Mind's legal enewsletter

Issue 7, November 2010

Welcome to Issue 7 of Mind's legal enewsletter – which is regrettably rather overdue. We hope that we have managed to include items that will inform or refresh your knowledge on matters of importance arising in 2010.

Mind's Legal Unit has been going through a period of change, but we are delighted now to be back up to a full complement of staff, and also very pleased to have been involved in many interesting areas of work. We have assisted with a number of cases relevant to those with experience of mental distress, and have responded to consultations – in particular relating to the Equality Act 2010. We hope that the new guidance on the definition of disability will clarify many points of concern that have made claims difficult for those with mental health conditions. Our legal briefing is now available on the Mind website – Disability Discrimination under the Equality Act 2010.

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

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For better mental health

FEATURE

New contracting regime costs more money, yet threatens representation of the mentally unwell

Introduction

In June of this year the Legal Services Commission introduced the results of much of their new contract for legal aid for some of the most vulnerable in our society, including representing those with mental health issues. The contract caused concern in several ways:

1. It has cost much more to arrange than the original system of representation. The Commission has increased its administration costs generally from £60m to £120m, much of the increase being in backroom paperwork to fund supervision of this and similar new contracting schemes.
2. The new scheme severely reduces the ability of many of the most experienced lawyers to continue to represent clients with mental health problems; whilst allowing some firms with little or no experience in the field to take a significant share of such representation.
3. It has continued the theme of great uncertainty as to where specialist lawyers stand as they strive to continue a proper service to their clients.

Background

The problem arises from the Commission's latest scheme to "tender" for new work in the field of mental health; and to do so in a way which the Commission considers acknowledges the European development of procurement law as well as allows for proper access to justice and complies with public law principles. Patients who are detained, and subject to compulsory medication, are entitled to representation without charge in compliance with the European Convention on Human Rights. The only other two areas of "core rights" which have the right to such representation are for those subject to arrest in a police station and those whose children have been removed by a Local Authority.

It has long been recognised that such lawyers who do this work need to have special skills and knowledge; and it was in this area of law that the Law Society set up its first specialist panel. The danger of the improper application of a contract-based work in this area of this area of law was recognised in some detail by Lord Justice Brook in the "MacIntosh Duncan" case, referred to below, when the 2000 contract scheme was being introduced.

In reality the rationale behind the limitation of case starts is on resource grounds, which may apply in other areas of law but does not apply for most mental health work. The Commission accepts that where a patient needs representation before a Tribunal, which still comprises the majority of legal aid work, they are under a legal obligation to provide funding in line with the Convention.

The latest version of the contract scheme, planned to start in October 2010 (although see also below), is complex in its detail, however generally it is based on a series of zones created to mirror strategic health authority boundaries; although ironically of course there are plans to abolish strategic health authorities. The rules allow for new entrants to provide legal services in this area of law, or for existing firms to

expand their work. The Mental Health Lawyers Association ("MHLA") supports this; however the same rules set no limit to the number of future cases, known as "matters" by the Commission, for which a firm can bid. This can effectively force existing firms, with a long established record for quality, away from being able to continue the work, whilst it has encouraged other firms, perhaps existing firms, to bid "speculatively" on the number of matters they might do if they employed more staff.

Example

This fictional example, although based on the scheme, illustrates what has happened.

Firm A and Firm B bid for matter starts in the area of Midshire Strategic Health Authority. A total of 8,000 "matter starts" are available. This figure appears to be based on representation figures of around two years ago.

Firm A has been representing clients for twenty years in this area. It has six members of the specialist Law Society Mental Health Tribunal, is headed by a recognised international authority in mental health law, and represented clients in 600 matters last year. Many clients have very longstanding complex mental health problems with a long history of representation by the firm over a range of legal issues, including detention and medication. It decides to bid for the same number of matters for this contract.

Firm B has never represented mental health clients in Midshire before. It decides to bid for the whole 8,000 matter starts. It has not employed anybody for this work yet, but is taking advantage of the rule that allows it to bid without having anyone in post. It knows that it only has to confirm the details 8 weeks before the contract start date.

A number of other firms bid, although none bid as high as 8,000. When the bids are analysed by the LSC, there are considerably more bids than "matter starts" available. These are then apportioned down based on the amount of the bid. Firm A finds it now has only 250 matter starts and will have to lay off experienced staff, some of whom have known their clients for years, and the managing partner has said he is looking at closing the business as it is no longer economically viable. Firm B, however, finds it has been allocated 2,800 matter starts. It now starts to advertise for staff and consider setting up a mental health department.

Implications

Whilst this is a fictional example, it demonstrates how "speculative" bidding can completely skew future business for established quality firms. It must be stressed that this is not competitive tendering, so Firm B has not in any way bid at a "lower rate" for the service it provides.

The Commission have indicated that it will look at some future re-allocation of matter starts, however there is no guarantee what will come from this review, or when it will take place or how far-reaching it will be.

These reassurances are insufficient for firm A from the example, which has to plan to make redundancies and closure plans now. The new contract is due to start on 15 October (although again see below) and

there is little time left to plan for its business; profit margins have already been skimmed to the bone following recent legal aid changes.

On the other hand firm B, even if they recruit staff to handle only 1800 matter starts, can return the "surplus" of 1,000 with no penalty from the Commission.

The MHLA is not claiming that firm B should not be allowed to enter the "market", however the mechanism used here, at considerable additional cost to the taxpayer, appears to drive away an existing, proven quality supplier, A, for the benefit of the unknown qualities of firm B. The MHLA already has had reports of new firms trying to poach staff from established firms and force proposed untrained supervisors through training programmes as soon as possible.

What is especially frustrating to some more experienced existing practitioners is that they felt encouraged to bid "responsibly" by the Commission; close to the work they were carrying out now. In reality, they should have bid much more extravagantly; closer to the practice employed by firm B.

Judicial View

As outlined above, the judiciary has had longstanding concerns about the view of the then Legal Services Commission (previously the Legal Aid Board) applying a contracting regime properly to this area of law. Here the Court stated:

> "We are worried, however, that the Board (as the Legal Services Commission was then called) has not yet appreciated how difficult mental health law is, and how generalist solicitors cannot pick up the expertise needed to serve their clients effectively unless they have a strong educational and practical grounding in this field of law. We hope that the Board will now take urgent steps to identify the really skilled solicitors who are willing to serve their clients in this field at legal aid rates of pay, and once it has identified them by a transparently fair process, to ensure that they have the same freedom to serve their clients as the Board is willing to afford to solicitors in the equally complex field of clinical negligence.....[para 568]
>
> Mental health law is difficult enough today. Reading the report of a psychiatrist, identifying its areas of weakness, commissioning evidence from the appropriate expert to challenge it, and representing a client at a tribunal requires expert professional skills born, 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 ..... [Para 571]
>
> There is a dearth of specialist practitioners in the field of community care and health law. ..... The cases are always urgent, particularly because clients are often passed from one organisation to another without their problem being adequately rectified. As a result, their condition deteriorates to the extent that they are at physical risk, or at severe risk of a mental health breakdown or relapse, and they may be a danger to the wider community in the absence of prompt and expert legal advice and action.....[para 120]

R v Legal Aid Board & LORD CHANCELLOR ex parte Duncan and MacIntosh [2000] EWHC Admin 294

It is worth noting in this context that the number of specialist Law Society Panel members was around 400 when this judgement was given: last year it was only a little over 300. Yet the number of people subject to the compulsory powers of the Mental Health Act and applying for a review of these by the Mental Health Tribunal has risen consistently since that time, with a rise of 13% last year, following introduction of the Mental Health Act 2007, and an ongoing current rate increase of 8% on this figure. The Commission has increased the "allowance" of new cases by 1500 for the next year; yet already the increase is looking to be around new 5,000 cases to come before the Tribunal: a very significant shortfall which in itself squeezes the availability of legal aid. Nor do these figures count legal issues relating to the thousands of patients now effectively detained in residential facilities following the Mental Capacity Act 2005 and European case-law, or other clients trying, for example, to obtain improvements in their aftercare provision.

At the time of writing the Courts have decided to intervene to effectively suspend two other new civil contracting schemes; welfare benefits and family.

With respect to the welfare benefits civil contract, in a case brought by the Birmingham's Community Law Partnership, the court's initial comments as to some of that scheme's selection criteria indicated they were "utterly absurd" and "totally irrational". Revealingly the Court indicated here:

> "Those tendering are entitled to take the view that access to justice criteria will be taken into account and discretion used, rather than just box ticking."
> *Law Society Gazette, 26 August 2010*

The case was adjourned for the Legal Services Commission to resolve; but with a clear indication that the claimants should be awarded a contract; and subsequently the Commission has awarded Birmingham CLP a contract. This the Commission has subsequently done.

In the family case bought by the Law Society, with other family firms joining, permission for judicial review has been granted by the Court, with the commencement of the new contract suspended for at least a further month, to allow for the full hearing.

With respect to mental health work, again at the time of writing, the Law Society's lawyers have apparently taken the view that the scheme is not challengeable, in part because the controversial selection criteria, applicable to family and welfare benefits, were not used in the main allocation of case matter starts; although they were in the allocation of work in the three Special Hospitals. This is notwithstanding some of the results produced being irrational and the protestations of many specialists that they were misled. The MHLA is at present looking to take its own legal opinion and trying to scrutinise details of the legal opinion provided to the Law Society.

However, it now appears that the whole Civil Contract is now to be suspended, including mental health work, for a period of at least a month. Again this is at the time of writing. This may look good news for some; however the extreme uncertainty of the whole process continues to make planning for the future very difficult for all mental health practices.

What can be done?

The MHLA favours a fundamental reform of the delivery of legal aid in this area; but without sacrificing quality and not including competitive "cut price" tendering. In particular we do not consider that case starts before the Mental Health Tribunal should be controlled. Clients have a right under the European Convention to have legal representation to challenge their detention. The situation is similar to another "core" area of Legal Aid that is not means tested, the representation of clients detained in a police station. Here there is no restriction to the number of "matters" for those detained for police questioning. The implication of the controlling of cases in this way in mental health is that there will come a time where a detained client cannot at best have his or her representative of choice; at worse no representative at all will be available. What, otherwise, is the logic in having such expensive control? Indeed many firms are very close, or up to, this position now, under the current contract with many firms turning away existing clients. In any event practitioners' files are swamped with a range of auditing and case reporting mechanisms which should enable the Commission to monitor the use, or abuse, of the legal aid fund.

However, if the scheme is to go ahead in its current format, conversely the MHLA considers strict compliance with the contracting requirements is essential, so that properly qualified supervisors are in place before the start of the contract, as required in the tendering process, and that consequently firms that have bid "speculatively" do have sufficient trained staff in place. Some "speculatively bidding" firms may also then have to surrender at least some of their "matter starts" to those firms that require them for existing clients requesting legal representation.

The MHLA asks everyone concerned with the provision of proper legal assistance to those subject to detention and compulsory medication to support us In particular:

1. Contact their local Member of Parliament. Many MPs are very sympathetic about the rights of those with mental health difficulties.
2. Contact local user groups such as within Mind to ensure they know about the problem.
3. Inform the Legal Services Commission and the Lord Chancellor, Kenneth Clark, of your concerns.
4. Let both the Mental Health Lawyers Association and the Law Society know what you are doing.

It has been said in the Cold War that what divided the civilised west from an uncivilised Russia was the proper legal review of those detained in psychiatric hospitals. This soon may no longer be possible in the UK.

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For better mental health

REPORT

Mental Health Alliance Briefing: the Mental Capacity Act 2005 Deprivation of Liberty Safeguards

April 2010 saw the first year anniversary of the Deprivation of Liberty Safeguards (DoLS). The DoLS scheme was introduced into the Mental Capacity Act by the Mental Health Act 2007. It allows care homes and hospitals to obtain a power to detain residents or patients who lack capacity if it is necessary in their best interests to protect them from harm and its purpose is to prevent their detention otherwise (except under the Mental Health Act) and promote less restrictive care.

In July the Mental Health Alliance issued a briefing by its DoLS lead Roger Hargreaves providing an initial review of implementation. This review identified some positive achievements but also revealed emerging concerns, particularly the large variations in use of the scheme, lack of understanding and lack of adherence to legal requirements.

First the positives. There is evidence of training, awareness and the authorisation process improving care and bringing greater focus on the individual service user. For example someone who had not been out of their care home for six months was now having regular trips out while others were benefiting from the involvement of a paid representative.

These gains were very uneven however. The Mental Health Alliance's estimation of variations in usage were borne out by official statistics for England released in July. These show that the rate of DoLS applications was much lower than expected (7,160 in England compared with 21,000 expected for England and Wales) although the rate of applications that were successful was higher than expected. There were big variations in usage between different parts of England; the rate of DoLS applications per authority ranged from 0 to 233, with some big differences between neighbouring authorities of similar size and demographic profile.

Although lack of applications can be attributed to providers successfully avoiding depriving people of their liberty – and in some cases this will be the reason – it is not a credible explanation for the whole of the variation. Two themes came up consistently in feedback to the Mental Health Alliance. One was lack of understanding of the Mental Capacity Act so that care staff did not know when they were exceeding their powers and needed to apply for DoL. There was a particular misunderstanding that things done in a person's best interests would not amount to a deprivation of liberty. Another problem was, in the absence of a definition, confusion over what in practical terms constitutes a 'deprivation of liberty'. Other reasons may include the bureacratic processes involved in DoLS and resistance among staff to believing that they may be depriving people of their liberty.

A Dear colleague letter from the Department of Health to Primary Care Trust chief executives reminded them that they "have a statutory responsibility for ensuring that no NHS care or treatment is offered without the necessary DOL safeguards in situations which amount to a deprivation of liberty".

Even when the process is invoked there are concerns that legal requirements are not always being adhered to. For example there have been instances of conditions not being complied with, of supervisory

bodies turning down applications without going through an assessment process, and of supervisory bodies not ensuring that assessors had skills and experience 'suitable to the particular case'.

These shortcomings are especially worrying when the safeguards in DoLS are so much less extensive than those of the Mental Health Act. A great deal hinges on the appointed representative who will often be a relative or friend. Initiating reviews and appeals is likely to be very difficult for friends and family, so it is important that they have access to Independent Mental Capacity Advocates (IMCAs) to support them through the process and recognise when legal processes are not being properly followed. However the appointment of IMCAs in cases where the representative is a friend or relative appears to be very low. The Mental Health Alliance recommends that appointment of an IMCA should be automatic unless the representative declines it.

There is also a concern that some authorities are not appointing family members who disagree with the deprivation of liberty. A Department of Health briefing issued in April reminded authorities that not being supportive of a deprivation of liberty is not of itself grounds for not selecting a family member as the 'relevant person's representative'. Other practice issues picked up in the briefing include the following:

- it is recommended that where a deprivation of liberty is taking place but the best interests assessor does not support it, managing authorities and supervisory bodies have a mechanism in place to bring the now unlawful deprivation of liberty to an end as swiftly as possible (this applied to about four per cent of applications in the first year)
- if a dispute with a family is not resolved by an authorisation it will require the last resort determination of the Court of Protection.

More information about the impact of DoLS should emerge from studies being carried out at the University of Cambridge. The Cambridge Intellectual and Developmental Disabilities Research Group is conducting two studies. One looks at the effectiveness of DoLS in safeguarding human rights and the other is about the interface between the Mental Health Act and Mental Capacity Act, including the characteristics of the groups treated under each regime. For further information about this project contact Isabel Clare at ichc2@medschl.cam.ac.uk

In conclusion, Mind wants to see these important safeguards properly used to minimise restriction in care and ensure that where it is used it is in the person's best interests and lawful.

Alison Cobb
Senior Policy Officer, Mind

For better mental health

ARTICLE

Section 117 aftercare and prescription charges

Section 117 of the Mental Health Act provides for free aftercare for psychiatric patients who have been detained under s3 or s37 (or transferred to hospital from prison) and discharged into the community. Aftercare services are not defined in the legislation. In Clunis v Camden and Islington Health Authority (1998), they were stated as including:

> "social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities."

The view of the Mind Legal Unit has always been that the fundamental purpose of aftercare is to support the patient by treating the underlying mental disorder and preventing relapse and consequent readmission to hospital. Medication should therefore be a basic part of the aftercare package and, in accordance with the ruling of the House of Lords in R v Manchester City Council ex parte Stennett (2002), should be provided free of charge.

Recently, however, we have discovered that the view of the Department of Health has been that once a patient has been discharged as a hospital outpatient into the care of his or her GP, the patient is expected to pay for their prescriptions, even if they are still eligible for s117 aftercare. Indeed, the Department of Health has confirmed in writing that they do not consider that medication is included in the aftercare services provided under s117 and, therefore, any medication dispensed by prescription should be charged for.

The Clunis case was concerned with accommodation, not medication. In Stennett, Lord Steyn identified "psychiatric treatment" as an aftercare service. Richard Jones states in his *Manual (12th Edition)* in regard to s117:

> "By virtue of the principle established in Stennett, medication provided by the Health Authority as an aftercare service is provided under this section and the National Health Service (Charges for Drugs and Appliances) Regulations 2000 do not apply."

Chapter 27 of the Code of Practice relates to aftercare and states that a thorough assessment of a patient's needs would include consideration of "continuing mental healthcare, whether in the aftercare community or on an outpatient basis." This clearly implies that medical treatment is an aftercare service and therefore should be provided free if s117 is applicable.

It is curious that the NHS regulations were amended to make it clear that patients subject to community treatment orders must be provided with their medication free of charge but this may have been a belt and braces exercise. In theory, if the Department of Health is correct in its view, a patient on a conditional discharge from ss37/41, or on extended leave of absence from s3, whose conditions include taking medication, might have to pay for it by way of prescription even though they are subject to recall. In our view the opinion of the Department of Health is incorrect and open to challenge. It seems to be more of

an administrative issue than anything else because medication dispensed from a hospital pharmacy is exempt from charge while medication dispensed by way of GP prescription has to be paid for. One way of dealing with the issue would be to add another exemption to charge on the reverse of the prescription form, to take into account the position of s117 patients. In addition, we see no reason why mental health patients, who often have long-standing conditions, should be treated any differently from patients with long-term physical illnesses, such as cancer, who may soon receive free medication in due course.

Request for information

We would be very grateful to hear from anyone who is being charged for medication even though they are entitled to free aftercare under s117. If you are aware of anyone in this situation please get in touch with us: legalunit@mind.org.uk

Michael Konstam
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RECENT CASE REPORTS

J v DLA Piper UK LLP

[2010] UKEAT/0263/09
Employment Appeal Tribunal
Underhill J (President)
15 June 2010

J was a barrister employed in a City law firm. She had suffered from depression (and been diagnosed as such by her GP) on and off for a number of years and had taken time off work. She had also been prescribed antidepressants and had received psychological support.

J decided to apply for a new job with the Respondent law firm and after the interview process was offered the job. She then disclosed her medical condition. The Respondent withdrew the job offer, stating that this was due to a recruitment freeze as a result of the credit crunch. J commenced proceedings for disability discrimination.

The Employment Tribunal dismissed the claim, deciding that at the material time J was not suffering from clinical depression amounting to a disability within the meaning of the Disability Discrimination Act 1995. The Employment Appeal Tribunal allowed the Claimant's appeal on two grounds:

1. That the Tribunal had declined to give weight to the evidence of J's GP because her GP was not a psychiatrist and therefore not an "expert"; and
2. The Tribunal had made a perverse finding on whether her depression could have amounted to a substantial adverse effect on J's ability to carry out normal day-to-day activities. This finding was relevant to the question of whether J had an impairment at the material time and whether the depression was likely to recur.

Accordingly, the EAT remitted the case back to the Tribunal but ordered a fresh Tribunal to be convened. The EAT upheld the approach in Godwin v Patent Office (1999) that each of the elements relating to the definition of disability should be taken in turn: is there an impairment, is there an adverse effect, is it substantial and is it long term. The requirement for a mental illness to be clinically well-recognised was repealed with effect from December 2005 and this was also discussed. The EAT explained that this obviated the need to diagnose a specific illness as it might not always be possible to do so. More importantly, the EAT confirmed that a pragmatic approach needed to be taken when considering the definition of "disability"; often the decision as to the impairment can be parked until the Tribunal has looked at the impact that the effects have on carrying out day to day activities and if there is clear evidence of adverse effect then it will not be necessary to examine the precise nature of the impairment (unless it is an excluded impairment). On the subject of GP evidence, the EAT was clear that this should be given due weight by a Tribunal when considering the effects that an impairment or condition have on a claimant, as the GP is often very well placed to carry out such an assessment. The Claimant sought to introduce a new claim on the ground that regardless of whether her condition in fact came within the definition of disability, the law firm had assumed that it was a disability and therefore J wanted to argue her case on the basis of perceived disability. The EAT refused leave to amend as any such request would need to be dealt with by the new Tribunal.

Comment

It is to be welcomed that the EAT emphasised the need for a pragmatic approach to be taken to assessing the definition of disability. It is somewhat surprising that the first instance Tribunal found against the Claimant when there was clear evidence that she suffered from depression and had not only been on medication but had also had psychological intervention and had taken time off work.

It should also be noted that the Claimant succeeded in obtaining an anonymity order to protect her against adverse publicity should she seek employment elsewhere.

Perceived disability claims are envisaged within the scope of direct discrimination claims brought under s. 13 of the Equality Act and it will be very interesting to see how this may apply to cases involving disability.

Michael Konstam (with additional material from Pauline Dall)
Mind Legal Unit

Rabone v Pennine Care NHS Trust

[2010] EWCA Civ 698
Court of Appeal
Rix LJ, Stanley Burnton LJ, Jackson LJ
21 June 2010

The Court of Appeal has dismissed the appeal by Mr and Mrs Rabone against the decision of the High Court (Simon J) that Article 2 of the European Convention on Human Rights was not engaged where a voluntary psychiatric patient took her life while on home leave.

Mr and Mrs Rabone's daughter, Melanie, had a history of suffering from depression and had attempted suicide on several occasions. She was an informal patient, having agreed to be admitted to hospital voluntarily following a suicide attempt. She was given home leave despite the concerns of her parents. On the day in question, she walked to her local park and, tragically, hanged herself.

The Rabones took proceedings for negligence and breach of Article 2, on the ground that the hospital had failed to take reasonable steps to prevent Melanie from taking her life.

With regard to the Article 2 claim, the Rabones relied on the Savage case, which held that Article 2 was engaged in relation to a detained psychiatric patient. They argued that the same principles should apply to a voluntary patient, as the risks associated with both types of patient were often indistinguishable. The same test should be used, namely, did the authorities know or ought they to have known of a real and immediate risk to the patient and, if so, did they take reasonable steps to prevent the death occurring.

The Court of Appeal rejected this argument and held that the position of a voluntary patient is different from that of a detained patient. Article 2 was not engaged in this situation and the appropriate cause of action was a claim in negligence.

Comment

We have been informed that Mr and Mrs Rabone have been granted permission to appeal to the Supreme Court. Mind is considering intervening in any appeal on the ground that the case raises significant issues of public importance.

We are mindful that the courts are reluctant to extend the scope of Article 2 (the van Colle and Smith cases are examples) but in many instances the position of a detained patient is no different to that of an informal, voluntary patient. This argument does, however, beg the question about the situation with regard to patients suffering from physical illnesses and also raises the concern about whether hospitals would be more likely to detain if they are to bear an Article 2 liability in any event.

Michael Konstam
Mind Legal Unit

GJ v The Foundation Trust and Others [2009] EWHC 2972

Family Court
Charles J

This case deals with the interface between the Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA), a relationship governed by complex provisions introduced into the MCA by the Mental Health Act 2007 in November 2008, and which came into force in April 2009, somewhat later than other MHA 2007 amendments. In circumstances where it might be possibly to apply either the MCA Deprivation of Liberty Safeguards (DoLS) or the MHA detention procedures, criteria for making a choice between the two procedures have now come under judicial consideration.

In this case GJ, an informal patient who had previously been detained, was assessed psychiatrically and socially for MHA purposes. The judge Charles J. concluded that he could fall within the potential scope of MHA 1983, i.e. was 'sectionable', because he met the criteria for detention under s.2 or 3. He needed treatment and care relevant to mental and physical conditions. He lacked the capacity to make treatment decisions but had refused insulin and tried to leave hospital on previous occasions. His actions indicated that he objected to treatment in hospital. The package of care for which a deprivation of liberty was considered necessary was treatment for diabetes, which he had refused on several occasions. Was it necessary to use the MHA in his case, as he was objecting to treatment?

The Judge made important statements concerning the relationship between the two procedures and examined the relevant provisions in some detail. The MHA 1983 was said to have 'primacy' over the MCA. This means that when MHA procedures are applicable, they should be applied in preference to the MCA DoLS. It should not be a question of the decision-maker picking and choosing between the two régimes. It had been the intention of Parliament that the MHA 1983 should be used when the grounds in s.2(2) and s.2(3) MHA are satisfied (the grounds for admission for assessment and treatment). The key underlying question for the decision maker is, what is the purpose of the deprivation of liberty – is it to provide treatment for the mental disorder, or symptoms of mental disorder, or is it to provide physical treatment for physical disorder?

The DoLS procedures cannot generally be used for anyone detained under MHA 1983, or liable to be detained. This may include a person who 'could' be detained, the determination of which would depend largely on the subjective judgment of the decision maker.

MCA 2005, Sched.1A specifies in greater detail those who are ineligible for DoLS:

- those currently detained in hospital under MHA 1983;
- those still liable to be detained because they are on leave from a detention section and a condition of leave is incompatible with DoLS because for example the DoL would require residence elsewhere than stipulated by the leave condition;
- those on a Community Treatment Order (CTO) in the community with a CTO condition incompatible with DoLS;
- those under MHA 1983 guardianship with an incompatible condition;
- those within the scope of MHA 1983 (i.e. an application could be made under s.2 or 3 and they could be detained in a hospital in pursuance of such an application if it were made) and objecting to treatment;
- if a person needs treatment for mental disorder in a hospital, s/he is objecting to the treatment, the proposed deprivation of liberty is for the purpose of allowing the treatment to take place, and s/he meets the criteria for detention under MHA 1983.

The correct approach when applying Schedule 1A, paragraph 5(3) was explained as follows in paragraph 132 of the judgment:

> "... the correct approach for the decision maker to take ... is to focus on the reason why P should be deprived of his liberty by applying a "but for" approach or test. And to do that he should ask himself the following questions, namely:

a) What care and treatment should P (who will usually have a mental disorder within the MHA 1983 definition) have if, and so long as, he remains in a hospital:

- For his physical disorders or illnesses that are unconnected to, and are unlikely to directly affect, his mental disorders (the package of physical treatment) and For
- (i) his mental disorders, and (ii) his physical disorders or illnesses that are connected to them and/or which are likely to directly affect his mental disorders (the package of treatment for mental disorder).

And then:

a) If the need for the package of physical treatment did not exist, would he conclude that P should be detained in a hospital, in circumstances that amount to a deprivation of his liberty. And then, on that basis
b) Whether the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of liberty, is his need for the package of physical treatment.

"If he answers part (b) in the negative and part (c) in the affirmative then the relevant instrument does not authorise P to be a mental health patient and the condition in paragraph 5(3) is not satisfied."

Charles J found that GJ was not being deprived of liberty for treatment of his mental disorder and that therefore he was eligible for DoLS procedures. The treatment for mental disorder and treatment for diabetes were different and separate, although both were promoted by the provision of nursing care and monitoring in a safe environment. It was concluded that he was not within the scope of MHA 1983.

It is important to establish whether the patient would need detention in hospital but for the need for physical treatment, and whether the only effective reason for detention is the need for physical treatment.

This case also suggests that a person subject to the MHA 1983 in the community, such as a supervised community treatment or guardianship patient, or a patient on s.17 leave, can be deprived of liberty under DoLS if he is not subject under MHA 1983 to any conditions conflicting with DoLS, such as a condition specifying where the person is to reside. It is likely therefore that DoLS could be used where, for example, the treatment is for a physical disorder even where the patient also has care and treatment needs relevant to mental disorder, or where the patient needs treatment for mental disorder but that this would take place in a setting other than a hospital.

Comment

Readers may be aware that this case has already been widely reported, for example, in the Legal Action journal and the Community Care Law Reports. However, given its landmark nature and as the first reported case to tackle this complex area of potential conflicts between the MHA and MCA Deprivation of Liberty procedures, we hope that a revisit to the case, with its useful revision and clarification of the vexed schedule 1A provisions, will have proved worthwhile. The case can be compared with that of W Primary Care Trust v TB and others [2009] EWHC 1737 (Fam), 17 July 2009, where the question for

determination was whether TB, a brain injury patient, was eligible for the DoLS procedures in order to receive a package of neuro-psychological and neuro-behavioural therapies, a plan which TB herself opposed. If she were 'within the scope of the MHA' she would have been ineligible for DoLS. However, the residential unit to which she was to be moved was not a hospital within s.34(2) MHA 1983, and a 'Mental Health Patient' within MCA Schedule 1A para 16 means a person who is accommodated in a hospital for the purpose of being given medical treatment for mental disorder. As she was not going to be in a hospital at the time of the proposed deprivation of liberty, she would not be a 'mental health patient', and therefore 'not ineligible', so that any deprivation of liberty would have to be authorised under the DoLS and could not be effected in any other way.

Joanna Sulek
Mind Legal Unit

MD v Nottinghamshire Healthcare NHS Trust

[2010] UKUT 59 (AAC)
UK Upper Tribunal (case on appeal from First-tier Tribunal)

This case concerns the question of whether 'appropriate medical treatment' (s.3(2)(d) MHA 1983) was available for a patient detained at Rampton Hospital. This was likely to have been the first occasion when the new statutory wording, which replaced the former 'treatability test' of s.3, was considered by the Upper Tribunal.

The patient MD was appealing against a decision of the First-tier Tribunal (Mental Health Tribunal) not to discharge him.

MD had a record of convictions, including indecent assault, supplying drugs, possession of firearms and shoplifting. In 2003 he was convicted on two counts of cruelty to children aged 3 and 5, including inflicting extensive injuries on them over a period of time. He was sentenced to 5 years' imprisonment.

In July 2006 he was transferred to Rampton Hospital under s.47 MHA 1983, and also subject to special restrictions under s.41 until December 2006, with the result that he continued to be detained in hospital at a time when he would have been released from prison.

He applied to the Mental Health Review Tribunal to be discharged in 2006, unsuccessfully, and applied again in 2007, which case was heard in February 2009, but by this time, jurisdiction had passed to the First-tier Tribunal. Again the Tribunal decided not to discharge him. MD applied for permission to appeal and this was granted in August 2009. The applicant was raising issues as to the interpretation of the criterion that medical treatment is available for the patient in s.72(1)(b)(iia) MHA 1983.

The Judge considered the relevant provisions. The conditions in paragraph (b) reflected the conditions for admission in s.3(2). Under subsection s.72(1), the Tribunal is under a duty to discharge the patient if it is not satisfied that one of the four criteria in paragraph (b) has not been met, but also has a power to do so - in other words, the subsection contains both a power and a duty to discharge.

The Judge also considered the definition of 'medical treatment' in s.145 MHA 1983:

> "medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care" (subsection 1)
>
> "Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (subsection 4)

This definition, stated the Judge, is inclusive but not exhaustive. Paragraph 4 provides that the test for medical treatment is its purpose, which is consistent with the 'basic distinction between containment and treatment" (para 14, judgment), and treatment is not defined by reference to its likely effect. The provisions define medical treatment but not the circumstances in which medical treatment may be available or appropriate. Medical treatment 'may be available without being appropriate, appropriate without being available, both or neither' (para15).

The Judge then quoted the MHA 1983 Code of Practice, Dept of Health 2008, Chapter 6, which discusses the appropriate medical treatment test. Paragraph 6.6 of the Code, in particular, emphasises that it should never be assumed that any disorders are inevitably untreatable, or that likely difficulties in achieving long-term and sustainable change in a person's disorder make medical treatment to manage the condition and behaviour inappropriate or unnecessary.

Para 6.3 goes on to state that the purpose of the medical treatment test is to ensure that no-one is detained for treatment unless they are actually going to be offered treatment for their mental disorder.

Medical treatment need not be the most appropriate that could be made available (para 6.12), but it must be an appropriate response to the condition and situation. It must also be actually available, rather than treatment that could be provided in theory (para 6.13). Depending on the circumstances, treatment may be appropriate even if it consists only of nursing and specialist day-to-day care (para 6.16); however, simple detention does not constitute medical treatment (para 6.17). A patient's unwillingness to co-operate with treatment will not of itself render that treatment inappropriate, and even psychological and other forms of treatment that require co-operation to be effective are not automatically inappropriate because a patient does not wish to engage with them. Such treatment remains appropriate and available as long as it is clinically suitable and would be provided if the patient were willing to engage with it (para 6.19).

The Judge then considered the status of the Code and the words of Lord Bingham in R (Munjaz) v Mersey Care NHS Trust [2006] 2 AC 148, who said that the Code does not have the same binding effect as a statutory provision, and is guidance rather than instruction, but it is guidance from which a hospital should 'depart only if it has cogent reasons for doing so ...' (para 21)

The Tribunal whose decision was the subject of the appeal had concluded that treatment for a personality disorder was long term and might only amount to nursing or specialist day-to-day care, and that therefore 'appropriate positive psychotherapeutic treatment' was available. Alternatively, the patient had been benefiting from specialist nursing care and 'milieu' therapy. 'Milieu' therapy is nursing and specialist day-

to-day care under the supervision of an approved clinician in a therapeutic environment with a structured regime.

The Judge did not accept the applicant's argument that detention without the reduction of risk is nothing more than containment. The treatment need not reduce the risk. It is sufficient if it will alleviate one of the symptoms or manifestations of the mental disorder, as long as it is appropriate.

In conclusion, the decision of the First-tier Tribunal held in February did not involve an error in a point of law and the appeal was consequently dismissed.

Comment

It may be helpful to read this case in conjunction with that of **DL-H v Devon Partnership Trust v Secretary of State for Justice** [2010] UKUT 102 (AAC), in which there was conflicting evidence as to whether the applicant had a mental disorder sufficient to justify his continued detention. The Judge heard evidence indicating that there is no demonstrably effective treatment for antisocial personality disorder, and that such treatment is still a matter for research. There may well arise a danger that 'a patient for whom no appropriate treatment is available may be contained for public safety rather than detained for treatment' (judgment, para 33). The Tribunal therefore has a duty to ensure that conditions for detention are satisfied, and make an individualised assessment for the particular patient. In that case, it was held that the Tribunal of the decision appealed against had failed to refer to important evidence, such as the assertion of staff that the patient was hostile to nurses and that there was no input from them unless the patient requested it, with nurses doubting that the patient was gaining any benefit from being on the ward. On this occasion, the Judge directed a rehearing by a new First-tier Tribunal.

Joanna Sulek
Mind Legal Unit

A Local Authority v Mrs A, by her Litigation Friend, the Official Solicitor and Mr A

[2010] EWHC 1549 (Fam), Court of Protection
Bodey J
24 June 2010

Mrs A was 29 years old and had been assessed as having a very low level of intellectual functioning. Medical evidence indicated that she suffered from significant learning difficulties and had an impairment of, or a disturbance in, the functioning of the mind or brain within the meaning of the Mental Capacity Act 2005 (the MCA). Her learning disabilities placed her at the lower end of 'mild' according to the International Classification of Diseases (ICD), 10th edition. She had been married to Mr A for two years at the time of the hearing (they married in 2008). She had already had two children removed at birth by the Social Services on account of concerns relating to her inability to care for them adequately.

Mr A had also been assessed with a significant impairment of intellectual functioning. Prior to her marriage Mrs A had been receiving regular support in the community from the Local Authority including arrangements for her to receive a monthly contraceptive depot injection and she had apparently

consented to this form of treatment. Some assessments of Mrs A's ability to cope with the prospect of childbirth and motherhood had shown that she had scant understanding of the processes of pregnancy and childbirth and that she responded to videos of these with fear, stating she did not wish to fall pregnant again, although she did not like the depot injections. It should be noted that this was in contrast to her earlier assertions that she regarded herself as a good mother and had at that time objected to the removal of her children. After her marriage, however, she had not consented to any contraception, because, as she explained, Mr A objected to it. Mr A discouraged any involvement by social services in the marriage, and the team supporting Mrs A were concerned about the absence of contraception and Mr A's reported physical abuse of Mrs A.

The Local Authority was applying for a best interests declaration from the Court that it would be lawful for them to arrange for the contraception to be given without her consent.

The Judge considered the question of whether Mrs A understood the information necessary to make the treatment decision, i.e. whether she satisfied the test for possessing the capacity to consent to, or refuse, the treatment in question, under s.2 Mental Capacity Act 2005 (MCA). Section 3 states that, for the purposes of section 2, a person is unable to make a decision for himself if he is 'unable … to understand the information relevant to the decision' (s.3(1)(a)), including information 'about the reasonably foreseeable consequences of … deciding one way or another' (s.3(4)(a) MCA). The Local Authority argued that she failed this part of the test because, although she understood that there was a risk of pregnancy without the use of contraception, she did not understand what caring for a child would involve. Bodey J rejected this argument. Indeed, it could be said that many women would fail to appreciate fully the reality of caring for a child before the actual fact, and, arguably, to have subjected Mrs A to the rigours of such an argument would have been to apply to her a test that many women might fail, risking "a move away from personal autonomy in the direction of social engineering" (para 63).

The difficulty with using the test of being able to appreciate the potential social consequences of giving birth to a child was that, to his knowledge, there had never been a case considering the test for capacity to consent to contraception, as opposed to other medical procedures. He accepted that contraception can be described as a form of medical treatment, but "the administration of contraception is different from any other medical procedure, since (leaving aside sterilisation) no other medical procedure, or the refusal of it, produces such significant social consequence [sic] as the potential creation of a child. So dicta from judgments which address the test for purely medical procedures lacking this feature, do not take the matter that much further." (para 59)

Use of this wider test would also create a risk of blurring the line between capacity and best interests (para 61), allowing the influence of a degree of subjectivity and the encroachment of paternalism. This would fly in the face of the "statutory embargo in s.1(4) [MCA] against finding incapacity on the basis that a given decision would be 'unwise'." (para 61)

In the Judge's opinion, the question for determination was whether Mrs A understood the "proximate medical issues" surrounding the use of contraception, such as what contraception operates to achieve, how it is used, the different types available and their advantages and disadvantages, and the side-effects and effectiveness of the different types. It was on the basis of this understanding that the Official Solicitor who was representing Mrs A in the proceedings, found that she did have capacity to decide whether or not to have contraceptive treatment, in contrast to the Local Authority's view. Bodey J found that Mrs A did possess adequate understanding of these issues, and it was therefore unnecessary to show if she understood what would be involved in bringing up a child or to consider the likelihood of any child that might be born being taken away from her care by the authorities.

There was, however, the question of whether she was 'unable … to use or weigh that information [the information relevant to the decision, or treatment information] as part of the process of making the decision …' (s.3(1)(c) MCA). The Local Authority's concern related to the degree of pressure to which Mrs A was being subjected by Mr A, flowing from his behaviour and attitudes, including domestic violence and bullying, for which there was evidence. Bodey J found that Mrs A's free will was overborne by the forceful behaviour of her husband, and the relationship based on a "completely unequal dynamic", with the result that "her decision not to continue taking contraception is not the produce of her own free will" (para 73).

The decision on the 'best interests' question – was it in her best interests for the contraception to be administered – was approached from the angle of how the contraception could be practically given in the face of Mrs A's objection. Hers was not, if the argument above, that the force of duress had annihilated her free will and so vitiated her power to consent, is to be accepted, an objection based on full capacity within the meaning of the MCA. In his opinion, it would be possible for the treatment to be administered by resorting to the use of force and anaesthetics, but such an option would not be acceptable. The only acceptable option would be to try and obtain a 'capacitated decision' from Mrs A to accept the contraceptive treatment, by holding discussions with her in circumstances where she would be free of excessive pressure from Mr A. Bodey J went on to justify his rejection of the possibility of using restraint techniques, saying that, in his view, this was "not one of those cases where there are felt to be risks to physical or mental health through pregnancy, childbirth, or the removal of a child".

As one commentator has pointed out, arguably, here was a missed opportunity to make full use of the MCA, which states that if an act in connection with the care or treatment of the incapacitated person P (s.5 MCA, 'a section 5 act') has the effect of restraining P, the act must be a proportionate response to the likelihood of P's suffering harm and to the seriousness of that harm (s.6 MCA). Here, the potential harm in question to be avoided would have been the physical harm flowing from pregnancy and childbirth, possibly exacerbating other serious health problems, and the emotional harm inflicted on Mrs A by the removal of her child once s/he was born. The MCA could have provided grounds for establishing that the granting of the order was in her best interests and that the contraceptive treatment could proceed lawfully.

It is, however, possible that this line of argument, had it been discussed, would not have been pursued by Bodey J. This is arguable because he found that, on the basis of Mrs A's intellectual functioning and learning difficulties alone, Mrs A would have had sufficient understanding of the treatment proposed to have capacity to refuse it, but that the factor vitiating her overall capacity to consent or refuse was the influence of Mr A and the possible duress and coercion inherent in their relationship, and this factor was treated as having more weight, for example, in considering whether treatment given by force would not merely be experienced by Mrs A as a further form of abuse, and whether the distress and after-effects produced would have outweighed other factors in the determination of what course of action would lie in her best interests.

Comment

We are indebted to an article by Jonathan Herring bringing this case to our attention, which appeared in the New Law Journal on 30 July 2010. The author also argues that there were several vital factors which were not accorded adequate weight in the course of judicial consideration, such as the great likelihood of harm stemming from the wide range of risks inherent in pregnancy and childbirth, the marginal benefits offered by pregnancy to Mrs A, the probability, on account of the abusive relationship in which she appeared to find herself, of the removal from her of any child or children who might be born to her and the emotional harm which that was likely to cause, and Mrs A's previously expressed consent to contraception prior to the supervening of Mr A's influence. Above all, a serious omission in the judgment

could be said to be the failure to consider the need to protect her human rights under the European Convention, in particular her rights to bodily integrity and protection from inhuman and degrading treatment, given the existing evidence that she was a victim of some degree of domestic violence.

It would seem likely that there was some feeling of uncertainty on the part of the judge, Bodey J, as to the seriousness of any abuse that might be taking place, the reliability of Mrs A's allegations in connection with the matter, and a feeling that this was not the proper place to explore the allegations further. The capacity issues were treated as the dominant theme for consideration and it is unknown what further steps were to be taken in respect of Mr A's alleged violent treatment of Mrs A.

Joanna Sulek
Mind Legal Unit

R (V) v (1) South London and Maudsley NHS Foundation Trust and (2) London Borough of Croydon

[2010] EWHC 742 (Admin)
Administrative Court
Wyn Williams J

This hearing concerned an application for habeas corpus on the grounds of procedural irregularity in an application for detention under section 3 MHA 1983.

The claimant, V, aged 42 and born in Singapore, had lived in the United Kingdom since the age of 11. He had been admitted as an in-patient in 2004 and 2005 to the Bethlehem Royal Hospital, for treatment of (unspecified) psychiatric illness(es). In June 2009 he was admitted again for assessment and was an in-patient for 2 weeks. On 31 December 2009 he was detained at the hospital under section 3 MHA, following application by the Local Authority. On 7 January the Trust relied on the provisions of section 5(2) (detention of a person already an in-patient), having reached the view that the section 3 admission was flawed and could not be relied upon. The section 5(2) detention, it was accepted by all parties, was to expire at 7.30 p.m. on 10 January 2010, and no other authority for detention existed.

Prior to that date, moves were being made to make an application for detention under section 3 MHA, although on 10 January, clinical records indicate that V had agreed to remain informally until reviewed by his community team the following day. On 11 January, the Local Authority Approved Mental Health Professional (AMHP) and a doctor attempted to perform an assessment on V, with which he refused to co-operate. The AMHP decided therefore to make an application for detention under section 3, and completed the relevant documentation. From that point onwards, V was detained, apparently under the powers of section 3.

The Judge considered the relevant provisions, including the statutory criteria for admission under section 3 of the Act, and section 6, which provides:

1. 'An application for the admission of a patient to a hospital under this Part of this Act duly completed in accordance with the provisions of this Part of this Act shall be sufficient authority for the applicant or any person authorised by the applicant to take the patient and convey him to the hospital at any time within the following period...

2. 'Where a patient is admitted within the said period to the hospital in such an application ... the application shall be sufficient authority for a manager to detain the patient in a hospital in accordance with the provisions of the Act.'

Section 6(3) concludes that any application for admission under Part II of the Act 'which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon ...'

Section 11(4) states further that an AMHP may not make an application for admission for treatment (a s.3 application) if the patient's nearest relative has notified the AMHP that he or she objects to the application being made, or the AMHP has not consulted that person, 'but the requirement to consult that person does not apply if it appears to the professional that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay.'

It was accepted by the parties to the action that the AMHP failed to consult V's nearest relative before she submitted the s.3 application. She knew that the claimant's nearest relative was his mother, and attempted to telephone his mother before completing the application. However, on failing to find the mother at home, she left a message with the claimant's father requesting that the mother contact her upon her return. The AMHP in her evidence claimed that this conversation occurred between 1.30 and 2.00 pm on 11 January 2010. The AMHP tried ringing again but still did not find the mother at home. By this time, according to her, it was now 2.30 p.m., so she decided to proceed with the section 3 application. She completed the form and handed it to the ward nurse, and from this moment, V was detained under section 3 of the Act.

The AMHP left her office to attend to other business and returned, it is thought, at approximately 4.00 p.m., where she found a message from the claimant's mother. She telephoned her and was able on this occasion to speak with her directly, confirming that the mother did not object to the admission of her son.

The written notes, however, indicated that the section 3 application on 11 January was received by the ward nurse at 12.15 p.m., somewhat earlier than was indicated by the AMHP in her evidence. The admission papers completed by the AMHP indicated that she believed that authority to detain V under section 5(2) was to expire at 7.30 p.m. later that day. The Judge emphasised that the AMHP was entitled under s.11(4) to proceed with a s.3 application without consultation of the nearest relative if it appears to him or her that the circumstances are such that consultation would involve unreasonable delay. Those circumstances "can only be those which are known to the professional or believed by the professional to subsist" (para 33 of the judgment). This test was, therefore, a subjective one, according to the dicta of Mr Justice Burnett in the case of **GD v The Hospital Managers of the Edgware Community Hospital and Another** [2008] EWHC 3572 (Admin), who stated that the Court would not normally interfere with the application of this subjective test unless, for example, the social worker had failed to apply the legal test in s. 26 MHA [which sets out criteria for determining the identity of the nearest relative], or "acted in bad faith or in some way reached a conclusion which was plainly wrong" – i.e. would interfere with a decision only on "well-recognised public law grounds" (para 41 of that judgment).

Judge Wyn Williams concluded on the basis of these dicta that he should interfere with the decision made by the AMHP in this case only if she was plainly wrong, and in his judgment, she was. She was acting on the basis that the claimant would be lawfully detained until 7.30 p.m. that evening and yet decided at 12.15pm that no consultation with the nearest relative would take place for the reason that this would cause unreasonable delay. As he continued, "... such a decision was not open to a reasonable decision-maker and was plainly wrong on the facts" (para 36, judgment), a comparatively harsh judgement on her decision, but one which, in his view, was justified. He was "left with the strong impression that ... [the

AMHP] ... took the view that she would make the application in the absence of consultation because she believed that the claimant's mother would consent." (para 42, judgment)

The AMHP was not acting unreasonably in assuming that the claimant's mother would consent to the admission, as she had consented in the past. However, that was not the point. As consultation is an appropriate safeguard in this statutory procedure, an AMHP should not make assumptions even if they appear to be justified assumptions about what the result of the consultation would be.

For reasons already elucidated in the judgment, therefore, the decision made by the AMHP shortly before 12.15 p.m. that day to make the s.3 application was "plainly wrong in the circumstances as were known to her and as she believed them to be" (para 43). Even the fact that her decision was partly based on misinformation did not redeem it from being thus plainly wrong, as it would have been plainly wrong even had the facts been as she understood them to be.

Finally, since this was an application for habeas corpus, there was no question of any discretionary withholding of relief, as "once the illegality has been identified then – certainly in the vast majority if not all cases – the remedy should be granted" (para 44). An application for damages under s.139 MHA on behalf of the claimant V was rejected, as was the defendant's request for leave to appeal, although it was left open to the defendant to seek leave to appeal in the Court of Appeal.

Joanna Sulek
Mind Legal Unit

NOTICEBOARD

Care in Crisis: an inquiry into acute mental health services

From Mind Policy and Campaigns:

Is crisis care working? Mind's Care in Crisis campaign is calling for evidence to be submitted to its independent inquiry investigating the state of acute and crisis mental health services. This includes all adult in-patient care, crisis resolution teams, crisis houses and alternative approaches.

Mind will use this evidence to campaign for improved care across all adult acute and crisis mental health services in England and Wales.

Service users, carers, staff, advisers, lawyers, advocates, tribunal members, commissioners and researchers – the independent inquiry team wants to hear about your experience, knowledge and ideas.

You can complete the Care in Crisis inquiry survey online, or write to Alison Cobb, Senior Policy and Campaigns Officer, Care in Crisis, Mind, Freepost (WD 2336), London. E15 4BR or email action@mind.org.uk. The deadline for submitting evidence is **17 November 2010**.

Get involved, give evidence and help us fight for improved acute mental health services.

Mind’s Legal Unit has received the following request:

Appeal for Feedback on Community Treatment Orders

Dear Readers,

I am currently undertaking qualitative research with Professor Mick Carpenter in the Department of Sociology at the University of Warwick, about Community Treatment Orders (CTOs).

The aim of the research is to consider the effects of some of the changes that have been brought about by the Mental Health Act 2007 and what this means for people receiving mental health care in the community. Part of the research includes the use of these CTOs in practice - taking into account the views of service users as well as medical, nursing, social care and legal professionals. If you would be willing to answer a few questions about the use of CTOs, I would be grateful if you email me at Bthakrar@hotmail.com so that we can get in touch with you.

Alternatively any comments about your experience of the use of CTOs, looking in particular at the following issues, would be gratefully received by email:

1. What benefits, if any, have you seen or experienced from the use of CTOs?
2. What problems, if any, have you seen or experienced from the use of CTOs?
3. What type of conditions, if any, have been attached to CTOs?
4. How often are CTOs reviewed and by whom?
5. How long have you seen or experienced CTOs to last?
6. Do you think that CTOs provide an effective form of support and care for service-users? If yes, how so? If not, why not?
7. Do you think that CTOs are an effective way of protecting a patient’s health or safety or the protection of other persons? Why?
8. Any other comments you may have.

Any responses would be treated as entirely confidential in any write-up, and people’s identities kept anonymous. We would convert emails to text files to be kept in a secure place accessible only to ourselves and permanently delete the emails.

Bindya Thakrar and Mick Carpenter
Bindya Thakrar is currently a Trainee Solicitor

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