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Legal Representation in Mental Health Cases

Legal protection for those diagnosed with mental disorder and subject to detention and compulsory treatment was seen as a key feature for those drafting the European Convention on Human Rights ("ECHR"). In the subsequent interpretation of enacting of the Convention, the Courts have been clear that to be effective these rights require frequent legal review and legal representation *Megyeri v Germany 13770/88 (1992) ECHR 49.*

The work of solicitors in this field was described by Lord Justice Brook in the case of *R v Legal Aid Board ex parte Mackintosh Duncan (2000) CO/4807/99* :

"Reading the Report of a psychiatrist, identifying its areas of weakness, commissioning evidence and the appropriate expert challenge to it and representing a client at a Tribunal requires expert professional skills borne, as we have said, of education and practical experience. It is not like going down to the Magistrates Court as a Duty Solicitor, arduous though those duties are."

In England and Wales the legal aid system as provided under contract by private firms of solicitors was adapted to provide most of the required legal representation with legal aid made available without contribution for those detained in hospital. Legal Aid for such work has, however, been increasingly constrained particularly in response to an avalanche of new criminal legislation, with a contracting regime of fixed fees. The very recent arbitrary reduction of 10% makes the provision of legal aid considerably more difficult; and, until very recently, the Legal Services Commission ("LSC") system of matter starts limited the work that some firms could carry out in certain areas.

However for those solicitors maintaining this work there are a key series of tasks which clients should still expect from their representatives.

Panel Membership

First, solicitors conducting this work should be members of the Law Society's Mental Health Tribunal Panel, although one Panel member can supervise up to six staff. Indeed for financial purpose frequently caseworkers (that is lawyers who are not Panel Members) are conducting this work under supervision. Panel membership requirements are currently under review, however at present assessment of both practical and legal knowledge is required in both written assessment and in interview. Membership is

reassessed every three years. Effectively a requirement of continued practice in the field is required for a renewal of membership to be feasible.

Membership of the Panel should guarantee a minimum quality of representation, although it is no reason for complacency; and regrettably a small number of very poor practices have been referred to the Law Society, Solicitors Regulation Authority, LSC and the Mental Health Lawyers Association ("MHLA"). Proper preparation is essential in every case. Regrettably there are now no current academic works covering necessary preparation in this area of law. The most recent was the exceptional book written by Professor Anselm Eldergill**,** *Mental Health Review Tribunals: Law and Procedure* published by Sweet and Maxwell in 1997. A free copy is available to access at the invaluable website www.mentalhealthlaw.co.uk. However, the recently updated LSC Peer Review Guide *Improving Quality*, to be found on the LSC website at http://www.legalservices.gov.uk/docs/cls_main/Mental_Health_Guide_Edition_3.pdf gives a clear indication of the steps and consideration that lawyers carrying out this preparation should frequently take.

Mental Health Tribunal Preparation

Every Mental HealthTribunal case requires proper preparation. This may sound obvious as this must be true for all legal cases. However there are particular demands in Mental Health Tribunal cases. In most other legal cases clients can give coherent instructions on which to start preparing a case. In mental health cases this is certainly not always the case and particularly so when clients' mental states, and therefore ability to provide instructions, may vary widely from one week to another; partly because, perhaps, the developments of their illness and partly due to the effect of powerful antipsychotic medication. This may, in turn, effect their capacity to provide instructions; however the capacity tests for such instructions is low and this is not an area in which the Official Solicitor intervenes (one reason for the establishment of the specialist panel). For further discussion of this issue see paragraphs 4 and 5 of *The Law Society's Practice Note Representation Before Mental Health Tribunals 2011* ("The Practice Note") at http://www.lawsociety.org.uk/productsandservices/practicenotes/mentalhealthtribunal/3386.article

There should always be adequate time allowed for a prompt initial visit which should identify the client's instructions and advise him or her of the legal options, together with a timetable for action. Significantly meetings with clients are covered by legal privilege which cannot be broken accept in very rare situations; these are explored in paragraph 5 of the Practice Note.

Subsequently the Tribunal should be informed that the solicitor is acting and any application lodged if it has not already been. At the same time the hospital should be informed of the application and that the solicitor is acting. An application should also be made for access to the client's medical records and contact made with the client's Nearest Relative listed under s26 Mental Health Act ("MHA") if this is appropriate and/or requested by the client. In addition, enquiries should be made as to whether the client

has a regular Independent Mental Health Advocate assisting and whether liaison and communication would help the client's application.

A request should also normally made for details of aftercare planning meetings to the Responsible Clinician. Such meetings should be held in accordance with paragraph 27.7 MHA Code of Practice and there should at least be a plan "in embryo" aftercare and perhaps accommodation arrangements for discharge. The lawyer may well want to attend such meetings.

The next step will usually be monitoring that Tribunal reports arrive within the time limits set down in *Practice Direction of 30th October 2008*.; The reports will usually comprise the Medical Report; the Social Supervisor's Report and that of the Nursing team. Again this is important to allow time for full instructions from the client and consider the next steps in preparation.. This might include considering important inaccuracies in reports and investigating them in the client's medical records.

EXAMPLE
In my early days of carrying out this work, I represented a client who had been transferred on s3 MHA to a private secure unit in Yorkshire far away from her home in East London. She had been transferred on a number of occasions, but was seen to represent a risk to others as she would not admit to an incident involving the use of a gun on the ward of a London hospital where she was said to have threatened staff and patients. Her lack of recognition of this fact was seen as confirmation that she was both treatment-resistant and a threat to others. As is still frequently the practice medical records do not travel with the patient and staff at the private hospital accepted what all was said in old reports. However, following her instructions I finally tracked down the nursing records covering the incident. The client's nephew had visited her on a semi-open ward and played with a toy gun with the client. Whilst staff felt this play had become mildly disruptive that was the end of incident. In a subsequent report covering the event the description "toy" was left out, but otherwise the incident was described accurately. Subsequent report writers, clearly never examining the source records, started to introduce alarm into their reports and, each report building on another, increased concern and risk accordingly. Regrettably the client had lost contact with her family members who might have corroborated her account.

When the Responsible Medical Officer (as he then was) was presented with this first hand evidence a few days before the client's Tribunal he was both embarrassed and apologetic to the client. He subsequently discharged her from s3 MHA shortly before the Tribunal hearing commenced

This problem was recognised by, Munby J at paragraph 129 *R (AN) v MHRT (2005) EWCA Civ 1605".....The Tribunal must be alert to the well-known problem that constant repetition in 'official' reports or statements may, in the 'official' mind, turn into established fact something which rigorous forensic investigation shows is in truth nothing more than 'institutional folk-lore' with no secure foundation in either recorded or provable fact."*

In any event Medical records should generally be examined in addition to considering reports. Key events favourable to the client may be missed from official reports; or alternatively a full account of incidents or events will frequently assist the client's case. Medical records are often the most reliable source of information in s2 MHA Tribunal cases and always provide a more updated picture than the latest report. They are of course examined by the Medical Member shortly before the Tribunal hearing, and therefore not to examine them would put the client at a disadvantage to both the clinical team and Tribunal members.

Following consideration of the Tribunal reports with the client there should then be a discussion with the client if any independent evidence is required. Guidance on this given in the LSC's "*Improving Practice*". Such reports can properly be obtained under legal aid thereby acknowledging the "equality of arms" provisions of the ECHR. An independent report could include obtaining the report of an independent consultant psychiatrist to counter the expert evidence of the Responsible Clinician supporting continued detention. Other independent experts instructed could include an independent social worker, particularly if the local social services department has not provided sufficient aftercare planning details, or details of supported accommodation. Other experts might be psychologists or even occupational therapists.

Independent reports, with very limited exceptions, are covered by privilege. So if the report does not support the patient's application the reports do not have to served. If the reports do support the patient's application consideration can be given for them to attend to give oral evidence.

Representation at the Tribunal can generally be carried out by any employee of a firm or organisation with an LSC contract with sufficient expertise, except in High Security Hospitals, as long as they are supervised by a Tribunal Panel Member. However, at High Security Hospitals only Panel members may carry out such advocacy. There is possibility that in future contracts only Panel members will be able to carry out advocacy under a legal aid contract.

If the Tribunal has evidence before it which the Responsible Authority thinks would cause serious harm to the patient or others, it can try to prevent this from being disclosed to the patient. A legal representative, however, has the right to consider such evidence under the provisions of Rule 14 of the Tribunal Procedure Rules 2008 and argue for its disclosure. If the patient is not legally represented this case would not be put.

During the hearing the legal representative will cross examine the professional witnesses and usually assist the patient with his or her evidence. At the end of hearing the representative will submit as to why the statutory basis for discharge has been met (assuming these are the patient's instructions)

If the Tribunal does not discharge the patient the solicitor should discuss the position with the patient and especially consider if the decision is unlawful. If appropriate the patients should be advised to request the First Tier Tribunal to review its decision and if necessary make an application to the Upper Tribunal. Subsequently counsel may be instructed for any appeal hearing there. The role of the Upper Tribunal has in many respects replaced the Administrative Court in this area of public law and is a rapidly developing area of jurisdiction.

Aftercare

In addition to Tribunal work mental health solicitors have a range of other critical areas on which to advise and represent clients.

Of particular significance at the moment is that of aftercare, including those eligible to s117 MHA support on discharge. Many readers will be aware that s117 has recently been subject to further scrutiny in cases such *as R (On the application of Mwanza) v Greenwich LBC [2010] EWHC 1462 (Admin)* . What is clear is that a number of local authorities are taking abrupt and unlawful steps to curtail appropriate support as part of the sudden need to save money. Mental Health solicitors have a critical role here in challenging such steps on behalf of these client who otherwise might even face a life-threatening collapse in support. Here Independent Mental Health advocates also have a vital role to play in obtaining expert legal assistance for their clients as frequently such clients have no access to specialist solicitors. It is encouraging to see such partnership working in at least some cases, and I have personally been involved in a number since April of this year However this must surely be hardly the tip of the iceberg. A list of available solicitors is available on the Mental Health Lawyers Association site (www.mhla.co.uk) and Mental Health Tribunal Panel members on the Law Society site (www.lawsociety.org.uk.)

Capacity Cases

Capacity cases, especially those involving Deprivation of Liberty (DoLs), are another area where mental health solicitors have core role with respect to Article 5 of the ECHR. Here Independent Mental Capacity Advocates have very important responsibilities in highlighting to patients, and their families, their rights to access a court. Many readers will be aware of the significant case of *Re Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP)* which reinforced the role of the Court ;and strongly emphasised the duty of Local Authorities (or Health Authorities) to bring such cases themselves to Court where they consider it appropriate . It is of considerable concern that far more cases have not come to the court subsequent this judgement.

Solicitors who conduct this work are listed on the MHLA website; www.mhla.co.uk.

Treatment Cases

Solicitors still bring appropriate cases to challenge compulsory treatment. However the courts are frequently not sympathetic and tests to challenge procedure and medical necessity often difficult *R(B) v Dr. SS [2005] EWHC 1936 (Admin).*

Conclusion

The role of a mental health solicitor is arguably never more challenging than it has been today. This is in particular with clients' situations evolving rapidly either under financial pressure and/or caselaw developments. Tribunal work, with over 25,000 applications a year, and with such clients subject to detention and compulsory treatment, remains an undiluted challenge. However a substantial, but unknown, number of patients subject to Deprivation of Liberty under the Capacity Act are frequently not even accessing legal advice.

In these demanding times it essential that specialist solicitors in this field work closely with advocates covering both mental health and capacity work to identify and assist some of the most vulnerable in our society.

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