

Mental Health
News

June 2008

Capsticks

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Mental Health Act 1983: Revised Code of Practice

The revisions to the MHA 1983 Code of Practice were recently laid before Parliament. In the absence of any objection (and everyone is probably 'punch drunk' with this and, therefore, unlikely to raise any or many issues) this draft will probably be the final one.

This Code, together with the 2007 Amendments to the MHA, will be effective on 3rd November 2008.

A brief snapshot of the main changes to the Code follows.

Chapter 3 – Mental Disorder

This new chapter gives guidance on the definition of a mental disorder and upon the exclusion of alcohol and drug dependence from it.

“Learning Disability Qualification”

No-one with that can be detained in the absence of abnormally aggressive or seriously responsible conduct (3.8 – 3.16).

Chapter 4 – Applications for Detention

This replaces the old chapters 2 and 5. There is a revised list of general factors to be considered, as well as specific ones concerning the patient's own health and safety, or regarding the protection of others (4.5 - 7). There is guidance on where detention may not be appropriate because of the MCA 2005 (4.13 – 23).

A joint medical recommendation does not have to be by two doctors at the same time, but they should discuss it with the potential applicant rather than leaving it somewhat vague, as at present, as being “desirable” (4.45). There is new guidance on when it may not be “reasonably practicable” to inform / consult a Nearest Relative (4.59 – 62). Medical recommendations must now state which hospital is appropriate for the treatment to be given (4.77).

At 4.97 the need to contact the Mental Health Unit of the Ministry of Justice is re-stated, where there is a conditionally discharged restricted patient who is re-detained.

Emergency applications for detention are dealt with at chapter 5 and that it is the responsibility of PCTs and not hospital managers, to ensure that second doctors are available (5.7). The current Code at 6.5 is changed by 5.8, so that it is no longer prescriptive as to what steps an approved mental health professional should take if no second doctor is available.

The Code at chapter 6 refers to the Appropriate Medical Treatment Test. As readers will be aware, this is a change to the 1983 Act, in that such treatment must be available. This chapter discusses the test.

Chapter 8 – Nearest Relative

Patients can apply to displace Nearest Relatives if they consider them to be unsuitable (8.16 – 19). There is new guidance on the circumstances in which an AMHP can apply to a County Court to displace.

Chapter 9 – Attorneys and Deputies

This new guidance deals with the interface between the Mental Capacity Act and the Mental Health Act, and how the powers of both are affected by the MHA 2007.

Chapter 10 – Police Powers / Places of Safety

Chapter 10 is replaced regarding s.136.

Local policies should cover both s.135 and s.136 and there is guidance on the powers to enter premises. Furthermore, local policies should set target times for the start of assessments in places of safety (10.43). All those detained must be told that the maximum period of detention is 72 hours.

Chapter 11 – Conveyance of Patients

This replaces chapter 11 of the current Code, but it includes a revised list of factors to be taken into account.

At 11.5, if a patient is sedated, then they must be accompanied by someone who not only knows the patient, but has access to the necessary emergency equipment. It is PCTs who are responsible for commissioning the transport arrangements required for NHS patients under the Act (11.6).

Chapter 12 – Holding Powers

This replaces chapter 8 and 9 in relation to the powers of doctors and nurses under 5.2 and 5.4 of the Act. 5.2 may now be used by non-medical approved clinicians in charge of a patient's care, as well as by doctors.

An issue that always crops up has been dealt with at 12.5, which says that a report under 5.2 may be “furnished” to hospital managers by being placed in the internal mail system. For the same reason, the chapter no longer advises that hospital managers must ensure that sufficient staff are authorised to receive reports at any time of the day.

Guidance is given to nurses when considering whether or not to use their powers under 5.4 (12.28 – 30).

Chapter 13 – Receipt and Scrutiny of Documents

Chapter 13.12 states that the adequacy of reasons given in medical recommendations should be scrutinised by someone with appropriate clinical expertise (i.e. does not have to be by a doctor).

Importantly, at 4.75 it states that clinical descriptions of the mental disorders should include a description of their symptoms and behaviour, not just a diagnostic classification.

At 13.19, hospital managers must have arrangements to audit the effectiveness of receiving and scrutiny of documents.

Chapter 14 – Responsible Clinician

This gives guidance on the allocation and duties of such a person who must be an approved clinician, but does not need to be a doctor. Hospital managers should have local protocols to allocate responsible clinicians.

Chapter 15 – Disturbed Behaviour

This chapter replaces chapter 19, which readers may recall is entitled “Patients Presenting Particular Management Problems”. This gives guidance on the need for hospitals to have policies on responding to disturbed behaviour with an emphasis on de-escalation.

For advice on physical restraint (5.21 – 30), seclusion (15.43 – 62) as distinct from longer-term segregation, (15.63 – 66).

There is brief guidance on observations of patients (15.40), restraint to administer medication (15.32 – 33) and deprivation of daytime clothing (15.67). Medication to control behaviour is referred to at 15.15 and at 15.32 – 33, concerning where a restraint is required.

There is much guidance about how to minimise challenging behaviour and factors that might give rise to it. On the subject of restraint, this should not depend on “deliberate infliction of pain”. This wording may come as a surprise to some as that form of restraint has never been appropriate in a healthcare setting.

Hospitals will need to ensure that their techniques are effective without. The chapter looks at patients who are restrained on the basis of authority under the Mental Capacity Act, deprivation of liberty provisions and which are expected to come into effect in April 2009 (15.35).

Training in restraint is dealt with at 15.36 – 39.

Observation policies at 15.41.

Unsurprisingly, seclusion is dealt with at some length, not least because of the Munjaz case in the House of Lords where Capsticks’ Ashley Irons and Francis Lyons successfully represented the hospital concerned. That case is also the leading authority on the status or weight to be given to the Code of Practice.

The distinction between longer-term segregation and seclusion will be of interest.

Chapter 16 – Privacy and Safety

In relation to searching, guidance is given at 16.10 – 27.

Access to telephones (16.3 – 7) and access and storage of personal property is dealt with (16.8). Visitors are referred to at 16.11. The resolution of disputes between clinical and security staff about the appropriateness of searching a patient had to be referred to the Hospital Medical Director, but this has been re-placed and simply says that it should be dealt with in a local policy (16.23).

Capsticks’ Ashley Irons, Lindsay Gee and Francis Lyons have all written and advised on search policies and on the practicalities and issues associated with their implementation.

Chapter 17 – Advance Decisions

The potential impact of these in a mental health setting is discussed in chapter 17. After all, much treatment given to patients detained will be for their physical needs, separate to mental health.

Chapter 18 – Confidentiality

Clinicians and managers will find this of help, because of the ‘minefield’ that is associated with confidentiality / DPA related issues. It does refer to the importance of information sharing to manage risk or treatment. It sets out when confidential patient information can be shared without consent and has been and, presumably, will remain, a thorny issue.

Chapter 19 – Visitors

This replaces chapter 26. It refers to the importance of visitors but also the basis upon which they can be excluded (19.9 – 12). It states that hospitals must have a policy in relation to visitors and which should include visits to patients by those who are young (19.17).

Chapter 20 – Independent Mental Health Advocates

There is guidance on the services that advocates provide and upon working with them – these are expected to be introduced in April 2009.

Chapter 21 – Leave of Absence

This replaces chapter 20. In view of Supervised Community Treatment powers, Leave of Absence (LOA) must be considered first under the 2007 Act. There is guidance on what constitutes leave and the factors to be considered (21.5 – 8). An SCT must be considered, which is intended to grant LOA for more than 7 days (21.9).

Responsible clinicians cannot delegate the decision to grant LOA, except for when they are absent and their case load has been taken over by a colleague. Clinicians are reminded that LOA can impose conditions such as on accommodation or services to be received.

We have come a long way since the first draft Mental Health Bill was announced and several years on, the changes are nothing like as significant as they were. Nevertheless, the changes and the reference to the need for local policies require hospitals to review all their procedures and update them. Capsticks' lawyers are regularly asked to audit and to bring up to date a host of policies for healthcare organisations in the public and the private sector. Ashley Irons, Lyndsay Gee, Francis Lyons and David Firth have recently advised and revised over 90 policies for one organisation. The Healthcare Commission will also expect policies to reflect the new legal position.



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Smoking ban upheld

G v Nottinghamshire Healthcare NHS Trust, Secretary of State for Health.

Just as this Newsletter was going to print, the High Court Judgment on 20th May upheld the Health Act 2006, which made provision for the prohibition of smoking in mental health hospitals, due to be implemented on 1st July.

The argument brought by patients was that they were detained and, therefore, should be in no different position to the exempted premises, which include care homes, hospices and prisons.

It is likely that this decision will go to the Court of Appeal but, in the meantime, all mental health hospitals must ban smoking upon their premises. As always, it is not quite that straightforward.

The Department of Health acknowledged "...that there could be cases (which we would expect to be rare) in which the protection of mental health requires that facilities to smoke be made available". The Rampton Policy document itself provided for very limited exceptions (acute psychiatric condition) and which, therefore, gave a discretion upon clinical staff (para. 109).

This Judgment will come as a surprise to many, as it is hard to square the rights of those detained in different establishments having different smoking rights. The High Court did not accept that Article 8 gave a general right to smoke and it was held that a failure to provide smoking facilities for mental patients, does not come within the ambit of Article 8 (para. 105). The Court's conclusion was that it was "...satisfied that the legislative objectives are sufficiently important to justify limiting any rights the Claimants have under Article 8" (para. 116). At the end of the Judgment it was held that it could not be said that "...the smoking ban is unlawful or that the Trust policy is being applied inflexibly".

The issue of flexibility is far from resolved. Despite the regulations assuming there will be no exceptions, it is clear the DOH and the Court accept that there needs to be a discretion. This must be taken into account when drafting policies.

Our next Newsletter will examine the Judgment in detail. In the meantime, contact Ashley Irons for further information or to discuss.

Corporate manslaughter

The Corporate Manslaughter and Corporate Homicide Act 2007 came into effect on 6th April 2008 although certain duties currently fall outside the Act. Corporate manslaughter cases will be investigated by the Police and tried in the Crown Court and the offence is also available as a verdict at an Inquest

Are my organisation's activities covered by the Act?

Readers may be aware that the Sections in the new Act relating to duties owed to persons by reason of their being held in custody (including as patients detained under the Mental Health Act 1983) are not expected to come into force for a further three to five years from 6th April this year. That is no reason for complacency, since the majority of activities undertaken by mental healthcare providers in relation to detained patients attract duties that are covered by other sections of the Act already in force now. These duties arise from the supply of goods and services (whether paid for or not), as the occupier of premises, and would almost certainly extend to the provision of healthcare and hotel services to detained patients.

Breach of duty

Corporate liability for manslaughter will arise if the way in which an organisation's activities are managed and organised by its senior managers, causes a person's death and amounts to a gross breach of the relevant duty of care owed to that person. Whether or not a breach is "gross" will depend on the circumstances of the case, but the prosecutor will look for evidence of a lax attitude to identifying and addressing risk, a failure to follow guidance and best practice and the risk of death posed by the activity in question. The greater the risk, the more stringent the requirement to take steps to mitigate it as far as possible.

Given the range of duties owed and the extent of inherently risk-rich activities undertaken by providers of mental healthcare services, the potential for liability under the Act is broad. Guidance on the Act issued by the Ministry of Justice gives examples of relevant failings, including those relating to systems of work, staff training, adequacy of equipment, supervision of middle management, arrangements for monitoring risk and auditing lessons learned from previous SUIs, Adverse Incidents and Near Misses.

Systems failures

Readers will be aware from the Middleton decision in the House of Lords that, certainly when patients are detained, an Inquest can look at the broad circumstances leading to the death of a patient, rather than the narrow test of how someone came by their death. Together with a narrative verdict, the scope for criticism has been significantly widened.

The Court of Appeal in *Savage* (covered in our last issue) found that in order to establish an Article 2 breach (right to life), the standard of organisational negligence does not have to be gross negligence. There has to be a "real and immediate risk" to life and where remedial steps were possible, but were not put in place. This issue refers to the implications arising from a Judgment concerning the death of an army soldier in Iraq.

Taken together, these features show increasing scrutiny, with the benefit of hindsight, on how organisations identify and manage risk. Organisations can now be judged to have the knowledge to be able to have reasonably safe systems of work – therefore, one would expect to see every hospital having a system of incident analysis and reporting, risk management with auditing etc.

Statutory duty

The Corporate Manslaughter Act itself imposes no new duties: it is an offence-creating statute, not an obligation-imposing one. If those duties are already met, then organisations have little to fear from the new Act, which punishes very severe management failure, involving corporate conduct that falls far below the standards that can be expected of it.

That said, the duties already in place are very extensive. In addition to the common law duty of care, the most wide-ranging statutory duty is owed under the Health and Safety at Work Act 1974 for organisations to conduct their activities in such a way as to protect, so far as is reasonably practicable, the health of safety of those they employ and those otherwise affected by their activities.

In the event of a suspected corporate manslaughter offence, the investigator may also examine the extent to which other relevant duties have been met, in order to ascertain the degree of any management failure. This review may include the Health Act 1999, s.18, which states "...it is the duty of each manager to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare which it provides for individuals".

The Department of Health in "A First Class Service" 1988 stated that clinical governance required "...an entire framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care...". This means that not only must policies and procedures be put in place, they must also be adhered to in practice in order to demonstrate robust systems for risk management.

Where, for example, a hospital had a system of monthly inspections of ambubags for resuscitation, there would be clear evidence of organisational failure if an emergency happened and the bag did not work, later found to be because the scheduled bag inspections were not, in fact, carried out. This was a situation faced by Ashley Irons at an Inquest concerning a mental health trust.

The Corporate Manslaughter law in practice

It will be interesting to see how, and in what circumstances, corporate manslaughter prosecutions develop. In the meantime, the best advice is for those in organisations, with direct responsibility for risk, to ensure that existing policies are followed and that there is an effective means of auditing their practice. As always, in the event of an Inquest or an HSE prosecution, having the paperwork to prove systems are working effectively is all-important.

The HSE have estimated that approximately 12 prosecutions under the new law will take place annually across all sectors, including those whose activities are the most inherently dangerous (construction, healthcare and transport respectively). The Department of Health's inquiries and investigation team consider that the HSE's best guess is a severe over-estimation. Any organisation that is convicted, however, will face an unlimited fine, heavy legal costs and very significant damage to corporate reputation and competitiveness.

The reality is that a manslaughter investigation alone, even if it does not proceed to prosecution, will be time-consuming and very stressful for staff members. However, perfection in risk management is not expected and if your organisation can provide evidence that reasonable is in a position to provide good evidence that risk were considered, and steps were taken to mitigate those risks, then it should be possible both to avoid prosecution under the Act and for any police investigation for corporate manslaughter to proceed as smoothly as possible and with the minimum of disruption to your organisation.

Please contact David Firth or Ashley Irons to discuss the implications of the new Act to your organisation.

Putting people first: new partnership working

At the beginning of this year a protocol was signed by representatives of health and social care services across the entire spectrum – from the Health Secretary, through CSCI, to organisations such as the English Community Care Association.

This protocol sets out aspirations and structures for partnership working between the independent sector, Local Authorities, and the NHS. Its goal is the transformation of adult social care – including services for people with mental health problems – into a more personalised system, with greater input and control by service users and their families. Funders, regulators and service providers alike are called on to participate in developing a Sustainable Community Strategy – informed by new Joint Strategic Needs Assessments undertaken by the NHS and Local Authorities. This is intended to improve a great range of functions, including hospital discharge, support packages, co-located services (to bring together social care, primary care and other professionals), and “universal” information, advice and advocacy.

The private and voluntary sector is encouraged to develop innovation in the delivery of services - for example, by means of social enterprise. Personal budgets will move farther into the mainstream (and may be introduced into the NHS too, for the benefit of people with long-term conditions, subject to the outcome of Lord Darzi's Health Review, which is due in June). The stigma endured by many mentally ill people should be tackled more pro-actively; and the protection of vulnerable adults from abuse should be improved.

Whether or not these admirable intentions will bear fruit remains to be seen. But this protocol offers service providers, in the private and public sectors, a new focus for partnership working, to empower patients and at the same time to afford staff greater job satisfaction. It also opens up plentiful opportunities for independent providers to take a more prominent role in service delivery and development, in this changing climate.



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Mental Health Seminars

For further information on these seminars contact the Capsticks Events team on 020 8780 2211 or visit www.capsticks.com/seminars

Risk in Mental Health: Are you ready for the New Changes

Wednesday 29th October 2008,
Maple House, 150 Corporation Street, Birmingham, B4 6TB

This interactive seminar will provide an opportunity to raise legal questions and discuss issues you may be dealing with, including:

- Duties of care – the Courts' view
- Foreseeability – responding to risk
- Learning Lessons from Compensation Claims – avoiding repetition
- Corporate Manslaughter
- New Inquest Neglect threshold
- Investigations – Healthcare Commission, HSE, SUI, MAPPA, Homicide
- Tips on Giving Evidence

Detention under MHA 2007 and the new Code of Practice

Wednesday 2nd July 2008,
Maple House, 150 Corporation Street, Birmingham, B4 6TB

From October the legal landscape changes. This interactive seminar will identify and resolve practice issues facing hospitals, including:

- October 2008 Changes
- Compulsion in the Community
- Informal Patients
- Interactive Discussion with Case Studies

Risk in Mental Health: Are you ready for the New Changes

Wednesday 19th November 2008,
Capsticks Solicitors, 77/83 Upper Richmond Road, London, SW15 2TT

This interactive seminar will provide an opportunity to raise legal questions and discuss issues you may be dealing with, including:

- Duties of care – the Courts' view
- Foreseeability – responding to risk
- Learning Lessons from Compensation Claims – avoiding repetition
- Corporate Manslaughter
- New Inquest Neglect threshold
- Investigations – Healthcare Commission, HSE, SUI, MAPPA, Homicide
- Tips on Giving Evidence

Detention under MHA 2007 and the new Code of Practice

Wednesday 9th July 2008,
Capsticks Solicitors, 77/83 Upper Richmond Road, London, SW15 2TT

From October the legal landscape changes. This interactive seminar will identify and resolve practice issues facing hospitals, including:

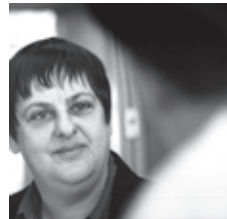
- October 2008 Changes
- Compulsion in the Community
- Informal Patients
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Impact of Capacity on Mental Health treatment: the position now

Date to be advised, please check our website
Maple House, 150 Corporation Street, Birmingham, B4 6TB

- Mental Capacity Act 2005 - Important Changes
- How to Decide?
- The Overlap Between the Mental Health Act 2007, Mental Capacity Act 2005 and Common Law
- Interactive Discussion with Case Studies
- An Alternative Perspective and Wrap Up

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