Where's the MHT going?

The MHT is changing

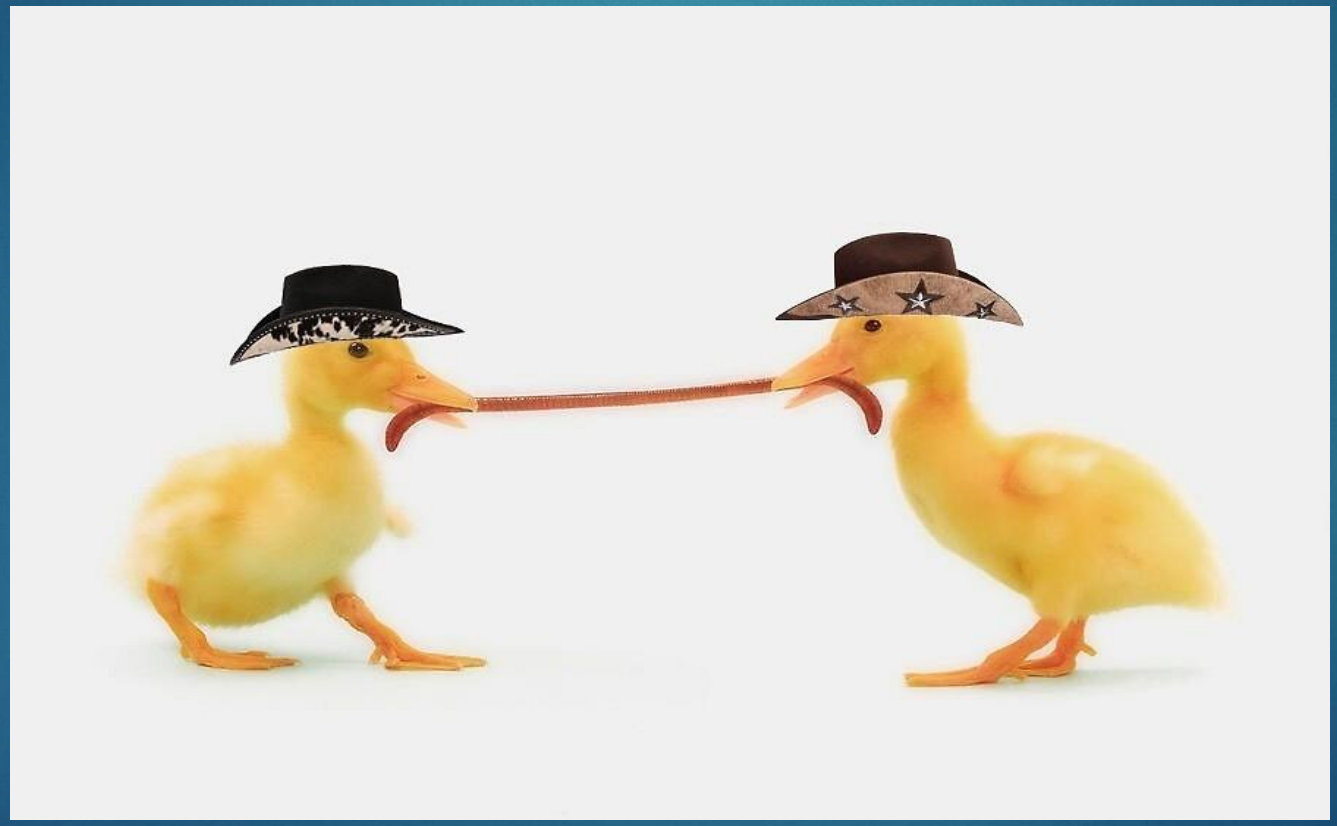
- We're still in the early stages, but the way cases are presented in the MHT is fundamentally changing
- In the longer term that's because of the proposed new legislation, which among many other things will allow the MHT to authorise what is called 'supervised discharge' for restricted patients. What that means is that the MHT would have the power to authorise a post-discharge DoL
- But the MHT can kinda do that already, even though they and everyone else has to pretend that they're not doing it. And that is causing confusion and perplexity…

The old platitudes don't work any more

- There's one MHT judge who (in my experience) approaches every restricted case in precisely the same way: he always asks 'Has the patient had unescorted community leave?'
- If the answer is no, then you can forget discharge
- There are obvious problems with this approach – e.g. if unescorted community leave is a precondition to discharge, then what is the point of Tribunals?
- Leave is solely in the gift of the RC and the SSJ, so on this judge's approach, it is they who decide whether and when the patient will be discharged
- It takes us back to the pre X v. UK days, when it was the SSJ and not the Tribunal who decided whether restricted patients were entitled to discharge
- The situation is made worse by the approach of the higher courts to judicial supervision of leave and transfer decisions, encapsulated in the judgment of the LCJ in YZ [2017] EWCA Civ 203 at para. 88 (it relates to transfers but applies by analogy to decisions about leave).
- So the patient's chances of discharge without leave are close to zero, as are his chances of challenging a decision to refuse to grant that leave.
- And so the courts and tribunals are often of no use to restricted patient who wants his liberty back
- But following the fallout from MM, unescorted leave need not always be a precondition to discharge

Ducks* and hats

*or possibly cygnets



MC v Cygnet Behavioural Health Ltd and Secretary of State for Justice (Mental health) (Rev 1) [2020] UKUT 230 (AAC)

- This case did not create new law, but it is useful because it summarises a line of authority that emerged after MM, and endorses it
- In a nutshell, it states the principle that a DoL conditional discharge is lawful as long as the DoL is authorised (under the MCA), and as long as the MHT doesn't itself purport to authorise the DoL
- What this means in practice is that if a patient (a) has demonstrated that he's safe while escorted, and (b) lacks capacity to make decisions about what's needed to manage the risks he's assessed as presenting, then (c) it's arguable that he's entitled to a DoL CD even if he hasn't had (and will never have) unescorted community leave
- I don't see why the same principles could not apply to unrestricted patients: if the COP can authorise a DoL to run alongside a CD, why couldn't it also authorise a DoL to run alongside a CTO or guardianship?
- Of course, the MHT cannot direct a CTO or guardianship, so patients' lawyers would need to seek the cooperation of the RC, and look at judicial review if they didn't get it.

Patients who don't understand what's needed to manage their risks

- This is where is gets tricky
- Many (perhaps even most) patients are detained in hospital because they do not acknowledge the risks inherent in being released
- You might even say that a patient who is asking the MHT for discharge, against the recommendation of his clinical team, by definition doesn't understand the risks – otherwise, why would he be asking for discharge?
- There are interesting questions (discussed in a few academic papers) about whether there's a difference between insight and capacity
- But in at least some individual cases, it seems to me that it's possible to say that a patient who lacks insight into his risk (and hence into what's needed to manage it) will also be unable to understand the information relevant to the management of his risks, and/or to retain or use or weigh that information when making a decision, and it will be arguable that it's in his best interests to be supervised (for the reasons quoted at para. 22 of MC)
- This is increasingly common as the basis for applications for discharge of restricted patients diagnosed with learning difficulties
- But it could apply equally to patients with schizophrenia, or dissocial PD, or bipolar disorder. It could apply to the many now elderly men who have committed grave offences, and are detained in low security, and who have had years of escorted leave but will never be granted unescorted leave because the risks are assessed as being too high, even after decades of treatment
- But my main point is this: in these cases, the question of unescorted community leave doesn't arise, because there's no need to do a dry run *before discharge* for something you're not planning to do *after discharge*
- And so the MHT needs to ask itself new and troubling questions

Old habits die hard

- The problem for some MHT judges is that this new approach is a challenge to the way they've approached cases for years
- They can no longer trot out the same old easy reasons for refusing discharge (such as the lack of unescorted community leave)
- They have to start afresh, and examine unfamiliar concepts like capacity and best interests, and must really interrogate what the old cliches about insight mean
- And they have to dive into the ridiculous procedural complexities of the MC approach, which means a lot of adjournments and delay
- As you can imagine, they don't like it

The procedural maze

- The complexity of the current procedure is exemplified by UTJ Jacobs resorting to comedy analogies to explain how it might be done: "ducks in a row" and "different hats" (although he gets confused and refers to the latter as "the same hat approach" in para.32)
- It results from the need for one jurisdiction (the MHT) to invoke another jurisdiction (the COP) in order for the first jurisdiction to do its statutory duty. One might even ask whether the MHT's jurisdiction – in a practical sense – has survived all this…
- The two jurisdictions operate on different principles, have different rules, and different funding regimes apply to each. The last difference is not trivial - in one case of which I'm aware, the patient was not entitled to legal aid for the COP and (understandably) refused to use his meagre savings to make an application to it. The local authority and responsible authority also did not want to apply, and so the application before the MHT ground to a halt.
- But in this situation the MHT needs a COP decision as a precondition to making its own decision – because otherwise it cannot know whether detention in hospital is necessary, and hence whether the s.72(1)(b)(ii) MHA criterion is satisfied.
- What is the patient to do in this situation? Seek judicial review of the authorities' refusal to go to the COP? Nope, because he'd need to pay for that too.
- As applications on this basis become more common, these problems will become more acute. It is a mess, and arguably violates art.5(4)
- Now consider a further complication. The patient is a restricted transferred prisoner, detained under ss.47 and 49 MHA. He needs to (a) persuade the MHT that theoretically he'd be entitled to discharge on the basis of a theoretical authorisation of a DoL by the CoP alongside theoretical aftercare, and *then*, if he gets that, he needs to turn theory into practice before the Parole Board, and persuade them that he can be released on licence conditions alongside a DoL (as far as I'm aware that has never yet been done). That's as long as licence conditions (or, e.g., a SHPO) cannot authorise a DoL, which as far as I'm aware has never been tested.

The real problem, reductio ad absurdum

- When something is as ridiculously messy as all this is, one must ask whether it indicates that something deeper has gone wrong.
- In my view it does, and it has.
- The vast majority of people who are detained are manageable if they are supervised 24 hours a day.
- That is, after all, why they are detained in hospital.
- But if one reasons from the principles in the recent authorities, it's possible to envisage huge numbers of such patients being entitled to discharge *because* they lack insight into what's needed to manage the risks they present to themselves or others.
- Not only that, but we know research suggests that large percentages of prisoners are suffering from personality disorder. An habitual burglar may well be suffering from a dissocial PD, and as a result lack insight into the need for management of the risks arising from that PD (i.e. burgling). But if he's supervised 24 hours a day, that risk could be managed. So could it be argued that (a) he suffers from a mental disorder, as a result of which (b) he lacks capacity to make decisions about what's needed to manage that risk, so that (c) it's in his best interests for him to be DoL'd, and hence (d) he need not be detained in prison or hospital?
- This is obviously absurd. We would end up with almost every patient and prisoner being dealt with under the MCA. And we'd then need to find buildings in which all these people could be supervised 24 hours a day. And those buildings would look very like secure hospitals and prisons. And so the circle closes.
- The thing is, this problem isn't going away. The new supervised discharged regime (if enacted) will entrench it. And patients' lawyers have a duty to follow the current authorities in building their clients' cases, which, for now at least, means looking at whether a DoL route out of hospital (or prison) is viable.

What about patients with capacity?

- For a time, it was thought that even patients with capacity could be the subject of a lawful DoL upon discharge: Hertfordshire County Council v AB [2018] EWHC 3103 (Fam)
- The inherent jurisdiction was invoked to give parity (you might even say equality) of rights to patients who could be discharged as long as their aftercare amounted a DoL
- That approach has since been deprecated: first by the SSJ in his post-MM guidance; then by Cobb J in Wakefield Metropolitan District Council and Wakefield Metropolitan Clinical Commissioning Group v DN and MN [2019] EWHC 2306 (Fam) – see especially paras 27, 37, 48 and 49. See also A Health and Social Care Trust v O and R [2020] NIFam 23, at para 76- 78 and 87.
- So now, if a patient wants and expressly asks for close supervision after discharge, he can't have it; but if he doesn't know that he needs it and would probably object if he did, then he can.
- Makes perfect sense

More on the inherent jurisdiction- and the Supreme Court

- You might think that a statutory procedure for dealing with a particular issue would preclude the use of the inherent jurisdiction. In his lecture of 10 December 2020 "Whither the inherent jurisdiction?" to the Court of Protection Bar Association, Sir James Munby provided 35 pages of analysis of the inherent jurisdiction and its limits. One of those was the De Keyser principle, where, as applies to the exercise of prerogative powers, the existence of a statutory scheme would oust the inherent jurisdiction.
- See however the Supreme Court decision Re T (A Child) UKSC 35. This held that it is lawful to accommodate children in secure accommodation that does not meet the regulatory requirements in relation to such accommodation where such arrangements are necessary for the protection of a child against risks of the gravest kind.
- This is a case about children, not incapacitated adults, but the court held that it was lawful to accommodate children in secure accommodation that fell outside the statutory scheme (albeit in circumstances where there is a statutory duty to accommodate the child).
- The appellants had not taken the point that the inherent jurisdiction was not available until the case reached the Supreme Court, so the arguments were somewhat hypothetical.