Mind's legal enewsletter

Issue 10, November 2011

In this edition, you'll find a variety of articles and reports from Mind's Legal Unit and Richard Charlton, Chair of the Mental Health Lawyers Association. We hope these items may refresh your knowledge, or inform you, on legal matters of importance in the mental health sector.

This newsletter includes coverage and analysis of:

- Section 117 of the Mental Health Act 1983 and the Health and Social Care Bill 2011
- Discrimination under the Equality Act 2010: update on the law on reasonable adjustments
- Enhanced Criminal Record Checks and Disclosure of Mental Health History
- Accommodation provided by social services under s21 National Assistance Act 1948
- Legal representation in mental health cases
- The case of Rabone v Pennine Care NHS Trust

We hope you enjoy reading our newsletter – and don't forget, we'd be delighted to receive your comments and suggestions for articles and reports on anything you think would be of interest to our readers.

Best wishes

Mind Legal Unit
legalunit@mind.org.uk
020 8215 2339

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ARTICLE

Section 117 of the Mental Health Act 1983 and the Health and Social Care Bill 2011

The Health and Social Care Bill has provoked huge controversy. This article is about just one clause in that Bill, clause 37. If enacted, it will change the way aftercare is provided under section 117 of the Mental Health Act 1983 (MHA).

What is s117 of the Mental Health Act?

Under s117, health authorities (currently PCTs or Local Health Boards in Wales) and social services authorities have a joint duty to provide aftercare services for people leaving hospital or prison after being detained under ss 3, 37, 45A, 47 and 48 of the MHA 1983. They also have to provide aftercare services to people in the community subject to Community Treatment Orders. The duty to provide aftercare services is in co-operation with relevant voluntary agencies. The services are free of charge. Services may include different types of accommodation; counselling and psychotherapy; welfare rights advice; and support to obtain employment as well as medication.

As a free-standing, joint duty, s117 provides the clearest possible entitlement to aftercare for people who have been required to accept compulsory treatment. A person who does not receive aftercare services can enforce his or her right to services against either provider – the health authority or social services. No aftercare service can be withdrawn unless both health and social services are agreed that there is no further need for that service.

How would the Health and Social Care Bill alter the way s117 aftercare is provided?

Clause 37 splits the responsibility for aftercare so that the health authority (the Clinical Commissioning Group under the proposed new regime) will only be responsible for the health elements in an aftercare package, and social services only for the social care. This may lead to arguments about which element of a care package is health care and which social care.

Clause 37 allows health providers to withdraw their health aftercare services from the care package without getting agreement from the social services. Mind considers close joint working between health and social services is particularly key for people who have mental health problems. The reference to providing aftercare in co-operation with voluntary agencies is omitted.

Mind also took legal advice about the wording used in Clause 37 to describe the provision of health care. We were advised that this wording could allow for charging for s117 aftercare health services, in cases where charging is currently possible in other health care contexts outside of s 117 - for example charging for prescriptions to people who are not exempt. In our view medication should be provided free of charge for so long as it is needed (regardless of how it is distributed) but this new provision puts this in doubt and would herald the end of the principle that s117 aftercare must be free.

The Amendment to clause 37

The Government did not explain its intentions to split the joint duty nor does it explain why it has removed any reference to services being provided in co-operation with relevant voluntary agencies in the *Explanatory Notes to the Health and Social Care Bill*. There has been no debate about this. Mind has been campaigning for an amendment to clause 37.The amendment tabled by Lord Patel of Bradford can be found at this link http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0092/amend/su092-irb.htm

This clause may look very complicated but it basically ensures that s117 remains unchanged, save for the necessary updating of references to reflect the new NHS structure. We want to retain the very useful joint responsibility of health authorities and social services as it recognises how closely the professionals need to work to provide a comprehensive aftercare service.

Law Commission Report on Adult Social Care (Law Com No 326)

In its final report on adult social care, published in May 2011, the Law Commission made recommendations to change s 117 of the Mental Health Act. see http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf. Some proposals are welcome - e.g. that patients have greater choice about accommodation provided in aftercare packages but it also recommends splitting up the joint duty. What is really important is that there is a full informed debate about any proposed changes to s117 Mental Health Act. It has been key in ensuring people leaving hospital do get free services and that health and social services work closely together.

Angela Truell
Mind Legal Unit

ARTICLE

Reasonable adjustments – how the law is developing

The Equality Act 2010 (EqA) – sections 21 and 22 and Schedule 8 (work) set out an employer's obligation to take reasonable steps to assist an employee with a disability to overcome any substantial disadvantage caused by a provision, criterion or practice at work. If an employer does not meet its obligation it will be unlawfully discriminating against that employee and may have to pay quite significant damages.

This raises a number of legal points such as:

- does the employee have a disability?
- what provision, criterion or practice is causing the problem?
- what is the substantial disadvantage?
- what is reasonable in given circumstances, and (linked to this) how can or should an employer assess whether the adjustment will assist the employee to overcome that disadvantage?

The employee needs only show that the disadvantage is more than minor or trivial (section 212 EqA) for the process to start.

Determining what is 'reasonable in the circumstances' is where difficulties in interpretation really start and the law has developed as a result of a number of legal decisions. In some circumstances, it may be that an employer should find a more secluded desk for one employee, or agree arrangements to allow another to work from home at certain times. In others, it may be necessary to build some discretion into absence management procedures so that disability-related absence is looked at separately from general absence.

However, if a post-holder is the only receptionist in a small company, some of the adjustments suggested above may not suit. Or an employer may look at the impact of a range of adjustments and feel that the cost or inconvenience is too much for the business to absorb. So the question then is whether an adjustment is still 'reasonable' and (as part of that assessment) is it going to assist the employee?

What does the law require?

We are all fairly familiar with many of the important cases, often involving large employers. This may involve trying to find alternative employment at a more senior level or even considering creating a new post to ensure that the employee is helped to

integrate back into the working environment: Archibald v Fife Council [2004] UKHL 32 and Chief Constable of South Yorkshire v Jelic [2010] UKEAT 0491_09_2904.

However, there are limitations on this, even with large employers; because it doesn't then follow that a job needs to be created that would not otherwise be necessary: Tarbuck v Sainsbury UKEAT/0136/06.

The duty does not mean that an employer should disregard disability-related absence completely: O'Hanlon v Commissioners for HM Revenue and Customs [2006] UKEAT 0109_06_0408. Generally employers are not expected to keep an employee on full sickness pay during a long absence, although in one case it was decided that an employer could not reduce pay down to half-pay under a sickness scheme (and likewise it is probably not appropriate to put an employee onto statutory sick pay) when the employer had not made reasonable adjustments and that prevented the employee from coming back to work: Nottingham County Council v Meikle [2004] EWCA Civ 859.

Consultation and discussion is always likely to improve the situation but putting consultation in place is not considered necessary as an adjustment (*Tarbuck*) and employers who take steps to put adjustments in place, even if they do not refer to them as 'reasonable adjustments', may still be considered to be doing what the law requires them to do: British Gas Services v McCaull [2001] IRLR 60.

Recent cases have looked at how effective an adjustment is likely to be in preventing disadvantage in order to decide if the employer is under a duty to make it (this is seen as part of the process of deciding what is reasonable). This approach is in line with the Equality and Human Rights Commission's (EHRC') Statutory Code of Practice.

In Lancaster v TBWA Manchester [2011] UKEAT 0460_10_1702, Mr Lancaster had social anxiety disorder and wanted his employer to give less weight in a redundancy selection process to the assessment of communication skills, as he was at a disadvantage if the employer used that 'criterion'. The employer kept this as one of the selection criteria and so Mr Lancaster brought a claim, arguing that the employer had failed to make a reasonable adjustment and had therefore discriminated against him. The Employment Tribunal decided that the employer was right in its choice of selection criteria. Mr Lancaster appealed to the Employment Appeal Tribunal (EAT). The EAT looked at whether anything would have been different if the employer had made that adjustment – as it would only be a 'reasonable' adjustment if it would have been effective in keeping Mr Lancaster in his role. Very sadly for Mr Lancaster, the EAT concluded that there would have been no difference in the outcome, with the effect that it was not a reasonable adjustment, and the employer had not discriminated by failing to make the adjustment that Mr Lancaster had requested.

In Salford NHS Primary Healthcare Trust v Smith [2011] UKEAT 0507_10_2608 the EAT took a similar approach. It asked if the disadvantage experienced by Ms Smith would have been alleviated if the employer had gone through a thorough consultation process,

including seeking detailed input from her GP about arrangements for a return to work. The EAT decided this would not have enabled her to get back to work (partly because she had been signed off as too unwell for the entire period) and concluded that the consultation was not a 'reasonable adjustment'. If the employer had consulted, this would have been a useful step (as had been decided also in the *Tarbuck v Sainsbury* case) but the fact that it had not did not breach the duty or lead to unlawful discrimination. Similarly, Ms Smith's suggestion that the offer of a career break would have been a reasonable adjustment – which the judges again felt would not have led to a return to work – was rejected.

There was a slightly more open approach taken in the case of Leeds Teaching Hospital v Foster [2011] UKEAT 0052_10_1406. While it is important, following earlier cases, that there is a real prospect of an employee staying at or returning to work with the help of an adjustment, an employee doesn't need to prove that the adjustment will definitely lead to his return. In some circumstances the 'mere prospect' of a return will be sufficient. The EAT felt that this approach is in line with a previous EAT decision in Romec v Rudham [2007] UKEAT 0069_07_1307.

Mr Foster had experienced bullying by his line manager and had to take time off work with stress as a result. He was expected to return to a role that was still under that manager's control – and argued that instead of applying that provision or practice his employer should, as a reasonable adjustment, re-deploy him to another position. The original Tribunal had decided that there was a good prospect that Mr Foster would have returned to work if he had been re-deployed. The EAT said in fact that any prospect at all of his return was enough to make the proposed adjustment a reasonable one. From an earlier case (HM Prison Service v Johnston [2007] UKEAT 0420_06_0608) it is important that there is some notion of what adjustment would help an employee, but beyond that the evidence that an adjustment to standard practice would assist doesn't need to be particularly high.

And is the cost reasonable?

The cost impact of making reasonable adjustments was looked at in the case of Cordell v Foreign and Commonwealth Office [2011] UKEAT 0016_11_0510. Ms Cordell is deaf and needed the services of a lip-reader in order to take up an overseas posting. She asked that certain arrangements be put in place by way of reasonable adjustments and as to the cost she pointed out that the cost of relocating a family would be as high as the costs in her case. These costs were around four times as much as her salary. The EAT confirmed that no single factor was conclusive, but overall the employer had made a thorough assessment, considered the difficulty in arranging for appropriate support staff and the decision not to make adjustments to allow Ms Cordell to take up the position did not amount to a failure to make reasonable adjustments by the employer.

What next?

Mind is working hard with employers to encourage a positive approach to maintaining mentally healthy workplaces. As part of this we encourage a pro-active and supportive approach to encouraging and responding to requests for reasonable adjustments. The law anticipates a balancing of interests at the stage when final decisions are being taken on what can be done, and whether particular steps will help. There may be times when an employee is unable to do particular tasks or to return to work, but where this is related to disability, we hope that employers will be prepared to consider going beyond the letter of the law. We have an employers' pack available as part of our Taking Care of Business campaign and are soon due to launch an employer's toolkit jointly with the Chartered Institute of Personnel and Development (CIPD).

Clearly this may not always work out in favour of people with mental health problems who are trying hard to stay in employment. Mind's Legal Unit will be happy to look at cases where employees are unable to resolve disputes with their employers. If a case raises points of particular significance, we may be able to offer particular assistance, by helping frame arguments or challenges. Individual claimants and their representatives are welcome to get in touch: legalunit@mind.org.uk

Pauline Dall
Mind Legal Unit

ARTICLE

Enhanced Criminal Record Checks (ECRC): Disclosure of Mental Health History

The Mind Legal Advice Line receives enquiries from callers who are concerned because some details of their mental health history are known to the police and they want to know whether the police will disclose this information in an enhanced criminal record check (ECRC). The Protection of Freedoms Bill 2010-2011 proposes a number of welcome changes to the current ECRC scheme. This article looks at the current system and some of the proposed changes.

When do you need an ECRC?

Part 5 of the Police Act 1997 requires employers to apply for enhanced criminal record checks of employees applying to work with children or vulnerable adults. The aim is to protect the clients from being harmed by those working with them. Enhanced criminal

record checks are also required for applications for various gaming and lotteries licenses, for registration for child minding and day care or to act as foster parents.

What is an ECRC?

A **standard** criminal record certificate includes details of all convictions and cautions held on police records, whether those convictions are spent or unspent. An **enhanced** criminal record certificate (ECRC) includes the same information as in a standard certificate together with soft intelligence - any other non-conviction information contained in local police records that is considered relevant.

The Act says that before issuing an ECRC, the chief officer of every relevant police force has to provide any information which in his or her opinion *might* be relevant to the post and *ought* to be included in the certificate (s 113 B (4) Police Act 1997 as amended by the Serious Organised Crime and Police Act 2005). Both conditions have to be satisfied before disclosure can be made. This gives very wide discretion.

What about our rights to privacy?

Article 8 of the European Convention on Human Rights provides that everyone has the right to respect for private life, home and correspondence. But it is also subject to exceptions. It allows that "there shall be no interference by a public authority with the exercise of this right except in accordance with the law and as is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others". In 2009, in a case involving disclosure of the past childcare history of a woman who was working as a casual midday assistant in a secondary school, the Supreme Court considered the impact that disclosure has on an individual. It found that disclosures from the information stored in files held by the police in an ECRC will interfere with the person's private life – their Article 8 rights. This can have a profound effect because if adverse information is disclosed about a person, it can affect their ability to get not only that particular job but also future jobs. The court found that a balancing exercise was needed. There is no presumption for disclosure but the police have to weigh up the disruption to private life against the risk of non-disclosure to the vulnerable group. Where there is doubt as to whether sensitive allegations could be substantiated then chief constables should offer the person an opportunity to comment on the information before it is released *R (L) v Commissioner of Police of the Metropolis (2009) UKSC*

Mental Health history

Disclosure of mental health status or other disabilities can change peoples' attitudes and lead to discrimination. This has a profound and lasting effect upon the individual concerned. So in weighing up whether to disclose any individual mental health information, chief constables need to be fully aware of the long term consequences of discrimination. They also need to avoid any stereotypical assumption that in itself a person's mental health status has any relevance.

For the job applicant what is particularly difficult under the present system is that there is no provision for checking in advance of the issue of the ECRC exactly what personal information is going to be disclosed, unless the police use their discretion to invite comments. One approach to this current problem is to make a request under s 7 of Data Protection Act 1998 for disclosure of all the information held on police records and to ask what would be disclosed if an ECRC is carried out. This gives an individual the chance to check through the information and make representations about accuracy and relevance and if there is a dispute, to get legal advice. However, this takes time and you would need to deal with this well before applying for a job that required an ECRC. But if you do not do this, under the current system, the ECRC is released to the applicant and to the prospective employer, giving the applicant no control over the information. If when s/he receives it, the applicant finds that the information is incorrect then she can make an application to the Secretary of State for a new certificate. This will only be issued if it is accepted that the information in the first ECRC was inaccurate (s117 Police Act 1997).

Changes to be made by the Protection of Freedoms Bill

The Protection of Freedoms Bill, which is now at the committee stage in the House of Lords, makes some welcome changes to the Police Act 1997.

These include providing that:
1. Children under 16 are not to be eligible for criminal record checks;
2. Certificates are to be issued directly to the applicant and not to the employer as well;
3. The test for disclosure of information is to be tightened - so that instead of "might be relevant," the test used by chief officers to make disclosure is to be "reasonably believed to be relevant";
4. There will be an independent monitor to deal with challenges to inaccurate or inappropriate disclosure;
5. There will be more centralised decision-making to ensure greater consistency.

Legal challenges and advice

People who are concerned about inaccurate or irrelevant disclosure of personal information in ECRCs may wish to seek legal advice about their remedies. Depending

on the circumstances, this might include taking advice about a public law challenge for breach of Article 8 rights if the disclosure is not proportionate, an action for disability discrimination or a complaint. Anyone with a mental health condition who wants to discuss how the present ECRC procedure affects their case can seek advice from:

Mind's Legal Advice Service
0300 466 6463
legal@mind.org.uk

Angela Truell

ARTICLE

Accommodation provided by social services under s21 of the National Assistance Act 1948

If you have mental health problems, adequate accommodation and care are key to recovery. It was for this reason that Mind together with the Medical Foundation for the Care of Victims of Torture (now known as Freedom from Torture) intervened to provide evidence and legal submissions in a case about accommodation and care for a person with a mental health diagnosis that the Court of Appeal considered earlier this year. This was the case of *R (SL) v Westminster City Council (2011) EWCA Civ 954.*
http://www.bailii.org/ew/cases/EWCA/Civ/2011/954.html

Mind used evidence of a statement from one of its senior policy officers and from a consultant psychiatrist to highlight the importance of social recovery and to argue that even what might at first sight appear as small interventions – like meeting with a key worker or talking to a befriender can make it possible for a person to manage a mental health condition. We also submitted that mental health care would be ineffective without suitable accommodation. Local Minds helped to provide evidence for this. Pro bono advice was provided by Kate Markus, a barrister at Doughty Street Chambers.

Background

Social services powers and duties to provide accommodation to adults are largely to be found in Part 3 of the National Assistance Act 1948 and particularly section 21. Section 21(1) (a) provides:

"Subject to and in accordance with the provisions of this Part of this Act, a local authority may with the approval of the Secretary of State, and to such extent as he may direct, shall make arrangements for providing –
(a) residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them".

So to qualify for accommodation under s 21(1)(a) of this Act, you have to be someone who is 18 or over and "by reason of age, illness, disability or any other circumstances" is "in need of care and attention", which is "not otherwise available" to you. Care and attention provided by the NHS is excluded (s21(8) NAA 1948). Also a person subject to immigration control may not be provided with residential accommodation if the need for care and attention has arisen solely because he is destitute or because of the physical effects or anticipated physical effects of being destitute.

The courts have considered the meaning of "care and attention" in a number of cases. The leading case is *R (M) v Slough BC (2008) UKHL 52*. In this House of Lords judgment, Baroness Hale held that this phrase meant "looking after" someone - that is, doing something for the person being cared for which she or he cannot or should not be expected to do for her or himself. This might be household tasks that an old person can no longer manage, or only manage with difficulty; or protection from risks that a person with a mental health condition cannot perceive; or help with personal care - such as feeding or washing.

The case of R (SL) v Westminster City Council (2011) EWCA Civ 954

(a) Meaning of "care and attention"

SL was a homeless Iranian who had sought asylum based on his fear of persecution in Iran because of his sexual orientation as a gay man. After apparently learning of the death of his partner in an Iranian prison, he attempted to kill himself. He received inpatient treatment for depression and post-traumatic stress disorder. When he was discharged from hospital, risk factors were identified of increased compulsion to self-harm, increasing depression and danger of becoming overwhelmed by the "daily struggle to contain and to cope". His aftercare consisted of weekly meetings with his social worker who gave advice and encouragement and monitored his mental health. The social worker also put him in touch with a befriender and referred him to support groups. The Court of Appeal held that this amounted to care and attention.

(b) Meaning of "not otherwise available"

Social services only have an obligation to provide residential accommodation when the care and attention is not otherwise available. The interpretation of this phrase was

considered and whether there has to be a nexus between the care and attention and the accommodation.

The Court of Appeal concluded that a local authority social services department will have a duty to provide accommodation to someone who is in need of care and attention when it would not be reasonably practicable and efficacious to supply the services needed without the provision of accommodation.

Comment

This was a helpful judgment which recognises that care and attention encompasses the kinds of help that can be essential for social recovery. It also articulates the relationship between 'care and attention' and accommodation. Westminster is applying for permission to appeal to the Supreme Court on both the issues that were determined in *SL*.

Angela Truell

FEATURE

Legal representation in mental health cases

Legal protection for people diagnosed with mental disorder and subject to detention and compulsory treatment was seen as a key feature for those drafting the European Convention on Human Rights ("ECHR"). In the subsequent interpretation of the enacting of the Convention, the Courts have been clear that to be effective these rights require frequent legal review and legal representation *Megyeri v Germany 13770/88 (1992) ECHR 49.*

The work of solicitors in this field was described by Lord Justice Brook in the case of *R v Legal Aid Board ex parte Mackintosh Duncan (2000) CO/4807/99* :

> *"Reading the Report of a psychiatrist, identifying its areas of weakness, commissioning evidence and the appropriate expert challenge to it and representing a client at a Tribunal requires expert professional skills borne, as we have said, of education and practical experience. It is not like going down to the Magistrates Court as a Duty Solicitor, arduous though those duties are."*

In England and Wales the legal aid system as provided under contract by private firms of solicitors was adapted to provide most of the required legal representation with legal aid

made available free for those detained in hospital. Legal Aid for such work has, however, been increasingly constrained particularly in response to an avalanche of new criminal legislation, with a contracting regime of fixed fees. The very recent arbitrary reduction of 10% in fees makes the provision of legal aid considerably more difficult; and, until very recently, the Legal Services Commission (LSC) system of matter starts limited the work that some firms could carry out in certain areas.

However for those solicitors maintaining this work there are a key series of tasks which clients should still expect from their representative.

Panel membership

First, solicitors conducting this work should be members of the Law Society's Mental Health Tribunal Panel, although one panel member can supervise up to six staff. Indeed for financial purposes, caseworkers (that is lawyers who are not Panel Members) are frequently conducting this work under supervision. Panel membership requirements are currently under review, however at present assessment of both practical and legal knowledge is required in both written assessment and in interview. Membership is reassessed every three years. Effectively a requirement of continued practice in the field is required for a renewal of membership to be feasible.

Membership of the Panel should guarantee a minimum quality of representation, although it is no reason for complacency; and regrettably a small number of very poor practices have been referred to the Law Society, Solicitors Regulation Authority, LSC and the Mental Health Lawyers Association ("MHLA"). Proper preparation is essential in every case. Regrettably there are now no current academic works covering necessary preparation in this area of law. The most recent was the exceptional book written by Professor Anselm Eldergill**,** *Mental Health Review Tribunals: Law and Procedure* published by Sweet and Maxwell in 1997. A free copy is available to access at the invaluable website www.mentalhealthlaw.co.uk. However, the recently updated LSC Peer Review Guide *Improving Quality*, to be found on the LSC website gives a clear indication of the steps and consideration that lawyers carrying out this preparation should frequently take.

Mental health tribunal preparation

Every mental health tribunal case requires proper preparation. This may sound obvious. However there are particular demands in mental health tribunal cases. In most other legal cases clients can give coherent instructions on which to start preparation. In mental health cases this does not always happen, particularly when clients' mental states, and therefore ability to provide instructions, may vary widely from one week to another; partly because, perhaps, the developments of their illness and partly due to the effect of powerful antipsychotic medication. This may, in turn, affect their capacity to provide

instructions; however the capacity tests for such instructions is low and this is not an area in which the Official Solicitor intervenes (one reason for the establishment of the specialist panel). For further discussion of this issue see paragraphs 4 and 5 of *The Law Society's Practice Note Representation Before Mental Health Tribunals 2011* ("The Practice Note").

There should always be adequate time allowed for a prompt initial visit which should identify the client's instructions and advise him or her of the legal options, together with a timetable for action. Significantly meetings with clients are covered by legal privilege which cannot be broken accept in very rare situations; these are explored in paragraph 5 of the Practice Note.

Subsequently the Tribunal should be informed that the solicitor is acting and any application lodged if it has not already been. At the same time the hospital should be informed of the application and that the solicitor is acting. An application should also be made for access to the client's medical records and contact made with the client's Nearest Relative listed under s26 Mental Health Act 1983 ("MHA") if this is appropriate and/or requested by the client. In addition, enquiries should be made as to whether the client has a regular Independent Mental Health Advocate assisting and whether liaison and communication would help the client's application.

A request should also normally be made for details of aftercare planning meetings to the Responsible Clinician. Such meetings should be held in accordance with paragraph 27.7 MHA Code of Practice and there should at least be a plan "in embryo" for aftercare and perhaps accommodation arrangements for discharge. The lawyer may well want to attend such meetings.

The next step will usually be monitoring that Tribunal reports arrive within the time limits set down in *Practice Direction of 30th October 2008*. The reports will usually comprise the Medical Report, the Social Supervisor's Report and that of the Nursing team. Again it is important to allow time for full instructions from the client and consider the next steps in preparation. This might include considering important inaccuracies in reports and investigating them in the client's medical records.

EXAMPLE

In my early days of carrying out this work, I represented a client who had been transferred on s3 MHA to a private secure unit in Yorkshire far away from her home in east London. She had been transferred on a number of occasions, but was seen to represent a risk to others as she would not admit to an incident involving the use of a gun on the ward of a London hospital where she was said to have threatened staff and patients. Her lack of recognition of this fact was seen as confirmation that she was both treatment-resistant and a threat to others. As is still frequently the practice medical records do not travel with the patient and staff at the private hospital accepted all that

was said in old reports. However, following her instructions I finally tracked down the nursing records covering the incident. The client's nephew had visited her on a semi-open ward and played with a toy gun with the client. Whilst staff felt this play had become mildly disruptive that was the end of incident. In a subsequent report covering the event the description "toy" was left out, but otherwise the incident was described accurately. Subsequent report writers, clearly never examining the source records, started to introduce alarm into their reports and, each report building on another, increased concern and risk accordingly. Regrettably the client had lost contact with her family members who might have corroborated her account.

When the Responsible Medical Officer (as he then was) ***(Editor's note: now known as the Responsible Clinician)*** *was presented with this first hand evidence a few days before the client's Tribunal he was both embarrassed and apologetic to the client. He subsequently discharged her from s3 MHA shortly before the Tribunal hearing commenced.*

This problem was recognised by Munby J at paragraph 129 *R (AN) v MHRT (2005) EWCA Civ 1605".....The Tribunal must be alert to the well-known problem that constant repetition in 'official' reports or statements may, in the 'official' mind, turn into established fact something which rigorous forensic investigation shows is in truth nothing more than 'institutional folk-lore' with no secure foundation in either recorded or provable fact."*

In any event medical records should generally be examined in addition to considering reports. Key events favourable to the client may be missed from official reports; or alternatively a full account of incidents or events will frequently assist the client's case. Medical records are often the most reliable source of information in s2 MHA Tribunal cases and always provide a more updated picture than the latest report. They are of course examined by the Medical Member shortly before the Tribunal hearing, and therefore not to examine them would put the client at a disadvantage in relation both to the clinical team and Tribunal members.

Following consideration of the Tribunal reports with the client there should then be a discussion with the client if any independent evidence is required. Guidance on this is given in the LSC's "*Improving Practice*". Such reports can properly be obtained under legal aid thereby acknowledging the "equality of arms" provisions of the ECHR. An independent report could include obtaining the report of an independent consultant psychiatrist to counter the expert evidence of the Responsible Clinician supporting continued detention. Other independent experts instructed could include an independent social worker, particularly if the local social services department has not provided sufficient aftercare planning details, or details of supported accommodation. Other experts might be psychologists or even occupational therapists.

Independent reports, with very limited exceptions, are covered by privilege. So if the report does not support the patient's application, the reports do not have to be served. If

the reports do support the patient's application, consideration can be given for them to attend to give oral evidence.

Representation at the Tribunal can generally be carried out by any employee of a firm or organisation with an LSC contract with sufficient expertise, except in High Security Hospitals, as long as they are supervised by a Tribunal Panel Member. However, at High Security Hospitals only panel members may carry out such advocacy. There is possibility that in future contracts only panel members will be able to carry out advocacy under a legal aid contract.

If the Tribunal has evidence before it which the Responsible Authority thinks would cause serious harm to the patient or others, it can try to prevent this from being disclosed to the patient. A legal representative, however, has the right to consider such evidence under the provisions of Rule 14 of the Tribunal Procedure Rules 2008 (SI 2008 No 2699) and argue for its disclosure. If the patient is not legally represented this case would not be put.

During the hearing the legal representative will cross examine the professional witnesses and usually assist the patient with his or her evidence. At the end of the hearing the representative will present submissions as to why the statutory basis for discharge has been met (assuming these are the patient's instructions).

If the Tribunal does not discharge the patient the solicitor should discuss the position with the patient and especially consider if the decision is unlawful. If appropriate the patients should be advised to request the First Tier Tribunal *(Mental Health Review Tribunal in Wales – Editor's note)* to review its decision and if necessary make an application to the Upper Tribunal. Subsequently counsel may be instructed for any appeal hearing there. The role of the Upper Tribunal has in many respects replaced the Administrative Court in this area of public law and is a rapidly developing area of jurisdiction.

Aftercare

In addition to Tribunal work, mental health solicitors have a range of other critical areas on which to advise and represent clients.

Of particular significance at the moment is that of aftercare, including those eligible to s117 MHA support on discharge. Many readers will be aware that s117 has recently been subject to further scrutiny in cases such as *R (On the application of Mwanza) v Greenwich LBC [2010] EWHC 1462 (Admin)*. What is clear is that a number of local authorities are taking abrupt and unlawful steps to curtail appropriate support as part of the sudden need to save money. Mental health solicitors have a critical role here in challenging such steps on behalf of these clients who otherwise might even face a life-threatening collapse in support. Here Independent Mental Health Advocates also have a

vital role to play in obtaining expert legal assistance for their clients as frequently such clients have no access to specialist solicitors. It is encouraging to see such partnerships working in at least some cases, and I have personally been involved in a number of these since April of this year. However, this must surely be hardly the tip of the iceberg. A list of available solicitors is available on the Mental Health Lawyers Association site (www.mhla.co.uk) and Mental Health Tribunal Panel members on the Law Society site (www.lawsociety.org.uk.)

Capacity cases

Capacity cases, especially those involving Deprivation of Liberty (DoLs), are another area where mental health solicitors have a core role with respect to Article 5 of the European Convention on Human Rights (ECHR). Here Independent Mental Capacity Advocates have very important responsibilities in highlighting to patients, and their families, their rights to access a court. Many readers will be aware of the significant case of *Re Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP)* which reinforced the role of the court and strongly emphasised the duty of Local Authorities (or Health Authorities) to bring such cases themselves to court where they consider it appropriate. It is of considerable concern that far more cases have not come to the court subsequent to this judgment.

Solicitors who conduct this work are listed on the Mental Health Lawyers association (MHLA) website: www.mhla.co.uk.

Treatment cases

Solicitors still bring appropriate cases to challenge compulsory treatment. However the courts are frequently not sympathetic and tests to challenge procedure and medical necessity are often difficult *R (B) v Dr. SS [2005] EWHC 1936 (Admin).*

Conclusion

The role of a mental health solicitor is arguably never more challenging than it has been today. This is in particular with clients' situations evolving rapidly either under financial pressure and/or case law developments. Tribunal work, with over 25,000 applications a year, and with such clients subject to detention and compulsory treatment, remains an undiluted challenge. However a substantial, but unknown, number of patients subject to Deprivation of Liberty under the Mental Capacity Act 2005 are frequently not even accessing legal advice.

In these demanding times, it is essential that specialist solicitors in this field work closely with advocates covering both mental health and capacity work to identify and assist some of the most vulnerable in our society.

Richard Charlton
Head Mental Health Department Creighton & Partners
Chair Mental Health Lawyers association

We would like to express our thanks to Richard Charlton for his thoughts on this important subject. The views expressed in this article are his own and do not necessarily reflect Mind's policy. Further information on the matters raised here can be obtained from the Mental Health Lawyers Association.

CASE NOTE

Mental health tribunal hearing held in public

For the first time, a hearing to review a patient's detention under the Mental Health Act 1983 (MHA) has been held in public. Albert Haines is detained under section 37/41 of the MHA (a 'restricted patient'). He has remained in hospital since 1986. After six years in Broadmoor Hospital, he moved to a medium secure unit, which should have been a first step towards being released. Then, in 2008, he was returned to Broadmoor. He has been asking since April 2009 that the review of his detention should be held in public because he felt that the system was closing ranks and he wanted to be able to explain his case.

The general position is that review hearings are held in private, given the vulnerability of patients and the sensitivity of the decisions being made. Tribunal rules state that a hearing must be held in private unless a public hearing is in the interests of justice, despite the fact that a private hearing may not seem to be in line with Article 6(1) of the European Convention on Human Rights (the right to a fair and public hearing).

Mr Haines' medical team initially opposed a hearing in public, arguing that this would not be good for his mental health. Mr Haines then appealed to the Upper Tribunal and, in July 2010, it accepted that a public hearing would be possible provided certain guidelines are followed: there needs to be clear evidence this is what the patient wants; that it will not harm his or her health; and the arrangements for the hearing must not place a disproportionate burden on the hospital. The decision to allow this review to be heard in public came in February 2011, with a further seven month wait for the hearing itself.

All of the normal procedures were followed, and the medical member of the panel carried out his assessment of Mr Haines in advance. The hospital argued that being treated in hospital was necessary for his own safety and that of others. Evidence on behalf of Mr Haines suggested that the hospital was not doing enough to engage with him and when he had the opportunity to speak, Mr Haines was very clear that he felt that it was being in hospital that was holding him back. He has a supportive family and his brother gave evidence that he could offer accommodation and support.

The panel of three (a judge, a medical expert and a lay person) felt that as the hearing had been in public that it was fair and in the interests of justice to publicise the decision. Mr Haines was not discharged from detention and remains in hospital for treatment, ideally in line with the recommendations of the independent social worker who gave evidence on his behalf.

This public hearing was a reminder that decisions normally taken behind closed doors should nevertheless be capable of standing up to public scrutiny. Anyone considering this would need to discuss it with a solicitor.

Pauline Dall

CASE REPORTS

DN v Northumberland Tyne and Wear NHS Foundation Trust [2011] UKUT 327 (AAC)

This Upper Tribunal decision continues the **GJ v The Foundation Trust** [2009] EWHC 2972, **[2010] Fam 70** line of cases and offers further observations on the interface of the Mental Health Act 1983 (MHA) and the Deprivation of Liberty Safeguards (DOLS) under the Mental Capacity Act 2005 (MCA).

Mr N had been detained for some years and had applied to the First-tier Tribunal (Mental Health Tribunal) on 30 April 2010. On his application to the First-tier Tribunal for discharge from s3 MHA, it was argued that he should be conditionally discharged, with deferred discharge so that arrangements could be made under the MCA. N lacked the capacity to make decisions on residence and alcohol consumption, but it was argued he would benefit from being subject to the MCA DOLS procedure as this would allow him to be accompanied at all times to prevent him from buying or acquiring alcohol. Detention then under the MHA would no longer be appropriate or necessary as supervision under the MCA would provide an alternative (and less restrictive) method of protecting his safety and the safety of others from the effects of his alcohol consumption. The Tribunal had decided that he should not be discharged as he continued to satisfy the MHA

detention criteria. It rejected the proposals for 'less restrictive options' as several attempts to treat him outside of hospital during his admission had failed.

The appeal to the Upper Tribunal concerned a consideration of the correct approach to be adopted by a First-tier Tribunal (Mental Health Tribunal) where there had been an application to discharge a patient into the community but, effectively, directly into care under a DOLS standard authorisation. The question was whether such an arrangement would be possible in law, considering the remarks of Charles J in **GJ** (above) to the effect that the MHA generally has primacy over the MCA.

Charles J in **GJ** had discussed who should be ineligible for DOLS-type deprivation of liberty under Schedule 1A MCA. The Upper Tribunal in this case considered his observations and referred to a letter on the subject from the Department of Health (DOH).

In its letter, the DOH recognised that decision-makers under the MHA, where the detention and treatment powers might be used or continue to be used, should consider various options, such as the use of the MCA (with or without an authorisation under MCA DOLS). If a person could be deprived of their liberty and given treatment under the MCA, it would not automatically be inappropriate to detain them under the MHA. In the same way, the possibility that someone with capacity may consent to their continuing treatment for mental disorder would not make their continued MHA detention improper.

The specific circumstances where the fact that someone is under compulsory measures under the MHA means that they cannot also be deprived of their liberty under the MCA DOLS are set out in the "eligibility requirements", para. 17, schedule A1 to the MCA. The Schedule 1A sets out five cases, A to E, where a person is ineligible for an MCA DOLS authorisation.

In Case A, a person currently detained in hospital under the MHA cannot simultaneously be subject to an authorisation under the MCA depriving them of their liberty either in that hospital or anywhere else. However, that would not be to say that a person could not be discharged from one regime to the other. The letter suggests that "there is nothing to prevent a prospective application being made for an MCA DOLS authorisation in anticipation of, or the expectation that, the person concerned will be discharged from detention under the MHA".

The main effect of Cases B, C and D is that a person subject to MHA compulsory measures which fall short of actual detention, such as MHA Guardianship or a Community Treatment Order, cannot be deprived of their liberty under the MCA if that would conflict with a requirement imposed on them under the MHA. So a person in the community who is on s.17 MHA leave from detention in hospital can, in general, be the subject of an MCA DOLS authorisation – but not if (for example) that authorisation envisages them living in one care home when it is a condition of their leave of absence that they live in a different care home.

Cases B and C also prevent people from being subject to DOLS in a hospital for the purpose of mental health treatment where this could be achieved by recalling them to hospital under the MHA provision (s.17 MHA leave, supervised community treatment/Community Treatment Order or conditional discharge).

Case E, concerning people who fall "within the scope" of the MHA, but are not actually liable to be detained under it, means that such a person cannot be deprived of their liberty in a hospital by means of MCA DOLS authorisation for the purposes of mental health treatment if they are objecting to it and they could instead be detained under the MHA.

Case E, moreover, only applies to detention in hospital, and only to deprivation of liberty for treatment for mental disorder under the MHA. It does not apply to deprivations of liberty in other settings, such as care homes, or for treatment for physical health problems, or for substance dependence separate from treatment for mental disorder within the meaning of the MHA.

The DOH noted that it was specifically in the interpretation of Case E that Charles J stated that the MHA should have primacy over the MCA, but that it did not understand him to have been making a general statement about the relationship between the two Acts. The policy intention of the Government was that people who lack capacity to consent to admission to hospital but who are clearly objecting to it, should be treated like those who have capacity and are refusing to consent to mental health treatment. If hospital admission is considered necessary, and they would have been detained under the MHA had they had capacity to refuse treatment, then the MHA should be used in preference to the MCA.

The Upper Tribunal, in reaching its decision, relied upon the approach of the Department of Health as outlined in the above-quoted letter and concluded that N was not ineligible (i.e. was eligible) to be deprived of liberty under the MCA DOLS procedures according to Schedule 1A MCA. N was suffering from a mental disorder but the regime proposed for him under DOLS did not involve specialist mental health care so he was not 'within the scope' of the MHA. The Tribunal had erred in failing to refer to the proposal for a regime of supervision under the MCA, and therefore its reasons were inadequate to deal with the submission made on his behalf. The Upper Tribunal set aside the decision and remitted the case for rehearing by a (First-tier) Mental Health Tribunal.

(Note: the judgment appears to confirm that DOLS may be used if a prospective application is made in anticipation of discharge from MHA detention. A discussion of the relevant cases of GJ v The Foundation Trust (above) and W Primary Care Trust v TB [2009] EWHC 1737, and the issues which they raise, can be read in Mind's Legal enewsletter, No 7, November 2010.)

Joanna Sulek
Mind Legal Unit

CX v A Local Authority and A NHS Foundation Trust [2011] EWHC 1918 (Admin)

This case concerns the rights of the Nearest Relative (NR) to be consulted under s.11(4) MHA 1983 in connection with a s.3 MHA admission and the granting by the court of a writ of habeas corpus against a local authority following the unlawful detention of a patient in hospital and the misadvising of his mother, the Nearest Relative.

CX was detained under s.3 MHA 1983 on 22 December 2010. He had a diagnosis of schizophrenia and had already been detained for assessment under s.2 on 30 November 2010. This section was to expire on 27 December 2010. His mother was not happy with his care in the hospital, had requested to be more involved whilst he was on the ward and for the section 2 to be ended. However, the Responsible Clinician (RC) had requested an assessment for admission under s.3 on the ground that he was a danger to himself and others. Under s.11(4) MHA an application for detention under s.3 must be accompanied by consultation of the Nearest Relative by the Approved Mental Health Professional (AMHP) and may not proceed if the Nearest Relative objects to the admission.

It was contended on CX's behalf that his detention was unlawful, as the AMHP's application was also unlawful, for two reasons, (1) a lack of proper consultation with his mother, the Nearest Relative, and (2) because she only withdrew her objection to the application to his s.3 detention because she was misled as to her statutory rights.

When the AMHP was seeking to make the s.3 MHA admission application, the Christmas holiday period was imminent and time was therefore of the essence. If the Nearest Relative was objecting, the application could only proceed if the AMHP applied to the county court to displace the Nearest Relative under s.29(3)(c) MHA (on the ground that the NR was unreasonably objecting to the s.3 application for admission). However, the Judge found that filing an application for displacement to the county court was an alternative open to the AMHP and that there would have been no practical difficulty in doing this. The evidence showed that the AMHP had consulted the solicitor in her Legal Department and been advised that any application to displace CX's mother as his Nearest Relative would not be heard until the New Year, but that the effect of applying for the displacement would be to extend the duration of the section 2 for the time needed to complete the displacement application in court (s.29(4) MHA), so there would have been no difficulty in CX remaining under MHA detention whilst the displacement issue was being resolved.

In a telephone conversation between the AMHP and CX's mother on 21 December 2010 it became clear that CX's mother was objecting to the s. 3 application for admission. Later that day the AMHP met CX's mother at her home and allegedly told her that if she wanted to maintain her objection in the face of court proceedings, she would need to be represented by a solicitor. The mother stated that she was told that she could have all her rights with regard to her son taken away from her should court proceedings go ahead and she were unsuccessful in maintaining her opposition to her son's s.3 admission. She wished to consult with her son before reaching a final decision as to whether to maintain her objection. The following morning she spoke to the AMHP withdrawing her objection, but on the basis that she had been left with no choice but to agree. CX was detained under s.3 MHA later the same day. An application to the mental health tribunal for discharge from detention under s.3 was made on 23 March 2011. Subsequently CX was legally represented and counsel's opinion sought as to the lawfulness of the s.3 admission, which led to the habeas corpus application for CX's release from detention.

It was argued for CX that the withdrawal of his mother's objection to the s.3 application for admission was vitiated by her being misled into believing that she could not oppose court proceedings to displace her as the NR, unless she was represented by a solicitor. She could not afford legal representation and this was what drove her to withdraw her objection the following day.

As the Judge remarked, "AY [the AMHP] told her she could object if she wanted to but never told her in terms that all she had to say was "I object" and the section 3 application would be stopped in its tracks." (para. 40 of the judgment)

"She was not told if there was an application to the court to displace her as the nearest relative she could represent herself, go to court and tell the circuit judge in her own words why she was objecting … In my judgment these were crucial matters of which she needed to be and should have been informed for there to be proper and effective consultation for the purpose of section 11(4) of the Act." (para.43)

Furthermore, he had no doubt that when CX's mother spoke to CX the evening before his detention under s. 3, to discuss whether to maintain her objection to the section 3, "prominent in her son's reasoning in encouraging her to withdraw her objection was his and her belief that she would have to engage a solicitor to act for her which she could simply not afford." (para. 52)

The Judge therefore accepted that a Nearest Relative's objection to a s.3 application can be vitiated so as to render a withdrawal ineffective and reinstate the objection. The legal authorities show that the duty to consult involves doing more than merely informing the Nearest Relative of what is being proposed (**Re Briscoe [1998]).** The Code of Practice to the MHA 1983 also confirms that the NR should be informed of their role and rights under the Act (para. 4.64). The case turned on whether the AMHP accurately and sufficiently explained the options open to CX's mother should she persist in her

objections to the section 3, and whether she therefore sufficiently consulted the NR by informing her of her role and rights under the MHA.

The Judge accepted that if the application was unlawful, then the detention itself was unlawful (**TTM v London Borough of Hackney & Others [2011] EWCA Civ 4**).

The Judge stated that the burden fell on the local authority to show that CX's detention had been lawful but it had failed to persuade him "that there was sufficiently informed consultation with MX to satisfy the requirement of the Act that the nearest relative be consulted before the section 3 application was made". He was not satisfied that a "full and effective" withdrawal of her objection to CX's detention had occurred. (para. 68)

He continued, "On the contrary, I am driven to conclude that her withdrawal of consent was initiated by the incorrect and misleading advice she was given that she could only maintain her objection in the face of a displacement application if she was legally represented in the court proceedings which would follow." (para. 68)

Although he was prepared to grant the writ of habeas corpus for the immediate release of CX from detention, he stressed that the case had turned on "its unusual facts … My findings are not intended to prescribe, and must not be interpreted as prescribing in any way what may or may not amount to sufficient consultation in another case. … Each case is different and what is required by way of consultation will depend upon the individual facts and circumstances and upon the personalities of those involved." (para 69)

(Note: a report on the case of TTM v London Borough of Hackney & Others cited above can be read in Mind Legal eNewsletter No 8, March 2011.)

Joanna Sulek

Jackson v Liverpool City Council [2011] EWCA Civ 1068

This case adds to the recent decisions on the subject of references for former employees. An employer is not generally under an obligation to give a reference, but if it does so, then the reference must be fair as well as being true and not misleading. In this case, Mr Jackson's former employer mentioned issues in a reference that would have led to the performance management process being started, but these only came to light after he had left their employ. The issues had not been investigated so Mr Jackson argued that it was not fair to mention them.

The Court of Appeal decided that an employer doesn't need to go that far. If information is factually correct and is set out in a way that does not mislead then a reference that mentions concerns that have come to light is still fair.

Pauline Dall

Rabone v Pennine Care NHS Trust

We have reported progress on the case of Rabone v Pennine Care NHS Trust in earlier issues of this Newsletter. Mind, along with Liberty, JUSTICE and INQUEST intervened in the appeal at the Supreme Court and the hearing took place on 7, 8 and 9 November 2011.

The appeal covered a number of issues, including whether the Court of Appeal had been correct to decide that there was no operational duty owed by a hospital to a patient under Article 2 of the European Convention on Human Rights (the duty to protect life) where that patient was not detained under the Mental Health Act 1983. Mind and the other interveners considered that it was appropriate to take part given the public interest issues in the case. We argued that, in certain circumstances, hospital trusts (and other public bodies) are required to take positive steps to protect an individual's right to life, even if the patient has not been detained, because in practice there may be very little difference in the circumstances of detained and voluntary patients. Mind is very aware that doctors and hospitals approach decisions whether or not to detain differently. Patients who are not under section may be just as vulnerable as other patients who are formally detained, and doctors may have just as much control over them.

If a patient takes his or her own life, the duty under Article 2 should be triggered. This would lead to a full inquest being carried out – extremely important for families as a way of finding out what went wrong, so that lessons can be learnt. It would also create a right of action under English law over and above any claim in negligence, which seems appropriate in circumstances where a public body has assumed this type of responsibility for a patient.

In 2008, Mind and the other organisations intervened in the case of Savage v South Essex NHS Trust [2008] UKHL 74. There the House of Lords established that a hospital has a positive, operational duty to protect life under Article 2, where patients are formally detained in hospital under the MHA.

Of course, in such tragic circumstances, whatever payment is received cannot properly compensate for the fact that someone has died. However the hope is always that by making the extent of the legal duty clear, public authorities will take more care to ensure that similar situations do not arise again. We will report the outcome of the case in a future Newsletter.

Pauline Dall

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