Mind legal newsletter

Issue 14, December 2013

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Welcome

Welcome to issue 14 of the Mind legal newsletter.

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

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We hope you enjoy reading it and welcome any comments and suggestions you may have. Our contact details are on the final page of the newsletter.

Mind Legal Unit

Articles

The Independent Commission on Mental Health and Policing Report

Introduction

Rowena Daw was appointed with Melba Wilson to co-research and write the report for the Independent Commission on Mental Health and Policing (the Commission), chaired by Lord Victor Adebowale. The Independent Commission on Mental Health and Policing Report was published in May 2013 and is available at www.turningpoint.co.uk.

The Commission was, it seems, the first of its kind. Set up at the request of Sir Bernard Hogan Howe, the Commissioner for the Metropolitan Police Service, (MPS) our brief was to review the work of the MPS with regard to people with a mental disorder who had died or been seriously injured following police contact or in police custody over the last 5 years, to identify themes and make recommendations. Every such death must be referred to the IPCC and will be investigated by them or by an internal MPS investigation and there will be an inquest. The cases were distressing; tragedies of preventable deaths for individuals and families. They were costly of time and resources for the police.

The Commission's findings were substantial and at times surprising. They made a compelling case for the police force to change behaviour at corporate and frontline levels in order that lives may be saved. Well before the Report was published the MPS had also been examining some of the relevant issues and now with the recommendations in the report have begun a programme of action. It is too early to assess the results.

The Commission found that outside the police role under the Mental Health Act mental health was somewhat invisible as an area of work, rather like domestic violence had been decades before. The MPS lacked the knowledge of how often the police respond to incidents linked to mental health, as the data is not systematically collected.

An MPS review, done for our project, estimated that 15% - 25% of incidents are linked to mental health. MPS police officers specialising in mental health estimate that mental health issues account for at least 20% of police time[1], rising to 40% if people who are particularly vulnerable because of a mental disorder are included. As well as the volume of work there are police roles under the Mental Health Act and their other legal responsibilities - to protect life, to uphold antidiscrimination law, to protect the mental health of their own workforce. There was evidence that some police officers consider that mental health is not legitimate police work. However the Commission came to a clear conclusion. Mental health is core business for policing. The Commission's recommendations flow from that conclusion.

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1 This also was quoted by Michael Brown, the Mental Health Cop to the Commission in March 2013. See also http://mentalhealthcop.wordpress.com/2013/02/13/twenty-percent/

The evidence

The Commission examined the files of 55 MPS cases covering the period of September 2007 – September 2012. Given the indifferent standard of MPS recordkeeping, we could not be confident that this figure includes every case of death in 5 years.

We met some bereaved family members, service users and carers and conducted a brief online public and service user survey. We received heartfelt pleas for better, kinder service for themselves and others with mental ill health. We interviewed senior members of the MPS and attended internal meetings, finding ourselves welcomed and supported at every stage. We had meetings with health and social care professionals, ambulance services and other stakeholders.

The 55 cases we reviewed covered a range of different contexts, including welfare visits, mental health assessments under the Mental Health Act, arrests and criminal charges, representing all the types of circumstances in which the police might become involved.

All of the 50 cases of death involved a person who was troubled or in an acute mental health crisis. There was a slight over-representation of people from minority ethnic backgrounds given the overall demographics in London. Thirty eight of the people who died took their own lives. In 20 cases the police were called by family, public or health services to attend a person in severe distress. In some cases delays, technical mistakes, poor coordination with other agencies or poor understanding of mental health contributed to the inability to prevent the death. There were 4 suicides of police officers while in MPS employment and 14 people died or committed suicide within 24 hours of a long stay in a police station. The two other types of cases involved the police even more directly. Five individuals died either during or after restraint by police, and one died from police wounds. Finally there were 6 cases in which a homicide occurred at the hands of a person with mental health problems after the perpetrator, known to have mental health problems, had been in police custody or in repeated police contact immediately prior to the event.

In about a quarter of the cases there was little that the police could have done differently, in the remaining cases the individual was let down by police shortcomings in police practice, procedures or attitudes. We also found instances of very good practice within the course of these cases and could only speculate on the numbers of occasions on which police had managed to save life when mistakes had not occurred.

Findings

The Commission concluded that the failings resulted from systemic problems at all levels of the MPS rather than from individual errors.

Evidence of this can be seen through shortcomings in current policies, training programmes, leadership and operational processes which do not add up to a systemic commitment to deal well with mental health issues nor constantly improve practice for the public good.

From our case analysis the following themes, in descending order of frequency emerged.

1. Failure of the Central Communications Command (which handles 999 and 101 calls from the public) to deal effectively with calls in relation to mental health
2. The lack of mental health awareness amongst staff and officers
3. Frontline police lack of training in suicide prevention
4. Failure of procedures to provide adequate care to vulnerable people in custody
5. Problems of interagency working
6. The disproportionate use of force and restraint
7. Discriminatory attitudes and behaviour
8. Failures in operational learning
9. A disconnect between policy and practice
10. The internal MPS culture
11. Poor record keeping
12. Failure to communicate with families

It has only been possible in this article to select some key themes and issues.

Police custody

In several cases a clearly disturbed individual with a known psychiatric illness was let out of police custody on to the street after a day in a police cell only for them to take their life soon after. Family members involved in one case bemoaned the fact that they were not alerted to the time of their relative's release so they could be there. Custody staff tended to rely on the forensic medical examiners (FMEs) whose assessment was based on a brief examination - in several cases of a few minutes - solely to decide fitness to be charged or interviewed. Custody staff recorded 'no risk' on risk assessment forms when the detainee had admitted to suicidal feelings or had attempted suicide in the very recent past. The Commission concluded that risk assessments and pre-release procedures to protect vulnerable people need to be improved and that the police need to be better assisted by input from health professionals. Bringing in the NHS into custody suites should raise the expected standards and would provide access to NHS health records where necessary. The underlying issue to explore here was why these individuals were in custody at all and whether diversion and liaison services should have been utilized. The Commission's firm view was that these services would have been of great assistance and probably saved life. Recommendations covered these issues.

Mental health knowledge

Again and again in the inquiry we found a poor level of mental health awareness in the police, particularly frontline police, a lack of confidence and sometimes resentment at the time they had to spend in this area. Service users, families, professionals and police reports alike all called for better training in mental health. In the MPS questionnaire to police officers only 22% of response officers and 28% of borough mental health liaison officers agreed that their training effectively prepared them to work with people with mental health problems. This included training on suicide prevention restraint, mental health awareness, and legal powers and duties.

Their lack of training led to relevant issues being overlooked or misconstrued, misunderstandings about a person's behaviour and the wrong decisions being taken. As the report also states, it led to any form of resistance from a person who was scared and unwell being characterized as violence.

There were examples of excellent training that had transformed police understanding and skill, and the Commission's Report sets out a template for training programmes to be delivered across the MPS. The MPS is devising new training programmes at present.

Restraint

A theme common to all 5 restraint cases was the need for better restraint practices and training, and better relations between the health and police. An allied problem was the use of police vans rather than ambulances to transport a very disturbed individual to hospital. This resulted from the fact that the London Ambulance Service (LAS) protocol did not prioritise a response to someone with a clear medical mental health crisis as an emergency if the police are present. Our recommendations covered all these issues.

Two cases involved the deaths of young black men after restraint and contained some of the most egregious failures by police and health services. The Commission met with their bereaved family members. The Commission's Report states

The tactics and behaviour used to restrain people with mental health issues is the most disturbing of our findings and one over which the police have the power to take complete control to improve their practice……In some cases it is at least questionable whether there was a need to take control with such force or in such numbers in any of the cases reviewed. In one case there was no evidence of any violence by the black man who was known to be mentally acutely unwell although his agitation in trying to get away from his situation and from those who wanted to contain him was evident. In another, also involving a man from a black community his fear and anger are alleged to have been exacerbated when the police intervened with handcuffs and restraint in a hospital setting. His struggling included remarks against the police for treating him like a criminal. In each case we examined there is little evidence that de-escalation techniques were used or that opportunities were taken at different stages for alternatives to be tried.

While the Commission did not find consistent evidence of discrimination on grounds of race it did record the "anxiety unease and scepticism" that families and professionals felt on this issue and recommended an external group to be set up to advise the MPS and monitor outcomes on faith race and mental health.

Interagency working with vulnerable people

Significant problems of interagency working with health and social services were evident at both operational and strategic levels in numbers of the cases reviewed. There seemed at times to be boundary disputes, a lack of coordination and a sense of buck passing driven partly by the need to manage limited resources.

While interagency working is not always easy and risks at boundaries between agencies always exist, it is clear from these cases that better, more standardised

interagency planning, procedures and protocols could be used to mitigate risk of tragic outcomes.

The Commission's recommendations on this issue focus on the role of the Mental Health Partnership Board to oversee and steer necessary improvements as they are identified.

In one typical case that the Commission examined, a man tragically killed a woman with whom he shared a regular friendship. He was acting under the delusion that God required this of him. He had made over 30 calls to 999 in previous weeks, mostly calls of a delusional nature, but also seeking help for bullying and homophobia (help he did not receive). He made a series of 10 calls immediately prior to the tragedy. The CAD (Computer Aided Despatch) reported that police attendance was not required. This was justified on the basis that the caller was a repeat caller with mental health issues and his case was closed. The MPS internal review of this case concluded that:

With the extensive intelligence available to the MPS over a period of time, the MPS should have been looking at managing the risks and his vulnerability and looking to seek engagement with partners who have those skills to deal with people with mental health issues.

The MPS are now exploring new systems similar to MARAC (Multi Agency Risk Assessment Conferences) to identify and monitor vulnerable people together with other partners.

Information systems

Surprisingly the most pervasive failing in the cases arose at the outset when information was received at the call centres and dealt with by call takers and supervisors. It includes inadequate or inaccurate collecting and recording of information (including past events), failures to grade a call correctly (according to the actual level of risk), to link calls with previous calls (and so to identify repeat callers), to pass on critical information, and to keep updating the frontline officers so that they understand the nature or degree of the emergency. This means that calls to CCC (Central Communications Command) can result in officers following false paths that are hard to remedy once an operation has begun. It also means that deaths that are preventable do occur.

We learned that the problem lies largely with the outdated technology that powers the information systems in the MPS.

The Commission believes this is a surprising and unfortunate weakness in a modern police force.

Members of the MPS stated that attempting to bolt on improvements to an outdated system, which is not designed for police purposes was not effective and that the only way forward would be to invest in up-to-date technology that can effectively identify, capture, link, upgrade and refer on relevant information.

Conclusions

Throughout the seven months working with the MPS we encountered real expertise and commitment to mental health among MPS police officers and staff,

efforts to implement changes and much agreement with our emerging conclusions. The interests of the police and of the public were not at odds. It is clear that the findings in the Report, which has relevance for police forces across the country is being taken seriously outside London as well. It is too early to assess the impact of the Commission's work but some positive signs have emerged to indicate that some, and possibly more, of the reforms we identified will be accepted and also implemented.

We would like to thank Rowena Daw for contributing this article to the Newsletter.

Judicial Review: Proposals for further reform

In September 2013, the Ministry of Justice published a second consultation aimed at further limiting people's access to judicial review as a remedy for the unlawful acts or omissions of public bodies. The consultation, entitled *Judicial Review: Proposals for further reform,* closed on 1 November 2013[2] The government set out in the consultation a number of reasons why the reforms are necessary, including the growing numbers of judicial review claims, delays in the system and the need to reduce the amount of unmeritorious claims brought. However, little evidence was provided to support these assertions. This article outlines Mind's concerns about the impact of some of the key proposals on people with mental health problems.

Increase in claims

The consultation stated:

> "The Government is concerned that there has been significant growth in the use of judicial review, and that this is sometimes used as a delaying tactic in cases which have little prospect of success … The number of judicial review applications has more than doubled in recent years. Administrative Court data shows that in 1998 there were over 4,500 applications for judicial review and that by 2012 this had reached 12,400. The main driver of growth in the overall number of judicial review applications has been an increase in immigration and asylum applications, which more than doubled between 2007 and 2012 and made up 76% of the total applications in 2012."[3]

The government is relying on figures which demonstrate an increase in claims in a specific field of law, namely immigration and asylum, as a justification for curbing the availability of judicial review as a remedy in all areas of law. The figures relating to judicial review in other areas of law do not show a dramatic increase, so the assertion made in the consultation is flawed. From 1st November 2013, most immigration judicial review applications will be dealt with in the Immigration and

[2] The consultation can still be viewed at: https://consult.justice.gov.uk/digital-communications/judicial-review

[3] Paragraphs 6, 9, 10

Asylum Chamber of the Upper Tribunal, which will result in a dramatic decrease in the number of cases being brought before the Administrative Court.

Delay

The government further asserted that delays inherent in the system result in delays to the implementation of policies and projects:

> "For cases lodged in 2012 it took, on average, around 83 days for an application to be considered for permission on the papers, and a further 95 days for decision on permission after oral hearing (where there was one). Overall, for applications lodged in 2011 which reached a final hearing, it took on average 313 days for these cases to reach a final hearing from the day they were lodged."[4]

This suggests that government reforms would be better directed at improving the court process in order that claims can be dealt with expeditiously, rather than limiting people's ability to access the courts. In any event, as explained above, moving forward most immigration judicial review applications will be dealt with in the Immigration and Asylum Chamber of the Upper Tribunal and these, by the government's own admission, account for almost 80% of judicial review claims. The removal of these cases from the Administrative Court will remove many of the historic delays in the system, so the figures that were quoted in the consultation do not provide an accurate picture.

Mind suggested in its response to the consultation that an alternative method for speeding up the process would be to improve people's ability to utilise the regional Administrative Courts, based in Birmingham, Cardiff, Leeds and Manchester. At present, proceedings are expected to be issued and determined in the region with which the claimant has the closest connection. The Quarterly Court Statistics on Judicial Review (Jan-Mar 2013) show that the vast majority of claims continue to be issued in London.[5] It would be useful for the government to explore the variation in timescales for dealing with cases in the regional courts.

Unmeritorious claims

Paragraph 20 of the consultation stated:

> "Our proposals are intended to act as a disincentive to those considering judicial review whose cases have no merit while helping to speed up those cases that proceed through the courts."

The majority of judicial review claims are funded by legal aid, as the cost for those who are ineligible for such funding often makes the option of pursuing a claim prohibitive. There is already a filter in place in legally aided cases to weed out vexatious/unmeritorious claims as the Legal Aid Agency (LAA) applies a stringent merits test in deciding whether to grant funding. Legal aid providers can vouch for the increasing difficulties faced in persuading the LAA that funding should be granted. The second filter in the process is the permission stage. Permission to proceed with an application for judicial review will only be granted if the judge

[4] Paragraph 16

[5] https://www.gov.uk/government/publications/court-statistics-quarterly-jan-mar-2013

who looks at the papers is satisfied that the claimant has an arguable case. This is not an easy threshold to cross and there is variation in Administrative Court judges' views on what amounts to an arguable case. The fact that the threshold is high is demonstrated by the fact that the majority of judicial review claims settle if permission is granted, as defendants recognise that claims have a good chance of succeeding if they proceed to a substantive hearing.

THE KEY PROPOSALS

Standing

It is proposed that the existing rules on standing should be tightened so that only those with a direct and tangible interest in the matter can make an application for judicial review. These proposals could be perceived as a direct attack from government on the integrity of organisations which work to protect, promote and uphold the rights of vulnerable and/or marginalised groups.

The courts have recognised the value of claims being brought by those without a direct interest in the proceedings:

> "Public law is not at base about rights, even though abuses of power may and often do invade private rights; it is about wrongs – that is to say misuses of public power; and the courts have always been alive to the fact that a person or organisation with no particular stake in the issue or the outcome may, without in any sense being a mere meddler, wish and be well placed to call the attention of the court to an apparent misuse of public power. If an arguable case of such misuse can be made out on an application for leave, the court's only concern is to ensure that it is not being done for an ill motive.[6]

Additionally, the government itself recognised in the consultation that cases brought by NGOs, charities and other pressure groups tend to be valid claims:

> "From Administrative Court records for cases lodged between 2007 and 2011 around 50 judicial reviews per year have been identified that appear to have been lodged by NGOs, charities, pressure groups and faith organisations, i.e. by claimants who may not have had a direct interest in the matter at hand. The identified cases tended to be relatively successful compared to other JR cases."[7]

Despite this, in the subsequent paragraph, concern was expressed that the wide approach to standing has "tipped the balance too far", yet no evidence was provided to support this claim, aside from the assertion that "Parliament and the elected government are best placed to determine what is in the public interest."[8] This begs the question whether this proposal is really about the fact that the government wishes to curb cases brought by pressure groups as they are more likely to succeed. The proposal undermines the role of the judiciary in a modern

[6] Sedley J in R v Somerset County Council, ex p Dixon [1998] Env LR 111

[7] Paragraph 78

[8] Paragraph 80

democratic society; it is the role of the courts to judge the reasonableness of a particular decision, act or omission.

Further, organisations that bring cases as representatives of a group of individuals are best placed to provide the court with an expert view. This means that the court can focus on the underlying issue rather than on the specific facts of an individual case. The risk posed by the proposal to change the rules on standing is that the courts will face a series of claims from various individuals when one would do. This would be neither cost effective nor efficient. The proposals to limit those with standing will impact on a minority of cases which are generally highly meritorious by virtue of their wider public interest.

Interveners

The consultation also sought views on whether the rules on interveners should be changed, in particular to tackle the perceived problem of judicial review being used as a campaigning tool. The assertion that interveners, such as Mind, use judicial review as a campaigning tool is a misrepresentation of the situation. Third parties make applications to intervene in a minority of cases in order to assist the court in understanding the wider implications of a case on often large numbers of people. The consultation used the following case study to support the assertion that judicial review is being used inappropriately as a campaign tool:

> *The process of developing permanent premises for a Free School was made much more complex and costly by litigation over the decision to grant planning permission. The Free School, which was occupying temporary premises, acquired a lease of land previously used as a garden centre, which had closed for commercial reasons. A local campaign group opposed to the closure of the garden centre had been formed. With this group's support, a local resident with disabilities applied for a judicial review of the council's decision to grant planning permission for the land to be used for the Free School's permanent premises. The judicial review relied on various grounds, including a breach of the public sector equality duty (PSED). The Council retook the planning decision in order to assuage concerns about the PSED, reaching the same conclusion.*
>
> *This decision was then subject to further challenge, and three applications for injunctions to stop the Free School proceeding with construction works were rejected by the High Court. After a full hearing, the High Court also rejected the application for judicial review on all grounds, and refused permission to appeal. After a delay of more than three months, the claimant renewed his application for permission to appeal to the Court of Appeal. The litigation has so far continued for two years. The claimant's stated aim of saving the garden centre could not possibly have been achieved. At most, the litigation could have prevented the Free School being sited there.*
>
> *The litigation caused uncertainty about the school's move to its permanent site, required the governing body to divert enormous amounts of time to the court process and cost tens of thousands of pounds of public money to defend. The Free School's core purpose of running a much-needed new school for the local community was severely and unnecessarily disrupted.*

The above example is neither a reflection of the typical cases in which third parties intervene nor of the types of organisations that apply to intervene. The

cases in which Mind has been involved concern breaches of individuals' fundamental rights and freedoms:

For example:

- *Savage v South Essex Partnership NHS Foundation Trust*[9] and *Rabone and another v Pennine Care NHS Foundation Trust*[10] established a positive duty on hospitals to ensure that they take reasonable steps to prevent mental health patients from taking their own lives. It was a challenge relating to the application of Article 2 of the European Convention on Human Rights.
- *MM and DM v Secretary of State for Work and Pensions*[11] involves a challenge to the Employment Support Allowance ("ESA") determination process based on the substantial disadvantage at which it places people with mental health problems.
- *Das v Secretary of State for the Home Department*[12] concerns the issue of whether people with mental health problems should be detained in immigration removal centres.

The above case examples concern matters of fundamental importance to individuals with mental health problems.

Legal Aid Payments

The consultation included a proposal that providers should only be paid for work carried out on an application for judicial review either where permission is granted, or where the LAA exercises its discretion to pay the provider in cases where proceedings are issued, but the case concludes prior to a permission decision. Aside from the fact that this appears to suggest that public lawyers pursue cases for reasons other than that their client has a valid claim and that the LAA grants funding for unmeritorious cases, there are a number of concerns relating to this proposal.

First, if these proposals come to fruition, there is a risk that the courts will become clogged with applications for costs determinations. This can be a lengthy process and will require providers to subsidise the costs of litigation which is not viable for many firms, particularly those which undertake predominantly legal aid work.

Second, the undesirable result of this proposal is that specialist public law firms, with many years' experience of judicial review, may cease taking on judicial review cases because it is not financially viable for them to do so. Instead, we could see the situation the government purports to exist now becoming a reality, as non-specialist lawyers attempt to turn their hand to judicial review which will increase the likelihood of unmeritorious/vexatious and poorly prepared claims being brought.

[9] [2007] EWCA Civ 1375

[10] [2012] UKSC 2

[11] 2013 UKUT 260 AAC

[12] [2013] EWHC 682 (Admin)

Third, vulnerable clients, for example those with mental health problems, often change their mind about pursuing a claim part way through the process – i.e. between issuing the proceedings and permission being granted. They may choose to discontinue a claim because they find the process too stressful, or because they have a lack of trust in the process as a result of a previous bad experience. Providers may be less willing to act for vulnerable clients due to the risk of not getting paid.

Finally, the introduction of a discretion for the LAA to pay providers in cases where proceedings are issued, but the case concludes prior to a permission decision, is likely to lead to a significant number of claims being brought against the LAA. Where its application of the criteria leads to non-payment, providers will have no choice but to mount such challenges. Ironically, this would increase the number of judicial review applications made.

CONCLUSION

Judicial review is a key tool for ensuring that the rights of people with experience of mental health problems are protected, promoted and upheld. If the proposals go ahead, they will result in a fundamental dilution of people's constitutional rights. This could be perceived as a reflection of the lack of importance the government attaches to the rights and protections afforded to citizens by judicial review. Mind has serious concerns about the proposals and the implications they would have for people with mental health problems. People with mental health problems are more likely to access health and community care services. Where the provision of such services is refused or reduced, the appropriate remedy is judicial review where all other avenues have been exhausted. If these proposals go ahead, such individuals will effectively have no remedy beyond pursuing a complaint, as they will struggle to find a lawyer able and/or willing to take on their case.

Free Legal Aid for people detained under the Mental Health Act 1983 – the right to go to court to challenge the lawfulness of your detention

In England and Wales, free legal aid is available to people who are detained under the Mental Health Act 1983. This means that they can have legal representation to challenge their detention before the First-tier tribunal, the mental health tribunal. However, until now, on the Isle of Man, people detained under the equivalent mental health law, the Mental Health Act 1998, have not been given free legal representation.

The Service User Network (SUN) on the Isle of Man has argued that mental health detainees need to have free legal representation. Mind and the Law Society have backed that call, arguing that the European Convention on Human Rights required the Isle of Man to provide free legal aid. The Isle of Man has now agreed to draft regulations to give free legal aid to detained patients.

The human rights arguments put forward were based on Article 5 (4) and Article 6 of the Convention.

Article 5(4) says that anyone who is deprived of their liberty has the right to take proceedings to have the lawfulness of their detention decided speedily by a court and their release ordered if the detention is not lawful. In a number of cases, the European Court of Human Rights has said that to ensure access to a court to challenge psychiatric detention, the state should provide patients with legal representation. In the case of *Megyeri v Germany* (1993) 15 EHRR, where a Hungarian man was detained in a psychiatric hospital, the European Court of Human Rights summarised previous principles established by case law, including the principle that it is essential that a person detained in a psychiatric hospital have access to a court and the opportunity to be heard either in person or to have some form of representation. It added that a person confined to a psychiatric institution for criminal offences for which he could not be held responsible on account of mental illness, should (save for special circumstances) receive legal assistance in the proceedings relating to the continuation, suspension or termination of his detention. In the later case of *Magalhães Pereira v Portugal* (2003) 36 EHRR 49 the presumption in favour of legal representation, save for special circumstances, was restated.

Article 6 of the Convention guarantees the right to a fair trial. A patient who wishes to challenge their detention under the Mental Health Act has to deal with complicated legal provisions and complex clinical evidence. Previous European cases have set out the factors that are relevant in determining whether free legal assistance should be provided to ensure a fair trial, which are: 'the importance of what is at stake for the applicant in the proceedings, the complexity of the relevant law and procedure and the applicant's capacity to represent him or herself effectively.'

Lack of free legal aid for people deprived of their liberty under the Mental Capacity Act 2005 in England and Wales

Under the Mental Capacity Act 2005, a person who lacks capacity to choose where they live or what treatment they have, has decisions made in their best interests. If this means that they are placed in a care home or a hospital where the care arrangements deprive them of their liberty, formal authorisation of this deprivation of liberty is required by a local authority and the person is then subject to safeguards (deprivation of liberty safeguards, DoLs). In this situation, people who wish to challenge a deprivation of liberty can make an application to the Court of Protection and are entitled to free legal aid at the outset. At the time of the writing, if the Court of Protection authorises the deprivation of liberty on an interim basis, then the person who lacks capacity loses their non-means tested legal aid and will only be able to access legal aid if they qualify financially for it. We understand that this is subject to a legal challenge at present and may be resolved.

If however, a person assessed to lack capacity is placed in settings other than a care home or hospital, such as a supported living placement where they are deprived of their liberty as they are not free to leave, or if they are unlawfully deprived of their liberty in any setting and so are not formally subject to either the Mental Capacity Act or Mental Health Act, then no free legal aid is available.

To ensure that vulnerable people who may lack capacity have access to legal representation and have their rights protected, when they are confined and unable to leave their placements by their care arrangements, it is essential that free legal aid should be available.

Updating the Code of Practice to the Mental Health Act 1983

The Welsh and English Codes of Practice to the Mental Health Act 1983 provide guidance on how the Mental Health Act should be implemented and applied. It is guidance that should be given great weight and any hospital should follow what the guidance says unless it has cogent reasons for adopting an alternative policy. In any legal challenge to a hospital's policy, a court will scrutinise very carefully any departure from the Code (Munjaz v UK (2012) ECHR 1704 http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112198%23%7B%22itemid%22:%5B%22001-112198%22%5D%7D).

The government's plans

In response to the scandal at Winterbourne View, the government published a final report: Transforming Care: a national response to Winterbourne View Hospital https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf in December 2012. In this report, it made 63 commitments to action, one of which was to revise the Code of Practice to the Mental Health Act 1983 in England (action 59).

The Code was last published in 2008 and the government acknowledges that since that time there have been developments in legislation, case law, policy and professional practice which require the Code to be revised. There will be a consultation on the new draft Code in 2014.

Starting with a pre-consultation review https://www.supply2health.nhs.uk/DH1/Lists/S2HNotificationsList/DispForm.aspx?ID=11, the government identified twelve aspects of the Code that required particular consideration. The areas are:

1. advocacy, wishes expressed in advance and legal representation;
2. the use of physical restraint, mechanical restraint, medication and seclusion;
3. decisions to hold and detain people, in police custody or hospital, and how reviews of detention take place;
4. how community treatment orders work;
5. how the Code applies to children and young people;
6. how the Code applies to individuals with a learning disability, autism or challenging behaviour;
7. how the Code applies to individuals of different ethnicities, especially those where English may not be their first language, or that are of Afro-Caribbean descent;
8. how the Mental Health Act works, and could work better, with the Mental Capacity Act and Deprivation of Liberty Safeguards;
9. how the mental health tribunal system works and could be better understood;
10. how the Code fits with the Care Quality Commission's regulatory model;
11. how the Code applies to non-English patients treated in England and what the arrangements are for English patients not treated in England (cross-border issues); and
12. how to make understanding and knowledge of the Code better understood for individuals, their families and carers.

Within these twelve areas, written responses were requested by 18 November on the three issues identified as most in need of revision, with explanations as to why the current Code did not provide satisfactory guidance on these. The government also asked for examples of particular issues that the Code did not address or where it was out of date in these areas. It sought suggestions for other areas where the Code needed updating.

Key areas for changing the Code of Practice: some initial thoughts

How often have you seen copies of the Code of Practice displayed on an inpatient ward? Frequently the only way to access the Code is via the internet from a busy computer terminal in the staff room. If patients, their relatives and friends, and visitors and staff are to know what the guidance says, and be able to use it to argue for better practice, then copies have to be accessible on every ward and advertised as such. If its guidance is to be followed then the Code should stipulate that every ward has a copy available and that staff must be trained in its provisions. Versions should be provided in different formats like **Easyread**.

Fresh air and exercise and good diet are of key importance in having good mental health but the Code has nothing to say about this. If people are to be detained in hospital then there should be provisions to confirm their right to have access to all of these.

In 2009, the United Kingdom ratified the Convention on the Rights of Persons with Disabilities (CRPD) http://www.un.org/disabilities/convention/conventionfull.shtml. This means the government is committed to realising the provisions of this international treaty here. So as far as possible the ethos and principles in the Code should reflect the CRPD's rights-based approach to care and treatment. This must at the least mean checking each part of the Code against the CRPD's provisions to promote compliance. The CRPD Article 5 sets out the principles of equality and non-discrimination, prohibits all discrimination on the basis of disability and guarantees to persons with disabilities equal and effective legal protection against discrimination on all grounds. Article 12 promotes a supported–decision making approach to any disabled person who is assessed to lack capacity to make a decision. It says that disabled people have the right to recognition everywhere as persons before the law and should be recognised as enjoying legal capacity on an equal basis with others. Appropriate measures must be taken to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Finally Article 25 deals with access to health care and says that health professionals should provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent and this includes raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities.

Ultimately the CRPD requires us to have a radical rethink of law and practice when it comes to the Mental Health Act. However, at the very least in redrafting the Code of Practice wherever possible, the Code needs to consider how to promote the participation and wishes of the patient and to respect their autonomy. Medication and other treatments administered without consent are great infringements of personal liberty and there have to be adequate safeguards, and arguments that any treatment has to be given, based on 'therapeutic necessity', must be subject to very careful scrutiny.

Mental Health Act Safeguards

Why did legal safeguards fail to protect patients detained at Winterbourne View? Winterbourne View was a private hospital registered for treatment of patients detained under the Mental Health Act 1983 (MHA 1983). Although over 73% of all admissions to the hospital between December 2006, when the hospital opened, and June 2011, when the hospital closed, were made under the powers in the MHA 1983, there is little information in the various public reports about how the safeguards provided in the Mental Health Act 1983 were accessed or used.

The Mental Health Act 1983 provides a range of protective measures for people detained under Part 2 of the Act. These include:

- Right to information (s 132 MHA 1983 & Code of Practice Chapter 2) and nearest relative's rights to information (s 132 (4) and s 20 (3) and The Mental Health Regulations 2008 reg 26 and Code of Practice 2.27- 2.33)

- Right to an Independent Mental Health Advocate (IMHA) (s 130 MHA 1983 & Code of Practice Chapter 20)

- Right to apply to a tribunal to challenge continuation of compulsory detention (s 66 (1) (a) and (b) & (h) (i) MHA 1983). This includes automatic referral to a tribunal if rights of appeal are not exercised (s 68 MHA 1983 & Code of Practice, Chapter 30.34-38)

- Hospital Managers' powers of discharge (s 23 MHA 1983 & Code of Practice, Chapter 31)

- Nearest relative's power of discharge (s 23 MHA 1983 & Code of Practice, Chapter 29.18-29.23) & right to apply to a tribunal if a barring certificate is issued (s 66 (1)(g) & (h) (ii))

- The Second Opinion Appointed Doctor (SOAD) procedure (s 58(3)(a) MHA 1983 & Code of Practice, Chapter 24)

- The Care Quality Commission's (CQC) protective functions (s 120(1) MHA 1983)

- Guidance provided by the Code of Practice to the Mental Health Act 1983 which is guidance that should be given great weight and which any hospital should consider with great care and from which it should depart only if it has cogent reasons for doing so.

Additionally there are the NHS and Social Care Complaints Procedures with the possibility of taking a complaint to the NHS Ombudsman.

The case of MH v the United Kingdom 2013 ECHR 1008 (22 October 2013) http://www.bailii.org/eu/cases/ECHR/2013/1008.html, decided by the European Court of Human Rights in October 2013, illustrates neatly that even if there is a safeguard it really has to be accessible. MH, a woman with Down's Syndrome, had been living with her mother but was then detained under section 2 of the Mental Health Act. She lacked the capacity to make her own application to a tribunal to challenge that detention. The question was how, in this situation, could it

be argued that she did have the right to have the lawfulness of her detention reviewed by a court and her release ordered, if detention was found to be unlawful. She had a right to this under Article 5 (4) of the European Convention on Human Rights.

During the first fourteen days of detention, a person who is detained under section 2 can apply to a tribunal to have the lawfulness of their detention reviewed by the Mental Health Tribunal, First-tier Tribunal (Mental Health). The Court found this remedy was not available in practice to MH because she lacked the legal capacity. They found that the special safeguards required under Article 5 (4) for patients like MH who lacked capacity to have the means to challenge their detention were missing. It found a violation of Article 5(4) of the Convention in respect of her first twenty-seven days of administrative detention for this reason.

We all need to consider carefully how accessible and available all the Mental Health safeguards are to patients like MH.

The Care Bill 2013 in England: some recent developments

The Care Bill has its second reading in the House of Commons on 16 December.

Background

Following the recommendations of the Law Commission for English law in their report on Adult Social Care http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf, The Care Bill http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0123/cbill_2013-20140123_en_1.htmhttp:/www.publications.parliament.uk/pa/bills/cbill/2013-2014/0123/cbill_2013-20140123_en_1.htmhttp:/www.publications.parliament.uk/pa/bills/cbill/2013-2014/0 aims to bring together and simplify in one statute the patchwork of community care legal provisions that have been enacted for England since the Second World War. It had its first reading in the House of Lords in May 2013 and completed the Report Stage there in October 2013. Now the House of Commons will consider the Bill.

Mind is part of the Care and Support Alliance (CSA), an alliance of over 70 charities that has campaigned together to make the Bill more responsive to disabled people's needs. Mind has focused on a number of key issues that can make a difference to people with mental health problems who use social care including:

1. Eligibility - Local councils will only be required to provide social care to people with 'substantial' needs. But people classed as having 'moderate' needs should also have access to social care; without it, they might struggle to take care of themselves or complete tasks around the home, and their health will deteriorate.
2. Advocacy - The social care system can be frightening and difficult to navigate if you are unwell. Those who will struggle the most should have a right to an independent advocate, to guide them through the process and ensure their voice is heard.
3. After-care services - People who have been detained under the Mental Health Act 1983 (MHA) often need a combination of health and social care

'aftercare' services when they leave hospital, in order to stay well. Mind has been concerned that the new definition of section 117 MHA after-care in the Care Bill may limit the services that will be provided to people as after-care.

Eligibility

The Care Bill will introduce a national level of eligibility for social care (Clause 13). Currently there are four levels of eligibility for social care – critical, substantial, moderate and low. Most councils only offer care to people who meet the critical or substantial threshold. Mind believes the minimum level of eligibility needs to be moderate as it is important that social care is provided to support people experiencing mental health problems and to prevent deterioration. The government has now published Draft national minimum eligibility threshold for adult care and support: A discussion document https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209595/National_Eligibility_Criteria_-_discussion_document.pdf with attached draft regulations and has asked for responses by 29th November 2013. The government then proposes to carry out further analysis and publish the final regulations in 2014 for consultation.

Advocacy provision

Following a sustained campaign, the government has agreed to include a duty to provide independent advocacy support in the Care Bill (see new clause 68 and 69 of the Care Bill http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0123/cbill_2013-20140123_en_8.htm#pt1-pb16-l1g68). It will be for individuals who do not have an appropriate person to support them for the time when they are assessed for social care, have care and support plans prepared or are in care reviews and they experience substantial difficulty in one or more of the following:

(a) understanding relevant information;

(b) retaining that information;

(c) using or weighing that information as part of the process of being involved;

(d) communicating their views, wishes or feelings (whether by talking, using sign language or any other means).

Likewise there will be a duty to provide independent advocacy for people who experience one or more of these difficulties and are subject to a safeguarding enquiry or safeguarding review.

Mental Health After-Care under section 117 MHA 1983

Clause 74 http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0123/cbill_2013-20140123_en_8.htm#pt1-pb19-l1g74 of the Care Bill makes various amendments to after-care provisions under section 117 Mental Health Act 1983. These include applying the ordinary residence provisions to section 117 after-care so that account should be taken of the patient's preferences in providing

accommodation as part of an after-care package. But correspondingly top-up payments are to be allowed.

Clause 74 (5) provides a two part definition of after-care services as services which have the purpose of (a) meeting a need arising from or related to a person's mental disorder, and (b) reducing the risk of deterioration of their mental condition (and accordingly reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).

This is the first time that there is a definition of after-care in law. Mind is concerned that if there is to be a definition then it should be wide enough to ensure that a social model or recovery model applies allowing a range of services to be provided as after-care services including generic services like employment support, vocational advice, welfare benefits advice as well as provision of medication and appointments with a psychiatrist. The definition now in the Bill has been modified but Mind remains concerned that Clause 74 (5)(a) is too restrictive, and so will continue to campaign for this clause to be removed.

Human rights protection for all users of social care

With a number of other charities, Mind has supported an amendment to the Care Bill to ensure that all users of social care, however these may be funded or arranged, will have the same protection. An amendment was passed by the House of Lords which is Clause 48 with the title *Provision of care and support services*. This confirms that all social care providers which deliver social care services and must register with and be regulated by the Care Quality Commission, are subject to the Human Rights Act 1998. The problem is that there is a grey area around this at the moment. If a local authority is involved in arranging care then the Human Rights Act usually applies. However if the local authority doesn't arrange the care, the care provider may not have duties under the Human Rights Act. This means you can have two people living in neighbouring rooms in the same care home, but because their care has been arranged or is paid for differently, the human rights of one of them are protected but those of the other person are not. The amendment ensures the same protection for everyone.

News

Mental Health (Discrimination) Act 2013

Just a reminder to our readers that the 'jury service' provisions have now come into force. From 15 July anyone receiving medical treatment for mental health conditions is eligible to sit on a jury unless they are liable to be detained under the Mental Health Act 1983, an in-patient receiving mental health care, subject to a Community Treatment Order (CTO) or under MHA guardianship. Those lacking the mental capacity to sit on a jury remain ineligible. The changes were introduced by the Mental Health (Discrimination) Act 2013 and were implemented by the Mental Health (Discrimination) Act 2013 (Commencement) Order 2013, SI No 1694.

This means that many people who in the past were considered ineligible on grounds of receiving mental health treatment may from now on be contacted by

the Jury Central Summoning Bureau to establish if they are eligible to do jury service.

Independent Mental Health Advocates

In England, local social services authorities are now responsible for commissioning IMHA services for qualifying patients (ss 130A – 130C MHA). In force from 1 April 2013 The National Health Service and Public Health (Functions and Miscellaneous Provisions) Regulations 2013 Si No 261 amend the Mental Health Act 1983 (Independent Mental Health Advocates) (England) (Regulations 2008) SI No 3166.

Post-legislative scrutiny of the Mental Health Act 2007

The House of Commons Health Committee has published its First Report: post-legislative scrutiny of the Mental Health Act 2007 on 14 August 2013 http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf. Following increased rates of detention under the MHA 1983, the committee recommends urgent investigation by the Department of Health to ascertain whether detention is used as a means of accessing hospital beds. It also recommends that the IMHA service should be an opt-out rather than opt-in service, and that the right to an IMHA should be extended to all in-patients in England, and not just qualifying patients. In Wales, the Mental Health (Wales) Measure 2010 gives all in-patients the right to access an IMHA. There were also recommendations aimed at improving the operation of s 136 MHA (power of police to convey a person to a place of safety), and recommendations for the review of the current operation of CTOs. The Committee also concluded that an urgent review of DoLS (the MCA 2005 Deprivation of Liberty Safeguards) was needed and should be presented to Parliament by the Department of Health within 12 months.

Preliminary medical examinations at the Mental Health Tribunal

The Tribunal Procedure Committee has conducted a consultation on a proposal to amend the rule on preliminary medical examinations (which closed in September 2013). Currently, the rules allow the medical member of the tribunal panel to examine the patient's medical records and take notes for the purposes of the preliminary examination (rule 34, Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 Si No 2699. Instead, the Committee proposes that medical records should be available to all members of the Tribunal panel. Preliminary medical examinations should continue for s 2 Tribunal hearings, but otherwise examinations would be at the Tribunal's discretion. It proposes to amend rule 39(2) to allow a hearing to proceed without the patient being present if a preliminary medical examination has been performed or the Tribunal considers that such an examination is unnecessary or not practicable; and that the Tribunal is satisfied that the patient has decided not to attend, or is unable to attend for reasons of ill health.

In its response, Mind stated that it does not agree that there should be any change to Rule 34 or Rule 39 as they provide important patient safeguards. In addition, before any decision is made to implement such changes, steps should be taken to consult those most closely involved in the process, in particular patients and those

who support them, such as IMHAs. Patients may be in dispute with their Responsible Clinician about diagnosis and treatment plans, and the preliminary examination may afford them an added opportunity to express their views.

Mind report on restraint in mental healthcare settings

The report, *Mental health crisis care: physical restraint in crisis,* published in June 2013, is available at www.mind.org.uk/campaigns_and_issues/current_campaigns/care_in_crisis/report_on_physical_restraint.

A year-long independent enquiry by Mind in 2010/2011 was followed by Freedom of Information Act 2000 requests to all 54 mental health trusts in England asking how they use physical restraint. Responses were received from 52 trusts and interviews were undertaken with people who had experienced or witnessed physical restraint.

The following were among the key findings of the report:

- Huge variations across the country in the use of physical restraint, with one trust reporting 38 incidents in a year while another reported over 3,000;
- Face down restraint, particularly dangerous because of the impact it can have on a person's breathing, was used over 3,000 times in 2011/12;
- While some trusts have put an end to face down restraint, over half of the incidents occurred in just two trusts;
- Figures for physical restraint used to administer medication are exceptionally high.

As there is currently no national framework in England to regulate the use of physical restraint, the report calls for an end to face down physical restraint in all healthcare settings, national standards for the use of physical restraint, and accredited training for healthcare staff in England.

TW v Enfield LBC and Secretary of State for Health (2013) EWHC 1180 (8 May 2013)

The Approved Social Worker (ASW)[13] who made the application for s 3 detention under the MHA 1983 in June 2007 had not consulted the patient's Nearest Relative, on the grounds that it was not reasonably practicable to do so. The patient had made several statements saying that she objected to the disclosure of information about her condition and treatment to her parents, as in the past such disclosures had had a negative impact on family relationships and on her mental health condition. The ASW also knew of the patient's allegations that her parents had abused her sexually in the past.

[13] The effect of the MHA 2007 was to amend the MHA 1983 to replace the role of the ASW with that of the Approved Mental Health Professional, AMHP, as from 3 November 2008

This case concerns an allegation by the patient that her s 3 detention had been unlawful because of the ASW's failure to consult her Nearest Relative as it was her duty to do under s.11(4) MHA, and the patient's action for damages for unlawful detention. The Judge (Bean J) considered the ratio of *R (E) v Bristol City Council* [2005] EWHC 74 (Admin) which he said was:

"…when an adult whose mental health is in issue has clearly expressed the wish that her nearest relative is not to be involved in decisions about her case, and it appears to the AMHP that to contradict that wish may cause the patient distress to the extent of affecting her health, the AMHP is entitled to regard consultation with the nearest relative as not reasonably practicable" (para 47 of the judgment in *R (E) v Bristol*).

New NHS Mandate

In November 2013, NHS England received a refreshed Mandate from the Government https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015, which sets out the Government's ambition of putting mental health on a par with physical health. NHS England responded that its vision is for a real change in attitude towards mental health and the way services are delivered, so that people experience a holistic approach to their care http://www.england.nhs.uk/2013/11/12/mandate-response/.

AM v SLAM and the Secretary of State for Health (2013) UKUT 0365 (AAC)

This Upper Tribunal case seems set to re-map the relationship between the Mental Capacity Act 2005 and Mental Health Act 1983.

A woman (AM) had been taken from her home by warrant under s 135 MHA and then detained under s 2 MHA. Her first application to the mental health tribunal for discharge from detention was refused, and the s2 detention was then extended while the nearest relative was displaced, followed by a second tribunal application. It was not disputed that AM lacked the capacity to consent to her care and treatment and to being in hospital.

The case reminds decision makers, the tribunal and Mental Health Act Managers and clinicians, AMHPs and other professionals of their duty to consider the least restrictive option for care and treatment. For a compliant person lacking capacity who is in hospital for care and treatment for a mental disorder, this would normally be care and treatment under the MCA 2005 with a DoLS (Deprivation of Liberty Safeguards) if they are eligible for one.

Charles J stated that the DoLS regime "applies when it appears objectively that there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty" (paragraph 59 of the judgment). However, First-tier Tribunals and other decision makers are unable to implement or compel the implementation of the MCA regime and the DoLS procedure, but discharge from MHA detention could be deferred to allow a DoLS authorisation to be sought. In this case he also appears to pull back from the principle of the primacy of the MHA, in circumstances where it might be possible that either the MHA or MCA procedures could be used, and gives each statutory framework a more equal status.

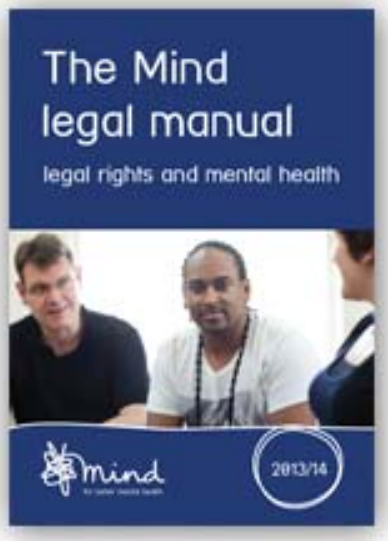
Available from Mind publications (coming in 2013)

The Mind Legal Manual: legal rights and mental health

An essential resource for anyone concerned about legal rights and mental health, the Mind Legal 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, such as the Mental Health Act 1983, mental health discrimination law (Equality Act 2010) and community care rights, and includes the leading legal cases relevant to these areas. An invaluable resource for anyone working in mental health, legal and advisory services.

The Mind Legal Manual is written in accessible language and divided into chapters and headings so it is easy to use as a reference tool and check on the latest law in the areas it covers. It contains a comprehensive overview of the following topics:

- Advocacy and legal advice and new rules about legal aid
- Care in the community and changes to the NHS framework and social care system
- Complaints, redress and human rights law relevant to mental health
- Information rights including an update on CRB checks (now Disclosure and Barring Service)
- Incapacity, Independent Mental Capacity Advocates, and Mental Capacity Act 2005 Deprivation of Liberty Safeguards caselaw
- Discrimination and the Equality Act 2010
- Introduction to legal rights in hospital and Independent Mental Health Advocates
- 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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We hope you have enjoyed reading the Mind legal newsletter 14. We look forward to your comments and suggestions on anything you think would be of interest to our readers.

If you would like to get in touch:

email: legalunit@mind.org.uk

Telephone: 020 8215 2339