

The Re-call of Conditionally Discharged Patients – the breadth of the Secretary of State’s discretion.

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**R (on the application of ‘MM’) v Secretary of State for the Home Department
Court of Appeal; 6 July 2007
[2007] EWCA Civ 687**

Introduction

This decision of the Court of Appeal addresses the circumstances in which the Secretary of State may lawfully exercise his discretion in section 42 of the *Mental Health Act 1983* (MHA) to recall to hospital a patient who has been conditionally discharged from detention for treatment.

The Facts

MM suffers from paranoid schizophrenia. He has a history of drug abuse. In May 1996 he was convicted of an offence of unlawful wounding: he believed that the victim was having an affair with his girlfriend, and had struck him on the leg with a hammer. MM was detained for treatment in hospital pursuant to section 37 MHA with a restriction order being imposed under section 41 MHA.

In June 1997 MM was conditionally discharged by a Mental Health Review Tribunal. The history of MM’s subsequent admissions to and discharges from hospital discloses an extraordinary succession of conflicting decisions by the tribunal and the Secretary of State for the Home Department, culminating in a claim in judicial review. On numerous occasions, following a conditional discharge by the tribunal, the Secretary of State exercised his power of recall under section 42 MHA. The longest period of recall was from February 2004 to December 2005.

On 13 December 2005 MM was again conditionally discharged by the tribunal. His responsible medical officer and approved social worker supported the discharge. The RMO gave evidence that MM was as well as he was ever going to be with regards to his schizophrenia, and noted that if he was going to relapse in the future it would be due to a lack of compliance with medication and illicit drug use; he recommended that the threshold for considering an assessment under the MHA should be low if his mental state suggested psychotic relapse. The tribunal imposed various conditions on the discharge pursuant to its discretion in section 73(4)(b) MHA, relating to residence, community treatment and random drug testing.

In the following month, MM admitted to his community RMO that he was using cannabis. He was warned that if his mental state was affected, he would be recalled. In the next month, MM’s father told the social worker that MM had been taking rock cocaine and associating with drug users. MM had also refused a drug screen. The social worker was of the view that this constituted a relapse signature. On 28 February 2006 the community RMO informed the Secretary of State of these developments, and

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commented that MM's community placements historically failed because of drug use and consequent rapid relapse, On 2 March 2006 the Secretary of State decided to recall MM to hospital; the case was referred to the tribunal pursuant to section 75(1)(a) MHA.

The tribunal met on 25 April and 9 May 2006; on the latter date it ordered MM's conditional discharge. The RMO had once again recommended discharge, on the basis that MM had been symptom free throughout the admission; he stated that MM's mental state was unchanged from the time of discharge in December 2005. The conditions of discharge were similar to those imposed in December 2005.

On 8 June 2006 one of MM's supervisors informed the Secretary of State that he had tested positive for cocaine use. The following day he was again recalled.

On 4 September 2006 MM was again conditionally discharged by the tribunal; once again, he had not exhibited any psychotic features during the admission. One of the conditions of discharge was that he abstain from illicit drugs; it soon became clear that he was in breach of this condition, although he continued to be free of psychotic symptoms. He was sent a warning letter by the Secretary of State, but a few days later it became apparent that he had continued to use a variety of drugs. On 19 September 2006 MM was once again recalled.

Judicial review claims were issued by MM and the Secretary of State during this time, but were abandoned because of the swift developments in the case. Finally, on 12 October 2006, MM was granted permission to pursue a claim in respect of the March and September recalls. On 23 November 2006 Mitting J dismissed the claims, and MM appealed, resulting in the present judgment.

In the meantime, MM was yet again conditionally discharged by the tribunal on 11 January 2007, and yet again recalled, on 12 February 2007.

The Law

The case centres on the Secretary of State's power in section 42(3) MHA to recall to hospital a patient subject to a section 41 MHA restriction order who has been conditionally discharged. The MHA does not provide any substantive or procedural rules about how the power is to be exercised.

It was accepted on behalf of the Secretary of State that the power is limited by the requirements of Article 5 of the European Convention on Human Rights and Fundamental Freedoms. *Winterwerp v Netherlands* (1979) 2 EHRR 387 requires that, where a person is detained on the ground that he is of "unsound mind", three conditions must be satisfied in addition to compliance with domestic law: (i) except in emergency cases, he must be clearly shown to be of unsound mind, i.e. a true mental disorder must be established before a competent authority on the basis of objective medical expertise; (ii) the mental disorder must be of a kind or degree warranting compulsory confinement; (iii) the validity of continued confinement depends upon the persistence of such a disorder.

Further, before the Secretary of State can lawfully recall a conditionally discharged patient, there must be "up to date medical evidence about the applicant's mental health"; *K v United Kingdom* (1998) 40 BMLR 21 (a Commission decision), i.e. there must be medical evidence upon which he can properly conclude that the relevant *Winterwerp* criteria are satisfied.

It was agreed by both parties that mere breach by a patient of the conditions of his discharge does not provide a freestanding ground for recall; the breach must enable the Secretary of State to form a reasonable judgment on the evidence before him that the criteria for recall are established.

Stephen Simblet (Counsel) argued on behalf of MM that for recall to be warranted, the medical evidence had to show that his mental state would warrant detention for treatment under the conditions provided for in section 37, and that no such view could reasonably be formed on the evidence in MM’s case: his continued drug consumption created no more than a risk of deterioration, and recall could not be warranted until psychotic symptoms had either recurred or become an immediate inevitability.

The Decision

The Court held that the language of the first of the statutory admission criteria (the “nature or degree” test) would be unduly circumscribed if there had to be either psychotic symptoms or the certainty of psychotic symptoms in the imminent future before detention for treatment could be appropriate. Treatment has a broad meaning, an obvious part of which is the avoidance or minimisation of risk, and there was no reason in law to prevent detention of a patient in MM’s position before psychotic symptoms recurred or were certainly imminent.

In order for recall to be lawful, the Secretary of State must have reasonable grounds to believe that information has emerged of sufficient seriousness to justify recalling the patient. He must have up to date medical evidence about the patient’s mental health, and only in exceptional circumstances would he not seek the patient’s RMO’s opinion.

On the facts, whilst the RMO had not explicitly recommended recall on either of the challenged recalls occasions, the Secretary of State had had sufficient information about MM to exercise his discretion to recall lawfully. MM’s appeal accordingly failed.

Comment

The foundation of the Court’s decision is that Stephen Simblet’s formulation was wrong, and that there is no requirement for active or imminent symptoms of mental disorder to be present before a patient is detained. The court thereby provided a statement of what the law is not, but the judgment is less helpful on the question of what the law is in these circumstances. Toulson LJ merely observed that

“...determining the point at which the risks are such as to make detention for treatment appropriate may involve a difficult judgment on the facts of a particular case.” [48]

and concluded:

“For the Home Secretary to recall a patient who has been conditionally discharged by a MHRT, he has to believe on reasonable grounds that something has happened, or information has emerged, of sufficient significance to justify recalling the patient... he must have up-to-date medical evidence about the patient’s mental health “ [50]

In other words, the Secretary of State may lawfully recall a patient where the decision is *Wednesbury* reasonable. One might respond that this is a rather trite statement that does no more than beg the question before the Court.

The Court seemed to accept, without saying so explicitly, that in order for recall to be lawful, the criteria for detention in section 37 MHA must be satisfied. Thus at paragraph [47] Toulson LJ relates those criteria to the evidence in MM’s case, and rejects the argument advanced on MM’s behalf by reference to them. On a somewhat generous analysis, the Court was relying here on the “nature” aspect of the test for detention for treatment, in that it was the nature of MM’s illness that it could be made symptomatic by his use of drugs and, once symptomatic, he could become a danger to others. Thus even though MM

was asymptomatic, and even though he was not a risk at the time of the decision to recall, his further detention was justified by reference to the fear that all that might change, and change quickly.

This brings us to the real issue in this case – probability. It is often said in tribunal proceedings about a patient who suffers from a mental illness, but who is currently asymptomatic, that at some point in the future it is likely he will require detention again. The present state of the law is that the mere prospect that at some unspecified future time in-patient treatment will or might be required, is not a justification for detention: *R (Epsom & St Helier NHS Trust) v Mental Health Review Tribunal [2001] MHLR 8*, per Sullivan J at [52].

If that is right, then Stephen Simblet's formulation was correct. Relapse, indeed sudden relapse, may have been a probability, and to that extent foreseeable, but if the period of time within which that probability operated was not readily identifiable, MM's case would fall into the category identified by Sullivan J in the *Epsom & St Helier* case.

In essence, the Court held that detention was justified *before* the patient reached a detainable state in order to *prevent* that detainable state arising. The difficulty with this reasoning is that it involves a blatant paradox: if the patient's mental disorder is not symptomatic when he is detained, and detention will prevent it becoming symptomatic, then detention itself will eliminate the grounds for that detention.

Paralysis is the inevitable consequence of paradox, as it was in this case. It was inevitable that the patient's RMO could not argue that he was detainable at each tribunal hearing, because detention had prevented him becoming detainable; similarly, it was inevitable that each successive tribunal would be obliged to direct discharge following every recall.

The paradox is further illustrated by Toulson LJ's rather airy assertion that "An obvious part of [treatment's] purpose is the avoidance or minimisation of risk." MM's RMO had repeatedly given evidence to the tribunal that MM was not suffering from psychotic symptoms. Indeed, he had gone so far in December 2005 to say:

"At this point I feel that a further stay in a low secure unit may become counter-productive as we have reached a therapeutic point where he is as well [as] he is ever going to be with regards to schizophrenia."
[5]

Moreover, at the April/May 2006 tribunal, the RMO said that MM's mental state was "unchanged from the time of discharge" [15]. One might then ask: what exactly did the Court of Appeal envisage him being treated for following recall?

What is immediately striking about this case is that a series of judicial decisions by the tribunal were nullified by successive decisions by the State. The question arises as to whether the actions of the Secretary of State were an expression of anything more than disagreement with the tribunal decisions. If that was the case, then it is hard to see the multiple recalls as legitimate exercises of executive power. In this respect, the argument advanced on behalf of the Secretary of State before the Court of Appeal is interesting. It was submitted that Mitting J at first instance was wrong to say that deterioration must be 'likely to occur' in order for recall to be justified; rather, the Secretary of State should ask himself whether there had been such a material change of circumstances since the Tribunal's previous decision that he could reasonably form the view that the detention criteria were now satisfied. This formulation commends itself for two reasons: first, it is at least a positive statement of principle, and second, it recognises the difficulty created by the tension between conflicting decisions of an independent court and the State.

This argument is in fact an extension of the principle established by the House of Lords in *R v (1) East London & City Mental Health NHS Trust (2) David Stuart Snazell, ex parte Count Franz Von Brandenburg (Aka Nicholas Hanley)*[2003] 3 WLR 1265, dealing with the lawfulness of administrative decisions to detain patients who have recently been discharged by a tribunal. It is easy to see why it was put forward by the Secretary of State as a reasonable approach to the interaction of the executive and the courts, and it is perhaps unfortunate that the Court does not appear to have endorsed it.

In this case therefore the Court of Appeal allowed the Secretary of State a greater breadth of discretion in relation to his power to recall conditionally discharged patients than the Secretary of State had himself asked for. Whilst this is of course an intensely difficult area, involving the balancing of personal liberty and autonomy against real risks to the public, this judgment’s lack of clear reasoning and failure to make any positive statement of principle beyond the obvious represents a missed opportunity.