THE COURT ORDERED that no one shall publish or reveal the name or address of the Appellant who is the subject of these proceedings or publish or reveal any information which would be likely to lead to the identification of the Appellant or of any member of his family in connection with these proceedings.

Michaelmas Term
[2018] UKSC 66
On appeal from: [2017] EWCA Civ 194

JUDGMENT

Welsh Ministers (Respondent) *v* PJ (Appellant)

before

Lady Hale, President
Lord Kerr
Lord Wilson
Lady Black
Lord Lloyd-Jones

JUDGMENT GIVEN ON

17 December 2018

Heard on 22 October 2018

Appellant
Jenni Richards QC
Peter Mant
Stephanie David
(Instructed by GHP Legal (Wrexham))

Respondent
Richard Gordon QC
Amy Street

(Instructed by Blake Morgan LLP (Cardiff))

Intervener (Mind)
Aswini Weereratne QC
Sophy Miles
Gemma Daly
(Instructed by Mind)

LADY HALE: (with whom Lord Kerr, Lord Wilson, Lady Black and Lord Lloyd-Jones agree)

1. In 2007, the Mental Health Act 1983 (the MHA) was amended to introduce a new form of order, a community treatment order (a CTO). This was designed so that patients compulsorily detained in hospital for treatment might be released into the community by their responsible clinician (RC) but subject to conditions which would support their continuing to receive the treatment they needed. The simple question in this case is whether the RC can impose conditions in a CTO which amount to depriving the patient of his or her liberty, within the meaning of article 5 of the European Convention on Human Rights. The same question has arisen in the case of *MM v Secretary of State for Justice* [2018] UKSC 60, in relation to the conditions which may be imposed upon a restricted patient who is conditionally discharged from hospital either by a tribunal or by the Secretary of State for Justice. The two cases were heard and determined together in the Court of Appeal: *M v Secretary of State for Justice, J v Welsh Ministers* [2017] EWCA Civ 194; [2017] 1 WLR 4681. However, the statutory regime governing the conditional discharge of restricted patients is quite different from the statutory regime governing CTOs for non-restricted patients. Accordingly, we have heard the cases separately and are giving judgment separately, while of course seeking to adopt a consistent approach to the principles involved. Our conclusion, differing from the Court of Appeal, is that under neither regime is it permissible to impose conditions which amount to a deprivation of liberty.

The facts

2. The patient, PJ, is 47 years old. According to his RC when making the CTO in 2011, he "has mild to borderline learning disability … He has also been assessed recently as having difficulties which fall within the autistic spectrum. This has been accompanied by abnormally aggressive and seriously irresponsible behaviour consisting of violent and sexual offending." That wording was no doubt chosen because a person with a learning disability cannot be compulsorily admitted to hospital for more than a short time or made the subject of a CTO "unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part" (MHA, section 1(2A), (2B)).

3. In 1999, PJ was convicted of assault occasioning actual bodily harm and threats to kill. The court imposed a hospital order under section 37 of the MHA (but not a restriction order). He was admitted to a medium secure unit and later discharged to a residential unit under a supervised discharge order (a predecessor to

a CTO but to different effect). In 2007 that unit became a hospital, but PJ remained there voluntarily as an informal patient. In May 2009, he was compulsorily detained for treatment under the civil power in section 3 of the MHA.

4. On 30 September 2011, he was discharged from hospital under a CTO and placed in a care home. This was a specialist facility for up to ten men with moderate to borderline learning disability and a history of challenging or offending behaviour. The CTO imposed the two conditions to which all CTO patients are required to be subject under section 17B(3) of the MHA:

> "1. The patient is to make himself or herself available for examination under section 20A as required.
>
> 2. If it is proposed to give a certificate under Part 4A in the patient's case, the patient is to make himself or herself available for examination to enable the certificate to be given, as required."

Section 20A provides for the duration and renewal of CTOs - initially for six months, then a further six months, then for a year at a time. Before deciding to renew the CTO, the RC must examine the patient and decide whether the criteria for renewal exist (section 20A(4)). Part 4A deals with the medical treatment of patients on CTOs who have not been recalled to hospital. Certain treatments cannot be given, even if the patient consents to them, without a certificate having been given. The details need not concern us.

5. The CTO also imposed three bespoke conditions under section 17B(2) of the MHA:

> "1. To reside at [the named care home with nursing] and adhere to rules of residence at [the care home].
>
> 2. To abide by joint 117 care plan drawn up by multidisciplinary team.
>
> 3. To abide by risk management plans for community access with regard to levels of staff supervision."

The reference to "joint 117 care plan" relates to section 117 of the MHA under which (in Wales) the Local Health Board and the local social services authority have a duty to provide after care services for, inter alia, patients subject to a CTO.

6. The RC confirmed on the form that she considered these conditions to be necessary or appropriate for one or more of the following purposes (listed in section 17B(2)):

> "– to ensure that the patient receives medical treatment
>
> – to prevent risk of harm to patient's health or safety
>
> – to protect other persons."

7. As required by section 17A of the MHA, an approved mental health professional (AMHP) agreed that the patient met the criteria for a CTO, that it was appropriate to make a CTO and that the conditions under section 17B(2) were necessary for one or more of the purposes specified.

8. It is common ground that the regime to which PJ was subject in the care home included:

> (i) his whereabouts were monitored at all times within the unit, with 15-minute observations;
>
> (ii) there was a "time out" policy in operation;
>
> (iii) he was escorted by staff on all community outings, including when attending college and meeting his girlfriend;
>
> (iv) all unescorted leave had to be agreed by the RC and social supervisor;
>
> (v) at the time of the tribunal hearing, he was allowed 30 minutes per week unescorted leave for banking; 30 minutes for shopping; 30 minutes on two other occasions 'as long as safe to do so'; and two to three nights with his mother every fortnight;

(vi) there was an absconding protocol allowing for restraint techniques to be used as a last resort;

(vii) his alcohol use was limited to four units per week and he was breathalysed to secure compliance; any alcohol reading after home leave or contact with his brother would result in immediate suspension of home leave;

(viii) unescorted leave would be stopped if risk factors increased.

9. According to the psychiatrist who prepared a report for a hearing before the Mental Health Review Tribunal for Wales (the MHRT) in 2014, PJ knew what "CTO" stood for. His understanding of its effect was that "in my language it means if you fuck up it's goodbye everything". His understanding of the conditions was that he had to listen to staff and stick to the rules. That psychiatrist, along with the RC and others, considered that he had the capacity to consent to the care plan and to the conditions in the CTO. The evidence before the tribunal was that he was happy to stay at the care home and understood that the CTO brought benefits because he needed clear boundaries, but that he would like more freedom to see his family and his girlfriend.

These proceedings

10. At the MHRT hearing in May 2014, the case put on behalf of PJ was that the arrangements under the CTO amounted to an unlawful deprivation of liberty and he should therefore be discharged from it. The Tribunal found that he had significant time when he was not supervised and there was a flexible and progressive plan in place to enable more time to be spent unsupervised. Accordingly, he was not under continuous supervision and control and thus not deprived of his liberty within the meaning of article 5, as interpreted by this court in *Cheshire West and Chester Council v P* [2014] AC 896. Even if he was, the need for a CTO must take precedence over any human rights issues. The MHRT upheld the CTO.

11. The Upper Tribunal heard the patient's appeal in May 2015. The judge, Charles J, made an order joining the Welsh Ministers and the Secretary of State for Health as parties but they chose not to play any active part in the case. Indeed, they both applied for the joinder to be lifted, the Welsh Ministers stating that they had no particular legal or policy perspective on the appeal. Charles J declined to remove them as parties, so that they would be bound by the decision, and could receive the documents and consider what views to offer on the important issues raised.

12. In his substantive decision, Charles J held that the MHRT had erred in their approach to whether or not PJ was deprived of his liberty: they had concentrated on the level of supervision, divorcing it from whether he was free to leave or to refuse to abide by the conditions. Charles J declined to decide whether or not PJ in fact had been deprived of his liberty, although he found it hard to see how further analysis would lead to the conclusion that he was not. He also held that the MHRT had been wrong to conclude that the CTO framework took precedence over the human rights issues: if PJ had been unlawfully deprived of his liberty the Tribunal could not allow the situation to continue. But he declined to remit the case to the MHRT because by that time PJ was no longer subject to a CTO.

13. Implicit in the conclusions reached by Charles J is that whether a person is in fact deprived of his liberty has to be judged by the concrete situation of the person on the ground rather than by the enforceability of his regime; and that it would not be lawful to impose conditions in a CTO which had the practical effect of depriving the patient of his liberty. The Welsh Ministers (but not the Secretary of State) appealed to the Court of Appeal. No-one sought to argue in that court that it had been open to the MHRT to hold that the conditions in the CTO did not amount to a deprivation of liberty. But the Court of Appeal concluded that by necessary implication the MHA permitted an RC to restrict the freedom of movement of the patient to such an extent that it amounted to a deprivation of liberty. The Court of Appeal also held that the MHRT had no power to discharge the CTO even if its terms meant that the patient was unlawfully deprived of his liberty.

14. The patient now appeals to this court. Once again, the Secretary of State has played no part in the proceedings. The relevant Secretary of State would be the Secretary of State for Health, whereas the relevant Secretary of State in the case of *MM* is the Secretary of State for Justice. In the *MM* case, the Secretary of State has argued, successfully, that there is no power to impose conditions upon a conditionally discharged restricted patient which have the effect of depriving him of his liberty. In this case, the Welsh Ministers' principal argument until shortly before the hearing in this court was that such conditions could be imposed in a CTO. It would, to say the least, have been helpful to this court to have the views of the Secretary of State for Health, no doubt after consultation with the Secretary of State for Justice, on an issue which affects England as much as it affects Wales. It may, however, be possible to deduce the views of the Secretary of State from the Mental Health Act Code of Practice, which he is required to draw up and lay before Parliament under section 118 of the MHA. The current edition (revised 2015) states quite clearly that "The conditions must not deprive the patient of their liberty" (para 29.31).

15. However, shortly before the hearing, Mr Richard Gordon QC, on behalf of the Welsh Ministers, put forward an alternative and diametrically opposed argument. This was, in short, that because the conditions in a CTO cannot be

enforced, they cannot amount to a deprivation of liberty and it is therefore permissible to impose them.

The statutory regime

16. The statutory regime governing the imposition and effect of a CTO is principally contained in sections 17A to 17F of the MHA, which are annexed to this judgment. The following features are particularly noteworthy:

(i) The conditions are imposed by the RC, with the agreement of an AMHP, without any judicial input. The MHRT has no power to revoke or to vary the conditions. Its powers are limited to discharging the patient from the CTO: under section 72(1), it has power to do this in any case and a duty to do so if it is not satisfied that the legal criteria for making a CTO are made out.

(ii) The conditions specified in a CTO are of two types. Under section 17B(3), the two conditions set out in para 4 above have to be specified in every order, and are normally referred to as the "mandatory" conditions. Under section 17B(2), other conditions may be imposed if the RC thinks them necessary or appropriate for the purpose of either ensuring that the patient receives medical treatment, or preventing the risk of harm to the patient's health or safety, or protecting other persons; these are normally referred to as the "non-mandatory" conditions. The conditions in issue in this case, set out in para 5 above, were of the "non-mandatory" type.

(iii) Under section 17D(2), while a patient remains subject to a CTO, (a) the power of the hospital managers to detain him in hospital is suspended, and (b) references to patients who are detained or liable to be detained do not include him. None of the elaborate provisions in the MHA, authorising the detention of patients and their recapture if they escape or go absent without leave, apply to community patients.

(iv) The power to impose medical treatment upon a detained patient, contained in section 63 of the MHA, does not apply to a community patient who has not been recalled to hospital: see section 56(4). Medical treatment is widely defined in section 145(1) to include "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care" but this is qualified by section 145(4), which requires that references to medical treatment in relation to mental disorder be construed as references to medical treatment "the purpose of which is to alleviate or prevent a

worsening of the disorder or one or more of its symptoms or manifestations". There is only authority to treat a community patient in three circumstances, which reflect the circumstances in which it would be possible to treat him without a CTO, but with some extra procedural safeguards, the details of which need not concern us. The three circumstances are: first, where there is a valid consent, given either by a patient who has capacity to give it or, if he does not, by a donee of a lasting power of attorney or a deputy appointed by the Court of Protection who has power to give it, or by the Court of Protection (section 64C(2)); second, where the patient lacks capacity and it is possible to give him the treatment without using force (section 64D); or third, where emergency treatment is needed by a patient who lacks capacity (section 64G). Extra procedural safeguards are required for particular treatments, including long term medication and ECT. But there is nothing in the MHA to authorise the giving of medical treatment to a community patient who has the capacity to consent to it and does not give that consent.

(v) There are no sanctions for failing to comply with the conditions in a CTO. Under section 17E(2), the RC may recall a community patient to hospital if he fails to comply with one of the "mandatory" conditions under section 17B(3) (see (ii) above). Under section 17E(1), the RC may also recall a community patient if in his opinion (a) the patient requires medical treatment in hospital for his mental disorder and (b) there would be a risk of harm to the health or safety of the patient or to other persons if he were not recalled to hospital for that purpose. Under section 17B(6), breach of the conditions may be taken into account in deciding whether these grounds exist.

(vi) If a recalled patient fails to return to hospital voluntarily, he is treated as absent without leave and the MHA provisions for recapturing such patients apply. Once in hospital, the patient may be given medical treatment without his consent, by force if need be, under section 63. Under section 17F(4) and (5), the RC then has a choice between revoking the CTO and keeping the patient in hospital or releasing the patient under the CTO. Under section 68(7), the hospital managers must refer the case of a recalled CTO patient whose CTO has been revoked to the MHRT as soon as possible and the tribunal would have to discharge him if the grounds for detention did not exist.

The Welsh Ministers' new argument

17. In effect, the Welsh Ministers now argue that the conditions imposed upon PJ cannot deprive him of his liberty because they cannot be enforced. There is no power to detain him, there is no power to impose medical treatment (widely defined)

without his consent, there is no sanction for failing to comply with the care plan, other than the limited power of recall, and there is no power to recapture him if he absconds or otherwise goes missing from the care home. Hence, they argue, it is lawful to impose these conditions, because they do not amount to a deprivation of liberty.

18. The Welsh Ministers are entirely correct in what they say about the legal effect of a CTO. But it does not follow that the patient has not in fact been deprived of his liberty as a result of the conditions to which he is subject. The European Court of Human Rights has said time and time again that the protection of the rights contained in the European Convention must be practical and effective. When it comes to deprivation of liberty, they and we must look at the concrete situation of the person concerned: has he in fact been deprived of his liberty? Otherwise, all kinds of unlawful detention might go unremedied, on the basis that there was no power to do it. That is the antithesis of what the protection of personal liberty by the ancient writ of *habeas corpus*, and now also by article 5 of the Convention, is all about.

19. Since the judgment in the Upper Tribunal, this case has proceeded on the basis that the factual circumstances in which PJ found himself under the CTO conditions did amount to a deprivation of liberty. Charles J found that the MHRT had applied the wrong test, but neither made the determination for himself nor sent the case back for the MHRT to do so. But it is enough for our purposes to proceed on the basis that there was a deprivation of liberty on the ground. The question is whether the RC has power, under the MHA, to impose conditions which have that effect.

Modifying Cheshire West

20. If he fails on his new principal case, Mr Gordon argues that the "acid test" of a deprivation of liberty, decided by this court in *Cheshire West*, should be modified for cases of this sort where the object is to enhance rather than further curtail the patient's freedom. He relies on cases such as *Austin v United Kingdom* (2012) 55 EHRR 14, where the European Court of Human Rights found that "kettling" demonstrators and passers-by for some hours was not a deprivation of liberty in all the circumstances of the case. As the court explained,

> "… article 5(1) is not concerned with mere restrictions on liberty of movement, which are governed by article 2 of Protocol No 4. In order to determine whether someone has been 'deprived of his liberty' within the meaning of article 5(1), the starting point must be his concrete situation and account must

> be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The difference between deprivation of and restriction upon liberty is one of degree or intensity, and not of nature or substance." (para 57)

21. This is indeed the test which has been propounded by Strasbourg for many years, beginning with *Guzzardi v Italy* (1980) 3 EHRR 333. The jurisprudence was examined in detail in *Cheshire West*, where all members of the court agreed that the "acid test" of a deprivation of liberty was whether the person was under continuous supervision and control and not free to leave. The concrete circumstances of PJ in this case are much the same as those of P in the *Cheshire West* case, although PJ is not as seriously disabled as was P. And in both cases, the object of the care plan was to allow them as much freedom as possible, consistent with the need to protect their own health or safety or, at least in PJ's case, that of others. But, as Lord Walker pointed out in the House of Lords in *Austin v Comr of Police of the Metropolis* [2009] AC 564, at para 43, "It is noteworthy that the listed factors, wide as they are, do not include purpose". There is no reason to distinguish this case from *Cheshire West* and we are not - and could not be as a panel of five - asked to depart from it.

22. And in any event, we are not being asked, any more than was the Court of Appeal, to decide whether PJ was in fact deprived of his liberty by the regime imposed upon him. We are asked to consider whether the MHA gives the RC power to impose conditions which have that effect. It is to that question which I now turn.

Can the RC impose conditions in a CTO which have the effect of depriving the patient of his liberty?

23. It is common ground that there is no express power in section 17B(2) of the MHA to impose conditions which have the effect of depriving a community patient of his liberty. The Court of Appeal nevertheless held that there was such a power by necessary implication. The purpose of a CTO, they said, is the gradual integration of the patient into the community (para 50). There must therefore be, by necessary implication, "a power to provide for a lesser restriction of movement than detention in hospital which may nevertheless be an objective deprivation of liberty provided it is used for the specific purposes set out in the CTO scheme" (para 51). The only limit was that the conditions could not impose a greater restriction than those applicable to detention in hospital (para 52).

24. With the greatest of respect to the Court of Appeal, this approach puts the cart before the horse. It takes the assumed purpose of a CTO - the gradual reintegration of the patient into the community - and works back from that to imply

powers into the MHA which are simply not there. We have to start from the simple proposition that to deprive a person of his liberty is to interfere with a fundamental right - the right to liberty of the person. It is a fundamental principle of statutory construction that a power contained in general words is not to be construed so as to interfere with fundamental rights. The best-known explanation for this principle is contained in Lord Hoffmann's opinion in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, at p 131:

> "Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual. In this way the courts of the United Kingdom, though acknowledging the sovereignty of Parliament, apply principles of constitutionality little different from those which exist in countries where the power of the legislature is expressly limited by a constitutional document."

This famous passage was quoted by Lord Reed in *AXA General Insurance Ltd v HM Advocate* [2012] 1 AC 868, para 151. Lord Reed went on to explain, at para 152:

> "The principle of legality means not only that Parliament cannot itself override fundamental rights or the rule of law by general or ambiguous words, but also that it cannot confer on another body, by general or ambiguous words, the power to do so. As Lord Browne-Wilkinson stated in *R v Secretary of State for the Home Department, Ex p Pierson* [1998] AC 539, 575:
>
> > 'A power conferred by Parliament in general terms is not to be taken to authorise the doing of acts by the donee of the power which adversely affect … the basic principles on which the law of the United Kingdom is based unless the statute conferring the power makes it clear that such was the intention of Parliament.'"

There is no need to labour the point. The very first case to be heard in this court, *Ahmed v Her Majesty's Treasury* [2010] 2 AC 534, held that the very general words in the United Nations Act 1946 could not authorise the Treasury to make orders freezing people's assets, which constituted an interference with their fundamental

rights, without due process of law. The very general words in section 17B(2) cannot authorise the RC to impose conditions which deprive a patient of the fundamental right to liberty.

25. In any event, as the Court of Appeal recognised, the test for a necessary implication is a strict one. As Lord Hobhouse put it in *R (Morgan Grenfell & Co Ltd) v Special Comr of Income Tax* [2003] 1 AC 563, para 45:

> "necessary implication is not the same as a reasonable implication, as was pointed out by Lord Hutton in *B (A Minor) v Director of Public Prosecutions* [2000] 2 AC 428, at 481. A *necessary* implication is one which necessarily follows from the express provisions of the statute construed in their context. It distinguishes between what it would have been sensible or reasonable for Parliament to have included or what Parliament would, if it had thought about it, probably have included and what it is clear that the express language of the statute shows that the statute must have included."

26. In fact, there is no reason to suppose that Parliament would have included such a power in the MHA had it been thought of. The purpose of a CTO is not necessarily or invariably "the gradual integration of the patient into the community". The purpose is explained in the Mental Health Act Code of Practice, para 29.5, as follows:

> "The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm - to the patient or to others - that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery."

The 2007 amendments to the 1983 Act were preceded by lengthy examination and consultation, by an expert committee chaired by Professor Genevra Richardson (*Report of the Expert Committee: Review of the Mental Health Act*, Department of Health, 1999) and then by government (Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, Cm 4480; *Draft Mental Health Bill*, Cm 3558; *Draft Mental Health Bill 2004*, Cm 6305). The Royal College of Psychiatrists had long been pressing for some means of ensuring that detained patients kept up with their medication and did not get lost after being discharged from hospital. But there was vigorous opposition to any form of compulsory or forcible medical treatment outside the carefully controlled environment of a

hospital. And, as explained earlier in para 16(iv), this cannot be imposed under a CTO.

27. Indeed, that is one of the strong indications from the other provisions in the MHA that CTO conditions cannot be used to deprive a person of his liberty. If he cannot be made to take his medication, how can Parliament have intended an even greater interference with his fundamental rights? Another indication comes from the very precise language used when detention is authorised under the MHA. If a patient is admitted to hospital for treatment under the civil power in section 3 of the Act, for example, section 6 provides that a duly completed application is authority for certain people to take the patient and convey him to the hospital within certain periods of time and, if he reaches there in time, for the hospital to detain him in accordance with the provisions of the Act. These include provision for the grant of leave of absence to the patient and for his recapture if he is absent without leave. As Sir Thomas Bingham MR explained in *In re S-C (Mental Patient: Habeas Corpus)* [1996] QB 599, p 603, because of the special problems presented by mental illness,

> "Powers … exist to ensure that those who suffer from mental illness may, in appropriate circumstances, be involuntarily admitted to mental hospitals and detained. But, and it is a very important but, the circumstances in which the mentally ill may be detained are very carefully prescribed by statute. … Thus we find in the statute a panoply of powers combined with detailed safeguards for the protection of the patient. … One reminds oneself that the liberty of the subject is at stake in a case of this kind, and that liberty may be violated only to the extent permitted by law and not otherwise."

28. The provisions which do apply to a CTO make none of the sort of detailed rules which we would expect if a CTO were to authorise the detention of the patient in a community facility. If the MHA had contemplated detention - or deprivation of liberty - in a place outside hospital, one would have expected, for example, a definition of the types of setting in which a patient could be so placed and the regulatory regime attached to them. And one would have expected an express provision saying who was entitled to detain the patient and who was entitled to recapture him if he escaped or went absent without leave.

29. I conclude, therefore, that the MHA does not give the RC power to impose conditions which have the concrete effect of depriving a community patient of his liberty within the meaning of article 5 of the European Convention. I reach that conclusion without hesitation and in the light of the general common law principles of statutory construction, without the need to turn further to the jurisprudence of the European Court of Human Rights or to resort to the obligation in section 3(1) of the

Human Rights Act 1998 to read and give effect to legislation in a way which is compatible with the Convention rights. However, it is doubtful, to say the least, whether the European Court of Human Rights would regard the ill-defined and ill-regulated power implied into the MHA by the Court of Appeal as meeting the Convention standard of legality.

The powers of the MHRT

30. Having reached that conclusion, a subsidiary question arises as to the powers of the MHRT if it finds on the facts that a community patient is being deprived of his liberty. As already seen, the MHRT has no power to revoke or vary the conditions. Its only power is to discharge the patient, either immediately or at some future date. But the MHA gives the MHRT a general discretion to order discharge in any case, alongside a duty to do so if not satisfied that the statutory criteria for the CTO are made out. (Incidentally, the Schedule attached to the judgment of the Court of Appeal, setting out the relevant sections of the Act, does not state section 72(1)(c) accurately).

31. It is argued for the patient that if he is indeed being deprived of his liberty unlawfully under the CTO, the MHRT should exercise its power to discharge him, either under the general discretion conferred by section 72(1), or because the tribunal cannot be satisfied that "appropriate medical treatment is available" for the patient. If the care plan amounts to unlawful detention, the treatment cannot be appropriate. If the patient is discharged but the grounds exist for his admission to hospital, then that can be arranged by an application for admission to hospital under section 2 (for assessment), in an emergency if necessary under section 4, or under section 3 (for treatment) in the usual way. If they do not, then there is no power under the MHA to deprive him of his liberty and he should be released.

32. Mr Gordon, on the other hand, argues that the MHRT is concerned only with whether the patient should be discharged and not with the legality of the conditions. The appellant's argument, he says, is a disguised way of conferring upon the tribunal a jurisdiction which it does not have. If the patient does need medical treatment which is available in hospital but cannot be given in the community, the proper course is for the RC to recall him to hospital, rather than for the tribunal to discharge him only to be "re-sectioned" immediately. If the patient is being illegally detained, the proper remedy is judicial review.

33. In my view, this problem is more theoretical than real. The MHRT has no jurisdiction over the conditions of treatment and detention in hospital, but these can be relevant to whether the statutory criteria for detention are made out, especially in borderline cases. The RC's report to the tribunal must cover, inter alia, full details

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

34. Furthermore, once it is made clear that the RC has no power to impose conditions which amount to a deprivation of liberty, any conscientious RC can be expected not to do so. This is reinforced by section 132A(1) of the MHA, under which it is the duty of the hospital managers to "take such steps as are practicable to ensure that a community patient understands … the effect of the provisions of this Act applying to community patients". Those steps must include giving the information both orally and in writing. The Mental Health Act Code of Practice makes it quite clear that community patients must be informed - in a manner which they can understand - of the provisions of the Act under which they are subject to a CTO and the effect of those provisions and of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their RC may recall them to hospital (para 4.13). This information should be copied to the patient's nearest relative, unless the patient requests otherwise (para 4.31). Patients should be told of this and there should be discussion with the patient as to what information they are happy to share and what they would like to be kept private (para 4.32).

35. The upshot is that patients and (usually) their nearest relatives, as well as the hospital and RCs, and the tribunal, should understand the true legal position under a CTO, as explained in this judgment.

Conclusion

36. I would therefore allow this appeal and declare that there is no power to impose conditions in a CTO which have the effect of depriving a patient of his liberty.

ANNEX (as referred to in para 16 above)

Section 17A - Community treatment orders

(1) The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below.

(2) A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment.

(3) An order under subsection (1) above is referred to in this Act as a "community treatment order".

(4) The responsible clinician may not make a community treatment order unless -

(a) in his opinion, the relevant criteria are met; and

(b) an approved mental health professional states in writing -

(i) that he agrees with that opinion; and

(ii) that it is appropriate to make the order.

(5) The relevant criteria are -

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;

(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and

(e) appropriate medical treatment is available for him.

(6) In determining whether the criterion in subsection (5)(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

(7) In this Act -

"*community patient*" means a patient in respect of whom a community treatment order is in force;

"*the community treatment order*", in relation to such a patient, means the community treatment order in force in respect of him; and

"*the responsible hospital*", in relation to such a patient, means the hospital in which he was liable to be detained immediately before the community treatment order was made, subject to section 19A below.

Section 17B - Conditions

(1) A community treatment order shall specify conditions to which the patient is to be subject while the order remains in force.

(2) But, subject to subsection (3) below, the order may specify conditions only if the responsible clinician, with the agreement of the approved mental

health professional mentioned in section 17A(4)(b) above, thinks them necessary or appropriate for one or more of the following purposes -

(a) ensuring that the patient receives medical treatment;

(b) preventing risk of harm to the patient's health or safety;

(c) protecting other persons.

(3) The order shall specify -

(a) a condition that the patient make himself available for examination under section 20A below; and

(b) a condition that, if it is proposed to give a certificate under Part 4A of this Act [that falls within section 64C(4) below] in his case, he make himself available for examination so as to enable the certificate to be given.

(4) The responsible clinician may from time to time by order in writing vary the conditions specified in a community treatment order.

(5) He may also suspend any conditions specified in a community treatment order.

(6) If a community patient fails to comply with a condition specified in the community treatment order by virtue of subsection (2) above, that fact may be taken into account for the purposes of exercising the power of recall under section 17E(1) below.

(7) But nothing in this section restricts the exercise of that power to cases where there is such a failure.

Section 17C - Duration of community treatment order

A community treatment order shall remain in force until -

(a) the period mentioned in section 20A(1) below (as extended under any provision of this Act) expires, but this is subject to sections 21 and 22 below;

(b) the patient is discharged in pursuance of an order under section 23 below or a direction under section 72 below;

(c) the application for admission for treatment in respect of the patient otherwise ceases to have effect; or

(d) the order is revoked under section 17F below,

whichever occurs first.

Section17D - Effect of community treatment order

(1) The application for admission for treatment in respect of a patient shall not cease to have effect by virtue of his becoming a community patient.

(2) But while he remains a community patient -

(a) the authority of the managers to detain him under section 6(2) above in pursuance of that application shall be suspended; and

(b) reference (however expressed) in this or any other Act, or in any subordinate legislation (within the meaning of the Interpretation Act 1978), to patients liable to be detained, or detained, under this Act shall not include him.

(3) And section 20 below shall not apply to him while he remains a community patient.

(4) Accordingly, authority for his detention shall not expire during any period in which that authority is suspended by virtue of subsection (2)(a) above.

Section 17E - Power to recall to hospital

(1) The responsible clinician may recall a community patient to hospital if in his opinion -

(a) the patient requires medical treatment in hospital for his mental disorder; and

(b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

(2) The responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition specified under section 17B(3) above.

(3) The hospital to which a patient is recalled need not be the responsible hospital.

(4) Nothing in this section prevents a patient from being recalled to a hospital even though he is already in the hospital at the time when the power of recall is exercised; references to recalling him shall be construed accordingly.

(5) The power of recall under subsections (1) and (2) above shall be exercisable by notice in writing to the patient.

(6) A notice under this section recalling a patient to hospital shall be sufficient authority for the managers of that hospital to detain the patient there in accordance with the provisions of this Act.

Section 17F - Powers in respect of recalled patients

(1) This section applies to a community patient who is detained in a hospital by virtue of a notice recalling him there under section 17E above.

(2) The patient may be transferred to another hospital in such circumstances and subject to such conditions as may be prescribed in

regulations made by the Secretary of State (if the hospital in which the patient is detained is in England) or the Welsh Ministers (if that hospital is in Wales).

(3) If he is so transferred to another hospital, he shall be treated for the purposes of this section (and section 17E above) as if the notice under that section were a notice recalling him to that other hospital and as if he had been detained there from the time when his detention in hospital by virtue of the notice first began.

(4) The responsible clinician may by order in writing revoke the community treatment order if -

(a) in his opinion, the conditions mentioned in section 3(2) above are satisfied in respect of the patient; and

(b) an approved mental health professional states in writing -

(i) that he agrees with that opinion; and

(ii) that it is appropriate to revoke the order.

(5) The responsible clinician may at any time release the patient under this section, but not after the community treatment order has been revoked.

(6) If the patient has not been released, nor the community treatment order revoked, by the end of the period of 72 hours, he shall then be released.

(7) But a patient who is released under this section remains subject to the community treatment order.

(8) In this section -

(a) "*the period of 72 hours*" means the period of 72 hours beginning with the time when the patient's detention in hospital by virtue of the notice under section 17E above begins; and

(b) references to being released shall be construed as references to being released from that detention (and accordingly from being recalled to hospital).