Capsticks

News Mental Health Law

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Establishing medical necessity

R v RMO Dr Haddock and MHAC/SOAD ex parte JB Court of Appeal 11th July 2006

In July the Court of Appeal determined how challenges brought by patients against medication being compulsorily given, should be decided. Their conclusions will be quoted in every compulsory treatment case that follows.

Background

JB was classified as suffering from S.37/41 psychopathic disorder (PD) in a high secure hospital. The RMO stated that the patient suffered from mental illness (MI) as well as PD and that treatment with antipsychotic medication would alleviate the condition and provide a "gateway" for treatment of the PD.

In 2005 an MHRT held that the patient was detainable under a PD but refused to add a second classification of MI.

The judicial review was brought by the patient on the basis that the Judge had failed to decide which disorder the patient suffered from and which justified the giving of medication. He also criticised the second-opinion-appointed doctor's (SOAD) opinion as giving insufficient justification to sanction compulsory treatment under S.58. A doctor and psychologist called by the patient said that the patient did not suffer from any mental disorder and therefore the patient could neither be compulsorily treated nor detained.

Medical Necessity Test

The leading case of *Herczegfalvy v Austria* said that the Court must "*satisfy itself that the medical necessity has been convincingly shown to exist*". It was argued on behalf of the patient that this involved 3 separate tests:-

- Did the patient suffer from a particular mental disorder; and
- What was the treatment for that; and
- Would the patient benefit from treatment?

The Court rejected this "compartmentalised" approach that was attempted upon the 3 tests proposed.

Proof

In looking at S.58, the Court said that the SOAD's task was a medical one "*to be undertaken on the Bolam principle of 'best interests'*".

Importantly, the Court of Appeal said about proof:-
"*I do not consider that the requirement on a Court to be convinced of medical necessity in the light of the medical evidence and other evidence, is capable of being expressed in terms of a standard of evidential proof. It is rather a value judgment as to the future - a forecast - to be made by a Court in reliance on medical evidence according to a standard of persuasion. If it is to be expressed in forensic terms at all, it is doubtful whether it amounts to more than satisfaction of medical necessity on the balance of probabilities or as a likelihood of therapeutic benefit*".

Diagnosis

The High Court Judge said:-
"*I do not think that it is necessary for me to decide for myself whether he is suffering from MI as well as from PD, provided the proposed treatment is convincingly needed to alleviate whatever mental disorder afflicts him*".

The Court of Appeal's agreement represents a significant easing in the approach of courts.

In citing the House of Lords judgment in the Ashworth B (2005) case that classification "*was irrelevant to decisions upon whether proposed treatment was necessary*", the MHRT view was irrelevant.

Review or cross-examination of doctors?

The patient had argued that following *Wilkinson v Broadmoor*, "a full merits review" meant that he should have the right to cross-examine the medical evidence at a judicial review.

The Court of Appeal disagreed and said that the High Court Judge was right *"to take his witness statement (i.e. of the RMO) at face value*".

The Court's function is much more of a review, than deciding for itself the diagnosis or indeed the benefit of treatment. The court simply reviews the evidence and if the RMO's evidence is sufficiently persuasive, there is nothing to be gained by cross-examination of that evidence in court, even if there is evidence produced by the patient that fundamentally disagrees with it.

This case reduces the opportunities for a successful challenge by a patient. Whether or not that was the intention, it is the most likely effect. The Court awarded the Trust the costs of the appeal.

Ashley Irons and **Francis Lyons** represented the successful Trust in this case. Capsticks' partners have represented the relevant Trusts in all the UK cases cited by the Court in this Judgment.

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Mental Capacity Act - draft Code of Practice

With the Mental Capacity Act (MCA) coming into force next year, a draft Code has been published. Below is a summary of the key points:

Assessing capacity

The Code (3.26) states that whilst capacity should be assessed each time there is a separate decision to be taken, there may be patients whose absence of capacity remains constant. It will be essential that the assessment is recorded at the time that assessment was done.

Best interests

The Code (4.51) says clinicians and staff "must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances and apply all elements of the checklist". The Code (4.6) warns against making assumptions about best interests based on an initial impression.

Protection from liability

The Code (5.9) states that treatment decisions "may attract protection from liability under S.5, but only in circumstances where the person concerned is believed to lack capacity and the act is considered to be in their best interests and is carried out in accordance with the Act's principles". This belief must be "reasonable". There is no protection however where there is neglect (5.33)!

Restraint

This does not just mean physical restraint, but can refer to restriction on liberty of movement. Of practical relevance is 5.43 - "It may be appropriate to have a secure lock on the door leading to a busy main road, but it would not be a proportionate response to lock someone in a bedroom all the time because they have a tendency to wander out onto the road. It may be appropriate to allow someone outside but not to be able to access, for example, a busy road as opposed to, say, a garden or somewhere free of traffic." As the Code says at 5.47 - "The difference between restriction of liberty and deprivation of liberty is complex".

Lasting Powers of Attorney

An Attorney also owes a duty of care in just the same way that clinicians do and "must act with due care, skill and diligence" as if they were managing their own affairs.

Advance Decisions

The Code at 8.16 sets out the format for written and oral Advance Decisions, often called Living Wills. At 8.53 the Code states - "Having a reasonable belief means that healthcare professionals must be able to point to reasonable grounds as to why they believe that a valid and applicable advance decision exists".

Relationship between Mental Capacity Act (MCA) and Mental Health Act (MHA)

If treatment is required for a physical condition, the MHA is irrelevant and the MCA must be used (12.6). The MHA will trump the MCA in relation to treatment for a mental disorder.

When wrestling with the detail of the MCA /Code, clinicians will need to keep in mind that "clinicians will need to provide care and treatment in their best interests as they would for any other patient who lacks capacity" (12.26).

Mental Capacity Act conferences

6th December 2006

A practical guide to Mental Capacity

In a free 2-hour seminar Capsticks' partners will look at issues that will arise in Mental Health, Acute and other healthcare sectors and give practical advice on how to meet them.

For further information visit our website at: www.capsticks.com/seminars

1st February 2007

Implementing the Mental Capacity Act

Healthcare Events (in conjunction with Capsticks) are holding a national conference at The Royal Society in London, looking at all those affected including:

- The patient's perspective
- Long-term care
- Acute care
- Mental health
- Palliative care
- Withholding lifesaving treatment
- Ethics

For details of this event contact *katie@healthcare-events.co.uk*

Recent cases

Primary health need

R v Bexley Care Trust and others ex parte Grogan (25th January 2006)

PCTs are regularly involved in determination of whether a person's primary need is for healthcare or not.

Here, G challenged a Trust's decision that led to the conclusion that she did not have a primary health need. The Health authority had issued guidance to PCTs as a result of that received from the Secretary of State following the *Coughlan* case in 1999. Readers will recall that this concerned the respective financial responsibilities of the NHS and local authorities in respect of continuing care services.

Accommodation could be provided by social services or by the NHS. G had been assessed as ineligible for NHS continuing care funding, and had been required to contribute to her care home costs.

The parties in this case agreed that the correct approach was that of "primary health need".

The Court noted that the Department of Health's guidance was "far from clear". The Trust's decision did not make it clear that they had adopted the primary health need approach. There was also a lack of clarity when it described the principles and evidence that it had taken into account, as well as the tests that were being applied. As a result, the Trust's decision was set aside for them to consider afresh, by revision of the continuing care criteria and a fresh assessment of G.

For all Trusts involved with service reconfiguration, it is a reminder of how important it is to extract the principles from the leading case of *Coughlan* (and those that followed) and implement a process that is capable of withstanding judicial scrutiny.

Call **Lindsay Gee** (who acted for the NHS in this case) for further discussion.

Hysterectomy for detained patient

Trusts A and B v H (25th May 2006)

Clinicians are often faced with dilemmas when a patient detained under the MHA needs treatment that is unconnected with a mental disorder.

In May, a Court granted a declaration authorising the treatment proposed for a patient who lacked capacity.

The patient was detained under S.3 suffering from schizophrenia and delusional beliefs. She had an ovarian cyst that suggested cancer and which caused her considerable physical discomfort, as well as creating breathing and eating difficulties. Doctors recommended that her best interests required a total abdominal hysterectomy, but H refused on the basis that she wished to have children. She had also refused less drastic surgery limited to removing the cyst and ovary.

The Court accepted the application brought by the PCT and the NHS Trust. It found that, whilst a detained patient is presumed to be competent, H who had delusional beliefs, did not appreciate that her life was threatened if she did not have necessary surgery. She therefore lacked capacity because she had an "impairment of mental functioning that rendered her unable to make a decision" on whether to have the surgery recommended.

No operation could go ahead unless it was in H's best interest. In line with other cases, the Court said that this was a very broad test which included social and welfare issues, as well as clinical ones. The Court noted that the advantages and disadvantages of various treatment options had been considered along with their likely effect upon the condition of the patient. The Court duly authorised a total hysterectomy.

Thirdly the Court accepted that in order to have this treatment, resistance could be met by a reasonable use of restraint, to include sedation. Whenever restraint is likely to be required, there always had to be an assessment of advantages and disadvantages. In other words, it had to be a proportionate response to the need for surgery. Here it was clear that her health would deteriorate without it. It was also hoped that her quality of life, including her mental health, would benefit from surgery.

Capsticks partners, **David Mason, Peter Marquand, Lindsay Gee** and **Ashley Irons** are regularly consulted about capacity and consent in relation to mental health patients and are currently giving seminars on the impact of the Mental Capacity Act.

Trust not obliged to fund leave of absence

R v West London Mental Health Trust ex parte K Court of Appeal (26th February 2006)

The Courts continue to encounter questions of NHS resources and allocations as is illustrated by this recent Court of Appeal decision.

K had been a S.37/41 patient at Broadmoor since 1982. Matters came to a head when K's RMO supported a potential move to a medium secure unit (MSU) by an initial trial Leave of Absence (LOA) under S.17 when, following a change of drug treatment in 2004, a private hospital offered a bed within a medium secure ward – but on the basis that the patient arrived on LOA (rather than as a formal transfer). Readers will be aware that this is common, because it makes it easier for the transferee hospital to send the patient back if the placement is not a success.

The crux of K's case was that as his own RMO supported the move by means of S.17 leave, the NHS must finance it. The Trust refused - hence the challenge made by judicial review.

The Trust used its own and separate medical evidence to the effect that K was not yet ready for a MSU placement and that when he was ready a placement should be sought within the NHS - only if that failed should a private option be considered.

The Court of Appeal supported the Trust, as had the High Court.It held that the RMO, whilst having power to grant LOA, did not also have the power to require funding to give it effect. The provision of services under S.3 of the 1977 Act was one that was delegated by the Secretary of State to the Trust.

It also found that the Secretary of State/ Trust was not bound to act upon the judgment of the RMO. When making a decision as to whether to devote resources to a particular treatment option, it had to be considered in the light of other factors. These would include:

- the seriousness of the patient's condition,
- the likely prospects of success of the move,
- its cost,
- and, importantly, the competing needs of other patients.

In other words, the funding decision could not be taken in isolation from all others faced by the Trust.

It would be "irrational" to oblige the Trust to fund what the RMO had in mind without question. The Secretary of State / Trust was entitled to look at all other information that was relevant.

Capsticks Partner **Lindsay Gee**, acted on behalf of the successful Trust; the outcome of the case will be a considerable relief to all funding authorities.

Discretionary life sentence or S.37/41 Order?

R v Paula Staines Court of Appeal (26th January 2006)

PS argued that a S.45A order was wrongly given. Section 45A enables a Crown Court, when imposing a prison sentence, to give a direction for immediate admission to a specified hospital if the offender is suffering from a psychopathic disorder (PD).

PS argued that at the time of the offence she was suffering from mental illness. She had pleaded guilty to manslaughter by reason of diminished responsibility. At the time, one expert decided she suffered from PD and the other stated she had borderline personality disorder. After the sentence, it became clear that she was treatable (at Broadmoor Hospital), making slow but consistent progress.

The Court of Appeal decided that S.45A could be used if someone was suffering from mental illness (MI) in addition to psychopathic disorder, but not MI alone. At the time of the offence, it was likely she suffered from both. The Court disagreed that a prospect of returning to prison would prevent further progress, as it had not done so to date. The Court felt that the Crown Court order was appropriate, giving the public "*a significantly enhanced and desirable degree of protection from the risk of danger from her*". Accordingly, there was no reason to change the discretionary life sentence.

Bournewood Proposals

The Department of Health has published an outline of its proposals for patients who are in the "Bournewood Gap". The provisions will be enacted through amendments to the Mental Capacity Act 2005 when the Mental Health Bill becomes an Act.

Who do the proposals cover?

The Department's provisions will cover adults, i.e. over the age of 18 (*age assessment*) who:

- are in a hospital or registered care homes; and
- suffer from a disorder or disability of mind (*mental health assessment*); and
- lack the capacity to give informed consent to the arrangements made for their care (*mental capacity assessment*); and
- for whom such care has been independently assessed as being in their best interests and necessary to protect them from harm (*best interests assessment*).

If patients do not consent to care proposed (or would not consent if they had capacity) and they need to be detained, then the Mental Health Act should be used as it is at the current time.

Need for Authorisation

If the staff at a hospital or care home identify a patient in their care who meets the criteria mentioned above they must apply to the "supervisory body" for authorisation. For care homes that body will be the local authority and for hospitals it will be the PCT. In Wales it will be the National Assembly for Wales. It is unclear who will monitor compliance with the regulations. It will be unlawful to detain someone under the amended Mental Capacity Act without authorisation from the supervisory body or the Court of Protection.

Authorisation Process and Notification

On receipt of a request for authorisation the supervisory body must confirm that:

- the patient meets the criteria
- the patient is not subject to conflicting provisions under the Mental Health Act (*eligibility assessment*);
- such a step is proportionate

If any of the criteria are not met the supervisory body must turn down the request for authorisation.

Representative

The best interests assessor will recommend who should represent the patient's interests, if authorisation is granted. The supervisory body must appoint someone to act as the person's representative. The patient can choose for themselves if they have capacity to do so. An advocate can be appointed to act as the representative. The representative should support the patient in all matters concerning the authorisation, request reviews and apply to the Court of Protection on their behalf, as necessary.

Authorisation

If the supervisory body grants the authorisation then:

- the authorised period will be determined by the best interests assessor and will be no more than 12 months.
- the authorisation must include the purpose of the deprivation of liberty, the time period, any conditions, and the reasons that each of the assessment criteria are met.

Managers' Duties and Review

The managers of the hospital and care homes where the patient is detained are under a duty to ensure that the patient and representative understand the authorisation, the appeal and review processes. They must ensure that the conditions are met; and monitor the patient's circumstances and the need for authorisation. Authorisation must be reviewed by the supervisory body if the hospital, care home, patient or their representative, a donee or deputy request it.

Following the review the supervisory body may: (a) terminate the authorisation, (b) vary the conditions or (c) change the reason for authorisation.

Appeal

The patient or their representative has the right of appeal to the Court of Protection against an authorisation decision at any time.

Should you have any queries regarding these developments please contact **Lindsay Gee, Ashley Irons** or **Francis Lyons**.

Capsticks clients win Stone Report case

Mr Justice Davis delivered his judgment on 11 July 2006 in Michael Stone's unsuccessful judicial review of a decision to publish an independent inquiry report in full. Capsticks' **David Mason** represented all three organisations defending their decision, having originally advised on all aspects of their decision-making process leading up to the publication decision.

Following Mr Stone's original murder conviction, the three defendants (South East Coast Strategic Health Authority, Kent County Council and the Kent Probation Board) commissioned an independent inquiry into Stone's care, treatment and supervision in the years up to the 1996 murders of Megan and Lin Russell, and the attempted murder of Josie Russell.

The report was completed by the end of 2000, and it was the panel's intention to publish the report in its entirety. However, whilst Mr Stone accepted that the full report could be disclosed to health professionals and others on a confidential basis, he considered that it was only appropriate for a version omitting virtually all references to his past medical history to be made publicly available. In his judicial review application in December 2005 he contended that to do otherwise would amount to a breach of Article 8 of the European Convention on Human Rights (right to privacy), and also a breach of the Data Protection Act.

The defendants' case was that the claimant's suggestion was impossible in practice, and relied particularly on the clear public importance of his case. Indeed, if the Judge ruled that publication was not possible in this case because of Mr Stone's right to confidentiality, it would be hard to see how any such inquiry report could have been published in the future without the consent of the perpetrator.

Mr Justice Davis found for the defendants, and agreed that publication of Mr Stone's confidential information was necessary in the public interest. He said the court must conduct a "*close and penetrating examination*" of the facts of the case, and that the defendants had succeeded in showing a "*compelling case… to justify publication of this report in its current form*". A threatened appeal was not pursued because Legal Aid was refused. The full report will now be published in the autumn.

If you would like to receive more information about this decision or about Independent Inquiries in general, please contact Partner **David Mason**.

Always obtain professional advice before applying this information to particular circumstances. Capsticks accepts no liability for errors of fact or opinion contained within this document.

The next edition of this newsletter will be available in the Autumn.
Email info@capsticks.co.uk to subscribe, or to request more copies of this edition.

Certificate in Mental Health Law 2006

Late bookings still available…

The 2006 course is under way, but we do still have a few places available for the remaining two seminars:

Wednesday 27 September

Governance and regulatory framework

- Duties of Care
- Handling complaints
- Healthcare Commission standards
- Health and safety
- Investigations

Wednesday 29 November

Specialist legal issues

- Breaches of confidentiality
- Learning disability perspective
- Children and adolescent issues
- Clinical negligence in mental heatlh
- Suicides and claims

For further information visit our website at *www.capsticks.com/seminars*.

For other courses and seminars turn over to final page.

Forthcoming seminars and courses

Wednesday 13 September (Diploma in Clinical Risk Management 2006-7)

Why accidents happen

A day designed to give an introduction to why accidents happen, including root cause analysis, the reporting of patient safety incidents and how this can contribute to effective risk management.

Thursday 21 September 4-6pm Free seminar

Disciplinary and grievance procedures - practical issues

- The statutory requirements
- Investigating grievances
- What is a grievance - a review of recent cases
- The modified procedure
- Multiple grievances

Wednesday 11 October (Diploma in Clinical Risk Management 2006-7)

Standards and risks

A day focusing on the key areas outside obstetrics

- Standards for better health explained
- Risk registers and risk reduction
- Integrated governance
- Compliance with CNS standards
- Audit and inspection

Wednesday 18 October 4-6pm Free seminar

Healthcare related deaths - Inquest reforms and the Human Tissue Act

- Post Mortems and the Human Tissue Act
- The Coroners Reform Bill - implications for healthcare providers
- The new Inquests regime - how it is working
- Mental health perspective
- Case study

Thursday 2 November 4-6pm Free seminar

Equal pay in the NHS

- Caselaw update
- Time limits
- Like work/work of equal value
- The material factor defence
- NHSLA and the handling of claims
- Test cases

Wednesday 6 December 4-6pm Free seminar

A practical guide to Mental Capacity

- Review of common law background
- Key principles and provisions
- Advance decisions to refuse life sustaining treatment
- The new ‘Lasting Power of Attorney’
- The role of the Court of Protection, the Office of the Public Guardian and the role of Deputies

Thursday 7 December 4-6pm Free seminar

Managing change

- Reconfiguration
- Handling redundancies
- Consultation
- TUPE
- Managing contractual changes
- Age discrimination

For further information contact Catherine Macartney on 020 8780 4759, email seminars@capsticks.co.uk or visit our website at www.capsticks.com

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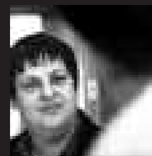

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