About this briefing Note

On 28th November and 17th December 2018 respectively the Supreme Court handed down its judgments in relation to the following two linked cases:

- Secretary of State for Justice (Respondent) v MM (Appellant) [2018] UKSC 60
- Welsh Ministers v PJ [2018] UKSC 66

The earlier Court of Appeal judgments in these same cases were the subject of a detailed briefing note produced by NHS England. The purpose of this was to assist practitioners dealing with the consequences of these legal decisions in particular within the context of the ongoing Transforming Care programme. The earlier document can be accessed at the following link:

http://www.mentalhealthlaw.co.uk/media/2017-11-24_MM_and_PJ_NHS_England_briefing_note.pdf

There has continued to be concern raised nationally about the impact of these judgments on the ability or otherwise to discharge some patients from hospital into the community, in particular those with learning disabilities, autism, or both. However, the judgment also has the potential to have an impact on the care of patients with mental illness and personality disorder and is a challenge where people who present high-risk behaviours are detained in hospital, have come into the system via the criminal courts and are subject to restrictions under section 41 of the Mental Health Act 1983.

The NHS long term plan continues to reflect government policy in maintaining a commitment to people with learning disabilities, autism or both, who have a mental illness or whose behaviour challenges services, with a particular focus on reducing the need for long term detention in hospital and meeting their needs wherever possible in the community.

Purpose

The purpose of this updated generic briefing note is to provide a summary of the recent Supreme Court judgments and to outline some of the possible implications for the programme, to be shared with Specialised Commissioning providers and commissioners. A briefing will also be directed at clinicians and social supervisors through their clinical supervisors, medical directors and Local Authorities.

This briefing note should not be seen as specific guidance on individual cases and where practitioners are dealing with particularly complex cases it may be appropriate for their organisation to seek independent legal advice.

Background

Both these cases involved appeals from judgments of Charles J in the Upper Tribunal (Mental Health), where the Court of Appeal (and now the Supreme Court) considered:

- the nature and extent of the powers of the First Tier Tribunal where psychiatric patients apply to be conditionally discharged into circumstances that deprive them of their liberty in the community.

- the situation where the conditions of a Community Treatment Order may amount to a deprivation of liberty and the case is being considered by the Tribunal.

The Facts

MM and PJ each had learning disabilities and autistic spectrum disorder, but had capacity to make decisions about the care which constituted a restriction of their liberty.

MM had been detained in hospital under s.37/41 Mental Health Act (MHA). He applied to the Tribunal seeking conditional discharge with a proposed care package that amounted to a deprivation of liberty (DoL).

- The Tribunal rejected his argument that as he had capacity to consent to this, the tribunal could impose a condition requiring him to comply with his care package.

- The Upper Tribunal disagreed and allowed MM's appeal, deciding that the Tribunal could impose conditions that amounted to a deprivation of liberty and that a patient with capacity could validly consent to such conditions.

- The Court of Appeal reversed this decision, supporting the decision of the first instance Tribunal, stating that when granting a conditional discharge to a restricted patient, there is no power that can be exercised by the Tribunal to authorise a patient's deprivation of liberty outside hospital, as there is no existing statutory authority for this within the MHA either express or implied.

PJ had been detained in hospital and discharged under a Community Treatment Order (CTO) with conditions that amounted to a Deprivation of Liberty.

- The tribunal refused his application for discharge.

- The Upper Tribunal overturned that decision, declaring that the Tribunal should have used its power of discharge to stop the ongoing breach of the patient's ECHR article 5 rights (the right to liberty).

- The Court of Appeal held that the Responsible Clinician's (RC) power to restrict the freedom of movement of a patient to the extent of objectively depriving him of his liberty by the conditions attached to a CTO *was* permitted as part of the MHA statutory framework.

Both cases were then appealed to the Supreme Court

The Supreme Court Judgments

Secretary of State for Justice v MM (Appellant) [2018] UKSC 60

On appeal from the Court of Appeal [2017] EWCA civ 194

For the full judgment (28 November 2018), see following link:

https://www.supremecourt.uk/cases/docs/uksc-2017-0212-judgment.pdf

In summary, the Supreme Court refused the appeal. It decided that the MHA does not permit either the First Tier Mental Health Tribunal or the Secretary of State to impose conditions amounting to detention or a deprivation of liberty upon a conditionally discharged restricted patient.

Considering the words of s.42 of the Mental Health Act (the Secretary of State's power of discharge of restricted patients either absolutely or conditionally) and s.73(2) (The Tribunal's parallel power to absolutely or conditionally discharge a detained restricted patient), they are very general. In the judgment Lady Hale noted that Parliament was not asked when drafting/reviewing the Act to consider whether these sections included a power to impose a different form of detention from that provided for under the MHA. She also noted that the MHA confers no coercive powers over conditionally discharged patients. Breach of the conditions is not a criminal offence. It is not even an automatic ground for recall to hospital, although it may well lead to this. The patient could withdraw his consent to the deprivation at any time and demand to be released: there is no contract by which the patient is bound.

The view of the Supreme Court therefore was that it would be "*contrary to the whole scheme of the MHA*" to allow the appeal. Lady Hale pointed out that in relation to powers of detention under parts II and III of the MHA, the Act gives specific powers, both to convey the patient to the hospital or a place of safety and to detain him or her there. However, there is no equivalent express power to convey a conditionally discharged restricted patient to the place where he or she is required to live or to detain them there; if the MHA had contemplated that such a patient could be detained, it was inconceivable in the view of the Supreme Court that equivalent provision would not have been made for that purpose.

The MHA also makes detailed provision for retaking people who absent themselves from the place of safety or hospital where they are detained, or for conditionally discharged patients who have been recalled. However these powers are not available for a conditionally discharged restricted patient who has not been recalled by the Secretary of State. Merely absenting himself from the place where he is required to live is not enough. Once again, if the MHA had contemplated that a patient might be detained as a condition of their discharge, it was inconceivable in the view of the Court

that it would not have applied the same regime to such a patient as it applies to a patient granted leave of absence under section 17.

Lastly, the Court noted that a hospital order patient (including a patient on leave of absence) can apply to the Mental Health Tribunal once within the second six months of their detention and once within every 12-month period thereafter. A conditionally discharged restricted patient who has not been recalled to hospital, however, can only apply once within the second 12 months of his discharge and once within every two-year period thereafter. The Supreme Court considered this to be an indication that it was not thought that such patients required the same degree of protection as did those deprived of their liberty; and thus again that this was an indication that it was not contemplated that they could be deprived of their liberty by the imposition of conditions.

The Court rejected the argument that consent played a role, considering this to be largely irrelevant to the issue in hand.

At paragraph 27 of the judgment, Lady Hale comments that whether the Court of Protection could authorise a future deprivation of liberty, once the Mental Health Tribunal has granted a conditional discharge, and whether the Tribunal could defer its decision for this purpose, were not issues which were appropriate for the court to decide at this stage in these proceedings. It is possible therefore that we will see further cases on this.

Welsh Ministers v PJ [2018] UKSC 66

On appeal from the Court of Appeal [2017] EWCA civ 194

For the full judgment (17 December 2018), see following link:

https://www.supremecourt.uk/cases/docs/uksc-2018-0037-judgment.pdf

The Supreme Court Judgment

In summary, the Supreme Court unanimously allowed the appeal. In a judgment consistent with the linked case of MM above, the Court declared that there is no power to impose conditions in a Community Treatment Order which have the effect of objectively depriving a patient of his or her liberty.

In their reasoning the Court commented that it is a fundamental principle of statutory construction that a power expressed in general words should not be construed to interfere with fundamental rights such as the right to liberty of the person.

They noted that there is no power to detain a patient on a CTO, no power to impose medical treatment without consent, and no sanction for failing to comply with the care plan, other than the limited power of recall. In addition, whilst there is a limited power

of recall, there is no power similar to that for section 2 or 3 patients to recapture them if they breach the care plan or are absent without leave.

They also commented that the 2007 amendments to the 1983 Act were preceded by lengthy examination and consultation; the Royal College of Psychiatrists had long been pressing for some means of ensuring that detained patients kept up with their medication and did not get lost after being discharged from hospital. However, these calls for coercive treatment in the community were rejected as there was great opposition to any form of compulsory or forcible medical treatment outside the carefully controlled environment of a hospital.

Deprivation of Liberty

Both of these cases dealt with the question of "objective" deprivation of liberty (DoL). This currently continues to be defined in the leading Supreme Court case of "Cheshire West" (19 March 2014) in which Lady Hale set out the "acid test" that an objective DoL is where the person is "*under continuous supervision or control and not free to leave*". Our previous briefing note sets out some useful points to note when assessing whether a patient's care plan or conditions amount to a DoL.

It is important to note that a new scheme to replace the existing Deprivation of Liberty Safeguards (DoLS) legal framework is set out in the Mental Capacity (Amendment) Act 2019, which received Royal Assent on 16 May 2019. It is known as the "Liberty Protection Safeguards" (or "LPS"), but has significant differences from the scheme of the same name as proposed by the Law Commission.

At the time of writing, it is anticipated that the new scheme will come into force on 1 October 2020.

An initial proposal that there should be a statutory definition of what is an objective DoL was dropped, so the "Cheshire West" test will continue to be the touchstone. The LPS do not change what is or is not a DoL, only the way in which a DoL can be authorised. However, it is anticipated that the related Code of Practice (expected to be out for consultation later in 2019) will provide further guidance on what arrangements amount to a DoL. It is proposed that the new Code of Practice will then be reviewed after 3 years, and thereafter every 5 years, to try to keep that guidance on the meaning of DoL up to date with case law.

It is also of note that the independent review of the MHA published in December 2018 included a recommendation that *"the Government should legislate to give the Tribunal the power to discharge restricted patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards"*.

Therefore it is important that commissioners, providers and practitioners continue to keep up to date with new legislation and case law as this develops.

What are the implications of these judgments?

Restricted patients subject to or being considered for a Conditional Discharge under the MHA

The Supreme Court has confirmed that for any restricted patient being considered for, or already subject to, a conditional discharge (either with or without capacity to consent to their care, residence and treatment arrangements), the MHA does not permit either the First Tier Mental Health Tribunal or the Secretary of State to impose conditions that taken together amount to detention or a deprivation of liberty.

Where the conditions proposed to manage the risk in the community amount to an objective DoL and the patient has capacity, it may therefore not be possible to discharge the patient from detention in hospital. Essentially this is because if a patient has capacity for those decisions then neither the Deprivation of Liberty Safeguards nor the Court of Protection has any jurisdiction to authorise the DoL. In addition as per the MM Supreme Court judgment any conditions of a conditional discharge under the MHA cannot amount to a DoL. Therefore there is no obvious legal route to authorise any DoL in the community.

As such, the following issues will need to be considered:

- there will need to be an increased focus on the assessment of capacity to ensure this has taken into account all relevant factors and is accurate
- there should be advance consideration of proposed conditions, whether these taken together may amount to a DoL, also whether where clinically appropriate such may be altered so as not to create a DoL
- where a patient will be required to keep to proposed care plans, these should be considered in detail to assess whether (where clinically appropriate) they can be altered to avoid any DoL
- in some cases where it is not clinically appropriate to alter the conditions/related care plan that the patient is required to abide by, there should be consideration of whether s.17 leave may be an alternative to discharge at least on a short term basis, to test out the patient in a less restrictive setting with a view to reviewing the care plan and conditions in the future. The Mental Health Casework Section of the Ministry of Justice has issued separate guidance in relation to this which can be accessed at the following link:

  https://www.gov.uk/government/publications/discharge-conditions-that-amount-to-a-deprivation-of-liberty

- In some exceptional cases such as that the case of ***Hertfordshire County Council v AB [2018] EWHC 3103 (Fam)*** the High Court may be persuaded that the court's inherent jurisdiction may be used to authorise a deprivation of liberty of a patient with capacity who is subject to a conditional discharge under the Mental Health Act 1983. However such cases are rare and are yet to be tested in the higher courts – it would be necessary to seek independent legal advice if this route were to be considered.

Where the patient is assessed as lacking capacity to consent to their care, residence and treatment arrangements, it remains possible for a DoLS standard authorisation or order of the Court of Protection authorising the aspects of a care plan amounting to a DoL to be sought. The DoLS standard authorisation or order of the Court of Protection can then run alongside a conditional discharge, as long as the two do not conflict with each other[1]. It would remain necessary in such a case that the conditions of the conditional discharge did not in themselves (or by reference to a requirement to abide by the care plan) amount to a DoL. Practitioners should be aware that this area of law may be subject to further appeals and case law, so it is important that legal advice is sought in such cases well in advance of any Tribunal hearing.

Patients subject to or being considered for a Community Treatment Order

The Supreme Court has confirmed that there is no power to impose conditions in a Community Treatment Order which have the effect of objectively depriving a patient of his liberty (whether or not that patient has capacity to consent to their care, residence and treatment arrangements).

Where the conditions proposed to manage the risk in the community amount to an objective DoL and the patient has capacity, it may therefore not be possible to discharge the patient from detention in hospital. The following issues will need to be considered:

- there will need to be an increased focus on the assessment of capacity to ensure this has taken into account all relevant factors and is accurate

- there should be advance consideration of proposed conditions, whether these taken together may amount to a DoL, also whether where clinically appropriate such may be altered so as not to create a DoL

[1] An example of the two conflicting would be a condition of the conditional discharge requiring the patient to reside at one address and the standard authorisation requiring the patient to live at a different address)

- proposed care plans should be considered in detail where a condition is proposed that the patient should abide by the same, to assess whether where clinically appropriate such may be altered so as not to create a DoL

- in some cases where it is not clinically appropriate to alter the conditions/related care plan that the patient is required to abide by, there should be consideration of whether s.17 leave may be an alternative to discharge at least on a short term basis, to test out the patient in a less restrictive setting with a view to reviewing the care plan and conditions in the future.

Where the patient is assessed as lacking capacity to consent to their care, residence and treatment arrangements it remains possible for a Standard DoLS authorisation or order of the Court of Protection authorising the aspects of a care plan amounting to a DoL to run alongside a CTO, as long as the conditions of the two do not conflict with each other. S.64B (3)(b)(ii) MHA also specifically provides for a situation whereby a patient can receive treatment whilst subject to a Community Treatment Order following consent being provided on their behalf by the Court of Protection. Practitioners should be aware that this area of law may be subject to further appeals and case law, so it is important that legal advice is sought in such cases well in advance of any Tribunal hearing.

A communication aimed at clinicians and social supervisors through their clinical supervisors, medical directors and Local Authorities is being produced; further information will be made available in due course.

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