result in confidential information being disclosed wrongly.

Lending Code: mental health issues

A new Lending Code (replacing the Banking Code), published by the British Bankers' Association, the Building Societies Association and the UK Cards Association, came into force on 1 November 2009.[3] The new Code provides more extensive guidance on how lenders should approach mental health issues and includes information on a form produced by the Money Advice Liaison Group (the 'Debt and Mental Health Evidence Form') which can be used, with the borrower's consent, to help people manage their financial affairs and share information from health and social care professionals, subject to appropriate confidentiality safeguards.[4]

The guidance in the Code covers what should be done by lenders when they realise that a borrower has a mental health problem. In such cases, lenders should act sensitively and flexibly. Lenders should also arrange to have staff specially trained to deal with mental health issues.

Comment: It is to be welcomed that lenders are becoming more aware of the difficulties facing people with mental health problems. However, it should be noted that the individual will still be bound by his/her obligations unless it can be proved that a lender knew, or ought reasonably to have known, that s/he lacked the capacity to make an informed decision about entering into a financial transaction. The new Code may help to ensure that lenders are more careful in the future, but it is always very difficult to set aside such transactions as the onus is on the individual borrower.

1 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109251.
2 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104949.
3 Available at: www.lendingstandardsboard.org.uk/docs/lendingcode.pdf.
4 Available at: www.moneyadvicetrust.org/section.asp?cid-53.


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Social circumstances reports for mental health tribunals – Part 1

Christopher Curran, Malcolm Golightley and **Phil Fennell** provide advice on the provision of a social circumstances report (SCR) for mental health tribunals, which was made a regulatory requirement in England under the Tribunals, Courts and Enforcement Act 2007. Part 2 of this article, which looks at drafting a SCR, will be published in July 2010 *Legal Action*.

Introduction

The Mental Health Review Tribunal Rules 1983 (the MHRT Rules) SI No 942, which applied formerly to England and Wales, have been replaced by separate rules for England and Wales. In England, the provision of information in mental health cases by the responsible authority and the Secretary of State for Justice is governed by the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the Tribunal Procedure Rules) SI No 2699 r32(5) and a Practice Direction issued by the tribunal in 2008.[1] The Practice Direction applies to a 'mental health case' as defined in rule 1(3) of the Tribunal Procedure Rules. In Wales, the matter is governed by the Mental Health Review Tribunal for Wales Rules 2008 (the Wales Rules) SI No 2705 r15 and the Schedule to the Wales Rules.

In England, a SCR is now a mandatory requirement in all but Mental Health Act (MHA) 1983 s2 cases, where it must be sent or delivered to the tribunal if it 'can reasonably be provided in the time available' (Tribunal Procedure Rules r32(5)(d)).[2] In Wales, there is not an absolute duty, but the information provided for the tribunal must, 'where reasonably practicable', include a SCR (r15(5)(c) and Part B para 2 of the Schedule to the Wales Rules).

Wales

The Wales Rules require that the responsible authority's statement, including biographical information, an up-to-date medical report, and, insofar as it is reasonably practicable to provide it, an up-to-date SCR, must be sent within three weeks (or two weeks if the patient is a recalled, conditionally discharged patient). Given the vital importance of the SCR to the patient's chances of discharge, it is submitted that cases where it is not reasonably practicable to provide one should be extremely rare. Indeed, it would be difficult to square non-provision of a SCR with the overriding objective to deal with cases fairly, justly, efficiently and expeditiously under rule 3 of the Wales Rules (the overriding objective in the Tribunal Procedure Rules is in rule 2). It may also be argued that there is a positive obligation on bodies exercising a review function under article 5(4) of the European Convention on Human Rights ('the convention') to seek information about the community support available to ensure that detention is a proportionate response to the patient's needs.

SCRs and human rights

Article 5(4) of the convention requires states to provide speedy access to independent review of the lawfulness of detention before a court or tribunal with the power to order discharge. In England, the task of reviewing the lawfulness of detention is exercised by the mental health tribunal (and in Wales by the Mental Health Review Tribunal). For convention purposes, lawfulness means more than conformity with national legal requirements. Reviewing the lawfulness of detention requires the reviewing body to be in a position to decide whether or not the *Winterwerp* criteria are met (that there is objective medical evidence that the patient continues to suffer from mental disorder which is of a kind or degree warranting confinement). Furthermore, the reviewing body must also be in a position to decide whether or not detention is a proportionate response (see *Winterwerp v the Netherlands* App No 6301/73, 24 October 1979; (1979) 2 EHRR 387 and *X v UK* (1981) App No 6998/75, 24 October 1981; 4 EHRR 188). If a person could be discharged and the risk of harm to self or others could be minimised if adequate aftercare support is in place, detention may not be a proportionate response.

In order for a tribunal to be in a position 'speedily' to decide whether or not detention is a proportionate response, it must have information about the patient's social circumstances and the level of support which could be provided in the community. We may conclude therefore that there is a positive duty under article 5(4) requiring a body reviewing the lawfulness of detention to obtain a SCR in order to conclude whether or not detention is a proportionate response. If a SCR is not available or does not contain adequate information and an adjournment is required, the speediness requirement in article 5(4) may be compromised. The Mental Health Act Commission has referred to the 'considerable number of tribunal postponements [appearing] to be caused by the unavailability of such reports, or by reports containing insufficient information.'[3]

Purpose of a SCR

The main purpose of a SCR is to provide the tribunal with 'hard' evidence of the patient's circumstances if discharged from hospital, in particular, what medical, social services and other support will be available in the community, together with 'soft' – but also potentially significant – evidence about the views of the nearest relative and non-professional others who play a significant part in the patient's care, the patient's own views and an assessment of the patient's strengths and positive factors. The SCR should provide evidence of planned aftercare, in line with the guidance in the MHA Codes of Practice for England and Wales on the duty to provide aftercare under MHA 1983 s117 and the English and Welsh policy guidance on the Care Programme Approach (CPA).

Aftercare under MHA 1983 s117

The English *Code of Practice. Mental Health Act 1983* (Department of Health (DoH), 2008) emphasises the importance of the s117 aftercare duty in discharge decision-making, and states that:[4]

When considering relevant patients' cases, the tribunal and hospital managers will expect to be provided with information from the professionals concerned on what aftercare arrangements might be made for them under section 117 if they were to be discharged. Some discussion of aftercare needs, involving [local social services authorities (LSSAs)] and other relevant agencies, should take place in advance of the hearing (para 27.7).

The equivalent provision of the *Mental Health Act 1983: Code of Practice for Wales* states that:[5]

Where a tribunal hearing has been arranged, the hospital managers should inform the relevant LHB and LSSA so they can consider the need for a section 117 after-care planning meeting before the tribunal takes place and, if necessary, to compile a report for the tribunal. Although the requirement to put in place after-care arrangements does not arise before the tribunal's decision, the hospital managers should consider whether it is necessary to start planning before the hearing (para 11.35).

Where the tribunal has decided provisionally to grant a restricted patient a conditional discharge, the PCT and LSSA must do their best to put aftercare in place which would allow that discharge to take place (para 27.9). In *R (W) v Doncaster MBC* [2003] EWHC 192 (Admin), 13 February 2003 (subsequently affirmed by the Court of Appeal in [2004] EWCA Civ 378, 6 May 2004), Stanley Burnton J held that the authority's duty was, before actual discharge, to use its 'best endeavours' to put in place the arrangements required by the tribunal as conditions of a conditional discharge, or which the tribunal required to be satisfied before a deferred discharge took effect, or which the tribunal provisionally decided should be put in place.

Care Programme Approach

A patient detained under MHA 1983 s2 will not be eligible for s117 aftercare, but may well be eligible for the CPA. Until recently, in England, all mental health service users, whether or not they had been detained, who had been in contact with the specialist psychiatric service, were entitled to be dealt with under the CPA. It required and continues to require a risk assessment, a needs assessment, a written care plan which will be reviewed regularly and a key worker (now known as a care co-ordinator).

In 1996, the CPA was extended to all patients receiving care from the specialist psychiatric services. There were two levels of CPA, standard and enhanced. Standard CPA was for people whose mental illness was less severe or who had low risk factors or an active informal support network.[6] People were on enhanced CPA if their mental disorder was assessed as posing a potential risk to their own safety or to that of other people. Wales continues to operate with two levels of CPA.

In 2008, the DoH issued new guidance for England, replacing the two levels of CPA with one 'new CPA'.[7] The guidance states that:

In the main, the individuals needing the support of (new) CPA should not be significantly different from those currently needing the support of enhanced CPA. The current characteristics of those needing enhanced CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk (page 12).

Among the indicators of eligibility for new CPA are that the service user suffers from a severe mental disorder, has complex clinical needs, or is currently, or has been recently, detained under the MHA 1983. The guidance states that: 'All service users subject to supervised community treatment (SCT), or subject to guardianship under the [MHA 1983] (section 7) status should be supported by (new) CPA' (pages 13–14). Individuals subject to 'new CPA' are entitled to the following:

- support from a CPA care co-ordinator;
- a comprehensive multi-disciplinary and multi-agency assessment covering the full range of needs and risks;
- a comprehensive formal written care plan, including a risk and safety/contingency/crisis plan;
- on-going review, ie, a formal, multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly;
- increased advocacy support; and
- any carers should be identified and informed of their rights to their own assessment (page 16).

The guidance states that:

(New) CPA is a process for managing complex and serious cases – it should not *be used as a 'gateway' to social services or as a 'badge' of entitlement to receive any other services or benefits. Eligibility for services continues to be in accordance with statutory definitions and based upon assessment of individual need* (page 13).

Jonathan Butler in *Mental Health Tribunals: law, practice and procedure* (2009, Jordans) states that: ' … accommodation is the commonest source of difficulties and authors of SCRs will often seek to avoid responsibility for failing to provide specific information as to dates by which accommodation will be available …' For individuals living alone following discharge from hospital, Barbara Hatfield, writing in the *British Journal of Social Work*, highlights the importance of effective discharge planning and suggests long-term support is fundamental to successful survival in the community.[8] It is therefore pivotal for the tribunal panel to have information on what housing facilities are actually available and when they will be available to the patient, along with the other requisite information

required under Section E (and Section H if subject to a community treatment order (CTO)) of the 2008 Practice Direction in England. In some situations this can be a real challenge as the author of the SCR will not necessarily make commissioning decisions in an increasingly tight financial environment, and will not control the waiting list for public housing.

Quality of SCRs

Anselm Eldergill in *Mental Health Review Tribunals: law and practice* (Thompson, Sweet & Maxwell, 1997) states that the most common fault with SCRs is simply that the writer was obviously unaware of the required content of such reports. Based on the authors' recent experience in England, the quality of a number of SCRs remains variable following the introduction of the 2008 Practice Direction. Where SCRs fail to comply with the 2008 Practice Direction, ie, providing insufficient information to reach an informed decision, the tribunal may be compelled to adjourn the case (with all that that involves in terms of resources, impact on the patient, his/her family and legal representatives, health care professionals and the tribunal) and 'direct' the responsible authority to furnish a supplementary SCR (Tribunal Procedure Rules r5(3)(d)). The Court of Appeal has said in *R (Ashworth Hospital Authority) v Mental Health Review Tribunal for West Midlands and North West Region* [2002] EWCA Civ 923, 28 June 2002; [2002] MHLR 314 that in the relevant circumstances: '[If] there is uncertainty as to the putting in place of the aftercare arrangements on which satisfaction of the discharge criteria depends, the tribunal should adjourn ... to enable them to be put in place, indicating their views and giving appropriate directions' (para 69).

In both England and Wales, the responsible authority and report writer must ensure that the SCR addresses all the requirements set out in the 2008 Practice Direction, Section E, paragraphs 16 and 17(a)–(i) or paragraph 2 of Part B of the Schedule to the Wales Rules, whichever is applicable. The report writer is responsible for delivering an up-to-date SCR for the tribunal.

Evidence of patient's and others' views

This needs to be approached conscientiously and carefully because it is hearsay evidence and the tribunal will need to decide how much weight to give to it. Care should be taken to reflect the views of the nearest relative and carers accurately and not allow the reporting of these to be influenced by the author's own views in this part of the report, particularly as those whose views are being reported may not be in attendance in order to give oral evidence and be questioned at the tribunal hearing. The provider of such views (often a nearest relative or other non-professional carer) should never be promised that his/her views will not be disclosed to the patient. There is a high threshold for non-disclosure: ' ... that such disclosure would be likely to cause that person or some other person serious harm' (Tribunal Procedure Rules r14(2)(a)). If the tribunal is asked to consider non-disclosure on this basis, care must be taken to provide that evidence to the tribunal in a separate document, clearly marked to that effect.

The 2008 Practice Direction

Rule 32(6) of the Tribunal Procedure Rules obliges the responsible authority to provide information and documents required by the Practice Direction. It is vital for those compiling SCRs to consult Section E of the Practice Direction, since it specifies the content of SCRs for all cases other than those involving CTOs. MHA 1983 s78 and paragraph 20.10 of the *Reference guide to the Mental Health Act 1983* (DoH, 2008) emphasise that the rules and Practice Directions must be followed by people involved in tribunal cases.[9] MHA Code of Practice 2008 paragraph 32.10–32.21 and MHA reference guide paragraph 20.8–20.10 provide helpful information.

SCRs in Wales

Paragraph 2 of Part B of the Schedule to the Wales Rules provides that an up-to-date SCR must include the following:

- the patient's home and family circumstances, including the views of the patient's nearest relative or the person so acting;
- the opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged;
- the availability of community support and relevant medical facilities;
- the financial circumstances of the patient.

In Wales, the SCR must be provided where practicable within three weeks. Also to be provided, where practicable and '[w]here the provisions of section 117 of the Act may apply to the patient', is a proposed aftercare plan (para 4 of Part B of the Schedule to the Wales Rules).

Duty of care

The English 2008 Practice Direction provides an important, albeit basic, template for a SCR. Over recent years, SCRs have been written by professionals who may not be social workers, and frequently are completed by community psychiatric nurses and occasionally by occupational therapists. Whatever the professional affiliation of the person charged by the responsible authority with the duty to provide a SCR, a duty of care is owed to the client in law, and under the respective codes of conduct of these professions.[10]

1 See Practice Direction. First-tier Tribunal. Health Education and Social Care Chamber. Mental Health Cases, available at: www.tribunals.gov.uk/Tribunals/Documents/Rules/Mentalhealthcaseshesc.pdf.
2 MHRT Rules r6(1) qualified the requirement to provide a SCR with the words: 'in so far as it is reasonably practicable to provide [it]'.
3 *Coercion and consent. Monitoring the Mental Health Act 2007–2009*, Thirteenth biennial report 2007–2009, 2009, para 2.102–2.103.
4 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597.
5 Available at: www.wales.nhs.uk/sites3/Documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf
6 *Audit pack for monitoring the Care Programme Approach* (DoH, June 2001).
7 See: *Refocusing the Care Programme Approach: policy and positive practice guidance*, 2008, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647.
8 Barbara Hatfield, 'Powers to detain under mental health legislation in England and the role of the approved social worker: an analysis of patterns and trends under the 1983 Mental Health Act in six local authorities', *British Journal of Social Work*, Vol 38, Issue 8, 2008, pp1553–1571.
9 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088162.
10 *The Code. Standards of conduct, performance and ethics for nurses and midwives, Nursing and Midwifery Council*, 2008, available at: www.nmc-uk.org/aArticle.aspx?ArticleID=3056 and *Codes of practice for social care workers*, General Social Care Council, 2002, available at: www.gscc.org.uk.

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