Weightmans

Mental Health
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Welcome to this, the first edition of Weightmans' mental health newsletter.

This is a good time to be going into print, for the many changes made over recent years by the Mental Capacity Act, the 2007 Mental Health Act and the Deprivation of Liberty Safeguards are finally starting to bed in.

Those changes are at the heart of this edition. Weightmans had the privilege of being involved in the first DoLS case to come before the courts, and Catriona Sangster now writes about it. My own companion piece asks, perhaps mischievously, why the safeguards aren't being used more often.

I have also written about a recent case on the nearest relative, a subject which is close to my heart, and about the vulnerable adult: just who is he? And I have mentioned a case which shows that the courts know the difference between suicide and self-harm (I plan to return to the subject of self-harm in a later edition).

Another notable recent case concerned Rampton Hospital and the nationwide smoking ban, and Kiran Bhogal now provides her own, distinctive take on that case. This edition concludes with a round up of other relevant cases, and with a few items of news you might have missed.

I should be every interested in your opinions - about this newsletter, certainly, but also about the issues it covers, and about any other aspect of mental health or mental capacity law. So, if there's something on your mind, please e-mail me at david.hewitt@weightmans.com

With good fortune and a following wind the second edition of this newsletter will be published in the New Year.

David Hewitt

Featured articles

Rampton smoking case
The ban on smoking in secure hospitals does not infringe patients' human rights. Kiran Bhogal, Partner at Weightmans, looks at the Court of Appeal's recent decision on how there had been no breach by Nottinghamshire Healthcare NHS Trust when it imposed a 'no smoking' ban at Rampton Hospital.

Newsletter

Disclosure in mental health tribunal proceedings
In its first mental health case, the new appeals tribunal didn't give judgement; instead, it provided guidance about the disclosure of medical records. David Hewitt, Partner at Weightmans, explains how the appeals tribunal has offered assistance on resolving disclosure disputes.

To DoLS or not to DoLS?
The Court of Protection has recently given judgment in the first DoLS case. Catriona Sangster, Paralegal at Weightmans, considers this case in which the Court of Protection explained what makes a patient eligible for the Deprivation of Liberty Safeguards where he or she might otherwise have been detained under the Mental Health Act.

Why aren't we locking up more old ladies?
Many hospitals and care homes now have the power to deprive people of their liberty. This article examines the latest statistics and wonders why, in some places at least, the Deprivation of Liberty Safeguards are being used so infrequently.

Nearest relative objection
The High Court has decided that an earlier discharge by a nearest relative might itself count as an objection to a subsequent admission. David Hewitt considers the recently reported case of **M v East London NHS Foundation Trust**.

Self-harm vs. suicide
There's a difference between wanting to kill yourself and simply wanting to harm yourself. This article explains how the law recognises the difference between self-harm and suicide.

What is vulnerable?
This is likely to be one of the hot questions of the next few months. David Hewitt considers how neither the law nor the courts can agree what it might be that classifies an adult as vulnerable.

Case law update
Some recent mental health cases, concerning such things as negligence, disclosure, detention and tribunals.

News in brief
Some things you might have missed including: new CAMHS guidance, a report on homicides by mental health patients, further work on criminal justice and mental health, and a proposal for revised directions for the high secure hospitals. Oh, and the small matter of the government's plans to suspend the Mental Health Act.

Mental health law specialists
Click here for details of the Weightmans specialists who can provide clear, concise advice, both on the Mental Health Act and on much more besides.

Weightmans

Rampton smoking case

The ins and outs of smoking

In July, the Court of Appeal confirmed that the right to smoke was not protected by Article 8 of the Human Rights Act 1998 (HRA), and so, there had been no breach by the trust at the centre of the challenge, Nottinghamshire Healthcare NHS Trust, when it imposed a 'no smoking' ban at Rampton Hospital.

The issue before the court was whether Article 8 conferred a right on patients detained in Rampton to smoke without arbitrary interference, and whether the appellants were being discriminated against in this respect.

Regulation 10 of the Smoke Free (Exemption and Vehicles) Regulations 2007, which was at the heart of the challenge, ceased to have effect on 1 July 2008. Since that date, a number of mental health units have permitted smoking outside (in the grounds) but not inside. Whilst it falls within the regulation, the **Rampton** case has, however, confirmed that if a policy was to be introduced that imposed a complete ban on smoking, it would not be unlawful.

Not only did the Court of Appeal undertake a detailed analysis of the rights protected by Article 8, it also considered whether, for those detained in hospital on a long-term basis, the hospital was their home. The court noted that a mental health unit was an establishment maintained wholly or mainly for the reception and treatment of persons suffering from mental disorder (as defined by the Mental Health Act), and that Article 8 conferred a right to respect for private life with which there could be no interference except in the interests of, amongst other things, public safety, the prevention of disorder and crime, and the protection of health, morals, or the rights or freedoms of others.

Rampton had introduced its no-smoking policy on grounds that it was necessary and proportionate to do so, having regard to the need to preserve the health of staff, patients and visitors; to protect and improve the physical and mental health of staff, patients, visitors and contractors; to protect such persons from the dangers of exposure to second-hand smoke; to encourage an environment that was conducive to giving up smoking; and to contribute to the management of the fire-risk. The Court of Appeal was therefore left balancing the need to protect people from harm on the one hand and to protect the freedom of choice on the other.

The Court concluded that Rampton (and similar establishments) could not be considered to be a private home within the context of Article 8, as it was a public institution; a public and not a private place. The court also differentiated between mental health units and prisons, and said the fact that patients at Rampton are in compulsory detention under the MHA made the hospital's relationship with its patients very different from its relationship with other patients who might wish to smoke. The court said the trust exists to deliver health care to its patients in Rampton in a secure and clinically appropriate environment, and that it owes a duty of care to them which covers both their physical and their psychological health and include a duty to take reasonable steps to prevent them from causing themselves harm. Consequently, the court held that the smoking ban did not have a sufficiently adverse effect on a patient's physical or moral integrity. It was necessary and proportionate for the protection of the health of both patients and staff.

For those mental health units where smoking has not already been banned, the door has been left open for a no-smoking policy to be imposed throughout the whole of their premises, provided that policy is necessary and proportionate. The obligation upon hospitals to provide smoking facilities has also been removed. Whilst the Court of Appeal made clear that its views were limited to patients detained at psychiatric units, the case has much wider implications - in particular, for the question whether a right to smoke exists in public institutions. In the **Rampton** case, the court considered that there was a "potentially legitimate aim to restrain

a person's article 8 rights for the protection of health". This leaves it open to the NHS to introduce measures which, whilst they may be restrictive in the short term, might lead to longer-term benefits for patients and the public at large. What is clear, though, is that there cannot be said to be a right to smoke.

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Disclosure in mental health tribunal proceedings

In its first mental health decision, the new appeals tribunal has given important guidance

Wherever possible, hospitals, patients and their solicitors should try to agree on what documents are to be disclosed in mental health proceedings. That is the view of a new appeals tribunal in its first ever mental health decision.

The new, 'second-tier' tribunal will hear a wide variety of health, education and social care appeals. In **Dorset Healthcare NHS Foundation Trust v MH** [2009] UKUT 4 (AAC) a detained mental health patient wanted access to his medical records. The 'first-tier' tribunal gave him that access but the hospital in which the patient was detained challenged the decision.

The appeals tribunal criticised many of those involved in the case: the hospital, for making the challenge in the first place; the patient's solicitors, for involving the tribunal prematurely; and the tribunal itself, for making its decisions too timidly. But the appeals tribunal also gave valuable guidance on how disclosure disputes should be resolved in the course of mental health proceedings:

- All parties should be flexible, seek to avoid formality and do all they can to avoid applying to the tribunal.
- Where a direction is required, the tribunal has broad powers.
- The starting point is full disclosure, and the burden will be on the hospital to show why it should not be given.
- If there is confidential information concerning a third-party, he or she should be invited to consent to its disclosure.
- Even without consent, it might still be possible for a hospital to disclose third-party information to a patient's solicitors, subject to their undertaking not to disclose that information to their client.
- If agreement still cannot be reached, the parties should commit their respective arguments to writing.
- Ultimately, it might be necessary for the party seeking an order to apply to the tribunal. If so, all parties should identify issues on which they have been able to agree.
- Ordinarily, it is the first-tier tribunal that will consider such an application.
- The tribunal might wish to obtain the third-party's views on disclosure. If so, those views should be solicited by the hospital. A third-party should not have any direct involvement in the tribunals' procedures.

There is something else this case reveals: the tribunal has far stronger disclosure powers now than ever before. Under the rules that used to apply, the tribunal could itself disclose documents, but only if it had already received them. And it couldn't compel one party to give disclosure to another. Under its shiny new

rules, however, a tribunal can direct anyone to disclose documents to anyone else, even if it has not received those documents and regardless of whether it even wishes to see them. This power might not be widely understood.

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To DoLS or not to DoLS?

The Court of Protection has explained what it might mean for a patient to be eligible for the DoLS

On 1 April 2009, the Deprivation of Liberty Safeguards (DoLS) came into force, and the Court of Protection has recently given judgment in the first DoLS case (W Primary Care Trust v TB and others [2009] EWHC (Fam) 1737). It did that, even though sadly, the patient concerned had already died. The court said the issue raised by the case was becoming common and needed to be clarified.

The facts
The patient, Miss TB, suffered from an acquired brain injury with an associated psychiatric disorder. Since 1995, she had complained of sensations in her head, neck and stomach. She was preoccupied with those sensations and thought, for example, that blood was flowing from her brain into her stomach and down her left leg. TB firmly believed her symptoms had a physical cause and therefore demanded a medical solution. A recent deterioration in her circumstances led to her being admitted to a registered care home, but TB said clearly that she did not want to be there and wanted to be treated in a NHS hospital. The relevant PCT and the official solicitor, asked the Court of Protection to declare that TB was 'eligible' to be deprived of liberty at the home.

The issue
It was assumed that the treatment given to TB was in her best interests. The issue, therefore, whether depriving her of her liberty in order to provide that treatment could be authorised by the court under the DoLS.

The evidence showed that it would not be helpful to detain TB under the Mental Health Act 1983 (MHA 1983), because the specialist treatment she required would not be available in mainstream psychiatric services. The care home, on the other hand, was situated close to the homes of TB's brothers and their continued involvement was an essential part of her treatment and rehabilitation. In any event, the home did not accept patients who were detained under MHA 1983.

The law
There were two ways in which TB might lawfully be deprived of liberty in order to receive the care she required: MHA 1983 or the DoLS. The DoLS, of course, are contained in the Mental Capacity Act 2005 (MCA 2005), and section 4A of that Act provides that an authority to deprive someone of liberty may be made by the Court of Protection under section 16, or by a Supervisory Body (here, a local authority) under schedule 1A. No such order may be made, however, if the person is 'ineligible' for the DOLS, and in such a case, the only proper course was would be to detain her under MHA 1983.

Eligibility for the DoLS is determined by schedule 1A, and among the cases specified in paragraph 2 is where a person is "within the scope" of MHA 1983 but "not subject to any of the mental health regimes." Further clarification is given in paragraph 5, which says that someone will not be eligible for the DoLS if first, MHA 1983

authorises her to be a mental health patient and secondly, she objects either to being such or to being given some or all of the mental health treatment.

In this case, the judge found that TB certainly was objecting. In order for her to be ineligible for the DoLS, however, it would also be necessary for her to be a 'mental health patient', which paragraph 13 of schedule 1A defines as a 'person accommodated in a *hospital* for the purposes of being given medical treatment for a mental disorder' (emphasis added). The crucial question, therefore, was whether the care home to which TB had been admitted was a 'hospital' (which under MCA 2005 has the same meaning as under MHA 1983). The judge found that the home was obviously not a NHS Hospital, and even though it was registered as a care home under the Care Standards Act 2000, that it was not an independent hospital.

As TB was not accommodated in a hospital, she could not be a mental health patient and was therefore eligible for the DoLS.

Discussion
Given the complexities of the DoLS and the nature of their interaction with other legislation, this clarification from the court is very welcome. The deprivation of liberty aspects of mental heath law are likely to generate more such cases, and care providers and DoLS authorities should be alive to the precise legal status of the accommodation given to incapable people. As this case demonstrates, that status can be the key to determining whether a deprivation of liberty is lawful.

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Why aren't we locking up more little old ladies?

Many hospitals and care homes now have the power to deprive people of their liberty. That is the result of the DoLS – the Deprivation of Liberty Safeguards – which came into force in April. The government sees the DoLS as protection, principally for the old or the incapable. So maybe we should be worried that the new safeguards aren't being used.

The government predicted that by next spring, approximately 21,000 people would have had their cases assessed, and that a quarter of them would have been brought within the DoLS. According to the first statistics, that isn't going to happen:

- Well over two-thirds of the local authorities and PCTs charged with implementing the safeguards say they have had fewer than five DoLS cases, and almost a quarter that they have had no cases at all.
- It seems that only just over a third of the forecast number of people will be assessed in the first year of the DoLS and brought within the substantive safeguards.
- These national figures conceal an even more striking regional picture. One council, for example, reported 105 DoLS cases in April and May, while only two of its neighbours even reached double-figures.

Could there be a simple explanation for this: that in quite a few parts of the country, DoLS-applications are being actively discouraged? That would be worrying, for it would mean that hospitals and care homes had

placed themselves 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.

Nearest relative objection

Where a nearest relative has discharged a patient from detention that alone might count as an objection to a subsequent admission. That is the suggestion of the **High Court in M v East London NHS Foundation Trust**, a case which, though it was heard in February, was only reported over the summer.

Facts
A patient, Mr M, had been detained under section 3 of the Mental Health Act, even though in a telephone conversation that took place earlier the same day his nearest relative had registered a clear objection.

Decision
The nearest relative's objection would, of course, have precluded use of the Act, but the Approved Mental Health Professional (AMHP) who applied for detention believed it had been withdrawn. The court ruled there were no reasonable grounds for that belief, and that as a result, the patient's detention was unlawful.

On two previous occasions when Mr M had been admitted to hospital under the Mental Health Act, his nearest relative had discharged him from detention, and the court held those events might also have been taken into account here. "Clearly," it said, "the nearer in time the previous events are, the more relevant they become, particularly if they show… a state of mind of the nearest relative which is unlikely to be changed…" (In the light of the nearest relative's subsequent, unambiguous objection, these earlier events were of limited relevance in this case).

Comment
It is helpful to have the confirmation the High Court has provided in this case. If an AMHP's actions are to be lawful, it seems sensible that they will have to be based upon a view that is not just genuinely held, but also objectively fair. And it will come as no surprise to practitioners to learn that an objection, or a non-objection, to detention can be reversed.

The most striking element of this decision, however, is the suggestion that a previous discharge by a NR might count as his objection to a subsequent admission. That is likely to prove controversial and it might also be burdensome. Clearly, an AMHP cannot take account of a previous discharge of which he is unaware. He might be deemed to have a duty of reasonable enquiry, of course, but another question arises: where he knows about such a discharge, is an AMHP bound to treat it as the objection of a NR who, for whatever reason, he has decided not to consult?

Summary
This is what we now know:

- When an AMHP intends to make an application for a patient to be detained he must tell the nearest relative so and explain why.
- The nearest relative must be given a proper opportunity to object to detention.
- The AMHP need not go so far as to say, "Do you object", unless he has been given reason to doubt whether the nearest relative has objected or whether a previous objection (or non-objection) has been reversed.

- Previous events might have to be taken into account in deciding whether the nearest relative objects to detention.
- Everything turns on the AMHP's reasonable belief, and a belief may be unreasonable, even if it is genuinely held.
- The nearest relative may object to a patient's detention, even though he has previously failed to do so, but any such objection will only forestall detention if it is made by reasonable means and before the detention has been carried into effect.

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The second edition of David Hewitt's book, *The Nearest Relative Handbook*, was nominated for a BMA Book Award. More details can be found at http://www.jkp.com/catalogue/book/9781843109716/

Self-harm vs. suicide

There's a difference between wanting to kill yourself and simply wanting to harm yourself... and the law recognises it

Just because you cut yourself, or burn yourself or bruise yourself, that doesn't mean you want to die. Practitioners have long understood the distinction and now, it seems judges understand it too.

Mr P has a long history of self-harm: he has placed foreign objects in his mouth and used them to open up old wounds, he has exposed tendons in his feet and hands, and he has inserted matchsticks and glass into his penis. For 15 months, he was detained in a young offenders' institution, and when he came out, he asked for an inquiry to be held concerning the care he received there.

Mr P's request was turned down by the Justice Secretary, and that decision has been upheld by the High Court and, now, the Court of Appeal. One reason is his own self-harming behaviour: the court said it was just that and not the same as attempted suicide. And because it is only suicide, or near-suicide, that actually demands an inquiry, one need not be held in this case (**R (P) v The Secretary of State for Justice** [2009] EWCA Civ 701).

Self-harm and the ways of addressing it are poorly understood by the general public as much as by the courts, so practitioners may find the reason for this particular decision reassuring.

What is vulnerable?

That is likely to be one of the hot questions of the next few months. It has been posed most recently by the Department of Health, which is reviewing adult protection guidance published in 2000 (Department of Health and Home Office, October 2008, *Safeguarding Adults*). At the moment, the guidance – and the safeguards to which it gives access – relate solely to 'vulnerable' adults. But what does that mean?

Vulnerability
The notion of vulnerability precedes the adult protection guidance. It is used in the Care Standards Act 2000, for example, and also at the heart of the special measures available to certain witnesses in criminal proceedings (Youth Justice and Criminal Evidence Act 1999, section 16).

The guidance of 2000 is contained in the *No secrets* document. It says that "a vulnerable adult is one who needs community care services because of disability, age or illness; and who cannot take care of himself, or protect himself against significant harm or exploitation" (Department of Health and Home Office, 2000, *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*). Such a person might expect to be protected by a comprehensive 'inter-agency' framework.

There is concern, however, that this framework is more restricted than it should be, and that the problem is one of definition.

The House of Commons Health Committee, for example, says *No secrets* should not be confined to people requiring community care services, and that it should also apply to old people living in their own homes without professional support and anyone who can take care of themselves (House of Commons Health Committee, 2007, *Elder Abuse*, 2007, Second Report of the Session 2003-04, Volume 1, HC 111-I, paragraphs 8 & 14).

This echoes the Association of Directors of Adult Social Services (ADASS), which has argued that 'vulnerability' "seems to locate the cause of abuse with the victim, rather than placing responsibility with the acts or omissions of others" (ADASS, 2005, *Safeguarding Adults: A National Framework of Standards*, page 5).

As the new consultation document notes, there is "a broad belief that the definition does need revision, but no clear agreement on how this revision may take place" (Department of Health and Home Office, October 2008, *op cit*, chapter 9) and the Law Commission has recently weighed into the debate. As part of a much wider review of adult social care law, it says it wants to look for itself at the notion of vulnerability (Law Commission, November 2008, *Adult Social Care: Scoping Report*, paragraphs 4.280-4.293).

Alternatives
So, what are the alternatives? The Law Commission speaks favourably of the Safeguarding Vulnerable Groups Act 2006, which, it says, understands vulnerability "purely through the situation an adult is placed [in]" (Law Commission, 2008, *op cit*, paragraph 4.290). Some have argued, however, that it would be better to abandon the notion of vulnerability and instead, seek to protect people who are simply at risk.

That, certainly, is the purpose of legislation recently enacted in Scotland. The Adult Support and Protection (Scotland) Act 2007 covers people who "(1) are unable to safeguard their own well-being, property, rights or other interests; (2) are at risk of harm; and (3) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected."

ADASS, too, supports the use of risk as the keystone of adult protection, although its definition differs from the one used in Scotland. It says an adult at risk is one "who is or may be eligible for community care services" and whose independence and wellbeing are at risk due to abuse or neglect (ADASS, 2005, *op cit*). This reference to community care need not fall foul of the Commons Health Committee, however, for ADASS says it includes "those people who are assessed as being able to purchase all or part of their community care

services but whose need – in relation to safeguarding – is for access to mainstream services such as the police" (*Ibid*).

It remains to be seen what the adult protection review will yield, and which notion the government will choose. But its task might be even more important than the consultation document suggests.

The stakes
With the coming of the Mental Capacity Act 2005 and the creation of a new Court of Protection, the High Court has lost the work it used to do with incapable people. Recently, however – and perhaps not coincidentally – it has set about transforming its inherent jurisdiction so as to offer protection to what it calls 'vulnerable adults'. It proposes nothing less than the regulation of "everything that conduces to [their] welfare and happiness" (*Re SA (Vulnerable adult with capacity: Marriage)* [2006] 1 FLR 867).

Conclusion
Adult protection is too important a task to be scuppered by questions of nomenclature. Everyone concerned needs to know precisely when the safeguards will kick in; when, it seems, an adult will be vulnerable. And the apparent willingness of the High Court to supplement the *No Secrets* guidance with real, enforceable rights means that as far as such people are concerned, the stakes have never been higher.

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Case law update

Negligence in mental health care
A NHS Trust was held not to have breached the Human Rights Act where one of its patients had left hospital and committed suicide. The woman had been an informal patient, and the High Court held that the relevant obligations applied only to those who were detained under the Mental Health Act 1983 (the Trust had already admitted negligence under the common law). **Rabone and Rabone v Pennine Care NHS Trust [2009] EWHC 1827 (QB)**

Disclosure in tribunal proceedings
In the first mental health tribunal appeal, the new second-tier tribunal gave guidance as to the proper approach where a hospital resists disclosure of confidential third-party information. In this case, disclosure had been ordered by the MHRT, but as the patient had in the meantime been placed on a Community Treatment Order, the Upper Tribunal came to no judgment. **Dorset Healthcare NHS Foundation Trust v MH (2009) UKUT 4 (AAC)**

Seriously irresponsible conduct
A patient's mental impairment would be associated with 'seriously irresponsible conduct' where he had a compulsion to pick up litter, even if that litter was in the road. The patient had been knocked down by vehicles but considered himself invincible. He was therefore likely to act in a dangerous manner, and the hospital managers were right not to discharge him from detention after an attempt by his nearest relative to do so had been barred by his consultant psychiatrist. **R (GC) v Managers of the Kingswood Centre of Central and North West London NHS Foundation Trust, Administrative Court, CO/7784/2008**

Capacity and sexual offences
Where someone is charged, under section 30 of the Sexual Offences Act 2003, with having sexual activity with someone who has a mental disorder impeding choice, it becomes relevant to ask whether the alleged victim had capacity to choose whether to agree to that activity. The House of Lords has held that a person may lack of capacity with regard to activity with one person or situation, even though she possesses it with regard to another; and secondly, that a person may lack capacity, even where her choice is inhibited by a fear that is irrational. **R v C [2009] UKHL 42**

Lost capacity
Where a person had capacity when he gave instructions for a will but had lost capacity by the time he executed it, the will would be valid if, on that later occasion, he believed that it gave effect to his previous instructions (and those instructions continued to represent his wishes). **Perrins v Holland (2009) EWHC 1945 (Ch)**

Admission under a hospital order
A hospital order will cease to have effect and a patient's continued detention will therefore be unlawful if he is not admitted to hospital within 28 days of its being made. So held the Court of Appeal, in a case in which confusion had arisen because the order in question was amended four days after it had been made. Time flowed, the court held, from the first event. **R (DB) v Nottinghamshire Healthcare NHS Trust [2008] EWCA Civ 1354**

Change of status pending a tribunal hearing
A mental health tribunal application made when a patient is subject to a restricted transfer direction will lapse when the restriction lapses. The Administrative Court also held, however, that to avoid delay in such a case, a tribunal might treat the application as having been made after the lapse, and proceed to a hearing without requiring the patient to apply again. **R (MN) v MHRT (2008) EWHC 3383 (Admin)**

News in brief

High security – Consultation on new directions
The Department of Health is consulting on new safety and security directions for the high secure psychiatric services provided at Ashworth, Broadmoor and Rampton Hospitals. The closing date for responses is 2 November 2009 and more information may be found at
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103930.pdf

Access to CAMHS – New guidance
Two government departments have published guidance on how the new, 18 week referral-to-treatment standard might be achieved. The standard was included in the NHS Operating Framework for 2009/10, and the joint Department of Health and Department for Children, Schools and Families guidance will apply to non-emergency, consultant-led CAMHS services and pathways. It may be found at
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103651

Criminal Justice
The Sainsbury Centre has recently published two briefing papers that between them look at the present and future of mental health care in the criminal justice system. The first paper is a response to the recent Bradley Report, which among other things called for nationwide coverage of specialist teams to divert people with

mental health problems to treatment and support at any stage of the criminal justice system. The Sainsbury Centre supports this call and says that creating those teams should be a priority for the NHS and the National Offender Management Service. Sainsbury also supports Lord Bradley's call for a 14 day maximum wait to transfer people needing urgent care from prison to hospital, but it warns that secure hospitals already hold record numbers of people and that better step-down care is vital to stop beds from being blocked. The briefing paper may be found at
http://www.scmh.org.uk/news/2009_implementing_Bradley_report.aspx

In its second briefing paper, which is an update of an earlier document, the Sainsbury Centre says that the quality of mental health care available in our prisons is frequently poor, and it makes recommendations for improvements. The briefing paper may be found at
http://www.scmh.org.uk/publications/mh_prisons.aspx?ID=527

Homicides by the mentally ill

The number of people killed by individuals suffering from mental illness in England and Wales increased between 1997 and 2005, researchers at the University of Manchester have found. Other findings in the annual report by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) include a fall in suicide by mental health patients overall and a continued fall in suicide by in-patients. The Director of the NCI, Professor Louis Appleby, has, however, warned that it is important to keep these findings in perspective. The rise did not occur in current mental health patients, he said, and, "The risk of being a victim of homicide in England and Wales is around 1 in 1,000 and the risk of being killed by someone with schizophrenia is around 1 in 20,000." The NCI report may be found at
www.manchester.ac.uk/nci

Approved clinician changes

The directions that specify who may, and who may not, be an Approved Clinician have been amended to reflect changes to the statutory regulation of psychologists. Now, in order to be an Approved Clinician, a psychologist must be registered with the Health Professions Council. More information may be found at
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_100707

Flu pandemic: government plans to amend the Mental Health Act

The government could suspend some parts of the Mental Health Act if a flu pandemic causes severe staff shortages. A consultation document published this month suggests that the number of medical recommendations might temporarily be reduced, time limits be extended and additional people be approved to undertake statutory functions. The consultation is open until 7 October 2009 and the document is available at
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103683

Weightmans specialists

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.

The following members of the team are specialists in the law relating to mental health, mental capacity and vulnerable adults:

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