MENTAL HEALTH MATTERS
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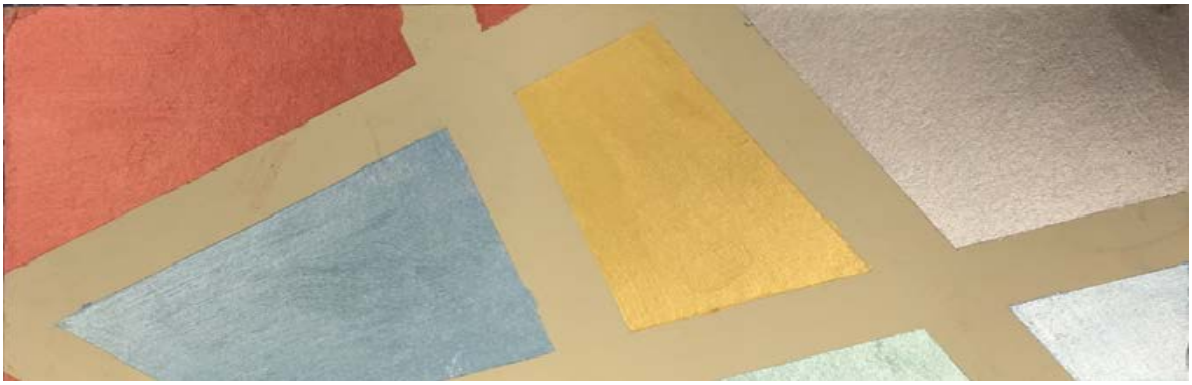

Welcome to the March 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Senior Judge Hilder lays down her baton; attorneys and failures to consult, and a research corner on anorexia and last resort options;

(2) In the Property and Affairs Report: new OPG guidance, 'third sector' deputyship and a reverse indemnity tangle;

(3) In the Practice and Procedure Report: notes from a fireside chat with DDJ Flanagan, and litigation capacity in the absence of subject-matter capacity;

(4) In the Mental Health Matters Report: conditional discharge and deprivation of liberty – the new regime, and conditional discharge into hospital;

(5) In the Children's Capacity Report: parental responsibility and confinement – the need for an appellate judgment;

(6) The Wider Context: assisted dying / assisted suicide update, Strasbourg's latest word on withdrawing life-sustaining treatment and mental capacity reform in New Zealand.

Circumstances beyond our control mean that we do not have a Scottish report this time.

A reminder that we have updated our unofficial update to the MCA / DoLS Codes of Practice, available here, and that, whilst Chambers have launched a new and zippy version of our website, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

Mental Health Act 2025 (very partially) into force and Explanatory Notes

The first parts of the Mental Health Act 2025 to come into force were commenced on 18 February 2026, and Explanatory Notes to the Act have now been published.

Sections 30(2), 32, 35, 36(1) and (3)(b), 38 and 39 of the MHA 2025 came into force on 18 February 2026, implementing changes to ss. 42, 48, 71, 73, and 75 MHA 1983 (concerning removal to hospital of a wider range of those under detention, and the provision for deprivation of liberty in the community presence of risk of serious harm to others for those conditionally discharged from hospital). Unfortunately, something, somewhere appears to have gone slightly awry in relation to the conditional discharge provisions.

In 2018, in *MM*, the Supreme Court upheld the ruling of the Court of Appeal that neither the Secretary of the State nor the Mental Health Tribunal had the power under the Mental Health Act 1983 as it then stood to impose conditions on the discharge of a restricted patient which would amount objectively to a deprivation of the patient's liberty.

As we set out at the time in our comment on the case, there were three reasons for this

1. The first was one of high principle. As the power to deprive a person of his liberty is by definition an interference with his fundamental right to liberty of the person, it engaged the rule of statutory construction known as the principle of legality, as explained by Lord Hoffmann in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, at 131:

> *… the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual.*

Lady Hale took the view that Parliament had not been asked – as they would have to have been – as to whether the relevant provisions of the MHA:

> *Included a power to impose a different form of detention from that provided for in the MHA,*

> *without any equivalent of the prescribed criteria for detention in a hospital, let alone any of the prescribed procedural safeguards. While it could be suggested that the FtT process is its own safeguard, the same is not the case with the Secretary of State, who is in a position to impose whatever conditions he sees fit. (paragraph 31)*

2. The second was one of practicality. The MHA confers no coercive powers over conditionally discharged patients; as Lady Hale noted (although many may not realise): "*[b]reach of the conditions is not a criminal offence. It is not even an automatic ground for recall to hospital, although it may well lead to this.*" The patient could therefore:

> *… withdraw his consent to the deprivation at any time and demand to be released. It is possible to bind oneself contractually not to revoke consent to a temporary deprivation of liberty: the best-known examples are the passenger on a ferry to a defined destination in Robinson v Balmain New Ferry Co Ltd [1910] AC 295 and the miner going down the mine for a defined shift in Herd v Weardale Steel, Coal and Coke Co Ltd [1915] AC 67. But that is not the situation here: there is no contract by which the patient is bound. (paragraph 32).*

3. That led on to what Lady Hale identified as the third and most compelling reason, namely that she considered that to allow a person to consent to their confinement on conditional discharge would be contrary to the whole scheme of the MHA. The MHA provided in detail for only two forms of detention (1) in a place of safety; and (2) in hospital. Those were accompanied by specific powers of conveyance and detention, which were lacking in relation to conditionally discharged patients – "*[i]f the MHA had contemplated that such a patient could be detained, it is inconceivable that equivalent provision would not have been made for that purpose*" (paragraph 34). There was, further, no equivalent to the concept of being absent without leave to that applicable where a patient is on s.17 leave, it again being "*inconceivable*" that "*if the MHA had contemplated that he might be detained as a condition of his discharge […] that it would not have applied the same regime to such a patient as it applies to a patient granted leave of absence under section 17*" (paragraph 36). Finally, the ability of a conditionally discharged patient to apply to the tribunal is more limited than that of a patient in hospital (or on s.17 leave), this being *"[a]t the very least, this is an indication that it was not thought that such patients required the same degree of protection as did those deprived of their liberty; and this again is an indication that it was not contemplated that they could be deprived of their liberty by the imposition of conditions."*

In 2018, also, the independent Review of the Mental Health Act 1983 recommended that:

> *Given the Supreme Court judgment, we suggest that 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. If a solution is not found, the numbers of offenders held in hospital will continue to rise because they are unlikely to get out again. Not only is this clearly wrong for the individuals*

> *concerned, it also means they are taking up valuable bed space, and obstructing efforts to transfer people in from prison.*

Fast forward to February 2026, and the first provisions of the Mental Health Act 2025 have come into effect to amend the MHA 1983 to provide for conditional discharge subject to conditions amounting to a deprivation of liberty. Guidance has been produced by both the First Tier Tribunal and HM Prisons and Probation Service[1] as to their operation. What both sets of guidance suggest, on their face, is that the intent to reverse *MM* may not have been achieved.

Whilst the MHA 1983, as amended, provides for the Secretary of State and the Tribunal to impose conditions on a conditional discharge giving rise to deprivation of liberty, both the Tribunal and HMPPS appear to take the view that such conditions are not enforceable. The former states:

> *Does a patient have to consent to being subject to conditions which deprive them of their liberty?*
>
> *A patient may or may not have the capacity to consent, but the legislation does not refer to capacity in this regard. The relevant question to ask in each case is whether the patient either agrees with (or at least does not object to) the condition which deprives them of their liberty. If they do object to it, then it is unlikely they will comply with it and so it should not be imposed. It is essential to remember that the new legislation cannot force a deprivation of liberty condition onto an unwilling patient and the Tribunal making a CD (Dep) does not give any power to the placement to restrain a patient who, in breach of a condition, chooses to leave their accommodation unaccompanied.*

The latter states that the new provisions are

> *2.2 […] not suited to patients whose risks to the public would be very difficult to manage in the community, recognising that the conditions of a conditional discharge are not enforceable and there is a requirement for the patient to accept supervision.*

There is, with respect, something of a logical conundrum in relation to the positions being adopted, given that the definition of deprivation of liberty within the MHA 1983 as amended is, via its linking to the MCA 2005, directly linked to Article 5 ECHR (see s.145 MHA 1983). As the law stands at present, the domestic interpretation of Article 5 is that a deprivation of liberty is:

1. A confinement to a restricted place for a non-negligible period of time, tested by asking whether they are free to leave that place, and subject to continuous supervision and control;
2. To which the person either cannot or does not consent,
3. Which is imputable to the state.

By definition, therefore, that means that the conditions under consideration must be ones

[1] Note, the HMPPS guidance refers to 'supervised discharge.' This is not a term which appears in the MHA 1983 as amended, and we would strongly suggest not using it; the Tribunal guidance says "[t]his term has fallen into common parlance when referring to the new provisions which will allow the Tribunal to conditionally discharge with conditions which deprive the patient of their liberty. Nowhere in the new Act's provisions is the term 'supervised discharge' used. It is not a new legal concept. It is not a new form of discharge. It is not an alternative to a conditional discharge."

which give rise to a non-consensual confinement, otherwise the person will not be subject to a deprivation of liberty at all. That, in turn, means that:

1. Asking whether the patient is agreeing / not objecting is not an immediately obvious question;

2. It appears that we may be in a Schrodinger's Cat situation of the person being labelled both as being confined but at the same time not actually be subject to any framework which enforces that confinement.

We anticipate, unfortunately, therefore, that:

1. It is likely that these provisions will be before the courts soon, although perhaps not until after the Supreme Court has handed down its decision in the *Attorney General for Northern Ireland's Reference* where it is examining the domestic interpretation of Article 5 ECHR; and

2. Trusts may well be continuing in the meantime to look to s.17(3) MHA 1983 (and / or, where relevant, the DoLS framework under the MCA 2005) as providing a clear route actually to deprive individuals of their liberty in the community.

For members of the Court of Protection Bar Association, the webinar with HHJ Simon Burrows on "Conditional Discharge and deprivation of liberty: Getting our Acts together", on 16 March 2026 at 5pm will be required watching.

Nottingham inquiry

The statutory inquiry chaired by HHJ Deborah Taylor into the killings committed by Valdo Calocane started on 23 February. The inquiry has a website on which recordings of the hearings can be found; the hearings themselves are broadcast on a dedicated YouTube channel.

Short note: conditional discharge into hospital

D*B v Humber Teaching NHS Foundation Trust and SSJ* [2026] UKUT 57 (AAC) was the appeal of a decision in the First Tier Tribunal (Mental Health) that it was not permissible to conditionally discharge a patient who would then remain in hospital as an informal patient. We would note that the facts of this are somewhat unusual, as many secure hospitals are unwilling to allow informal patients to remain in hospital; however, in the present case, the patient was not in a secure hospital, and the hospital was content for DB to remain on an informal basis.

DB was detained under ss.37/41 MHA 1983, and was later conditionally discharged. He was recalled to hospital on 27 November 2024 on the basis that his mental health had declined. He was referred to the First-Tier Tribunal and his case was ultimately heard on 24 April 2025, at which point the FTT declined to discharge him. The FTT found that DB's treatment could only be given if he were detained. It was 'tentatively' put to the Tribunal "*that the Tribunal could have discharged the section on the basis that DB was able to remain on a voluntary basis at [the] ward. Having considered this matter subsequently and in reaching its decision, the Tribunal was satisfied that this was also not a possible option for the Tribunal – see Lady Hale in Secretary of State for Justice v MM [2018] UKSC 60, para 20, where she says "'discharge' in …section 73(2) when referring to the conditional discharge of restricted patients, cannot mean discharge from the liability to be detained, because the patient remains liable to be detained. It must therefore mean discharge from the hospital in which the patient is currently detained.*"

The Upper Tribunal (UTJ Jacobs) considered that the FTT was in error in determining that it did not have the power to conditionally discharge DB

while he remained in hospital as an informal patient for the following reasons:

1. Under s.131 MHA, which governs informal admissions,"'[s]*ubsection (1) deals with two possibilities: (a) a patient who is admitted informally: and (b) a patient who remains informally after ceasing to be liable to be detained. If DB were to remain informally in hospital once the conditional discharge took effect, he would technically be admitted informally under possibility (a). Although he would in practice remain in the hospital, possibility (b) would not apply, because he would not cease to be liable to be detained*" (paragraph 20);

2. "*Detention cannot be a condition of discharge under section 73(4)(b). But a patient may remain in the hospital, or later be admitted, informally during a conditional discharge. This possibility is one of the factors that may be taken into account when deciding whether to discharge a patient conditionally*" (paragraph 21).

Comment

While the FTT in this case did not grant the conditional discharge, the decision appears to raise some difficult questions about how discharge to informal status might be used, particularly under the new conditional discharge regimes which allows conditions to be imposed which amount to a deprivation of liberty (though with no apparent authority to enforce such conditions). If the FTT was convinced that a patient could be managed informally while arrangements in the community were finalised, would the FTT be obliged to make conditions for the patient to reside in the hospital 'informally,' though in reality, the breach of this condition might amount to a recall? For such a patient, once the community arrangements were ready, the patient would have already been conditionally discharged, and there would appear to be no mechanism for the FTT to revert to consider what more appropriate conditions would be used to manage the patient in the long-term. These questions will need to wait for further consideration of this issue, which appears likely given the complexities it may cause.

Short note: psychological distress and Personal Independence Payments

In *AH and AK v SSWP* [2026] UKUT 50 (AAC) the Upper Tribunal has given guidance on the proper approach to psychological distress in cases under the Personal Independence Payment ("PIP") regulations.

In conjoined appeals heard before a three-judge panel – reflecting the importance of the issues of law under review – the UT was presented with difficult issues of law regarding the proper interpretation and application of the meaning of "mobility activity" in Schedule 1 of the Social Security (Personal Independence Payment) Regulations 2013 (S.I. 2013/277) ("the 2013 Regulations").

The cases concerned AH and AK. AH applied for PIP in January 2022. She suffered from anxiety, depression, panic attacks, back problems and fainting. In her PIP2 questionnaire she said she did not really leave her home and, if she did so, she usually had someone with her, as "I don't go without support". Rather than invite her to assessment, the DWP assessed AH's PIP entitlement on documentary evidence from her GP which included a telephone call to a friend, acting as an informal representative. The healthcare professional advising the DPW advised that AH should be awarded AH mobility descriptor 1e – *"Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant"*. On the basis of this advice, the DWP awarded AH 13

points for PIP daily living activities (descriptors 1.d, 3.b, 4.c, 6.c, 9.c and 10.b) and 10 points for PIP daily living activities (mobility descriptor 1.e) which resulted in an enhanced daily living component for PIP but the standard rate only for the mobility component.

AH requested mandatory reconsideration, maintaining that she ought to have been awarded descriptor 1.f (12 points) in relation to mobility. The First-tier Tribunal determined that in order for AH to score points for mobility descriptors 1.d and 1.f, she would need to demonstrate the passive presence of another person would be sufficient on the facts to reduce her psychological distress below a level where it was overwhelming (citing *AA v SSWP (PIP)* [2018] UKUT 339 (AAC).

AK' s claim for PIP dated back to June 2021. He declared a number of conditions including anxiety, depression, eczema and sight loss in one eye. Following a telephone assessment with a healthcare professional, AK was awarded no points for PIP activities. He appealed to the FTT and was awarded 13 points for daily living activities (descriptors 1.e, 3.b, 4.c, 6.c, 9.b and 10.b) and 10 points for mobility activities (descriptor 1.e). The mobility activity descriptors. He brought an appeal challenging the mobility component which was refused in April 2024, the Tribunal determining that : *"The law provides that where a person satisfies descriptor 1e, the Tribunal should not go on to consider 1f."*

AK disputed the AK Tribunal's decision to award him mobility descriptor 1.e instead of descriptor 1.f. On 01 August 2024, having been refused permission to appeal by the First-tier Tribunal, AK renewed his application to the Upper Tribunal.

The Upper Tribunal on appeal considered a number of previous Upper Tribunal decisions that had considered how regulation 4(2A) should be applied in the context of a "cannot do" descriptor for PIP activity 9 (Engaging with other people face to face). It also considered the relevant sections of the Welfare Reform Act 2012 and the Social Security (Personal Independence Payment) Regulations 2013 (S.I. 2013/277) ("the 2013 Regulations"). This included in particular both Regulations 4(2A) and 7 of the 2013 Regulations and Schedule 1, Part 3 which deals with Mobility Activities and sets out in table of descriptors and the points to be awarded for each, these being

> *a. Can plan and follow the route of a journey unaided.*
> *b. Needs prompting to be able to undertake any journey to avoid overwhelming psychological distress to the claimant.*
> *c. Cannot plan the route of a journey.*
> *d. Cannot follow the route of an unfamiliar journey without another person, assistance dog or orientation aid.*
> *e. Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant.*
> *f. Cannot follow the route of a familiar journey without another person, an assistance dog or an orientation aid.*

On the basis that it was the "*the logical path to adopt, consistent with the decision-maker's task, but it also provides a workable means of applying regulation 4(2A) in a manner that respects the structure of these descriptors, the wording of regulation 4(2A) and the underlying purpose of PIP and the 2013 Regulations*" (paragraph 71), the UT determined the correct approach to applying the descriptors for mobility activity 1. In so doing, the Upper Tribunal made clear that, it was not simply a case of moving through (a) to (f), but rather, to proceed in an order which reflected an increasing level of limitation, namely 1.a, 1.b, 1.c, 1.d, 1.f and then 1.e. The Upper Tribunal also set out a two-part inquiry required in relation to

descriptors 1.d and 1.f to address the situation of those with psychological distress, which are

> *82.* […] *aimed at those who cannot follow the route of an unfamiliar / familiar journey safely, to an acceptable standard, repeatedly and within a reasonable time period unless they have the benefit of one of the forms of assistance referred to in those descriptors. If the person in question is unable to undertake these activities to the regulation 4(2A) standard even with the prescribed forms of assistance then the decision-maker will need to proceed to consider whether descriptor 1.e applies.*

This was important for those who experience psychological distress:

> *83. We have concluded that the regulation 4(2A) criteria are to be applied to both aspects of descriptors 1.d and 1.f in the way we have just described, for the following reasons. If the regulation 4(2A) criteria were only to be applied to the first part of descriptor 1.f (assessing whether the claimant cannot follow the route of a familiar journey to a regulation 4(2A) standard when unaided), then descriptor 1.e would be otiose for those suffering from psychological distress, as every claimant suffering from certain levels of psychological distress would satisfy descriptor 1.f on the basis that they cannot follow the route of a familiar journey to the regulation 4(2A) standard even if accompanied. However, applying the regulation 4(2A) standard also to the second aspect of descriptor 1.f means that a person who, with another person, assistance dog or orientation aid, is still unable to follow the route of a familiar journey to the regulation 4(2A) standard does not satisfy descriptor 1.f and so consideration must be given to descriptor 1.e.*

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in April. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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