
GARDEN COURT
CHAMBERS

Overlapping problems in the Court of Protection and the First-Tier Tribunal (Mental Health)

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Introduction

- Capacity to make an application to the First-tier Tribunal
- Capacity during First-tier Tribunal
- Mental Health Act patient in the Court of Protection
- ‘Best endeavours’ on s.117 discharge

Capacity to make an application to the First-tier Tribunal

- *SM v Livewell Southwest CIC* [2020] UKUT 191 (AAC)
- Decision to strike out application for discharge appealed
- Majority (2:1) dismissed appeal
- Dissenting judgment – 'the relevant information'
- *RD and Others (Duties and Powers of Relevant Person's Representatives* [2016] EWCOP 49

Capacity during FtT

- Appointment of a representative – see Law Society Practice Note (appendix D, Jones')
- Rule 11(7)(b) In a mental health case if the patient has not appointed a representative the Upper Tribunal may appoint a legal representative for the patient where—

(b) the patient lacks the capacity to appoint a representative but the Upper Tribunal believes that it is in the patient's best interests for the patient to be represented

- 'This capacity issue should be considered and kept under review by all involved and so the responsible clinician, the hospital managers, a tribunal appointed representative, any representative who has been or has purportedly been appointed by the patient and the tribunal itself' (para 105)

Capacity during FtT

- *YA v Central and NW London NHS Trust & ors* [2015] UKUT 0037 – to have capacity = to appreciate his/her ability to conduct proceedings unaided
- i) the underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reasons for the detention,
- ii) the vulnerability of the person who is its subject and what is at stake for that person (i.e. a continuation of a detention for an identified purpose),
- iii) the need for flexibility and appropriate speed,
- iv) whether, without representation (but with all other available assistance and the prospect of further reviews), the patient will practically and effectively be able to conduct their case, and if not whether nonetheless
- v) the tribunal is likely to be properly and sufficiently informed of the competing factors relating to the case before it and so be able to carry out an effective review

Mental Health Act patient in the Court of Protection

- *MC v Cygnet Behavioural Health Ltd and Secretary of State for Justice* [2020] UKUT 230 (AAC)

- Long term s.17(3) leave in nursing home; still needs medication but no longer needed to be in hospital; applied for conditional discharge, adjourned to obtain standard authorisation; FtT – regretted – could not conditionally discharge conditions with conditions which amounted to a deprivation of liberty and refused to discharge her.

- UT Judge Jacobs quoted from *MM* (para 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'.*

Mental Health Act patient in the Court of Protection

- Guidance January 2019 (Mental Health Casework Section)
- 'While the MCA does allow for a DoL where the best interests requirement is met on the basis of preventing the patient from re-offending, generally, the Secretary of State considers that such patients are best managed under the provisions of the MHA' (para 4.2)

- *Birmingham City Council v SR* [2019] EWCOP 28
- SR and JTA – both lack capacity to make decisions re care package, liberty and where to live

- *DN v Northumberland, Tyne & Wear NHS Foundation Trust* [2011] UKUT 327 (AAC) – CoP can make orders in advance of discharge under MHA

‘Best endeavours’ on s.117 discharge

- *R (on the application of H) v Secretary of State for the Home Department* [2003] UKHL 59 “no power to require any psychiatrist to act in a way which conflicted with the conscientious professional judgement of that psychiatrist” (Lord Bingham para 29)

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Focus on the Court of Protection: Issues

- The lawfulness of the discharge from detention under the Mental Health Act 1983 to circumstances of detention under Mental Capacity Act 2005 – requirement of a DOL
- Discharge RC, Managers, or Tribunal
- S 3, s 37, s 17 and CTOs: Classes of patients e.g. dementia or severe brain injury. In addition 37/41 and Conditional discharge - Helen
- Approach of the Court of Protection, what procedures are used.
- Capacity disputes
- Best interest disputes
- Limits and problems of s 17 leave
- Resolution of other conflicts, s 117 Mental Health Act 1983, CHC needs and Care Act 2014 needs

Supreme Court

- Since the Supreme Court in *MM* [2018] UKSC 60 and *Welsh Ministers v PJ* [2018] UKSC 66, issues have remained about the position of individuals lacking capacity to make decisions about residence and care arrangements (the individuals in both cases having that capacity). Can they leave hospital into circumstances of deprivation of liberty either on a community treatment order or by way of conditional discharge, where that deprivation of liberty is authorised by way of either the Court of Protection or DoLS? Or does the Supreme Court's approach in those two cases that any confinement to which the person is subject is unlawful?

- In *Welsh Minsters v PJ* [2018] UKSC 66 the Supreme Court held that there was no implied power in community treatment orders which have the effect of depriving a patient of his liberty.

- Baroness Hale turned to the real issue in the cases as to whether the power to impose conditions amounting to a deprivation of liberty could be read into the Mental Health Act 1983 by necessary implication. She considered that the approach of the Court of Appeal had been to put before the cart before the horse, taking the assumed purpose of a CTO - the gradual reintegration of the patient into the community - and works back from that to imply powers into the Mental Health Act 1983 which are simply not there.

Applying *MM* in *PJ* Baroness Hale – RC powers

"[…] the MHA does not give the RC power to impose conditions which have the concrete effect of depriving a community patient of his liberty within the meaning of article 5 of the European Convention. I reach that conclusion without hesitation and in the light of the general common law principles of statutory construction, without the need to turn further to the jurisprudence of the European Court of Human Rights or to resort to the obligation in section 3(1) of the Human Rights Act 1998 to read and give effect to legislation in a way which is compatible with the Convention rights. However, it is doubtful, to say the least, whether the European Court of Human Rights would regard the ill-defined and ill-regulated power implied into the MHA by the Court of Appeal as meeting the Convention standard of legality."

MM in *PJ* Baroness Hale – Powers of the MHT

- "[...] The MHRT has no jurisdiction over the conditions of treatment and detention in hospital, but these can be relevant to whether the statutory criteria for detention are made out, especially in borderline cases. The RC's report to the tribunal must cover, inter alia, full details of the patient's mental state, behaviour and treatment; and there will also be a nursing report and a social circumstances report (Tribunals Judiciary, Practice Direction, First-tier Tribunal Health Education and Social Care Chamber, Statements and Reports in Mental Health Cases, 2013). His treatment and care may well feature in the debate about whether he should be discharged. The tribunal may recommend that the RC consider a CTO and "further consider the case" if the recommendation is not complied with (section 72(3A)(a)). Similarly, the tribunal has no power to vary the care plan or the conditions imposed in a CTO, but the tribunal requires an up to date clinical report and social circumstances report, including details of any section 117 aftercare plan. The patient's actual situation on the ground may well be relevant to whether the criteria for the CTO are made out. Furthermore, if the tribunal identifies a state of affairs amounting to an unlawful deprivation of liberty, it must be within its powers to explain to all concerned what the true legal effect of a CTO is. But the patient can only apply to the tribunal once during each period for which the CTO lasts (six months, six months, then once a year). If the reality is that he is being unlawfully detained, then the remedy is either habeas corpus or judicial review."

Relevant powers of the Responsible Clinician

- Often a vital precursor to discharge is the grant of leave under s 17 of the Mental Health Act 1983, save for when you have restriction under s 41 this is at the discretion of Responsible Clinician under s 17 of the Mental Health Act 1983 – often identification and authorisation of a specific placement or type of accommodation. It could be a specialist care placement or a discharge home with a proposal of support at home.
- CTOs are open to RC to consider leave on a long terms basis under section 17A of the Mental Health Act 1983
- Apart from the express power is section 17(3) Mental Health Act 1983:

  > 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.

  There is no power to detain or deprive patient of liberty save for conveyance (see s 18(7) and 137 Mental Health Act 1983
- The limits of the RC's is reinforced by s 132A(1) Mental Health Act 1983 and the Code of Practice

PJ and discretionary issue of CTO

- The discretionary CTO conditions in PJ's case expressly required compliance with his care plan, in which the deprivation of liberty was to be located. What if that condition was absent, but the concrete situation of the care plan amounted to a deprivation of liberty? As PJ had capacity, he should logically have been entitled to agree to or refuse those care arrangements. And if he lacked capacity to do so, the MCA could be used to authorise the deprivation of liberty.
- Since the decisions of the Supreme Court in *MM* and *PJ*, issues have remained about the position of individuals lacking capacity to make decisions about residence and care arrangements (the individuals in both cases having that capacity). Can they leave hospital into circumstances of deprivation of liberty either on a community treatment order or by way of conditional discharge, where that deprivation of liberty is authorised by way of either the Court of Protection or DoLS? Or does the Supreme Court's approach in those two cases that any confinement to which the person is subject is unlawful?
- As reported in a blog by Alex Ruck Keene on 8 July 2020 in the https://www.mentalcapacitylawandpolicy.org.uk/ctos-and-community-deprivation-of-liberty-some-welcome-clarity/ on 5 July 2020 Hayden J took the view in relation to CTOs that there was no jurisdictional bar to the Court of Protection authorising deprivation of liberty of a person on a CTO lacking the material decision-making capacity, so long as the conditions on the face of the CTO did not give rise to a confinement.

So how do we go about this?

- No power exists to deprive a patient of their liberty when granted leave of absence under section 17 of the Mental Health Act 1983.
- Thus if the implementation of the care plan of a mentally incapacitated individual has the effect of depriving them of their liberty the deprivation may be authorised either under Sch.A1 of the Mental Capacity Act 2005 or under section 16(2)(a) of the Act.
- If it is possible for the procedure to be used under Schd A1, an application should not be used for authorisation (see *A Local Authority v PB* [2011] EWCOP 2675 para 64(iii)). An authorisation can only be granted if there is no conflict between it and a condition of the patient's leave: see Sch.1A, case B.
- The cases of *A Hospital Trust v CD* [2015] EWCOP 74 and *R (on the application of Ferreira) v HM Coroner for Inner South London* [2017] EWCA Civ 31 identify the key issues on deprivation of liberty.
- Limits of 21A – does not apply to all care placement and does not apply deprivation of liberty in a domestic setting.
- Key point of when to engage with Court of Protection.

Limit of the jurisdiction of COP

- COP concerned with determining “best interests”: s 16 MCA
- Public body responsible for “well-being”
- In the context of the Care Act 2014 and best interests decisions a failure to promote a person’s well-being may constitute a breach of the statutory duty under section 1 of the Care Act 2014 with the “well being” duty under section being under section 1(2).
- In the context of the Court of Protection a public body will seek to make an application to the court, especially when there are safeguarding issues or to be a party to an application for example within the DOLS framework
- Options for care packages and discharge of statutory duties
- The question which arises therefore is to what extent may the Court of Protection compel the a public body to discharge its statutory duties and functions in a certain way or make specific funding decisions or deliver a care package in a particular time frame or ensure, for example, there are sufficient resources available to meet the needs of disabled people in its area and comply with policies, and authorise deprivation of liberty and packages of care as in persons best interests.
- Role of parallel proceedings?

Potential problems

- S 21A proceedings not means tested legal aid
- S 16 proceeding means tested – could this raise an access to justice issue? Particularly when patient in Tribunal can access non-means tested legal aid? How will their interests be represented if they do not have sufficient means to pay. Also role of financial deputy authorising litigation.
- Best interests options – what if conflict with s 17 leave? How is this resolved
- Care packages:
  - S 117 After care – no contribution but with option of top ups (funding decisions)
  - CHC – no contribution
  - Care Act 2014 – aspects of care may fall outside s 117 means tests.
  - Implication for funding packages
- Fact finding hearings and evidence from RC and other parties on Best Interests – can be lengthy process
- What is COP does not authorise DOL or not consider chosen placement in persons BI despite they are ready to be discharged and no basis to detain them in hospital further?

Problems with funders: guiding case law

- *A v A (Health Authority)* [2002] Fam 213; *Re S (Vulnerable Adult)* [2007] 2 FLR 1095.
- Supreme Court in *Re MN (N v ACGG and ors)* [2017] UKSC 22 and prior to that in the Court of Appeal in *Re MN (An Adult)* [2015] EWCA Civ 411.

- Guiding principle:
  "The function of the Court of Protection is to take, on behalf of adults who lack capacity, the decisions which, if they had capacity, they would take themselves. The Court of Protection has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party, whether a private individual or a public authority, than the adult if he had capacity would be able to obtain himself."

- The caveats
- Delays in enacting care plans
- The process in bringing a claim in the Administrative Court? When can you bring one? What processes might impede the claim
- Decision making in the Administrative Court – how it differs from the Court of Protection
- Process over merits

Funding and Legal Aid

- In respect of section 21A proceedings non-means tested Legal Aid is available for P and the RPR, for other parties it will dependent on their eligibility for funding.
- In respect of personal welfare application under section 16 of the Act. Funding is available but subject to means testing and you can have the perverse scenario where is a respondent is funded but not P.
- Funding for any deputyship applications are out of scope unless you can secure exceptional funding
- Funding for end of life issues means tested
- OS will only act where there are funds and where lack of funds may seek an indemnification from Public \body
- Other litigation friends and ALR
- Funding other than Legal Aid. Little option other than privately funding – seems perverse when dealing with issues of liberty

Conclusions and questions

- Difficult and complex system to navigate
- Potential for injustice and unfairness
- May not meet someone's needs or best interests
- A great potential for conflict between various statutory bodies e.g RC v COP, funding decisions and best interests
- Reform of legislative framework and funding of complex care packages?
- Northern Ireland draft legislation – one legislative scheme
- Reform of MHA 1983 in UK
- Role of the Administrative Court – delay?
- "bully pulpit" of the COP judge and role of mediation and co-operation in COP proceedings?

Thank you

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