Conditional Discharge Rights Launch

Breakout Session for Health Social Care and Legal Professionals

May 2022

Four areas

1. Setting up a Conditional Discharge
2. Review and Monitoring Arrangements
3. Recall
4. Absolute Discharge



Legal Frameworks For Conditional Discharges

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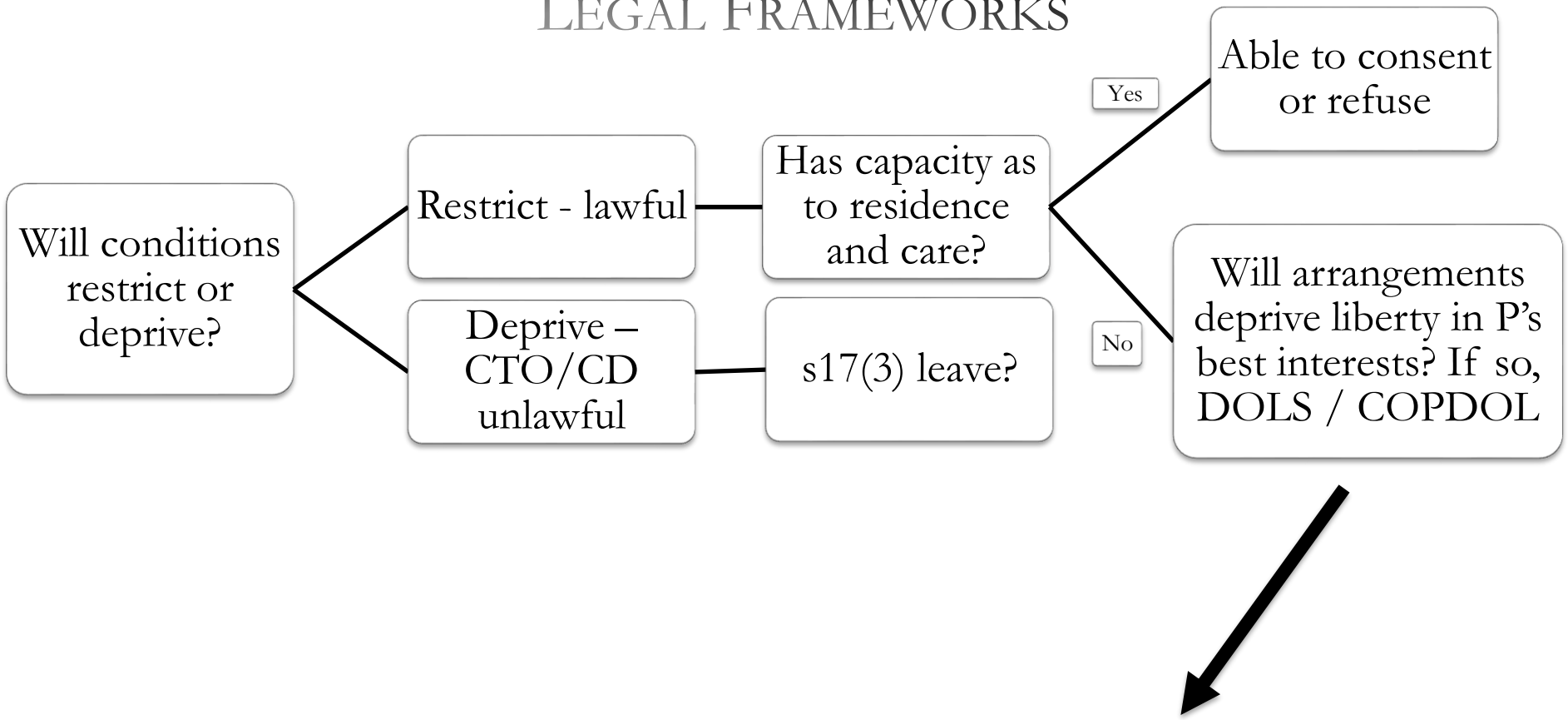
Arranging a Conditional Discharge: Legal Frameworks



- What is covered by MHA? What by MCA?
- Distinguish between the (MCA) care arrangements created by the care plan and the (MHA) conditions of the CD.

DOL AND CONDITIONAL DISCHARGES

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

- 32 years old with mild learning disability, autistic spectrum disorder and pathological fire starting. Convicted of arson: restricted hospital order (MHA ss37/41).
- Sought a conditional discharge on the basis that his capacitous consent to a care regime in the community meeting the acid test.
- Supreme Court held (4-1) that it is unlawful to discharge into conditions meeting the acid test because:
    1. MHA does not expressly permit it
    2. No coercive powers: "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." So MM could withdraw consent at any time
    3. To allow a person to consent to their confinement on conditional discharge would be contrary to the whole scheme of the MHA which only permitted detention in a place of safety or in hospital.

- What about those lacking capacity to consent to care arrangements?

"27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings."

CONDITIONAL DISCHARGES: INCAPACITY

S/S for Justice v KC [2015] UKUT 0376 (AAC):

The tribunal made a provisional decision to discharge him from hospital on the following conditions:

- He will reside at the placement and will not leave the premises unless accompanied and supervised at all times by an appropriate member of staff.
- He will comply with all aspects of the care package which is devised for him by the organisation, and accept supervision and support from their staff.
- He will accept psychiatric and social supervision from his community responsible clinician.
- He will refrain from taking any alcohol and submit to any routine testing which may be required of him.

Lacking capacity to consent to residence/care:

> "… if the implementation of the conditions selected by the MHA decision maker would result in a deprivation of liberty it can be authorised under the MCA by the Court of Protection or under the DOLS (provided of course that the relevant tests and assessments are satisfied)." (para 113).

CONDITIONAL DISCHARGES: INCAPACITY

Birmingham CC v SR; Lancashire CC v JTA [2019] EWCOP 28

Re X/COPDOL11 application for those on conditional discharge.

"41. … It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, "*to keep him out of mischief*" and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.

42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event.

46. There is no inconsistency between the two orders, it is merely that under the MHA, as interpreted in M, there is no power to deprive the patient of his/her liberty. That does not prevent the MCA powers being used."

Conditional Discharges

MC v Cygnet Behavioural Health Ltd and SSJ [2020] UKUT 191 (AAC)

MM does not bar the tribunal from co-ordinating the discharge with MCA to authorise DOL. If DOL has been authorised, tribunal can proceed. If not, two approaches:

(1) Different hats: use judge sitting in COP and tribunal.

(2) Ducks in a row: tribunal adjourn, make provisional discharge or defer discharge for MCA authorisation to be arranged.

DOL and Conditional Discharges

HM Prison & Probation Service

Mental Health Casework Section

Guidance:

Discharge conditions that amount to deprivation of liberty

January 2019

Section 17 Leave

S17(3): "Where it appears to the responsible clinician that it is necessary so to do in the interests of the patient or for the protection of other persons, he may, upon granting leave of absence under this section, direct that the patient remain in custody during his absence; and where leave of absence is so granted the patient may be kept in the custody of any officer on the staff of the hospital, or of any other person authorised in writing by the managers of the hospital or, if the patient is required in accordance with conditions imposed on the grant of leave of absence to reside in another hospital, of any officer on the staff of that other hospital."

- Responsible clinician may grant leave indefinitely or for specified occasions or period (with MoJ permission for restricted patients).
- Conditions may be added if "necessary in the interests of the patient or for the protection of other persons".
- MHA s137: person authorised has "all the powers, authorities, protection and privileges which a constable has within the area for which he acts as constable".
- MHA s138: if escapes, may be retaken.

Section 17 Leave

- Patient does not remain an in-patient.

- Hospital treatment must comprise a "significant component" of the treatment plan:
  - –May be minimal (eg attendance for monitoring or ward round) but must be essential (*Hallstrom, DR, CS*);
  - –Example of no hospital treatment = *DB v Betsi Cadwaladr UHB* [2021] UKUT 53 (hence discharged from detention);
  - –Broad definition of "hospital" – includes any institution for the reception and treatment of persons suffering from illness as well as clinics, dispensaries and out-patient departments maintained in connection with any such institution (NHS Act 2006 s.275(1)).

Conditional Discharges: With Capacity

Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG [2021] EWHC 2990 (Fam)

Conditionally discharged and had capacity to make relevant decisions. Technically recalled after *MM* and placed on s.17(3) leave. Tribunal found no element of hospital treatment so discharged him. Appealed.

> 70… It is therefore possible to read the sub-section that makes "liable to be detained" mean liable in law to be detained for treatment, even where that treatment is being provided in the community, so long as it could lawfully be provided in hospital.
>
> 74. It is therefore possible to construe s.72 as to not require the Tribunal to discharge, even where the link to the hospital is tenuous (as here), where such a construction is necessary in order to avoid a breach of Article 5…

Obiter: cannot use inherent jurisdiction to authorise confinement of capacitous person.

Consequence? Likely to lead to greater use of s.17(3) leave for those with capacity.

Restricted Patients - long-term s17(3) escorted leave of absence

The Secretary of State would consider consenting to a s17(3) long-term escorted leave of absence in these circumstances, with conditions that require constant supervision, if that would be a safe and appropriate way of enabling the patient to continue treatment and rehabilitation away from the hospital, while remaining a detained patient.

Such a leave of absence would not be permanent, and the Secretary of State will generally only provide his consent for a maximum of 12 months at a time and would review the appropriateness of it continuing when the responsible clinician applies for an extension.

MoJ 2019 HMPPS Report Template (publishing.service.gov.uk)

Implications of extended & long term s17 leave

- ***For the Person:***
  - Enables community living, least restrictive environment
  - Can enable building confidence in risk management in the community
  - Registering details with police if on specific registers – receiving visits
  - Finance – see later

- ***For Providers:***
  - Enables longer community based risk testing with safety of immediate hospital recall if needed
  - Accepting delegation of custody for a detained patient – responsibility and powers
  - Requires adjustment to some procedures and how providers operate (reporting procedures etc.)

Implications of extended and long term s17(3) leave

- ***For Clinical Teams:***
  - Enables greater detailed risk testing and information to support least restrictive environment
  - Clinical reviews and MDT (inpatient vs community) – need clarity of what is delegated and what is not
  - Inpatient bed to recall to if needed – virtual vs physical
  - Provision of physical health services for proactive checks
  - Need to demonstrate continued need for inpatient treatment at Tribunal – becomes harder the longer leave continues

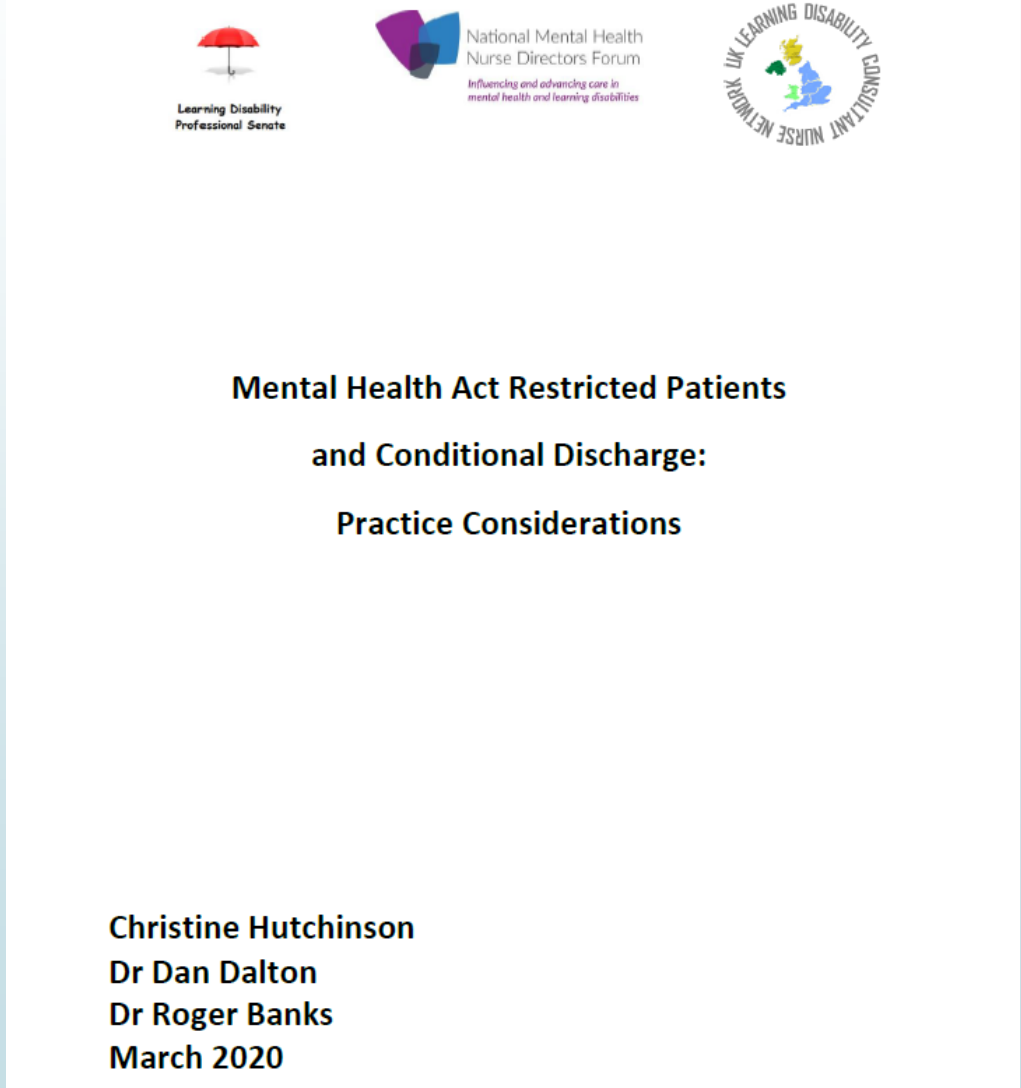
- ***For Commissioners:***
  - Limited finance (s3 s37 & CPI) or no benefits (s47)
  - Funding of inpatient bed availability and community solution (staffing; rent; utilities; food; rehabilitation activities; transport; expenses)
  - Personal finance – not able to claim full benefits or housing benefit

- ***MAPPA and Police Notifications:***
  - Need to ensure local police are aware someone is in their locality on s17 leave

Practice Guide

- Published March 2020
- Available here https://www.bild.org.uk/wp-content/uploads/2020/04/MM-practice-Guidance-FINAL.pdf
- Also here https://mhforum.org.uk/publications

- **Update in progress to be issued May/June 2022**



Review and Monitoring in the Community

Guidance Here [Working with restricted patients - GOV.UK (www.gov.uk)]

Monitoring in the community

The purpose of the formal supervision resulting from conditional discharge is to protect the public from further serious harm

It is important that, wherever practicable and possible, conditionally discharged patients are supervised in such a way as to sustain public confidence in the arrangements as a whole, and so as to respect the feelings and possible fears of victims and others who may have been affected by the offences.

The Secretary of State's ability to act effectively is reliant on the quality of information he receives from individual supervisors. He recognises that this places great reliance on the personal skills and dedication of supervisors.

Supervisors should therefore have a positive and constructive approach towards the patient's social rehabilitation rather than simply monitoring progress.

Close supervision is important

Monitoring in the community

Minimum contact: least once each week for at least the first month after discharge reducing to once each fortnight and then once each month as the supervisors judge appropriate.

Close liaison between the supervisors is essential if supervision is to be effective.

- ***Clinical Supervision:***
  - Responsible Clinician – responsible for all matters relating to health of patient (includes wider determinants)
  - Can delegate aspects of clinical supervision to others
  - Must have cover for off duty and absences
  - MoJ guidance on the role – being updated

- ***Social Supervisor:***
  - Usually a Social Worker
  - Must have cover for off duty and absences
  - MoJ guidance on the role – being updated

- ***CPA/MDT meetings:***
  - Best held just before each report submission
  - Should lead to an update of the joint s117 aftercare plan

Reports to MoJ

Every CPA or risk management plan should include a contingency plan to deal with any relapse. This should be regularly reviewed and updated and copies sent to the Ministry of Justice.

It is absolutely crucial to the effectiveness of your supervisory role that reports should be comprehensive and honest.

- One month after conditional discharge
- Three monthly after that unless otherwise stated by MoJ

- Joint report in three parts
    1. Demographics
    2. Social supervisor section
    3. Clinical supervisor section
- Need to be completed in that order

Submit a conditional discharge report for restricted patients - GOV.UK (www.gov.uk)

Reports to MoJ

- Supervision arrangements
- Accommodation
- Care, support and treatment
- Relationships
- Activities & Achievements
- Finances
- Victim/victim group exposure
- Behaviours and risks
- Drugs and alcohol
- Criminal activity
- Diagnosis
- Treatment
- Physical Health
- Suicide & Self harm
- Admissions

Plans and Changes

- Must be explored with both clinical and social supervisors. Some changes may require permission.

- Holidays – consider very carefully
  - Risk management
  - Supervision arrangements
  - Locations
  - Police notifications

- Accommodation/Address

- Care, support and treatment

Changes to conditions

- Useful to explore with both clinical and social supervisors who, if supportive, they may be able to facilitate the changes desired with the MoJ.

- Change requested in writing, practical change after confirmation of approval/change received in writing

- Removing all conditions:

  there is nothing intrinsically irrational in removing the conditions while maintaining the liability to recall DA v Central and North West London NHS Foundation Trust [2021] UKUT 101 (AAC)

Tribunal Rights

- No right to tribunal in first 12 months post discharge
- Right of application starts after 12 months post conditional discharge
- Right of application starts 24 months after each tribunal hearing
- Can be referred in same timescales if lack capacity to apply/instruct representation
- Tribunal can consider applications for change of conditions or an absolute discharge
- Automatic referral to tribunal if recalled under warrant
- if admitted under civil section rather than full recall - tribunal rights as per s2/3

Lawfulness of the conditional discharge

- aspects that need consideration
  - Does the person continue to lack capacity
  - Do the circumstances still amount to Deprivation of Liberty (DoL)
  - Is DoL still necessary and proportionate
  - Is the DoL still lawfully authorised
  - Would an absolute discharge be appropriate

Recall

Guidance here Recall of conditionally discharged restricted patients - GOV.UK (www.gov.uk)

Recall

- If the person is a risk to themselves or others
  - Breaching conditions but not increasing risk does not warrant recall
- Is an admission needed? Consider stepping up community offer
- Would a civil admission suffice (s2/3)?
- Is recall onto 37/41 needed
  - Supervisors in person review of the patient
  - Supervisors liaison with MoJ
  - Bed finding – NHSE Spec Comm / Lead Provider Collaborative
  - Warrant issued

Those who become subject to recall

- Highlights questions that need to be answered to ensure all systems and agreements are in place
  - Is the grounds for recall linked to deteriorating mental state and/or increasing risks
  - Do the circumstances amount to 'technical recall' with a view that long term section 17(3) leave is needed/agreed
  - Are there system and case specific arrangements in place for both
- Technical recalls fall outside how services currently work; need to work collaboratively; think flexibly and creatively to find the best local solutions

Absolute Discharge

Guidance here [Lifting restrictions on restricted patients - GOV.UK (www.gov.uk)]

Absolute Discharge

MHCS's policy is not to grant absolute discharge unless it is clear that the restrictions are no longer required to ensure the patient's safe management. This means that the Secretary of State will not grant absolute discharge where the patient still has a mental disorder, and has the potential to present a risk to others if not well supervised in the future, and where future supervision is not guaranteed.

- The Tribunal is not satisfied that the 's3' criteria for detention are met.
- The Tribunal is satisfied that 'it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment'

- Additional case law criteria to meet

Absolute Discharge via FTT

*nature, gravity and circumstances of the patient's **offence**, the nature and gravity of his **mental disorder**, past, present and future, the risk and likelihood of the patient **re-offending**, the **degree of harm** to which the public may be exposed if he re-offends, the risk and likelihood of a **recurrence** or exacerbation of any mental disorder, and the risk and likelihood of his **needing to be recalled** in the future for further treatment in hospital. The Tribunal will also need to consider the nature of any **conditions previously imposed**, whether by the Tribunal or by the Secretary of State, under sections 42(2), 73(4)(b) or 73(5), the **reasons why** they were imposed and the extent to which it is desirable to continue, vary or add to them.*

*one of the key questions that the Tribunal will wish to ask itself …. is **whether** it is "**satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment**."*

R (SC) v MHRT [2005] EWHC 17 (Admin)

It is lawful (but not necessary) for the panel to place on the patient the burden of demonstrating the inappropriateness of continuing liability to be recalled

RH v South London and Maudsley NHS Foundation Trust [2010] UKUT 32 (AAC)

Absolute Discharge via MoJ

The Justice Secretary can discharge under s42(2) either absolutely or conditionally. No criteria are set out – the Act says 'if he thinks fit' – though obviously similar considerations would apply. A Ministry of Justice discharge would follow a recommendation from the patient's RC, but such discharges are rare.

Mental Health Law online

In LSC learning disability Services – two absolute discharges achieved

- Case 1 man moved across boundaries; clinical and social supervision lapsed as a result of poor communication and handover; provider had changed supervision levels outside the conditions; no risks evident – couldn't demonstrate necessity to manage risk
- Case 2 man lacked capacity; case was CoP authorisation provided greater public protection and authorisation of plan; recall into forensic hospital would not be required.

Further information

- Mental Health Law on line www.mentalhealthlaw.co.uk
- LPS Law https://www.lpslaw.co.uk/

- NHSE MHA public page Mental Health Act - NHS (www.nhs.uk)
- NHSE MHA Easy read leaflets Mental health act (easy read) - NHS (www.nhs.uk)

- MoJ MHCS forms and guidance Working with restricted patients - GOV.UK (www.gov.uk)

- MoJ Mental Health tribunal info First-tier Tribunal (Mental Health) - GOV.UK (www.gov.uk)
- MHRT forms and guides incl easy read Mental Health Tribunal forms and guidance - GOV.UK (www.gov.uk)

- Parole Board easy read Easy Read guides for prisoners - GOV.UK (www.gov.uk)