

Mind legal newsletter

Issue 11, April 2012



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Welcome

Welcome to issue 11 of the Mind legal newsletter.

In this issue we've included coverage and analysis of recent legal matters that affect the mental health sector.

Highlights in this issue include:

- Making best interests decisions under the Mental Capacity Act 2005 on page 4
- Rabone v Pennine Care NHS Trust - the right to life under Article 2 of the European Convention on Human Rights on page 9
- The right to independent living – is it working? on page 11
- Updates including latest news on discrimination on page 23

We hope you enjoying reading it and welcome any comments and suggestions you may have. Our contact details are on page 29

Mind Legal Unit

Articles

Making best interests decisions under the Mental Capacity Act 2005

by Martha Spurrier, Mind Legal Unit

In 2010 to 2011, the Norah Fry Research Centre at Bristol University, the University of Bradford and the Mental Health Foundation undertook the first large-scale national research into how best interests decisions are being made under the Mental Capacity Act 2005 (MCA). The resulting [report](#) offers an insight into how the MCA is being used by professionals, observing both good practice as well as some worrying trends in the application of this complex statutory scheme.

Unlawful best interests decisions

The report identifies that a significant number of best interests decisions are being made with no lawful basis. In almost 10 per cent of cases a best interests decision was made where a person had been assessed as having the capacity to make the decision themselves. In a further seven per cent of cases a best interests decision was made where professionals were not sure whether a capacity assessment had been done. This approach is unlawful.

Assumptions of incapacity

In 26 per cent of cases, the reasons people gave for concluding that a person lacked capacity are specifically ruled out in the guidance, indicating a widespread lack of understanding of the [MCA](#):

- In 17 per cent of cases a person was deemed to lack capacity because of their disability, diagnosis or illness
- In six per cent of cases a person was deemed to lack capacity because they were making an unwise decision
- In three per cent of cases a person was deemed to lack capacity because of their age, appearance or behaviour.

For those with dementia this erroneous approach was particularly pronounced. In a number of cases the fact that a person had been diagnosed with dementia led to an assumption that they lacked capacity. Underlying this was a tendency to confuse the ability to carry out an action with the ability to decide on it.

This is in stark contrast to the assumptions made about those with strong personalities who were vocal about their wishes. In such cases capacity was sometimes overestimated because a person's ability to speak up for what they wanted belied their lack of

understanding. The flip side of this was that those who could not communicate verbally often had their capacity underestimated.

Assessing the capacity of people with mental health problems was shown to be particularly difficult where their capacity fluctuated. In such circumstances effective best interests decision-making was marked by informality, calm contexts and the involvement of trusted and familiar people.

Insight and incapacity

The professionals surveyed frequently used the word 'insight', equating a lack of insight with a lack of capacity. The word insight does not appear in the MCA. The MCA is concerned with those who lack the cognitive understanding about the nature of a decision or its consequences not with those who have a perceived lack of insight into their own needs. These findings demonstrate that some professionals have lost sight of the presumption of capacity at the heart of the MCA.

Loss of capacity and loss of freedom

The report found few best interests decisions that resulted in someone living more independently than before. This was particularly the case for older people where the inability to manage one's own independence and care were confused with an inability to make a decision about living independently. This should put professionals on their guard: lack of capacity surrounding a particular decision should not equate to a restriction on personal freedom overall.

Deprivation of Liberty Safeguards

The [Deprivation of Liberty Safeguards](#) (DoLS) are a procedure under the MCA to govern situations where someone's liberty is restricted. They are designed to ensure that the right to liberty is not unlawfully interfered with. According to the DoLS, professionals making a best interests decision that results in someone's liberty being restricted must seek authorisation before they proceed. The report found that some professionals were completely unaware of the DoLS even though authorisation may have been required in a third of the cases. In light of the likelihood that best interests decisions will result in a loss of independence, the knowledge gap in relation to the DoLS is troubling.

The findings in this report chime with the [recent research on DoLS by the Care Quality Commission](#) (CQC). On 28 March 2012 the CQC announced that while many services in the UK had developed good practice in their use of the DoLS, especially in involving people and their families in the decision-making process, some were confused as to when restraints or restrictions on a person amounted to a deprivation of liberty. In addition, between a third and a quarter of care homes had not provided their staff with training on the DoLS, and in some cases only the manager had received training. Most hospitals had held training on the DoLS, but the proportion of staff involved in the training was sometimes as low as 20 per cent.

The overall message of confusion and underuse of these safeguards is concerning. The report into best interests decisions recommends that health and social care services should receive more training in this area and be audited regularly for their compliance with the DoLS.

Role of Independent Mental Capacity Advocates

The report found that there was some confusion amongst professionals about the role of Independent Mental Capacity Advocates (IMCAs), namely that some thought that IMCAs should participate in making a best interests decision, advise others and resolve family conflicts. This is not the role envisaged for IMCAs by the MCA. However, professionals were clear about the value of IMCAs being able to get to know the person lacking capacity and bring information to the decision-making process that medical professionals would not ordinarily have access to.

Good practice: lessons and recommendations

The following aspects of good practice for professionals involved in best interests processes can be drawn out of the report.

- Keeping capacity assessments and best interests decisions separate: An assessment of capacity should always come before a best interests decision. However, in 49 per cent of cases the capacity assessment was made on the same day as the best interests decision, and sometimes at the same time. While this is to be expected in urgent cases, professionals should be wary of deciding what they think is in a person's best interests *before* a capacity assessment in case the capacity assessment becomes a way of enforcing a preconceived idea of the 'right' outcome for the person.
- Reviewing capacity assessments and best interests decisions: Care homes should review assessments of capacity and best interests decision-making on a weekly basis. Care homes should ensure that all staff are able to undertake capacity assessments themselves, rather than contacting specialists for that purpose.
- Involving the person: In a very positive finding, the report shows that in 88 per cent of cases the person lacking capacity was involved in the best interests process in some way. One way of involving the person is by supporting them to make the smaller decisions that surround a best interests decision.
- Making routine decisions: The report shows that there are gaps in the application of best interests principles in the context of routine decisions. Professionals should remember that any decision being taken in someone's best interests must be guided by the legal framework of the MCA, no matter how small or insignificant it may seem.
- Taking an informal approach: The report identified the importance of using informal processes to build a rapport with the person who lacks capacity and put them at ease. Informal meetings and conversations may be particularly appropriate where the subject matter is sensitive. Where an informal approach is taken, it is important that professionals still keep formal records.
- Sharing and consulting: Professionals reported that the most effective best interests processes were those that were multi-disciplinary. Good communication, information sharing and different services working together helped to produce positive outcomes.
- Using the formal structures of the MCA: The report found a widespread underuse of the formal processes created by the MCA, such as making a lasting power of

attorney, using advance decisions (advance directives) and involving a corporate deputy. These processes are designed to assist with best interests decisions and are overseen by the [Office of the Public Guardian](#). Professionals should be familiar with these structures and use them in safeguarding those who lack capacity.

Listening to experience – Mind’s report into acute and crisis mental healthcare

by Angela Truell, Mind Legal Unit

Crisis and acute mental health services provide for people when they are at their most unwell and vulnerable. Over 1.25 million people used NHS specialist mental health services in 2009-2010; 107,765 spent time as inpatients and 16,647 people were detained in hospital as at 31 March 2011.

Between Autumn 2010 and Summer 2011, Mind’s independent inquiry heard evidence from 400 service users and professionals in relation to acute mental healthcare in England and Wales, producing a report in November 2011 entitled [Listening to Experience](#).

The inquiry found that in some places excellent acute and crisis care existed, including some innovative services that were easy for people to access. However, many people explained that they had poor and even traumatic experiences. They said that services should not:

- Leave people with urgent mental health needs isolated, frightened and unsupported
- Traumatise those who use services
- Give people a sense of abandonment when they try to use services
- Manage those with acute care needs in some of the worst hospital environments in the NHS
- Discriminate against people, treating some groups more neglectfully or coercively than others.

The report says that to give people the crisis care they need, when they need it, requires concentrating on four areas:

- **Humanity:** Action to ensure that acute care is built on humane values and embodies a culture of service and hospitality so people can be treated in a warm, caring and respectful way.
- **Commissioning for people’s needs:** People’s needs and home circumstances are different and the way services are delivered must reflect this diversity. For example, different services may be needed in rural and urban areas.
- **Choice and control:** People need more direct ways to get help. This means that people can self-refer. There should be an explicit acknowledgement that people themselves know how they need to be treated. People should have more say over what happens to them.

- Reducing the medical emphasis in acute care: The things people said they need in a crisis – care, safety, someone to listen to them, and something to do – did not need to be delivered by a doctor. They play a valuable role, but this does not mean that they should deliver all of the care.

The report has prompted Mind's Legal Unit to consider the legal entitlements and duties to protect people experiencing crises. We are planning a series of articles where we consider:

- What rights a person with mental health problems has to access care
- What challenges they may have to particular forms of treatment
- What rights to consultation and involvement with treatment they can exercise.

As one witness to the enquiry remarks: "Access at a time of your choosing to a service you can trust is hard to find"

People are experienced at dealing with their own conditions and will frequently detect when their own mental health begins to deteriorate. At this point they may ask for mental health care of the kind they know will help. Unlike a person with a deteriorating physical condition, they have an added concern. Mental treatment can be coercive and so it is particularly important that their requests for support and care are listened to and acted upon.

Policy statements like the 1999 [English National Service Framework for Mental Health](#), focusing on the mental health needs of working age adults, commit to providing access to services (standards 2 to 5).

The coalition's 2011 policy statement [No Health without Mental Health](#) sets six shared objectives and number four states:

"More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence- based interventions and approaches that give people the greatest choice and control over their own lives, in the least restricted environment and should ensure that people's human rights are protected."

The practical realities of accessing care can be very different and we hear on the Legal Advice Line from people who are struggling to get the help they need.

The right to life under Article 2 of the European Convention on Human Rights

by Pauline Dall, Mind Legal Unit

As promised last time, we now have the Supreme Court's decision in the case of [Rabone v Pennine Care NHS Trust \[2012\] UKSC 2](#) where the claimants were successful in arguing that Article 2 of the European Convention on Human Rights (the duty to protect life) can extend to patients who are being treated voluntarily.

Mind, along with Liberty, JUSTICE and INQUEST intervened in the Rabone case in the Supreme Court. Judgment was given on 8 February 2012.

This puts voluntary patients in the same legal position as patients who are formally detained under the Mental Health Act (MHA). Detained patients come within Article 2 protection if they were at risk of suicide, as established in the case of [Savage v South Essex NHS Trust \[2008\] UKHL 74](#). The decision in Rabone also brings the law into line with the Equalities and Human Rights Commission's recommendation that Article 2 should extend to voluntary patients. This was highlighted in its Human Rights Review 2012 as a human rights 'gap' in UK law.

Mind and the other interveners were concerned about that distinction in legal responsibility towards patients. In practice, there may be very little difference in their circumstances and if a patient is at risk of suicide, then the same approach should be taken to care decisions so that he or she is protected. The Supreme Court agreed that it was important to look at the particular circumstances in order to decide whether a claim can be made under Article 2, rather than making a distinction based on whether or not someone had been formally detained under the MHA. If certain features can be identified, the law should apply to hospital in-patients, detained or not, in the same way. The decision corrects an unfair imbalance in legal protection.

So now, a public authority (such as a hospital trust) will have a positive duty to protect the life of a patient who is vulnerable and at risk, where it is clear that it has taken responsibility for, and is able to exercise a degree of control over, that patient. If the hospital authority knew, or ought to have known, of a 'real and immediate' risk (one that is present and continuing) that someone would take their own life, then it has a duty to take all reasonable steps to prevent that from happening. If it fails to do so, it will have failed in its Article 2 duty, and the patient's family will have a right of action over and above any claim in negligence. An Article 2 claim gives an opportunity to identify what went wrong – so that lessons can be learned and steps taken to ensure that similar failures won't be repeated.

Another Article 2 case where a family was challenging a failure in the systems and safeguards being operated by a health authority is [Reynolds v United Kingdom \[2012\] ECHR 437](#), decided in March 2012. David Reynolds became very unwell and was hearing voices telling him to kill himself. He was very afraid and was admitted to a crisis facility and placed in a room on the sixth floor. He was left unattended and was able to take his life by jumping from the window. The case was decided by the European Court, because David had not been detained, so his family could not (until the decision in Rabone) bring an Article 2 claim in the UK. Arguably, using the positive duty under Article 2 as part of a claim helps focus attention on that kind of failure – and it was telling that the authority chose to re-locate the crisis room soon after David's death.

It is difficult to know if that variance in legal responsibility may have influenced health professionals one way or the other when making decisions about use of sectioning

powers. We are aware that the number of formal MHA detentions has increased over the last few years, although the larger proportion of in-patients receiving treatment for mental health problems are voluntary patients. Anecdotally, Mind is aware that many different factors may influence decisions, and that there can often be perceived benefits for patients in avoiding formal detention. Mind's independent inquiry into acute and crisis mental health care published its [Listening to experience](#) report in November 2011. This highlights the importance of working with patients to develop an appropriate care plan, aimed at helping patients towards recovery and a return home.

Understandably some concerns have been raised that extending legal responsibility in this way (with a potential increase in claims as a result) may mean that care teams will become very risk-averse in their decisions, restricting freedom and making the regime on wards intolerable. Arguably, voluntary patients now have a stronger position from which to argue for appropriate decision-making aimed at protecting them from a 'real and immediate' risk of suicide, in a way that is respectful. The examples of good practice and good decision-making, highlighted in the [Listening to experience](#) report, should show the way.

There is another important aspect of Article 2 also worthy of comment – the duty on public authorities to ensure that there is an effective and impartial system for investigating suicides and other unexpected deaths that occur while someone is in hospital, prison or another institution.

The EHRC's Human Rights Review 2012 draws attention to the fact that there is no single agency automatically responsible for investigating deaths that occur in mental health settings. There will be a 'serious untoward incident' investigation, but this is undertaken by the same public body responsible for running the hospital where the incident took place. If Article 2 applies there will be an inquest into the circumstances of the death, but the EHRC questions whether even this goes far enough towards meeting the investigatory obligation under Article 2, and calls for independent investigations to be conducted immediately after a death in such circumstances.

The right to independent living – is it working?

by Angela Truell, Mind Legal Unit

The Joint Committee on Human Rights (JCHR) published its report [The implementation of disabled people's right to independent living](#) on 1 March 2012. Their enquiry reviewed over 100 pieces of oral and written evidence to examine how the right to independent living, Article 19 of the UN Convention on Rights of Persons with Disabilities (UNCRPD) is being applied in practice in the UK. Their focus was on:

- how effective existing strategy, policy and legislation is; the impact of spending decisions
- the extent to which disabled people are involved in developing policy and decision-making
- and the monitoring and implementation of the convention.

The report is important reading. It demonstrates implementation gaps and makes a number of key recommendations including, for example, that any forthcoming Bill on adult social care in England should have the right to independent living as an outcome.

What is independent living?

The report quotes from the [Independent Living Strategy](#) and earlier government policy statements which define independent living as all disabled people having the same choice, control and freedom as any other citizen – at home, at work and as members of the community. This does not necessarily mean disabled people 'doing everything for themselves', but it does mean that any practical assistance people need should be based on their own choices and aspirations (para 9). So for example, people with mental health problems may need advocacy support or choose supported living settings in order to be able to be independent. It is important to understand that the concept of independent living applies equally to residential settings as it does to community settings.

What is the UN Convention on Rights of Persons with Disabilities (UNCRPD)?

The [UN Convention on Rights of Persons with Disabilities](#) is the international treaty which reaffirms the rights of disabled people – rights that are already contained in other UN treaties. Using [a social model of disability](#), it sets out the steps that states need to take to protect and promote and ensure the human rights of disabled people. The convention is arranged in Articles of which Arts 1 to 9 explain general principles, Arts 10 to 30 deal with substantive rights and Arts 31 to 50 concern implementation and monitoring. It provides an important tool for measuring how rights of people with mental health problems are protected and implemented in the UK. The Joint Committee's report finds that many disabled people are unaware of the Convention (para 124) and recommends that the Government work with disabled people to address this. The Convention provides a set of standards against which to assess experience and hold public authorities to account. It also specifically requires disabled people to be involved in the implementation of the Convention.

What is the Right to Independent Living in the UNCRPD?

Article 19 of the UNCRPD is titled "Living independently and being included in the community". Countries that sign up to the UNCRPD are agreeing to recognise the equal right of all disabled people to live in the community, with choices equal to others, and to take effective and appropriate measures to facilitate full enjoyment by disabled people of this right and their full inclusion and participation in the community, ensuring that:

- 19(a) They have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement
- 19(b) They have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community
- 19(c) Community services and facilities for general population are available on an equal basis to disabled people and are responsive to their needs.

Article 19(a) implies right to self-determination in where you live. It applies equally to residential settings as to community settings with a need for legal and /or administrative mechanisms to protect and promote choice. Article 19(b) recognises social and economic rights of disabled people, while Article 19(c) is a kind of civil and political right to non-discrimination.

What is the UNCRPD's status in the UK?

The UK has ratified the Convention as has the European Union. The Convention is legally binding in International law on countries that have ratified it but it does not have direct effect in their domestic courts. However, it has legal effect via the Human Rights Act 1998 (HRA) and the European Communities Act 1972. So, if someone brings a claim under the Human Rights Act 1998 for a breach of his or her convention rights, the UNCRPD may be used to interpret the way the HRA is applied. One illustration of this in a mental health context is [a recent case](#) where a patient appealing to a tribunal against his detention successfully argued that he should be allowed to have a public hearing rather than the usual private one. The UNCRPD was cited in support of his right to a fair trial under Article 6 of the convention.

The UK has also ratified the Optional Protocol which allows individuals to petition the UNCRPD committee but only if domestic remedies have been exhausted.

What progress has there been in realising the right to independent living in the UK?

The report reviews recent legal and policy developments that have played a part in securing rights for disabled people from the Disability Discrimination Act 1995, now superseded by the Equality Act 2010 and the Human Rights Act 1998 and the establishment of the Office for Disability Issues in 2005. It concludes that there is political consensus for removing barriers for disabled people (para 47). However, witnesses to the committee expressed particular concern about reduction of social care expenditure at local authority level; the replacement of Disability Living Allowance by Personal Independence Payment (PIP) and the closure of the Independent Living Fund as well as the cap on housing benefit. The Joint Committee is also concerned about the impact of the Legal Aid, Sentencing and Punishment of Offenders Bill upon access to justice for disabled people.

The report observes that expenditure on independent living should be seen as investment, reducing long-term costs. It expresses regret that the UNCRPD has not played a central role in the development of policy and recommends that, given the breadth of current reforms, the Government should publish a unified assessment of the likely cumulative impact of the proposals on independent living (para 112). Evidence suggests equality impact assessments have not played an important part in assessing the impact of recent policies on disabled people.

Recommendations made by the report

The report makes a number of recommendations, not all of which can be covered here.

Some key ones are:

- The existing matrix of human rights equality and community care law is insufficient to protect disabled people and so a right to independent living should be included as an outcome in any forthcoming adult social care bill in England (para 65).
- The Government needs to consider independent living in the round, as the complex interconnections between services and benefits mean that changes to one service may have unintended consequences for another. Given the breadth of current reforms, the Government should publish a unified assessment of the likely impact of the proposals on independent living and set out mitigations in its forthcoming Disability Strategy (paras 75 and 111).
- The Disability Strategy is to be the basis for a UK national implementation plan for the Convention. It needs to be robust and targeted and deliverable and co-produced by disabled people. The Strategy should include measures to monitor the impact of restrictions on eligibility for social care upon independent living. It should set out how the Government intends to take action.
- In its Disability Strategy Action Plan, the Government should commit to enabling disabled people in residential settings to access their full Article 19 rights (para 82, 138, 181).
- The Disability Strategy should include action to be taken to ensure disabled people's access to redress and justice (para 214).

- Access to information and advocacy is critical for all disabled people to benefit from personalisation and the Government should implement the advocacy provisions in ss 1 and 2 of the Disabled Persons Act 1986 and support and develop the role of Disabled People's User-Led Organisations (para 199).
- The NHS Commissioning Board should produce guidance for Health and Wellbeing Boards on the need to incorporate human rights into their commissioning strategies (this happens in Scotland) (para 193)
- The Health and Social Care Act 2012 should include a provision ensuring that private and third sector home care providers are defined as carrying out a public function when providing publicly-arranged care, bringing them within the scope of the Human Rights Act 1998 (para 194). This recommendation mirrors the concerns raised in the EHRC's report [Close to Home](#) but attempts to amend the Health and Social Care bill in the House of Lords to include such a provision failed, unfortunately.

Case Reports

The Secretary of State for Justice v RB and Lancashire Care NHS Foundation Trust [2011] EWCA Civ 1608

12 October 2011

reported by Joanna Sulek, Mind Legal Unit

This case concerns the issue of whether conditional discharge of a restricted patient into the community on conditions amounting to a deprivation of liberty constitute a breach of that individual's Art 5 ECHR rights (note: where there is no possibility of applying for a Deprivation of Liberty Safeguards (DOLS) authorisation under the Mental Capacity Act (MCA) 2005).

The respondent, RB, was 75 years old with a persistent delusional disorder, an ongoing condition that warranted his detention in hospital as a restricted patient under section 37/41 MHA. Such a patient is liable to be detained indefinitely, until discharged by the Secretary of State for Justice or a mental health tribunal (here, the First Tier Tribunal).

The medical evidence showed that RB could be cared for in conditions of lower security than his detaining hospital, but that his transfer to such an institution would need to be subject to certain conditions, including that he should only be allowed into the community under escort. RB had obtained an order under s.73 MHA that he should be conditionally discharged into a care home, but it was agreed that the conditions imposed on him would amount to a deprivation of liberty. RB was agreeable to these conditions, presumably happy to exchange his hospital detention for discharge into a care home, and the move was also supported by his doctors.

The Secretary of State for Justice was appealing against that order on the grounds that section 73 MHA does not confer power to make such an order.

Lord Justice Moses explained the legal background to the case. One of the purposes of the MHA is to give effect to rights guaranteed by the European Convention, and in any case, the Act would have to be interpreted so as to be compatible as far as possible with Convention rights. Article 5 guarantees the right to liberty and security of person. In particular, it provides for the 'lawful detention' of persons of unsound mind', and that:

"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful." Article 5(4)

In the case of *Winterwerp v The Netherlands* (1979-1980) 2 EHRR 387, the European Court of Human Rights held that arbitrary detention of a person of unsound mind would be unlawful and that detention has to be justified by objective medical evidence that justifies compulsory detention. Moreover, the nature of deprivation of liberty considered in that case required a review of lawfulness to be available at reasonable intervals, and that

this should be a suitable judicial procedure. Finally, the person should have access to a court and the opportunity to be heard in person or through representation, and these procedures should be enshrined in domestic legislation.

He discussed the case of *HL v United Kingdom* (2005) 40 EHRR, the 'Bournewood' case, where the claimant's complaint that his detention violated Article 5(4) because he had not had any right to test the legality of his detention was upheld. He referred to the 'high value' which the Court in Strasbourg attaches to the procedural guarantees secured by Article 5(4).

Emerging from the cases of *Winterwerp* and *HL* are certain conditions for the lawfulness of the detention of a person with unsound mind, which he named the 'Winterwerp conditions'. In addition to the need for reliable medical evidence of the existence of a mental disorder and the requirement that the mental disorder must be of a kind or degree warranting compulsory confinement, as mentioned above, there were further requirements that the mental condition must persist throughout the period of confinement, and that the criteria for detention must be prescribed by law, in other words, set out in legislation so that effective proceedings could be brought to challenge such detention.

Section 73 MHA sets out the Mental Health Tribunal's power to grant a conditional discharge into the community to a patient restricted under ss.37/41 MHA. According to a dissenting judgment in the case of *R v Canons Park Mental Health Review Tribunal, Ex parte A* [1995] QB 60 at p 77, but cited with approval in the case of *R v Secretary of State for Scotland* [1999] 2 AC 512 at p 528, the policy of the Act towards patients with psychopathic disorders, was one of treatment not containment and, as Lord Justice Moses asserts in the case under discussion, the same would be true in relation to other types of mental disorders, and there is currently no power for a tribunal to recommend the transfer of a restricted patient to another hospital. Also, the Act (specifically sections 42 and 73) makes no reference to detention elsewhere than in a hospital, and had Parliament intended such detention to be part of the statutory scheme, specific reference would have been made to detention in an institution other than a hospital, and Parliament would have ensured that this detention, too, satisfied the 'Winterwerp conditions' (as mentioned above).

In previous cases, the word 'discharge' had been assigned differing meanings. In one case, *Secretary of State for the Home Department v Mental Health Review Tribunal for Mersey Regional Health Authority* [1986] 1 WLR 1170, in the view of Mann J, the word 'discharge' means, and could only mean, release from hospital. A condition of a conditional discharge could not require a patient to remain in hospital, as that would be inconsistent with the duty to discharge albeit conditionally. However, in another case, *R (PH) v the Secretary of State for the Home Department* [2002] EWHC 1128 (Admin), the judge, Elias J, considered the test of whether there was a discharge to be whether a patient was given back his or her liberty. A patient could be discharged within the same hospital provided he or she was no longer held on terms that amounted to a deprivation of liberty. Under these terms discharge from detention would also, at times, mean release from liability to be detained.

"The central issue, it seems to me, is whether or not the conditions constitute a continuing detention. If they do not, it is irrelevant where the patient resides thereafter." (para 30)

The Upper Tribunal in this case had taken a view that 'discharge' should mean merely that a person was being released from the state of being in detention, but not necessarily that this was release from a state of detention to one of liberty.

They thought it unlikely that Parliament intended that tribunals should make fine distinctions in order to determine whether particular conditions led to a deprivation of liberty or detention for the purposes of Article 5 ECHR. It would be sufficient for a tribunal to ensure that discharge was to an institution such as a care home, which was not a hospital. They agreed with the case of PH in so far as in their view a tribunal cannot conditionally discharge a person with conditions that amount to detention in a hospital for treatment. This was not because such a discharge would be contrary to a person's human rights, but because if a tribunal reached a finding that such conditions are necessary, this would be inconsistent with the basis of a conditional discharge under section 73 MHA, which would be that the tribunal is not satisfied as to the matters in section 72(b)(i), (ii) or (iia):

- 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
- that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or
- that appropriate medical treatment is available for him ...

On the appeal in the present case, it was argued on behalf of the Secretary of State that references in the MHA to detention are to detention in a hospital and if detention criteria are not satisfied, the duty of the tribunal is to discharge the patient absolutely. It cannot order the transfer of a restricted patient from one state of detention to another state of detention. The original hospital order could not authorise any further detention during a period of conditional discharge because the detention authorised by the hospital order was detention in hospital, whereas here RB would be living in a hostel and not in a hospital.

Counsel for the other side, arguing for the patient RB, replied that the conditions being proposed fell far short of arbitrary deprivation of liberty, which was what the Human Rights jurisprudence was aimed at preventing. The powers of the tribunal were powers "prescribed by law" and therefore there were procedural safeguards in place. The patient would still have the right to have his detention reviewed (although less frequently than if he were still detained in hospital), and he would have a better quality of life in an institution other than a hospital. He agreed with the majority in the Upper Tribunal that the most important consideration for tribunals was the best interests of the patient and in this case, the best interests of RB were to be conditionally discharged to another institution in the community where he would be supervised but which would provide him with a better quality of life than a hospital.

In his judgment in this case, Lord Justice Moses stressed that the core issue was whether there was any statutory authority for a deprivation of liberty after conditional discharge has been granted. It is important that the grounds on which the patient would eventually be released from the conditions imposing a deprivation of liberty, should be found in legislation.

He found himself in sympathy with the decision of the Upper Tribunal in this case, as the proposed conditional discharge would be more beneficial to RB than continued detention

in hospital. However, he accepted the submission made on behalf of the Secretary of State that the original s.37/41 order authorised detention in hospital, and in hospital alone. He stressed that the right to liberty of the person is a fundamental right existing since the provisions of the Magna Carta, which cannot be taken away except where it is clearly done by statute.

The only provision available for the authorisation of the continued deprivation of liberty post-conditional discharge, section 72(3), would not assist in this case because it merely states that a patient who does not need to be detained in hospital for the purposes of treatment can be conditionally discharged on the basis that the tribunal is not satisfied that it is not appropriate for him to be liable to be recalled to hospital for further treatment (if it were, they would discharge absolutely). Although it dealt with the need to remain liable to be recalled, it did not give any reasons why the individual should also be deprived of his liberty. He agreed with Counsel for the Secretary of State that Parliament could not have intended to create a new type of detention that is 'potentially more detrimental to personal liberty than detention under the MHA' (para 57). The MHA does not specify circumstances where a tribunal can order conditional discharge 'on terms that there is a deprivation of liberty'. The absence of conditions 'prescribed by law' prevented him from interpreting the power of conditional discharge as authorising release to another institution which is not a hospital on terms that there is a continued deprivation of liberty.

The judge then turned to the question of the 'incompatibility issue' – whether such a use of the MHA to conditionally discharge a person into conditions amounting to deprivation of liberty would involve a breach of Art 5 and the 'Winterwerp conditions'. Would it not be possible to justify non-compliance with these conditions, where it could be argued that RB would benefit from the abandonment of one of the safeguards?

Although this particular situation was not specifically addressed in the MHA, Moses LJ commented that it was Parliament's intention that the MHA should comply with Convention rights. There was no indication that Parliament wished to depart from following Convention rights in the situation now being considered, nor any indication that there might be a reason for doing so. The rights of a restricted patient conditionally discharged to an institution would be inferior to those of a restricted patient still detained in hospital, and that would produce a disparity of rights that would breach Article 14 (prohibition of discrimination on grounds of status) of the Convention.

Also detention under section 73(2) in an institution which was not a hospital, other than for purposes of treatment, and without appropriate medical treatment being available for the patient, would be inconsistent with the admission criteria under sections 3 and 37, and contrary to the scheme of the MHA.

He therefore could not agree with the view of the Upper Tribunal and concluded that "a tribunal cannot rely on a patient's best interests as a ground for ordering conditional discharge on terms that involve a deprivation of liberty. This is more particularly so if the detention would not be for the purpose of any treatment" (para 66).

In appropriate cases the Secretary of State could instead exercise his powers of transfer in the interests of the patient, and the tribunal could also make non-statutory recommendations for the patient's transfer.

Further reading

Subscribers may wish to refer back to the case of *DN v Northumberland Tyne and Wear* [2011] UKUT 327, reported in [Mind Legal Newsletter 10](#).

In that case the appeal to the Upper Tribunal concerned the discharge of a patient directly from section 3 MHA detention into deprivation of liberty under the Mental Capacity Act 2005 DoLS (Deprivation of Liberty Safeguards). The question of 'primacy' of the MHA over the MCA was also discussed. It is possible to question whether these two cases are compatible, although certain points of difference do distinguish the two cases; DN was to be subject to an actual DoLS authorisation for the purpose of treatment for a condition other than the mental disorder which had warranted his detention. Arguably, the MCA DoLS scheme was devised to be Article 5 ECHR compliant and clearly 'prescribed by law'. In RB's case, on the other hand, his capacity to agree to the proposed discharge conditions was not in question. There would have been no possibility of DoLS for RB, and therefore no suggestion that the discharge conditions amounting, it was agreed, to a deprivation of liberty, could be authorised by the MCA. The Court of Appeal here decisively rejects any suggestion that they could be authorised by the MHA either. The question is: in light of the comments in RB, can a Tribunal absolutely discharge a patient into another form of (albeit statutory and arguably Article 5 compliant) detention? Such an outcome is clearly not envisaged in the MHA scheme, but is it contrary to the spirit and intention of that scheme?

Cheshire West and Chester Council v P (by his litigation friend The Official Solicitor) [2011] EWCA Civ 1257

9 November 2011

reported by Joanna Sulek, Mind Legal Unit

This case continues arguments along the lines of *P & Q v Surrey County Council* [2011] EWCA Civ 190.

P was a 39 year old man with cerebral palsy and Downs Syndrome. He had significant physical and learning disabilities, and it was not disputed in the case that he lacked the mental capacity to make decisions about where he should live and about his care. When his mother could no longer care for him, he had been placed into care, and was living in a small group home and was not subject to a MCA DoLS authorisation.

P required a high level of intervention and personal supervision on account of the risks posed by his behaviour. In particular, staff would intervene when he pulled apart incontinence pads and attempted to put pieces into his mouth. His management also included the wearing of a restrictive body suit. He was allowed out under supervision on a regular basis for the purpose of taking part in social activities. He was also allowed free access to the entire building and to the garden but was not allowed to leave the building unescorted. P had regular contact with his family and the visits were encouraged.

P argued that the living conditions imposed on him by his care plan amounted to a deprivation of his liberty, and at first instance (in the Court of Protection), this argument succeeded. Although staff had taken care to ensure that he lived as normal a life as possible, Baker J found that he was ‘completely under the control of members of staff’ and the intrusive nature of the steps required to manage his behaviour meant that he was in fact being deprived of his liberty, although he granted a declaration that it was in his best interests to remain in the group home.

On appeal by Cheshire West and Chester Council, the Court of Appeal did not agree with the ruling of the first-instance judge in the Court of Protection.

The Court of Appeal reviewed the authorities on Article 5 and deprivation of liberty, referring also to the principles set out in the case of *P & Q*. It was necessary to take account of the individual’s whole situation, including the type, duration, effects and manner of implementation of any measures under scrutiny. The presence of restraint was not in itself determinative of whether there was a deprivation of liberty. In determining whether a person was being deprived of his or her liberty, it was necessary to have regard to the objective reason for the placement and the treatment of the individual, and the objective purpose. Subjective motives might have only limited relevance. It was necessary to consider whether a person’s situation was relatively and subjectively ‘normal’ for the individual in question. Care of children or vulnerable adults in a domestic environment, foster placements or placements in small specialist units did not usually amount to a deprivation of liberty.

The ‘normality’ of a setting, according to Munby LJ, must be compared:

“...not with the previous life led by X (nor with some future life that X might lead) nor with the life of the able-bodied man or woman on the Clapham omnibus, but with the kind of lives that people like X would normally expect to lead. The comparator, in other words, is an adult of similar age with the same capabilities as

X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations (call them what you will) as X. Likewise, in the case of a child the comparator is a child of the same age and development as X.” (para 97)

A husband might be depriving a wife of her liberty in a domestic setting if he confined her to the house in order to enjoy his ‘conjugal rights’, but would not be, if he were to confine her to the house to protect her safety by preventing her from wandering into the path of a passing car. The crucial factors would be the husband’s reasons, purpose and motives. In some circumstances, improper motives or intentions could render conditions that would not constitute a DoL and otherwise be neutral, into a deprivation of liberty. However, the converse would not be true. A good motive or intention could not transform a deprivation of liberty situation into a situation of liberty.

Owing to the nature of P’s disabilities, his life was ‘inherently restricted’ and he would always be subject to the same or similar restrictions, no matter where he lived or who cared for him. The Court found therefore that although P was subject to physical restraint and otherwise intrusive measures in order to manage his medical condition and challenging behaviour, as the home was providing a “strong degree of normality” for him, he had not been deprived of his liberty and upheld the appeal from the local authority.

This case has triggered much comment, and a consensus is emerging. There may, for example, be consequences for people such as P in supported living whose physical and learning difficulties require strict management and a high degree of intervention. Such people are often subject to a high degree of control from local authorities in important areas of life. What is ‘normal’ for such a person will depend on his or her level of disability, and the application of such criteria may in fact make it less necessary to apply for DoLS authorisations in an increasing number of cases. This will make it harder for certain vulnerable people in such settings, whose mental capacity to make life decisions is in question, to challenge, and request regular reviews of, significant restrictions on their liberty introduced in the name of ‘best interests’. Article 5 safeguards risk, to all intents and purposes, being bypassed, in contrast to those whose mental health condition justifies detention under the Mental Health Act.

O’Cathail v Transport for London [2012] EWCA Civ 92

20 January 2012

reported by Pauline Dall, Mind Legal Unit

This case may be helpful to anyone trying to explain or justify missing a Tribunal deadline due to ill-health. Mr O’Cathail was appealing against a disability related harassment claim. As is often the case, receiving the judgement and preparing to appeal took quite a toll, particularly so given that he was already affected by depression. He had managed to lodge a notice of appeal within the deadline, but as a result of his illness, had forgotten to lodge a copy of the judgment at the same time, and it took a few days before he managed to do so. Initially he was not given permission to appeal, but this was reconsidered by the Court of Appeal. It was decided that his appeal could go ahead, partly because the delay was minimal but also in recognition that the error and resulting delay appeared to be linked to his disability.

Updates

Discrimination news

We receive a large number of enquiries from people experiencing discrimination at work, and while most cases going through the courts are still looking at aspects of the Disability Discrimination Act 1995, decisions on key points are relevant also to interpreting many aspects of the Equality Act 2010. In [Mind Legal Newsletter 10](#), we looked at the duty to make reasonable adjustments – and the case of Wilcox (below) tries to clarify when an employer's duty to make adjustments arises. There have also been interesting decisions about treatment amounting to harassment, and discrimination because of an association with a disabled person.

An employer's duty to make reasonable adjustments is a very specific duty owed to any employee who has a disability, and there have been many decisions clarifying what the duty involves, when an employer should be put on enquiry about the possible need to make some adjustments, and what the employer needs to do to assist an employee to overcome a disadvantage.

In [Wilcox v Birmingham CAB Services Limited \[2011\] UKEAT/0293/10](#) the Employment Appeal Tribunal (EAT) reviewed a decision in which a Tribunal had decided that Ms Wilcox's employer had not known about her disability and so was not under a duty to make reasonable adjustments to help her.

Ms Wilcox had told her employer that she experienced anxiety when travelling on public transport, and wanted to be able to work from home (as it was no longer possible to drive to work). Her employer had asked her to seek medical advice on her condition. Ms Wilcox did not do so, and her employer did not put in place the adjustments that she was asking for. The EAT decided that although it is not necessary for there to be a precise diagnosis, the duty to make adjustments depends on the employer knowing that an employee has an impairment with adverse effects, and that these are significant and also long-term. Often this will become clear during an OH assessment and employers must try to obtain medical information. Then, when the impairment and its effects have been identified, the duty to make adjustments will arise.

Employers then need to take steps that are reasonable to take, and also (in light of the cases discussed in the article *Reasonable adjustments – how the law is developing*, page 4 of [Mind Legal Newsletter 10](#)) that are focused on helping the employee overcome disadvantages at work. In this case, the EAT found, it was not until the Tribunal case was underway that it became clear that Ms Wilcox had a disability – agoraphobia – but as the employer had not known this, it had not failed in its duty to take steps to assist.

Decisions in the Employment Tribunal have looked at discrimination by an employer where someone is associated with a disabled person (but is not disabled himself). In the case of *Macdonald v Fylde Motor Company* in (2011), Mr MacDonald was put under pressure by his employer to work over-time despite explaining that he had to care for his disabled step-father in the evenings. The Tribunal agreed that his employer was harassing him by persistently asking him to do so. Harassment is regarded as an aggravated form of direct discrimination. Discrimination 'because of' disability is not limited only to an employee's disability, but can catch situations where the employee has close links to another person who is disabled.

In another case, *Perrot v Department of Work and Pensions* (2011), Mr Perrot was given special unpaid time off as he needed to look after his disabled sister. Unlike other leave, this special leave was not included as working time for the purposes of calculating holiday entitlement, and Mr Perrot claimed that this was direct discrimination 'because of' disability – and he brought the claim as someone associated with a disabled person. The Tribunal looked at the employer's rules around special leave and found that – whatever the reason for the leave – the time off did not count towards holiday entitlement. Therefore Mr Perrot had not been treated less favourably than any other employee because of disability.

Finally, again from the Employment Tribunal, is a case where a decision to pass on confidential information about a disabled employee, however well-intentioned, was viewed as an act of harassment related to disability. In *Gomez v Glaxosmithkline Services* (2011), Mr Gomez had been dismissed for gross misconduct. He had been seen by the company's occupational health doctor who knew he had depression, and was worried about his state of mind following his dismissal. She contacted his GP and his mother and told them what had happened. Mr Gomez considered this to be harassment – unwanted conduct that was as a result of his disability with the purpose, or effect, of violating his dignity. The Tribunal felt that the case was very finely balanced, but that the OH doctor's actions had been disrespectful and under-mining to Mr Gomez and so amounted to harassment.

There are also a number of cases awaiting hearings or decisions in the Court of Appeal and the Supreme Court, that deal with interpretation and scope of protection from discrimination, and we will report on these in future Newsletters.

Section 117 of the Mental Health Act 1983 and the Health and Social Care Bill 2012

As we explained in a previous newsletter (WHICH ONE), Mind has campaigned to preserve section 117 of the Mental Health Act 1983. To recap, s.117 imposes a joint duty on NHS and social services to provide free aftercare services to people who have been detained for treatment. With support from Mind, the Mental Health Alliance, the Law Society, the Mental Health Lawyers Association and others, Lord Patel of Bradford tabled an amendment to the Health and Social Care Bill to ensure that the joint duty would not be split. This amendment was adopted by the government and [s.40 of the Health and Social Care Act 2012](#) retains the joint duty, which will now be shared between the Clinical Commissioning Groups and local authority social services in England.

Changes to mental health tribunal rules and procedure

Hearings of cases of people subject to community treatment orders referred under section 68 MHA 1983 by hospital managers

In [Mind Legal Newsletter 9](#), we mentioned The Tribunal Procedure Committee's (TPC) consultation on amending rule 35 of the Tribunal Procedure Rules to allow for the tribunal to determine a reference under s.68 of the MHA 1983 in respect of a community patient (a person subject to a community treatment order) without a hearing, provided that patient gave consent.

Mind responded to that consultation and opposed the change, pointing out that the purpose of the referral system was to provide protection for people who might be particularly vulnerable. The TPC has recently published its [response to the consultation](#).

The TPC has decided to amend Rule 35 to allow the tribunal to make a decision without a hearing. This is when the case of a person subject to a community treatment order is referred by hospital managers under s.68 of the MHA to the tribunal, provided that person is at least 18 years old and:

- either has stated in writing that he or she does not wish to attend or be represented at a hearing and the Tribunal is satisfied that the person has capacity to make that decision
- or their representative has stated in writing that the person does not wish to attend or be represented at a hearing of the reference.

The [secondary legislation](#) to affect the required rule changes has been tabled in Parliament with an implementation date of 6 April 2012.

A leaflet is being prepared that will be sent to all patients affected when the referral is received by the tribunal. It will outline the options open to them and will ask them, or their legal representative, to indicate their preferred option on an enclosed form.

In order to ensure that patients have the capacity to decide to opt out of the hearing, the Responsible Clinician's Report in all CTO referral cases will, from 6 April, have to provide an assessment of the patient's capacity to decide whether or not to attend, or be represented, at a hearing of the reference. This requirement will be contained in a new Judicial Practice Direction on statements and reports which will be published on the [judicial website](#).

The secondary legislation will also introduce a new procedure for reports on conditionally discharged (CD) patients, and make minor updates to the information required in reports. From 6 April, reports from Responsible Clinicians and Social Supervisors in CD cases must be sent directly to the tribunal, rather than to the Secretary of State for Justice. The reports should be sent to the tribunal within three weeks of the application or reference, and copies sent to the Secretary of State. The new Judicial Practice Direction will outline the information required in each type of report.

Care Quality Commission

The Care Quality Commission produced a report in March 2012 on the operation of the Deprivation of Liberty Safeguards in England in 2010/11 <http://www.cqc.org.uk/dolsreport>

The key findings include:

- of 8,982 applications for DoLS processed, 50 per cent were authorised
- although good practice in the use of the safeguards had been developed by many services, especially in involving people and their families in the decision-making process, some services were confused as to when restraints or restrictions on a person amounted to a deprivation of liberty
- between a third and a quarter of care homes had not provided staff with training on the safeguards, and in some cases only the manager had received training
- most hospitals had provided some training, but the proportion of staff involved ranged between 20 and 100 per cent.

A summary of the findings is also available [here](#).

Chartered Institute of Personnel and Development (CIPD) Toolkit

Mind and CIPD have launched a toolkit for employers - [Managing and supporting mental health at work](#) - to help them manage and support mental health at work and to encourage more employees to disclose mental health issues and be supported if they do so. Employees may find it helpful to have a Wellness Recovery Action Plan (WRAP) in place so that colleagues can help if difficulties arise.

Proposed DVLA changes: fitness to drive

DVLA deal with issues around continuing fitness to drive and contacted Mind in January to seek our views on whether medical professionals other than doctors should give opinions on withdrawing (or re-issuing) driving licences. It is difficult to predict whether this offers more benefits than disadvantages, and what safeguards may be needed should differences of opinion arise. It isn't yet clear if proposals will be made to change current procedures, but we would like to hear from anyone who has views on this.

Court of Protection

In July 2011 the Court of Protection produced its 2010 report. The Report outlines the personnel of the Court and its work, including:

- summaries and figures for property and affairs applications
- objections to the registration of EPAs (Enduring Powers of Attorney) and LPAs (Lasting Power of Attorney) and its work on wills
- settlements of property and trustees
- personal welfare deputyships and Deprivation of Liberty Safeguards.

It emphasises that personal welfare applications should only be made as a last resort and only in the most difficult cases. Permission is most likely to be refused where the applicant is seeking both personal welfare and property and affairs powers (*hybrid* applications for the appointment of a deputy).

A review of performance and outlines of important decisions of the Court also feature. Statistics on the volume of business and appendices listing Court of Protection judiciary in London and other regions, the Court leadership and Court User Group complete the report.

It can be viewed [here](#)

Now available from Mind publications

Legal Rights and Mental Health Manual

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.

Published in ring-binder format and written in accessible language, it is easy to use and to update. It contains a comprehensive overview of the following topics:

- Advocacy and legal advice
- Care in the community
- Complaints, redress and human rights
- Information rights
- Incapacity
- Discrimination
- Introduction to legal rights in hospital
- Admission for assessment and/or treatment and holding powers of doctors and nursing staff
- Police, courts and prisons
- Consent to treatment
- Discharge from hospital

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The Mind legal newsletter provides you with coverage and analysis on legal matters of importance to the mental health sector.

We hope you've enjoyed reading Mind legal newsletter 11. We look forward to your comments and suggestions on anything you think would be of interest to our readers.

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