[2019] AACR 16

(LW v Cornwall Partnership NHS Trust and associated cases [2018] UKUT 408(AAC))

HM/1472/2018
Judge Ward **HM/1969/2018**
29 November 2018 **HM/2188/2018**

Mental Health Act 1983 – Community Treatment Orders – whether defined degree of imminence of likely relapse required in order to justify not discharging a patient from a Community Treatment Order – what is to be expected of the First-tier Tribunal's reasons in such a case

The case concerned three unconnected appellants: LW, SE and TS. LW has paranoid schizophrenia, was placed on a Community Treatment Order (CTO) in October 2017. She applied for a discharge, which was refused by the First-tier Tribunal (F-tT). SE has paranoid schizophrenia. He was placed on a CTO in July 2015. He applied for discharge, which was refused by the F-tT. TS has an underlying psychotic disorder which may have been triggered by drug abuse. He was placed on a CTO in July 2016. He applied for discharge, which was refused by the F-tT. All three appellants appealed to the Upper Tribunal (UT). The grounds for appeal argued that there was, as a matter of law, a degree of imminence of relapse required before, under section 72 of the Mental Health Act 1983, a person could be lawfully retained as a community patient on a CTO; and what was required of a tribunal in terms of giving reasons in such cases.

Held, dismissing the appeals, that:

1. where there is a risk of relapse which might necessitate recall, it will be a relevant consideration when it is thought likely such a relapse will occur; but that factor is not itself determinative; other factors, including risk to the patient and/or others if a relapse were to occur may also be relevant (paragraph 49(a) to (b));
2. the authorities do not establish as a matter of law that likely relapse must be "soon", "in the near future" or within the permitted duration of a CTO for discharge to be lawfully refused. The case for discharge may be stronger if the anticipated timescale for relapse is protracted, but all relevant circumstances must be taken into account in deciding "appropriate" for the purposes of section 72(1)(c); and
3. a tribunal must comply with established legal principles in relation to giving reasons, which includes explaining why the case for discharge has not succeeded. The UT should be slow to infer that the F-tT has overlooked basic features of a CTO, such as that, if used to secure against the patient's wishes that medication is taken in the community, it may trespass upon the patient's personal autonomy.

DECISION OF THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

HM/1472/2018

Mr Roger Pezzani, instructed by Conroys Solicitors for the Appellant

HM/1969/2018

Mr Roger Pezzani, instructed by Conroys Solicitors for the Appellant appeared pro bono

HM/2188/2018

Mr Roger Pezzani, instructed by Donovan Newton Solicitors for the Appellant

No attendance or representation for the Respondents:

Decision

Save for the cover sheet, this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)). That sheet is not formally part of the decision and identifies the appellants by name.

All three appeals are dismissed. The decisions of the following tribunals did not involve the making of an error of law:

HM/1472/2018:
The tribunal sitting at Bodmin Hospital on 23 March 2018 under reference MP/2018/01483

HM/1969/2018:
The tribunal sitting at Haytor Unit, Torbay Hospital on 11 June 2018 under reference MP/2018/10479

HM/2188/2018:
The tribunal sitting at Reaside Clinic, Birmingham on 19 July 2018 under reference MP/2018/16093

REASONS FOR DECISION

1. Put shortly, these cases concern what is to be expected of the First-tier Tribunal ("F-tT") when it is deciding whether or not to uphold the making (or continuation) of a Community Treatment Order ("CTO"). The issues raised are substantially similar and the cases were heard together so as to provide a range of scenarios against which the issues could be considered. What in particular they examine is the correct approach to the likelihood of relapse if a patient, once free of the CTO, does not take his or her medication and the possible consequences if such a relapse were to occur.

2. In each case, the respondent NHS Trust indicated that it intended to play no active part in proceedings and remained neutral.

3. The Secretary of State for Justice was offered the opportunity to apply to be joined, which he failed to take up. That was regrettable, as, coupled with the lack of participation by the respondents, it means that the Upper Tribunal only received submissions on behalf of the appellants and none on behalf of the State.

4. That said, Mr Pezzani sought to present the issues fairly and responsibly and I am grateful to him for his submissions before and at the hearing and for his follow-up note.

5. The appellant in HM/1472/2018 is LW. She has paranoid schizophrenia. It is a long-standing condition, with a relapsing and remitting course that responds at least partially to anti-psychotic medication. She has a substantial history of admissions. In October 2017 she was placed on a CTO. Her application for discharge was refused by the F-tT on 23 March 2018. Permission to appeal was refused by a judge of the F-tT but given by Upper Tribunal Judge Levenson. On 25 September 2018 LW was discharged from her CTO.

6. The appellant in HM/1969/2018 is SE. He has paranoid schizophrenia. He has a substantial history of admissions. His most recent admission under section 2 commenced on 31 March 2015 and was followed by detention under section 3, prior to being placed on a CTO on 23 July 2015. It was renewed for 12 months on 11 July 2017. His application for discharge was refused by the F-tT on 11 June 2018. Permission to appeal was given by a judge of the F-tT, who was aware of the pending appeal in LW's case.

7. The appellant in HM/2188/2018 is TS. The F-tT found that he has an underlying psychotic disorder, such as schizophrenia, one that may have been triggered by drug abuse. He was admitted (for the first time) on 13 March 2015 under section 2, continued under section 3 and on 7 July 2016 was placed on a CTO. His application for discharge was refused by the F-tT on 19 July 2018. Permission to appeal was given by a judge of the F-tT.

8. There is no issue regarding the capacity of any of the appellants, though the insight of each is imperfect. Both SE and TS (but not LW), when unwell, were involved in acts of aggression and violence. In TS's case the incidents were particularly serious. There is more to be said about all three cases and I return to the detail below.

9. The cases were transferred to me with a view to holding the combined oral hearing.

10. I had originally understood the grounds to be arguing that there was, as a matter of law, a degree of imminence of relapse required before a person could lawfully be retained as a community patient on a CTO. In the course of argument, the position appeared to evolve into what was required of a tribunal in terms of giving reasons in such a case. I consider both.

11. I gratefully adopt parts of the description of the CTO regime set out in the Court of Appeal's decision in *Secretary of State for Justice v MM; Welsh Ministers v PJ* [2017] EWCA Civ 194. Whilst I am aware that an appeal to the Supreme Court has been heard in those cases and that (in *PJ*) judgment is awaited, it does not detract from the utility of the Court of Appeal's summary, from which I have removed matters specific to the point at issue in *PJ*, which does not arise in any of the present cases.

> "47. The CTO scheme is set out in sections 17A to 17E, inclusive, of the MHA. The powers of tribunals in respect of patients under the scheme are set out in section 72. … . It is necessary to appreciate the roles and responsibilities of those involved in the CTO scheme in the context of the overall statutory framework in order to interpret that framework in a way that is consistent with the fundamental features of the legislation.
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> 48. … [T]he authority for the detention of a patient who is subject to a CTO ('a community patient') is suspended during the CTO by reason of section 17D(2)(a). A community patient is not liable to be detained in hospital although he may be recalled for treatment under section 17E. The exercise of the power of recall, which rests solely with the responsible clinician, is not dependent upon any compliance with or alleged breach of the CTO conditions. … .
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> 49. Sections 17A and 17B MHA provide the lawful authority for a responsible clinician to make a CTO. Section 17B(2) is the source of the power for the responsible clinician to make conditions that are necessary and appropriate for one or more of three defined purposes: a) ensuring that the patient receives medical treatment, b) preventing risk of harm to the patient's health or safety, and c) protecting other

> persons. Those purposes have to be read in conjunction with the power granted to the responsible clinician to make a CTO. That power is constrained so that a CTO may not be made unless the relevant criteria are met. The criteria are set out in section 17A(5). They include the continuing necessity for medical treatment for the patient's health and safety or the protection of other persons, the necessity of the retention of the power of recall to hospital and that appropriate medical treatment is available and can be provided for the patient without his continuing detention in a hospital.
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> 50. The terms of the power are wide. It is clear from the nature and extent of the CTO scheme that the object of the power is to provide a balance between the protection of the patient and the public and the receipt by him of medical treatment without his continuing detention in hospital, where that is appropriate. …
> …
>
> The safeguards:
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> 54. The CTO scheme is provided for in a statutory framework that is a procedure prescribed by law. The criteria for the imposition of conditions that may deprive a patient of his liberty are specified in sections 17A(4) to (5) and 17B(2) MHA. They are limited to the purposes of the legislation, for example, for medical treatment. They are time limited by section 17C and they are subject to regular rights of review by sections 20A and 66 which are equivalent to the rights enjoyed by a patient detained in hospital so that there is no incoherence or lack of equivalence in the safeguards provided by the scheme. The conditions in a CTO have to be in writing: see, for example sections 17A(1) and 17B(4). The responsible clinician has the power of recall (sections 17E(1) and (2)) and the powers of suspension and variation (sections 17B(4) and (5)). … "

12. In terms of the generally applicable principles, Mr Pezzani's submission has three parts. First, he submits (my emphasis added) that "in relation to *detained patients* there is a clear line of authority that proximity in time between the point of discharge from detention and the likely need for readmission for treatment determines the decision about whether a detained patient is entitled to discharge." Then, he submits that the same principle applies to CTO patients. Finally, he examines the reasons behind that principle.

13. I examine each in turn. All the authorities are persuasive, rather than strictly binding. In examining them, I am mindful of the important fundamental principles underpinning mental health legislation, in particular the principle of least restriction.

14. It is convenient at this point to set out MHA, section 72(1) which stipulates in paragraphs (b) and (c) when a tribunal is required to discharge, respectively, a detained patient and a community patient. Sub-section (1A) is parasitic upon it. The cases which then follow are governed by paragraph (b) but Mr Pezzani submits they should be applied by analogy to paragraph (c).

> "(1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and—
>
> (a)…;

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—
(i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
(ii) that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or
(iia) that appropriate medical treatment is available for him; or
(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself.

(c) the tribunal shall direct the discharge of a community patient if it is not satisfied–
(i) that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or
(ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or
(iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or
(iv) that appropriate medical treatment is available for him; or
(v) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself.

(1A) In determining whether the criterion in subsection (1)(c)(iii) above is met, the tribunal 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 to continue not to be 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)."

15. *R v London and South and South West Region MHRT ex p Moyle* [1999] MHLR 195 concerned a man who when unwell had committed the offence of unlawful wounding of his wife. Some years later, his condition had been stabilised and the psychiatric evidence was that his condition would not lead to him being detained if he was in the community but that he would relapse if he did not take his medication and pose a danger to himself or others. The MHRT was found to have erred by directing itself that the criteria for admission in MHA section 3 and for discharge in section 72 did not mirror each other. The tribunal then had to deal with a submission from the patient's counsel that the patient could only be detained if his failure to comply with medication arose from his illness. It was in rebutting that submission that Latham J observed at [36] that:

"The correct analysis, in my judgment, is that the nature of the illness of a patient such as the applicant is that it is an illness which will relapse in the absence of medication. The question that then has to be asked is whether the nature of that illness is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment. Whether it is appropriate or not will depend upon an assessment of the probability that he will relapse in the near future if he were free in the community. That value judgment has to be exercised in the context of the reversed burden of proof. If the Tribunal are not satisfied that there is no probability of relapse in the near future,

> they would be unlikely to be able to conclude that this criteria *(sic)* had been satisfied."

16. The formulation is made complicated by the burden of proof then in operation, since modified. More importantly for present purposes, the judge was addressing a case where it was not in dispute that relapse in the near future was likely. That his remarks were not intended to suggest that relapse in the near future was the only basis on which the "nature" of a patient's illness might make detention appropriate is further supported by the extensive quotation from "Mental Health Review Tribunals, Law and Practice" by Mr Anselm Eldergill which in the judgment follows the passage I have set out above. As well as cases where there is a "probability of a serious, further deterioration of the patient's condition in the near future" it also refers to cases where there is a "long history of re-admissions indicative of a severe, chronic condition which is resistant to treatment or a record of poor compliance with informal treatment following previous discharges." In *Moyle* the judge was not engaged in determining where a line needed to be drawn.

17. *Smirek v Williams* [2000] EWCA Civ 3025 was an application for permission to appeal only. However, the judgment is a reasoned one by Lady Justice Hale (as she then was) on behalf of a two judge court and is entitled to considerable respect. The case was an unusual one in that the MHRT had ordered the discharge of the patient, following which an immediate fresh application was made to readmit him for treatment. This and other aspects of the conduct of the health and social care services were clearly of concern to the court. Nonetheless, whereas the MHRT had accepted the patient's assurances that he would continue to take his medication, there was a finding that the patient had subsequently told four professionals that he would not do so. A change in circumstances justified a new application.

18. Counsel for the patient submitted that while an illness might be of a sufficient nature or degree if a patient did not take his medication, that condition was not fulfilled so long as he continued to take it, thus it was necessary for him to be let out, fail to take his medication and then for his condition to deteriorate. In finding that "an impossible proposition to accept", Hale LJ indicated at [19] that

> "There are of course mental illnesses which come and go, but where there is a chronic condition, where there is evidence that it will soon deteriorate if medication is not taken, I find it impossible to accept that that is not a mental illness of a nature or degree which makes it appropriate for the patient to be liable to be detained in hospital for medical treatment if the evidence is that, without being detained in hospital, the patient will not take that treatment."……

19. Once again, the court was not having to draw a line about imminence in order to deal with the point before it. Mr Pezzani invites me to conclude that Hale LJ was using the word "soon" advisedly. No doubt she was, but because that was the evidence in the case before her, to which she needed to allude in order to rebut the point counsel for the patient had put forward.

20. In *R (Epsom and St Helier NHS Trust) v MHRT* [2001] EWHC Admin 101, the patient's mental ill-health manifested itself in a serious unwillingness to take nutrition, her actions in relation to which threatened to place her life in jeopardy. While she would, at some unknown point, need hospital treatment in order to address the PEG tube by which it was intended she receive nutrition, she was being cared for in a nursing home, something which is outside the scope of MHA section 3, and so the tribunal discharged her. In dismissing the

application by the NHS Trust for judicial review of the tribunal's decision, Sullivan J (as he then was) observed:

> "51. At this stage in its reasons, having described W's illness, the Tribunal was very much alive to the need to look to the future to see what in-patient treatment would or might be required. It was probing the extent to which that was likely over the next few months. The likelihood of treatment being required in the future within the period of detention is plainly a relevant contention. It would be inconsistent with the scheme of the Act, which affords protection to the patient by making provision for regular six-monthly reviews, if the mere prospect, that at some unspecified future time in-patient treatment would or might be required, compelled a tribunal to reject a patient's application for discharge.
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> 52. The matter has to be looked at in the round, including the prospect of future in-patient treatment, but there will come a time when, even though it is certain that treatment will be required at some stage in the future, the timing of that treatment is so uncertain that it is no longer "appropriate" for the patient to continue to be liable to detention. It is the Tribunal's function to use its expertise to decide whether the certainty, or the possibility, of the need for in-patient treatment at some future date makes it "appropriate" that the patient's liability to detention shall continue.

Probing what was likely "over the next few months" was clearly regarded as acceptable. That in-patient treatment would or might be required at some unspecified future time was not. Between the two there is a wide gap which once again the judge was not required by the case before him to address. In any event, the matter had to be looked at "in the round" and the prospect of future in-patient treatment was one factor to be included in that consideration.

21. In *CM v DHNSFT and Secretary of State for Justice* [2011] UKUT 129 (AAC), Upper Tribunal Judge Levenson was faced with the same situation as I have been, namely no submission on behalf the hospital or the Secretary of State. He set the tribunal's decision aside (at [27]) for four errors of law. One of them was that there was "no real evidence to support [the tribunal's] view that non-compliance with medication and the risk of consequent relapse in the near future would probably occur". I am not clear from reading the decision that the tribunal did in fact hold the view attributed to it, but it evidently was the judge's view that that was the test it needed to have applied. At paragraph 12 he held:

> "If the nature of a patient's illness is such that it will relapse in the absence of medication, then whether the nature is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment depends on an assessment of the probability that he will relapse in the near future if he were free in the community and on whether the evidence is that without being detained in hospital he will not take the medication (Smirek v Williams (2000) 1 MHLR 38 – CA; R v MHRT ex parte Moyle [2000] Lloyd's LR 143 – High Court)."

The decision does not contain a detailed consideration of the effect of the cases cited.

22. The judge found that (while he could not find the evidence on which it relied) the tribunal appeared to have been envisaging a scenario of release, followed by six months before the patient had resumed a chaotic lifestyle (which risk would not by itself justify continued detention), eventually leading to non-compliance with medication, with a risk of

relapse in his mental state after at least two months of non-compliance, something which he considered "would be a lengthy period in view of the meaning of "nature" discussed above".

23. With respect, I find the case somewhat difficult to apply. The primary focus of the decision appears to have been on whether, despite the F-tT's recognition (paragraph 21) that it was not entitled to detain the patient because he behaved in an anti-social and chaotic way, it had in fact done so. It may be that the four errors identified in the closing paragraph of *CM* are to be understood as aspects of this, in that because of the errors identified the tribunal had failed to demonstrate that its decision validly rested on any basis other than the impugned one.

24. For the reasons I gave at [16] and [19], for my part I do not regard either *ex p Moyle* or *Smirek* as providing an authoritative basis for the views expressed at paragraph 12 of *CM*. Neither of those cases, for the reasons I have given, involved setting a requirement that relapse be in the "near" future. Nor does either case suggest that the imminence of relapse is an exclusive consideration so if by "depends" is meant "depends exclusively" then I would respectfully disagree.

25. Mr Pezzani had a fall-back position: that even if relapse in the near future was of itself not determinative, it was at least very strongly influential. I do not have any difficulty with the notion that when relapse may occur is a material consideration. However, I do not consider that it is for the Upper Tribunal to usurp the role of the specialist First-tier Tribunal in deciding what weight should be given to the various considerations which are before it.

26. In my view the most helpful guidance is provided by Sullivan J in the *Epsom* case: that it is for the Tribunal to use its expertise to decide looking at the matter in the round whether the certainty, or the possibility, of the need for in-patient treatment at some future date makes it "appropriate" that (in a section 3 case) in such cases the patient's liability to detention shall continue. "Appropriate" is a broad term. Clearly as that decision, and all the others referred to, make clear, imminence of relapse will be a relevant consideration. I return to this below.

27. I am not ruling on a section 3 case but on a section 17A case. If and to the extent that I need to reach a view on the section 3 cases for the purposes of Mr Pezzani's argument by analogy, I do accept that the time within which a relapse is thought likely to occur is a material consideration but am unable to discern a principle that such a relapse must be "soon" or "in the near future". While clearly the case for detention may prove to be stronger if it is, that falls short of accepting Mr Pezzani's formulation that proximity in time "determines" the decision about whether a detained patient is entitled to discharge.

28. The second part of Mr Pezzani's submission seeks to establish that what goes for patients who are detained under section 3 should apply equally to community patients.

29. He relies first on the similarity between section 3 and section 17A. I accept that there is a very close parallel between them. However, that reflects that both are measures necessitated by the nature or degree of a person's mental disorder, that it should be necessary for identified reasons that it be treated and that there be appropriate treatment available. In a system where both detention in hospital and being made subject to a CTO,while different in degree (reflected in section 3 being in the background when a person is on a CTO), are used for in essence the same specific, identified purposes, that is unsurprising.

30. However, to confine the analysis to that would in my view be to overlook the context of the legislative provisions relating to CTOs and to 'fail to' recognise the reality that, while they undoubtedly still represent an interference with a person's autonomy, it is, at least in general, a lesser interference than detaining them in hospital. As the Court of Appeal noted in *PJ* at [50]:

> "It is clear from the nature and extent of the CTO scheme that the object of the power is to provide a balance between the protection of the patient and the public and the receipt by him of medical treatment without his continuing detention in hospital, where that is appropriate. … "

31. He then seeks to make a comparison between the situation of patients on long-term leave from detention in hospital and those on a CTO, including that the section 117 aftercare duty applies to both. The former have the protection afforded by *Smirek* (which as will have been apparent he submits is greater than I consider it to be), whereas CTO patients are always liable to immediate detention by recall under section 17E and revocation under sections 17F and 17G.

32. The paradigm situation for a detained patient is not long-term leave, it is being in hospital. The Mental Health Act 1983: Code of Practice indicates at paragraph 27.11 that "leave shall normally be of short duration and not normally more than seven days". It does acknowledge that there are circumstances where longer term leave may be appropriate, indicating at paragraph 31.5 that:

> "Leave for a longer period should also be for a specific purpose or a fixed period, and not normally more than one month."

33. While Jones[1] criticises the guidance as "unduly restrictive" it is nonetheless clear that situations of long-term leave are a response to specific situations. It is inappropriate in my view to reason from a person in such a limited and specific situation on to drawing conclusions affecting the generality of detained patients.

34. Mr Pezzani then submits that, while their purpose is the same, the consequences of a relapse and re-detention for a CTO patient are more immediate, with fewer protections than a fresh detention under section 3. The latter would require medical recommendations from two doctors (section 3(3)), an application to the hospital managers by an Approved Mental Health Professional ("AMHP") and the consent of the nearest relative (section 11(4)). He contrasts recall from a CTO which requires only the opinion of the responsible clinician and revocation which only requires the opinion of the responsible clinician and the agreement of an AMHP.

35. This is of course accurate as far as it goes. But in my view it is an important distinction that while section 3 may be used for re-admissions, it is also used for people who have had no previous restrictions on their liberty at all; a CTO by contrast is only available in respect of those who are already detained patients[2]. It is in the nature of a controlled relaxation of constraints upon them, by allowing them to be in the community rather than in hospital. It permits the testing out of approaches to their treatment against the backdrop that if there appears to be a risk of things going wrong, they can be brought back for the detention in hospital which they had previously been found to require. This is one of the features of CTOs

[1] Mental Health Act Manual, Twenty-First edition at 1-237
[2] i.e. a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment: section 17A(1) and (2).

which was not found in the previous regime of supervised discharge, which it replaced. It is an entirely logical position that the legislator should have provided for a relatively high degree of control to be potentially exercisable by a responsible clinician in respect of a patient on a CTO in order to encourage the responsible clinician to take the (controlled) risk of making a CTO, thereby enabling a reduction of the constraints upon the patient to take place. Mr Pezzani submits that because section 3 is always in the background for a community patient it would be anomalous that the patient should have to experience several periods of potential liability to detention before being actually liable to detention when the relapse occurred. However, whilst it is clearly important that even periods of potential liability to detention are only imposed when they are justified, there is nothing intrinsically odd in this structure given that a CTO is a controlled relaxation.

36. Mr Pezzani argues that, according to the Court of Appeal in *Welsh Ministers v PJ* [2017] EWCA Civ 194, a CTO can involve a deprivation of liberty, so if a CTO may be used to objectively deprive the patient of their liberty, why, he asks, should they then have less protection than a patient in a hospital? The answer to that is to be found in *PJ* at [64], where the court said:

> "In so far as it is necessary to deal with the second ground of appeal, we agree that it necessarily follows from this court's interpretation of the statutory framework in the non-criminal context that there is a distinction to be drawn between deprivation of liberty consequent upon compulsory detention in hospital for treatment and a lesser restriction on a patient's freedom of movement that nevertheless amounts to an objective deprivation of liberty. The latter circumstance is a statutory alternative to compulsory detention for a clear purpose as long as the patient is not exposed to a greater restriction than would be the case if s/he were to be compulsorily detained in hospital."

37. He then submits that the requirement under both (b) and (c) of sections 72(1) to examine whether the patient is then suffering from mental disorder of a nature/degree (etc.) is harder to satisfy when risk of relapse is further in the future. No doubt that may in some cases be so, but it does not add to the consideration of what constitutes the "nature" of the mental disorder for such a purpose.

38. It follows that while there are plainly some parallels between the section 3 regime and CTOs, they are not such that the same principles necessarily apply to both. Even were I to be wrong in my view of the effect of the line of authority represented by *Moyle*, *Smirek* and others, I would not consider that it should automatically be applied to CTO patients.

39. The third strand of Mr Pezzani's argument is said to be strictly unnecessary because the line of authority is unequivocal. As I do not accept that the line of authority says what he contends, much less than it is unequivocal, nor even that it is necessarily applicable to CTOs, I turn to the third strand in rather more detail. Indeed, as will become apparent, I consider it holds the key to the relevant principles.

40. He submits that the alternative to the principle for which he contends is an unattractive one: that people who are mentally well are subject to compulsion (including as to medical treatment) against their will on the ground that they may "at some remote or uncertain time in the future" require readmission for treatment. Much in the treatment of mental health may be "uncertain" as Mr Pezzani acknowledges. To be able to point to a time with certainty is not required. I accept that the risk of relapse and of the need for further treatment may be too

remote. The remoteness of the need for treatment was a highly relevant factor in the *Epsom* case. Proximity may be relevant in the sense that it is necessary to ask in cases where the risk of relapse is the issue how soon or otherwise this is likely to occur. What I cannot accept is that in all such cases it is, in effect, a requirement that relapse be likely to occur soon, or in the near future.

41. Indeed, at this point Mr Pezzani's submissions acknowledge this. He rightly acknowledges that it all depends on the individual case. Every case has a "too remote" (I agree). The more remote the need for inpatient treatment, the less likely it is to justify continuation of the CTO (again, I agree, although remoteness in my view is not the only consideration).

42. He submits that in some cases the period of liability (regulated by section 20A) of 6 months may be helpful as a measure, referring to *Epsom* in this regard. Sullivan J did indeed observe that "The likelihood of treatment being required in the future within the period of detention is plainly a relevant consideration." However, the argument is used in support of his view that it would be inconsistent with the scheme of the Act if there was a "mere prospect" of inpatient treatment being required at some "unspecified future time". That is certainly not tying the proximity test to a statutory test such as the 6 month period (which, moreover, in any event may in certain circumstances be one year: section 20A(3)(b).)

43. Mr Pezzani's submissions in my view go too far in suggesting that if the patient is likely to remain well with or without a CTO for a "non-trivial" period, it is not appropriate for the responsible clinician to retain a right of recall. Nor, for the reasons above, does it follow merely because they are likely to remain mentally well for the authorised period of the CTO. In support of his submission on this point, Mr Pezzani relied on section 17A(6). That provision has to be read in conjunction with section 17A(5) which sets out relevant criteria which have to be fulfilled before the responsible clinician is permitted to make a CTO. By (5)(d) these include that "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." Sub-section (6) then provides:

> "(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)."

44. In my view, Mr Pezzani's submission on this point confuses the question of whether it is necessary for the responsible clinician to have the power with whether the circumstances for exercising the power arise.

45. Mr Pezzani submits that possible negative consequences to the patient are relevant but not determinative (sc. in considering "nature"- the patient's health and safety is in any event a separate head under section 17A(5)(b)). I agree inasmuch as they cannot be used to trump a need for treatment that is simply too remote: *Epsom*.

46. An important factor in some cases will be the risk to the patient or to others if a relapse were to occur. It does not make consideration of the imminence of relapse irrelevant, but the seriousness of the consequences if a relapse were to occur is undoubtedly a factor to be

weighed up along with proximity and others. In *MD v Mersey Care NHS Trust* [2013] UKUT 127 (AAC) (a case on section 72(1)(b)) Upper Tribunal Judge Jacobs considered it to be "beyond argument that risk is relevant to both paragraphs (i) and (ii)" (at [9]) and (at [13]) that "risk can be relevant to all the statutory criteria". Mr Pezzani sums up the position on this, pithily and in my view accurately, as being that "the MHA is not a general risk prevention tool. There must be a mental disorder in need of treatment for it to be lawfully used."

47. Finally, in relation to the issue generally, he makes a number of points emphasising by reference to general principles and to specific provisions of the Code the importance to be given to protecting patients' autonomy. I fully accept the importance of those principles and recognise, in particular, that the use of a CTO to ensure the patient receives medical treatment (cf.s.17B(2)(a)) which the patient might not have chosen freely to accept, is an intrusion on their autonomy. Being on a CTO will however, at least in the majority of cases, involve a lesser intrusion on their autonomy than being detained in hospital would.

48. In view of the significance of individual autonomy, he submits that the F-tT's reasons:

> "must demonstrate that it has properly been considered and weighed in the balance. Otherwise only clinical interests are considered, rather than being balanced against the individual person's wishes about how to deal with their own bodies and minds."

The authorities about a tribunal's duty to give reasons are well-established. It is difficult to see how one could explain to a patient who wanted to be discharged rather than kept on a CTO why he or she had lost their appeal without addressing why the tribunal had not accepted what they said or had concluded that it was outweighed by other considerations. I do not consider however that the duty to give adequate reasons is modified because it is a CTO that is involved. In particular, a specialist tribunal may in my view be taken to be well aware that a CTO represents an intrusion on a patient's autonomy (albeit less of one than being in hospital). There was a suggestion that it might be necessary to address the particularly heightened perception of the importance of loss of autonomy to an individual patient. To the extent that such was in evidence before the F-tT, it can be addressed if necessary as part of explaining why they lost.

49. To sum up:

> a) in cases where there is a risk of a relapse which might necessitate recall, it will be a relevant consideration when it is thought likely such a relapse will occur;
>
> b) that factor is not of itself determinative; other factors, including the risk to the patient and/or others if a relapse were to occur, may also be relevant;
>
> c) the authorities do not establish as a matter of law that likely relapse must be "soon", "in the near future" or within the permitted duration of a CTO for discharge to be lawfully refused;
>
> d) the case for discharge may be stronger if the anticipated timescale for relapse is protracted, but all relevant circumstances must be taken into account in deciding what is "appropriate" for the purposes of section 72(1)(c);

e) a tribunal must comply with established legal principles in relation to the giving of reasons. That includes explaining to the patient why his or her case for discharge has not succeeded. In my view, the Upper Tribunal should be slow to infer that the First-tier Tribunal has overlooked basic features of a CTO, such as that, if used to secure against the patient's wishes that medication is taken in the community, it may trespass upon the patient's personal autonomy;

f) I have reached these conclusions primarily from consideration of the statutory framework of CTOs and the legislative purposes behind them. I do not accept that there is a necessary and complete read-across from authorities relating to section 3. Even were I to be wrong in that, I consider that the cases cited do not provide authority for a requirement that relapse be likely soon or in the near future if the patient is to be refused discharge.

50. I turn to applying the general principles to the specific cases before me.

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51. The F-tT found that the nature of the patient's mental disorder was longstanding with a relapsing and remitting course that responds at least partly to antipsychotic medicine. It found that she did not accept that she suffered from a mental disorder and saw no link between taking medication and remaining well. She had always eventually declined to take a therapeutic dose when not in hospital. The evidence of the responsible clinician, which the FtT implicitly accepted, was that a deterioration in mental health commenced within three months of her stopping medication. LW's evidence was that, if not on a CTO, she would seek to negotiate a reduction in medication. When unwell her behaviour can provoke a reaction that could put her at risk of retaliation from others.

52. LW's solicitors have suggested that the evidence of the responsible clinician was that the deterioration in LW's health would commence within 3-6 months rather than 3 months as recorded by the F-tT. However that is not a material issue. The point being made was that neither amounts to relapse "in the near future" but, as I have indicated, that is not the test.

53. I do not accept that the F-tT erred in law in its reliance on LW's evidence that she would negotiate a reduction in, rather than stop taking, medication. The F-tT found that she would "relatively quickly stop medication or at least negotiate a reduction to a non-therapeutic dose" if not subject to a CTO. That conclusion was plainly open to the F-tT given that it could not be excluded that if a reduction could not be agreed, LW would simply refuse to take medicine as part of "negotiations" and her track record of always eventually declining to take a therapeutic dose when not in hospital. As there is no requirement that relapse be soon, in the near future or by reference to any period prescribed by statute, "relatively quickly" sufficiently addressed the likely imminence of stopping treatment and the tribunal's findings on the consequences are as set out above.

54. Although not, as such, part of the original grounds of appeal, Mr Pezzani then submits that the F-tT failed to give reasons for its apparent preference for the responsible clinician's evidence over that of LW. When the decision is read as a whole, I do not think that is correct. Even LW's evidence created real doubt as to whether she would continue to take medicine at a therapeutic dose if not subject to a CTO, as did the history. In paragraph 16 of its decision, the F-tT addressed points made by LW's solicitor. He had submitted (as was indeed the case from the evidence) that as well as looking at history, LW was currently presenting well and

having psychological therapy. The F-tT concluded that such factors were not as yet sufficiently protective to ensure that she would comply with all aspects of her treatment and support. In other words, they had to evaluate what LW was saying. Their conclusion as a specialist tribunal was that she would need protective factors to help her achieve what needed to be achieved; and that those factors were insufficiently present. That in my judgment is a sufficient explanation of why, to the extent that they were in conflict, the F-tT preferred the evidence of the responsible clinician to that of LW on this issue. It was ultimately a question of judgment for the specialist tribunal. To say as Mr Pezzani does that it was necessary for the F-tT to say more about what part those factors played and why they were considered insufficiently protective would be to require the tribunal to give reasons for reasons and thus imposes too high a duty upon it.

55. Mr Pezzani then says the tribunal ought to have done more to address the impact on the patient's autonomy. The F-tT will have realised perfectly well that maintaining the CTO in force was an infringement of the patient's autonomy. It knew that she wished to reduce her medication and had a reason for that wish. However, it concluded for reasons it gave that she needed to receive medication to an extent that she was unlikely to continue to agree to. If the tribunal's reasons for maintaining a CTO in force were otherwise adequate, it is hard to see how an appeal to individual autonomy would add anything.

56. The evidence showed that LW had begun a journey in a positive direction. That journey appears from her subsequent discharge on 25 September 2018 to have been maintained, but the F-tT had to make a judgment on the evidence as it stood 6 months before that. They did so and in my judgment did not err in law. They were not required to apply a test said to be derived from *CM* that a specific degree of imminence of relapse was required. The factors they took into account were relevant to considering what was "appropriate" for the purposes of section 72(1)(c) and their reasons, as I have endeavoured to show, were adequate.

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57. SE's case to the F-tT was, as it noted, based on an argument that there had been lengthy periods of time when SE was living in the community without the constraints of a CTO and that, if he were to disengage with treatment, any relapse would be likely to be over a prolonged period. He sought to rely on *CM* as authority that a risk of relapse must relate to the near future.

58. The F-tT accepted that there had been periods of time when SE had lived in the community without a CTO and noted that when the last CTO was revoked it was not until 16 months later that an MHA assessment resulted in his being readmitted. The F-tT directed itself that *CM* related to detained patients and not to CTO patients but was satisfied that it was helpful in identifying speed of relapse as one factor that must be considered. In the light of the conclusions I have reached above, that was correct in law.[3]

59. The evidence to the F-tT was that there had been a recent change, described as "striking" and "stark", to SE's insight, leading to an apparent willingness to accept, contrary to the position that he had earlier adopted, that he may have been unwell in the past. The treating team considered that the appropriate course in response to this would be to continue with medication and for there to be a referral to psychology. The F-tT found that SE's

[3] It reached a similar conclusion in relation to *R(H) v MHRT (N and E London Region)* [2001] EWCA Civ 415. That case addresses a somewhat different issue but overall it does not vitiate the FtT's reasoning in relation to *CM*.

approach to the proposed psychology referral was consistent with his approach when lacking in insight and agreed with SE's care coordinator that he would be unlikely to engage with it if the CTO were discharged. As regards medication, SE himself had said that if the CTO were discharged he would accept only one more depot injection and then would switch to oral medication. However, the F-tT found there had been a previous history of non-compliance with oral medication. It explained, with adequate reasons, why it thought non-compliance was likely.

60. Even with such findings, why did it consider a CTO continued to be required? It had reminded itself of paragraph 29.5 of the Code of Practice – that the function 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 others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs."

It directed itself (at [38]) that:

> "[G]iven that a CTO patient is already in the community, the speed of any relapse will only be one feature that may indicate the necessity or otherwise for the power of recall to remain. The structure of a CTO provides an opportunity for mental state to be observed and assessed without waiting for mental state to have deteriorated to such an extent that a Mental Health Act Assessment is required. If necessary, the power of recall can be used to prevent a deterioration in mental state that might otherwise lead to a full-blown relapse."

61. It went on to find, for reasons it explained, that in the event of relapse there would be a real risk of recurrence of incidents of aggressive behaviour towards others, some of which had resulted in arrest, thus the power of recall was necessary in the interests of SE's own health and safety and the protection of others. It took on board (paragraph 51) that it might be some time before SE's mental state might justify a further MHA assessment but concluded that that did not mean other factors, notably risk, had to be disregarded. Its conclusion that retaining the CTO was a proportionate response and the least restrictive option, far from being (as Mr Pezzani submitted) broad assertions that were lacking in detail, was a high-level recapitulation of what the F-tT had said in the preceding paragraphs.

62. Once the view has been reached that proximity of relapse is only one factor among others, in reality SE's case largely falls away. The F-tT explained why, notwithstanding the accepted chronology of past relapses, it was appropriate to maintain the CTO in force. It explained why it did not accept the patient's position where it needed to and, when it did accept it, it explained why other factors nonetheless led it to conclude that maintaining the CTO in force was appropriate.

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63. There had only been one instance of an acute episode of mental ill-health, in March 2015. As to that, the F-tT recorded:

> "On the day of his admission [TS] carried out a very serious violent assault on a healthcare assistant at the hospital after the Healthcare Assistant had told him that he was not allowed to smoke in the hospital but could smoke in the courtyard. He punched the worker several times in the face, grabbed his swipecard and then stabbed him in the chest and in the hand with a 5-inch knife that he had brought into the clinic undetected. When the police were called, [TS] had to be restrained and was taken into custody. At the police station where he was assessed by the Forensic Outreach Team, he presented as extremely distressed and agitated, responding to unseen stimuli and reported hearing voices…[D]uring the transfer to hospital it is reported that he was extremely agitated, had to be restrained in handcuffs and with two "ERB belts" and in the process of restraining him, a police officer was bitten causing significant injury and [TS] himself sustained cuts and bruises. [TS] was charged with section 18 Wounding with Intent and in October 2016 he was given a suspended sentence for 18 months with two years' probation."

The F-tT also recorded that a day or two before his admission TS had attempted to hang himself.

64. The F-tT noted that a medication-free trial had been carried out over 4 weeks in August/September 2015 without signs of psychosis emerging.

65. TS's evidence was that he would stop taking medication immediately if not subject to the CTO.

66. The F-tT dealt with "nature" at paragraph 12 of its decision saying:

> "In psychotic disorders such as schizophrenia, particularly where there has been only one episode, the possibility of relapse can never be predicted with any degree of accuracy. However, given the nature of the disorder combined with the severity of the episode in [TS's] case and the consequences of a relapse, we are satisfied that it remains appropriate for him to be treated with antipsychotic medication at this time."

67. Having addressed the other statutory criteria and having declined to exercise their discretionary powers of discharge, the F-tT concluded by urging the responsible clinician to "consider a tapering down of the dosage and another medication-free trial as a guide to [TS's] ongoing treatment."

68. I have before me a witness statement by Mr Bradley, a solicitor and accredited member of the Law Society's Mental Health Accreditation Scheme who represented TS in the F-tT, attaching an attendance note of the F-tT proceedings. In it, he notes, amongst other things, that:

> (a) the responsible clinician indicated in evidence that he could not say whether it was more likely than not in TS's case that there would be a relapse, but had referred to general statistics about the incidence of relapse in schizophrenia patients;
>
> (b) the responsible clinician's best estimate was that, if there were to be a relapse, it would take 6 to 12 months before a full-blown relapse would occur;

(c) the responsible clinician indicated he was limited in what he could say about relapse timing, chronicity and prognosis as there had only been one clear episode of mental disorder;

(d) the responsible clinician believed the medication-free trial in 2015 should have continued for longer and he would be prepared to conduct a further such trial.

69. I accept as accurate Mr Bradley's attendance note, which is from a reliable source, coherent and in any event uncontested.

70. It is clear from what is written at [66] that in the light of the undoubtedly very serious actions of TS when ill, posing an acute risk to both himself and others, the F-tT's concerns were with the difficulty of prediction with regard to relapse, following the cessation of medication which would undoubtedly occur if the CTO were discharged. Their recommendation of a new medication-free trial can only be seen as an attempt to bolster the evidential basis to allow a more informed view to be reached in the future on a nonetheless difficult question. For now, though, the risk and difficulty of prediction made it "appropriate" to maintain the CTO.

71. The evidence from Mr Bradley does not in my judgment undermine the F-tT's conclusions. If it had relied on the evidence that any relapse if it occurred would take place approximately 6-12 months after stopping medication (which its decision does not in terms suggest that it did) that would in my view only have strengthened the decision, given my view that there is no requirement as a matter of law for relapse to be within any particular period of proximity. Nor was the F-tT required to find on a balance of probability that it was more likely than not that a relapse would occur. The overall statistic for patients with schizophrenia (which included that two-thirds of all patients with schizophrenia relapse) certainly made that a very distinct possibility. It is not in dispute that the F-tT was entitled to take risk into account and that involves taking into account the consequences if the risk materialises as well as the possibility that it may. For that reason I do not accept Mr Pezzani's submission that there is an inconsistency between paragraphs 12 and 13 of the F-tT's decision.