



# **Mental Health Act Restricted Patients and Conditional Discharge: Practice Considerations**

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## **Version 2 Acknowledgments:**

Updated in 2022 as part of release of multiple information sources relating to conditionally discharged patients and their rights<sup>2</sup>

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<sup>1</sup> These are people’s details as at March 2020 when version 1 was published.

<sup>2</sup> <https://advocacyfocus.org.uk/services/independent-mental-health-advocacy-imha/> under the subheading rights leaflets and here <https://advocacyfocus.org.uk/news/masterclass-on-conditional-and-absolute-discharge/> for broader links and information

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## Introduction

This document has been developed by clinicians to support their peers and colleagues in progressing the clinical pathway for Mental Health Act (MHA) Restricted Patients, namely those on sections 37/41 sections 47/49 or CPI (restricted)<sup>3</sup> and those conditionally discharged in the community.

This document should be read alongside the briefing paper from NHS England and NHS Improvement (August 2019<sup>4</sup>) and the Guidance issued on this matter by the Ministry of Justice Mental Health Casework Section (MHCS<sup>5</sup>) of the HM Prison and Probation Service (January 2019<sup>6</sup>). It is intended to complement these two publications by providing additional practice-based information to describe practice change required as a result of the impact of the Supreme Court's judgment in MM<sup>7</sup> until such time as the proposed changes in a new Mental Health Act become available.

In order to continue to progress the pathway for restricted patients, it is essential for teams to have a greater depth of information earlier in the clinical pathway to determine whether conditional discharge of the patient would be lawful. It is important that practitioners should try to keep up with developing case law relevant to this area.

There are three key questions that lead to the establishment of whether a conditional discharge would be lawful:

- Do the person's discharge arrangements amount to confinement (i.e. continuous/complete supervision and control without freedom to leave to live elsewhere)?
- Does the person have capacity to consent to their discharge arrangements (namely community accommodation, care and support)?
- Is the purpose of the arrangements to manage risks to the public, to prevent reoffending and can risks be safely managed in the community?

All restricted patients are affected to a greater or lesser extent by the judgment; at the very least discharges of restricted patients may be delayed whilst practitioners ensure, and judicial bodies secure, the collation of relevant evidence to ensure that the discharge would be lawful. At the other extreme the impact of the judgment may prevent the conditional discharge of a restricted patient.

The MHCS guidance proposes that for those who cannot be discharged, but whose risks can be safely managed in the community, the use of long-term section 17(3) leave may be considered appropriate. The MHCS guidance also highlights those that have already been conditionally discharged, who may be subject to a 'technical recall' can then be placed onto long-term section 17(3) leave. The implications of long-term section 17(3) leave and the delegation of MHA responsibility will be further explored below.

Whilst it is proposed to amend the MHA 1983<sup>8</sup>, any legislative changes are unlikely to be implemented for some years; clinicians and practitioners cannot await legislative change in making decisions about existing patients.

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<sup>3</sup> CPI - Criminal Procedure (Insanity) Act. Those detained under this are sometimes referred to as 'notional 37/41'

<sup>4</sup> <https://www.england.nhs.uk/wp-content/uploads/2020/03/updated-mm-pj-briefing-august-2019.pdf>

<sup>5</sup> Often referred to by patients as 'Ministry of Justice' or 'MoJ'; for those patients detained for some time they may refer to this service as the 'Home Office'

<sup>6</sup> <https://www.gov.uk/government/publications/discharge-conditions-that-amount-to-a-deprivation-of-liberty>

<sup>7</sup> <https://www.supremecourt.uk/cases/uksc-2017-0212.html>

<sup>8</sup> A new form of supervised community discharge has been proposed in the Mental Health Act Reform Bill.

This document also draws on the experience of a project conducted in Lancashire following the first case judgment in MM; some of their work is replicated with their permission.

## **Legal context**

In *MM v Secretary of State for Justice*, the Supreme Court held that, with few exceptions, the Mental Health Act 1983 prescribes the legal procedure for in-patient *hospital* detention. Thus, it is unlawful for a conditional discharge to amount to a deprivation of liberty. It is therefore only lawful to discharge a restricted patient if the conditions *restrict* – but do not deprive – the patient of their liberty. It is of course lawful to deprive liberty using a different procedure, such as the Mental Capacity Act 2005, but using the MHA to do so is not an option.

### ***Prison Transfer Patients:***

These restricted patients are affected to a similar extent where their section 49 remains in place at the time of appearing before the First Tier Tribunal (Mental Health).

The First Tier Tribunal (Mental Health) in their consideration of those restricted by virtue of MHA section 49 treat each case as if they were on sections 37/41 and as such the same parameters in terms of capacity, risk and discharge planning have to be met before the First Tier Tribunal (Mental Health) will consider recommending the person's case for consideration by the Parole Board. At this time information will be considered to determine if a recommendation for the person to remain in hospital should be made to the Secretary of State.

As such, whilst eventual release into the community of those prison transfer patients who remain in hospital (rather than transferring back to prison) is not affected by the Supreme Court judgment in MM, their access to the Parole Board is. The Parole Board will also need to see lawful authorisation of any arrangements amounting to a deprivation of liberty. In these cases, Responsible Clinicians should liaise with the patient's Probation Officer who will be able to give more detailed advice on the processes involved.

## **(In)capacity is key to discharge**

The Mental Capacity Act 2005 (MCA) provides that a person is assumed to have decisional capacity unless it is established that they lack capacity, and that all practicable steps need to be taken to enable the person to make the decision themselves. Helpful guidance is available in this regard from 39 Essex Chambers<sup>9</sup>.

It is currently unlawful for a restricted patient to consent to conditional discharge into community confinement and the First Tier Tribunal (Mental Health) cannot use conditions that singularly or cumulatively amount to a deprivation of liberty given they have no statutory powers to authorise such confinement.

The current legal landscape means that the determination of capacity indicates the legal processes available relating to the person's detention or discharge status where a conditional discharge is

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<sup>9</sup> <https://www.39essex.com/tag/mental-capacity-guidance-notes/>

sought. The case law at the time of writing highlights how the law can enable discharge of some, but not of others.

Capacity to decide on accommodation and care arrangements can change with time; those lacking capacity may regain it; those with capacity may lose it. It is therefore not an exact science or a permanent position and is dependent on the specific decision that needs to be made at a particular time. The concept of micro and macro decisions and of longitudinal decisions has been considered in the Court of Protection and will be explored further in the section on fluctuating capacity below.

For many restricted patients the assumption of capacity would complicate the possibility of discharge from detention. This consequence is significant to the person's human rights and, in this particular context, a formal capacity assessment is essential.

It would be unethical to lead a person to believe that they can achieve a conditional discharge and then, as they come close to that point, advise that this is not lawful. As such, where restricted patients need accommodation, care and support on discharge that amounts to confinement, the sooner the team identify those who have capacity to decide on their discharge arrangements, the better able they will be to define the person's pathway through services, put in place arrangements for regular reviews of the legal impact and be open and honest with the restricted patient about what can lawfully be achieved.

For restricted patients it is not possible to have accommodation in the community without the care and support as set out in the conditions of discharge and the care plan (including related documents such as risk mitigation plans). At the very minimum, these conditions will stipulate the address where the person must reside; the requirement for contact with their clinical supervisor and social supervisor; and their supervisor's access to the accommodation if reasonably required. These conditions alone restrict, but do not deprive, liberty.

#### **Sharing Practice:**

The Lancashire MM Project considered in depth how to frame the decision for the assessment of capacity in the context of restricted patients by reflecting on their experiences to date with those not restricted in the community and cases of restricted patients they had already successfully progressed through the legal processes. From the learning in the Lancashire project it is suggested that the decision should be framed as:

*Does P have capacity to decide on the community-based accommodation and support arrangements, including any control and supervision that may or will be proposed when they are ready for discharge?*

The Lancashire MM project assessed the capacity of all restricted patients (who had not already been assessed), regardless of level of security or duration of inpatient stay.

It is important to apply a level of rigour to the assessment of capacity to understand the proposed accommodation, care and support in the community including all conditions imposed, regardless of whether there is a deprivation of liberty implicit in the conditions or not. It is important to consider that this capacity assessment may be subject to scrutiny or challenge by any party involved.

#### **Executive Function:**

This is an area of significant importance in the capacity assessment of a number of people and is relevant to the field of learning disability and autism, in addition to acquired brain injury, but has been more widely commented on and researched in the latter field. There have been specific

publications on the impact of executive function in the capacity assessment process. George & Gilbert (2018)<sup>10</sup> consider that in many capacity assessments actual performance in practical terms is missing from people's approach and methodology, relying too heavily on verbal ability in a 'test' situation only. They cite Wood and Bigler (2017)<sup>11</sup> who stress that it is *'unwise, even negligent, to form opinions on how test performance is likely to influence everyday behaviour, without carefully interviewing those with direct experience of the person's real-world behaviour over a period of time'* (p.93). George and Gilbert (2018) articulate quite strongly that *'differences of opinion regarding the outcome of Mental Capacity Act (2005) assessments can have a profound impact upon the lives of people with whom we work. The stark reality is that this may place them in situations of high risk without adequate safeguards being put in place.'*

For those who have good verbal skills it is possible, for example through offender treatments, to arrive at a point where people are able to retain and recall very important information including options and consequences of options but not have sufficient cognitive ability to apply or use that knowledge in everyday situations. Understanding information from how a person functions on a day to day basis, from positive risk testing or from concerns and incidents formally recorded is important to a good quality capacity assessment. There is a fine line between not being able to use information at the appropriate time and making an unwise decision to set aside information and act contrary to what others may consider to be right. In this context the person conducting the capacity assessment requires a level of skill and may need the support of clinical specialists in the field.

So the functional assessment of capacity that considers the person's ability to use and weigh information is of significant importance. In *A Local Authority v AW* [2020] EWCOP 24, executive functioning was described as *"the ability to think, act, and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we've learned in the past, and use this information to solve problems of everyday life."* Ruck Keene et al<sup>12</sup> consider the learning from Court of Protection cases over a ten-year period where capacity was considered and highlight that *'most contested cases hinge on the 'use or weigh' ability and that good quality evidence on this ability is particularly pertinent'*. They cite the case of *NCC v PB and TB* [2014] EWCOP 14, where a deficit in executive functioning was tied to the inability to 'use or weigh'. The courts have stressed, for example in *Sunderland City Council v AS and Others* [2020] EWCOP 13, the importance of real-world observation. A single assessment is unlikely to be sufficient when determining whether repeated mismatch between what the person says and what they do is evidence of their inability to use and weigh.

It is therefore essential that the person's Responsible Clinician (RC) ensures that the Multi-Disciplinary Team (MDT) support the person assessing capacity, that all are agreed on the salient details of the decision and are aware of the approach and methodology to be taken. It is essential for whoever is assessing capacity to have access to all other relevant assessments and to read them. These will provide further evidence of capacity or lack of capacity. A good assessment needs a lot of preparatory work, and the ability of the assessor to understand and analyse a wide range of professional material is key to digging beneath the surface of superficial capacity. It is far easier to

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<sup>10</sup> George, M., & Gilbert, S. (2018). Mental Capacity Act (2005) Assessments: Why everyone needs to know about the frontal lobe paradox. *The Neuropsychologist*, 5, 59-66.

<sup>11</sup> Wood, L.I & Bigler, E. (2017). Problems assessing executive dysfunction in neurobehavioural disability. In T.M McMillan & R.L.I Wood. (Eds.), *Neurobehavioural Disability and Social Handicap Following Traumatic Brain Injury* (pp.88-100). Oxford: Routledge.

<sup>12</sup> Ruck Keene, A; Kane, N B; Kim, SYH and Owen, G S (2019) Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection *International Journal of Law and Psychiatry* Volume 62, Pgs 56-76.

negotiate and provide specialist support to assessors at the time of the assessment being needed rather than trying to deal with differences of opinion subsequently.

### ***Fluctuating capacity and anticipatory capacity***

There are particular aspects of capacity that need careful consideration and are better dealt with through specific advice on a case. There have been Court of Protection cases that have considered the matters of fluctuating capacity and, separately anticipatory capacity which have provided some insight into matters for consideration such as:

- There should be a distinction drawn between making isolated decisions and those that relate to the management of affairs<sup>13</sup>
- The management of affairs requires a longitudinal perspective<sup>14</sup>
- When assessing capacity for some decisions they need to be considered at a '*macro level or as a group of micro decisions because the decisions had to be consistent and coherent with each other over time, and because decisions at one time would be affected by decisions taken earlier*'.<sup>15</sup>

The decision in *Cheshire West and Chester Council v PWK* [2019] EWCOP 57 is particularly relevant as the judge determined that deciding on one's care arrangements involves repeated decisions, like managing one's property and affairs. Accordingly, a longitudinal view of that person's capacity ought to be taken:

*'19. Some have referred to this as taking a longitudinal view. In my view, this approach has the value of clarity. It establishes that the starting point is incapacity. The protection for the protected person lies in the mandatory requirements of Section 4 ... (emphasis added)*

*20. It seems to me that the closer the protected person is at the moment of actual decision to capacity, the greater the weight that his views must carry and of course, any decision made must take in to account that he may acquire capacity and, therefore, it must not be beyond change.'*

Anticipatory incapacity deals with the issue of the Court of Protection's powers to make an order as to the lawfulness of an act to be done in the event that the person lacks capacity at some point in the future.

In the case of *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24, the High Court considered a situation where P had capacity to make a healthcare decision, but there was a clear and foreseeable risk that they would lose capacity at a particular moment in time in the near future. In this case the individual was detained under the Mental Health Act, regained capacity to make decisions about her obstetric care, but risked losing capacity at a critical moment during the labour. On the specific facts of the case the court was willing to authorise contingent and anticipatory declarations in the event that CD lost capacity.

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<sup>13</sup> *Cheshire West And Chester Council v PWK* [2019] EWCOP 57.

<sup>14</sup> As above.

<sup>15</sup> *RB Greenwich v CDM* [2019] EWCOP 32.



### ***Sharing the outcome and dealing with differences of opinion***

The written report of the assessment should be shared openly with the person and their representatives and other MDT members to enable them to understand the rationale underpinning the professionals' position on capacity for the arrangements of the conditional discharge and provide an opportunity for challenge and review. An example of a robust capacity assessment report is detailed in Appendix Three (this is anonymised and contains information from a range of people's capacity assessments to avoid identification).

Where there is a difference of opinion on the outcome of the capacity assessment, this should be discussed at length and resolved. In many situations open discussion of the reasons for the difference will lead to resolution, but in those cases that remain unresolved despite best efforts and mediation it may be necessary to involve local staff specialising in law, legal professionals, independent experts and the Court of Protection. If this action is required it should not be unnecessarily delayed.

#### **Sharing Practice:**

Lancashire County Council and Mersey Care NHS Foundation Trust undertook a project to review the capacity of all restricted patients falling into the Transforming Care cohort for whom they shared responsibility.

A flowchart<sup>16</sup> is appended considering how to approach an assessment of capacity in these circumstances and setting out the salient points.

The reflections of those undertaking the capacity assessments highlighted the following themes and learning which may assist others in considering their approach.

**Moral dilemmas:** Assessing capacity regarding discharge plans can raise expectations for the individual that discharge will happen. Should the individual know the outcome of having / lacking capacity to consent to restrictions that amount to DoL i.e. that having capacity may mean they cannot be discharged? How should the reasons for this assessment be presented to the person? How should the outcome be explained?

**Responsible Clinician and other hospital staff:** Non community-based staff may have little knowledge of models of care in the community and may see 'secure residential' as the only viable option. It is essential to get the full MDT and family or friends interested in the person's welfare involved in the assessment process as early as possible, and to ensure they have a clear understanding of all the potential models of care available and the extent to which each model may be able to support greater independence; continue rehabilitation in the community and mitigate or manage residual risk.

**Challenges to capacity assessments:** Capacity assessments need to be very robust. Whatever the outcome, this is likely to be challenged by the person's solicitor, other professionals involved, family or friends or the person themselves.

**Setting the bar for capacity:** The salient points in any decision about capacity differ from person to person and from decision to decision; restricted patients have additional salient points that other patients / people making an accommodation decision do not have. It is important that it is understood by all concerned that carrying out 'a robust capacity assessment' for a serious and complex set of linked decisions, is not about 'setting a high or too high a bar for capacity' but ensuring that this wider field of relevant issues is considered.

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<sup>16</sup> Thanks to Lancashire County Council and Mersey Care NHS Foundation Trust for allowing us to share this development. If you choose to use this, please acknowledge this source.

**Executive functioning:** It is difficult to assess capacity when an individual is very articulate and can go through details of their MoJ restrictions, SOPO etc. and reasons for them, but has not been tested out in real, rather than hypothetical situations. This is an area where shadowed leave and positive risk testing may be able to add important information. Capacity is about whether the person can understand, retain, use and weigh relevant information to make the decision at the time that it needs to be made. If the individual is faced with a risky situation in the community, they may not be able to control reactions or execute them (even if they know how to respond 'on paper'). Executive functioning is about the cognitive processes needed when required - not just a memory test out of context. One way of digging a bit deeper into the person's ability to apply salient information to a situation is through role play, asking open ended questions about what the individual would need to think about in specific scenarios. Even where people may be able to apply information in this situation further information about practical application of knowledge may be required before concluding that there is an executive function issue rather than it being the person is making a capacious unwise decision. It is therefore essential to consult with others involved with the person to ask about other situations where the person has not been able to execute a decision despite being able to articulate what they would / wouldn't do. Using these indirect methods can provide a deeper insight into the person's level of functioning but will not ultimately be robust enough to determine lack of capacity in all individuals – for some there will still need to be graduated testing of understanding in real life situations.

**Timescales:** To fully understand the person and their communication, and to carry out a robust capacity assessment required multiple visits over a period of time, and considerable preparation reading of background information and reports, and consulting with relevant professionals and family.

**Capacity to consent to 24 hr. care:** If the person lacks capacity to consent to some restrictions in the proposed care plan but is aware of this deficit and can consent to 24 hour staffed support, this still means they lack capacity to consent to the care arrangements as a whole. This is because the decisions around accommodation, care and support are interlinked. As such, whilst a person may be able to understand sufficiently around some aspects of the overall support plan e.g. the need for 24-hour staffing, if they demonstrated a lack of capacity regarding other necessary elements, they would be considered to be lacking capacity overall. Capacity is not the same as compliance and the person would have the right to withdraw consent at any time, and if they did so would not have capacity to manage the risks.

**Sex Offenders Treatment Programme (SOTP).** Assessing capacity when a person has not completed their SOTP may not give an accurate picture as the SOTP can enhance capacity for some individuals.

### **Case Vignette – Paul (key point: capacity assessment)**

Paul is a young man with mild learning disability. He has been in and out of detention since his teens spending most of his adult life in prison and secure hospital. Paul has well developed daily living skills and is able to advocate for himself. During his detention he has developed the skills to advocate for his peers and regularly attends meetings. Through his many years in detention and the therapy he has completed he has learnt the various factors that are important to his risks and vulnerabilities – he has learnt what to say. He has also become confident with specialist terms such as deprivation of liberty and can place them in context within a conversation.

Whilst the assessment of capacity was commenced by the community social worker involved, it became clear that it would be necessary to have the specialist involvement of a clinical psychologist within the capacity assessment

During the process of assessing his capacity it emerged that his verbal ability masked a significant cognitive deficit. Whilst he was able to use phrases and terms that appeared to indicate a level of understanding and

weighing, he was unable to give any further detail as to what these terms / phrases actually meant. It was also noticed that there was a gap between his verbal ability and performance ability with many examples of him having acted contrary to what he would describe as the right option to choose. When debriefed about these events he was unable to provide any cogent rationale for his actions.

The additional evidence from the clinical psychologist about cognitive ability and evidence from Paul's performance led to a finding that Paul lacked capacity for the community accommodation care and support proposed on discharge.

### **Case Vignette: Jackson (Key point: capacity assessment)**

Jackson has a mild learning disability and was detained on a s37/41 following convictions for sexual offending. His first conditional discharge several years ago resulted in a recall to hospital after 3 months. On his second (current) conditional discharge, Jackson was assessed to require a care plan that amounted to a DoL. Jackson was assessed to have capacity, and he consented to the care plan. One of his conditions was that he followed his care plan.

The RC worked with Jackson and the MDT to test out reducing the restrictions in his care plan. This was possible to a minimal extent, but he still required a care plan that amounted to a DoL due to his risk primarily to others but also to himself.

After the MM case and MHCS guidance, Jackson's social worker and RC reassessed his capacity. It was concluded that Jackson lacked capacity. This was because he thought he was no longer a risk, and that he was 'better now'. Although he agreed to continue with a high level of supervision, he denied that this was necessary and said he would be fine without it.

Jackson's social worker therefore put in an application to the Court of Protection for authorisation of the DoL. At the hearing, the Judge referenced similar cases recently heard (*Birmingham City Council v SR* and *Lancashire County Council v JTA* [2019] EWCOP 28). An order authorising the DoL for 12 months was given.

Jackson had a Tribunal shortly afterwards. The Tribunal noted that he required a care plan that amounts to a DoL and that this had CoP authorisation. The Tribunal removed the condition that related to him following his care plan. The Tribunal upheld Jackson's continued conditional discharge.

## **Deprivation of Liberty (DoL)**

It is not the intention of this paper to discuss the various views and interpretations in relation to Deprivation of Liberty. Much has been written on this matter and legal rulings have progressed as far as possible with providing a framework to guide determinations of how care arrangements may or may not constitute a deprivation of liberty.

The Mental Capacity (Amendment) Act 2019 has introduced the Liberty Protection Safeguards expected to be implemented in 2023/24. This will bring to bear a new approach to the authorisation of DoL, but not change the understanding of what constitutes a DoL.

Currently the ‘acid test’ set out by the Supreme Court in *Cheshire West*<sup>17</sup> guides our practice and has two key facets to determining whether someone is confined:

Is the person

- under continuous supervision and control; and
- not free to leave (to live elsewhere)?

Anything that falls short of this may include restrictions on liberty, but would not amount to deprivation of liberty or confinement.

At the point of determining whether a restricted patient’s accommodation, care and support on discharge would amount to confinement, we are again guided by the same judgment which stipulated that the following are not relevant:

- the person’s compliance or lack of objection
- the relative normality of the arrangements
- the reason or purpose behind the proposed arrangements.

There is very helpful guidance from the Law Society to aid the broader understanding of what is meant by the judgment<sup>18</sup>.

Given the factors that are not relevant, it is possible that many restricted patient’s proposed discharge arrangements could amount to a DoL, not due to forensic risks but on the basis of their physical health needs or their need for support due to vulnerability or lack of skill. Whilst it is not relevant to the determination of a DoL to consider purpose, it is important for an MDT to understand the reasons why they believe that the level of supervision and control is required as part of the person’s proposed support plans.

When thinking about the ‘acid test’ and its related guidance it becomes clear that there is the possibility of an amount of physical freedom within a care plan that would still amount to continuous supervision and control. Continuous supervision and control does not mean that the person must be within eyesight of others at all times, and that the potential to limit a person’s freedom to leave is probably as significant as the actual limitation at any given time. If a person is free to leave at a given time, but this freedom could be curtailed by others, then they are probably subject to a deprivation of liberty. For example, a person needing to inform and seek permission from staff of their destination and planned time of return, on every occasion they intend to go out would be subject to a significant intrusion into their liberty, even if they were to be wholly unsupervised when allowed to go out. The fact that there is control over where the person goes, when they go, how long they go for and for what purpose, combined with plans for monitoring or taking action if the person deviates from what is agreed meets the threshold of DoL, despite the fact that they may be undertaking all the acts without direct observation or escort.

It is important to note that in the Supreme Case judgment in *Cheshire West* a specific statement was made that we should ‘*err on the side of caution in deciding what constitutes a deprivation of liberty*’.

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<sup>17</sup> <https://www.supremecourt.uk/cases/docs/uksc-2012-0068-judgment.pdf>

<sup>18</sup> <https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>

In pragmatic terms if professionals are unsure of whether the situation amounts to a DoL it is suggested that they seek further advice including legal opinion and possibly judicial opinion on the case.

**Case Vignette – James (Key point: circumstances amount to DoL)**

James is a 42-year-old man who suffers with persistent hallucinations as a result of treatment resistant schizophrenia. Following conviction for a violent offence in 2011 and a period of inpatient detention, he has been discharged since 2015, subject to conditions including residence at a care placement. He suffers significant and disabling attacks of panic when in social settings. He requires support to manage his day to day care and wellbeing, including 5 hours of 1:1 support from staff on a daily basis, and is supported with meals and budgeting. He is placed in a residential care setting that offers him access to rehabilitation in the community but where he is accompanied by staff at all times to manage the effects of social contact on his anxiety and to avoid him being exploited and spending recklessly. When there are staff shortages, James needs to reschedule his planned trips into the community to ensure he is safely escorted at all times.

**Case Vignette – Paul (Key point: circumstances amount to DoL)**

Paul has mild learning disability and a long history of varying offences. He has never lived in the community as an adult and despite progress through rehabilitation he continues to have gaps in his daily living skills. Paul is also a very vulnerable person, he was exploited and suggestible as a young person which led him into a life of crime and he is still vulnerable to exploitation by others or, in an effort to be accepted, to being 'carried along'. Paul aspires to live a successful life in the community, to further his education and develop a role as an Expert by Experience gaining paid employment.

Paul is being discharged into a supported tenancy, he will have the support of staff during the day and a sleeping in staff at night. The support will help him with planning positive activity and meaningful engagement; reengaging with family and developing new social networks; with financial management; and with dynamic risk assessment. Whilst he will have some time unsupported in the community, this will be to specific places for structured activity for an agreed duration, there is a plan in place to ensure that he has safely arrived and that others know of his whereabouts; action would be taken to secure his safety should he not arrive / return as planned. His contact with others is monitored to ensure that he is not exploited or abused.

**Case Vignette – Jennifer (Key point: circumstances amount to DoL)**

Jennifer is a 69-year-old woman with longstanding bipolar affective disorder. She has several complicated physical health needs as a result of longstanding poorly managed diabetes. These include mild cognitive impairment thought to be due to a vascular dementia, and chronic peripheral neuropathy which limits her mobility. She is cared for in a nursing home where her physical health needs are supported comprehensively. The home is in a rural location with no local public transport. Although she is free to leave and there are spacious grounds to which she has access, she nevertheless needs to ask permission from staff to unlock the door, and is required to inform staff when she will return, so they can send assistance if she does not return on time.

### ***Necessity and Proportionality:***

Part of the process of treatment in hospital is the concept of taking positive risks and testing the extent to which a detained patient may need supervision or control mechanisms post discharge. It is an important part of rehabilitation and a means by which the outcomes of treatment can be measured.

Positive risk testing can take many forms depending on the individual's needs, risks and offence history. It is a process of taking calculated, well-planned risks to determine the progress the person has made as a result of their treatment, examples such as having access to 'sharps', having time without staff escort, having access to money, technology, medication etc. all form part of this process and will inform the support plan post discharge, the restrictions needed as well as the setting of conditions for a conditional discharge.

Positive risk testing also provides critical evidence to judicial processes that may be asked to authorise restrictions in support plans that individually or cumulatively amount to DoL and who will expect that the legal requirements of necessity and proportionality of restrictions can be described and evidenced.

#### **Case Vignette: John (Key point: positive risk testing)**

John has a mild learning disability and personality disorder with a history of sexually offending against children and vulnerable adults and the use of weapons. Over a lengthy period of time John was supported to use the strategies he had gained in the Adapted Sex Offender Treatment Programme and anger management programme in collaboratively predicting and managing risks.

A plan of staged development of unescorted community leave was set out whereby John would plan a specific activity; the routes and travel to and from the activity; the money required and the duration. He then set out the plan and agreed with staff how he could gradually move from having full staff escort to having no staff escort for the leave. The plan gradually faded the staff presence back.

The MDT arranged for random, covert shadows to establish whether John was maintaining the plan as agreed. This provided valuable evidence for further unescorted community leave.

#### **Case Vignette: Frank (Key point: positive risk testing)**

Frank has a history of sexually offending against children and women. The forensic assessment highlighted an obsessional personality whereby everyday obsessional behaviours such as gambling and internet use set the conditions for offending.

Frank was supported through a process to use the strategies he had gained in various treatment programmes and therapy to collaboratively predict and manage risks. He progressed through a staged development of unescorted community leave in the nearby town and covert shadows demonstrated that he maintained all aspects of the agreed plans.

Frank requested access to a town farther away from the hospital, he engaged well in the planning and early stages of fading staff escort. The MDT arranged for random covert shadows to establish whether Frank was maintaining the plan as agreed. This provided valuable evidence that Frank was accessing a betting shop and purchasing pornography from the newsagents. In discussion with Frank he identified that he felt that as he was further away from where staff are based, he thought he could '*get away with it*'. This informed the future plans for escorted and unescorted leave.

## Gateways into the Community

There are four gateways into the community (not necessarily discharge):

- To rehabilitate a person to the extent that the discharge arrangement would NOT amount to confinement (i.e. the support might restrict but not deprive the person of liberty)
- For the person to lack capacity to decide on the community arrangements amounting to a DoL and the relevant authorisation to be in place under the Mental Capacity Act 2005
- To be successful in an application for absolute discharge (see below)
- To be given permission for long term section 17(3) leave, where custody is delegated to another authority. This would not be a discharge but can allow for support in the least restrictive setting (see below).

There is little to say on the first point above, for each of the remaining points further information is contained in the sections below.

### ***Those lacking capacity to decide on the discharge arrangements– discharge planning***

The powers under the MCA can only be used for those where the person is assessed (or judged by the Court) as lacking capacity in relation to the relevant decision(s) and where the deprivation of liberty is in the person's best interests. Those who are assessed as lacking capacity to decide on the proposed community accommodation, care and support will need their discharge planning organised well in advance and in a particular order.

Before a First Tier Tribunal or the Secretary of State can order a conditional discharge, they need to be assured that any deprivation of liberty arising from the restrictions within the care plan has been authorised by the appropriate legal body. For those being discharged into residential care this will usually be through a DoLS authorisation from the local authority and for those being discharged into other settings (such as supported tenancy or own home) this authorisation will come from the Court of Protection<sup>19</sup>. It has been noted however that in some situations where the DoLS would apply, the local authorities have considered there is a need to apply to the Court of Protection for authorisation; sometimes because there is an element of public protection.

In order to get the authorisation of the DoL, the support plan for the post discharge arrangements will need to be sufficiently detailed and have been documented to be in the person's best interests as per the statutory checklist. There will need to be clear risk assessments, mitigation plans and crisis contingency plans. It will take some time to develop these and as such the provider of the post discharge support will need to have been commissioned some time prior to discharge and have had sufficient information shared with them, including all positive risk testing. Furthermore, the expected community MDT will also need to have had sight of these documents, been involved in their development and have agreed the content and restrictions contained therein.

It is also helpful for the proposed accommodation and support to have been risk tested through section 17(3) leave. In the case of *MC v Cygnet Behavioural Health Ltd and SSJ* [2020] UKUT 191 (AAC) they stated that the "*decision of the Supreme Court in MM [2018] does not serve as a bar to the Mental Health Tribunal "coordinating" the discharge of a patient on conditional discharge with*

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<sup>19</sup> Please note this will change on the implementation of the Liberty Protection Safeguards, as both of these scenarios would be authorised by the local authority.

*the provision of authority under the MCA to deprive her of her liberty*". They went on to state that there are two possible approaches: *the different hats approach* where a judge with jurisdiction in both the First Tier Tribunal (Mental Health) and the Court of Protection could sit and determine in each case; or alternatively the *ducks in a row approach* where the panel would adjourn or defer a decision to discharge to allow the necessary authorisation to be arranged.

### ***Restrictions that also protect the public***

There is no direct power to use the MCA to protect the public from harm, although sometimes the restrictions deemed to be in the person's best interests and amounting to a DoL would also reduce the risk of harm to others. There might be an indirect case to argue that preventing a person from acting to harm others would also be in the person's best interests in terms of preventing the possible physical, emotional or psychological harm to themselves from their actions or in preventing the impact of the consequences of harming others such as retaliation, criminal processes etc. Examples would include where there is evidence that during previous spells in custody or detention there was an increase in self-harming behaviour and psychological distress, or where the person has previously been the subject of or been threatened with vigilante attacks following offending behaviour.

There is no power under the MCA to authorise a deprivation of liberty indefinitely; additionally, there would be no power to recall to hospital a person who fails to comply with the restrictions and plans amounting to deprivation of liberty authorised under the MCA and, as such, this cannot in isolation provide the necessary framework for the protection of the public. That is why a conditional discharge is in place.

In the MHCS guidance it suggests that even where the person lacks capacity, if the purpose of restrictions is for the protection of the public then *'where a patient falls into this group, the Secretary of State considers caution should be exercised when considering whether to conditionally discharge such a patient with a care plan that would require a DoL authorisation under the MCA'*.

This has been tested in the Court of Protection in the case of *Y County Council v ZZ (2013)*<sup>20</sup> where it was held that the measures were in ZZ's best interests, notwithstanding his objections, because *'they are designed to keep him out of mischief, to keep him safe and healthy, to keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him, and they are there to prevent him from getting into serious trouble with the police'*.

This was further supported in the cases of *Birmingham CC v SR* and *Lancashire CC v JTA*<sup>21</sup> where it was held that it is lawful for the Court of Protection to authorise support that is designed to prevent reoffending given such support was deemed to be in the person's best interests.

### ***Conditions of Discharge and Care and Support in the Community***

Discharge conditions are statements set out by the discharging authority (either a First Tier Tribunal or the MHCS on behalf of the Secretary of State). They are based on recommendations from the RC and MDT and target specific factors that are necessary to monitor and manage the person's mental disorder or to protect the public. Some examples of conditions are set out in Appendix Four.

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<sup>20</sup> [https://www.39essex.com/cop\\_cases/y-county-council-v-zz/](https://www.39essex.com/cop_cases/y-county-council-v-zz/)

<sup>21</sup> <https://www.bailii.org/ew/cases/EWCOP/2019/28.html>



It is not necessary for the person to have capacity to consent to the conditions, but it is important that a condition that is used is understood by the person who is subject to it, otherwise it would be of limited value in helping the person to keep to a course of action that protects their own health and safety and/or that of the public. This places a duty on practitioners and clinicians to define conditions that enable the person to engage in care and support, and to work with the person to enable their understanding of the conditions, their purpose and impact.

The status of conditions imposed upon a person subject to a conditional discharge is not a binding contract. A person might breach all or any of the conditions, and yet face no direct consequences. Similarly, it is quite possible for a person to be recalled to hospital without explicitly breaching any of their conditions. The rationale for recall to hospital relates primarily to the medical necessity of the person being detained in hospital at that time, whether in their own or other's interests. The conditions can be considered as a framework within which the person might reasonably determine how best to avoid the risk of recall, in order to make subsequent decisions.

It is important that the MDT approach the agreement and recommendation of conditions in a logical manner. Consider what conditions are necessary and proportionate to the person's mental disorder and offence risk. They should review whether they either individually or collectively amount to a deprivation of liberty, then explore the legal implications of this and whether alternative legal frameworks can address the factors required before determining that the law poses a barrier to discharge.

## **Absolute Discharge**

An absolute discharge is granted by either the First Tier Tribunal (Mental Health) or the Secretary of State where both:

- The criteria for detention are no longer met (i.e. nature / degree / health / safety / others) under s72(1)(b); and
- It is not appropriate for the patient to remain liable to be recalled to hospital for further treatment - s73(1)(b).

Whilst not impossible, it is rare to obtain an absolute discharge straight from hospital.

A conditionally discharged patient can apply for an absolute discharge, but only has access to the Tribunal in their second-year post discharge and every two years after that.

Under section 71(1) MHA, the Secretary of State has the power to make a discretionary referral to the Tribunal at any time. A decision to make a discretionary referral may be taken at the Secretary of State's own volition, or on request of the patient or the responsible clinician. Where such a referral is made, it is generally on receipt of a request from the patient or their RC. Consideration will be given to the reasons for the request and, if refused, MHCS will provide reasons for the refusal<sup>22</sup>.

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/670679/MHCS\\_Tribunal\\_guidance\\_-\\_restricted\\_patients\\_v1.1\\_Dec\\_2017.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/670679/MHCS_Tribunal_guidance_-_restricted_patients_v1.1_Dec_2017.pdf)

The Secretary of State can absolutely discharge under s42(2). No specific criteria are set out - the Act says, "if he thinks fit". The MHCS has recently updated their guidance for supervisors<sup>23</sup> on this matter providing further detail of the information required and considered in these circumstances

Helpfully case law has addressed the matter of absolute discharge and provides some further guidance specifically for First Tier Tribunals<sup>24</sup>. In this case the judgment provides the following guidance when considering the Tribunals' powers to absolutely discharge a conditionally discharged patient:

*'57. Accordingly the Tribunal when exercising these powers will need to consider such matters as the 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...*

*59. The consequence of an order under section 75(3)(b) is that the restriction order ceases to have effect; in other words, that what was previously only a conditional discharge becomes in effect an absolute discharge. But, as section 73 demonstrates, the difference between the two is the difference between the patient who is, and the patient who is no longer, liable to be recalled to hospital for further treatment. So, in effect, one of the key questions that the Tribunal will wish to ask itself when considering how to exercise its powers under section 75(3) is whether it is – as section 73(1)(b) puts it – "satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment." If the Tribunal is not so satisfied, then it is difficult to see that it could be appropriate for it to make an order under section 75(3)(b).'*

### **Those with capacity unable to be discharged due to conditions amounting to DoL – reducing restrictive nature of the detention and the use of section 17(3)**

The element of coerced consent needs to be borne in mind; it is recognised that the person could never be considered able to capably and freely give consent to any condition to which they are subject, given the power of recall and consequences of breaching conditions where that breach would increase risk to the public.

For those who are deemed to have capacity to decide on the proposed community arrangements, positive risk testing is an essential part of determining whether restrictions can be reduced sufficiently to such an extent that the post discharge support would not amount to confinement. If this can be achieved, then a conditional discharge could be possible.

Sometimes even after restrictions have been reduced as far as possible, the remaining factors within the proposed accommodation, care and support will still amount to confinement. Where this is the

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<sup>23</sup> <https://www.gov.uk/government/publications/submit-a-conditional-discharge-request-for-restricted-patients>

<sup>24</sup> *R (SC) v MHRT* [2005] EWHC 17 (Admin)

case a conditional discharge with conditions that meet the acid test would not be lawful and the use of section 17(3) long term leave with the permission of the MHCS might need to be considered.

**Section 17(3) delegated custody:**

Section 17(3) of the Mental Health Act is quite different from other parts of section 17; it enables patients to be kept in the custody of staff or persons authorised by the hospital managers. Historically this has only been used for the transfer of a patient from one hospital to another for trial leave or medical treatment, but more recently it has been used by some hospitals as part of transition and discharge planning delegating custody to social care providers. In this situation the Hospital Managers retain responsibility and accountability for the detention overall and there are specific requirements to satisfy before being able to use this MHA provision.

The MHCS suggest in their guidance that for those who cannot be conditionally discharged, the use of *'long term escorted leave of absence'* using the provisions of section 17(3) is a consideration. The use of this aspect of the MHA authorises any deprivation of liberty as the person remains detained under MHA inpatient powers and provisions and has access to the various safeguards from that legislation. In these situations the MHCS will grant this leave for a specific period of time after which it will be reviewed and can be renewed. This would be in addition to any review by a First Tier Tribunal of the detention itself.

In *Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG* [2021] EWHC 2990 (Fam), a conditionally discharged patient was technically recalled because of the impact of MM and was granted section 17(3) leave on the same day. The First Tier Tribunal felt it had no choice but to discharge him as he had had no connection whatsoever to a hospital for 7 years. On appeal it was held that *"liable to be detained"* could mean *"liable 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"*. As a result, even though his link to hospital treatment was, at best, tenuous, the detention criteria for ss.37/41 were still satisfied whilst he was on long term section 17(3) leave.

Whilst the MHCS position is clear in their guidance on the appropriate use of this MHA provision, there is a need to consider the practical implications for monitoring; clinical and social supervision; access to advocacy; the funding arrangements of the professional MDT, the accommodation and the 24 hour care and support; and the arrangements for suspending leave and returning to hospital where needed (a recall warrant is not required in these situations as the patient is merely on leave from hospital, but remains in custody/detained).

**Sharing practice:**

Mersey Care NHS Foundation Trust's Whalley based services have arrangements in place for the delegation of MHA responsibility from the Trust Board to the RC to agree section 17(3) delegation of custody, this includes delegation to social care providers and is applied for both restricted and non-restricted patients in order to authorise any DoL arising from proposed discharge arrangements until such time as those are authorised by another process and the person can lawfully be discharged / conditionally discharged.

Their service level procedure for leave of absence sets out the requirements for the monitoring of patients on section 17(3) leave and is based on learning from best practice and serious incidents.

Their procedures require that:

It is essential when delegating that the RC and the joint inpatient and community MDT are content that the provider to whom custody is being delegated are competent and capable of undertaking the duties delegated to them and ensuring that all in the provider service are fully aware of their legal obligations. The steps that need to be taken are: -

- outline clearly to a senior manager from the provider and the joint community and inpatient MDT that delegation of detention would be needed during section 17 leave due to the Deprivation of Liberty whilst in the community.
- get the provider's agreement to accepting that delegation in writing; this can be done through a letter / email from the provider service to record the agreement to accept the responsibilities.
- The Mersey Care MHA Scheme of delegation then requires that a letter of authority be written to the relevant provider organisation confirming the delegation of custody. The letter of authority can be written by the Responsible Clinician, any MH Law Administrator, Lead for MH & Mental Capacity Law, the MHA Trust Lead, the MCA / DoLS Trust Lead or any Trust Executive Board Member
- the leave principles will need to be updated so there is a specific subheading in each section for 'when under section 17(3) leave and escort by XX' with specific expectations of the provider organisation and clarity on reporting.
- arrange for the ward manager / deputy to meet with a manager from the provider to go through the leave principles and related documents (care plan; risk management plans etc.) in some detail; the daily note / reports and the reporting requirements if there are any concerns or incidents and also action for any physical health matters. Ensure this meeting is recorded in the electronic care record
- ensure there is a separate leave permission specific to being '*under the escort of staff from [insert name of provider service] using section 17(3) delegation of custody*'
- ensure the provider staff have a printed copy of the leave principles and specific leave permission

Whilst on section 17(3) leave the Trust remains legally responsible for the person and contact must be maintained.

- daily contact from a registered nurse by phone with the service user (this is documented in electronic care record)
- daily contact from a registered nurse by phone with the provider (this is documented in electronic care record)

If the leave progresses to 24/7 continuous section 17(3) leave for 5 nights or more then the following contact is the minimum standard.

- daily contact from a registered nurse by phone with the service user (this is documented in electronic care record)
- daily contact from a registered nurse by phone with the provider (this is documented in electronic care record)
- weekly face visit at the discharge address by a registered nurse (this is documented in electronic care records)
- Monthly face contact with RC and speciality doctor either at the hospital or discharge address (may require additional contacts on request or if indicated) (documented through the relevant record)
- visits by Mersey Care's Community Forensic Service staff
- visits by managers of the provider to the service user in the new home
- There is also sometimes contact from the community health team, social worker, probation officer and police offender manager

**Extended section 17(3) leave** Should the patient/service user remain on continuous s17(3) leave for a period longer than 3 months, then a formal review of the detention should be made by the RC with an RC independent of the case and someone from the MHA Administration team.

**For Patients/Services users restricted by the Ministry of Justice** it is essential that the Mental Health Casework Section are notified that section 17(3) leave is being used either as an update for an existing permission or during the application for permission process and that MoJ permission is received in advance of any leave commencing in accordance with s.41(3)(c) MHA. They should also be notified of the plan for the leave; the provider that custody is to be delegated to and that the hospital have met their obligations under the MHA and Scheme of Delegation.

### ***The challenges of section 17(3) long term leave***

Whilst this option provides a legal remedy for the reduction of restriction in the setting where people are detained, it is not without its challenges.

Firstly, this approach undermines the principle that hospital should only be used to provide treatment that cannot be given elsewhere, and that people should not stay in hospital for a day longer than needed. There is a clear risk that, when setting a pragmatic precedent that admission, in whatever guise, is a substitute for out of hospital care, this introduces a risk of misinterpretation and a reduction in the threshold for admission in general.

Secondly, there is a challenge in managing the pragmatic elements of the detention, which is beyond the scope of this guidance to redress. The practical implications arising from this are further considered below. There will also be challenges establishing clinical governance and performance systems to ensure that care can be managed safely and quality assured in the correct forum. Local systems will need to resolve these issues as a matter of policy, but it should not be for clinicians to do this on an individual basis.

### ***Practical Implications of s17(3) leave:***

There are a number of practical implications of progressing with the use of long-term section 17(3) leave.

The person remains detained in a named hospital; they are not discharged; this therefore limits some of their rights and access to services.

They remain subject to restrictions stated by the detaining hospital which will be set out in the 'leave principles' or 'leave permission'.

They require a Responsible Clinician (RC) who has the ability to suspend the s17(3) leave authority resulting in the person returning back into hospital detention at a moment's notice should risks begin to increase. The report to the MHCS may lead to them terminating the leave authority outright.

They require a full MDT to progress care, treatment and rehabilitation as set out in MHA and associated Code of Practice and guidance.

They require access to Independent Mental Health Advocacy.

An inpatient bed needs to be available in a timely way for the person to be returned to that would allow continuity of clinical team and care and treatment. It is not necessary to have an identified bed per person on s17(3) leave, however a bed must be able to be made available in a timely manner should suspension of leave and a return to hospital be necessary. For people with learning disability and or autism any return to hospital would ideally be back to a clinical team that already knows the person so that care and treatment is not delayed or pathways lengthened by a 'getting to know you' process.

The patient, by virtue of being detained under MHA, may be unable to access a full entitlement of benefits, including housing benefit, and as such any financial difference between benefits received and the cost of a community lifestyle may have to be funded by the commissioning body. But specialist advice in this regard may be required on a case by case basis as according to Jones' MHA Manual<sup>25</sup>:

*'A patient who has been granted leave of absence to reside in the community has been discharged from the hospital for the purposes of the social security legislation, although he has not been discharged from the section that provides the authority for his continued liability to be detained. There is no requirement for the hospital to keep a bed open for the patient while he is on long-term leave of absence.'*

For those on prison transfer sections, they are not entitled to any benefits until the day of their release from prison and as such the financial gap for these patients is significant.

Detained patients cannot register with a GP until they are discharged from hospital. A temporary registration is an option, but these typically last for 6 weeks and cannot be extended or renewed. The hospital that is the MHA Responsible Authority is also responsible for the delivery of physical health care. This does not negate a local arrangement being created through existing contract variations or specific spot purchasing to enable a willing GP to provide services, however what is required for the detained patient may differ from the usual primary care services GPs are contracted for. For example, the provision of an annual health check to people with learning disability is an optional enhanced service in the community, but usually a mandated requirement of a specialist hospital provider.

Whilst the patient on long term section 17(3) leave has the same rights as a detained patient, the reporting to MHCS is different to that of a conditionally discharged patient. For a detained patient an annual statutory report is required to be submitted to MHCS by the RC only. For a conditionally discharged patient a three-monthly joint report by the social supervisor and RC is required to be submitted to MHCS. As such there is less oversight by the MHCS of the detained person on section 17(3) who is essentially living in the community.

Amongst other things section 17 leave allows the testing of the section 117 after-care arrangements. Many local authorities do not contribute financially to section 117 after-care whilst a patient is on section 17 leave but might do so upon conditional discharge. Both local authorities and ICBs hold statutory responsibility for the provision of section 117 after-care and this is applicable to patients on section 17 leave, so reviewing and/or amending local arrangements to take account of this may be necessary.

There could be the potential for clinical MDTs to be working across a broad geographic patch to deliver the required care, treatment, rehabilitation and supervision necessary for section 17(3) leave. This might not be appropriate, nor sustainable and would need further local consideration.

### **Sharing Practice:**

Cumbria Northumberland Tyne and Wear NHS Foundation Trust have arrangements in place within their learning disability and autism services for the provision of long-term section 17(3) leave. In providing the full pathway of inpatient and community provision for this population it has allowed

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<sup>25</sup> Jones, R. (2022) *Mental Health Act Manual 24<sup>th</sup> Edition* (London Sweet and Maxwell) at p141.

colleagues within the health sector to share and delegate aspects of the responsibility for the detained restricted patient on long term section 17(3) leave.

In the case of a conditionally discharged patient recalled as a result of the MM judgement arrangements have been put in place for his continued stay at the discharge address with the support in place.

In order to enact the recall, the patient needed to attend the hospital and have admission paperwork completed and logged on the electronic records and with the MHA Administration team.

To confirm the funding and social supervision arrangements will continue, a letter sets out the agreement between the relevant organisations (see appendix five). This ensures the continued social supervision of the person and clarifies the position on funding (which has changed).

Their key learning points are

- don't make knee jerk decisions
- deal with hurdles as they present themselves
- ensure good working relationships with the ICB and Local Authority
- this is a more complex arrangement than it appears on the surface. Time and effort has to be given to making this work.
- RCs and clinical teams taking on patients who have been technically recalled and are on long term s17(3) leave need to be well supported by their Trust in order to be willing to take on that responsibility
- further practical challenges are anticipated and will need a speedy response

### **Monitoring the DoL in the community**

The notion of positive risk testing does not end when the person is discharged from detention in hospital or released into the community on long term s17(3) leave. It is important for community MDTs to continuously review restrictions, reducing them wherever possible and considering whether it is appropriate to apply for an absolute discharge were indicated.

In addition, it is important to maintain the decision making capacity of the individual under review. Given as stated before that capacity can change, the person's legal position may also change, and MDTs may be required to discuss cases with the MHCS or Court of Protection where there is a change in capacity determination.

The review of the determination of capacity requires the same level of robustness as described above. It is important therefore to ensure that the person assessing capacity has the relevant knowledge skills and experience for such complex assessments of capacity.



The Code of Practice for the Deprivation of Liberty Safeguards<sup>26</sup> sets out specific guidance on the selection of assessors and includes relevant factors for supervisory bodies to consider when appointing assessors including:

- *the reason for the proposed deprivation of liberty*
- *whether the potential assessor has experience of working with the service user group from which the person being assessed comes (for example, older people, people with learning disabilities, people with autism, or people with brain injury)*
- *whether the potential assessor has experience of working with people from the cultural background of the person being assessed, and*
- *any other specific needs of the person being assessed, for example communication needs.*

It could therefore be argued that any assessor should be someone experienced not only in the field relating to the person's diagnosis, but also in the detention of restricted patients or the clinical or social supervision of conditionally discharged patients. Clearly to be an eligible assessor they must be approved by the supervisory body, but it is helpful to note that the DoLS Code states:

*“4.32 Supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this [the mental capacity] assessment, if they think it would be of benefit. This will primarily arise if somebody involved in the person's care is considered best placed to carry out a reliable assessment, using their knowledge of the person over a period of time. It may also help in reducing any distress that might be caused to the person if they were assessed by somebody they did not know. ...*

*4.38 As with the mental capacity assessment, supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this [the mental health] assessment, if they think it would be of benefit.”*

It is also important to ensure that where there is an authorisation of the DoL that this continues to be authorised. Whilst the lapsing of an authorisation may not immediately lead to a recall to hospital, it is necessary that all involved are aware of this and that the person's situation, risks and responses to the legal framework lapsing may create the conditions and concerns regarding risk that could reach the threshold for recall.

Early arrangements should be made to renew the authorisation of the deprivation of liberty. If an authorisation lapses, the MHCS is governed by the fact that there is no legal power to keep the person deprived of liberty and they are free to come and go as they please. They will ask if the MDT is confident that the patient's risks can be managed temporarily on that basis (for example, a patient may not want to access the community without assistance). In this situation the MHA Responsible Authority will carry liability for the situation. But, for others, there may be a need to technically recall if the MDT through the supervisors have said they couldn't be managed safely without the authorisation of deprivation of liberty in place.

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<sup>26</sup> [https://www.cqc.org.uk/files/deprivation-liberty-safeguards-code-practice\\_or](https://www.cqc.org.uk/files/deprivation-liberty-safeguards-code-practice_or)  
[https://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085476](https://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476)



### ***Is the condition necessary?***

Conditions put in place at the point of discharge are based on the matters set out at the time relating to the mental disorder and risk to the public. As with anything, people and circumstances change over time and therefore the mental disorder and its impact on risk to the public may also change; it is therefore necessary to review these.

The conditions that are used at the point of discharge may well become superfluous with time, but often remain in place. An example might be a requirement to comply with regular drug testing, which becomes unnecessary with prolonged abstinence from drugs, or to avoid a geographical area that no longer pertains to any victim sensitivity.

It may also apply in circumstances where someone, through long term management of and stability in the mental disorder, lengthy presence in the community and, by being supported to follow a positive lifestyle, has demonstrated a reduction in their offence risks including, for example, change in sexual preferences.

There are some circumstances that pose a challenge to the clinician, for example where there has been substantial progress in risk reduction for a person who was previously thought to be unable to benefit from treatment, or a review of the level of risk that the individual poses, based on the benefit of hindsight. The clinician must have confidence that the change that is being considered reflects a genuine departure from the prior state of the individual, or there was a clear misunderstanding of the person's risk contemporarily to the drafting of the conditions. Both require confidence in the clinician that their view is more robust than that of the various people involved in the original decision. Doing this without the benefit of a very clear understanding of the contemporary decision makers' reasoning would be unwise; it is unlikely that restrictive conditions were ever imposed lightly or without regard to necessity. Clinicians would also need to consider whether the apparent risk reduction is a benefit of the DoL. For example, the apparent reduction in sexual interest might be thought to arise as a result of reduced contact with available victims, rather than due to internal motivational change.

The MHCS has indicated willingness to work with clinicians to review any conditions as to the need for these to remain in place. It would be critical to consider the clinical risk robustly using a model of structured professional judgment that takes account of the person's strengths and ongoing areas of need in light of the information that was known at the time of the offence, and subsequently.

#### **Case Vignette Michael (Key point: varying conditions for a person who lacks capacity)**

Michael was conditionally discharged prior to the initial MM judgment; he was deprived of his liberty in the community and this had been authorised by the Court of Protection.

Within the conditions of discharge were two conditions that amounted to DoL

- that he should comply with the care plan
- that he be escorted at all times when outside of the home

The community MDT with social supervisor and clinical supervisor reviewed the care plans authorised by the Court of Protection and the restrictions contained within them, at that time no restrictions could be reduced

all continued to be necessary and proportionate. They then reviewed the conditions of discharge and noted that the two conditions as above were restrictions where the care plan had been authorised by the Court of Protection, they agreed that they were no longer necessary as conditions of discharge; all other conditions regarding residence, contact with social and clinical supervisor and access to children were considered to be necessary. The Clinical Supervisor applied to the MHCS for a variation of the conditions and subsequently received written confirmation of the varied conditions. (note: conditions cannot be varied until the written confirmation has been received)

The MHCS review conditions through receipt of the quarterly discharge reports and will question any case where they believe that the arrangements put in place (as part of the care plan) amount to such a severe restriction of liberty as to amount to a deprivation. Only for those patients with an authorisation of a Supervisory Body or Court of Protection will be recognised as having legal authority.

The MHCS would have to address a situation where a person is said to have 'regained' capacity or those cases where it is said the person has 'partial' capacity. The benchmark for the MHCS in terms of evidence on capacity is the provision or otherwise of an authorisation of deprivation of liberty. If an authorisation is ended or not renewed because there has been a change in evidence on capacity, then this is a material change of circumstances and the MHCS would have to consider its impact and the possible recall of the person.

***Already conditionally discharged in the community who become subject to recall and then section 17(3) leave***

There may be a very small number of cases where people have been conditionally discharged but as a result of the judgment in MM become subject to recall and are then given permission from the MHCS for long term section 17(3) leave.

In these circumstances the priority for clinicians should be to ensure that the patient, although recalled in law, in reality experiences no change in the level of care and support that they receive. Therefore, clinical teams working with people who have been recalled and sent on leave should maintain the same level of contact and correspondence as had the recall not occurred.

There will be some changes to the duties of those involved. The Clinical Supervisor will effectively be acting as the inpatient Responsible Clinician (given the recall the person becomes a detained patient again). Many community RCs will not be able to be a named inpatient RC (arising from their contractual status or job plan); they will likely be acting as the proxy of whoever is designated as the inpatient service RC. This will require the confidence of both RCs and clinical teams to work together and trust each other's level of practice which may be difficult if they do not know each other or have never worked together before.

Whilst this is not impossible, it is difficult to see how this can be achieved where these clinicians are not in regular contact, on at least a quarterly basis, and with the support of shared CPA processes. Effectively this might mean an increase in the level of supervision and support for the person, which might be considered appropriate given the need for oversight of the DoL.

There is a risk that having two senior clinicians responsible for the care of a single individual, possibly working in different providers, and very different contexts could introduce tensions and scope for

clinical disagreement. There is also a risk that diffusion of responsibility could undermine the safe management of the case and introduce gaps in communication that might lead to adverse events.

As in other circumstances where there are unresolved conflicts of opinion that are impeding progress in a person's care and support, we would encourage clinicians to develop / participate in local clinical networks, together with commissioners to provide support and dialogue on how to resolve these differences, also to develop clear strategies for resolution using such supportive measures as C(E)TRs, second opinions, senior practitioner, clinical director or medical director oversight and if needed the Court of Protection (for capacity or best interests disputes).

In practical terms, this suggests that the best way to achieve a safe recall and long term s17(3) leave would be when the inpatient RC and previous RC/clinical supervisor are colleagues who have a positive and close working relationship, and where there is the smallest possible risk of lapses in communication. In some instances, this might be achieved by working outside of conventional professional roles and specialisms, taking account of the needs of the patient first and foremost.

#### **Case Vignette: Charles (key point use of long-term section 17(3) leave)**

Charles is a 52-year old man with mild learning disability who has been conditionally discharged for eight years. He has capacity to consent to his community accommodation care and support. He has a condition that requires him to *accept and comply with personal supervision... whenever he is outside the grounds of his place of residence... except that the patient is permitted up to 2 hours a week free time on a Saturday on an unsupervised basis in [local town]*. This condition alone amounted to DoL.

Charles had a history of sexual offences against children and non-vulnerable females. There had been some minor pro offending behaviours noted since his conditional discharge and whilst the risks were well managed in the community, he was considered to continue to pose a risk of sexual offending. There was careful consideration of the consequences of removing the condition that amounted to DoL and it was felt that risks would escalate if this step was taken.

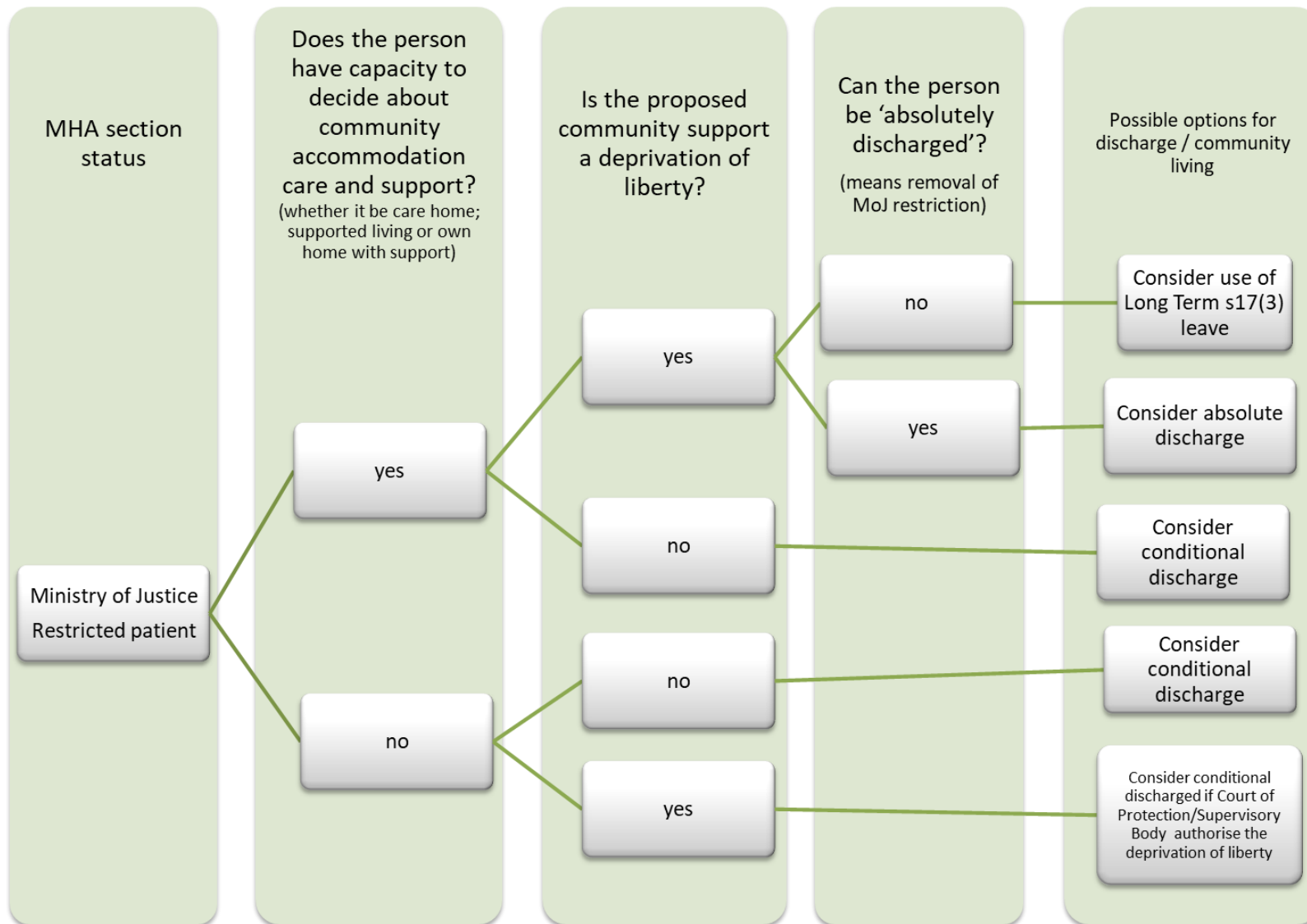
Charles has established a positive life in the community. He is a valued member of staff at his supported employment where he works with wood and is considered to be highly skilled. He has good relationships with his family; works well with professionals; is accepting of care and supervision and has stable mental state.

It was agreed that the appropriate course in Charles' case would be to arrange for his recall and use the option of long-term section 17(3) leave. Legal advice was taken, and practical arrangements made. A communication plan for informing Charles was agreed

#### **Community of Practice**

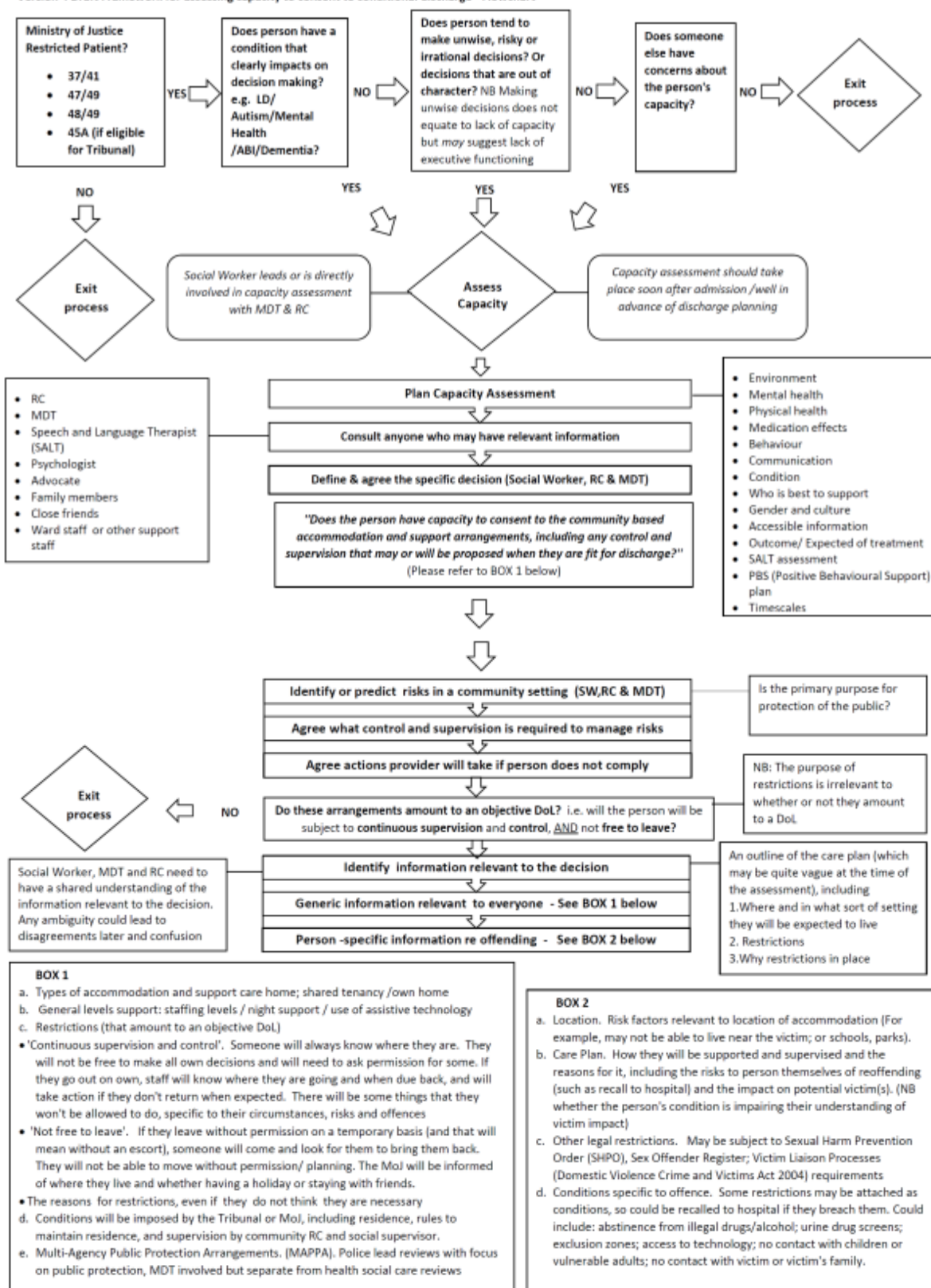
It has been identified that this area of practice is quite niche with only a small number of the practitioners and clinicians across the country working with these specific aspects. There is therefore an informal Community of Practice to support people with sharing practice and cases from across the country which can be accessed through NHSE/I Programme clinical directors and NHSE/I Specialised Commissioning Clinical Reference Groups.

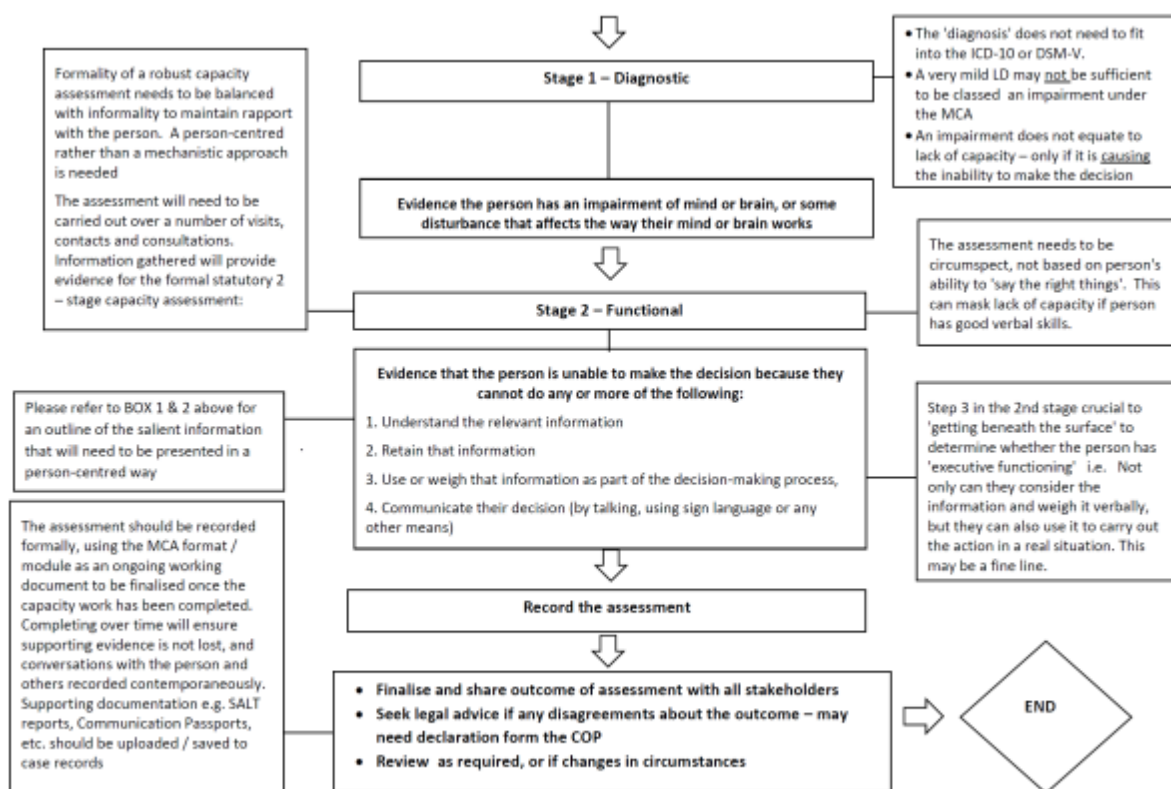
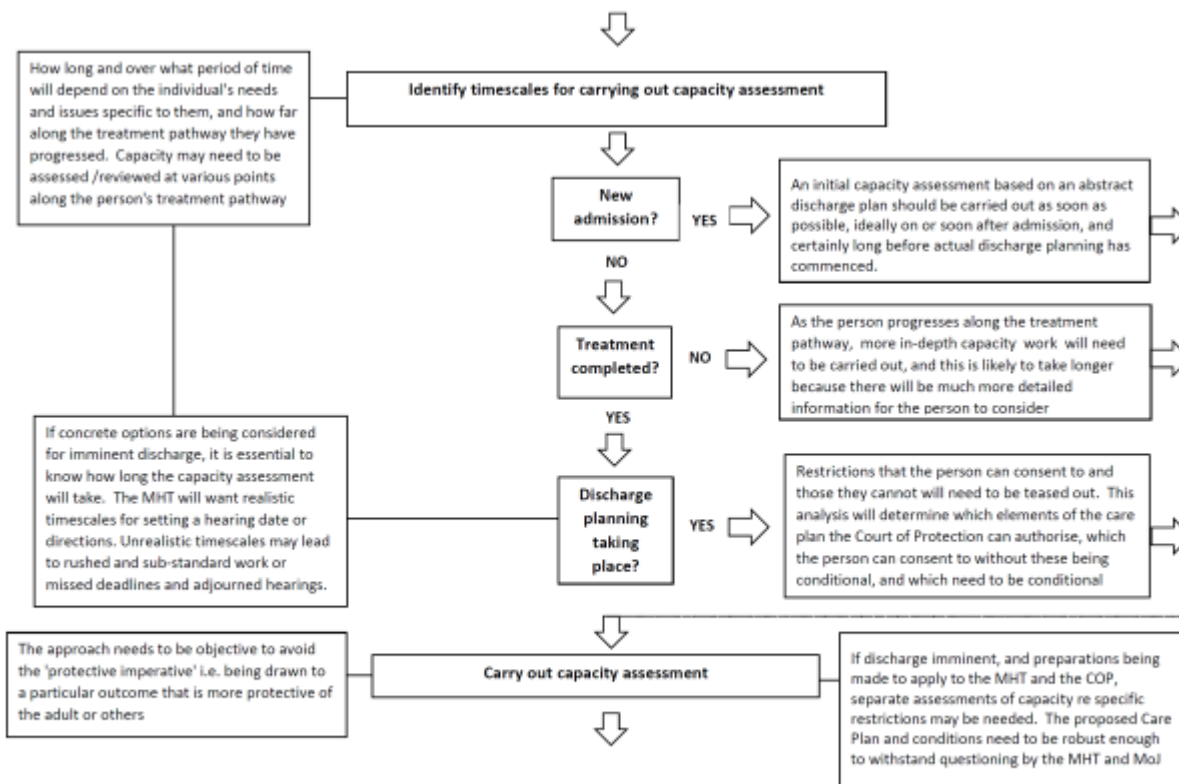
Flow chart of key questions



### Sharing Practice: Capacity Algorithm

Appendix 2 MM Project Report: Lancashire County Council in partnership with Mersey Care  
Version 4 Draft Framework for assessing capacity to consent to conditional discharge - Flowchart







## References and further information

1. Mental Health Act (1983) Code of Practice. See <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>
2. Mental Capacity Act (2005) Code of Practice - in particular Chapter 4: How does the Act define a person's capacity to make a decision and how should capacity be assessed? See <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>
3. A Brief Guide to carrying out Capacity Assessments - 39 Essex St Nov 2017 <http://www.39essex.com/content/wp-content/uploads/2017/11/Mental-Capacity-Guidance-Note-Capacity-Assessment.pdf>
4. Mental Health Act Reference Guide <https://www.gov.uk/government/publications/mental-health-act-1983-reference-guide>
5. MM PJ (2017) Full Judgement <http://www.baillii.org/ew/cases/EWCA/Civ/2017/194.html>
6. Briefings on MMPJ Judgement:
  - Mental Health Law online [http://www.mentalhealthlaw.co.uk/551-v-MM-Welsh-Ministers-v-PJ-\(2017\)-FWCA-Civ-194-\(2017\)-MHL0-167d-080517-1](http://www.mentalhealthlaw.co.uk/551-v-MM-Welsh-Ministers-v-PJ-(2017)-FWCA-Civ-194-(2017)-MHL0-167d-080517-1)
  - 39 Essex St [http://www.39essex.com/cop\\_cases/secretary-state-justice-v-mm-welsh-ministers-v-pj/](http://www.39essex.com/cop_cases/secretary-state-justice-v-mm-welsh-ministers-v-pj/)
  - Browne Jacobson <https://www.brownejacobson.com/health/training-and-resources/legal-updates/2017/04/conditional-discharge-or-ctos-under-the-mha-and-deprivation-of-liberty>
  - Hill Dickinson <https://www.hilldickinson.com/taxonomy/term/613/feed>
7. NHS England Letter & Briefing Re: MM and PJ Court of Appeal Hearing and Judgements: Publications Gateway Reference 07333 <http://www.mentalhealthlaw.co.uk/media/2017-11-24-MM-and-PJ-NHS-England-briefing-note.pdf>
8. MAPPA Guidelines <https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-2>
9. N V A Local Authority - Mr Justice Peter Jackson. <http://www.baillii.org/ew/cases/EWCOP/2016/47.html> Briefing: [http://www.39essex.com/cop\\_cases/n-v-local-authority/](http://www.39essex.com/cop_cases/n-v-local-authority/) This case is about
  - a. whether N has capacity to decide on his care arrangements, and specifically to decide whether or not he should be accompanied in the community, and
  - b. if he does not, whether the deprivation of his liberty is necessary and proportionate and in his best interests.

Peter Jackson concludes that (1) he does not have capacity because of his LD, and that "For him to go into the community alone would not be merely an unwise decision, but an action taken without any real understanding or balancing of the risks he poses and the risks he faces, and (2) he upheld the professional view that "The level of risk if he was unsupervised is real and the nature of the risk is serious. It could lead to N being returned to a prison or hospital environment indefinitely, quite apart from the risk of a violent response from others.
10. [2016] EWCOP 47LB Islington v QR - District Judge Battern. [http://www.39essex.com/cop\\_cases/islington-v-gr/](http://www.39essex.com/cop_cases/islington-v-gr/) . This case is about the salient points that need to be taken into account when determining if a person has capacity to consent to a tenancy agreement when they are subject to CTO conditions.
11. Y County Council v Z [2012] EWCOP B34 (Moor, J) <http://www.baillii.org/ew/cases/FWHC/COP/2012/B34.html> This case shows that restrictions under MCA/DOL for public protection can still be in P's best interests. Judge Justice Moor states 'I have no doubt that the restrictions upon him are in his best interests. They are designed to keep him out of mischief, to keep him safe and healthy, to keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him, and they are there to prevent him from getting into serious trouble with the police.'
12. Mental Health Act – A focus on restrictive intervention reduction programmes in inpatient mental health services, CQC <http://www.cqc.org.uk/publications/themed-work/mental-health-act-restrictive-intervention-reduction-programmes>
13. Mentally disordered offenders - the restricted patient system. Background Briefing (MoJ/Prison & Probation) [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/670671/RP\\_Background\\_Brief\\_v1\\_Dec\\_2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/670671/RP_Background_Brief_v1_Dec_2017.pdf)

## Glossary of terms

**Conditionally discharged (MoJ) restricted patients.** Patients who have been discharged into the community but are subject to conditions. Conditionally discharged patients are supervised in the community by a community RC (psychiatrist) and a social supervisor (social worker). The Mental Health Casework Section (MHCS) receives regular reports from both supervisors. These patients can be recalled to hospital if they pose a risk to others as a result of their mental disorder. They may be recalled to hospital by the Secretary of State if they breach their conditions (they cannot be recalled simply for breaching them).

**Conditions.** Requirements imposed on the patient at the time of discharge (by the MHRT or the Ministry of Justice); usually include residence, supervision by a community RC and a social supervisor, abstinence from drugs / alcohol, drug screening, voluntary compliance with treatment, exclusion zones and any other conditions aimed to protect the public (as long as they fall short of deprivation of liberty)

**COP: Court of Protection.** The specialist court set up under the MCA with powers to make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make those decisions for themselves. The COP can also decide whether a person has capacity to make a particular decision.

**Executive functioning / executive functions.** An umbrella term covering multiple processes that all have to do with managing oneself and one's resources in order to achieve a goal. It refers to the neurologically-based skills involving mental control and self-regulation. Executive functions generally cover the set of cognitive processes involved in the organisation and control of mental and physical activity. At a minimum executive functions enable an individual to:

- STOP doing one thing: this involves inhibitory control and the ability to disengage attention from a current stimulus, ongoing thought process or action
- SWITCH to something else: this involves mental flexibility, shifting attention to a new stimulus or shifting mental set
- START on something else: this involves generating a new focus of attention; planning how to achieve the goal and initiating the selected behaviour

Executive functions are also involved in:

- ORGANISING ongoing behaviour
- MONITORING on going behaviour
- TROUBLESHOOTING or MAKING CORRECTIONS if required

These additional components may involve strategy generation, decision making, self-monitoring and action-outcome monitoring as working memory (Boucher, J, 2009).

**Lack of capacity.** A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain. (MCA 2005)

**MAPPA: Multi-Agency Public Protection Arrangements.** These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

**MDT: Multidisciplinary Team.** The MDT generally includes medical, nursing, social work, occupational therapy, speech and language therapy and psychology professionals (as necessary) with relevant specialist experience, from both hospital and community.

**MHA: Mental Health Act (1983).** The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

**MCA: Mental Capacity Act (2005).** The legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

**MHCS: Mental Health Casework Section** in the Ministry of Justice. The Secretary of State's powers under the MHA in relation to restricted patients are exercised by officials in the Mental Health Casework Section (MHCS) in Her Majesty's Prison and Probation Service (HMPPS)

**MHT: Mental Health Tribunal.** The First-tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal for Wales. The Mental Health Tribunal must discharge restricted patients conditionally rather than absolutely, unless satisfied that it is not appropriate to do so.

**MoJ: Ministry of Justice.** Often used as shorthand to refer to the Mental Health Casework Section in the Ministry of Justice. The MoJ is the government department responsible for all aspects of the justice system.

**PBS: Positive Behavioural Support.** Person-centred approaches to support people with a learning disability who may display behaviours which challenge. It involves understanding the reasons for behaviour and considering the person as a whole to implement ways of supporting the person.

**RC: Responsible Clinician.** The clinician, usually a psychiatrist, responsible for the care of the restricted patient either while detained in hospital or under supervision in the community. The RC does not have the power to decide on certain matters relating to the management of the restricted patient such as transfer between hospitals or leave in the community without the consent of the Secretary of State. The RC cannot discharge a restricted patient without the permission of the Secretary of State.

**Ministry of Justice (MoJ) restricted patients.** Mentally disordered offenders detained in hospital for treatment and who are subject to special controls by the Secretary of State for Justice. They include offenders who are diverted from the courts to the hospital system, and those who are transferred to a secure hospital from prison and made subject to a restriction order or direction. Restricted patients differ from unrestricted or civil patients in that the restriction order or direction imposed by the Crown Court or the Secretary of State under the Mental Health Act 1983 (MHA) limits the powers of the Responsible Clinician and in some cases the Tribunal to make decisions about the patient.

#### Ministry of Justice (MoJ) restricted patients - Types

1. Section 37/41 A restricted hospital order (s37/41 MHA) imposed by the Crown Court;
2. Section 45A (if eligible for Tribunal) A hospital and limitation direction (s45A MHA) imposed by the Crown Court alongside a sentence of imprisonment
3. Section 47/49 A transfer from prison for serving prisoners
4. Section 48/49 A transfer from prison for those on remand or civil or immigration detainees

**Secretary of State.** The Secretary of State for Justice who has various powers concerned with managing a restricted patient's contact with the community, designed to ensure that the public is protected (but does not have any form of clinical role) The Secretary of State's powers under the MHA in relation to restricted patients are exercised by officials in MHCS in HMPPS. The Secretary of State may discharge restricted patients conditionally or absolutely.

**Sex Offender Register.** The requirement for sex offenders to notify local police of their personal details i.e. name, address, date of birth, national insurance number etc.

**SHPO: Sex Harm Prevention Order.** Prohibits the offender from doing anything described in it. The prohibitions must be necessary to protect the public in the UK, or children or vulnerable adults abroad, from sexual harm perpetrated by the offender

**Victim Liaison Processes (Domestic Violence Crime and Victims Act 2004).** The statutory Victim Contact Service (VCS) processes for informing the victims of violent or sexual offences about key developments. e.g. conditional discharge from hospital and recall. Victims' views will be represented at MAPPA meetings

Cate Short, COP Coordinator, LCC 06/02/2018



## Anonymised Mental Capacity Assessment for ' ZX'.

**NOTE:** ZX is a fictitious person whose discharge pathway is affected by the MM judgment because he is a restricted patient under Section 37/41 MHA. The content of this assessment is based on a number of anonymised transcripts of other assessments; therefore any similarity to a known individual is purely coincidental

### What prompted this capacity assessment? (i.e. summary of relevant history)

This capacity assessment has been prompted by the need to identify whether ZX has capacity in broad terms to make decisions about his future accommodation and care as this will determine the appropriate care pathway. The Supreme Court MM Judgement (28 November 2018) has confirmed that MoJ restricted patients who have capacity to consent to a conditional discharge under circumstances that amount to a deprivation of their liberty (DoL), cannot lawfully do so.

However, restricted patients who lack capacity may be discharged if the DoL is clearly separate from the MoJ conditions and is authorised by the Court of Protection or under the Deprivation of Liberty Safeguards (DOLS).

#### Summary of Relevant History:

ZX has a diagnosis of Learning Disability, Emotionally Unstable Personality Disorder and Autism.

ZX was taken into care when he was 11 years old following sexual, physical and emotional abuse and neglect, and was placed in various foster homes until he was 18. He had a turbulent time as a teenager with numerous aggressive incidents towards his peers and inappropriate sexualised behaviour. His education was spasmodic. He has a history of offences against children and vulnerable adults (women), and assaults on staff. When he left foster care, he lived in a tenancy in the community for 3 years before being convicted and transferred under Section 37/41 to T Hospital in 2010.

In 2014, ZX was transferred to S NHS Trust as a step down into medium secure care.

ZX manages his own personal care and day-to-day finances. He is clear that his goal is to be discharged back into the community, to manage his own affairs and to "have a normal life by getting a job and having a girlfriend".

#### Record of known convictions

- 1 conviction of indecent assault against a child
- 2 convictions of possessing indecent images of children
- 1 conviction of rape
- 2 convictions of violence against the person
- 2 cautions for theft

#### Current circumstances

ZX is currently detained at S NHS Hospital under Section 37/41 of the Mental Health Act 1983. He is in the Medium Secure Unit and consideration is being given to a move to a Low Secure Unit. He is mid-stage on the discharge pathway. However, the arrangements being proposed for his future discharge will meet the objective element of Deprivation of Liberty in that ZX will be likely to require continuous supervision and control and will not be free to leave. This capacity assessment will identify whether or not ZX can give valid consent to his anticipated discharge arrangements

### What is the specific decision to be taken? (If this is a review, detail previous decision about capacity)

**Does ZX have the capacity to decide on the proposed community based accommodation and support arrangements including any control and supervision that may or will be proposed when he is fit for discharge?**

The salient information relevant to the decision includes:

- 1) ZX's care needs, to include what areas of support are needed and what would happen without the support i.e. Risks in a community setting: both to ZX and to other people (with negative consequences for ZX). Risks ZX would face without appropriate support are of social isolation, vulnerability to exploitation by others, deterioration in mental health and re-offending
- 2) ZX's accommodation, to include an understanding of some different options, broad information about the area, payment of rent and bills and a basic understanding of a tenancy and the obligations to comply with the rules
- 3) ZX's SHPO (Sexual Harm Prevention Order) restrictions and failure to comply
- 4) ZX's MOJ conditions and failure to comply
- 5) Requirements of the SOR (Sex Offenders Register) and failure to comply

And more specifically, as currently identified by MAPPA and /or ZX's RC & MDT that:

1. ZX will:

- a) Comply with legal conditions required from his being on the Sex Offenders Register, under a SHPO and MoJ conditions.
- b) Receive staff support at all times (1:1 or background as set out in his care plan). This would not necessarily be within his own defined private area (i.e. bedroom or flat within larger complex). To also accept 1:1 at times when out in the community or other requirements as set out in his care plan
- c) Be required to take medication as prescribed
- d) Allow professionals (RC, psychologist, social worker etc.) into his accommodation and engage with them for reviews
- e) Engage with other medical professionals regarding his physical health, such as the GP
- f) Engage with staff and be supported with aspects of daily living, as set out in his care plan

2. ZX must not:

- a) Leave his home without staff agreement, or to fail to return from a planned outing. Were ZX to do so, staff would seek to contact him and escort him home. Were they to be unable to locate ZX, they would report him to police as a missing person.
- b) Use any device capable of accessing the internet unless (1) it has the capacity to retain and display the history of internet use and (2) he makes the device available on request for inspection by a police officer and (3) he makes the device available to the care provider for inspection on a daily basis
- c) Delete any such history
- d) Possess any device capable of storing digital images unless he makes it available on request by a police officer and care provider staff on a daily basis
- e) Have or seek contact or communication with any child under the age of 16, other than (1) with the permission of the said child's parent or guardian and for that person to be made aware of convictions AND only with the express approval of Social Services or a member of the Sex Offender Management Unit for the area. (2) such as is inadvertent and not reasonably avoidable in the course of daily life
- f) Use the internet to contact or attempt to contact any child known or believed to be, or who asserts him/herself to be under the age of 16
- g) Attend or attempt to attend any children's play area, park, school playground, funfair, family fun day and swimming pool. If he is unsure whether it falls within this prohibition, he should seek advice from any officer within the local sex offender management unit within a reasonable period (at least 7 days) before the visits.

Have or seek contact or communication with any vulnerable adult female other than (1) with the permission of his staff, and for that person to be made aware of convictions AND only with the express approval of Social Services or a member of the Sex Offender Management Unit for the area. (2) such as is inadvertent and not reasonably avoidable in the course of daily life

**What practicable steps were taken to maximise the person's capacity to make the decision?**

- Ensuring I understood ZX's level of functioning and abilities by reading any available reports
- Consulting with ZX's RC and multi-disciplinary team and agreeing the salient information that would need to be presented to ZX during the assessment
- Consulting with people who know him well
- Relationship building
- Making ZX aware of the reasons for the assessment prior to assessment.
- Preparing the information ZX would need to understand in an accessible format, according to SALT recommendations
- Assessing at ZX's pace over a number of visits
- Identifying gaps in knowledge then preparing Easy Read information
- Asking ZX where and when he would want to meet and talk to me, to ensure he felt comfortable
- Asking ZX if he would want anyone else to be present to support him during our meetings
- Checking whether ZX may have any identified gender related or cultural needs that would affect his ability to communicate with me as an assessor.
- Checking whether ZX had any physical health difficulties or sensory needs that would affect his communication.

**Details:**

I prepared by reading and familiarising myself with the following documentation:

- LCC Face Overview Assessment .../.../....
- LCC Mental Capacity Assessment (Accommodation) .../.../....
- LCC Mental Capacity Assessment (Care and Treatment) .../.../.....
- Mental Health Tribunal Report .../.../....
- Nursing Report .../.../....
- Responsible Clinician Tribunal Report .../.../....
- S NHS Hospital Treatment Review .../.../....

- S NHS Hospital Integrated Care Plan .../... / ....
- s117 Meeting Minutes .../.../....
- s117 Meeting Minutes .../.../....
- Psychological Treatment Service, Post Admission Assessment .../.../....
- PTS Psychology Reports .../.../....
- HCR20 Risk assessment.../.../....
- SALT assessment.../.../....
- Communication plan.../.../....
- PBS Plan.../.../....
- SHPO conditions .../.../....
- SOR requirements .../.../....

I met with the Responsible Clinician on the .../.../.... to gather some initial information to better understand ZX's history, current situation, ongoing risks and likely arrangements upon discharge. I clarified if ZX has any specific requirements to aid his communication: the use of age appropriate symbols or drawings to aid understanding was advised, supported by discussion.

I also spoke with ZX's current social worker and previous allocated social worker who had worked with him for over 8 years, for further advice on how best to communicate with ZX and gain his trust. I therefore commenced this assessment with a good understanding of how best to communicate with ZX and this helped in establishing a good therapeutic relationship in a relatively short space of time.

I then attended a s117 meeting for ZX and introduced myself, explained the purpose of my involvement and made contact with the various members of the MDT. I was again able to clarify what the likely restrictions would be for any move into the community and from this to determine whether this will amount to a deprivation of liberty.

I asked ZX if he would be willing to engage in a capacity assessment around his understanding of his discharge arrangements and he agreed. A date was then made that was convenient for ZX as he explained he has a busy weekly schedule made up of on-site and off-site activities. ZX was asked if he would like his advocate (IMHA) to be invited and he agreed. He did not want the involvement of any family members.

During an eight - week period, I attended a ward round and met with his MDT, and had individual discussions with the ward manager, ZX's case manager, his forensic social worker and his specialist doctor.

Having discussed and agreed the specific decision and salient information with the RC and MDT, I produced a written outline (as set out above) of what information I would be presenting to ZX during visits.

I prepared and provided ZX with Easy Read, pictorial information sheets, explaining the following areas that we would be discussing:

- What is a mental capacity assessment?
- Different types of community accommodation options that are available.
- What care and support he may require and why.
- What is the Sex Offenders Register (SOR) and what are the conditions he must comply with.
- What is a SHPO and what are the conditions he must comply with
- What is a conditional discharge under S37/41 of the MHA?
- What conditions will MAPPA require following any future conditional discharge?
- What conditions will the MDT require that need to be complied with following any future conditional discharge.

I visited ZX on six separate occasions over a period of two months. I always checked with him what time of day he felt was best for our meetings and always gave him and his IMHA advance notification.

I went at ZX's pace in going through the above information, discussing everything in more detail and encouraging him to give his responses. I checked his understanding both at the end of a visit and again at the next, asking him to recap from his own understanding of what we discussed. I continued to provide reassurance throughout that this was not a test, that there is no right and wrong answers and I used humour between us to keep the sessions as light as possible for ZX, who has remained engaged with me throughout the whole process.

I asked permission from ZX to talk with either of his last set of foster parents with whom he has kept in touch and who visit him once a month, but he has not wanted this to happen. He told me that his foster mum is not very well at the moment and he prefers me not to talk with his former foster dad, therefore I have complied with his wishes.

<b>Can the decision be delayed because the person is likely to regain capacity in the near future?</b>
Not likely to regain capacity
Details:
Due to his diagnosed learning disability he is unlikely to gain capacity

<b>Who was consulted about the decision? (Give names and roles)</b>
Dr SR – Consultant Psychiatrist Dr CP - Clinical Psychologist FSW - Forensic Social Worker DM - Ward Manager CL - Clinical Leader Dr Y - Speciality Doctor CM - Case Manager IMHA - IMHA

<b>Is there an Enduring Power of Attorney (EPA), Lasting Power of Attorney (LPA), Court of Protection Deputy (CPD), Advocate (IMCA/IMHA) or another key role?</b>
No

## Assessment of capacity

<b>Is the person able to understand information related to the decision?</b>
Yes
<p>Details: Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.</p> <p>ZX has his own criteria for whom he will and will not engage with, which is a view confirmed by staff and ward manager. As a result, he has a varying presentation dependent upon his willingness. In the past ZX had taken part in the Sex Offender Treatment Programme (SOTP) and psychological work. ZX has been friendly, co-operative and engaged in our sessions</p> <p>I brought a range of Easy Read and pictorial information (as detailed above) that I shared with ZX during our various meetings together. He was also given copies of the information to take away with him, I encouraged him to discuss our meetings and show the information to his IMHA and ward staff who could also support him. I kept the ward manager updated on our progress so he could feed back to staff in order to help ZX with the information should he be willing to do this.</p> <p><b><u>Understanding of What is Mental Capacity - YES</u></b> At our first meeting together I gave ZX an Easy Read guide explaining what is meant by "having capacity" and what is involved in assessing somebody's capacity. I explained the reasons that I had been asked to carry out the assessment that it was necessary in order to identify what the legal framework may be for future discharge planning. I also explained that my assessment of his capacity was decision specific - so in this instance it was only around his future accommodation, care and support needs and the conditions that would potentially be attached to any future discharge.</p> <p>ZX shared that he had been told he needed "the capacity thing" before he could do more work with his MDT about developing his Moving on/Discharge Plan. We spent time talking about it not being a test, there being no right or wrong answers and how he could demonstrate that he understood our conversation and the information.</p> <p><b><u>Understanding of Accommodation for the purpose of receiving care and treatment - YES</u></b> I gave ZX an Easy Read booklet that contained pictures of the various types of community residence options, such as residential, shared lives, supported living and nursing home. Together we looked through the booklet and I enquired what he thought each option involved. I also linked the different types/levels of support that each option may offer, and what the differences were across the range. We then spent a long time talking about ZX's preference of living on his own in his own place or at his ex-foster mum's house, which he also suggested.</p> <p>ZX was aware of the main responsibilities of being a tenant and explained that he had rented a property in the past so has some experience of this. ZX was able to identify that the person or organisation owning the property is the Landlord and the person renting the property is the Tenant. ZX was aware that a form would need to be signed and recalled that this was called a "Tenancy Agreement". ZX knew that the tenant is obliged to pay rent on time, pay for utility bills, report any faults, pay for any self-inflicted damage, keep the flat/house clean and tidy and maintain the garden.</p> <p>ZX told me that he would not live in a nursing home as that was for old people. He wanted to talk about when he could get "his own place". He wanted to get a job, not be on benefits, get a girlfriend and do his own thing. ZX does not consider that he has many support needs, telling me he could cook his own food, go to the post office and do his own laundry as he does this now. ZX shared that he would get a job to pay for his flat and he wanted to work for Aldi as they pay £10 an hour.</p> <p><b><u>Understanding of Information about any future conditional discharge – YES</u></b> I then gave ZX some Easy Read and pictorial information that included</p>

- What is a package of care and support, what does ZX think his care and support needs will be when living in the community.
- Sex Offender Register, what it means and its implication
- SHPO, what it means and its simplification
- MOJ 37/41 conditional discharge, what it means and what those conditions are likely to be
- MAPPA, what it is and how it effects offenders

ZX was able to tell me the correct Section of the MHA that he was detained under. He explained what S37 and S41 meant respectively. ZX referred to "the Home Office", rather than the Ministry of Justice and told me it "was part of the government". ZX was already aware that the next step would be a "conditional discharge" and that there would be rules for him to abide by. He explained that he would be "brought back" if he did not comply. The MDT has given me a copy of likely conditions which I shared with ZX.

In respect of the SOR and SHPO, ZX was able to understand what these meant in general and how they would apply to him, but felt that it was 'over the top'.

ZX responded much better to "what" type questions than "why". For example, he appeared to enjoy telling me what he would like to do when he leaves S NHS Hospital. This was to get a job, earn a lot of money and get his own place. He was also very accepting of any discharge conditions on a superficial level and that he is very aware it is what he needs to do in order for any discharge to take place. I did not feel this reflected insight into any impact on his future or how the conditions would contradict his own plans and how he sees his future but that he did have a basic understanding of the information given to him.

**Understanding of Support needs relating to Learning Disability, Autism and Personality Disorder - YES (although he doesn't agree that he needs them all)**

ZX is aware that he has a learning disability and is also aware that he was more recently been diagnosed with "Autism". ZX was asked about if he had a Personality Disorder and denied this stating that he has never heard of Personality Disorder before. However following a simple explanation of PD, ZX did demonstrate that he understood the term, though still insisted it didn't apply to him. ZX was unable to say how his diagnoses may affect his decision-making. ZX could identify that he has a few learning needs (around paying bills and shopping) but puts this down to lack of experience due to his many years living in institutions.

ZX expressed that he does not require 24 hour staffing but did add that it would be helpful to have someone nearby if needed. ZX was not familiar with the difference between background staff and 1:1 staff and considered that 24 hour staffing meant around the clock 1:1 staffing in line of vision, which he did not feel is needed. ZX described roughly the type and level of support he envisaged for himself which was support only for the things he needs help with. ZX was unable to identify that staff support would also be a means of monitoring of his behaviour and his compliance with any conditions or that staff would play a role in feeding this back to his RC and Social Supervisor.

ZX expressed that he won't need support when he gets a flat (his preferred option), apart from to get help with paying bills but will need more support when outside for help with shopping and finding a job. ZX was asked about his skills around cooking and said he can do this on his own if he has a recipe book to follow. When asked, ZX said there were no restrictions around his use of knives although they are kept in a locked cupboard which is general hospital policy. With regard to medication, ZX said, "I'd take my own meds at 6 and 10 o'clock. I could manage without any help"

ZX said he expects that he will also be allowed out on his own at times using a similar system to the one he currently has in place, (where his route, destination and return time are all agreed beforehand and he is not allowed to deviate from this). ZX said "I wouldn't be stupid enough to break my conditions" and when asked about the possible consequences listed them as "Lose all leave, get told off, get into trouble with the police and probably end up back in hospital".

ZX was able to understand that any unescorted community access once he leaves hospital will have to be agreed in advance and was able to link this to his current situation where his RC has applied to extend the area of his unescorted leave and stated that he had been "knocked back".

ZX said he was not aware that MAPPA would also have a right to know of his address and of arrangements for unescorted access to the community.

In respect of other restrictions, ZX said he knows there will be restrictions but doesn't yet know what all of these will be. He was aware that he would not be able to live near a school. ZX is aware that these are put in place to manage the risks that he poses due to his previous offences and gave us an outline of these stating that his offences have been towards children and women. ZX said that he is now able to self-manage the risk of re-offending due to his SOTP and the strategies he now has in his mental "tool-kit". ZX was able to list and roughly describe his strategies adding that these are all now in his head and he can use them when needed. ZX said, "I am well in control of my impulses" and stated there have not been any problems since he has been having unescorted leave. With regard to diary sheets, ZX said they do not help him and that he only does them now because his RC needs them.

ZX was aware that his other risk area was around anger, explained that he has undertaken work around this, and again has strategies in place to manage his anger and prevent it from escalating. ZX was able to identify that certain situations can act as a trigger/"start me off" such as when he can't see his ex-foster mum or when there are no staff available to take him to the gym. ZX said that it is better if he is given some warning that something has to be cancelled as he can then find "something else to do". ZX said he likes to be busy and hates to be bored. ZX talked about when he is feeling angry and could identify strategies that help him in these situations such as having space/time alone and listening to music. ZX did not feel that talking to staff was helpful in reducing his anger.

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ZX was able to explain how staff check his phone currently, as they need to see his texts and call history. ZX was then asked why they were concerned and said he had sent his friend some sexual messages a few months ago but there were no other issues. ZX was also aware of the internet and that he would need to allow staff to check up on this when he left hospital (he does not have access in the hospital)

### Are they able to retain information related to the decision?

Yes

#### Details:

Record how you tested whether the person could retain the information and your findings.

ZX and I discussed accommodation options, what care and support needs ZX considered he had and an outline of the MOJ conditions likely to be imposed on any future discharge. This was done over several sessions at a pace I felt he was comfortable with. We also looked at various Easy Read information a number of times, going back and repeating everything at least twice or sometimes three times. ZX was asked to recap after each session in his own words and again the next time we met. When following on a few days later, he did initially need some prompts to jolt his memory about the broader issue, he could then go on to recall information but only in a few words and often not giving a comprehensive account of what we had last talked about. ZX could not repeat aspects relating to the "why" type discussions we had but found it much easier to recollect the information, such as what the specific conditions were from the MOJ.

ZX's verbal communication is assessed as being average using the Wechsler Intelligence Scale (WAIS-1V) which was apparent in his limited ability to expand and explain some of what we had discussed and so demonstrate what he had retained. I was aware of his limitations and so I was able to find ways of supporting and encouraging him to recall beyond his initial summary offered.

However, having consulted with ZX's psychologist and specialist nurse, it appears that there is no evidence of ZX not retaining information and this has been tested many times in his weekly SOTP sessions which would build on work done during the previous session. ZX's apparent inability to recall the discussion, is felt to be more of a strategy to avoid topics or themes which he feels are negative and which he may find unhelpful to dwell on in terms of his own objectives.

The WAIS had also assessed ZX's working memory as average in the same assessment. I felt that ZX could demonstrate his retention of the salient factors with time and encouragement sufficiently well.

### Are they able to use or weigh the information whilst considering the decision?

No

#### Details:

Record how you tested whether the person could use and weigh the information and your findings.

ZX has a diagnosis of Learning Disability, Unstable Personality Disorder and Autism. A factor of both Unstable PD and Autism is a lack of impulse control, which is likely to contribute significantly to ZX's inability to manage his emotions and reactions when presented with certain triggers.

Last year psychologist Dr CP carried out assessments and undertook talking therapies with ZX. He was successful in forming a positive therapeutic relationship with him and as a result, there are now better-informed reports that more accurately reflect this man's level of understanding and abilities than previously. Dr CP described how ZX tried hard with practical assessments and demonstrated an ability to discuss his past that he had not previously been willing to do. He has made real progress since moving to S NHS Hospital. ZX has fewer outbursts of anger and presents as more alert, communicative and motivated - but only if he chooses to engage; the importance of positive relationships in communication with ZX is of great significance.

The following information was gathered over six visits during a two-month period. I was able to establish a good positive therapeutic relationship quite quickly. He displayed humour and good eye contact with relaxed body language in my company. I followed ZX's communication passport, keeping visits to no more than an hour each time, presented a range of information in a range of ways using pictures and Easy Read formats. I used simple, direct language when communicating with him and covered all areas several times on different visits.

ZX was able to talk with me about his index offences when aged 21, though he has always maintained he did not intend to rape the young woman with a mild learning disability who he was going out with at the time. He told me that he did not think he would get in any trouble and he found it difficult to give any reasons as to why he had done it but said he now knows it was wrong. Dr CP's report of --/-- concluded a lack of understanding of the right of a partner to say no, but that ZX had capacity to consent to sex. During our conversations, he sometimes showed frustration and confusion that he has been treated differently from other offenders and talked of "others done the same thing or worse, gone to prison and then been let out free". He appeared aggrieved that he "had not been given a second chance" and had been kept locked up for a long time. ZX does not see himself as vulnerable, he found it difficult to comprehend why he had gone to hospital rather than prison and relating that to his learning disability.

Accommodation, Care and Support - I started by asking ZX where he would want to live following any future conditional discharge. He talked about wanting to live with his ex-foster mum in her house near (P) at first, and that he would then get a good job to save up and then get a place of his own. He talked about moving to Hollywood where people can make lots of money in the film industry.

I asked ZX if he thought he would need staff support following future discharge, I gave examples of shopping, cooking and maintaining a clean home. ZX told me he would not need any support. He talked about going to the local supermarket by himself, that he could cook and would buy what he needed.

I asked what he had made for himself in the past (bearing in mind he has been detained from age 21). ZX talked of making Sunday dinners with his ex-foster mum, and that he had made a curry but couldn't remember what went in it. He likes pizza and Kentucky Fried Chicken so would go there as well.

We talked about personal hygiene and laundry and cleaning his room; ZX told me he does his own laundry now, which is correct, and not an issue. He told me he has a shower when he needs to - staff fed back that he will only have a shower if going out into the community, if not then he will refuse. However as he goes out several times a week, he showers without being told and not considered an issue currently.

Maintaining his environment: I asked ZX about cleaning his bedroom, he told me that it was his room and his private area so he keeps it how he likes it. Staff informed me that there are significant environmental ongoing issues with the state of his room. For a long period, he has not allowed anyone in to clean and refuses to do it himself. Recently following an expected CQC visit, the ward manager was able to persuade ZX to agree to a one off deep clean by specialist staff. This was done without incident but they were not allowed to touch or remove certain items such as drinks containers that ZX hoards. This will be an area of concern for the future. I have recommended that the ward manager consult with their autism specialist and structure some work around agreeing boundaries, this needs doing as a priority as is a potential issue post discharge.

Finances: I queried if ZX felt he could look after his own money, he told me he could and that he does now. As I am aware that currently his money is managed by S NHS Hospital, I queried this with him but found it difficult to get a clear picture from what was described to me. ZX told me that all his money is given to him every week, he then goes to the local town with staff and has a McDonalds and maybe buys something else. Then he puts all his money into the Post Office whilst in town before returning to hospital. ZX talked of having savings and that he wanted to buy his own furniture when he had his own place. I later queried this with staff, it is not a true account, he is not given the full amount of his benefit payments received and he has less than £100 in the Post Office. However ZX clearly understood what bills had to be paid when living in the community, he knows how much things cost and could do basic calculations of how much change he would receive when buying items.

From the above work that took place between ZX and myself over several visits, I felt that he had a good understanding of what was required generally to function independently in a community setting day to day. However, he had almost no insight into the potential problems and issues he is likely to face, not least from having lived within an institutional setting for the last 9 years. One example of this was that ZX has expressed a strong desire to work in a well-paid job. He has no interest in volunteering to build up his skills, telling me he would not work for nothing. I suggested to him that a future employer may have concerns about his conviction but ZX disagreed as "I have done my time". I asked did he think a future boss might see him as a risk; he did not think they would. I asked what sort of job he would try for; he thought Aldi as they paid well and he could get cheap clothes. From our discussions, I felt that ZX displayed the naivety one would expect of a young teenager and understandable from his many years removed from a real world experience with opportunities to grow and develop his independence. However, additionally ZX demonstrated a lack of insight and some delusion when talking of his own abilities and lack of need for any practical care and support in the future. When I suggested some practical problems he may face, he dismissed them out of hand.

ZX has long held a fascination with film stars and followed many of them via Facebook and other Internet platforms. He spends time looking at expensive luxury items, apartments, cars and celebrity lifestyles. When for example he talked of buying a yacht, I got a sense of not just escapism, but of a disconnect from his reality. I found ZX unresponsive to my suggestion of potential problem areas - for example finding a job, there was a lack of insight and little ability to consider what barriers he may face from his conviction and time detained under the MHA. I found that if ZX did not agree with me I was not able to persuade him to consider or reflect on my opinion, it was dismissed.

Using the pictorial aids ZX showed a good understanding of different types of community accommodation options. He told me that a residential home is "for old people"; he knew he would only have his own bedroom in that setting. He thought that nursing homes were for sick old people. He also understood about supported living, again telling me it involved having staff all the time and having his own bedroom with a shared living room. ZX told me he didn't want any of those options.

Although ZX had previously told me he wanted to live with his ex-foster mum, he accepted that a conditional discharge was unlikely to allow this because his ex-foster mum lives near school. ZX was aggrieved that he and his ex-foster mum should be made to suffer, as it was not their fault that a school happened to be in the area.

We went on to talk about him having his own flat, within a complex of other flats and with 24/7 staff support within the building. He liked this option, told me he didn't care about having to have staff around as long as they didn't come into his flat all the time. I encouraged him to consider what the benefits and burdens of this option might be and gave an example of having his own TV. ZX was able to recognise it as a benefit once given to him, but could not suggest any of his own, though able to agree or disagree with additional suggestions. Being able to identify plus and minus factors requires some degree of perceptual reasoning and fluid intelligence of problem solving, which I considered ZX was unable to do. His WAIS-IV showed his abilities in this area as borderline to low, which concurs with my assessment.

MOJ, Sex Offender Register, SHPO and Conditional Discharge

ZX had confirmed that he was currently detained under S37/41 of the MHA and described what this meant. He was aware that the MOJ would set conditions for discharge and he was able to tell me that the outcome of his breaking these conditions would be a return to a secure setting. He told me what the Sex Offenders Register (SOR) was and the Sexual Harm Prevention Order (SHPO).

He told me what the conditions of SOR and SHPO are with little prompting. ZX was interested in knowing what the exact conditions of his discharge would include, I provided the following information to him but that the list is likely to be added to (in view of more recent convictions of assault whilst detained in ---- and ----).

- Comply with legal conditions required from his being on the Sex Offenders Register and a SHPO

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- Consent to 1:1 support at all times, though not necessarily within his own defined private area (i.e. bedroom or flat within larger complex). To also agree to possible 2:1 at times when out in the community
- To accept and take medication as prescribed
- To allow professionals (RC, psychologist, social worker etc.) into his accommodation and engage with them on a meaningful level for reviews
- To engage with other medical professionals regarding his physical health, such as the GP
- To maintain his own living environment area to an acceptably hygienic standard and abide by mutually agreed boundaries around his hoarding behaviours

I have talked with ZX about what risks he thinks the MDT and MOJ may consider he poses when living in a community setting. I suggested to him that he may be at risk from others but this was not something he could accept. ZX sees himself as much more able and self-sufficient than he is. I am of the opinion that he would be vulnerable to manipulation and possible abuse, particularly financial but he has no insight into this and is unwilling to engage in that type of discussion. When reminded of the risks of vigilantes, ZX said that he planned to take up boxing in order to be able to defend himself.

I talked with ZX about his aggression and violent outbursts towards staff, the most recent being in October last year. ZX does not show any remorse following these attacks, he minimises them and blames actions that staff have taken prior. Usually they are individuals whom he does not like and takes exception at how they have talked to him. I asked ZX how he would control this from happening when living in the community; he told me that it depended upon who his staff were. I highlighted that the frequency of his assaults had reduced and could he see how that was due in part to his ability to better control his responses. ZX agreed, and told me he tried to walk away when people annoyed him but sometimes it just happened. I asked did he then think that was one of the risks from him for the future to which he nodded his head.

At a later date, I again talked with ZX about what risks he may pose to others when living in a community setting; ZX told me there were no risks. I went on to talk about why MOJ was insisting on conditions, he told me that it was because of his past offences. He talked about how he is different now, has grown up and has changed. A psychology report from Dr CP in ---- referred to ZX claiming he had no risk "problems", minimising his violence and sex offending, describing it as "it just happened, I was bored". A report in June ---- by Dr CP observed that whilst ZX knew his actions were "wrong", he could not express any reasons why he did it, how the victim may have felt or how he himself felt during the offence. Whilst carrying out this assessment, I have found no evidence from ZX that he has developed insight into himself and/or his actions. Nor do I think he considers himself any sort of potential risk in the future.

Throughout the weighing up part of the assessment, and when asked to explain the rationale "why" ZX would repeat the same phrases word for word and I felt these were stock rote answers that he had learnt. His lack of self-regulation, impulse control and mental flexibility is evidence of his lack of executive functioning - an umbrella term covering multiple processes that all have to do with managing oneself, mental control and self-regulation. I do not feel ZX has the ability to weigh up future consequences or impact on his life from the conditions attached to any future discharge. I found it very difficult to engage ZX in thinking of benefits and burdens of leaving S NHS Hospital again he showed no ability to conceptualise but could give a view when something was suggested for him.

### Are they able to communicate their decision by any means?

Yes

#### Details:

Record your findings about whether the person can communicate the decision.

ZX has presented as engaged and communicative throughout this assessment. He has demonstrated the ability to disagree with things I have suggested to him and contradicted me with his own views and perspective. I understand from previous assessments that professionals have questioned his motivation and lack of ability to engage or communicate, however I have no doubt ZX is able to do this should he decide to.

### Is there an impairment of or disturbance in the functioning of the person's mind or brain?

Permanent impairment

#### Details:

ZX has a diagnosed Moderate Learning Disability (F71 – originally diagnosed by Dr A in 1995), Emotionally Unstable Personality Disorder (F60.9 – diagnosed by Dr B at T Hospital, 7/8/2003) and Autism (F84.1 – diagnosed by Dr C at S NHS Hospital 9/12/2015). He has a Full scale IQ of 59 from WAIS assessment completed in 2013

## Determination of Capacity

It is my reasonable belief that the person LACKS capacity to make their own decision regarding this decision.



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Yes
<b>Record your evidence of the causal link between their mental impairment and lack of ability to make this specific decision.</b>
ZX has a diagnosed learning disability which causes cognitive impairment. It is my professional opinion that ZX's cognition and executive functioning is impaired to the degree that it prevents him from using and weighing up the necessary information regarding any future conditions for discharge and his accommodation, care and support needs. It also affects his level of insight and understanding of consequences. Furthermore, ZX has Unstable Personality Disorder and Autism, which are both, associated with lack of impulse control.

<b>It is my reasonable belief that the person HAS capacity to make their own decision regarding (insert decision information).</b>
No

<b>Does the person, their family or anybody involved in the person's care disagree with your capacity assessment?</b>
No

<b>Detail next steps:</b>
I have met with ZX and explained the outcome of my decision. He accepted this and asked if he could now move forward in planning his conditional discharge, I confirmed yes and have informed his allocated social worker.

### Suggested wording for conditions of discharge

The following has been shared by colleagues from the MHCS as suggestions; they should not be used unless relevant to the person who will be subject to conditional discharge and where relevant will need amending to be more specific to the person and their circumstances.

- 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 MHCS should be informed of any change of address at least 14 days prior to the move taking place
- Allow access to the accommodation, as reasonably required by the responsible clinician and social supervisor.
- 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.
- Engage with and meet the clinical team, as directed by the responsible clinician and social supervisor.
- Abstain from alcohol [save as directed by the responsible clinician and social supervisor].
- Abstain from illicit drugs and 'legal highs'.
- Submit to random drugs and alcohol testing, as directed by the responsible clinician and social supervisor.
- 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.
- Not seek to contact directly or indirectly [specify names].
- Disclose to the responsible clinician and social supervisor any developing intimate relationship with any other person.
- Disclose all pending and current [employment, whether paid or voluntary] [all educational activities] [all community activities] to the responsible clinician and social supervisor.
- Not leave the UK without the prior agreement of the responsible clinician and social supervisor.

**Example Letters between NHS Trust RC; ICB and Local Authority regarding arrangements for Long Term Section 17(3) leave**

To: General Manager Adult Social Care and Commissioner ICB

Dear [General Manager Adult social care] and [ICB Commissioner]

Re: *[details of detained person requiring section 17(3) long term leave]*

I am writing to you in my position as responsible clinician for the above named gentleman to ask for confirmation and clarification around some areas of responsibility. Since Mr XXXX's recall to hospital and commencement of Section 17(3) leave the legal responsibility for monitoring his service in the community now lies with me as his responsible clinician. On previous discussions that have happened, I have received verbal assurance that the monitoring of his placement in the community will in practical terms continue to be carried out by adult social care on my behalf. Please could you provide official written confirmation of agreement to this monitoring arrangement?

I am aware that the current position has been that as Mr XXXX is now on Section 17(3) leave, this changes the funding agreement and at the moment his funding is all being taken care of by health. On discussions I have had with [Trust Legal Representation] they voiced concern that his needs legally still come under Section 117. I understand that this is a developing situation which may practically change over time.

However, I am seeking written assurance that the ICB and local authority will ensure that his funding continues seamlessly, however, the legal landscape shifts in the background.

Finally, I would like to thank you for involving [your benefit welfare officer] to offer clarification around the benefits situation to ensure that he has continued access to the funds he needs to live in the community successfully. Please can you confirm that if any further problems occur with his benefits that [your benefit welfare officer]'s department will work with us to resolve any issues?

If there are other unanticipated issues which may involve the ICB or local authority input, I will be back in touch.

Yours sincerely

Dr XXXXX  
Consultant Psychiatrist

**Reply received:**

Dear Doctor X

Re: **[details of the detained person on section 17(3) long term leave]**

Thank you very much for your correspondence regarding XXXXX and the circumstance we find ourselves in.

Both XXXX Integrated Commissioning Board and Local Authority are of the view that we should treat the funding and supervision of the placement as if XXXXX were discharged from hospital.

We will ensure that you are kept fully informed about any reviews and changes to his community care plan and will ensure our representation at any meetings you convene.

Of importance is how we communicate **XXXXX** inpatient status to the Department of Work and Pensions should there ever be an enquiry or inpatient census. Our involvement should this occur would be greatly appreciated.

Yours sincerely

General Manager  
Adult Social Care

Senior Head of Commissioning  
ICB