HM Prison & Probation Service

Mental Health Casework Section

Guidance:

Discharge conditions that amount to deprivation of liberty

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1 Introduction

This document sets out the Secretary of State's position on the discharge of restricted patients on conditions that involve a deprivation of liberty, following the decision of the Supreme Court in *The Secretary of State for Justice v MM* [2018] UKSC 60 which was handed down on 28 November 2018.

The Supreme Court held that the Mental Health Act 1983 (MHA) does *not* permit either the First-tier Tribunal (Mental Health), the Mental Health Tribunal for Wales ("the Tribunal") or the Secretary of State to order a conditional discharge of a restricted patient subject to conditions which amount to detention or a deprivation of liberty.

The independent review of the MHA, published on 6 December 2018[1] included a recommendation (number 136) in relation to this issue as follows:

> "The Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards."

Relevant Government leads, including the Ministry of Justice and the Department of Health and Social Care are currently considering all recommendations in the MHA review's final report.

More immediately, the Justice Secretary will implement the following operational policy in relation to patients affected by the issue of discharge conditions that amount to a deprivation of liberty.

The aim of this operational policy is to ensure that, where appropriate, restricted patients do not need to remain in hospital beds and can continue their rehabilitation in a community-based setting, while on a long-term escorted leave of absence under section 17(3) MHA. This will ensure affected patients are managed safely, detained in an appropriate setting, detained in accordance with a procedure prescribed by law and are subject to the safeguards of a detained patient.

This document sets out the Secretary of State's view and guidance for his own officials. It is not intended as any kind of guidance for the Tribunal who, as an independent judicial body, will set their own guidance on the judgment.

2 Deprivation of liberty

Conditions objectively will give rise to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights if the patient:

a) is not free to leave his placement; and
b) is subject to continuous supervision and control (per Baroness Hale in *P v Cheshire West & Chester Council* [2014] UKSC 19, [2014] AC 896 at § 49 and 54).

[1] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The deprivation of liberty will breach Article 5 if it is not authorised in accordance with a procedure prescribed by law.

The Secretary of State recognises that there are some patients already living in the community subject to conditions amounting to a deprivation of liberty and, therefore, unlawful conditions. Our policy on how we intend to deal with those patients is set out in section 5. There are also patients living in the community whose conditions of discharge in and of themselves are not unlawful, but who are subject to a care plan that includes arrangements that amount to a deprivation of liberty.

3 Patients with capacity

Where the patient has capacity to decide whether or not s/he should be accommodated at the relevant discharge placement with a care plan that includes arrangements that amount to a deprivation of liberty (DoL), the placement cannot be authorised under provisions of the Mental Capacity Act 2005 (the MCA), and the patient cannot validly consent to the arrangements. If a patient is being considered for discharge and the responsible clinician considers that they no longer require treatment in hospital, but are not yet suitable for discharge without constant supervision, the Secretary of State can consider providing his consent to a long-term escorted leave of absence, under section 17(3) MHA. Please refer to section 6 for further details.

The Secretary of State is aware of the case of *Hertfordshire County Council v AB [2018]* EWHC 3103 (Fam) where the High Court used its inherent jurisdiction to make an order authorising the DoL that arose from the patient's care plan. The Secretary of State does not consider that this is the correct approach. Where a patient continues to present such a risk to public protection, linked to his mental disorder, the Secretary of State considers that his treatment is best managed under the provisions of the MHA so that either the Secretary of State or the Tribunal can consider the public protection aspect of detention under the MHA. If further treatment and rehabilitation could be given in a community setting for such a patient, then a section 17(3) long term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DoL authorisation under the inherent jurisdiction of the High Court.

4 Patients lacking capacity

The earlier Court of Appeal decision in *MM* indicated that it could be appropriate for the Tribunal to defer conditional discharge of a patient who lacks capacity and whose discharge care plan would involve constant supervision. Such a deferred conditional discharge would enable the jurisdiction of the Court of Protection to be invoked to authorise the deprivation of liberty on discharge under section 16 of the MCA. At paragraph 27 of the *MM* judgment, the Supreme Court stated:

> "Whether the Court of Protection could authorise a future deprivation, once the (Tribunal) has granted a conditional discharge, and whether the (Tribunal) could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings."

Where the Secretary of State or the Tribunal is considering discharge from detention in hospital for treatment under the MHA and considers that it is not satisfied that it is necessary for the health or safety of the patient or for the protection of other persons that s/he should receive such treatment, then a conditional discharge decision can usually be made.

The Secretary of State's view is that there are broadly two groups of patients lacking capacity who may be subject to a proposed discharge plan which would involve a deprivation of their liberty. The first set of patients are those who lack capacity and in their best interests, it is proposed that they live in a residential care home (or similar) as they are not able to look after themselves without the support such a placement would provide. In most of these cases, the need for such a care plan is due to the patient's inability to perform Activities of Daily Living or self-care without support that would involve an objective deprivation of their liberty.

The second set of patients are those who lack capacity and the argument is made that it is in their best interests for their care plan to involve constant supervision in order to prevent them from re-offending (i.e. it is in the best interests not to suffer the trauma of being prosecuted for an offence, or face physical threats from others should they re-offend). While it is recognised that there will be some cross-over between the first and second group, it is considered that there are a specific group of patients who, but for the risks they present to others, could live independently, without the need for constant supervision. Where a patient falls into this group, the Secretary of State considers caution should be exercised when considering whether to conditionally discharge such a patient with a care plan that would require a DoL authorisation under the MCA. (See section 4.2 below)

4.1 Patients lacking capacity – care plan that requires Deprivation of Liberty (DoL) to be authorised under the MCA

Where the care plan requires a Deprivation of Liberty (DoL) authorisation under the MCA, that is a separate consideration and the Secretary of State considers that the Tribunal can direct a deferred conditional discharge. Once conditional discharge is deferred, the necessary arrangements to put a DoL authorisation in place can be made and the patient discharged accordingly once the Tribunal has confirmed its decision. As the Secretary of State does not have the power to defer conditional discharge, in these circumstances, he can give an *indication* that he is minded to conditionally discharge on the basis that a DoL authorisation is put in place.

If, after a Tribunal decision to defer conditional discharge with a care plan that amounts to a DoL (or a Secretary of State indication that he would be minded to conditionally discharge), the Local Authority or the Court of Protection *declines* to issue a DoL authorisation, it is likely this would mean that the proposed placement is no longer available. In those circumstances, and where the responsible clinician can no longer support conditional discharge, he should inform the Tribunal and invite it to reconsider its deferred conditional discharge decision.

This procedure was set out in the case of R (on the application of H) v the Secretary of State for the Home Department [2003] UKHL 59, which upheld the Court of Appeal's decision where it summarised the following:

> "(i) The tribunal can, at the outset, adjourn the hearing to investigate the possibility of imposing conditions.
>
> (ii) The tribunal can make a provisional decision to make a conditional discharge on specified conditions, including submitting to psychiatric supervision, but defer directing a conditional discharge while the authorities responsible for after-care under section 117 of the Act make the necessary arrangements to enable the patient to meet those conditions.
>
> (iii) The tribunal should meet after an appropriate interval to monitor progress in making these arrangements if they have not by then been put in place.

(iv) Once the arrangements have been made, the tribunal can direct a conditional discharge without holding a further hearing.

(v) **If problems arise with making arrangements to meet the conditions, the tribunal has a number of options, depending upon the circumstances; (a) it can defer for a further period, perhaps with suggestions as to how any problems can be overcome; (b) it can amend or vary the proposed conditions to seek to overcome the difficulties that have been encountered; (c) it can order a conditional discharge without specific conditions, thereby making the patient subject to recall; (d) it can decide that the patient must remain detained in hospital for treatment.**

(vi) It will not normally be appropriate for a tribunal to direct a conditional discharge on conditions with which the patient will be unable to comply because it has not proved possible to make the necessary arrangements." (emphasis added)

4.2 Patients lacking capacity – care plan that requires Deprivation of Liberty to be authorised under the MCA where the best interests requirement under the MCA is primarily managing risk to the public

As noted above, the Secretary of State considers that there is a much smaller set of patients who lack capacity, and a care plan which amounts to a DoL is required on discharge in order to manage the risks they continue to pose to others. In those cases, the Secretary of State considers that conditional discharge would not be appropriate, but would be open to consideration of a s17(3) MHA long-term escorted leave of absence in the alternative (see section 6).

While the MCA does allow for a DoL where the best interests requirement is met on the basis of preventing the patient from re-offending, generally, the Secretary of State considers that such patients are best managed under the provisions of the MHA. This enables either the Secretary of State for Justice or the Tribunal to consider the public protection aspects of the criteria for detention under the MHA, rather than this important consideration being made under the provisions of the MCA. It also means that where such a patient can no longer be subject to a care plan with a DoL (for example if the DoL authorisation is not renewed), there is no immediate risk to the public, as the patient remains detained under the MHA.

While it is not easy to describe in general terms what characteristics such a case may have, a compelling factor will be what the care plan provides. For example, if the treatment set out in the care plan was analogous to that which would be delivered in an MHA setting (e.g. psychological/therapeutic interventions to reduce risk) and that appears to be the primary reason for the need for constant supervision, then it is likely that is the sort of patient who continues to meet the MHA detention criteria. If further treatment and rehabilitation could be given in a community setting for such a patient, then a section 17(3) long term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DoL authorisation under the MCA. The Secretary of State does not consider that there would be any requirement for a parallel authority under the MCA where a patient is subject to 17(3) long term escorted leave under the MHA.

5 Discharged patients on existing conditions

The Secretary of State is aware that there are a number of patients (both with and without capacity) who, prior to this decision, were discharged on conditions or a, which objectively amount to a deprivation of liberty. As

these cases are identified, the Secretary of State will consider their case in the light of the Supreme Court's judgment, and will have a number of options:

a. Exercise the Secretary of State's power to revoke or amend a condition to remove the illegality, if it is considered that the public would remain adequately protected without that condition (or with an amended condition);

b. Recall the patient to hospital on the grounds that the clarification of the law constitutes a material change of circumstance. **In these circumstances, the Secretary of State will at the same point consider granting immediate consent to the use of long term escorted leave of absence under section 17(3) MHA to enable the patient to remain in the community, where this appears to be in the patient's best interests and where any risk to the public can be safely managed during the patient's period of leave.** Where this option is appropriate, the Secretary of State will generally only give consent to long-term escorted leave of absence for up to 12 months and the recall will only be a technicality (i.e. the patient should not actually be physically returned to hospital). Both considerations and decisions will be made concurrently to enable the patient to remain where they are currently placed while a decision is made. The Secretary of State could extend consent to longer-term escorted leave of absence on the application of the responsible clinician after 12 months, but it will be necessary to review the continued appropriateness of such a leave of absence before extending it;

c. Absolutely discharge the patient, if it is considered that the public would remain adequately protected without restrictions (including the power to recall to hospital at a later date);

d. Refer the case to the Tribunal to consider amending or removing the relevant condition, or to consider absolute discharge.

In most cases, once the Mental Health Casework Section (MHCS) has identified that existing conditions are unlawful, the Secretary of State will initially ask the responsible clinician whether s/he considers that a restriction of the kind imposed by the unlawful condition remains necessary in order to protect the public. In some cases, MHCS will seek further information in order to decide the best approach, which might include a request for an updated risk assessment. On consideration of the case once this information is received, the Secretary of State will decide which of the above options to take. Where the Secretary of State considers that he is unable to take any of the first three options, he will refer the case to the Tribunal. It is anticipated that this will only be necessary in cases where closer examination of the issues by the independent Tribunal is required.

Where the discharged patient's conditions of discharge do not in their own right amount to a DoL, but where the care plan does, responsible clinicians should review the care plan to ascertain whether the arrangements remain necessary and proportionate. If they do, the responsible clinician should contact the MHCS and seek advice on whether any action is necessary. If such a patient lacks capacity and there is a DoL authorisation under the MCA in place, it is unlikely any action will be required.

If you are a professional responsible for the supervision of a restricted patient and consider that their conditions or implementation of their care plan may be unlawful, please contact the MHCS for advice:

https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list

6 Detained patients whose current discharge plans include a requirement for constant supervision in the community – long-term escorted leave of absence

As noted above, the Secretary of State will consent to the use of a long-term escorted leave of absence, under s17(3) MHA (i.e. leave for more than seven consecutive days) if it appears appropriate in an individual case.

The Secretary of State will always initially consider whether a restricted patient could be conditionally discharged rather than consenting to a long-term escorted leave of absence.

6.1 Where the patient lacks capacity, it may be possible for the Secretary of State to consent to the use of a long-term escorted leave of absence to test the suitability for a conditional discharge to a community placement if this is considered a necessary step. If the patient will need to live in a residential care home (for example) and as such their liberty would be severely restricted on discharge, the Secretary of State, at the appropriate time, would indicate his willingness to discharge to such a placement, on the basis that a DoL authorisation could be put in place under the MCA. While such a patient is on a long-term escorted leave of absence to the proposed discharge placement under s17(3) MHA, the Secretary of State considers that there is no need for an additional DoL authorisation under the MCA. A restricted patient on a long-term escorted leave of absence remains a detained patient and continues to have all the protections of the MHA, including the entitlement to apply to the Tribunal every 12 months. As paragraph 26 of the Supreme Court judgment in *MM* states, a restricted patient who is actually detained in hospital is ineligible for a DoL authorisation under the MCA. It is only at the point of conditional discharge that a DoL authorisation would be required.

6.2 Where the patient has capacity and the responsible clinician considers that s/he no longer needs treatment in hospital, but his risks are such that s/he could only be safely managed in the community with conditions that amount to a DoL (for example constant supervision while in the community), the Secretary of State (or the Tribunal) would not be able to conditionally discharge with such conditions.

The Secretary of State would consider consenting to a s17(3) long-term escorted leave of absence in these circumstances, with conditions that require constant supervision, if that would be a safe and appropriate way of enabling the patient to continue treatment and rehabilitation away from the hospital, while remaining a detained patient. Such a leave of absence would not be permanent, and the Secretary of State will generally only provide his consent for a maximum of 12 months at a time and would review the appropriateness of it continuing when the responsible clinician applies for an extension. Where there is a breach of leave conditions, or the responsible clinician is concerned that risks have increased, the responsible clinician may revoke the leave of absence and recall the patient to hospital without needing to apply for a recall warrant from the Secretary of State, as described in s17 MHA. Once the risks reduce such that constant supervision is no longer necessary, the responsible clinician can then apply for conditional discharge.

The Secretary of State will not generally agree to a long-term *unescorted* leave of absence in cases where the responsible clinician simply wishes to test a proposed discharge placement. Where there are no requirements for constant supervision and the application is simply consent for unescorted overnight leave prior to discharge, the Secretary of State's current policy of only granting up to 5 nights overnight leave remains in place. This is to ensure that s17 leave is not being used where conditional discharge is more appropriate.

MHCS INTERNAL GUIDANCE:

IN ALL CASES, WHERE THERE IS A KEY DECISION MADE, SUCH AS RECALL, LEAVE, CONDITIONAL DISCHARGE OR ABSOLUTE DISHARGE, PLEASE ENSURE THAT VICTIM ISSUES ARE CONSIDERED AND THE VLO INFORMED IN ACCORDANCE WITH EXISTING PROCEDURES AND GUIDANCE.

Section 1 - Conditionally discharged patients

Case Managers:
When reviewing CD reports, check the discharge conditions for any that could amount to a deprivation of liberty (e.g. "the patient must be escorted at all times"). If you think a condition might amount to a deprivation of liberty, refer the case to your Head of Team by creating a manual milestone allocated to the "B9 Discharge Requests and Decisions" list.

Senior Managers:
When reviewing unlawful conditions where the patient is already discharged:

Ascertain whether the patient lacks capacity.

1) **If the patient lacks capacity:**

a. Is there a DoL authorisation in place under the MCA? If there is an authorisation, consider whether removal of the unlawful discharge condition has any effect on the protection of the public.

b. Where a patient is subject to a DoL authorisation (and therefore his liberty has been lawfully deprived under the MCA), it is likely that you can remove the unlawful condition with no practical change to how the patient is being managed or any subsequent increase in risk to the public. It is important to note, however, that were circumstances to change in the future, and the patient no longer be subject to a DoL authorisation, consideration will need to be given to whether this increases their risk and, if so, how that can be safely and appropriately managed. In the majority of cases, however, the DoL authority under the MCA will not solely be in place due to public protection concerns and there will be other reasons in the patient's best interests that it was put in place.

c. If the conditions can be safely removed, create a "change of conditions review" in the usual way. Letters to the patient and RC should also include the following lines, to ensure MHCS is informed of any change to the DoL authorisation:

"Further, the responsible clinician is to notify the Secretary of State within twenty-four hours of any (i) imposition, removal or variation of a Deprivation of Liberty (DoL) Safeguard concerning your supervision in the community; (ii) any application for the imposition, removal or variation of such a DoL; and (iii) any forthcoming significant procedural step in respect of any such application."

d. You should also create a manual milestone to ensure that the case is reviewed when the DoL authorisation is due to be renewed (usually every 12 months).

e. If the patient lacks capacity, but there is no DoL authorisation in place, discuss with the clinical and social supervisors why there is no authorisation and whether it is possible to put one in place. If none can be imposed, then treat the case as though the patient has capacity.

2) If the patient has capacity:

a. Consider whether removal of the unlawful condition has any effect on the protection of the public or the safety of the patient.

b. Where, on the surface, it appears that the condition was imposed in order to manage a high risk of offending, you should contact the responsible clinician and social supervisor to seek their views on the current risk presented by the patient, should the condition be removed. It may be necessary to seek an up to date clinical assessment of risk.

c. Where the condition appears to have been imposed not to manage risk to others, but due to the patient's risk to himself, you should contact the responsible clinician and social supervisor to seek their views on the current risk presented to the patient, should the condition be removed. It may be appropriate to ascertain whether the patient has capacity; if not the most appropriate way forward may be to remove the condition while ensuring that a DoL authorisation is put in place under the MCA.

d. Where the patient has progressed such that removal of the unlawful condition would not mean the public is at risk and that the patient can be safely managed in the community, then it may be appropriate to remove it. If so, create a change of conditions review in the usual way.

e. Where it is clear that removing the condition would mean the risk to the public is elevated (or that the patient would be a danger to himself if not escorted in the community), it may be appropriate to recall the patient to hospital, on the basis that there has been a material change in circumstances. If so, create a recall review in the usual way. This step should first be discussed with the responsible clinician, together with the consideration for immediate leave of absence, set out at f. below. If you are able to agree to an immediate leave of absence as set out at f. below, then the recall will be a technicality and the patient should not actually be physically returned to hospital. Both considerations and decisions should be made concurrently to enable the patient to remain where they are currently placed while a decision is made.

f. If recall does appear to be necessary, consideration should always be given to immediate consent for a long-term escorted leave of absence under section 17(3) MHA. In order to maintain public protection, the Secretary of State's consent to leave may well involve imposing conditions on the leave of absence that amount to a deprivation of liberty, which would be lawful under the MHA, as the patient is now a detained patient, having been recalled. If recall, followed by immediate consent to leave of absence under the same conditions to the current placement is appropriate, you will still need to identify a hospital for the recall warrant. You should issue the recall warrant and the leave authority together. A long-term escorted leave review should be created at the same time as the recall review. Generally, the Secretary of State will only agree to a long-term escorted leave of absence up to a period of 12 months, at which point the responsible clinician will need to request the consent is extended for a further 12 month period (or they can apply for conditional discharge).

g. It should be noted that where the Secretary of State recalls a conditionally discharged patient (even with an immediate leave of absence) this means that:

i. the patient's legal status changes from being a conditionally discharged patient to a recalled detained patient;
ii. the patient's case will be immediately be referred to the Tribunal following recall;
iii. the patient thereafter has the right to apply to the Tribunal annually (and in the absence of such an application, the Secretary of State must refer the case every three years); and
iv. the indefinite leave of absence will only be consented to for a period of up to 12 months, which can be extended on the application of the responsible clinician.

h. In order to ensure the leave of absence is reviewed regularly, the senior manager should decide how often progress reports are required (minimum of every six months) and create a manual milestone for 11 months' time to remind the responsible clinician that the consent for long-term leave will shortly expire.

i. The senior manager should ensure that the Secretary of State's statement to the Tribunal makes it clear that while the patient has been recalled, due to the material change in circumstances, he is on a long-term escorted leave of absence. The statement should also explain why the Secretary of State considered that the unlawful condition could not be safely removed.

j. When reviewing these cases, the option of lifting the restrictions (absolute discharge) must always be considered. If none of the first three options set out in section 5 above appear appropriate, then it is likely you will need to make a discretionary referral to the Tribunal. In doing so, you should explain your reasons for making the referral and the Secretary of State's formal statement to the Tribunal should set out why he did not consider he could exercise his own powers within one of the first three options.

Section 2 - Detained patients

Tribunal proceedings

Case managers:

When reviewing tribunal discharge decisions or preparing tribunal statements:

Check whether the conditions imposed (or requested) could amount to a deprivation of liberty (e.g. "the patient must be escorted at all times"). If you think a condition might amount to a deprivation of liberty, refer the case to your Head of Team by creating a manual milestone allocated to the "B9 Discharge Requests and Decisions" list.

Senior Managers

When reviewing cases before the Tribunal where there is a clinical recommendation for discharge with conditions that objectively amount to a DoL:

1) Ascertain whether the patient lacks capacity;

2) If so, does the discharge plan include a DoL authorisation? If so, ensure that the Tribunal statement sets out the Secretary of State's position as above in Section 4, with regard to the imposition of conditions and potential for deferred CD to enable arrangements for a DoL authorisation. Bear in mind that where a DoL authorisation will be in place, any request for conditions that objectively amount to a DoL is likely to be superfluous (it would add nothing to the safeguard provided by the DoL authority) and such a condition would be unlawful;

3) If the patient has capacity, ensure that the Tribunal statement sets out the Secretary of State's position as above. You particularly need to consider what the implications are for public protection if a patient with capacity is discharged without such a restrictive condition, where the clinical assessment is that s/he needs constant supervision and whether it is appropriate for the Secretary of State to offer a view on suitability for discharge (e.g. in cases where the responsible clinician recommends discharge but has requested an unlawful condition which amounts to a DoL);

4) If the patient has capacity and the responsible clinician is requesting an unlawful condition, it may be appropriate to suggest that an alternative approach might be for him to seek consent for a long-term leave of absence.

5) If the unlawful conditions have already been imposed by the Tribunal (post the *MM* UKSC decision), seek legal advice on the best way to resolve the situation.

Applications for escorted overnight leave / long-term escorted leave of absence:

Case managers:

1) If the patient lacks capacity and the responsible clinician is requesting escorted overnight leave to a proposed discharge address, make sure it is clear whether eventual discharge is likely to involve a DoL authorisation. You may need to check with the responsible clinician. If so, escorted overnight leave is likely to be appropriate (and necessary). You should make your risk assessment as usual, but take into account the fact the overnight leave will be escorted. Bear in mind that the patient will not have had access to unescorted day leave. This is not an issue in these circumstances and not a barrier to escorted overnight leave.

2) Not all patients who lack capacity will need a long-term escorted leave of absence and may only require escorted overnight leave in the usual way (i.e. up to five nights per week). Ensure that the responsible clinician has clearly expressed what type of leave they are requesting and clarify with them if it is not clear.

3) If the patient does not lack capacity, but the responsible clinician is requesting an escorted leave of absence for the purposes of testing at a proposed discharge address, you should ask the responsible clinician to clarify why escorted overnight leave is being sought. It may be appropriate to consent to a leave of absence with restrictive conditions for detained patients in the same way it would be considered for those already in the community after recall (see below).

4) If in doubt, consult your Head or Deputy Head of Team for advice before completing your recommendation. Please note that a long-term leave of absence will generally only be considered if

such leave is to be escorted. Where the patient can take unescorted overnight leave, a long-term leave of absence will not generally be appropriate and the Secretary of State's policy remains that most patients will only require a period of testing on overnight leave for a maximum of five nights per week, prior to consideration of conditional discharge.

Senior managers:

1) Deputy Heads of Casework should ascertain whether the application is for a long-term escorted leave of absence. If so, the case should be referred to the Head of Team for a final decision. Please ensure that the correct review has been opened (i.e. the new "long term escorted leave" review) to enable MHCS to monitor volumes of such applications.

2) Where the application is for a long term leave of absence, please apply the following considerations:

a. Is the long-term leave of absence to be unescorted? If so, ascertain why the responsible clinician considers this step necessary. Generally, the Secretary of State will not agree to allow a long-term *unescorted* leave of absence and would prefer shorter periods of testing (up to five nights per week) and/or consideration of conditional discharge at the appropriate point.

b. Is the long-term leave of absence to be escorted? If so, ascertain why this is necessary. If the patient lacks capacity, is there a plan for eventual discharge that would require a DoL authority to be in place under the MCA? Is testing via a long-term escorted leave of absence necessary prior to consideration of conditional discharge?

c. You should always consider whether periods of overnight leave (up to five nights per week) or conditional discharge is more appropriate than a long-term leave of absence, before consenting to such a step.

Applications for conditional discharge where a responsible clinician has requested a condition that amounts to a deprivation of liberty

Senior managers:

1) Ascertain whether the patient lacks capacity;

2) If so, is there or will there be a DoL authorisation in place? If yes, consider whether you are content that, where relevant, the DoL authorisation is a sufficient safeguard to manage risks in the community on discharge. Bear in mind that the majority of DoL authorisations will be with regard to the patient's best interests with regard to assistance with daily living, rather than on the basis of management of risk to others. It is possible, however, to argue that a DoL authorisation is in the patient's best interests to prevent him causing harm to others due to the consequences of re-offending. If this is the case, you should satisfy yourself that it would be appropriate to conditionally discharge in these circumstances – does the patient still require treatment in hospital; can the risks be safely managed in the community? You should continue to consider the case like any other, bearing in mind that the patient will not be able to have been tested on unescorted leave. This is not a barrier to discharge. The fact the discharge plan will involve a lawful deprivation of liberty under the MCA will be relevant to your consideration, but may not be central to the decision;

3) If not, and the responsible clinician has requested a condition that objectively amounts to a deprivation of liberty, you should not, in any circumstances, impose such a condition. You should continue to consider the case like any other. It may be appropriate to consider a long-term escorted leave of absence (subject to the appropriate conditions), rather than discharge in these circumstances.