

Mental Health

April 2010

Welcome to this, the third edition of Weightmans mental health newsletter.

If it has themes, the first is restricted patients. Georgina Rowley writes about a Court of Appeal case that might entitle more of them to welfare benefits, while Sallie Harrington reports on a decision about recall from conditional discharge and just how much say a patient's doctor should be given. And then there's the prison-to-hospital transfer: as Simon Charlton points out, a recent case turned on the question of 'treatability' (hands up: who thought that question disappeared when the 2007 Act came into effect?).

A second theme might well be police powers: limits have been placed on the use of 'life or limb' concerns to justify entry without a warrant, and it seems the police are becoming very fond – some might say too fond – of the MCA. Elsewhere, Emma Galland writes about a new nearest relative case and Sallie Harrington comments on the Law Commission's ongoing consultation on the reform of adult social care law.

The third theme of this edition might well be liberty. As far as the DoLS are concerned, I have written – again – about the comparatively small number of authorisations, and in a second article, I consider the limits of the code of practice. And a final article of mine looks at the practice of self-harm minimisation, and whether a legal basis can be found for it. This is something that has been much on my mind of late, not least because I have taken part in a new film on the subject and it will shortly be due for release. I'm hopeful that the film, and maybe even my article, will provoke a few thoughts.

In closing, I should like to extend my thanks to the editors of the *Solicitors Journal*, *Jane's Police Review* and the *New Law Journal*, in which versions of some of the articles here first appeared, for their continued support. And I should also like to thank our growing band of readers for taking the trouble to engage with us and the issues that concern us. Please do keep those e-mails coming.

David Hewitt, Partner

Newsletter



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The Law Commission's consultation on adult social care will run until 1 July. It comes amid growing calls for significant change.

Feeling the benefit

A life sentence-prisoner whose tariff expires will be entitled to welfare benefits, even if he is detained under the Mental Health Act at the time.

The Court of Appeal has recently looked at the benefits entitlements of some Mental Health Act (MHA) patients. The patients concerned are those detained under sections 45A and 47 whose sentence 'tariff' has already expired, and the chief question was whether the Social Security (Hospital Inpatient) Regulations 2005 treat them less favourably than other patients, including those detained under a mere Hospital Order (**R (RD and others) v Secretary of State for Work and Pensions** [2010] EWCA Civ 18).

The Court held that the regulations had been drafted with the intention of excluding serving prisoners from means-tested benefits. The distinction between section 37-patients and other patients detained under hospital orders is that in the case of the former, the hospital order is an alternative to imprisonment and they cannot be transferred to prison when their treatment is at an end. Consequently, the regulations do not treat those subject to section 37 as prisoners, but as patients. The position is different where a patient has been placed under section 45A of the MHA or transferred to hospital under section 47: he may be transferred to prison and, the court held, is therefore to be regarded as a prisoner for all purposes, including that of benefit entitlement.

But what of post-tariff life-sentence prisoners who are detained in hospital. Given that the tariff portion of their sentences has expired, are they entitled to welfare benefits? It seems they are.

The starting-point is regulation 2(4) of the Social Security (General Benefit) Regulations 1982, which states that a prisoner will become entitled to benefits at the date upon which he might have expected to be discharged from detention. (In the 2005 regulations, paragraph 2A of Schedule 7 says much the same thing.) Although a 'lifer' can have no expectation of complete discharge, he might be released from custody once he has become eligible for parole. But if at that point the prisoner is receiving treatment in hospital under the MHA, he will only be able to apply for parole when (and if) he is returned to prison. Does that mean that he is to be denied benefits until that point? The court said not. It held that a patient's eligibility for release would arise when the Parole Board could first direct his release – in other words, at the end of the tariff period. Consequently, a prisoner would be eligible for means-tested benefits once his tariff had expired, even though he was detained in hospital under the MHA at the time.

This decision is unlikely to affect very many MHA-patients, but those to whom it does apply are likely to feel a significant benefit.

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The full judgment in this case may be found here: <http://www.bailii.org/ew/cases/EWCA/Civ/2010/18.html>



The importance of procedure

Where the law requires reports from doctors, it is they, and they alone, who must provide them.

That, at least, was the finding of the High Court in a recent case concerning DK, a man who was imprisoned in November 2001, having been convicted of three offences of violence (**R (DK) v Secretary of State for Justice** [2010] EWHC (Admin) 82). DK's release date was 29 August 2008. In April 2006, however, he was transferred to Broadmoor Hospital under section 47 of the Mental Health Act 1983, so that he could be treated for psychopathic disorder. On 12 July 2007, a Mental Health Review Tribunal decided that DK could be discharged from hospital, a decision that would have seen him returned to prison.

The Tribunal was not satisfied that the 'treatability test' had been met in DK's case; it felt that, in part because of his own failure to co-operate, he had not received any treatment that assisted his condition. For his part, DK wished to ensure that he *was* returned to prison, so that he could qualify for release on a particular date, rather than being detained in hospital indefinitely.

Once DK was back in prison, it became clear to the doctors treating him that he was suffering from psychopathic disorder, and the possibility was mooted of his being returned to hospital. The psychopathic disorder alone would not suffice, of course: for any transfer to be warranted, hospital treatment would have to be likely to "alleviate or prevent a deterioration" of DK's condition, and the Secretary of State would have to be satisfied that that was the case on the basis of reports from at least two registered medical practitioners.

This 'treatability' issue had been recognised as crucial by the Ministry of Justice, and a report was commissioned that confirmed that treatment would prevent further deterioration of DK's condition. That report was based on the views of a Dr Ross, a registered medical practitioner, and a Dr Walker, who is a psychologist.

In his judgment, Mr Justice Collins carefully examined the relevant provisions of the Mental Health Act, and he reviewed the forms used when a patient becomes a prisoner (and *vice versa*). The judge noted that alongside Doctors Ross and Walker, three registered medical practitioners had produced reports, but that none of them had explicitly dealt with the question as to whether DK was treatable. Thus, only one registered medical practitioner – Dr Ross – had addressed the 'treatability' issue and the correct procedure had not been followed.

It was held, therefore, that the Secretary of State's decision once again to return DK to Broadmoor had been unlawful. Collins J found that if DK had not been detained in hospital, he would have been released from prison on 31 August 2008, and his license would have expired at the end of June 2009. The judge therefore ordered that DK be released forthwith. (It is apparent from the note of exchanges between the judge and DK's barrister that, because of his ongoing mental disorder, DK was to be detained afresh immediately upon his release, this time under section 3 of the Mental Health Act).

The exact circumstances of this case are unlikely to repeat themselves, not least because, as from November 2008, it is the *availability* – rather than the *taking of* – treatment that is material to the question whether an individual should be detained under the Mental Health Act. This is, nevertheless, a cautionary tale for those who do not adhere to the relevant procedures, especially when the liberty of an individual turns upon their decisions.

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The full judgment in this case may be found here: <http://www.bailii.org/ew/cases/EWHC/Admin/2010/82.html>

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Perfect recall?

In some cases, conditional discharge may be brought to an end without up-to-date medical evidence.

The High Court recently considered the process for recalling a conditionally discharged patient to hospital, and whether it requires the Home Secretary to consult with the relevant clinician (**R (Munday) v Home Secretary** [2009] EWHC (Admin) 3638).

The case concerned a restricted patient, Mr Munday, who was conditionally discharged from Rampton Hospital in 2005. His behaviour subsequently deteriorated, and in 2008, he was recalled to hospital. He claimed that the Home Secretary had failed to seek medical advice, had acted contrary to such medical advice as there was and had issued his recall warrant without sufficient reason. (The events of this case pre-date the amending of the Mental Health Act, and references to the patient's 'Responsible Medical Officer' should therefore now be read as being to the 'Responsible Clinician').

The Home Secretary had been notified that Mr Munday had been arrested for (though not charged with) arson. He had spoken to the Responsible Medical Officer (RMO) by telephone, but neither had kept a contemporaneous note of the conversation and each had a different understanding of what was said.

The court accepted, however, that although the RMO was initially reluctant, the Home Secretary did not understand him to object to recall. Subsequently, the matter was referred to the Mental Health Review Tribunal and the RMO wrote a report, indicating that he did not consider the arson allegations sufficient to justify recall. The tribunal decided to re-instate Mr Munday's conditional discharge.

Although the Mental Health Act does not say how the Home Secretary should go about exercising the power of recall, there are several cases on the point. In **K v United Kingdom** (1998), it was suggested that up-to-date medical evidence always be sought, while in **R (MM) v Home Secretary** (2007), the Court of Appeal said it was hard to imagine that the Secretary of State would not seek advice from a patient's RMO.

Here, it was agreed that the decision to recall Mr Munday could only be challenged if it was '*Wednesbury-unreasonable*' (in other words, if no reasonable Home Secretary could have made it). Adopting the approach taken in *MM*, the High Court said:

- The Home Secretary should consider the last tribunal decision and ask whether there has subsequently been such a material change of circumstances that the detention criteria are now satisfied. If not, it will be hard to justify recall.
- It is appropriate to seek up-to-date medical evidence before recalling a patient to hospital. Here, however, the RMO did not question recall on medical grounds, but because he did not believe the allegation of arson provided sufficient justification.
- On that basis, the Home Secretary's decision had not been unreasonable.

Where recall is in prospect, therefore, it seems clear that although up-to-date medical evidence will often be appropriate, decisions as to risk won't always demand it.

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I know what you're thinking

Where a patient is to be detained under the Mental Health Act, professionals should not make assumptions about the views of his nearest relative.

That was the decision of the High Court in a recent, and so far unreported, case concerning V, whom it was planned to detain under section 3 of the Act (**R (V) v South London and Maudsley NHS Foundation Trust**, Queen's Bench Division (Wyn Williams J) 8 February 2010).

V had already been detained under section 3, but the relevant hospital trust was not satisfied that his detention was lawful. He was therefore brought within section 5(2) of the Act, which, of course, allowed for him to be detained for up to 72 hours. The day after this period had expired, V was reviewed by an Approved Mental Health Professional (AMHP) and a doctor, a process with which he refused to co-operate. The AMHP made an application for V to be detained under section 3 once again, but in completing the requisite form, erroneously stated both that V was currently detained under section 5(2) and that his nearest relative was not known to her. At trial, the AMHP said that, notwithstanding the form, she had unsuccessfully attempted to contact the nearest relative before making the detention application.

The court upheld V's challenge to his detention. It referred to section 11(4) of the Mental Health Act, which provides that an AMHP may not make an application for treatment without consulting the nearest relative unless it appears to the AMHP that consultation is not reasonably practicable or would involve unreasonable delay. The court said this must relate to circumstances known to, or believed by, the professional at that point-in-time. Although V's detention under section 5(2) had expired, and his detention had become even more urgent, the AMHP had not been aware of this and so, the court found, she could not rely on section 11(4) and claim that consulting the nearest relative would cause an unreasonable delay.

The AMHP suggested that in any event, the section 3 application was lawful even without consultation, because the nearest relative had consented to detention in the past and it was reasonable to infer that she would have done so now (the nearest relative confirmed that if she had been consulted, she would not have objected to the patient being detained). The court did not agree. It said consultation with the nearest relative is a necessary safeguard and it is not appropriate for any professional to make assumptions as to that person's views.

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Can you smell gas?

It might be possible to enter premises without a warrant, but ‘welfare concerns’ aren’t a good enough excuse.

Although it may be possible under PACE to enter premises so as to protect people or property, that won’t be so where a constable’s only concern is welfare. That is the lesson of a recent case, in which a man who spat at one constable and head-butted another was found not to have assaulted them in the execution of their duty (**Syed v DPP**, Divisional Court, 13 January 2010).

The relevant provision is section 17(1)(e) of the Police and Criminal Evidence Act 1984, which says that a constable may enter premises for the purpose, amongst other things, “of saving life and limb or preventing serious damage to property”. Last year, the Divisional Court said this power would cover protecting someone from themselves, as well as from someone else, but that in ‘life and limb’ cases, it can only be used where a constable reasonably believes serious bodily injury is imminent (**Baker v CPS** [2009] EWHC (Admin) 299).

Here, the situation was not sufficiently serious to justify the use of PACE. Two constables had attended Mr Syed’s house following reports of a disturbance. He claimed to have been arguing with his brother, but became evasive when questioned further. The constables told Mr Syed that under section 17, they could enter his house if they were in fear for the welfare of anyone there. Mr Syed did not accept that this was so, and he reacted in the way that led to the charge.

The magistrates convicted Mr Syed, but the Divisional Court took a different view. It said section 17(1)(e) was clear: there would be a right of entry without warrant only where something serious had occurred or was in prospect. Here, there was no sign that anyone on the premises had been injured (or any property damaged) and Mr Syed’s explanation had not been contradicted. The threshold applied by the constables – concern for welfare – was too low. When entering the premises, therefore, they had not been acting in execution of their duty, and whilst Mr Syed might have acted improperly, his conviction could not be allowed to stand.

Though colourful, these circumstances might not be typical. Certainly, the section 17 power is sometimes invoked in the case of people with mental disorder, where a warrant has not been obtained under section 135 of the Mental Health Act and, because all concerned are on private premises, section 136 will not permit an arrest. Understandable though it may be in such circumstances for constables to ‘smell gas’, they should ensure before invoking PACE that what they wish to guard against really is serious harm.

The full judgment in this case may be found here: <http://www.bailii.org/ew/cases/EWHC/Admin/2010/81.html>

Home, sweet home?

The DoLS are unpopular and under-used, but their complexity may be only part of the problem.

For over a year, many hospitals and care homes have had the power to deprive people of their liberty. That is the result of the DoLS – the Deprivation of Liberty Safeguards.

The government prefers to see the DoLS as protection: a way of preventing the arbitrary detention of the old and the incapable. It is certainly true that the DoLS were introduced to fill a gap in the law; a gap rather embarrassingly revealed by the European Court of Human Rights (ECtHR) in the 2004 case of **Bournewood v United Kingdom**. Presumably, therefore, it would be a cause for concern if the new safeguards were not being used.

The government had forecast that by now, around 21,000 people would have had their cases assessed under the DoLS and a quarter of them would have been brought formally within the safeguards. But that hasn't happened.

- The number of people brought within the safeguards is only around a third of the predicted number.
- Of the more-than-300 local authorities and PCTs charged with implementing the safeguards, a large number claim to have had very few DoLS cases.

So, what is going wrong?

The powers given by the DoLS are not unfettered: they can only be used with prior permission from a PCT or a local authority. That in itself is controversial, given that it means that decisions about people's liberty are now being taken by what are, with the greatest respect, administrative bodies. One problem in the **Bournewood** case was the patient's lack of ready access to a court, and although the Court of Protection remains a long-stop, that problem might not have been solved by the DoLS. It is perhaps surprising that the Daily Mail hasn't shown more interest.

Furthermore, the procedure for seeking DoLS permission is complex and bureaucratic – many would say unnecessarily so. It can take up to three weeks and involves several lengthy forms, six separate assessments and, usually, at least one psychiatrist and a social worker. Maybe that is what has made the procedure unpopular.

There are also broader problems with the DoLS, not least the fact that because of the way they are drafted, they might not even apply to the patient whose case led the ECtHR to do what it did. Furthermore, a recent decision of the House of Lords in a public order case might mean that there is no one – not a single patient with a learning disability or little old lady with dementia – to whom the DoLS apply. Maybe that explains the figures.

And there is also great uncertainty about precisely when the DoLS apply, reflecting similar uncertainty about just what it means to be deprived of liberty. Surprisingly, given its importance to what are, after all, the *Deprivation of Liberty Safeguards*, the term is not defined, either in the DoLS or in the slim code of practice that accompanies them. And now, there is growing anecdotal evidence that practitioners are taken wildly divergent views. That is unfortunate, both in itself and for a further reason: the statistics suggest that where a request for DoLS permission is refused, the commonest reason is that the patient was not deprived of liberty. If that conclusion was reached in error, permission is being refused where in truth it should have been granted, and a vulnerable person is being unlawfully detained.



But there might be another, perhaps related, explanation for the low take-up of the DoLS: that in some – quite a few, in fact – parts of the country, applications are being actively discouraged. That would be very worrying, and not just because public bodies would be failing in their duties. Hospitals and care homes too would be placed in jeopardy. Where permission is required to deprive an incapable person of liberty, the failure to obtain it will be unlawful and that one was discouraged from seeking it will be no defence.

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The most recent DoLS statistics may be found here:

<http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/mental-health-act/quarterly-analysis-of-mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-quarters-1-to-3-2009-10>

Scaled down

Liberty is important, not least for the safeguards that take its name, but what does the word mean?

The Deprivation of Liberty Safeguards (DoLS) are intended to protect incapable people admitted to hospitals or registered care homes. As the title suggests, they say that permission will be required before such people can be deprived of liberty. Given the importance of the notion, you might imagine that ‘deprivation of liberty’ is carefully explained. It isn’t: the DoLS use the term but don’t define it, and the accompanying code of practice says little that is original. In fact, the code simply restates the existing law, which might be where the problems begin.

The DoLS seek to remedy defects identified by the European Court of Human Rights (ECtHR) in the *Bournemouth* case. Those were defects in the common law, which the court said was too vague and too lacking in procedural safeguards to give many incapable people the protection demanded by the ECHR (**HL v United Kingdom** [2004] 40 EHRR 761).

The defects would only be apparent where Article 5 of the Convention was engaged; where, in other words, someone was deprived of liberty. The ECtHR said, “the starting-point must be the concrete situation of the individual concerned”, and that in deciding whether a particular intervention deprives someone of liberty, “account must be taken of a whole range of factors arising in a particular case[,] such as the type, duration, effects and manner of implementation of the [intervention] in question.” Crucially, the court said the distinction between deprivation of liberty, which will engage Article 5, and a mere *restriction upon* liberty, which will not, “is merely one of degree or intensity and not one of nature or substance” (**HL v United Kingdom**, above, paragraph 89). These words have proved extremely resonant.

The DoLS code draws heavily upon *Bournemouth*. Noting the comments of the ECtHR on the crucial distinction, the code says: “It may therefore be helpful to envisage a scale, which moves from ‘restraint’ or ‘restriction’ to ‘deprivation of liberty’. Where an individual is on the scale will depend on the concrete circumstances of the individual and may change over time.”

There are, however, several problems with the ‘scale’ theory of deprivation of liberty. The first concerns its range: rather than with ‘restriction of liberty’, which surely comes some way along, shouldn’t the scale begin with ‘liberty’ itself?



Logically, of course, there must be a number of points on the scale, each one representing a particular intervention in a patient's life, from those that represent only a slight diminution of liberty to those that approach deprivation of liberty. But the number of possible interventions is not fixed; new ones might be made from-time-to-time, and any of them might be modified in numberless ways. The second problem, therefore, is that we can never know precisely how to populate our scale. Imagining, as it seems we must, that the poles represent complete liberty and its deprivation, where on that scale are the various interventions to be placed, and, crucially, where in relation to each other? Is putting someone in a low chair closer to deprivation of liberty than to liberty, for example, and how does it stand in relation to shepherding someone away from an open door?

The third problem relates to something else said by the code: when deciding whether someone is deprived of liberty, we might ask "does the cumulative effect of all the restrictions ... amount to a deprivation of liberty, even if individually they would not?" This begs an obvious question: if all we have is the scale, on which single interventions are placed side-by-side, how are we to take account of the aggregate of two or more of them? How, in fact, are we to aggregate them at all, and even if we succeed in doing so, where precisely are we to place the aggregated intervention? Is shepherding someone away from an open door closer to deprivation of liberty than putting him in a low chair *and* reducing the length of his visits from friends? How will the scale help us decide?

Finally, of course, there is a problem inherent in the very notion of a scale. All it does is display subtle progressions between two points, so it cannot help us with the DoLS. The knowledge that the use of 'baffle locks' tends rather more to the right-hand end than to the left is worthless. When what we most require is a 'yes/no' answer, the scale is deliberately designed to yield no such thing.

If, as seems to be the case, there is widespread confusion about what it means for someone to be deprived of liberty, the Code of Practice only serves to compound the problem. It advances a 'scale' theory that is both logically and logistically flawed, and in so doing, it misrepresents the problem it purports to have solved.

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The DoLS Code of Practice may be found here

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Self-harm minimisation and the law

There's a limit to how often you can counsel caution – whether you're a nurse or a lawyer.

Kate is approaching middle age and for much of the last 25 years, she has cut herself. There are proud weals, and also fresh, livid scars, on her arms and thighs. What she does might be about control or exhilaration; it might have its roots in abuse or even mental disorder. It certainly makes other people uneasy.

Kate is a cipher, of course; someone to stand for the 170,000 people who are said to attend A & E every year after deliberately harming themselves. Sometimes, she finds sympathy there and a comforting word. More often, her wounds are stitched up disinterestedly and maybe, as some kind of lesson, without anaesthetic. Occasionally, Kate even finds herself being detained under the Mental Health Act.

Lately, though, something has begun to change. It seems to Kate that the nurses and doctors are less quick to condemn, and some have even begun to say that to prevent her cutting herself might actually compound the problem. None has gone so far as to hand Kate a razor, but she has been told which part of her body is safest to cut, and she has been given both privacy and sterile dressings. There is a name for that approach: self-harm minimisation.

Until recently, anyone practising such an approach did so in a vacuum, with little to guide them. Little, that is, but the still, small voice that counsels caution, but that might equally ask whether there isn't a better way of doing things.

Now, the position is a little surer. In 2004, the National Institute for Clinical Excellence published guidance that put minimisation alongside other techniques practitioners might choose to discuss with their self-harming patients. This was a modest start, but two years later, at its annual congress in Bournemouth, the RCN gave self-harm minimisation qualified support. Meanwhile, pilot projects supported by the Department of Health have been underway in Stafford and Newcastle.

There is, undoubtedly, something unsettling about self-harm, and, for the lawyer, about any intervention that seeks to do something other than prevent it entirely. But should such an intervention be viewed any differently from surgery, physiotherapy or the giving of medicine? How does it differ from handing our syringes and needles to drug-addicts?

It seems likely, in fact, that self-harm minimisation falls within accepted notions of 'medical treatment', which Lord Denning once defined, rather broadly, as "the homely art of making people comfortable and providing for their well-being". What matters, surely, is that any intervention satisfies the '*Bolam* test'.

That, of course, is the standard test for health care negligence (and for many other forms of negligence besides). To be lawful, an intervention, or a failure to intervene, must be consistent with a practice accepted as proper by a responsible body of relevant opinion. Doctors and nurses, in short, are to be judged by the standards of their peers.

When deciding whether self-harm minimisation was lawful, a court might consider how well the patient's background – and in particular, any history of self-harm – was researched, and how well understood; how carefully her needs were considered; and how closely those needs corresponded to the intervention that was made. An intervention might be least difficult to defend where a patient had tried to harm herself before and had done so in a fairly consistent way and to a fairly consistent degree. The NICE guidance said much the same thing.

There is no guarantee, of course, that an intervention – or the decision to use self-harm minimisation in the first place – would comply with *Bolam*. Now, however, we need no longer assume that it would not.

Even where they favour self-harm minimisation, those who encounter Kate will tread cautiously. That would be sensible, for the law is particularly suspicious about anything new. It has long recognised, however, that the requirements of the *Bolam* test cannot be allowed to impede clinical progress.

There is, of course, a danger for advocates of self-harm minimisation: if they get what they want, they will raise the expectations of Kate and many thousands like her, and those raised expectations will be difficult to manage. As all clinical innovators have found, every attempt to devise or even discuss an appropriate level of care runs the risk of elevating that level even higher.

And the still, small voice persists: how can it be lawful to help someone cut – or burn or bruise – themselves? It would be understandable if lawyers faced with that question gave the advice they would have doctors and nurses give to their patients: don't do it. Yet, that is an unimaginative response, and it is also becoming an irrelevant one. In far too many cases, it neglects the realities of the situation as surely as a nurse who does no more than scour a patient's bedroom for sharps.

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The NICE guidance may be found here: <http://www.nice.org.uk/nicemedia/pdf/CG16FullGuideline.pdf>

It's not just what's expedient

The protection given by the Mental Capacity Act is different from the power contained in section 136 of the Mental Health Act.

Some police forces have leapt very eagerly upon the Mental Capacity Act (MCA); so eagerly, in fact, that they have begun to use it in preference to the Mental Health Act. That might be a perilous course.

Section 5 of the MCA gives all manner of people the power to provide care to an incapable person. It seems it is now being used to take people to hospital who appear to be suffering from mental disorder.

That is already covered by section 136 of the Mental Health Act (MHA), of course, provided the person concerned is in a public place and appears to be in immediate need of care and control. Thereafter, he may be held in hospital for up to 72 hours while being assessed for possible admission, whether as an informal or a detained patient.

It is not hard to see why, in this situation, the MCA might be preferred to the MHA: a constable who uses section 136 might have to remain with the patient while a bed is found for him, which might not be for several hours. The section 5 power, however, appears to carry no such expectation, and it is not subject to the formal arrangements that would otherwise apply.

But there are significant problems with this approach. First, of course, while section 5 may be invoked in a public place, it will only apply to someone who is, or appears to be, incapable, and so might not cover everyone to whom section 136 could apply.

The second problem will affect doctors and nurses more than constables, but it should be no less compelling for that. While section 136 includes the power to detain a patient after he arrives at hospital, section 5 does not: the relevant constable cannot confer such a power on those who receive the patient, and the MCA itself does not contain it. If the patient is incapable, it might be possible for the hospital authorities to invoke the Deprivation of Liberty Safeguards (although they will have to act with great speed in order to do so); but if he is capable, they will only be able to detain him substantively by using the MHA, a possibility section 136 would have given them fully 72 hours to investigate.

The use of section 5 of the Mental Capacity Act instead of section 136 of the Mental Health Act might well be expedient for chief constables, but that will almost certainly be at the expense of the NHS. It should not be contemplated, therefore, without proper, informed consultation with all concerned.

Reforming adult social care law

The Law Commission's consultation on adult social care will run until 1 July. It comes amid growing calls for significant change.

The aim of any reform will be to streamline the currently complicated and fragmented legislation and guidance, making it easier to understand and apply. In its new consultation document, the Law Commission says this will in turn lead to efficiency savings, because less time and effort will have to be expended in training staff, seeking legal advice and dealing with disputes.

The document does not, however, contain a draft bill. Instead, the Commission sets out the existing legal framework for adult social care, explores a variety of alternatives (some of which are quite radical) and makes wide-reaching proposals for reform.

Some key aspects of the proposed reforms are:

- Overarching principles to be enshrined in statute. Eight possibilities are suggested, reflecting current thinking about such matters as choice and control, person-centred planning, perceptions of need and promoting independence.
- A single duty to assess community care needs. The Commission suggests that, rather than being service-led, any assessment should be focussed on social care needs and the outcomes a service-user wishes to achieve. It seeks views first, on whether entitlement should be defined by reference to user groups; and second, on what should be recognised as a community care service. The Commission also recommends that the assessment process be specified in regulations. It says pure self-assessment is currently unlawful, and it proposes that service-users and local authorities 'co-produce' assessments.
- A statutory duty to all carers. This would extend beyond those who provide substantial and regular care, even to those engaged via direct payments (as the Commission believes their relationship with service-users is often not a purely professional one). The consultation invites views on aligning the community care assessment and the carer's assessment.
- The 'ordinary residence' rules should be simplified and made clearer.
- The eligibility framework that is currently set out in the *Fair Access to Care* guidance might be set out in regulations. Indeed, there might be national eligibility criteria and a nationally-set eligibility threshold.
- There might also be a statutory duty to produce a care plan, as well as regulations setting out what it should contain (furthermore, regulations might require local authorities to allocate a personal budget in meeting eligible needs).



- Service–user choice of residential accommodation. The current responsibility, which is contained in mere directions, might be made statutory (and direct payments might be extended to include accommodation).
- There should be a clearer distinction between child services and adult services, but with greater flexibility for 16 and 17 year olds moving from one to the other.
- The existing distinction between health and social care should be maintained.
- There might be a clear, statutory safeguarding duty to make enquiries where an adult is at risk.

The Commission presents its proposals as quite distinct from policy. It is apparent, however, that the consultation document supports key aspects of the current government’s policies, including personalisation and an increased emphasis on early intervention. Detailed thought will have to be given to the likely effect of the various reforms – for example, the application of any new legislation to people subject to immigration control (a subject that has already given rise to a significant body of case law).

The Law Commission will review its proposals in the light of the responses it receives, and it expects to make its final recommendations in 2011. More details about the consultation exercise may be found here:

<http://www.lawcom.gov.uk/1331.htm>

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Weightmans has unrivalled expertise in health and social care law, and the firm’s dedicated team provides clear, concise, reliable advice and representation to a wealth of NHS trust, local authorities, regulators and third sector bodies.

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