria. The tribunal stated that it was not satisfied that the statutory criteria had been met; noted the large amount of medical opinion it had heard and that the applicant behaved well in the hospital; and said it was "not persuaded that because of the applicant's improved behaviour within the strict regime of the hospital it necessarily follows that such behaviour would be maintained in the community."

Forbes J held that these reasons were inadequate because it was impossible to understand what issue the tribunal was addressing. Generally, the tribunal must give reasons in relation to two issues: First, the tribunal must decide the medical issue as to whether the person is suffering from a form of mental disorder which makes it appropriate for him to be detained in hospital for medical treatment (as to the construction of this phrase see paras. 11.06.1 and 18.08.2 *ante*). This is essentially a question of psychiatric classification or diagnosis. The tribunal is entitled to form its own view based upon medical evidence. But it must give reasons why it is accepting or rejecting the evidence. (If the medical evidence is all one way, the tribunal as a matter of law may have to accept it unless it has well grounded reasons to the contrary). Second, the tribunal must decide the "public policy" issue as to whether it is necessary for the patient's health or safety or the protection of others that he should receive such treatment. While Forbes J refers to this as a "policy" question, it is really a question of assessment and prediction of future behaviour. The tribunal must give reasons for its conclusion on this matter based upon evidence from psychiatrists, psychologists, social workers, nurses or others; it can also take into account past behaviour including the offence itself and behaviour in the hospital.

Forbes J said that it is essential to bear in mind the distinction between these two issues. On reading the tribunal's reasons it could not be ascertained as to which of these two issues were being addressed. Since the applicant and the responsible medical officer were entitled to know why the application was unsuccessful, it followed that the reasons were inadequate.

The cases of *Bone*, *Clatworthy* and *Pickering*, demonstrate that tribunals must give full and comprehensible reasons for their decisions.<sup>2</sup> In practice, tribunals must go further than a mere recitation of the statutory criteria. They must address all of the issues they are required

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<sup>1</sup> [1986] 1 All E.R. 99, Forbes J.

<sup>2</sup> In the case of *R. v. South West Thames Mental Health Review Tribunal ex parte Demetri*, CO/3440/94 (2 July 1997) (Transcript: Smith Bernal) Q.B.D., the tribunal had decided to reclassify a patient from mental impairment to psychopathic disorder. A previous tribunal had expressly rejected a finding of psychopathic disorder, and the diagnosis was made long after the violent incidents that were thought to justify such a classification. The court quashed the reclassification on the basis that the reasons given by the tribunal were inadequate to justify the decision.

to examine under the statutory criteria for discharge, and state clearly what evidence and opinions led them to their conclusion on each issue. Where the tribunal makes a conclusion that is contrary to the clear weight of the evidence it should state clearly why it has come to this decision. In the absence of a strong and comprehensible justification, the High Court should critically review any decision for which there is demonstrably insufficient evidence upon which to come to the particular decision.

The court in *R. v. South East Thames Mental Health Review Tribunal ex parte Ryan*<sup>1</sup> did not follow the judicial trend of carefully reviewing the tribunal's decision to determine if it was based upon sufficient evidence. The only medical evidence before the tribunal was from the RMO who stated that the patient was not in need of medical treatment and should be discharged from the hospital. While the court held that "this Tribunal was well equipped with evidence to reach its conclusion", it did not clearly enunciate why this was the case. Watkins LJ implied that the tribunal was entitled to reject the evidence of the R.M.O. based, in particular, upon the conclusions of the medical member of the tribunal. See further para. 18.25.1 below.

Courts are likely to refrain from reviewing the reasons for the tribunal decision unless there is some public interest in doing so.<sup>2</sup> In *Re Jones*<sup>3</sup> the court refused to review a tribunal's decision where the patient shortly would be eligible to make a further application to a tribunal. The tribunal's decision was that the patient should not be discharged because treatment was necessary for his health and safety and for the protection of others. But the tribunal went on to say: "We are not satisfied that he was in need of maximum security provided by the hospital and find . . . that he could be accommodated in the community in a suitably and fully staffed hostel." Rose J did not find these reasons "inconsistent or unintelligible," but rather saw them as "no more than an expression of hope."

### 18.25 Case Stated

Section 78(8) of the Act provides that a tribunal may, and if so requested by the High Court must, state in the form of a special case for determination by the High Court any question of law which may arise. This procedure allows the High Court to determine questions as to law (e.g. whether the Rules were correctly followed) but not fact. For the procedure to be adopted, see the Rules of the Supreme Court, Ord. 56.

There is mounting uncertainty about the interpretation of a number of relevant provisions, both in the Act and in the Rules. Increasingly it becomes clear that there is a need to clarify ambiguous points of law, *inter alia*, in order to encourage a greater degree of consistency in the

<sup>1</sup> QBD, CO/98/87. 30 June 1987. See further para 18.13 above.

<sup>2</sup> *Don Pasquale (A Firm) v. Customs and Excise Commissioners* [1990] 3 W.L.R. 1108, CA.

<sup>3</sup> CO/102/91 (Transcript: Marten Walsh Cherer), 8 March 1991, Rose J.

operation of tribunals in different parts of the country and with different presidents.

The Court in *Bone v. Mental Health Review Tribunal*<sup>1</sup> said that, in seeking to bring a decision of a tribunal before the High Court, consideration should be given to proceeding by the way of judicial review as an alternative to case stated as provided by section 78(8). Judicial review allowed a broader consideration of the issues and also offered a more comprehensive range of relief. Under Order 94, rule 11(5) of the Rules of the Supreme Court, the Courts' powers under the case stated procedure are limited to giving any direction that the tribunal ought to have given under Part V of the Mental Health Act.

#### 18.25.1 *Tribunal which proceeds on opinion of medical member*

Where a tribunal decides to proceed upon the basis of some point which has not been put before it and which on the face of the matter is not in dispute, it is important that the person whose case is being considered by the tribunal should be alerted. In *Mahon v. Air New Zealand Ltd*<sup>2</sup>, Lord Diplock said that the rules of natural justice "require that any person represented at the enquiry who will be adversely affected by the decision to make a finding should not be left in the dark as to the risk of finding being made and thus deprived of any opportunity to adduce additional material of probative value which, had it been placed before the decision-maker might have deterred him or her from making the finding even though it cannot be predicted that it would inevitably have had that result."

If a Mental Health Review Tribunal proceeded upon the basis of the medical member alone, which was known only to themselves, then its proceedings could be flawed and subject to review by the Divisional Court.<sup>3</sup> The implications of this decision are that, if material evidence is contained in the medical member's report (see para. 18.02.2 above) which is not apparent in any document made available to the parties to the case, then the report or the substance of the report might have to be disclosed by the tribunal.

#### 18.26 Assessment Applications

The procedure in relation to assessment applications are governed by rr. 30-33. In general terms the differences between the proceedings in assessment applications and in other applications relate to the need to expedite the proceedings in assessment applications.

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<sup>1</sup> [1985] 3 All E.R. 330.

<sup>2</sup> [1984] 3 All E.R. 201, at 210.

<sup>3</sup> *R. v. Mental Health Review Tribunal, ex parte Clatworthy*, [1985] 3 All E.R. 699.

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