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Publications Gateway Reference 07333

BRIEFING NOTE

About this briefing note

At the end of March 2017, the Court of Appeal handed down its judgment in the two joined cases of PJ (A Patient) v A Local Health Board and Secretary of State for Justice v MM.

Concern has been raised nationally about the impact of this judgment on the Transforming Care agenda, in particular on the ability to discharge some patients from hospital into the community.

The Transforming Care programme reflects government policy that is committed 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 needs wherever possible in the community. This can be a particular challenge in cases 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.

Purpose

This briefing note is aimed at providing practitioners within Transforming Care Partnerships (TCPs) with a summary of the recent court of appeal judgement, and to outline some of the possible implications for the programme.

It also provides a framework for regions around enhancing understanding of those individuals on whom this will have an impact and some suggestions for the handling of future cases.

Background

Both these cases involved appeals from judgments of Charles J in the Upper Tribunal, where the Court of Appeal considered:

- In MM - 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, AND:

- In PJ - The situation where the conditions of a Community Treatment Order (CTO) may amount to a deprivation of liberty and the case is being considered by the Tribunal.

- The judgment does not change anything for people who lack the capacity to consent to the community accommodation care and support arrangements. The Court of Appeal in this judgment recognised that the Mental Capacity Act or Deprivation of Liberty Safeguards (DoLS) can still be used to authorise a deprivation of liberty of a restricted patient who lacks capacity. However the tribunal must be assured that the Court of Protection or Supervisory Body have given the relevant authorisation BEFORE they direct a conditional discharge (usually wanting to see the actual authorisation). In these cases the First Tier Tribunal can defer conditional discharge until a DoLS authorisation/order from the Court of Protection has been sought.

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

The appeals were heard together by the Court of Appeal and were both allowed, in each case supporting the decision of the First Tier Tribunal, and overturning the decision of Charles J in the Upper Tribunal.

Deprivation of Liberty

In each case, we are dealing with the question of "objective" deprivation of liberty (DoL) - ("objective" here just distinguishes it from the two other elements of the definition of DoL – i.e. the lack of valid consent, and imputability to the state). This is defined in the leading case, the Supreme Court judgment in "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 [elsewhere she says "constant"] supervision and control and not free to leave".

It is important to remember that:-

- The purpose of the restrictions, the nature or extent of the patient's disability or care needs, their contentment or acquiescence, and the quality of the care being provided ARE NOT relevant to the question of whether there is an objective DoL. As Lady Hale put it, "a gilded cage is still a cage", and the existence of a DoL simply needs to trigger independent scrutiny and procedural safeguards to meet a patient's rights under Article 5 of the European Convention of Human Rights (ECHR). To avoid denying those safeguards to a very vulnerable group of people, her expectation was that we should "err on the side of caution".
- "Continuous" or "constant" supervision does not require a patient to be in sight 24 hours a day, or to have staff with them at all times. It may be enough, for example, that the care plan may require the patient to adhere to a particular route or timescale when out of sight, and that there may be consequences for failure to do so.
- Even if well intentioned and appropriate restrictions are instinctively considered to be "support", for example, rather than "control", this characterisation should not negate the reality that control is or could be exercised over some or all aspects of the patient's life.
- The restrictions must be taken as a whole, collectively and cumulatively, and considered in terms of their overall impact on the patient, so it can be dangerously reductive to consider any particular individual factor in isolation as necessarily indicative of a DoL.
- "Free to leave", in this context, does not mean just coming and going from a particular placement, but whether a patient would be permitted to freely decide where they will live.

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It is recognised that the definition of DoL, following Cheshire West, is significantly wider than had been previously appreciated.

PJ - CTOs and Deprivation of Liberty

Summary of judgment (See **Appendix 1** for a more detailed overview of PJ**)**

The Responsible Clinician (RC) can authorise conditions under a Community Treatment Order (CTO) that can restrict the freedom of movement of a patient to the extent of objectively depriving him of his or her liberty. Although CTO conditions may amount to a DoL, a CTO is nevertheless intended to be a *lesser restriction on freedom* of movement than detention in hospital for medical treatment.

But it is not appropriate for the Mental Health Tribunal to investigate or determine whether there is an objective DoL as a consequence of a CTO. The power of the Tribunal is simply to discharge if the statutory criteria for detention are not met.

Implications for the Transforming Care programme:

- Responsible Clinicians have an implied power to deprive a person of their liberty by way of the conditions of the person's CTO, although in general terms this should represent a less restrictive option than the package being provided in hospital under section 3 or 37.

- For those patients subject to section 3 or 37 of the MHA, the judgment arguably makes it easier to discharge them into the community, as it is now confirmed that the conditions attaching to the CTO may amount to a DoL. Therefore if the community package requires a DoL in order to manage the risk, the judgment implies that this can be achieved via the conditions attached to a CTO.

- However, it should be noted that this may require revision of the Mental Capacity Act code of practice which sets out at chapter 29.31 that a DoL must not arise from CTO conditions. The judgment does nothing to reconcile that apparent contradiction, and this aspect, at least, is likely to be challenged in the courts in due course, if not in an appeal against that judgment itself.

MM – Conditional Discharge and Deprivation of Liberty

Which patients does the MM Court of Appeal judgment affect?

Any patient who is:

- detained under the Mental Health Act 1983 and
- is subject to a restriction order under either s.41 or s.49 and
- applies to the Mental Health Tribunal and
- has capacity to consent to their care and treatment arrangements

  is potentially affected by this judgment.

Most commonly this will apply to patients detained under s.37/41 or s.47/49 of the MHA, but could also potentially affect patients subject to s.48/49 and those patients subject to s.45A who are also subject to a restriction order, where they are eligible for a Tribunal application.

Summary of judgment (See **Appendix 2** for a more detailed overview of MM)

Neither the MHA nor the Mental Health Tribunal can authorise a restricted patient's package of care outside a hospital setting, even where the person has capacity to consent to those arrangements, where those conditions amount to a deprivation of liberty. There is no existing statutory authority for this within the Mental Health Act.

Where the restrictions amounting to a DoL are imposed compulsorily by law, the patient's consent does not stop it being an objective DoL which therefore still needs lawful authorisation to avoid breach of ECHR Article 5. The Court of Protection and DoLS cannot be used to do so where the patient has capacity to make the relevant decisions, and so is outside their jurisdiction. This case makes clear that the MHA cannot be used to do so on a conditional discharge either, arguably leaving no lawful way in which a patient with capacity can be discharged into the community where there needs to be post discharge restrictions that amount to a DoL, applying the low threshold of the Cheshire West test.

Implications for the Transforming Care programme

- This judgment is likely to raise a significant barrier to the discharge of patients subject to criminal sections where there is the additional Ministry of Justice restriction (such as a section 37/41 or 47/49) into the community, where the care and support arrangements proposed to manage any risk in the community amount to an objective deprivation of liberty and the patient has capacity. (This clearly applies not only to people with a learning disability and/or autism.)

- There are some clear steps / question that the MDT need to ask themselves and consider and to help we have included a flow diagram at appendix 3

- In such cases there are three options once the patient no longer requires secure hospital care 1) the patient remains on section in a hospital, 2) discharge with conditions that do not amount to a DoL if the Tribunal/care team be persuaded that these are sufficient to manage the risk. For some high risk patients such as those who are a risk to children and require constant supervision, this may be very difficult to achieve. 3) the clinical team feel there is sufficient evidence to apply for an absolute discharge (removal of the restriction section and Ministry of Justice oversight).

- For the Transforming Care programme this is potentially significant – currently almost a quarter of all inpatients are subject to Ministry of Justice restrictions. However, not all of these people will be seeking conditional discharge, we do not know how many have capacity, and it will be dependent on whether the arrangements in the community in each case amount to a deprivation of liberty.

- There is a major ethical consideration at play for practitioners supporting people who fall within the remit of this judgment in supporting people to progress through an inpatient pathway to discharge leading them to believe this is a real possibility – if they fall into the same situation as described in MM they cannot be discharged so should practitioners actually plan for this with the person if it can never be a reality or should they be open and honest and start working towards transfer out of security.

- The impact of this judgement is specific to those who HAVE capacity for the community accommodation care and support decision because the MCA framework does not apply in these cases and there is no other process in law to authorise the DoL. The earlier it is known that the person has capacity, the easier it will be to plan the most appropriate pathway. There is the argument that to present the possibility of discharge from hospital to someone only to then advise that it would be unlawful

amounts to emotional abuse, and managing a patient's expectations appropriately is essential.

- There are therefore responsibilities for RCs and MDTs in:
    - ensuring the robustness of capacity assessments in relation to proposed accommodation, care and support. Ensure you all agree on the salient points and the methodology of communication and information giving before anyone embarks on a capacity assessment rather than trying to deal with differences of view on the outcome.
    - the clarity and robustness of purpose of any control and supervision. Ensure you are all agreed on the risks and the appropriate steps to mitigate / manage these, have the restrictions been reduced as far as possible? Is further positive risk testing required? Then consider the various legal structures that might be able to authorise the restrictions (e.g. MoJ/tribunal conditions; offender licence; tenancy agreement etc) Also be clear about what the commissioner and MDT will expect in terms of action by the provider if the person doesn't comply with the restrictions and care plan; all of this will enable you all to understand what the supervision and control elements are and whether they are continuous (NB as above, the purpose of the restrictions is irrelevant to whether or not they amount to a DoL).
- These will be subject to scrutiny not just by the MCA authorisation process, but also by the MoJ/Tribunal. Be prepared to submit the evidence with a statutory report or to receive directions for the release of the information.
- Note that, perhaps perversely, this situation (whereby the Court of Protection could authorise a post discharge DoL and therefore facilitate discharge for a patient who lacks capacity, while a patient with capacity may have no such route available where the post discharge package amounts to a DoL) creates an incentive for patients and their representatives to argue that they lack capacity, and/or that the restrictions post discharge do not amount to a DoL. The assessment of capacity may therefore pose greater challenges.

<u>Patients who lack capacity for decisions about care and residence</u>

- As stated earlier, the judgment does not change anything for those lacking capacity for the accommodation care and support decision, however given the tribunal/MoJ need assurance of the authorisation before they can conditionally discharge this means that it is necessary for those parties applying to the court to have prepared their application well in advance of the person going before tribunal or an RC applying directly to MoJ for a conditional discharge and you are advised to ensure you have requested the order be shared with the tribunal and Ministry of Justice.
- In relation to "best interests" decisions to justify restrictions for the purposes of Court of Protection / DoLS for patients who lack capacity, there is arguably a fine line between an individual's best interests for his/her own safety and in relation to the protection of others, although, it could be argued that the latter also protects the individual (e.g. by preventing re-offending behaviour). There has been experience to date where the support plan being submitted to the Court of Protection includes all the restrictions that also provide protection of the public through the prevention of offending behaviour. The advice is to include all restrictions that the person lacks capacity for within the Court of Protection application highlighting to the court which restrictions the person has capacity to consent to and which they do not. It a matter

then for the Court to decide which of the care plan they will authorise which will inform the request for the Tribunal in relation to conditions.

What can usefully be done at present in cases covered by this judgment?

Appendix 3 provides a simple flow diagram for considering the impact of the MM judgement on individual cases; it sets out the questions that MDTs need to ask themselves and leads through to whether discharge will be possible or not in order to prevent professionals misleading patients.

- Together with the experience and findings of some Care and Treatment Reviews this judgment underlines the need for optimal clarity and documented evidence of:
    - Diagnosis, formulation and related treatment plans
    - Focussed and consistent treatment with evaluation of treatment outcomes
    - Contemporary and detailed assessments of risk and risk management plans
    - Proposed discharge plans and related assessments of capacity

- Capacity assessments should be carried out earlier in pathways of care. If individuals have capacity to consent to 'abstract' propositions for their future residence and care (potential plans and details rather than actual) then they would be in the same position as MM and the focus of the clinical work would need to be on whether and how restrictions might be reduced to a situation where future support does not amount to an objective deprivation of liberty.

- For those who do not have the capacity to consent to abstract plans then further more detailed work on plans for discharge needs to be carried out and the individual's capacity then reassessed at various points in the pathway and with regard to concrete proposals.

- Regions should ensure that the population likely to be affected by the judgment is more clearly known. Commissioners should be establishing directly with providers and RCs who falls within the population potentially affected and what actions are proactively being taken to determine if they are directly affected, whether assessments of capacity have been carried out and whether the proposed discharge plans amount to objective deprivations of liberty.

- RCs, commissioners and legal representatives should be working to establish what is in the best interests of individuals who lack capacity and what cases may be able to be supported if there is more clarity about the nature and degree of supervision in the community.

National activity and potential solutions

- We are engaging with system partners, including the Department of Health and the Ministry of Justice about the judgment, and have raised our concerns about the likely impact on the Transforming Care programme;

- We are working with the Regions to clarify the scope and numbers of people affected together with a sharing of experience and learning in working within these restrictions;

We appreciate that the implications of this judgment, and MM in particular, may be significant and, in many cases, unhelpful. There are a number of potential solutions:-

- An appeal against the judgment to the Supreme Court – we understand that this is currently under active consideration by some of the parties, and we will of course monitor this.
- A separate test case on the interpretation of DoL in the community on discharge in this context. In PJ and MM each case took as read that the restrictions would amount to a DoL, and applied the Cheshire West test. But the facts of Cheshire West were very different, and the Courts have shown some readiness in other cases to distance themselves from the Cheshire West judgment where the context justifies this and / or the effect of mechanistically applying it would be perverse (as for example in the Court of Appeal judgment in Ferreira, January 2017, holding that Cheshire West should not be held to apply in life saving medical treatment – in the context of a case about treatment in Intensive Care – recently endorsed in another Court of Appeal - Briggs, July 2017).
- Legislation
- Revision of the Code of Practice (though this would have limited value in terms of allowing departure from the implications of a Court of Appeal judgment).

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Date: November 2017

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Appendix 1 – further information – PJ

- PJ had been detained in hospital and discharged under a Community Treatment Order (CTO) with conditions that amounted to a DoL. PJ applied to the tribunal which 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).

Reversing the Upper Tribunal, the Court of Appeal held:

- 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 is permitted as part of the MHA statutory framework. The criteria for the imposition by the RC of conditions that may deprive a patient of his liberty under a CTO are specified in sections 17A(4) to (5) and 17B(2) MHA. They are limited to the purposes of the legislation and they are also time limited. Although CTO conditions may in principle amount to a deprivation of liberty, a CTO is nevertheless intended to be a lesser restriction on freedom of movement than detention in hospital for medical treatment.

- The Tribunal has a distinct and separate power: that of discharge if the statutory criteria for detention are not met. The statutory framework does not permit the Tribunal to regulate the conditions made by the RC and there is no power for a tribunal to consider the terms of a CTO or to change those terms. As such neither is there any power to examine the legality of the CTO including the proportionality of the interference with the patient's Article 5 (right to liberty) or other ECHR rights.

- Therefore it is not appropriate for the Tribunal to investigate or determine whether there is an objective deprivation of liberty as a consequence of a CTO. The remedy for any illegality, including any Convention illegality, is to challenge the CTO by way of an application for judicial review.

Appendix 2 – further information – MM

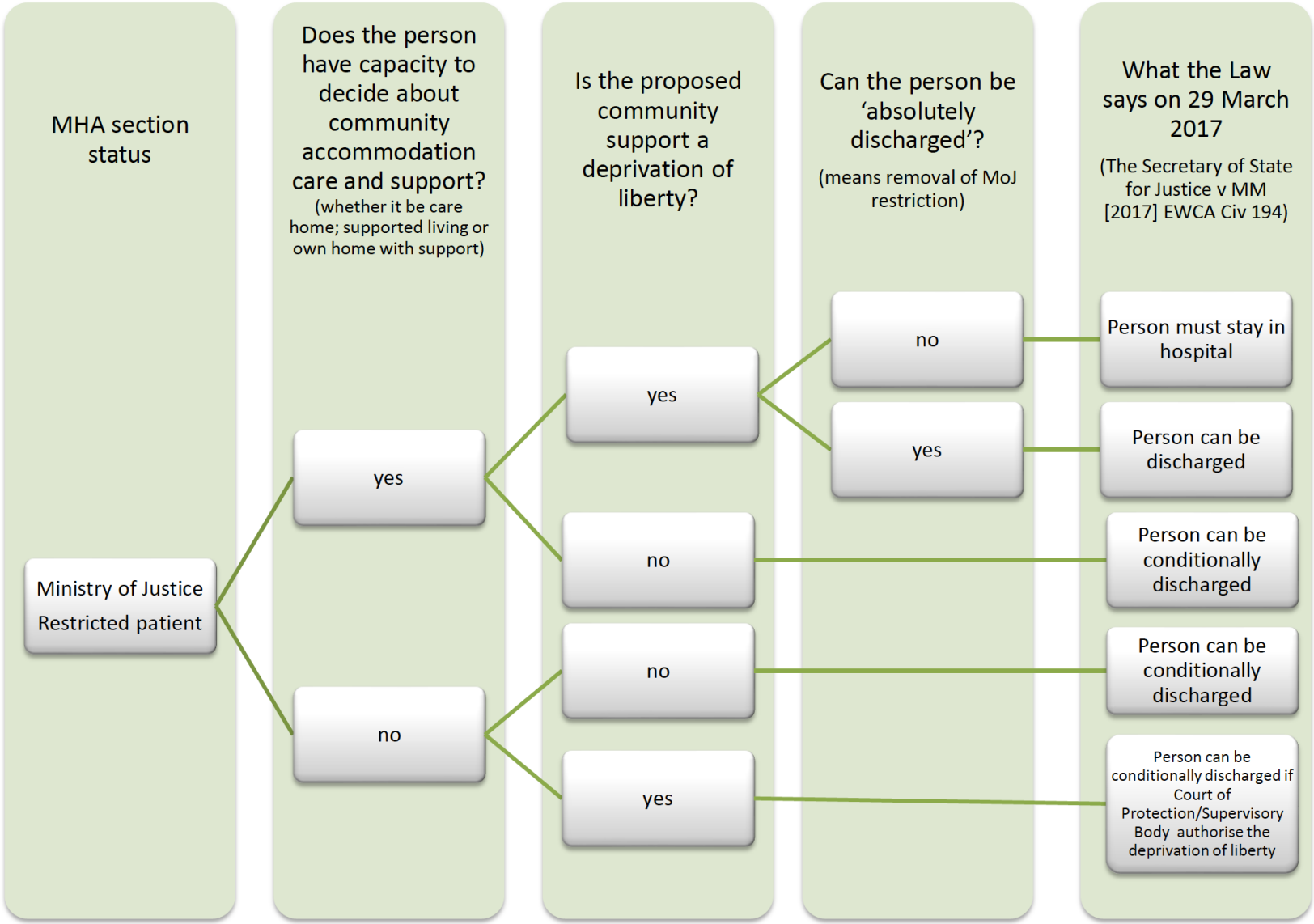
- MM had been detained in hospital under s.37/41 Mental Health Act (MHA). He applied to the Tribunal seeking conditional discharge with a proposed care package that amounted to a deprivation of liberty (DoL). The Tribunal rejected his argument that as he had capacity to consent to this, the Tribunal 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.

Reversing the decision of the Upper Tribunal, the Court of Appeal held:

  - 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. The earlier case of Secretary of State for Justice v RB [2011] EWCA Civ 1608 was correct and binding and the Upper Tribunal should not have gone against it.

  - Where conditions amounting to a DoL are compulsorily imposed by law, the fact that the individual has consented to them does not prevent a DoL occurring and purported consent cannot give the Tribunal the jurisdiction to impose a condition that amounts to an objective deprivation of liberty.

  - The Tribunal can impose a conditional discharge with conditions that do not amount to an objective DoL or it can grant an absolute discharge it is satisfied that the patient is validly consenting to supervision to protect them and the public. .



Christine Hutchinson June 2017

Suggested wording for conditions of discharge

1. Reside at [specify address] [24 hour supported/supported/residential accommodation as directed by the RC and social supervisor] [and abide by any rules of the accommodation], and obtain the prior agreement of the responsible clinician and social supervisor for any stay of one or more nights at a different address.

NB: This should also include a clause whereby the Ministry of Justice should be informed of any change of address at least 14 days prior to the move taking place

2. Allow access to the accommodation, as reasonably required by the responsible clinician and social supervisor.

3. Comply with medication and other medical treatment [and with monitoring as to medication levels] [including… [Specify here any particular non-pharmacological medical treatment]], as directed by the responsible clinician and social supervisor.

4. Engage with and meet the clinical team, as directed by the responsible clinician and social supervisor.

5. Abstain from alcohol [save as directed by the responsible clinician and social supervisor].

6. Abstain from illicit drugs and 'legal highs'.

7. Submit to random drugs and alcohol testing, as directed by the responsible clinician and social supervisor.

8. Not enter the area[s] of [specify general location] as delineated by the zone[s] marked on the map[s] supplied by [specify name of person/organisation producing map] and shown to the Tribunal today, save as agreed in advance by the responsible clinician and social supervisor.

9. Not seek to contact directly or indirectly [specify names].

10. Disclose to the responsible clinician and social supervisor any developing intimate relationship with any other person.

11. Disclose all pending and current [employment, whether paid or voluntary] [all educational activities] [all community activities] to the responsible clinician and social supervisor.

12. Not leave the UK without the prior agreement of the responsible clinician and social supervisor.