Mind's legal enewsletter

Issue 9, July 2011

Welcome to Issue 9 of Mind's legal enewsletter.

Here you'll find items that will inform or refresh your knowledge on legal matters of importance in the mental health sector. In this latest newsletter there are a variety of articles and reports from Mind's Legal Unit and Rowena Daw, Co-Author of the Draft Model Fusion Law.

This newsletter includes coverage and analysis of:

- True non-discrimination in mental health law: discussion of a draft model Fusion Law
- Law Commission Proposals for Adult Social Care Law
- Independent Mental Health Advocates
- Community Treatment Orders (CTOs)
- Deprivation of Liberty
- Equality Act 2010 update

Several of our articles invite your responses on current issues. Please do get in touch to share your experiences, preferably by e-mailing us at legalunit@mind.org.uk. If you need to contact us by phone for any reason, you may call us on 020 8215 2339.

For better mental health

FEATURE

Time for change – true non-discrimination in mental health law

The Richardson Committee on Reform of the Mental Health Act 1983 came to a wise and brave conclusion in 1999 - that mental health law should be governed by the principle of non discrimination between mental and physical health. Consequently they proposed that, with some provisos, a person should not be subject to compulsory powers unless s/he lacked capacity to make decisions about his/her treatment or care for their mental disorder (as their remit did not include treatment for a physical disorder). In advancing this vital principle they set the scene for a new era in mental healthcare.

In Scotland the Millan Committee made a similar recommendation and, unlike in England, the Scottish Parliament accepted it and enacted the Mental Health (Care and Treatment) Act of 2005. In Northern Ireland the Bamford Review came up with a more far-reaching proposal, that there should be a single act dealing with mental health combining the existing laws on mental health and mental capacity. It would be based on the twin principles of best interests and capacity. The government has accepted this and we await draft legislation. Now that Wales has full legislative power in mental health it will be interesting to see if they follow suit.

During the various stages of mental health law reform In England and Wales, Members of Parliament argued for a capacity based law, to no avail. We now have the curious situation of two schemes for detention, the first under the Mental Health Act 1983 ignoring capacity and the second, under the Mental Capacity Act 2005, based on best interests and lack of capacity. It is said by those involved in the practice of the two Acts, that the mismatch between the two laws causes many problems and is unfair. Indeed a new area of expertise and training – how to decide which Act to use – has sprung up. For service users and their families it must be unfathomable.

In 2010 George Szmukler, John Dawson and I published a draft statute (that we called the Model Law because it is not as detailed as an actual statute would need to be), which shows that a single act based on the principle of non discrimination between mental and physical health is feasible and makes a consistent whole [draft legislation based on this concept, and of fusing incapacity and mental health legislation, is sometimes referred to as 'Fusion Law' – ***Editor's note***].

In our proposed scheme, with some minor exceptions, the power to detain a person and impose compulsory treatment is restricted to those who lack capacity. So, when a person lacks capacity on account of their mental illness, learning disability, brain damage or dementia related illness, and decisions need to be taken about their health or welfare, a coherent legal régime would stipulate how this might occur. So it would cover equally, for instance, the person with schizophrenia who needed to be hospitalised for treatment for a psychotic episode, the person with learning disabilities who needed an operation for removing their gall bladder and who had a phobia about needles, and the man with dementia who needed to be put into residential care.

The statute deals with situations where the person is resisting the treatment as well as where they are not: whether there should be compulsory care and treatment would depend on the usual additional criteria of risk to self or others and also (generally) whether this was in the person's best interests. A structured approach to the assessment and treatment is set out with the appropriate safeguards of medical and other professional opinions certifying the illness, input from family or carers, the right to the assistance of advocates and the right of redress before a tribunal.

It deals with emergency situations, stipulates where a second opinion is required because of the seriousness of the intervention, and it provides for substitute decision-making by a nominated person. It contains some protections for informal patients in residential care. Underlying the law are the concepts of capacity and best interests, largely as they are found in the English Mental Capacity Act but in a manner that is sufficiently flexible to cover the complex and subtle forms of incapacity found in some mental disorders.

The statute does not preclude compulsory treatment for the protection of others, which is permitted in two sets of circumstances - first, where treatment for the protection of others is in the patient's best interests - and second, where in the course of providing treatment in the best interests of the patient, there arises a risk of harm to others.

There are other final features of such a law that we would consider important, and this would include advance directives, already part of the Mental Capacity Act 2005, where they are known as 'advance decisions'. They would be given a greater role to include wishes expressed about future care as well as refusals of treatment.

The most controversial issues arise in relation to the criminal justice system when the person who has a mental disorder has been charged, remanded to prison, convicted or indeed is already in prison and then needs treatment. The issues are complex, different at each stage and cannot be discussed here beyond stating the central dilemma. Should a lack of capacity be the threshold for the compulsory intervention of the health system into the case of someone who is judged by those who know and treat him to be dangerous? If the answer is yes, then the doctor may be powerless to intervene to prevent a tragedy, if the answer is no, the criminal justice system will need to be more vigilant. The boundaries of the responsibilities of health and of the criminal justice system would be thrown into sharp relief.

This dilemma aside the argument seems straightforward. For there to be a future in which mental health problems are seen properly as health problems and not a mark of Cain on those who have them, we need to have a law like the one described above which sets mental care in a new non discriminatory environment.

Rowena Daw
Co-author, Draft Model Fusion Law

ARTICLE

The Law Commission Proposals for Adult Social Care Law

The Law Commission has published its report on proposals for the reform of Adult Social Care Law.

This report recommends simplifying the current confusing patchwork of law and guidance with one adult social care statute, supplemented by regulations and a Code of Practice. It has 76 recommendations.

Summary: some important points

The statute would have an *overarching purpose* – social care must promote the well-being of the service user – with a checklist of factors to consider. There should be a duty to provide community care services for eligible needs after an assessment. Eligible needs are defined by an eligibility framework set out in regulations and locally determined eligibility criteria. Section 21 of the National Assistance Act 1948 should be retained, located in the adult social care statute rather than stand alone. For carers there should be a single duty to provide a carer's assessment for anyone providing care on a regular basis to a potential user of care services. No request should be needed to trigger the duty to assess.

Community care services should be defined by a list of services provided in accordance with the wellbeing principle and a list of outcomes. Local authorities would have a duty to produce a *written* care plan for people with assessed needs. Direct payments should be extended to cover residential accommodation. The policy of personal budgets must be more closely aligned with the legal framework with a regulation-making power to require local authorities to allocate a personal budget to service users and carers. There should be a general duty for social services to co-operate with a range of services including NHS and housing which is enhanced at key times eg. when assessing and providing services.

Local social services authorities should lead in responsibility for safeguarding with a duty to investigate adult protection cases. Adults at risk should be those who appear to have health or social care needs, be at risk of harm and unable to safeguard themselves because of health or social care needs. The Government and the Welsh Assembly Government should review applying Guardianship under the Mental Health Act 1983 (MHA) to people with learning disabilities and consider how to protect adults at risk who are being ill treated but not subject to the MHA 1983 or mentally incapacitated.

If the policy decision is made that prisoners should be included in adult social care, there should be a legal framework to facilitate this.

The right to advocacy in the Disabled Persons (Services, Consultation and Representation) Act 1986, so far unimplemented, should be retained.

Care packages become a bit more portable by promoting cooperation between local authorities when service users move from one local authority to another and requiring the receiving authority to assess and provide a written explanation if it provides a significantly different support package. Regulations provide that when service users move across authority boundaries, the new authority must continue their existing care package until a new assessment.

As now, local authorities should not provide healthcare services. If direct payments are extended to healthcare, then NHS should consider reasonable requests to continue direct payments to social care service users. Social services should not provide ordinary housing and connected services, if these are authorised or required to be provided under other legislation.

Proposals for section 117 of the Mental Health 1983

Section 117 MHA currently imposes a free-standing duty *jointly* upon health and social services to provide after-care services to people discharged from hospital after being detained under ss 3, 37, 47, 48 and 45A. Services are free and apply to patients irrespective of nationality or immigration status. Proposals are:

a) Section 117 should remain in the MHA as a separate duty to provide after-care services and not be included in the adult social care act;

b) *Choice of accommodation directions* be extended to people receiving after-care under s117, with the option of a s117 service user or third party on their behalf being able to make top-up payments for residential accommodation of their choice that costs more than the local authority would expect to pay.

   Under the *choice of accommodation directions*, when local authorities provide residential care under s21 of the National Assistance Act 1948 they have to accommodate a person at the place of their choice in England and Wales if:

   - the accommodation is suitable
   - the accommodation is available
   - the accommodation would not cost more than the authority would usually pay for someone with those assessed needs
   - the provider of the accommodation will provide it subject to the council's usual terms and conditions.

c) The concept of *ordinary residence,* used to decide which local authority is responsible for providing community care services and for resolving disputes between authorities, should also apply to s117, as this would lead to greater consistency and clarity. How this is applied to s117 should be part of a Government review of this policy.

d) The joint duty should be divided between health and social care. The s117 duty on the NHS should continue until it is satisfied that after-care is no longer required and likewise the duty on the local social services would continue until it is satisfied that after-care is no longer required.

e) Amending s117 to clarify that social services may commission services from other providers - currently s 117 allows health and social services to provide after-care *"in co-operation with relevant voluntary agencies"*.

f) To recast s117 from a free standing duty to a gateway provision in England and Wales so that the rules that apply to a person's care package are the same irrespective of their status. The Law Commission emphasise that this recommendation is made ***only*** *on the basis that these services would continue to be provided free of charge and irrespective of immigration status or nationality*. It is proposed that the Code of Practice will clarify how local authority and eligibility criteria mesh.

g) To define after-care services in MHA 1983 as those services necessary to meet a need arising from the person's mental disorder, and aimed at reducing that person's chance of being readmitted to hospital for treatment of that disorder. The Code of Practice should provide guidance on distinguishing between accommodation that is, or is not, related to mental disorder.

Mind's Concerns

When people have been detained for treatment then their after-care should be provided free of charge irrespective of country of origin. It is vital that there should continue to be joined up working between health and social care providers.

Does ordinary accommodation constitute a s117 after-care service?

In a case decided last year (**R (Mwanza) v London Borough of Greenwich (2010**) EWHC 1462 (Admin)), the Judge held that ordinary accommodation could as a matter of law comprise a s117 service but it was difficult to envisage circumstances where a mere roof over the head – bare accommodation on its own – would be necessary to meet a person's mental health needs. The Law Commission considers that bare accommodation should be excluded from s117. Mind's view is that suitable accommodation is a key component in recovery. Nowadays this is most likely to be ordinary accommodation in the community. There may be occasions when bare accommodation is required as a s117 service to prevent relapse.

The Report can be viewed at

http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf

Angela Truell
Mind Legal Unit

ARTICLE

Independent Mental Health Advocates

Introduction: patchy provision of IMHA services

Independent Mental Health Advocates (IMHAs) provide an important safeguard for patients who are being treated under the Mental Health Act (MHA) 1983. Their role is to help patients to obtain information about, understand and exercise their rights under the Act, and to obtain information about any medical treatment that they are receiving or might be given, the reasons for the treatment and what the legal authority is for that treatment.[1]

Since April 2009, in England, Primary Care Trusts have had the legal responsibility for providing an IMHA service for all qualifying patients.[2] Patients are entitled to have IMHA support if they are:

- detained under the Mental Health Act (except the holding sections 4 & 5 and sections 135 & 136)
- subject to guardianship
- subject to community treatment orders (CTOs)
- conditionally discharged
- not detained but are being considered for s57
- not detained, are under 18 and being considered for Electro Convulsive Therapy (ECT)[3]

Hospital managers have a duty to take whatever steps are practicable to inform patients of their right to an IMHA. The local social services authority must do the same for people under MHA Guardianship and the Responsible Clinician for people who have been conditionally discharged (under s.37/41 MHA).[4]

Despite these provisions, in 2009/2010 the Care Quality Commission reported that 18 per cent of hospital wards visited, that is 56 wards, did not provide patients with access to IMHAs.[5]

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1 s130B(1) and (2) Mental Health Act (MHA) 1983
2 s130A MHA1983 inserted by MHA 2007 s30(2) &The Mental Health (IMHA) Regulations 2008
3 s130C MHA1983; Code of Practice, Mental Health Act 1983 ch.20.4
4 s130D MHA1983; Code of Practice, Mental Health Act 1983 ch.20.12
5 CQC Mental Health Act Annual Report 2009/2010 p.13; www.cqc.org.uk/db/

The CQC also found that 40 per cent of the wards visited did not display information about any type of advocacy. In some cases IMHA services were not available in NHS specialist or forensic wards but were available in general wards of the same trust.

Research by Mind found that a large proportion of PCTs failed to put IMHA contracts out to tender and this led to a noticeable failure to address key issues for BME users.

http://www.mentalhealthalliance.org.uk/resources/Independent_Mental_Health_Advocacy_report.pdf[6]

There is evidence therefore that in 2009/2010, some PCTs had not complied with their duty to provide an IMHA service – Mind Legal Unit would like to hear from anyone whose PCT still does not provide an IMHA service.

IMHA Service in Wales to be extended to informal patients

Advocates promote participation and aim to empower. Mind considers that people may well need an IMHA service, whether or not they are detained. Providing an advocate may be a reasonable adjustment required by the Equality Act 2010. Recognising the wider need for an IMHA service, the National Assembly for Wales has amended the Mental Health Act 1983 to empower Welsh Ministers to extend the IMHA service in Wales to all detained patients including those under s136 and s135 and informal inpatients.[7] Consultation on the Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011, which will require Local Health Boards to implement the changes, closed on 16 May 2011. It is anticipated that by January 2012 in Wales informal patients will be entitled to access an IMHA.

Guidance note on the role of IMHAs in hearings of the First-tier (Mental Health) Tribunal

Judge Chamberlain conducted a consultation in Autumn 2010 on the role of the IMHA at Tribunal Hearings when the patient already has instructed a legal representative.

http://www.mhrt.org.uk//Documents/News/DraftGuidTribRoleIndpndtMHAdvocates_141010.pdf

A Guidance Note was produced in May 2011 recognising that the IMHA has a distinct role to play in ensuring that the patient has understood the issues and in supporting the patient to communicate his or her views.

It does not require IMHAs to apply in advance to the Tribunal for permission to attend and aims at clarifying procedural issues.

[6] Briefing Paper 3: Independent Mental Health Advocacy Feb 2011 Mental Health Alliance.
[7] Part 4 of the Mental Health (Wales) Measure 2010 which received Royal Assent on 15.12.10

A Word document of the Guidance Note can be accessed via the following link from the Tribunals section of the www.justice.gov.uk website.

http://www.justice.gov.uk/downloads/guidance/courts-and-tribunals/tribunals/mental-health/forms-and-guidance/Guidance-on-role-IMHAs-Tribunal-Hearings-30March2011.doc

Mind wants to ensure that any patient entitled to an IMHA has access if she or he wants and that patients are properly informed of their rights. If you have particular concerns about your PCT or your access to an IMHA service , the Legal Unit can provide advice. Please email Mind Legal Unit at legalunit@mind.org.uk.

Angela Truell

ARTICLE

Supervised Community Treatment Orders

Community Treatment Orders (CTOs) were introduced into the Mental Health Act 1983 in November 2008 by the Mental Health Act 2007. A person who is detained under certain sections of the MHA1983[8] can be discharged into the community as a "community patient" provided that they comply with specific conditions. These conditions focus on aspects of treatment and risk management and can extend to restrictions on residence. A community patient remains liable to recall to hospital by their responsible clinician (RC). The RC can recall the patient if s/he believes the patient needs treatment in hospital for his/her mental disorder and there would be a risk of harm to health or safety to self or to other persons if not recalled.[9] Non compliance with the condition to be available for examination by professionals can be a ground for recall. After recall, a patient can be held for up to 72 hours and then released on CTO unless the CTO is revoked. Revocation means that the patient reverts to being a detained patient.

Use of CTOs in practice

The rationale for the CTO was to assist 'revolving door' patients and prevent repeat hospital admission. Four hundred CTOs were predicted in the first year. Evidence indicates that the CTO is being used far more extensively.[10] There were 6,237 CTOs between November 2008 and March 2010[11] and only 31 per cent of these had ended by March 2010, suggesting that people are remaining on Supervised Community Treatment for long periods. Thirty per cent of patients on CTOs in the sample for the CQC's 2009/2010 report did not have a reported history of non compliance or disengagement with services after discharge. The CQC has concerns about the over-representation of black and ethnic minority groups in the sample of patients on CTOs. A recent study of 195 patients found only 15 per cent received SOAD certification within the time required and points to an increased use of antipsychotic long acting injections with Community Treatment Orders. It also raises concerns about conditions in CTOs being compliant with 'the least restrictive principle'.[12]

[8] Patients detained under ss 3, 37 or 45a, 47 and 48 are eligible but not restricted or s 2 patients

[9] s17F MHA 1983

[10] See Briefing Paper 2: Supervised Community Treatment: Simon Lawton Smith, Head of Policy, The Mental Health Foundation, August 2010 http://www.mentalhealthalliance.org.uk/resources/SCT_briefing_paper.pdf

[11] CQC Monitoring the Use of the Mental Health Act in 2009/2010, and Count Me In, April 2011

[12] Increased use of antipsychotic long-acting injections with community treatment orders. Therapeutic Advances in Psychopharmacology (2011) 1(2) 37-45 Maxine X. Patel and 8 others

Amendment to the current criteria for being placed on a CTO

An RC can place a patient on a CTO if s/he considers the following criteria are met and an Approved Mental Health Professional (AMHP) agrees in writing:

- that the patient is suffering from a mental disorder of a nature or degree which makes it appropriate to receive medical treatment
- it is necessary for the patient's health or safety or for the safety of other persons that the patient should receive such treatment
- subject to being liable to recall, such treatment can be provided without the patient continuing to be detained in hospital
- it is necessary that the responsible clinician should be able to exercise the power to recall
- appropriate medical treatment is available for the patient[13]

The Mental Health Alliance is seeking an amendment to the Health and Social Care Bill that would make *significantly impaired decision-making* a criterion for Supervised Community Treatment in addition to the existing criteria in s17A. The amendment proposed by the Alliance addresses the breadth of the criteria for CTOs and in particular the continuing concerns that, regardless of whether a person is able to make informed decisions about their own medical treatment, they can be placed on a CTO. The amendment sought would mean that a person could only be placed or remain on a CTO if their ability to make decisions about the provision of medical treatment was significantly impaired in addition to the other criteria. If you would like to know more please contact Simon Lawton Smith (slawton-smith@mhf.org.uk).

Angela Truell

[13] s17 A MHA1983

CASE REPORT

London Borough of Hillingdon v Neary [2011] EWHC 1377 (COP)

This Court of Protection case is notable for its high profile in the press and that the parties have been identified, but also gives very clear guidance on the approach to be taken by local authorities when reviewing cases in which there is a possible deprivation of someone's liberty.

Steven Neary is now 21 years old. He has autism and a severe learning disability and needs considerable supervision and support. He lived with his father and received a package of care from his Local Authority including help from carers and access to a range of activities until December 2009. He did not have capacity to decide where or with whom he should live.

Around Christmas, his father asked that Steven go to a unit which provided respite care as he was finding it difficult to manage some aspects of his behaviour. Unfortunately, Steven was not then permitted to leave – his social workers had concerns about his behaviour and his weight – and it took almost a year before he was allowed to return home. This case helps clarify how someone in Steven's position can seek to protect his right to live with his family and to ensure that there is no unlawful deprivation of his liberty, both of which are (and since the Magna Carta in 1297 have always been) fundamental rights.

The judge identified two key principles. If an adult does not have full capacity to make decisions, then it is lawful for the family and the Local Authority with responsibility for his or her care to act together in the adult's best interests. Then, should any disagreements arise, the Local Authority must act under the powers granted to it by legislation seeking court approval for proposed care arrangements where appropriate. A Local Authority failing to do so may find that it is liable to pay compensation to the person in its care - for unlawfully depriving him or her of liberty (a breach of Article 5 of the European Convention on Human Rights) as well as breach the right to respect for family life under Article 8.

The law allows for restrictions on someone's freedom so that he or she can be cared for safely. However, if the arrangements may have the effect of controlling the person's ability to come and go – particularly where the family do not agree – the Local Authority has to take certain steps in order that it acts legally. This involves obtaining what is known as a Deprivation of Liberty (DOL) authorisation, designed to safeguard the rights of the person in care. This judgment makes clear that the Local Authority must follow the procedure in a way that makes sure that these safeguards are effective.

The key responsibilities are:

- For the Local Authority to ensure that decision making procedures clearly assess what care arrangements will be in the person's best interests and test any proposals that remove freedom against a range of alternatives that would be less restrictive;
- each professional involved in the process has an independent responsibility to do what he or she feels is the best thing to do even if this means challenging the decisions of others;
- in particular, a Best Interests Assessment needs to be an independent analysis of appropriate arrangements;
- an Independent Mental Capacity Advocate must be involved to act on the person's behalf and it is the Local Authority's responsibility to arrange this;
- when taking on the role of supervisory authority – to review and consider granting a DOL authorisation – there must be an effective and independent scrutiny of the recommendation in the Best Interests Assessment, and
- if concerns remain, the Local Authority should refer the matter to the Court of Protection for guidance.

In many cases, ongoing disagreement about care arrangements will become very heated and polarised. Sometimes the family will voice grave concerns, and may even start court proceedings; others may be less vocal. The judge here was very clear that the Local Authority cannot take a less challenging response as a sign of consent to its proposals. It should seek court authorisation unless the family's consent is absolutely clear. This need not be on an adversarial basis – the Court is more than willing to hear cases where it is effectively being asked for clarification on what should be done in the best interests of the person whose care needs are disputed.

The Court decided that the London Borough of Hillingdon had failed in its responsibilities when making and reviewing arrangements for Steven's care. Its failures meant that he had to live away from his family for many months when his best interests pointed to an early return home. The Local Authority, as a supervising body, had authorised his deprivation of liberty, but as its process was not robust and independent, they did not meet the legal standards. As a result, Steven had been unlawfully detained. Steven had been allowed to return home after the first court hearing in December 2010. He will now be allowed to stay with his father, with a new care package in place to support him to live at home.

Pauline Dall
Mind Legal Unit

CASE NOTE

McKie v Swindon College

Although there is no legal obligation to provide a reference for an ex-employee, an employer could be liable if a reference is misleading or wrong and prevents the employee from getting another job. The High Court has recently taken this further in a situation where a former employer included damaging information in an email sent after the ex-employee had taken up a new role.

Mr McKie was given a good reference when he left Swindon College and he took up a new role at Bath City College. However, the HR Manager at Swindon College then raised concerns in an email sent to his equivalent at Bath mentioning safeguarding concerns for the students and serious staff relationship problems which occurred whilst Mr McKie worked there, although no formal action had been taken before he left. Bath City College dismissed Mr McKie and he sued Swindon College.

It was very clear that the information led to the decision by Bath College to end Mr McKie's employment. However, when the Court looked at the evidence, everything pointed to Mr McKie having a good employment record. The comments in the email had not been checked and appeared to be untrue.

The High Court found that Swindon College owed a duty of care to Mr McKie, and that it had failed to act fairly when it passed information to his new employer. It made no difference that the information was not in a formal reference.

Many employees are concerned about what former employers may say about them in references or otherwise. This case shows that there are consequences for anyone who unfairly blocks someone from finding new employment and this decision should discourage careless or offhand comments about work performance or difficulties at work.

Pauline Dall

NEWS

Mental Health Act s64C

Mental Health Online report that a Bill is being drafted which would remove the need for a SOAD (Second Opinion Appointed Doctor) Second Opinion certificate for Community (CTO) patients. This would apply where a patient has capacity to consent to treatment and the aim would be to reduce the workload of the SOAD service. See

http://www.mentalhealthlaw.co.uk/MHA_1983_s64C

Ministry of Justice Court of Protection Consultation: a Consultation exercise is currently being conducted on whether certain decisions normally taken by the Court of Protection itself should be delegated to Officers of the Court. The consultation period lasts until 20 September 2011. The Consultation document can be viewed at

http://www.justice.gov.uk/downloads/consultations/court-protection-authorised-officers-consultation.pdf

Adult Social Care Funding: Dilnot Commission Report

A report from the Commission on Funding of Care and Support was published by the Department of Health on 4 July 2011 – the Fairer Care Funding Report. The independent commission was created in July 2010 in order to propose a 'fair and sustainable' funding system for adult care in England. The Report recommends that individual contributions towards social care costs, currently unlimited, should be capped over a person's lifetime, after which individuals would receive full state support. The figure of £35,000 was suggested as fair but the cap could lie between £25,000 and £50,000. The threshold for means-testing would be raised to £100,000 (from the current threshold of £23,250). It is only when people reach this threshold that they would be eligible for their full care costs. National eligibility criteria would also be introduced and all those with a care and support need when they reach adulthood would be eligible for state support without having to pay a contribution immediately, instead of being means-tested. The text and other relevant items are available at

http://www.dh.gov.uk/en/Aboutus/Features/DH_128017

Ministry of Justice: Draft Charter for the Current Coroner Service

The MOJ is currently holding a consultation on its latest draft charter, beginning on 19 May and ending on 5 September 2011**.** It is intended to publish the response to the consultation exercise by 5 December 2011, and with it the final version of the Charter. Although primarily circulated to a list of relevant organisations, views are welcomed from all who have an interest in the Coroner system in England and Wales.

The introduction explains that the Government is committed to addressing inconsistencies and inefficiencies within the system by creating national standards for the delivery of the Coroner service, and to set these out in an accessible and user-friendly way. The Charter will explain what people can do if they are unhappy with the service they receive. The MOJ stresses that an Impact Assessment (including an Equality Impact Assessment) has been conducted, which shows that no particular groups are likely to be disproportionately affected, and that no additional costs are likely to be imposed on Coroners or Local Authorities.

This consultation follows in the wake of a policy consultation conducted by the last Government with a view to drafting secondary legislation to support the Coroners and Justice Act 2009. The areas consulted on included the conduct of inquests, post-mortem examinations, types of death to be reported for investigation, the proposed new complaints system and Coroners' training. The current consultation does not include the plans for a new appeals system or introduction of a Chief Coroner office, and therefore follows the current law as set out in the Coroners Act 1988 (it will be revised when relevant provisions in the Coroners and Justice Act 2009 are implemented).

The Ministry has decided that it will be more cost-effective to publish the Charter as one document alongside the current *Guide to Coroners and Inquests*. As the Guide has already been consulted upon, there is no provision for changes to the Guide to be proposed within this consultation. The scope of the Charter is now extended to all with a proper interest in the system, and does not aim to focus exclusively on bereaved people and witnesses. General information about Coroners and Inquests will feature in the Guide rather than the Charter – the latter will set out minimum standards of performance for the Coroner service. Consultees may, therefore, find it useful also to read through the Guide, which is included within the consultation document, for information on the framework of the system, e.g. it is stressed that Legal Aid is not generally available for *representation* at inquests, as an inquest is essentially a fact-finding process, although it may be available in very exceptional cases, which are outlined. Legal representation is distinguished from Legal Advice and Assistance, via the Legal Help scheme, which is generally available to people who qualify financially (pass the means test).

The Charter covers aspects such as the rights of bereaved people, including: the right to be contacted by the Coroner, to be consulted about the timing of the inquest and to receive specified information about it, and the right to receive post-mortem examination reports, although it advises that the details contained in these may prove distressing. Bereaved people and other properly interested persons have the right to attend the hearing and ask witnesses relevant questions, or to have them asked by a legal representative or other third party, provided the third party is considered an appropriate

person by the Coroner. It is possible to challenge a Coroner's decision or verdict by bringing an application for Judicial Review proceedings within three months of the decision or verdict. The Charter additionally covers other non-judicial ways of complaining about the standard of service received, and about the conduct of the Coroner or of the other members of staff involved.

Views are, moreover, being sought about the proposal that monitoring of adherence to the standards will be carried out by a committee of voluntary bereavement organisations.

The draft Charter can currently be viewed at

http://www.justice.gov.uk/downloads/consultations/draft-charter-coroner-service.pdf

Responses can be sent until **5 September 2011** to coroners@justice.gsi.gov.uk, or to: Hazra Khanom, Ministry of Justice, Access to Justice, Justice Policy Group, 4th Floor (post point 4.38), 102 Petty France, London SW1H 9AJ.

McKenzie Friends Practice Guidance (Civil and Family Courts)

Issued on 12 July 2010 by Lord Neuberger, Master of the Rolls and Sir Nicholas Wall, President, Family Division, it summarises principles and law regulating McKenzie Friends, and supersedes the guidance in **Practice Note (Family Courts: McKenzie Friends) (No 2) [2008] 1 WLR 2757,** now withdrawn. It is a response to the increasing number of litigants-in-person representing themselves in the civil and family courts, an issue growing in prevalence in a climate where legal representation and/or Legal Aid funding become more difficult to obtain.

Litigants-in-person have a right to reasonable assistance from a lay person, known sometimes as McKenzie Friends (MFs). MFs have no right to act as advocates or conduct litigation, and they do not act as an agent for the Litigant in relation to the proceedings. They may not sign Court documents on the Litigant's behalf or address the Court in any manner, including making oral submissions or examining witnesses. MFs may provide moral support, help with case papers, and give advice on conducting of the case (this must be done quietly).

The Guidance stresses that the Court retains the right to refuse to permit MF assistance, and this may occur where the Court is satisfied that 'the interests of justice and fairness do not require the litigant to receive such assistance.' Litigants need to inform the Court of the identity of the MF as soon as this is known. It is necessary to supply a short CV indicating the MF's relevant experience and confirm that he/she has no interest in the case and understands the MF's duty of confidentiality. It is possible for the Court or a third party to object to the presence of, or the assistance given by, the MF, but in such a case, it is for the party objecting to supply reasons for the objection (not for the Litigant to establish why the MF's participation should be allowed). In any case, the Litigant should be given the chance to argue the point, and the MF would normally be allowed to attend, and participate in, such a hearing.

There will be times when a Litigant may wish their MF to be granted full rights of audience. This is different from merely receiving MF assistance, which is described above. The Litigant must apply for rights of audience to be granted to the MF at the start of the hearing, as MFs have no statutory right of audience or to conduct litigation, and it is an offence to do so without appropriate qualifications and authorisation from an appropriate regulatory body. The Court may, however, grant such rights to a lay individual including an MF on a case-by-case basis (Legal Services Act 2007 ss12-19, Schedule 3), but they should not be granted without good reason and without due consideration. They will not be granted automatically. It is more likely for rights of audience to be granted where the MF is a close relative of the Litigant, the Litigant has health problems preventing him or her from addressing the Court directly, or the Litigant has problems with articulating his or her arguments which might prolong the proceedings.

It is more likely that the Litigant will be refused a grant of MF rights of audience at the start of a hearing if the case is straightforward (e.g. a directions or case management hearing), the Litigant appears capable of conducting the case without assistance, is unrepresented by choice, the other party is not represented, the proposed MF belongs to an organisation promoting a particular cause, or the proceedings are confidential.

It is in addition possible for the Litigant to request that the MF be granted the right to conduct litigation. This is separate from the right of audience. As the Guidance stresses, if both rights are sought 'their grant must be applied for individually and justified separately'.

There are therefore three distinct applications that appear in the Guidance, (1) for MF assistance, (2) for MF rights of audience and (3) for MF right to conduct litigation.

The Court can also circumscribe the right of the MF to assist during a hearing, or may issue a warning, where, for example, the MF is giving assistance which 'impedes the efficient administration of justice'. The High Court can also impose a restraint order on MFs who repeatedly act in ways that undermine the efficient administration of justice.

Additional services for Litigants are available from Personal Support Units (PSUs) and Citizens' Advice Bureaux (CABx), such as the CAB based at the Royal Court of Justice.

The full text of the Practice Guidance is available at

http://www.mentalhealthlaw.co.uk/images/Mckenzie-friends-practice-guidance-july-2010.pdf

The problems, arising particularly in the High Court, which may have led to the issuing of the Guidance, and the constraints now possibly flowing from it, are highlighted in an article by Peter Thompson QC in the 25 February 2011 issue of the New Law Journal (NLJ vol 161, Issue 7454).

Law Society Practice Note: Representation before Mental Health Tribunals

Published on 19 May 2011, the Practice Note summarises the rights of clients to legal advice and representation before the Tribunal, including the role of the Hospital and of Independent Mental Health Advocates (IMHAs), changing solicitors, and guidance for solicitors on communication with the client and duties towards the client. There is a special section on representation of children and young people. It is aimed at all legal practitioners who represent clients before the First-tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal for Wales, including solicitors, legal executives, trainee solicitors and solicitors' clerks who are members of the Law Society's Mental Health Review Tribunal Accreditation Scheme, and was prepared by specialist lawyers who are members of the Law Society's Mental Health and Disability Committee.

It explains that the right of access to a court, in addition to being a fundamental right at common law, is guaranteed by Article 6 of the European Convention on Human Rights (ECHR). Article 5(4) guarantees the right to legal representation. Where an individual is being detained on the grounds of mental disorder, this must be effective and provided by the State free of charge, unless there are 'special circumstances'. The fact that the detainee has enough money to instruct his or her own lawyers makes no difference, but he or she may opt out of legal representation if the choice is informed and he or she has the mental capacity to make such a choice. This means that in England and Wales, public authorities have the duty under the Human Rights Act 1998 to ensure that detained patients are represented, so that a Tribunal has a duty to consider appointing a legal representative under rule 11(7) of the First-tier Tribunal Rules 2008 where a detainee is unrepresented, unless it is satisfied that the individual has the capacity to choose not to have representation. It should also be noted that, included in the Tribunal's overriding objective to deal with cases fairly and justly, is the duty to avoid delay where this is compatible with a proper consideration of the issues.

A hospital, on the other hand, has no duty to ensure that a client is represented or that they are put in touch with a legal practitioner. The Hospital Managers (Mental Health Act Managers) are, however, bound by s132 MHA 1983 to inform clients in an accessible way of their right to apply to a Tribunal, which should include information on the right to legal representation. Although the following is not a statutory duty, it is suggested that a hospital through its Mental Health Act Administrator should provide a list of mental health lawyers on the ward.

IMHAs may accompany clients to Tribunals and Hospital Managers' hearings and assist them to exercise their rights. However, the Guidance stresses that they are not the same as legal representatives and are not expected to take over legal practitioners' duties.

Comment: It is still, however, possible under the Tribunal Procedure (First-tier Tribunal (Health, Education and Social Care Chamber) Rules 2008, Rule 11, for a client to appoint a non-legally qualified person to act as their representative at the Tribunal (subject to certain restrictions). The position is the same under the Mental Health Review Tribunal for Wales Rules 2008, Rule 13. A client may, therefore, choose an IMHA to represent him or her if that is what he or she wants.

The Note also contains guidance for representatives on complex issues such as the client's mental capacity to instruct a representative and what to do in the face of instructions which may seem inconsistent or contradictory or not in the client's best interests. It may be necessary for a legal representative to pursue the client's best legal interests even if it may prove detrimental to his or her best clinical interests – i.e. adversely affect his or her health (**RM v St. Andrew's Healthcare** [2010] UKUT 119 (AAC)). Legal representatives are subject throughout Tribunal proceedings to the Law Society's Professional Code of Conduct, but there are other codes which may prove useful, such as the Mental Health Lawyers' Association Code of Conduct and voluntary Codes developed by some NHS Mental Health Trusts.

Comments or queries on the Practice Note should be addressed to the Law Society's Practice Advice Service. The full text of the Note can be viewed at

http://www.lawsociety.org.uk/productsandservices/practicenotes/mentalhealthtribunal.page

Joanna Sulek
Mind Legal Unit

Legal Aid Update

The Legal Aid Sentencing and Punishment Offenders Bill had its second reading and is being fast-tracked through the commons. It provides that employment, welfare benefits, education (except special educational needs), clinical negligence, private family law (where domestic violence is not present) and debt (unless a person's home is at immediate risk) will no longer be covered by the legal aid scheme. Advice may be restricted to telephone advice in certain cases

http://services.parliament.uk/bills/2010-11/legalaidsentencingandpunishmentofoffenders.html

These changes seriously disadvantage people with mental health problems. Mind is a member of Justice for All, a coalition of organisations campaigning to protect access to justice http://www.justice-for-all.org.uk/

Local Government Ombudsman update

Having a mental health condition can impact on your ability to manage your finances. An investigation by the Local Ombudsman into a complaint against Torbay Council found maladministration leading to injustice when the council bankrupted a council tax debtor without proper regard to his personal circumstances, particularly his mental health.

http://www.lgo.org.uk/news/2011/may/torbay-council-criticised-bankruptcy/

Concern about standards of adult social care has led the LGO to make a public statement.

http://www.lgo.org.uk/news/2011/jun/help-concerned-about-adult-social-care/

Tribunal Procedure Rules Consultation

A Consultation is under way on amendments to Tribunal Procedure Rules for Community Treatment Order (CTO) patients. The dates are 1 June – 23 August. Further information is available at

http://www.justice.gov.uk/downloads/about/moj/advisory-groups/amends-health-education-social-care-tribunal.pdf

The Tribunal Procedure Committee proposes to amend rule 35 of the Tribunal Procedure Rules so that a hearing is no longer required where a patient on a CTO has his or her case referred to the Tribunal and that patient consents to the matter being decided without a hearing**.**

When must a referral of a patient on a CTO be made? Section 68 MHA 1983 places a duty on hospital managers to refer the case of a patient on a CTO to the Tribunal within six months of the patient's admission to hospital if that person has not herself or himself made an application to the Tribunal. Thereafter the Managers must refer a case to the Tribunal if a period of more than three years has elapsed since a tribunal last considered the patient's case (s68(2) MHA 1983).

Why have a referral system? The purpose of the referral system is to protect patients who lack the ability or confidence to make their own application to the Tribunal by giving them an independent review in any event. In Mind's experience, the people subject to referrals may have less understanding or confidence about their legal rights. They may be people who find it particularly hard to access legal advice and advocacy services.

Mind will be responding to this consultation and is currently carrying out a consultation of its own with users of mental health services for their views and experiences on this proposal.

Angela Truell

Equality Act Update

Since October 2010, section 60 of the Equality Act makes it generally unlawful for employers to ask health questions as part of a recruitment exercise until after a job offer has been made. The risk for employers who do so is that an unsuccessful candidate who had to answer such questions will have a much easier task of proving discrimination if he or she chooses to bring a discrimination claim (because the presumption will be that the refusal was because of disability/perceived disability, which the employer then has to prove was not the case). In addition the Equalities and Human Rights Commission has a power to take court proceedings against an employer continuing with that practice. We have been advised that EHRC will be issuing guidance in the near future. They have made informal approaches to a number of employers against whom complaints have been made, and those employers were willing to change their applications forms in line with the new requirements. As yet no formal action has been taken.

If you come across an employer who has not changed its practice - then please contact the EHRC Helpline (see below) to share your concerns. Please also let us know (legalunit@mind.org.uk). Mind campaigned for this change as a fairly simple but important step in giving disabled people, particularly those with experience of mental health problems, equal access to the jobs market. Applicants have the opportunity to explain any ongoing health needs after the offer has been made, at a stage when a realistic assessment can be made of the person's needs (if any) in the new role.

England: **0845 604 6610**
Email: englandhelpline@equalityhumanrights.com

Wales: **0845 604 8810**
Email: waleshelpline@equalityhumanrights.com

Pauline Dall

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Legal rights and mental health manual

Updated in July 2011 (forthcoming)

An essential resource for anyone concerned about legal rights and mental health, the Mind manual contains everything you need to know about the law as it applies to people with mental health problems. Written and updated to reflect recent changes in the law by members of Mind's Legal Team, this comprehensive publication contains briefings on mental health law and practice in England and Wales, and focuses on commonly encountered aspects of the law. An invaluable resource for anyone working in mental health, legal and advisory services.

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