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Restricted Patients and Detention in the Community: The Human Rights Implications of Supervised Discharge under the Mental Health Bill 2025

1. Introduction

This article focuses on gaps in the law governing community mental health patients that were exposed by two UK Supreme Court decisions in 2018: *Secretary of State for Justice v. MM* [2018] UKSC 60 ('*MM*') and *Welsh Ministers v. PJ* [2018] UKSC 66 ('*PJ*'). Both cases concerned patients diagnosed with learning disabilities[1] and autistic spectrum disorder (ASD) with histories of offending. In both cases, the Supreme Court ruled that it was impermissible for a community patient to be made subject to conditions that deprived them of their liberty under the Mental Health Act (MHA) 1983. Deprivation of liberty was defined according to the 'acid test' in *Cheshire West* [2014] UKSC 19 (para. 49): 'that the person concerned "was under continuous supervision and control and was not free to leave".'

MM and *PJ* caused significant upheaval, as an unknown number of patients were already living in the community under conditions that deprived them of their liberty. The judgments were also significant in clarifying the scope of liberty protections under Article 5 of the European Convention on Human Rights (ECHR) and the review powers of the Tribunal. Both judgments were delivered by Lady Hale, a leading mental health law expert. Lady Hale's reasoning made it clear that there is a distinction between deprivation of liberty and restrictions on liberty that fall short of deprivation of liberty. The conditions under which a person is detained makes no difference to the question of whether a person has been deprived of their liberty for the purposes of Article 5. As we discuss in this article, this ruling has significant implications for the status

[1] Here we use the term 'learning disability' as this is the term used by the MHA 1983, s1(2A). This is broadly consistent with the internationally-recognised term 'intellectual disability'.

of the principle of the 'least restrictive alternative' in the law of England and Wales and the interpretation of the ECHR.

The judgments have also had paradoxical results for patients' right to liberty. Rather than leading to greater freedoms for people discharged from hospital, the decision in *MM*, in particular, has led the UK Government to seek new ways of detaining restricted patients in the community. In September 2022, the Department of Health and Social Care (DHSC) published proposals in a Draft Mental Health Bill to create a power for Tribunals and the Justice Secretary to discharge restricted patients from hospital subject to conditions that would deprive them of their liberty in the community (Department of Health and Social Care, 2022, Clause 30, pp. 40-41). This proposed power was referred to as 'supervised discharge' (Department of Health and Social Care, 2021, p. 76).[2] This power now appears in the Mental Health Bill 2025, which, at the time of writing, has passed through the House of Lords and is at the report stage in the House of Commons. In the meantime, an unknown number of restricted patients are subject to a stop-gap measure that allows them to be deprived of their liberty in the community long-term under the power to grant patients leave of absence from hospital under section 17(3) of the MHA 1983.

As this article shows, both the provisions for restricted patients in the Mental Health Bill 2025 and the cases that preceded them may be understood as products of a tension between the social control function of mental health law and increasingly stringent liberty protections under human rights law. The cases further expose the limits of policies of de-institutionalisation and official ambitions to move people with learning disabilities and ASD out of psychiatric hospitals and to support them to live in the community. As we argue in this article, such

[2] This power is distinct from aftercare under supervision – a power that was abolished by the MHA 2007 that was also referred to as 'supervised discharge'.

seemingly progressive moves are tempered by a political drive to continue to control those who are thought to pose risks to others.

This drive in England and Wales has led to a form of re-institutionalisation in the community, as patients are 'discharged' or given leave of absence from hospital only to be detained in care homes or supported living settings, under the guise of giving effect to the principle of the least restrictive alternative. In order to resist such efforts to circumvent long-established protections for individual liberty, this article makes clear that detention in the community is not a lesser form of detention than detention in hospital, and that it requires the same stringent safeguards.

This article is structured as follows. Section 2 sets out the context for the extension of compulsory powers into the community and explains the legal controversies leading up to the proposals for a new 'supervised discharge' power. Section 3 draws out the implications of the case law for the least restrictive alternative principle. Section 4 develops a critique of the proposed 'supervised discharge' power based on domestic and European Court of Human Rights (ECtHR) jurisprudence on Article 5(1)(e) and Article 5(4). Section 5 puts forward an alternative approach and highlights the need for practical and legal reforms.

2. The Extension of Compulsion into the Community

There are longstanding tensions between executive attempts to exert control over groups who are perceived to pose risks to others and a rights-based legal framework that seeks to limit the use of compulsory powers and to enable people to live in the community. As Lucy Series (2022, p. 18) highlights, the contested place of people with developmental disorders and dementia within the MHA 1983 is the result of the partitioning of 'those with psychosocial disabilities and those with long-term "cognitive" impairments rooted in longstanding historical distinctions between those with temporary or permanent conditions'. This distinction stems from the

underlying rationale for detention under mental health law: 'that (compulsory) treatment can cure – or at least improve – "mental disorder", thereby managing putative associated risks to the person themselves and/ or others' (Series, 2022, p. 20).

This broad distinction between mental health detention and treatment for the 'curable' and social care for the 'incurable' is, however, not clear-cut. The treatment rationale frequently comes under pressure from the broader purpose of social control that underpins mental health legislation. This purpose draws individuals with developmental disorders who are not straightforwardly treatable in psychiatric terms (i.e. who do not require treatment for a mental illness) into detention under mental health law on the grounds of managing risk. A key example of this tension is the debate over the use of long-term detention with people with learning disabilities and/or autism on the grounds of risk to others, which recently came to a head in England and Wales following the cases of *MM* and *PJ*. Before discussing the cases in detail, it is first necessary to explain the legal framework for detention under mental health law, and to provide important details of the clinical context.

In brief, compulsory inpatient treatment for people with mental disorders can be delivered under the MHA 1983 where a person is detained under a civil section under Part II or a forensic section under Part III of the MHA 1983. Part III allows for the detention of patients with mental disorders involved in criminal proceedings or after sentence. More specifically, detention under a hospital order (MHA 1983, s. 37) is available to judges when sentencing an offender who meets the relevant criteria. In cases where the court determines that the person poses a risk of causing serious harm to members of the public, judges may additionally impose a restriction order (MHA 1983, s. 41). This requires the Justice Secretary to have oversight of the discharge and leave arrangements of the patient.

While most individuals with an offending history detained in secure forensic hospital settings are there under Part III, some patients are detained in these settings under long-term civil (Part

II) detention powers, for example under section 3 MHA 1983 (detention for treatment) (see Galappathie, Khan & Hussain, 2017). This may come about where patients with offending behaviours and escalating risks in the community are detained to prevent further offending, and thus with a view to protecting the public. Such cases may arise where the police and prosecutors decide not to proceed with a case, despite clinical risks, or it may be that patients are undergoing unfinished criminal proceedings, and their detention under Part II leads the courts to remand them on bail to the hospital without using the more formal Part III powers open to the courts (such as MHA 1983, ss. 35 and 36).

Where a learning disability is associated with abnormally aggressive or seriously irresponsible conduct, it is included within the definition of mental disorder for the purposes of detention under the MHA 1983. ASD is also considered a mental disorder under the MHA 1983, although the additional conduct criteria that apply in the case of learning disabilities are not required. Where the relevant criteria are met, a person with a learning disability and/or ASD can therefore be subject to compulsory admission under a hospital order with restrictions (sections 37/41) or under detention for treatment (section 3).

The rationale for inpatient hospitalisation of offenders with learning disability is to provide offence-specific treatment adapted to the cognitive needs of the offender, whilst offering a secure and therapeutic environment which would not be available in prison (Royal College of Psychiatrists, 2014, pp35-37, Alexander et al., 2011). Learning disability, however, is rarely present on its own, with offenders frequently having a constellation of other mental disorders contributing to the offending behaviour (O'Brien et al., 2010, Alexander and Cooray 2003, Hogue 2006). This group therefore often requires specialist treatment (Taylor, 2016; Lindsay, 2005; Large and Thomas, 2011; Hall, 2005).

The Department of Health and Social Care (2021, para. 81) has stated that 'both learning disability and autism are lifelong conditions, which cannot be removed through treatment' and

that detention under the MHA 1983 often provides 'little or no therapeutic benefit' to people with these conditions (Department of Health and Social Care, 2022b, para. 27). However, this ignores evidence that adapted offence related-treatment programmes can be effective (Novaco and Taylor, 2015). Nevertheless, there is a paucity of studies comparing outcomes between offenders with learning disability who are hospitalised, those who are imprisoned, and those who remain in the community.

In May 2011, BBC Panorama exposed severe abuse of patients with learning disability and ASD in an independent sector hospital at Winterbourne View (Plomin, 2013). The DHSC embarked on large-scale inpatient bed closures for people with learning disabilities under its Transforming Care programme (Department of Health, 2012). Specialist forensic beds for offenders with learning disabilities have not been immune from these closures (Taylor et al., 2017). Consequently, services started to look at ways to discharge offenders with learning disability from hospital, including individuals subject to monitoring by the Ministry of Justice under hospital orders with restrictions.

Towards the end of the 2010s, it came to light that a substantial number of patients who had been discharged into the community were subject to care arrangements that deprived them of their liberty. These arrangements were in place with the aim of maintaining public safety in the community and regardless of the patient's mental capacity to consent to them (Banks, 2019; Boer et al., 2023). This development led to a two-fold problem. On one hand, doubts over whether it was legal to discharge patients into the community under conditions that deprived them of their liberty could lead to some patients who wished to be discharged becoming stuck in hospital. On the other hand, it was unclear whether those patients who were already living in the community under conditions that deprived them of their liberty could remain there.

MM concerned a restricted patient who was subject to a conditional discharge while *PJ* concerned a civil patient subject to a community treatment order (CTO). The two regimes differ

in significant respects. CTOs are granted by a patient's responsible clinician; patients are generally required to adhere to conditions such as attending for treatment; and they are subject to monitoring in the community. They can be recalled to hospital by their responsible clinician if their condition deteriorates. Forensic patients who are subject to restrictions can be discharged by the Justice Secretary or by the First Tier Tribunal (Mental Health) in England or the Mental Health Review Tribunal for Wales absolutely or subject to conditions (MHA 1983, ss. 42(2) and 73(2)). The Justice Secretary or Tribunal sets the conditions of the patient's discharge; the patient is monitored in the community by the Mental Health Casework Section (MHCS) of HM Prison and Probation Service; and he or she can be recalled to hospital by the Justice Secretary (Department of Health, 2015, 22.53).

The Supreme Court ruled definitively in *MM* and *PJ* that there was no power to deprive patients of their liberty in the community under a conditional discharge or under a CTO. In *MM*, placement in a care home under constant supervision and control was presented by the patient as the least restrictive alternative to continued detention in a psychiatric hospital. Nevertheless, the use of conditional discharge powers to detain community patients was found to be impermissible by the Supreme Court. While PJ consented to his highly restrictive care arrangements and merely sought to have greater freedom within them, the Supreme Court ruled that he should not have been deprived of his liberty at all under a CTO. The MHA 1983 therefore seemed to present a stark choice between detention in a hospital setting and relative freedom in the community.

MM was described as having a diagnosis of 'mild learning disabilities, autistic spectrum disorder, and pathological fire-setting' (*MM*, para. 2). Since receiving a hospital order with restrictions in 2001 following a conviction for arson, MM had been continuously detained in hospital, apart from a brief period of conditional discharge between December 2006 and April 2007. At the time of the Supreme Court's decision, he was 'considered to represent a serious

risk of fire setting and of behaving in a sexually inappropriate way towards women' (*MM*, para. 2).

MM applied to the First Tier Tribunal (Mental Health) in May 2015 for a conditional discharge. His responsible clinician and treating team opposed his discharge but considered that he would benefit from a transfer to a different low secure forensic unit. Two external experts considered that MM could be safely managed in the community under a conditional discharge with a suitable care plan that would deprive him of his liberty. Under this plan, MM 'would be required to live at a particular place, which he would not be free to leave, and would not be allowed out without an escort' (*MM*, para. 3).

Unusually, the patient in *MM* sought to convince the Supreme Court that it was *permissible* for the Tribunal to discharge him into the community under conditions that deprived him of his liberty. He was prepared to consent to his community placement and argued that this would be the least restrictive alternative to continued detention in hospital. The Justice Secretary was therefore in the odd position of arguing that it was unlawful to discharge a restricted patient subject to conditions that deprived him of his liberty. Odd because, as became clear in the aftermath of *MM*, an undisclosed number of conditionally discharged restricted patients were already living in the community subject to such conditions. Consequently, the Justice Secretary was arguing that practices known to his own Ministry were unlawful.[3]

MM's legal counsel sought to distinguish between *deprivation of liberty* under Article 5 and *detention* under the MHA 1983. They argued that subjecting a conditionally discharged restricted patient to conditions that amounted to *deprivation of liberty* in the community did not mean that the patient was *detained*. They further argued that limitations on the powers of

[3] The Explanatory notes to the Draft Mental Health Bill 2022 (Department of Health and Social Care and Ministry of Justice, 2022b, para. [223]-[224]) note that, historically, a small number of high-risk restricted patients were conditionally discharged, with their consent, subject to conditions of constant supervision in the community.

the Tribunal to discharge the patient subject to conditions would breach the principle of least restriction, which they defined as a 'right not to be placed in greater conditions of confinement unless less severe measures have been considered and found to be insufficient to safeguard the individual or public interest' (*MM*, para. 4). Thus, MM's counsel sought to invoke the principle of least restriction in relation to detention conditions, while at the same time arguing that MM would not in fact be detained in the community.

Counsel for the Justice Secretary submitted, by contrast, 'that Parliament intended for conditional discharge to entail release from detention, rather than permitting a transfer to another form of detention' (*MM*, para. 5). Rather than protecting the patient's rights, they submitted that patients subject to detention under a conditional discharge would have inferior rights to Tribunal reviews. This was because detained hospital order patients can apply to the Tribunal for a review of their detention after six months of detention and every 12 months thereafter (MHA 1983, s. 70). Conditionally discharged restricted patients can only apply 12 months after discharge from hospital and once every two years thereafter (MHA 1983, s. 75(2)).

Lady Hale, with whom the majority in the Supreme Court agreed, decided the case in favour of the Justice Secretary. She considered that conditional discharge under conditions amounting to a deprivation of liberty *was* a form of detention. According to the principle of legality, a statute could not override fundamental rights, including the right to liberty, by using general or ambiguous words. Lady Hale held that the words of sections 42(2) and 73(2) of the MHA 1983 were 'about as general as it is possible to be' and therefore did not create any explicit power to detain a conditionally discharged restricted patient (*MM*, para. 32). Furthermore, she held that any such power 'would be contrary to the whole scheme of the MHA' which provides in detail only for two forms of detention: detention for no more than 36 hours in a place of safety and detention in a hospital as a civil or forensic patient (*MM*, para. 33). Lady Hale further found

that the absence of machinery to re-detain a conditionally discharged restricted patient who absconds implies that Parliament did not contemplate that such patients could be made subject to conditions that deprived them of liberty in the community. Consequently, the MHA 1983 did not give the Tribunal or the Justice Secretary the power to impose such conditions.

Significantly, Lady Hale commented that it was 'difficult to extract the principle of the "least restrictive alternative"' from the ECtHR's case law on Article 5:

> This has not concerned itself with the conditions of the patient's detention (which may raise issues under article 3 or 8), as long as the place of detention is appropriate to the ground upon which the patient is detained: thus, in *Ashingdane v United Kingdom* (1985) 7 EHRR 528, the court rejected a complaint that the patient should have been transferred from Broadmoor to a more open hospital setting much earlier than he was.

This suggests that Article 5 does not require that the person be detained in the least restrictive setting, so long as that setting is appropriate for the detention of a person of unsound mind under Article 5(1)(e). Lord Hughes in his dissenting judgment in *MM* argued that deprivation of liberty under a conditional discharge could be conceived of as a more 'relaxed' or 'less severe form of detention' than detention in hospital (*MM*, para. 42). However, it is clear from Lady Hale's decision in *MM* and from the case law of the ECtHR that deprivation of liberty under Article 5 is not a graded concept. As the ECtHR held in *Stanev v. Bulgaria* (2012) 55 EHRR (para. 115), the distinction between 'deprivation of liberty and restrictions on liberty of movement' 'is one of degree or intensity'. But once the threshold of deprivation of liberty is crossed, the conditions of one's placement do not make a difference.[4] The fact that a restricted patient may be held under more 'relaxed' conditions in a community placement than a similar

[4] See also *Ashingdane v. United Kingdom* (1985) 7 EHRR 528, in which the ECtHR accepted that the patient was deprived of his liberty in a hospital despite the relative openness of the conditions, which included regular unescorted access to unsecured hospital grounds and the possibility of unescorted leave outside the hospital. See also discussion in *Cheshire West* (para. 21).

patient in a secure hospital does not change the fact that both are deprived of their liberty. Thus, a Tribunal is not obliged to discharge a patient who is detained under overly restrictive (yet not inappropriate) conditions. We return to this point in Part 3 below.

The Supreme Court decided *PJ* shortly after its decision in *MM*. PJ was described by his responsible clinician as having 'mild to borderline learning disability' and 'difficulties which fall within the autistic spectrum' 'accompanied by abnormally aggressive and seriously irresponsible behaviour consisting of violent and sexual offending' (*PJ*, para. 2). Although PJ had been a forensic patient in the past, by the time he was discharged from hospital under a CTO in 2011 he was a civil patient (*PJ*, para. 4). The CTO conditions required PJ to reside at a care home for men with 'moderate to borderline learning disability and a history of challenging or offending behaviour' (*PJ*, para. 4). He was required to adhere to the home's rules of residence and to abide by the care plan and risk management plans drawn up by staff.

The regime in the care home was highly restrictive. PJ was subject to constant supervision while in the unit and escorted on all community outings, including when attending college and meeting his girlfriend. All unescorted leave had to be approved by his responsible clinician and social supervisor, and his leave would be stopped if his risk factors increased. His alcohol intake was limited to four units per week and he was breathalysed to secure compliance. Any alcohol reading after home leave or contact with his brother would result in immediate suspension of home leave. PJ's understanding of the effect of his CTO was: 'if you f**k up it's goodbye everything' (*PJ*, para. 9). While PJ was 'happy to stay at the care home and understood that the CTO brought benefits because he needed clear boundaries' he wanted 'more freedom to see his family and his girlfriend' (*PJ*, para. 9).

Lady Hale, delivering the unanimous judgment of the Supreme Court in *PJ*, held that the MHA 1983 did not create a power for the responsible clinician to impose CTO conditions that amounted to deprivation of liberty. Using similar reasoning to the decision in *MM*, she found

that the MHA 1983 made no provision as to the settings in which a person subject to a CTO may be detained, nor did it make any provision for recapturing a CTO patient who escaped or absconded. Consequently, apart from the responsible clinician's power to recall the patient to hospital, there was no power to detain a patient under a CTO.

The judgments in *MM* and *PJ* had paradoxical implications for patients' liberty. While both judgments could be interpreted as requiring patients discharged into the community to be given greater freedom, they also had the potential to lead to lengthier detentions in hospital. This is because a responsible clinician could decide to leave a patient in hospital for as long as they met the criteria for detention rather than to risk granting a CTO without very restrictive conditions. Similarly, Tribunals and the Justice Secretary might be more reluctant to grant a patient conditional discharge if they were not confident that any residual risk could be managed through conditions that fall short of detention in the community.

The impact of the judgments on the number of people in hospital beds is unclear at this stage, although there is a clear pattern of reductions in the numbers of people with learning disabilities and ASD in secure services over time. NHS England Assuring Transformation (AT) data between September 2015 (Health & Social Care Information Centre 2015, Table 3) and August 2024 regarding people with learning disability and autism (NHS England 2024, Table 4.2) show a 22% reduction in the total number of inpatients, from 2,595 to 2,015. There have been commensurate reductions over the same period in the numbers of patients in medium secure beds (from 465 to 295, a reduction of 37%) and low secure beds (from 865 to 475, a reduction of 45%). However, the number within general inpatient beds has barely changed (from 1,170 to 1,100, a reduction of 6%). Comparing data on types of section over the period show a 14% reduction in Part II civil sections (from 1,285 to 1,100), and an 11% reduction in the number of restricted patients (from 610 to 540). Patients detained under unrestricted hospital orders (section 37) have seen a larger reduction of 44% (from 365 to 205).

After the decision in *MM*, the Mental Health Casework Section (MHCS) swiftly enacted an interim policy for conditionally discharged restricted patients already subject to conditions that deprived them of their liberty. It advised that responsible clinicians could give patients with mental capacity long-term section 17(3) leave of absence under the MHA 1983, subject to the consent of the Justice Secretary (Department of Health and Social Care, 2021, p. 76; HM Prison and Probation Service 2019, p. 2). Those patients who lacked capacity and whose care arrangements were for the purposes of protecting the public could also be dealt with under section 17(3) leave of absence. Those patients who lacked capacity and whose arrangements aimed to support them in looking after themselves could be dealt with through a deprivation of liberty authorisation under the MCA 2005 (HM Prison and Probation Service, 2019, p. 2). In this article, we focus on those patients with capacity who are or may be subject to the MHA 1983 and therefore we do not engage in detail with arrangements under the MCA 2005.

The subsequent case of *Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v. EG* [2021] EWHC 2990 ('*EG*') concerned a patient who was also subject to very restrictive conditions, even though his care arrangements were presented as the least restrictive alternative to hospital detention by his treating team. *EG* exposed a gap in the MHCS policy: how can a patient be made subject to a conditional discharge or section 17(3) leave when recall to hospital would go against his rights under Article 5(1)(e)?

EG had a history of sexual offending and was diagnosed with 'pervasive developmental disorder (but not a learning disability), emotionally unstable personality disorder with some features on the autistic spectrum, and paedophilia' (*EG*, para. 1). He had a history of committing sexual assault and had been made subject to a hospital order with restrictions by a court in 1994. He had spent nearly 30 years in detention, mostly in a medium secure hospital. He was conditionally discharged by a Tribunal in 2014 subject to conditions that required him to live in a care home in a remote rural setting. The staff of the care home were required to be

aware at all times of EG's location within the home and its grounds. If, at any time, the staff were unable to locate EG, all staff were required to conduct a thorough search of the grounds. If EG could not be found, the police would be called and staff would search the surrounding area.

EG had capacity to consent to his care plan and therefore could not be detained under the MCA 2005. He was technically recalled to hospital by the Justice Secretary after the decision in *MM* and immediately granted section 17(3) leave of absence. He never re-entered hospital and had not received any treatment in hospital since 2014.

In 2020, a First Tier Tribunal (Mental Health) concluded that it had no choice but to discharge EG as it was not satisfied that he was suffering from mental disorder of a nature or degree which made it appropriate for him to be liable to be detained in a hospital for medical treatment (MHA 1983, s 72(1)(b)(i)). This was on the grounds that there was 'no element of treatment at or in a hospital' in EG's case, and that his treatment team was 'actively avoiding a readmission to hospital' (*EG*, para. 50). EG's responsible clinician gave evidence that EG could only be managed in the community under conditions that deprived him of his liberty, and that this was the least restrictive alternative to detention in hospital. EG's treating team believed his condition would deteriorate and his risks would increase if he were recalled to hospital. The First Tier Tribunal recognised that a conditional discharge would not be in the interests of EG or of the public, but its members felt they had no choice given the state of the law. The First Tier Tribunal therefore suspended its decision so that the matter could be appealed to the Upper Tribunal.

In the Upper Tribunal, Mrs Justice Lieven found that the First Tier Tribunal had applied the law impeccably. According to the applicable case law, a 'significant component' of hospital treatment was required for it to be 'appropriate for [a patient] to be liable to be detained in a hospital for medical treatment' (*EG*, para. 50). EG's care did not meet this requirement for the

reasons noted by the First Tier Tribunal, and he therefore could not remain on section 17(3) leave in the community. However, the Upper Tribunal found that recall to hospital would breach EG's rights under Article 5(1). This is because, following the recent decision of the ECtHR in *Rooman v. Belgium* [2019] ECHR 105; [2020] MHLR 250 ('*Rooman*'), his detention in hospital would not be justified on the grounds that he was receiving suitable therapy. While the Upper Tribunal found that the care home was providing an appropriate therapeutic milieu, after the ruling in *MM*, EG could not be detained there under a conditional discharge. Thus, the Upper Tribunal found a conflict between domestic law and the ECHR.

In order to resolve this conflict, Lieven J. applied the power under section 3 of the Human Rights Act 1998 to construe domestic law in conformity with the ECHR. She interpreted section 72(1)(b)(i) of the MHA 1983 so that 'liable to be detained' meant 'liable in law to be detained for treatment, even where that treatment is being provided in the community, so long as it could lawfully be provided in hospital' (*EG*, para. 70). The Upper Tribunal further made a declaration, applicable to future cases, that where it is necessary to do so to avoid breaching a patient's ECHR rights, section 72(1)(b)(i) of the MHA 1983 'should be read to mean "liable in law to be detained for treatment" even where that treatment is being provided in the community'.

The decision in *EG* was a stopgap measure that did not fully resolve the problems with the applicable law and policy. The Upper Tribunal's reinterpretation of section 72(1)(b)(i) was questionable given that the reason EG could not remain on section 17(3) leave was that he could not be treated in hospital. Thus, it was unclear how the treatment EG was receiving in the care home could lawfully be provided in hospital given that 'hospital' refers to the hospital from which the patient was given leave of absence. This is despite the reality that the care plans and arrangements for EG would be identical whether in hospital or in the community care home. Similar problems were likely to arise for other patients using this work-around. The

longer the patient spends receiving treatment in the community, the more tenuous the connection to hospital was likely to become.

The law has since changed significantly with the decision of the UK Supreme Court in *Re RM Application for Judicial Review (Northern Ireland)* [2024] UKSC 7. This decision concerned article 15 of the Mental Health (Northern Ireland) Order 1986, a similar provision to section 17 of the MHA 1983. In *Re RM*, the Supreme Court held that the 'significant component' test was not 'necessary or indeed helpful, when deciding whether a patient's ongoing treatment is treatment in a hospital' and was merely a 'gloss on the statutory words' that should no longer be followed (*Re RM*, para. 82). Instead, the Supreme Court held that the fact that the patient 'has a hospital at which he or she is detained when not on leave' and the power to recall the patient to hospital under article 15 provided a sufficient connection to a hospital for a patient that is liable to be detained (*Re RM*, para. 82).

The decision in *Re RM* does not fully resolve the problem faced by patients like EG. When a Tribunal comes to determine whether a restricted patient ought to be discharged, it will be required to consider whether it is 'appropriate' for that patient to be 'liable to be detained in hospital for medical treatment' (MHA 1983, s 72(1)(b)(i)). That is to say, to consider whether it is appropriate for the patient to be subject to recall to hospital. The fact that a patient is on leave of absence and already subject to a recall power cannot be sufficient to determine this question. In a case such as EG's, where recall to hospital would be clearly therapeutically inappropriate, it would also be inappropriate for the patient to continue to be subject to a recall power. In which case, the patient should be discharged. Consequently, the problem identified in *EG* remains.

The MHCS policy does not refer to the need acknowledged in the *EG* case to ensure that the conditions of the patient's detention are compliant with the ECHR. While EG was receiving appropriate care and treatment in the care home in which he was detained, the policy does not

require responsible clinicians or the Justice Secretary to be satisfied that the patient is detained in a suitable therapeutic environment in the community. In order for detention to be compliant with Article 5, the conditions of that detention ought to be scrutinised. This is another gap in the current legislation, as the Tribunal is required to consider the appropriateness of the patient remaining liable to be detained in hospital for medical treatment, but not the appropriateness of the treatment being administered in the community. Patients in the community on long-term leave under section 17(3) are also deprived of safeguards available to patients in hospital, including the inspection regime conducted by the Care Quality Commission (CQC) of institutions designated as hospitals under the MHA 1983. Such community placements are unlikely to be commissioned to provide an equivalent of inpatient care for some patients whilst providing standard community care for others, and under different legal regimes (MCA 2005 and MHA 1983).

The routine use of section 17(3) to authorise long-term leave of absence from hospital also allows the use of coercive powers in the community to pass under the radar. Patients subject to section 17(3) leave of absence can be treated without their consent in the community: something that is not possible under a CTO or conditional discharge without recall to hospital under the MHA 1983 (s. 56(3)-(4)).[5] The use of section 17(3) leave of absence to circumvent the prohibition on using conditional discharge or a CTO to detain a patient in the community may therefore lead to disproportionate restrictions on patients' rights to refuse treatment. It is unclear how predisposed managers of community placements are to be responsible for the delivery of 'medical treatment' under Part IV MHA 1983, or indeed whether Responsible Clinicians will be willing to 'outsource' inpatient responsibilities to third parties in the community. There is also the risk of blurring the commissioning responsibilities for such

[5] Separate treatment powers may be available under the Mental Capacity Act 2005 if the relevant legal criteria are met.

patients; patients discharged from detention attract joint health and social care aftercare under section 117, but local authorities may be reluctant to contribute where a patient remains legally detained under the MHA 1983. There is also a risk that asking care home personnel to deliver care and treatment under two very different legislative regimes (MCA 2005 and MHA 1983) with different criteria and powers may cause confusion. Thorough training and supervision of staff will be required to avoid unlawful interventions with patients.

As a result of the *EG* and *MM* cases, the MHA 1983 requires amendment to regularise the position of restricted patients with capacity who are deprived of their liberty in the community under section 17(3) leave of absence due to the risks they are thought to pose to others. The Mental Health Bill 2025 proposes to do so by creating a new 'supervised discharge' power for the Tribunal and Justice Secretary. However, for the reasons set out in the next two sections, the proposed new power would not adequately respond to the problems exposed by the case law, and it runs the risk of resulting in unlawful detentions in the community in light of Article 5.

3. The Least Restrictive Alternative

This section draws out the implications of the cases discussed above for the principle of the least restrictive alternative: a principle that is well-embedded in policy in England and Wales but has a much less clear status in domestic law and under the ECHR. There are four different versions of this principle that ought to be distinguished from each other, as each principle has a different status under domestic law and policy in England and Wales and under the ECHR.[6]

[6] The least restrictive alternative also features in the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN, 1991). See Kelly (2024). It does not, however, feature in the more recently adopted framework of the UN Convention on the Rights of Persons with Disabilities, which instead requires states to ensure that people with disabilities enjoy the right to liberty and security of the person on an equal basis with others.

In its broadest sense, the least restrictive alternative principle 'requires the government to pursue its ends by means narrowly tailored so as not to encroach unnecessarily on important competing interests' (Zlotnick, 1981, p. 381). In the context of mental health law in the US, the principle has been interpreted as being applicable in four different contexts: as requiring consideration of alternatives to institutionalisation; as requiring consideration of less onerous detention conditions; as requiring consideration of less intrusive forms of treatment; and as supporting a right to treatment (Zlotnick, 1981, pp. 401-401).

Turning to England and Wales, these different versions of the least restrictive alternative principle are often blurred together in the MHA 1983 Code of Practice. According to that document, the 'least restrictive option and maximising independence' is one of the guiding principles that underpin the MHA 1983. The Code requires decision-makers to consider alternatives to detention, advising that 'where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained' (Department of Health, 2015, para. 1.2). The Code specifies that, for people with learning disabilities and/or ASD, identifying 'the least restrictive way of achieving the proposed assessment or treatment...means they should usually be treated in the community' (Department of Health, 2015, para. 20.40). The Code also links the decision to detain with detention conditions, stating that '[i]f the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available' (Department of Health, 2015, para. 1.4). The Code also refers to the need to consider less restrictive means of providing assessment, care and treatment, stating that 'any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action' (Department of Health, 2015, para. 1.4).

The Code explicitly links the principle of least restriction to patients' rights to liberty under Article 5 of the ECHR, stating that '[t]he person's article 5 right to liberty should also be protected by developing and applying the least restrictive option and maximising independence principle in care and treatment regimes' (Department of Health, 2015, para. 20.43). However, as set out above, Lady Hale's judgment in *MM* and the wider case law implies that Article 5 of the ECHR does not require a person to be held in the least restrictive detention conditions. This is significant, as it shows that Article 5 does not, in principle, recognise grades or levels of detention. Either a person is detained or they are not detained, and detention conditions do not make a difference to the question of whether someone is, in fact, detained.

Detention conditions do matter, however, when it comes to assessing the appropriateness of the place in which a person is detained. The more recent decision of the ECtHR in *Rooman* summarised and extended the court's case law on the meaning of appropriateness. The Court held that detention is unlawful under Article 5(1)(e) unless it is effected in a hospital, clinic or other appropriate institution (*Rooman*, para. 208). It further ruled that:

> Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for eventual release (*Rooman*, para. 208).

While *Rooman* does not establish a right for a person to be detained in the least restrictive setting, if the conditions of detention are so restrictive that they are anti-therapeutic or fail to prepare the person for release, this would raise an issue under Article 5.1(e). Nevertheless, a more secure setting that is providing an adequately therapeutic environment could still be

appropriate even where less restrictive settings were available, including detention in community settings such as a care home.

While the ECtHR's case law does not straightforwardly endorse the principle that patients ought to be detained in the least restrictive environment, it does recognise that detention should be a last resort. Thus, in *Witold Litwa v. Poland* (Application no. 26629/95 4 April 2000, para. 78), the ECtHR held that:

> a necessary element of the 'lawfulness' of the detention within the meaning of Article 5 § 1 (e) is the absence of arbitrariness. The detention of an individual is such a serious measure that it is only justified where other, less severe measures, have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. The deprivation of liberty must be shown to have been necessary in the circumstances.

Thus, while Article 5 does not require that a patient be *detained* in the community rather than in a hospital, it does support a right to be *discharged* from hospital when it is no longer necessary for a person to be detained. That person could then be treated in the community without being deprived of their liberty.

The MHA 1983 itself requires that detention for more than 36 hours under the Act can only take place in a hospital, as defined by s.145(1) (*Re Brammal; W Primary Care Trust v. TB* [2009] EWHC 1737 (Fam)). Consequently, if the Government wishes to make it legally possible to detain restricted patients in care homes, like the homes in which PJ and EG lived, or in supported living accommodation, the MHA 1983 must be amended to allow for long-term detention in such places. We return to this in Part 5 below.

4. Human Rights Implications of the Mental Health Bill 2025

As the Supreme Court recognised in *MM* and *PJ*, patients who are subject to conditions that deprive them of their liberty in the community are detained patients. Any amendment of the MHA 1983 to permit conditionally discharged patients to be detained in the community therefore must adequately protect patients' rights under Article 5(1)(e) and Article 5(4) of the ECHR. However, the Government's proposals fall short of these standards.

Whilst the Bill, if implemented, would not amend the detention criteria for forensic patients, it would amend the discharge criteria for both civil and forensic patients. New discharge criteria for all detained patients other than those detained under section 2 would appear under sections 20(4) and 72(1)(b) of the amended MHA 1983 (Mental Health Bill 2025, Clauses 5 and 7).[7] If implemented, the new criteria would introduce additional grounds for discharging patients and would therefore make it easier for at least some patients to be discharged. For example, the current criteria require the Tribunal to discharge a patient where it is not satisfied that '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 it is 'necessary for the health or safety of the patient or for the protection of other persons' that he should receive treatment under detention in hospital or that 'appropriate medical treatment is available for him' (MHA 1983, 72(1)(b)(i) - (iia)). The new criteria would require the Tribunal to discharge where it is not satisfied that 'the patient is suffering from psychiatric disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment', 'serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment', that 'it is necessary, given the nature, degree and likelihood of the harm, for the patient to receive medical treatment', that 'the

[7] The interpretation of the Mental Health Bill 2025 presented in this article is based on Alex Ruck Keene's very helpful (but unofficial) *Annotated Mental Health Act 1983 with changes proposed in 2024 Mental Health Bill* (Ruck Keene, 2024). <https://www.mentalcapacitylawandpolicy.org.uk/annotated-mental-health-act-1983-with-changes-proposed-in-2024-mental-health-bill/> accessed 9 June 2025.

necessary treatment cannot be provided unless the patient continues to be liable to be detained', and that 'appropriate medical treatment is available for the patient' (Mental Health Bill 2025, Clauses 5 and 7).

As is the case under the current Act, if the proposed changes in the Bill are implemented, the Tribunal would have a choice of discharging a restricted patient absolutely or subject to conditions (Clause 30). The provisions in the Bill are not sufficient to distinguish between patients who can lawfully be detained in the community under Article 5(1)(e) and those who cannot. Concerningly, the Bill proposes to enable Tribunals to subject patients who are entitled to be discharged from detention in hospital under the Act to detention in the community under a new supervised discharge power. This power would be available where the Tribunal: (a) is satisfied that the new discharge criteria are met; (b) is satisfied that conditions amounting to a deprivation of the patient's liberty would be necessary for the protection of another person from serious harm if the patient were discharged from hospital, and is also satisfied that for the patient to be discharged subject to those conditions would be no less beneficial to their mental health than for them to remain in hospital, and (c) is satisfied that it is appropriate for the patient to remain liable to be recalled to hospital for further treatment (Mental Health Bill 2025, Clauses 7 and 32).[8] These criteria would make it possible for a patient who is no longer legally detainable in hospital to be detained in the community, and may therefore lead to breaches of Article 5 of the ECHR. This is the implication of the *Cheshire West* and *MM* cases: individuals who are subject to 'continuous supervision and control' who are 'not free to leave' are detained, and their detention can only be lawful if it falls under one of the exceptions to the right to liberty and security of the person under Article 5. If their detention is to be justified on the

[8] These clauses would amend s 73(1) and s 73(2) of the current MHA 1983.

grounds that they are of unsound mind under Article 5(1)(e) then the criteria in *Winterwerp v. Netherlands* (1979 – 80) 2 E.H.R.R. 387 must be satisfied.

Winterwerp requires sufficient evidence that the person suffers from a 'true mental disorder' established by 'objective medical expertise' and that the mental disorder is 'of a kind or degree warranting compulsory confinement' (*Winterwerp*, para. 39; *R(B) v MHRT* [2002] All ER (D) 304). The combination of the new discharge criteria and the supervised discharge criteria are not sufficient to ensure that this is the case. While the new discharge criteria largely mirror *Winterwerp*, the criteria for supervised discharge do not, and they will therefore not require Tribunals or the Secretary of State to scrutinise whether the patient's detention is still justified under Article 5.1(e) and *Winterwerp*. Moreover, the new supervised discharge power is intended to apply to patients who are entitled to be discharged from detention in hospital under the MHA 1983. This could conceivably mean that a person who no longer suffers from mental disorder or whose disorder is no longer severe enough to warrant detention, whether in hospital or in the community, could be detained in the community under the supervised discharge power. This eventuality would clearly violate Article 5.1. As Tribunals ought to have regard to the ECHR when determining decisions to discharge, it will be for them to interpret the new provisions in conformity with Article 5.1(e). This situation could be avoided by creating much clearer criteria for the supervised discharge power that confine the use of this power to patients who can legally be detained under mental health law in the community.

Furthermore, the Bill makes no provision whatsoever as to the community settings in which conditionally discharged restricted patients would be detained, if it were implemented. The Bill, as it stands, would not prevent detention in settings such as the patient's own home, a police cell, or even a prison. This raises serious concerns, particularly given the absence of any requirement in the supervised discharge criteria to ensure that appropriate treatment is available in the setting in which the patient is to be detained. Under *Rooman*, it is insufficient for

treatment to merely have the purpose of preventing the patient's condition from worsening. Rather, treatment should involve real therapeutic measures that have the aim of preparing the patient for eventual release. Under the proposed powers, a patient could conceivably be discharged from hospital because treatment there is no longer appropriate or necessary but then subsequently be detained in a community setting that provides treatment that is just as unnecessary or inappropriate. Given that neither setting is providing appropriate or necessary treatment, the community placement would 'be no less beneficial to [the patient's] mental health than for them to remain in hospital' (Mental Health Bill 2025, Clause 36). But the patient's detention in such a setting would clearly be contrary to *Rooman*. Similar concerns can also be raised against the use of long-term section 17(3) leave of absence to detain patients in community settings which may not be providing an adequately therapeutic environment.

What is more, the proposals in the Bill do not fully address the *EG* case. The reason why EG was entitled to be discharged from detention was because his care plan did not involve any element of hospital treatment. As recognised by the court in *EG*, recalling a patient to a hospital that cannot provide appropriate treatment or an appropriately therapeutic environment would be incompatible with the *Rooman* principles and therefore with Article 5(1)(e). But under the Bill, the only means of enforcing conditions that deprive conditionally discharged restricted patients of their liberty will be to recall them to hospital.

Given that patients subject to supervised discharge would be detained in the community, the starting point should be that these patients are entitled to the same safeguards against unlawful detention under Article 5(4) as patients detained in hospital. The proposals in the Bill fall short of these standards. As the *EG* and *PJ* cases demonstrate, patients subject to supervised discharge may be required to live under very restrictive regimes in community placements in the name of managing risk. The idea that detention in the community is somehow a lesser form of detention cannot support fewer safeguards for patients subject to supervised discharge than

for other detained restricted patients. As set out earlier, domestic law and the ECHR does not recognise grades of detention.

The flaws of the supervised discharge criteria discussed previously raise further concerns about the Tribunal's power to review a patient's detention under supervised discharge. Under the Bill as it currently stands, a Tribunal could find that a person is entitled to be discharged from hospital yet impose conditions that deprive them of their liberty in the community without verifying the lawfulness of that detention under the terms of Article 5(1)(e). Again, the Tribunal would be required to exercise its powers in conformity with Article 5(1)(e). However, the legislation as currently drafted risks misleading Tribunals, and they will be required to read the *Winterwerp* criteria into the legislation in order to determine when a person is entitled to be discharged. In addition, a restricted patient detained in the community would have much less frequent reviews of the legality of their detention than a restricted patient detained in a hospital. Restricted patients are currently entitled to apply to a Tribunal between six and twelve months after their hospital order was first made and every twelve months thereafter (MHA 1983, s. 70). Under the Bill, by contrast, a restricted patient subject to supervised discharge would be entitled to apply between six and twelve months after they were first made subject to conditions amounting to a deprivation of liberty but would only be entitled to apply every two years thereafter (Mental Health Bill 2025, Clause 29). Given supervised discharge would be a form of detention, this differential treatment is not justified.

An objection could be raised that the supervised discharge power is necessary to prevent patients who have been discharged from hospital from causing harm to others. There is, however, no obligation for the state to violate a person's rights under Article 5 in order to protect the public. As the ECtHR noted in *Osman v. UK* [1998] ECHR 101, the state's duty under Article 2 to take measures to protect individuals from 'real and immediate' risks to their lives from third parties must be interpreted in conformity with the guarantees in Articles 5 and

8 of the ECHR. The Tribunal's independent discharge power is required under Article 5(4) to ensure that people who are detained unlawfully are released from detention. Individuals cannot be detained under mental health law solely on the grounds of perceived risks to others: the *Winterwerp* criteria must also be met (*X v. United Kingdom* (1982) 4 E.H.R.R. 188). Given that the supervised discharge power would compromise the ability of Tribunals to act as an adequate safeguard against unlawful detentions under Article 5(1)(e), the Mental Health Bill 2025 needs urgent reconsideration.

5. An Alternative Approach

An alternative approach is available. This solution would maintain the current distinction between detained patients, who can be deprived of their liberty, and patients given conditional discharge, who cannot be detained unless they are recalled to hospital. Instead of creating a new power with insufficient safeguards that could lead to unlawful detentions in the community, the Department of Health and Social Care and the Welsh Government should instead make available suitable hospital-based residential and supported living accommodation for patients who continue to meet the criteria for detention under the MHA 1983 but for whom detention in a secure hospital setting would be unduly restrictive. While these new settings may not be the least restrictive environments that could be envisaged, they would impose fewer restrictions on patients' everyday lives than secure hospital settings and benefit from an established inspection and oversight regime to ensure that patients' human rights are respected. Such settings would also provide an alternative to secure hospitals for patients who have made progress but who still present risks that mean they are unsuitable for conditional discharge. It should be acknowledged that external risk management is an appropriate and necessary part of responsible care planning for people who have residual forensic risks but who no longer require the restrictions of a secure inpatient environment. Such external risk management is required

where patients are unable to reduce their offending risk without the support of staff. Therefore, it can be argued that this support is genuinely in their interests because it reduces the risk to potential victims and reduces the risks to the patient such as exposure to the criminal justice system, or reprisals from others.

Restricted patients could be transferred to and detained in such designated accommodation under existing powers. These settings should be akin to care homes or supported living accommodation, and be more open than secure hospital settings, but should also be flexible enough to meet the complex and nuanced needs of people with learning disability or ASD. Given the heterogeneity of care needs for people with these mental disorders, a range of types of accommodation would need to be made available, mirroring those currently in existence. This may include residential individual or 'core and cluster' placements, as well as more bespoke placements for those with additional care needs.

Amendments would be required to adapt the definition of 'hospital' in the Act to incorporate such hospital-based residential settings and to ensure that they are subject to the same inspection regime as hospitals by the Care Quality Commission (CQC) or Health Inspectorate Wales (HIW). As amending the definition of hospital would have significant implications for other detained patients under the Act, we propose that this amendment should only apply to restricted patients. These settings would need to employ approved clinicians, including those with medical qualifications in order to satisfy the certification of any medication required for mental disorder. There would be a need for registered nurses and access to an inpatient multidisciplinary team, and personnel would need to be employed as hospital employees, and will need to undergo any statutory training as set out by NHS England or Ministers of the National Assembly of Wales. This course of action would resolve the problems raised by *EG*, as it would ensure that patients were detained in an appropriate setting under appropriate safeguards with no risk of recall to another hospital. It would also ensure that patients who are

deprived of their liberty in community settings would have the same protection as detained patients. Placements in these residential settings must also comply with the requirements of *Rooman*. If such accommodation is not currently available, then adequate resources should be allocated to create it.

Following this course would ensure that restricted patients who are not legally detainable under the MHA 1983 or under Article 5.1(e) in appropriate community settings would have to be discharged from detention. This would maintain the principle of least restriction as recognised under Article 5 of the ECHR: the right not to be detained if this is unnecessary. As is currently the case under the MHA 1983, patients could be discharged under conditions, but these conditions should not amount to deprivation of liberty. Where a person can no longer be detained but a conditional discharge is not thought to be sufficient to protect the public, criminal justice measures are available. Ultimately, it may not be possible to prevent all instances of reoffending. However, this course of action would prevent mental health law being inappropriately used solely for the purposes of social control where a person's detention is no longer justified under Article 5(1)(e) of the ECHR.

There are substantial limitations associated with implementing these measures. Significant costs will be involved in re-registering residential settings as hospitals. Consideration will need to be given to the model of care within these establishments, and this should vary depending upon the clinical and care needs of the detained person. Thought should given to what constitutes hospital treatment, especially in the light of *Rooman* and recent case law in England and Wales (see *SF v Avon and Wiltshire Mental Health Partnership NHS Trust* [2023] UKUT 205 (AAC)). Detaining patients in these settings may be seen as a step backwards in the Transforming Care agenda, and they would appear as detained patients in NHS statistics. However, this would be a more honest way forward than labelling patients detained in care homes or supported living settings as 'discharged' patients.

Our proposal is to create specialist care homes or supported living settings that would be designated as hospitals under the MHA 1983 but that would provide patients with more freedom and better quality of life than would be possible in secure hospital settings. Our proposals do not extend to the creation of powers to deprive patients of their liberty in other settings, such as in their own privately-owned or privately-rented home, by subjecting them to continuous supervision and control in the *Cheshire West* sense. Other supportive non-institutional community placements could be envisaged that could allow patients greater autonomy and quality of life than the settings we propose, and such settings may be more therapeutic than those we propose. However, we argue that if a patient is detained under the MHA 1983 then the safeguards and inspection regimes that currently apply to other detained patients should also apply. The reason for this is that the MHA 1983 allows people with capacity who object to treatment to be treated without their consent, and these powers should therefore be carefully regulated and supervised. Such regulation and supervision would be much more difficult if detention powers were to be used in private residences. The creation of powers to detain patients in their own home or other private settings under the MHA 1983 would therefore require greater democratic debate and consideration than is possible in this article.

6. Conclusion

The provisions of the Mental Health Bill 2025 must be reconsidered in order to address the complex needs of restricted patients whilst safeguarding their human rights. The proposed supervised discharge power poses a risk of unlawful detention, as patients who are no longer detainable in hospital may be detained in the community without adequate safeguards. The ECHR does not recognise degrees of deprivations of liberty. For that reason, detained restricted patients should be entitled to the same safeguards, whether they are detained in hospitals or in community settings. The proposals in the Bill do not go far enough to ensure that supervised

discharge will comply with the existing safeguards for detained patients in the MHA 1983 or be compliant with Article 5.1 and Article 5(4) of the ECHR.

It has been proposed that one way forward may be to create hospital-based residential accommodation under the MHA 1983 and to subject these settings to the same regulation as hospitals. Patients could be detained in these settings under existing powers under the MHA 1983. This would obviate the need to create a new, and complex, supervised discharge power. Where a person can no longer be detained under the MHA 1983 in such a placement, then they must be discharged from detention and allowed to live in the community without being deprived of their liberty. If there are concerns that a patient is likely to reoffend, criminal justice powers can be used instead if appropriate.

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