

Mental Health January 2010

This is the second edition of Weightmans' mental health newsletter, and you are very welcome to it.

The reception for the first edition was extremely gratifying, with many readers commending its clarity and concision. That's just what we're after, and I hope we have achieved it again here.

Changing status is one of the themes of this edition, and in particular, what happens to a tribunal application when a patient is suddenly subject to a different section. Georgina Rowley considers the problem from the perspective of a patient whose restrictions fall away, and I do the same for patients transferred onto SCT.

Community compulsion continues to cause controversy, and real problems, so another of our articles is particularly apposite. It looks at the latest MHA statistics which suggest that SCT is being used disproportionately at the expense of men. And those same statistics suggest something else that is worrying: the section 136 'place of safety' power is being used to deal not just with mental disorder, but also with *public* disorder. I've had a look at that, too.

Liberty is also one of our themes (as it tends to be most of the time now). Catriona Sangster provides a commentary on the two latest DoLS cases (one of which involved Weightmans again) while another article of mine considers whether, *Munjaz* notwithstanding, mental health patients retain some measure of freedom even after they have been detained in hospital.

We haven't neglected litigation either, for another article explains why permission for Mental Health Act proceedings might now be harder to get. We also have Kiran Bhogal's expert distillation of the government's recent *New Horizons* document, which is presented as the next stage of national mental health policy. And this issue concludes with a note on a report concerning IMCA activity that offers some misleading conclusions about adult protection work.

Please do continue to let me know what you think about this newsletter and the issues it covers, or that you think it *should* cover. You can find me at david.hewitt@weightmans.com

The next edition of Weightmans' mental health newsletter will be published in the spring.

David Hewitt, Partner



Featured articles

Restricted practices

A restricted patient might have to make a fresh application to the tribunal when his restrictions fall away. Georgina Rowley considers a wealth of recent, and not-so-recent, cases.

Developing the DoLS

The courts continue to develop the Deprivation of Liberty Safeguards, but as Catriona Sangster explains, they sometimes take an unexpected approach to the task.

Number crunching

They're neither lies nor damned lies. In fact, as David Hewitt writes, the new Mental Health Act statistics reveal some interesting, if inconvenient truths.

Is something going on with public place detentions?

The Mental Health Act allows you to be arrested in a public place, but only if you're suffering from mental disorder. David Hewitt wonders whether that important caveat has been forgotten.

Harder to get?

Some mental health claims will now be easier to defend, reports David Hewitt, and correspondingly harder to bring.

When you got nothing, you got nothing to lose

So sang Bob Dylan, but is that always the case? David Hewitt asks whether it is possible that someone in detention retains a measure of freedom, even after his liberty has been taken away.

Missed tribunals

Some mental health patients might have missed out on tribunal hearings they were entitled to.

Some mental health hospitals are failing in their statutory duties

A new survey suggests that when they are admitted to hospital, many people with mental illness are being denied their rights.

MCA advocacy: the second year

The Department of Health has just reported on the second year of Independent Mental Capacity Act activity.

New Horizons

The government's new initiative sets out to achieve a great deal, writes Kiran Bhogal, but it just might work.

Restricted practices

A restricted patient might have to make a fresh application to the tribunal when his restrictions fall away. Georgina Rowley considers a wealth of recent, and not-so-recent, cases.

There is a perennial question for mental health lawyers: what happens to a patient's discharge-application if his status changes before it can be heard? The High Court has recently provided another answer to that question, this time, with regard to one-time restricted patients (**R (MN) v Mental Health Review Tribunal** [2008] EWHC (Admin) 3383).

The facts

MN was detained in secure conditions, having been transferred from hospital under section 47 of the Mental Health Act (MHA). He applied to the Mental Health Review Tribunal (as was) at a time when he was subject to a Restriction Direction made under section 49 of the Act. Subsequently, however, his prison sentence expired, the Restriction Direction fell away and he had to be treated as if he were subject to a standard Hospital Order.

The issue

The tribunal refused to hear the case, claiming that as MN was not now under restrictions, his application was extinct. Hospital Order patients have a different right to apply to the tribunal, and it was said he should now make a fresh application in that way. MN, though, argued that because he had been entitled to make his application when he did so, it should remain live and still be heard.

The judgment

The court considered two earlier cases concerning a patient's change-of-status. In the first, an application made by a patient detained under section 2 of the MHA did not come on for hearing until after he had been detained under section 3. His changed status was not allowed to deprive him of a hearing (**R v South Thames Mental Health Review Tribunal, ex parte M** [1998] COD 38). Here, though, the judge said that was wholly different from what had happened to MN.

The second case concerned a tribunal application made while a patient was detained under section 3 of the MHA but not heard until he had been placed on Aftercare under Supervision, under section 25A (which has now, of course, been abolished). There, the court said that if the application were kept alive, the patient would have two tribunal challenges, conceivably within short order: the first to his detention under section 3, and the second, to his supervised discharge. This would be so, even if there were no change in his circumstances between the first and the second challenge (**R (SR) v Mental Health Review Tribunal**, CO/1738/2005). Here, the judge noted that although this might also fit the facts of MN's case, it was "a result that Parliament is unlikely to have intended", which in itself demonstrated the falsity of MN's argument.

The judge also noted that MN would not need the fresh application right he enjoyed as a mere Hospital Order patient if, as he claimed, his original right lived on. The judge therefore found against MN. He also refused to grant him permission to appeal to the Court of Appeal and ordered him to pay the costs of the case. (It is highly unlikely that those costs will be enforced.)

Discussion

The courts had already made a clear distinction between cases in which a patient's tribunal application will survive a change-of-status and those in which it will not. The key question seems to be whether the change is between similar or quite different forms of compulsion.

This decision places the restricted/unrestricted change in the latter category. In fact, when the decision is combined with those on the section 2/section 3 change, and on the section 3/supervised discharge change, it might seem that we have almost a full set – almost: the 2007 Mental Health Act has created an array of fresh possibilities, and it remains to be seen what will happen if a tribunal application made while a patient is detained under section 3 of the MHA has not been heard by the time he is put on a Community Treatment Order. The instant case would seem to suggest that the application must fall.

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Developing the DoLS

The courts continue to develop the Deprivation of Liberty Safeguards, but as Catriona Sangster explains, they sometimes take an unexpected approach to the task.

In two recent cases, the Court of Protection has unpacked some key elements of the Deprivation of Liberty Safeguards (DoLS), including the extent of the cover provided by section 5 of the Mental Capacity Act, and the interaction between that Act and the Mental Health Act.

DCC v KH and others

This case concerned a young man, KH, who lived in a residential placement and was subject to ‘best interests’ proceedings in the Court of Protection. His mother lived 100 miles away, and the court had made declarations concerning his contact with her.

On one occasion, KH said he would not return home the next time he had visited his mother. He had recently assaulted a member of staff and further contact with his mother was a few days away. This caused concern, for although a standard authorisation was already in place, permitting KH to be deprived of liberty in the placement, there were fears that it would not cover restraining him at his mother’s and driving him home (a journey whose duration was estimated, perhaps optimistically, at 2.5 hours). The local authority therefore sought an urgent declaration in that regard, and explained that without an express order permitting the use of force, the police might decline to assist.

The application was resisted by the official solicitor, on behalf of KH, on the basis that either the standard authorisation or, in any event, the common law doctrine of necessity would be sufficient.

The judge held that the local authority’s application was unnecessary: if KH refused to return to the placement, it would be “perfectly proper for appropriate restraint to be used whether with or without the assistance of the police because of it being in his best interests”. The standard authorisation would apply not just to the placement in which KH lived; it would also enable him to be returned there. And even if there had been no standard authorisation, what was contemplated would be covered by the protection afforded by section 5 of the Mental Capacity Act 2005 (MCA).

This decision appears to set very wide the boundaries not only of section 5, but also of the DoLS standard authorisation. It should offer local authorities some considerable comfort.

GJ v The Foundation Trust and others

This case concerned GJ, a 65 year-old-man with Korsakoff’s Syndrome, which is, of course, accepted as a form of mental disorder within the Mental Health Act 1983 (MHA). GJ also had diabetes, which, following the recent

death of his partner, he controlled poorly. GJ lacked capacity to make relevant decisions and the prospect arose of his being admitted to hospital and deprived of liberty there.

A person will not be 'eligible' for the DoLS, of course, if he is a mental health patient, so the key question was whether the treatment that necessitated deprivation of liberty was for GJ's physical or his mental health.

In his judgment, Mr Justice Charles explored in detail the interaction of the MHA and the MCA. He found that under paragraph 12(1) of Schedule 1A to the MCA, GJ would be a mental health patient, and so ineligible for the DoLS, if:

- an application in respect of him *could* be made under section 2 or section 3 of the MHA, and
- he *could* be detained in a hospital pursuant to such an application.

Crucially, this would be a question for the decision-maker, such as a Best Interests Assessor under the DoLS. It would be subjective in nature, so the conclusion of the ordinary reasonable person would be of little concern.

Clearly, the people to whom this judgment is most relevant are those who, as well as being incapable within the meaning of the MCA, are also suffering from mental disorder. Charles J said that when deciding whether such a person *could* be detained under the MHA, a decision-maker should apply the 'but for' test, and ask:

- (a) What care and treatment should the person have in hospital: [1] for any physical disorders not connected to his mental disorder and [2] for his mental disorders (or for physical disorders that are connected to them)?
- (b) If no physical treatment had in fact been necessary, would deprivation of liberty still have been required?
- (c) Is the need for physical treatment all that requires deprivation of liberty here?

The judge said that if question (b) were answered 'no' and question (c) 'yes', the person concerned would not be a mental health patient.

By applying this test, the judge concluded that in this case, GJ was to be deprived of liberty in order to receive treatment for his diabetes – a purely physical disorder. Accordingly, he was not a mental health patient and would not, therefore, be 'ineligible' for the DoLS. A standard authorisation would be appropriate in his case.

This decision provides welcome clarification of an obscure, but nonetheless important, provision. In a hospital setting, the 'eligibility' assessment is crucial, not least because its outcome can prevent a person being brought within the DoLS. In that situation, of course, a person who is instead detained under section 3 of the MHA will be entitled to free after-care when he is finally discharged from hospital. In addition, this decision further demonstrates the primacy of the MHA over the MCA; the latter is not simply an alternative to the former, and decision-makers simply cannot pick and choose between them.

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Number crunching

They're neither lies nor damned lies. In fact, as David Hewitt writes, the new Mental Health Act statistics reveal some interesting, if inconvenient truths.

The government has recently published fresh statistics on the use of the Mental Health Act. It seems that in the year to April 2009, nearly 29,000 people were admitted to hospital compulsorily. That represents a rise of two per cent on the previous year and nearly six per cent in the last decade. We also know that section 2 is becoming more popular and section 3 less; that the use of emergency admission under section 4 has more than halved in the last decade; and that patients detained because of learning disability make up only an eighth of one per cent of the total.

For the first time, the statistics include Supervised Community Treatment (SCT), to which a lot of attention has been paid in recent months. It seems that the use of SCT is three times greater than the government predicted, and that has caused real problems with the consent to treatment provisions in the Act. But the statistics show another interesting thing, which has excited little comment.

To be put on SCT, a patient must first be detained under section 3 (or section 37). Of all section 3 patients, just over a half are male and just under a half are female. Yet the ratio among community patients is two-thirds to one-third. SCT was introduced seven months into the relevant period, of course, so the figures quoted here are for only five months. Yet they suggest that where male patients are concerned, disproportionate use is being made of community powers.

More generally, it seems that of 2,134 patients who had been subject to SCT at 31 March, 207 had been recalled to hospital and 33 discharged, and 143 had had their CTO revoked (and so became in-patients once again).

The new figures show that around 16,000 people are detained in hospital on any one day, with three-quarters in the NHS and a quarter in the independent sector. But that doesn't tell the whole story. There has been a dramatic increase in the number of patients detained in private hospitals, which is up more than 220 per cent over the decade and fully 42 per cent since last year. The government says this might be because new facilities have opened, and also because more independent sector providers are now returning MHA data. It might also be because the independent sector is now more popular than ever before.

These are merely statistics, of course. They tell us how many people were detained but not what their experience was like. Yet that too has recently been the subject of controversy, with the Care Quality Commission and the National Director of Mental Health squaring up to each other publically. At times, their dispute was like something from *Gulliver's Travels*. Its subject was the Commission's survey of acute in-patient mental health services, in which a quarter of respondents said their care was poor or only fair. The director said the focus of the story should have been the three-quarters who said their care was good. And recent figures on the ethnicity of detained patients have caused some concern as well, not least because it seems the number of 'black' and 'black British' patients detained under the Mental Health Act went up by nearly 10 per cent in a year.

Whatever they tell us, this year's figures are likely to be less interesting than next year's. They will cover detentions up to April 2010, which is also, of course, the first 12 months of the Deprivation of Liberty Safeguards. So far, the DoLS have been significantly under-used, but we'll have to wait another year to see whether that's because of greater interest in the possibilities offered by the Mental Health Act.

The new statistics can be found here:



<http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/mental-health-act/in-patients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subjects-to-supervised-community-treatment:-1998-99-to-2008-09>

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Is something going on with public place detentions?

The Mental Health Act allows you to be arrested in a public place, but only if you're suffering from mental disorder. David Hewitt wonders whether that important caveat has been forgotten.

Where a person is in a public place and seems to be suffering from mental disorder, a constable may arrest him and take him to a place of safety. Once there, the person may be held for up to 72 hours, while he is assessed for detention under the Mental Health Act.

The relevant power is contained in section 136 of the Act and there have long been concerns that in some cases, mentally disordered people are present in a public place only because they have been enticed there by the police. Following publication of latest statistics on the use of the Mental Health Act, we now have to ask whether section 136 is being used against people who aren't even suffering from mental disorder.

Anyone arrested under the Act may be taken either to a hospital or to a police station. The new statistics concern only the first group of people (which is probably smaller than the second), and they show that in the year to April 2009, the section 136 power was used almost 8,500 times. That represents an increase of 20 per cent on the year before, and of more than 300 per cent over the decade.

Perhaps there are more mentally disordered people outside hospital, and perhaps more of them find their way into public places. And yet the new statistics show that the number of people detained under the Mental Health Act has gone up by two per cent in a year and by six per cent over the decade.

The conversion rates are equally noteworthy, for of the people held in hospital under section 136, almost three-quarters were not detained once they had been assessed. That figure is itself up a quarter on the previous year, and by 330 per cent over the last ten years. Only 1,751 of these people were subsequently detained under section 2 or 3, which means that anyone taken to hospital as a place of safety is almost four times more likely to be discharged than to be detained.

These statistics concern only a minority of people arrested under section 136, yet they beg some obvious questions: are constables genuinely getting it wrong? Are the signs of mental disorder so hard to discern? Or is the Mental Health Act arrest power being used on occasions to deal with people who are merely troublesome in a social context, simply to get them off the streets?

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The latest MHA statistics are discussed elsewhere in this newsletter

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Harder to get?

Some mental health claims will now be easier to defend, reports David Hewitt, and correspondingly harder to bring.

Where he says he is the victim of acts performed under the Mental Health Act, anyone wanting to claim damages will now face a more difficult task. That is the result of an interlocutory decision in **Johnston v The Chief Constable of Merseyside Police** [2009] EWHC 2969 (QB), which concerned a proposed claim by a man who had been apprehended by the police.

In January 2006, Mr Johnston, who has a history of mental health problems, was at a property on Merseyside. An occupier of the property became concerned about his behaviour and summoned an ambulance. In accordance with usual practice, the police attended as well. Mr Johnston acknowledged that he had needed medical help, but said he had not wanted the police to be called.

On the basis of the witness statements and other evidence, there is a profound conflict between the parties as to what happened next. It appears to be common ground, however, that Mr Johnston was sprayed with CS gas and sustained severe blistering to the skin on his face, left ear and chest. He was detained, put in handcuffs and taken to hospital, but he was not subsequently charged with any criminal offence.

Mr Johnston alleges that these acts amounted to false imprisonment and assault. The Chief Constable, however, claims they were covered by section 136 of the Mental Health Act 1983 (MHA) which applies where someone who appears to be suffering from mental disorder is found in a public place, and permits a constable to take that person to a place of safety. Under section 139(2), no claim concerning the use of MHA powers may proceed without the permission of the High Court. The Chief Constable argued that Mr Johnston should be denied such permission.

The test

The leading authority on permission claims of this kind is still **Winch v Jones** [1986] 1 QB 296, in which Sir John Donaldson, MR said, “The issue is whether, on material evidence immediately available to the court, [...] [the claim] deserves the fuller investigation which will be possible if [it] is allowed to proceed.” Subsequently, the House of Lords said that by this test, “the threshold for obtaining leave under section 139(2) has been set at a very unexacting level [...] an applicant with an arguable case will be granted leave” (**Seal v Chief Constable of South Wales Police** [2007] UKHL 31, per Lord Bingham at [20]).

For the Chief Constable, it was argued that, 25 years on, the **Winch v Jones** test should be tightened. It was noted that the Civil Procedure Rules now provide, amongst other things, that summary judgment may be given where a claimant “has no real prospect” of success (rule 24.2(a)(i)).

Notwithstanding the changes wrought by the CPR, the judge, Mr Justice Coulson said “it would be wrong to modify in any significant way” the **Winch v Jones** test (see [12]). He went on, however, to permit himself one modification, noting that it would be “absurd” for a court to grant permission under section 139 where, had it asked itself the “CPR Part 24 question”, it would have concluded that the proposed claim had no real prospect of success (see [13]). For that reason, the judge said the CPR question should indeed be asked upon any claim under the MHA (see [14]).

In fact, Coulson J concluded that the Mr Johnston’s proposed claim did have a real prospect of success, and he therefore granted the necessary permission under section 139. (The proceedings also included a limitation point, which, again, was decided in the claimant’s favour).

It isn't every potential defendant whose position will be strengthened by this decision. For esoteric, historical reasons, no permission has ever been required for proceedings concerning the acts or omissions of the Secretary of State or the NHS under the MHA (MHA, section 139(4)). Where a claim relates to the use of section 136, however, or to the initial decision to detain a patient in hospital, this case will make a difference.

The **Winch v Jones** test for permission under section 139 has not been displaced. In fact, it is now considerably tighter, with a potential claimant having to show that his case is not merely arguable, but that it has a real chance of success. That is a palpable change, whose effect might well be to forestall claims that would otherwise have proceeded all the way to trial. And plainly, therefore, the change is a good deal more 'significant' than the judge was prepared to allow in Mr Johnson's case.

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When you got nothing, you got nothing to lose

So sang Bob Dylan, but is that always the case? David Hewitt asks whether it is possible that someone in detention retains a measure of freedom, even after his liberty has been taken away?

A recent decision of the Court of Appeal suggests that he does, at least if he is a prisoner (**Iqbal v Prison Officers Association, 2009**). But hasn't the court already told us that in the case of mental health patients, the reverse is true?

Mr Iqbal is serving a 15-year prison sentence. In August 2007, when he was at HMP Wealstun, there was a one-day strike by prison officers. All prisoners were locked in their cells by order of the governor and as a result, Mr Iqbal lost the five hours he would have spent at work or in the gym. He claimed that he had been falsely imprisoned by the prison officers, but he lost his case in the Court of Appeal.

The governor could not be liable to Mr Iqbal because the Prison Act 1952 says that a prisoner may be lawfully confined by the governor. If a prisoner enjoys no 'residual liberty', that would, of course, have been a further reason for rejecting Mr Iqbal's claim but it did not figure here.

The Court of Appeal felt that there was such a thing as residual liberty. One of judges said, "even if [he is] lawfully within a prison by order of a court, a prisoner enjoys the liberty not to be further restrained by unauthorised action whether by fellow inmates or prison officers".

But that idea seems inconsistent with the decision in the **Munjaz** case, which, of course, concerned a patient detained in a high secure hospital under the Mental Health Act 1983 (MHA). He was placed in seclusion for days on end and claimed that he had seen a doctor too infrequently (**Munjaz v Mersey Care NHS Trust, 2003**). The case turned upon the MHA Code of Practice and whether its requirements were fully met, but the Court of Appeal and the House of Lords also found that for detained patients, residual liberty – or what was called "prison within a prison" – did not exist.

Iqbal clearly has resonance in mental health cases, for under the MHA, the managers of a hospital enjoy powers similar to those endowed upon the governor of a prison: a valid detention application enables a patient to be detained, but also to be re-taken if he absconds, treated against his will and, following **Munjaz**, placed in



seclusion (MHA, section 6(3)). In most cases, that authority will cover the hospital managers and those that do their bidding, but it won't apply in other circumstances.

The cases of Iqbal and Munjaz are different, not least because the first was about a prisoner and the second about a patient, and also because they were decided according to substantially different authorities. Yet each concerned a man who said he retained some freedom, even after his liberty was lawfully taken away. It may be, therefore, that in entertaining the notion of residual liberty, the Court of Appeal has placed itself at odds not only with its earlier self, but also with the House of Lords.

And yet, the decision in this case goes to the heart of mental health care: it implies that in the right circumstances, a detained patient may challenge the decision to seclude him. No such challenge will lie against the principal detainers, of course: like the Prison Act in Iqbal, the Mental Health Act makes sure of that. But a claim might succeed where one patient locks another in a cupboard, or even where a formal decision to seclude a detained patient is inconsistent with established hospital policy.

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Bob Dylan, *Like a Rolling Stone*, copyright ©1965; renewed 1993 Special Rider Music

Missed tribunals

Some mental health patients might have missed out on tribunal hearings they were entitled to.

Where a detained patient is placed on compulsory community treatment before his case can be heard by a tribunal, he won't have to make a fresh appeal. That was the decision of the new Upper Tribunal in an appeal considered recently in its Administrative Appeals Chamber (**AA v Cheshire and Wirral Partnership NHS Foundation Trust, ZZ and the Secretary of State for Health** [2009] UKUT 195 (AAC)).

The patient concerned had been detained in hospital under section 3 of the Mental Health Act 1983 (MHA). An application for his discharge was made to the inelegantly named First-tier Tribunal (Health, Education and Social Care Chamber) – the successor to the Mental Health Review Tribunal – but by the time it could be heard, the patient had been discharged from hospital onto Supervised Community Treatment (SCT). So-called community patients have a separate right of access to the tribunal, so the question here was whether the original application would survive. The Upper Tribunal held that it would, and that the First-tier Tribunal, which decided that the application had lapsed and therefore refused to consider the patient's case, had made an error of law.

Supervised Community Treatment was introduced in amendments to the MHA made in November 2008, and the Upper Tribunal said the wording of those amendments was clear: the First-tier Tribunal may discharge a community patient, even though he was still detained in hospital when the relevant application was made. Yet earlier decisions had suggested something different.

In the case of **M**, too, a fresh application was held to be unnecessary and a tribunal was ordered to continue to hear a patient's case, even though his status had changed (**R v South Thames MHRT, ex parte M** [1998] COD 38, QBD). The court said the patient's right to a tribunal arose not from his detention, but from his admission, which happened in a single moment of time. In that case, however, the change – from section 2 of the MHA to section 3 – had been relatively un-dramatic, and the patient had remained detained in hospital throughout.

In cases involving more profound change, the courts have generally taken the view that an existing tribunal application will lapse. In **SR**, for example, a patient had been discharged from detention under section 3 of the MHA and placed on supervised discharge by the time his hearing came round. The Administrative Court held that a fresh application would be required (**R (SR) v MHRT** [2005] EWHC 2923 (Admin)). It did the same recently in **MN**, a case concerning a man who had been transferred to a mental health hospital from prison. Special restrictions applied to him when he made his tribunal application, but they had fallen away by the time it was ready to be heard. The court said this change in his status was highly significant (**R (MN) v MHRT** [2008] EWHC 3383 (Admin)).

The circumstances of the new case resemble those of the last two – particularly **SR**, for although SCT is not the same as supervised discharge, patients leaving detention for either would make a similar journey. And there was another reason to believe that in **AA**, the Upper Tribunal Judge would decide that a fresh application was required: when giving judgment in an earlier case, he had suggested precisely that (**Dorset Healthcare NHS Foundation Trust v MH** [2009] UKUT 4). His comments were *obiter*, however, and the judge did not consider himself bound by them.

This case was not, however, the same as its predecessors. Neither **SR** nor **MN** concerned SCT, nor was the legislation in either case so clear as it was here. So clear, indeed, that the judge was surprised that the First-tier Tribunal failed to notice it. The case was remitted for reconsideration. The tribunal will indeed have to decide whether the patient should be discharged, this time from SCT.

Proceedings such as these would have been inconceivable before last November: we have only recently lost supervised discharge and gained the First-tier and Upper Tribunals and Supervised Community Treatment. The case is therefore completely emblematic of the Mental Health Act changes made a year ago.

At first sight, this decision of the Upper Tribunal appears to confound established authority: the nature of a change-of-status is not, after all, the key determinant of tribunal rights. The decision is, however, likely to be significant for many community patients – not, perhaps, those that made a fresh discharge-application when they left hospital, but certainly any that imagined their tribunal applications had lapsed and so did not refresh them. It seems those patients, too, were entitled to their day in court.

Some mental health hospitals are failing in their statutory duties

A new survey suggests that when they are admitted to hospital, many people with mental illness are being denied their rights.

More than 7500 former-patients told the Care Quality Commission (CQC) about their experiences of acute inpatient care. Some were broadly happy, but a significant minority were not.

The CQC has now reported its findings. What many patients were concerned about was simple good practice. A quarter of patients, for example, had not had the talking therapies they wanted, and that NICE says can be helpful; and a similar proportion said they had been less involved in decisions about their care than they wanted to be.

In many cases, however, hospital shortcomings might actually have broken the law:

- Many patients who responded had been detained in hospital, and more than a quarter of them said their rights had not been explained to them in a way they could understand. This is a clear breach of the Mental Health Act (albeit one that has long been suspected to be occurring).
- The position was similar when it came to medication, with another quarter of patients saying the purpose of the medication had not been properly explained and almost a half saying its potential side-effects had been ignored. Some of these patients were detained, of course, and could therefore be forced to have their medication, but the law says this should make no difference.

The CQC's findings have proved controversial, with not least with the National Director of Mental Health, Professor Louise Appleby. He argued that the Commission's focus should not have been on the quarter of respondents who made critical comments, but on the three-quarters who said their care was good.

Whatever the means by which they were presented, the CQC's recent findings are worrying, not least because they suggest that in a large number of cases, hospitals and practitioners are failing to comply with their statutory duties.

MCA advocacy: the second year

The Department of Health has just reported on the second year of Independent Mental Capacity Act activity.

There have been increases across the board, with women more likely than men to have an Independent Mental Capacity Advocate (IMCA), and those over 80 years-of-age the likeliest of all. Because of some schoolboy errors, however, the report's conclusions about adult protection work are too pessimistic.

The largest rises were in the use of IMCAs in care reviews and with serious medical treatment, where the first year's figures had been troublingly low. Decisions about a change in accommodation were also more likely to involve IMCAs, but overall, the Department doesn't think that the service is reaching all the people it needs to.

When it comes to adult protection work where the new report is equally downbeat, the picture is a little more complicated. This is for two reasons:

- The report mis-states the rate of increase in IMCA referrals. There were 681 in 2007/08 and 960 in 2008/09, a rise of 41 per cent (not the 29 per cent claimed).
- And the report has an exaggerated view of the powers of local authorities. It says an IMCA may be appointed even where there is only an allegation of abuse. In fact, that step can be taken only where adult protection proceedings have already been commenced or are at least in prospect. (That state-of-affairs was the subject of adverse comment last autumn, following research into the use of IMCAs in adult protection proceedings.)

These reservations notwithstanding, the latest figures are troubling. They show, for example, that while Cornwall made 50 adult protection referrals to IMCAs in 2008/09, and Devon made 43 and Birmingham 33, only 20 local authorities made more than ten referrals, and ten local authorities made no referrals at all.



New Horizons

The government's new initiative sets out to achieve a great deal, writes Kiran Bhogal, but it just might work.

The path that has led to New Horizons began with recognition that more had to be done to support those with mental health problems. This in turn led to the introduction of the National Service Framework for Mental Health (NSF).

Progress with the NSF was slow, but it has – finally – yielded a better understanding, on the part of government and professionals, of the fact that at any one time, one-in-six adults will have mental health problems. What has not, however, been commonly recognised is the toll that mental ill-health can have on its victims, their families and friends, and on the public at large.

The government's new initiative, *New Horizons: a shared vision for mental health* (New Horizons) seeks to build on the transformation of mental health services that began a decade ago. It recognises that, as the Secretary of State says in his foreword, “for the first time, mental health and wellbeing [are] not just a health concern, but... a major social issue demanding action across all parts of the Government”. The government has therefore stepped up its game, by setting an extremely challenging timetable to take the transformation to the next level.

New Horizons adopts a dual approach, combining service-improvement with a new partnership of central and local government, the third sector and the professions. A key aim is encourage more people to recognise depression and the fact that a failure to deal with it at an early stage can lead to other mental health problems. The emphasis is on early identification and treatment, and on improving the quality and accessibility of services, which in turn (it is envisaged) will lead to the improvement of the mental health and well-being of the population. How is this to be achieved?

First, we are told, government departments involved in New Horizons will establish a ministerial board to ensure high-level oversight, with the Department of Health (DoH) offering support and advice, both to the new board and to other statutory agencies as they carry out mandatory impact assessments. In addition, there will be a ministerial advisory group, which will be chaired by the Minister of State for Care Services, involve external stakeholders, and help monitor progress and advise on strategy.

A plethora of guidance and other publications is heading our way this spring, including a report on *Public Mental Health Framework and Review of Supporting Evidence*, an atlas for mental well-being in England and a violence and abuse prevention framework. These will be supported by an online cost calculator and a series of short briefings. Also to be launched this year is *WordsMatter*, a voluntary sector-led website, which will enable people to pass on their praise (or complaints) to journalists writing about mental health issues, and to provide expert support to NHS Trusts and SHAs over media coverage of homicide inquiries.

Another approach announced by the government in what it calls its ‘bold statement of intent’ is a focus on ‘personalisation’ – in other words, adopting a personal approach to the way services are delivered. This is seen as fundamental if the needs of individuals in the most vulnerable groups are to be addressed. To this end, we are told, the DoH, the Future Visions Coalition and other partners will shortly hold a summit on personalisation and mental health, with a view to determining how those with the greatest need can be best supported, whether there is life beyond individualised budgets and how personalisation can contribute to value-for-money.

Multi-agency collaboration and commissioning, and value-for-money, form another key theme of New Horizons, with the message that this is not about cost-cutting but about the efficient use of the resources available. This is a particularly welcome message in a NHS that faces a much harsher financial environment: it is said that the



financial cost of mental ill-health will double over the next 20 years. New Horizons seeks to draw in employers (the cost to them is around £26 billion a year), education services (to raise awareness of the need for early-intervention and to eliminate the stigma attached to mental health), children's and adolescent services (to ensure an effective transition to adult services) and housing services and the 'Third Sector' (to ensure that appropriate support is available in the community).

The transformation of mental health services was always going to be a mammoth task, but the good news is that we seem to be heading in the right direction. With New Horizons and the guidance that is to come later this year, there appears to be light at the end of what has otherwise been a dark and undulating tunnel. There remains much to be done, however, and much to be read, but there is real hope for the millions of people who suffer from, or who might have to face, mental health problems.

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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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