

Clinical Disagreement with a Deferred Conditional Discharge

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R v. Camden and Islington Health Authority ex parte K [2001] EWCA Civ 240
Court of Appeal (21st February 2001). The Master of the Rolls, Buxton LJ and Sedley LJ.

Introduction

In *R v. Camden and Islington Health Authority ex parte K*, the Court of Appeal had to grapple with a problem which has repeatedly been brought before English Courts, i.e. that which arises where a Mental Health Review Tribunal (a “Tribunal”) directs the conditional discharge of a restricted patient under section 73(2) of the Mental Health Act 1983 (“the Act”), but imposes conditions on that discharge and defers the direction for discharge until such time as those conditions are satisfied under section 73(7) of the Act. Difficulties arise, as they did in *ex parte K*, where it becomes practically impossible to fulfil the conditions prescribed by the Tribunal, with the result that the patient remains in detention under the Act, with no prospect of being discharged in accordance with the Tribunal’s deferred direction.

Background

The starting point for any consideration of this difficulty is the decision of the House of Lords in *R v. Oxford Regional Mental Health Review Tribunal ex parte Secretary of State for the Home Department* [1988] AC 120 (hereafter “*Campbell*”). The case concerned the question whether or not Mental Health Review Tribunals who have directed a deferred conditional discharge have any power to reconsider their decisions in the period between the original direction and the actual discharge of the patient. The House of Lords, in a speech delivered by Lord Bridge, held that they did not and that a direction for a deferred conditional discharge was a final direction which could not subsequently be varied or revoked. Lord Bridge, in his speech, recognised that a Tribunal’s decision about discharge will “inevitably be coloured by the conditions they have in mind to impose” and that:

“..if the tribunal are only able to be so satisfied [about discharge] by the imposition of conditions to which the patient will be subject on release, it is obvious that in many, perhaps most, cases some time must elapse between the decision that conditional discharge is appropriate and the effective order directing discharge of the patient, for the purpose of making the necessary practical arrangements to enable the patient to comply with the conditions, eg. securing a suitable hostel placement for him and finding a suitable psychiatrist who is prepared to undertake his treatment as an out-patient” (at p.127).

It necessarily followed from the decision of the House of Lords that, where a Tribunal directs a conditional discharge, it has no power to reconsider the nature of the conditions, or the nature of the order, in the event that it proves difficult or impossible to comply with the conditions. The unfortunate result for the patient is that he or she remains detained without any redress during

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this period other than the possibility of challenging either the Tribunal decision or the failure to implement the decision by judicial review, or after the requisite period has expired, re-applying to the Tribunal for a further hearing.

In *R v. Ealing District Health Authority ex parte Fox* [1993] 1 WLR 373, the patient successfully applied for judicial review of the Health Authority's failure to implement the conditions set by the Tribunal which led to the indefinite deferral of his order for a deferred conditional discharge. The Tribunal in *Fox* had directed that the applicant, a restricted patient, should be conditionally discharged but that his discharge should be deferred until the Tribunal was satisfied that conditions relating to residence and after care, including supervision by a responsible medical officer, had been met. Otton J. held that the duty to provide aftercare services under section 117 of the Act was mandatory, and was both a general duty and a specific duty owed to the applicant to provide him with aftercare services until such time as the district health authority and local social services authority (together the aftercare authorities) were satisfied that he was no longer in need of such services. He held that the duty was a continuing duty owed to patients who "may be discharged" although the actual duty to provide services was only triggered at the moment of discharge (at p.385). However, Otton J. also dealt with the difficulty where the Health Authority's doctors were disinclined to make the necessary arrangements. He said:

"..if the district health authority's doctors do not agree with the conditions imposed by the mental health review tribunal and are disinclined to make the necessary arrangements to supervise the applicant on his release, the district health authority cannot let the matter rest there. The district health authority is under a continuing obligation to make further endeavours to provide arrangements within its own resources or to obtain them from other health authorities who provide such services so as to put in place practical arrangements for enabling the applicant to comply with the conditions imposed by the mental health review tribunal or, at the very least, to make inquiry of other providers of such services. If the arrangements still cannot be made then the district health authority should not permit an impasse to continue but refer the matter to the Secretary of State to enable him to consider exercising his power to refer the case back to the mental health review tribunal under s.71(1)." (at p.386).

These difficulties were subsequently considered in the case of *Johnson v. UK* (1997) 27 EHRR 296 in the European Court of Human Rights. On 15th June 1989 a Tribunal had ordered a deferred conditional discharge of Johnson on the ground that whilst it accepted that he was no longer suffering from mental illness, he required rehabilitation under medical supervision which rehabilitation could only be provided in a hostel environment. Following this decision efforts were made to find hostel accommodation for Johnson but to no avail. Johnson applied again to the Tribunal, hoping for an absolute discharge in the light of these difficulties. However, on 9th May 1990 the Tribunal again directed a deferred conditional discharge subject to the same conditions. From late 1990 Johnson began to reject the rehabilitation plans which had been foreseen for him. In April 1991 his case was again considered by a Tribunal which again directed deferred conditional discharge subject to satisfaction of the same conditions. On each occasion the Tribunal accepted that Johnson no longer suffered from mental illness. However, it was not until 12th January 1993 that an absolute discharge was directed and Johnson subsequently released from Rampton Hospital.

In these circumstances, the European Court found that it was legitimate for the 1989 Tribunal to impose conditions on Johnson's discharge notwithstanding their finding that he was no longer suffering from mental illness. This was because a responsible authority is entitled to exercise a

“measure of discretion in deciding whether, in the light of all the relevant circumstances and the interests at stake it would in fact be appropriate to order the immediate and absolute discharge of a person who is no longer suffering from the mental disorder which led to his confinement.” (at para 63). It was, however, “of paramount importance that appropriate safeguards are in place so as to ensure that any deferral of discharge is consonant with the purpose of Article 5(1) and with the aim of the restriction in sub-paragraph (e) and, in particular, that discharge is not unreasonably delayed” (at para 63). The Tribunal concluded in the case of *Johnson* that the imposition of the hostel condition had led to the indefinite deferral of Johnson’s release from Rampton Hospital. The real problem in the UK system which led to it not complying with Article 5 was that “neither the Tribunal nor the authorities possessed the necessary powers to ensure that the condition could be implemented within a reasonable time” (at para 66). One cannot help feeling, at least in part, that the inflexibility of the approach of the later Tribunals in *Johnson* was a significant factor in the decision of the European Court that there had been a breach of Article 5 in his case.

Another relevant decision is that of the Court of Appeal in *R v. Mental Health Review Tribunal ex parte Hall* [2000] 1 WLR 1323 (CA). At first instance in *Hall* ([1999] 3 All ER 132), Scott Baker J considered the case against the various potential aftercare authorities. He held that “the whole purpose of section 117 is that there should be a working together to ensure that when a patient is released he is given the kind of support that gives him the best prospect of settling in the community” (at 144g-h). He held that this duty imposed on the aftercare authorities a duty to make a full multi-disciplinary assessment prior to the Tribunal hearing and to plan arrangements prior to the Tribunal hearing. Scott Baker J found that the aftercare authorities had acted unlawfully on the facts of that case in failing to take sufficient steps to secure that aftercare planning took place for Mr Hall. This was in part due to their failure to appreciate that as Mr Hall had been resident within the area covered by those authorities prior to his detention, they were the relevant aftercare authorities for the purposes of section 117 of the Act (at p.143f-g). Scott Baker J also held that the Tribunal had acted unlawfully in failing properly to take account of all relevant circumstances when, on the second occasion that they considered Mr Hall’s case they had continued to impose the type of conditions (in fact more stringent conditions) which had proved difficulty to comply with in the past, and had failed to ensure that they had before them an up to date care plan for Mr Hall’s aftercare.

On appeal by the Tribunal, the Court of Appeal reversed Scott Baker J’s finding that the Tribunal had acted unlawfully. The Court of Appeal held that a tribunal which simply discharged its obligations and left other agencies to discharge theirs, as this Tribunal did, was not judicially reviewable because it did not do more. In this case, notwithstanding the history, the decision of the Tribunal was not irrational or otherwise open to judicial review. The flaw in Scott Baker J.’s reasoning was that it blamed the tribunal for failing to exercise a power which it did not have. Whilst it could shame others into action, it could not otherwise ensure that reasonable conditions were met within a reasonable time. Whilst the Tribunal clearly had the power to be more interventionist, for example by adjourning and calling for a care plan which might have “achieved a good deal”, and to do everything in its powers to encourage other agencies to fulfil their statutory duties, “that is a long way from saying that a tribunal which simply discharges its obligations and leaves other agencies to discharge theirs is to be regarded as judicially reviewable because it did not do more” (at 1353).

In *Hall* the CA expressly noted that the decision in *Johnson* did “call into question the efficacy of the measures available to ensure that when a Tribunal imposes conditions which are themselves reasonable those conditions are complied with within a reasonable time”. Given that statement it is difficult to see

quite how the Court of Appeal in *Hall* then concluded that “the procedure [of the Tribunal] would have satisfied all of the requirements of Article 5.1 as interpreted by the European Court”. It manifestly lacked the one requirement criticised in *Johnson* that of putting its decision effectively into practice.

Facts

The Court of Appeal in *R v. Camden and Islington Health Authority ex parte K* grappled with a slightly different problem. In this case the appellant was a restricted patient detained under sections 37/41 of the Act. On 4th November 1997 she had committed, and was on 2nd February 1998 convicted of, the offence of causing grievous bodily harm with intent. Since June 1998 she had been detained in a Medium Secure Unit. She applied to the Tribunal which, on 24th May 1999, adjourned for a care plan to be formulated in accordance with the authority of *Hall*, and for a psychiatric report to be prepared by the North London Forensic Service on her suitability for conditional discharge. This report recommended that she be moved to a Regional Secure Unit in London, nearer to her family. Her RMO gave evidence at the adjourned Tribunal hearing on 16th August 1999 and his view was that she could then be moved to appropriately supported hostel type accommodation but that there should be no conditional discharge.

Notwithstanding this evidence, the Tribunal ordered a deferred conditional discharge on condition that K should reside at her parents’ home and should co-operate with social supervision by a social worker to be allocated to her case and with supervision by a forensic Consultant Psychiatrist, and should comply with such treatment as might be prescribed for her. The Tribunal was satisfied that K was suffering from mental illness, namely schizophrenia, the symptoms of which were being fully controlled by medication and that she needed ongoing treatment and medication in order to control her illness. The Tribunal’s conclusion was, however, that K was well enough to be discharged to live with her parents and sister at home under psychiatric and social supervision.

The discharge was, however, not effected because those psychiatrists who could have been responsible for supervising her in the community disagreed that conditional discharge was appropriate and, in the exercise of their clinical judgment declined to supervise her in the community. They would only supervise her if she were to live in supported accommodation. Consulting forensic psychiatrists from outside the Health Authority’s area were also consulted but no willing forensic psychiatrist was found. The Health Authority was not, therefore, able to satisfy the conditions imposed by the Tribunal and thereby to enable K’s discharge. Ultimately, on 3rd March 2000 Dr Kennedy of the North London Forensic Service (by then K’s RMO due to her having been transferred to Avesbury House), wrote to the Home Office advising his opinion that the Tribunal’s conditions were impossible to meet and asking if the Home Secretary would consider exercising his powers to refer K to a Tribunal for a further hearing². On 17th March 2000 the Home Secretary referred K’s case to a further Tribunal.

The Judgments

K argued her case as a matter of domestic law arguing that under section 117 of the Act there was an absolute duty upon the health authority to provide necessary aftercare services, and under the ECHR on the basis that her continuing detention was unlawful under Article 5. Burton J. found

² Section 72 (1) of the Act empowers the Secretary of State to refer the case of a restricted patient to a Tribunal ‘at any time’.

that there was no breach by the Health Authority of its obligations and dismissed the application for judicial review. He found that in the circumstances of K's case, it was perfectly proper for the Secretary of State to refer to matter to a further Tribunal.

The Court of Appeal had no difficulty in finding that, as a matter of domestic law, the obligation on the aftercare authorities was, following *R v. Ealing District Health Authority ex parte Fox* [1993] 3 All ER 170 (Otton J), "to attempt with all reasonable expedition and diligence to make arrangements so as to enable the Applicant to comply with the conditions imposed by the Mental Health Tribunal" and to "make practical arrangements for after care prior to that patient's discharge from hospital". More particularly, the Master of the Rolls in *ex parte K* at paragraph 29 held that:

"...Section 117 imposes on Health Authorities a duty to provide after care facilities for the benefit of patients who are discharged from mental hospitals. The nature and extent of those facilities must, to a degree, fall within the discretion of the Health Authority which must have regard to other demands on its budget. In relation to the duty to satisfy conditions imposed by a Tribunal, I would endorse the concession made by the Respondent Authority as to the extent of its duty [i.e. normally to give way to a Tribunal decision and to use reasonable endeavours to fulfil the conditions imposed by such a decision insofar as they relate to medical care and that failure to use such endeavours, in the absence of strong reasons, would be likely to be an unlawful exercise of discretion]".

As to the question of whether or not Article 5 of the ECHR dictated a different interpretation of section 117 the Court of Appeal unanimously held that it did not. However, the Court of Appeal did consider the wider question of whether or not K's detention some 15 months after the Tribunal ordered a deferred conditional discharge was unlawful. The Master of the Rolls drew a distinction (not accepted by Buxton and Sedley LLJ) between the case where the Tribunal concludes that the patient is not suffering from a mental illness (as in the case of *Johnson*) on the one hand, and cases such as *K* where the Tribunal concludes that the patient is mentally ill and requires treatment but that under appropriate conditions that treatment could be provided in the community. In the latter case, the Master of the Rolls held that if it proves impossible or impracticable to arrange for the patient to receive the necessary treatment in the community then the *Winterwerp* criteria³ were made out and the detention was lawful under Article 5. This was because "whether or not it is necessary to detain a patient in hospital for treatment may well depend upon the level of facilities available for treatment within the community" (at para 34) - this echoes the speech of Lord Bridge in *Campbell* that the nature of the conditions imposed necessarily inform a Tribunal's decision to order a deferred conditional discharge.

Of interest, however, is the Master of the Rolls' conclusion in relation to cases where a Tribunal concludes that the patient is no longer suffering from mental illness. In such cases, he held, it is clearly legitimate to order a deferred conditional discharge but "the deferral must be proportionate to its object and cannot become indefinite." (at para 35). His view was therefore that the statutory scheme as interpreted by *Campbell* (i.e. where the decision to order a deferred conditional discharge is a final decision) may not be consistent with Article 5 because "if the Tribunal imposes a condition which proves impossible of performance, too lengthy a period may elapse before the position is reconsidered as a result of a subsequent referral." (para 35). He observed that the

3 *Winterwerp v The Netherlands* (1979) 4 EHRR 387. The criteria can be summarised as follows: (1) Except in emergency cases, the individual concerned must be shown by prior objective medical expertise to be suffering

from a true mental disorder; (2) the disorder must be of a kind or degree warranting compulsory confinement; (3) the validity of continued confinement requires the persistence of such a disorder.

solution to this problem may be to reinterpret section 73(7) so as to enable a Tribunal to revisit an order for a deferred conditional discharge.

Buxton LJ disagreed with the distinction suggested by the Master of the Rolls. In his view, the ECHR jurisprudence provided that “once the Tribunal made a decision as to Miss K’s release that was contingent on the provision of forensic psychiatric supervision, it became the responsibility of the state to provide that supervision” (at para 44). In his view the lawfulness of a patient’s continued confinement during a period of deferral would depend upon whether or not the patient could during that period be said to be suffering from a mental disorder of a kind or degree warranting compulsory confinement (the *Winterwerp* criteria). He did not decide how this applied to K. He was quite clear that if a patient did not meet those criteria then the order of the Tribunal would be frustrated and the patient would be deprived of her Article 5(4) protection. What is not clear, however, is whether or not Buxton LJ considers that there is such a breach in all cases where a Tribunal decision is effectively frustrated, or only in those cases where the *Winterwerp* criteria would not be satisfied. It would appear from the tenor of his judgment that the latter interpretation is correct.

As for the position of K, Buxton LJ held that it did not follow from his conclusion that she may have been deprived of her Article 5 rights that she was entitled to relief as against the Health Authority. In his opinion if she had a complaint about detention, that complaint would have to be directed against the authority responsible for the hospital where she was detained. Such liability depended not upon fault, but upon the fact of K being detained in breach of Article 5(4).

The solution proposed by Buxton LJ was the same as that proposed by the Master of the Rolls, i.e. to reconsider the decision in *Campbell*.

Sedley LJ also considered the human rights dimensions of the case. He differed from both the Master of the Rolls and Buxton LJ in his view that the statutory scheme was in principle Convention-compliant (see para 56). His reasoning appears to be as follows:

- The decision of the Tribunal depended, for its efficacy, upon the professional judgments of those responsible for implementing it.
- If there is an honest difference of professional judgment between the Tribunal and those who would be responsible for implementing its decision, then the condition of practicability, i.e. whether it is practicable for the patient to be treated in the community, is not met and discharge is for the time being not lawfully possible.
- That there is no distinction in principle between the *Winterwerp* class of case and the *Johnson* class of case, they illustrate the differential effect of the same principle on different fact situations.
- That the role of the judge in this is to ensure that the professional judgment is made honestly, rationally and with due regard only to what is relevant. Within this boundary more than one legitimate judgment - that of the community psychiatrist as well as of the MHRT - may have to be accommodated for the purposes of Article 5(4) at least to the extent that the decision of the MHRT is explicitly dependent on the collaboration of the psychiatrist.

Commentary

Ex parte K, in particular the judgments of the Master of the Rolls and Buxton LJ (but not Sedley LJ), has certainly opened the door to challenges to continuing detention for a protracted period of

time following a Tribunal order of deferred conditional discharge where the Tribunal has concluded that the patient no longer suffers from mental illness. Beyond that, however, there is little consensus to be found in the judgments of the Court of Appeal. The broadest judgment, that of Buxton LJ, was that there could be an ECHR problem in any case where an order of the Tribunal is not effected. But according to the Master of the Rolls, the difficulty lies in particular hard cases, i.e. where a Tribunal concludes that a patient is no longer suffering from mental illness at all but discharge is not effected. However, Sedley LJ disapproved of this distinction (as did Buxton LJ) and found that even in cases where the Tribunal concludes that there is no mental illness but nonetheless orders that discharge should be deferred until certain conditions are met, the statutory scheme allowing the impasse was ECHR compliant.

It is, however, clear that following *ex parte K* English courts will not be receptive to challenges against the Health Authority relying upon section 117 of the Act where the impasse is the result of a genuine clinical disagreement. The Court of Appeal reiterated its respect for clinical judgment even in the face of ECHR challenges. Indeed Sedley LJ's view was that the statutory scheme was explicitly dependent upon the collaboration of the psychiatrist. This is a little surprising in the circumstances of *ex parte K* given that there is in fact no reference to such collaboration in section 73 of the Act which governs the discharge powers of the Tribunal in relation to restricted patients. Perhaps Sedley LJ was referring to the general scheme of the Act which is, in many significant respects, one which relies upon collaboration between doctors, social workers, and detaining authorities for its efficacy.

Lest it be suggested that this is a situation which applies only to restricted patients, it must be remembered that similar arguments could (albeit with less force) apply to unrestricted patients in relation to the prospect of a supervised discharge under the Act. A Tribunal may well recommend that an RMO consider making an application for a supervised discharge⁴ and a failure by the RMO to do so, or actually to make such an application, may well be challenged where the basis of the Tribunal's recommendation was a finding that it would be appropriate for further treatment of the patient to be provided in the community but under supervision.

The real problem is that the UK has still not addressed the problem identified in *Johnson* of patients being unlawfully detained pending satisfaction of the conditions of a deferred conditional discharge. The possible solution, as suggested by two members of the Court of Appeal in *ex parte K*, is to enable the Tribunal to reconsider its orders for deferred conditional discharge. The difficulty with this is that, as *Johnson*, *Hall*, and *K* show, in such cases Tribunals often reach substantially the same conclusion on their reconsideration of the case. If, in any particular case, the evidence suggests that a patient requires supervision then the likely order even of the fresh Tribunal is likely to be a deferred conditional discharge. The only flexibility lies in the terms of the conditions, and in a case where the requirement is for supervision in the community such flexibility is minimal. If a past impasse suggests that such conditions are unlikely to be met, the only real alternatives are for the Tribunal to try to shame a health authority into activity (which in a case of a longstanding impasse may well not succeed) or to decline to order discharge at all. Few patients are likely, in these circumstances, to be encouraged at the prospect of a further Tribunal hearing.

An alternative solution is for the Tribunal to have more far reaching powers against the aftercare authorities so as effectively to enforce its orders against them. This, however, involves the unpalatable prospect of clinicians being ordered to treat patients contrary to their clinical judgment. That, however, may simply be the cost of being ECHR compliant.

4 In accordance with its power under section 72 (3A) of the Act