

**An Examination of How the Care  
Programme Approach Affects the  
Community Care of Working-Age Adults  
with Mental Ill Health in England**

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## ABSTRACT

The care programme approach<sup>1</sup> is supposed to be the backbone of the mental health services. Yet this provision was introduced in the early 1990s by a series of government circulars at the same time as the *National Health Service and Community Care Act 1990* introduced almost identical provisions<sup>2</sup>.

This paper compares the genesis and practice of these two measures and examines their relationship to each other. It examines the complexity of statutes, which make up English community care law and asks whether CPA provides any extra benefit over and above these.

The power of government circulars is analysed with reference to social services, the National Health Service<sup>3</sup> and case law and the power of CPA is examined within the context of the Code of Practice to the Mental Health Act<sup>4</sup>.

There is very little case law involving CPA, but two cases are analysed in depth leading to the conclusion that the courts have a limited understanding of this complex subject and, in any case, are much more concerned with enforcing statute law.

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<sup>1</sup> Hereafter referred to as CPA

<sup>2</sup> National Health Service and Community Care Act 1990 (c. 19), hereafter referred to as NHSCCA, at s. 47

<sup>3</sup> Hereafter referred to as the NHS

<sup>4</sup> Code of Practice to the Mental Health Act 1983, Department of Health and Welsh Office, 1999, HMSO, London, hereafter referred to as the Code of Practice

It is concluded that CPA provides no additional benefit to people with mental ill health and probably acts as a hindrance. Community care law cries out for a complete revamp but pending this, recommendations are made about practical ways in which practitioners can influence events. The likely effects of abolishing CPA are examined and found to be quite attractive.

## INTRODUCTION

CPA is viewed by professionals working in mental health as the key quasi-legal structure upon which their services are based. Yet there is huge ignorance about what is meant by the term and a general failure to differentiate between form-filling and assessing and meeting people's needs.

During the course of this research the author spoke to many people in his Mental Health Trust to try and gauge their understanding. Generally, the nearer the individuals were to the top of the 'management tree', the greater their understanding; but this still did not prevent a Trust Board member from making the following legally inaccurate statement: 'We have a *statutory* duty to carry out CPA'. It was clear from conversations with this individual that the Board, which was party to a partnership arrangement<sup>5</sup> with the local authority, did not understand that the local authority *did* have a statutory duty to implement s.47 *NHSCCA* and was unaware that the fact that the terms of their partnership arrangement did not address how this duty would be carried out was a significant omission.

At the 'coal face' there is an almost universal belief that CPA equates to a meeting to fill in forms rather than the 'ongoing process' envisaged in 'Modernising the Care Programme Approach, Effective care co-ordination in mental health services'<sup>6</sup>. This was brought home graphically to the author one day when a mental health team spent 20 minutes discussing the

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<sup>5</sup> Under s. 31 Health Act 1999 (c. 8)

<sup>6</sup> Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services. A Policy Booklet, Department of Health, January 1999, hereafter referred to as Modernising the Care Programme Approach

management of a deteriorating patient in the community, including assessing the risk of inaction, looking at his health and social needs as well as how their concerns would be communicated to him and his family. All these discussions were documented by the team scribe, action plans were agreed and then someone mentioned in passing that they “...had not had a CPA with him for some time” and that one needed to be arranged.

Far from reducing bureaucracy as outlined in ‘Modernising the Care Programme Approach’ the author’s Trust has managed to create a form running to 13 pages long<sup>7</sup> whilst still omitting any reference to the requirement to include care management and the ‘Fair access to care services’<sup>8</sup> criteria. Not surprising, then, that the Assertive Outreach Team leader, herself a social worker, was unwilling to authorise needs assessments on patients in her team because of the extra bureaucracy and duplication this would entail.

Knowledge of the concept of needs assessments is still patchy; some people do not even manage to gain access to an assessment, never mind the services that might follow from it<sup>9</sup>. The author, in seeking a needs assessment for a relative who had seemingly only had a ‘CPA assessment’<sup>10</sup> was informed by the duty clerk of the Community Care Office of the London Borough of

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<sup>7</sup> When printed with sufficient space to fill it in (compared to the 2 page form used throughout most of the ‘90s). See Appendix A for compacted version

<sup>8</sup> Fair access to care services: Guidance on eligibility criteria for adult social care, published under cover of LAC (2002) 13, Department of Health, hereafter referred to as FACS

<sup>9</sup> Rummery, K., Ellis, K., Davis, A. (1999) Negotiating access to community care assessments: perspectives of front-line workers, people with a disability and carers. *Health and Social Care in the Community*, 7, pp. 291-300

<sup>10</sup> C.f. R (on the application of HP and KP) v London Borough of Islington [2004] EWHC 7 (Admin) at para. 40 and see Chapters 9 and 10 for further discussion of this case

Redbridge that “We can’t tell you what he needs; you have to tell us and then we look at providing it”.

One indicator that CPA has acted as a ‘comfort blanket’ to staff, obscuring the statutory rights of mental health patients lies with the finding that in the teams the author works in, the only ‘coal face’ social worker who was familiar with the FACS guidance was one who had recently transferred from a physical disability team, where this was carried out for every client.

This paper sets out to explore how things have gone so wrong. What was, on the surface, an idea to bring best practice to psychiatric care in the NHS seems to have developed a life of its own and taken on almost iconic status whilst important statutory provisions, with at least the potential to benefit patients, have been completely sidelined.

Chapters 1 and 2 chart the history of the CPA from its origins to the latest governments directives, whilst chapters 3 to 5 look at the background and development of the *NHSCCA*, arguably the most significant statutory power relating to the community care of people with mental ill health in England. Chapter 6 examines those other statutes which have the potential to contribute to the community care of people with mental ill health and looks at their relationship with *NHSCCA* where applicable.

Chapter 7 examines the legal power of governmental regulations, directions and guidance within social services and the NHS; this is continued in chapter



8, which looks at the power of circulars focusing down on the power of CPA. In particular there is an examination of whether the fact that CPA receives a mention in the Code of Practice<sup>11</sup> alters its power. The chapter concludes with an analysis of the planned inclusion of care plans in the Draft Mental Health Bill 2004<sup>12</sup>.

In chapters 9 and 10 there is an examination of relevant case law culminating in a critical analysis of *R (on the application of HP and KP) v London Borough of Islington*<sup>13</sup>, an interesting case that has been the subject of much commentary. The paper concludes with chapter 11, which draws conclusions and make some recommendations.

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<sup>11</sup> Code of Practice to the Mental Health Act 1983, 1999, op. cit.

<sup>12</sup> Draft Mental Health Bill 2004, Cmnd. 6305, HMSO, London

<sup>13</sup> *R (on the application of HP and KP) v London Borough of Islington* [2004] EWHC 7 (Admin)

## CHAPTER ONE

### THE GESTATION AND BIRTH OF THE CARE PROGRAMME APPROACH

#### *Origins*

According to the Care Programme Approach Association<sup>14</sup> ‘The Care Programme Approach was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11’<sup>15 16</sup>. However, as Ryan et al note: ‘The care programme [sic] did not happen overnight. Its origins can be traced back to at least the 1985 Social Service[s] Committee Report’<sup>17</sup> which states:

‘Nobody should be discharged from hospital without a practical individual care plan jointly devised by all concerned, communicated to all responsible for its implementation, and with a mechanism for monitoring its implementation or its modification in the light of changing conditions; and *that the resources for this be made available*’<sup>18</sup>

In 1987 the Mental Health Act Commission<sup>19</sup> first applied this concept to patients subject to aftercare under the *Mental Health Act 1983*<sup>20</sup>:

‘After-care plans for patients to whom Section 117 applies should be drawn up on a multidisciplinary basis as soon as possible after the patient is admitted, and liaison should take

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<sup>14</sup> An organisation to promote the use of the care programme approach and to give information about current developments. It can be found at: <http://www.cpa.co.uk>

<sup>15</sup> HC (90) 23/LASSL (90) 11, The Care Programme Approach for People with a Mental Illness Referred to Specialist Psychiatric Services, Department of Health, 1990, hereafter referred to as HC(90)23

<sup>16</sup> <http://www.cpa.co.uk/cpa.html>

<sup>17</sup> Ryan, P., Ford, R., Clifford P. (1991) Case Management and Community Care, Research and Development for Psychiatry, London, at p. 25

<sup>18</sup> Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People, House of Commons, Social Services Committee, Second Report, Session 1984–85, HC13-I HMSO, 1985 at para. 45, author’s emphasis

<sup>19</sup> A Special Health Authority established by virtue of s. 121 Mental Health Act 1983 (c. 20) under s. 11 National Health Service Act 1977 (c. 49), hereafter referred to as MHAC

<sup>20</sup> Mental Health Act 1983 (c. 20), hereafter referred to as MHA at s. 117 which applies to people detained under: s. 3 (Admission for treatment), s. 37 (Hospital Order), s. 47 (Transfer of a sentenced prisoner from prison to hospital), s. 48 (Transfer of an un-sentenced prisoner from prison to hospital)

place prior to discharge between workers from the community and the hospital team...’<sup>21</sup>

The next year the ‘Spokes Report’ recommended extending such arrangements to informal patients:

‘... health and local authorities, in co-operation with relevant voluntary agencies, should have a duty jointly to provide suitable aftercare for former informal hospital patients who are, or have been, suffering from a mental disorder until those authorities decide jointly that the need no longer exists’.<sup>22</sup>

‘... before discharge from in-patient treatment, a plan should be prepared for a psychiatric patient. The plan should set out the proposals for community care and the time when the plan will come up for review...’<sup>23</sup>

*The Care Programme Approach for People with a Mental Illness Referred to Specialist Psychiatric Services*

The circular named in the title of this section, HC(90)23<sup>24</sup>, states that ‘It builds on the general circular on hospital discharges (HC(89)5)<sup>25</sup> 26. However HC(89)5 refers only to ‘special groups (e.g. those discharged following periods of *detention under the Mental Health Act*, large groups of patients *discharged when mental illness hospitals are closed...*) for whom specific guidance, existing and proposed, will supplement what is in this circular’<sup>27</sup>. No mention is, in fact, made of more general guidance for all patients with mental illness. Indeed HC(89)5 was accompanied by a booklet<sup>28</sup>, which states that ‘Community Nursing Services, including

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<sup>21</sup> The Mental Health Act Commission Second Biennial Report, 1985-1987, HMSO, October 1987 at p. 66 (Ch. 21, recommendation 14. (i))

<sup>22</sup> Report of the Committee of Inquiry into the Care and Aftercare of Miss Sharon Campbell, Chairman John Spokes, Cmnd. 440, Department of Health and Social Security, July 1988 at para. 16.5

<sup>23</sup> Ibid. at para. 16.20

<sup>24</sup> HC (90) 23/LASSL (90) 11, Department of Health, 1990

<sup>25</sup> HC (89) 5, Department of Health, 1989

<sup>26</sup> HC (90) 23/LASSL (90) 11, op. cit. , Summary

<sup>27</sup> HC (89) 5, op. cit., at para. 12, author’s emphasis

<sup>28</sup> Discharge of Patients from Hospital, Department of Health, February 1989

psychiatric ... nurses, *once contacted*, will make arrangements for continuing care at home<sup>29</sup>. It is clear that the responsibility for contacting them is that of the consultant who will 'Arrange assessment of home requirements by therapist(s) ...'<sup>30</sup> and who will not discharge patients until it is 'agreed ... that everything practicable has been done to organise the care the patient may need in the community'<sup>31</sup>. Furthermore 'No patient may be discharged from hospital without the authority of the doctor holding responsibility for that patient'<sup>32</sup>.

One reason for believing that HC(89)5 may be a precursor to CPA lies in the concept that '*responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given to one member of staff caring for that patient*. The member of staff should have a check-list of what should have been done. If the completed check-list is filed in the patient's notes it will provide a permanent record...'<sup>33</sup>. Notwithstanding later statements about policy background, there is a strong impression that CPA, far from being a solution to an identified problem, actually developed as an amalgam between general discharge policy and the perceived need to empty the asylums.

The concept of joint planning with social services emerges from the local authority circular which accompanied HC(89)5: LAC(89)7<sup>34</sup>. Social services

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<sup>29</sup> Ibid. at G4, author's emphasis

<sup>30</sup> Ibid. at B4

<sup>31</sup> Health Circular HC (89) 5, Department of Health, 1989 at para. 5

<sup>32</sup> Ibid. at para. 4

<sup>33</sup> Ibid. at para. 6, emphasis in original document

<sup>34</sup> LAC (89) 7 Department of Health, 1989

‘... are asked to *co-operate with health authorities* in planning jointly for the discharge of patients from hospital’<sup>35</sup>. However it remained unclear who leads the process; the Social Services Committee<sup>36</sup> believed that ‘consultant psychiatrists, in consultation with nursing and other professional colleagues, [will] decide whether a person referred to the specialist psychiatric services can, *in the light of available resources*, realistically be treated in the community’<sup>37</sup> but the annex states that ‘modern psychiatric practice calls for effective inter-professional collaboration between psychiatrists, nurses, psychologists, occupational therapists and other health service professional staff, social workers ... and proper consultation with patients and their carers’<sup>38</sup> causing MIND to opine that the guidelines ‘removed the requirements that the consultant psychiatrist should decide whether community ‘treatment’ was a viable option’<sup>39</sup>.

HC(90)23 also claims that ‘the care programme approach [was] envisaged in HC(88)43’<sup>40</sup>. In fact all this document states is: ‘Every District should by 1991 have a “Care Programme” (in line with the guidance in a forthcoming Health Circular), to provide coordinated care for people disabled with chronic mental illness living mainly in the community’<sup>41</sup>. It sounds very

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<sup>35</sup> Ibid. at para. 1, author’s emphasis

<sup>36</sup> Appointed under SO No 130 by the House of Commons to examine the expenditure, administration and policy of the Department of Health and Social Security [as it then was] and associated bodies, hereafter referred to as Social Services Committee

<sup>37</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, House of Commons, Social Services Committee, Eleventh Report, Session 1989-90, HC 664, HMSO, 1990 at para. 84, author’s emphasis

<sup>38</sup> HC (90) 23/LASSL (90) 11, op. cit. at Annex para. 9

<sup>39</sup> Sayce, L. (1990) *Waiting for Community Care: Implications of Government Policy for 1991*, MIND, London

<sup>40</sup> Health Circular HC (88) 43, Local Authority Circular LAC (88) 14, Family Practitioner Notice FPN (88) 457, Department of Health and Social Security, 1988

<sup>41</sup> Ibid. at Annex 4, *Services for People with a Mental Illness*, para. 3

much as if the compiler of this circular did not have a clue what was envisaged.

*Better Services for the Mentally Ill & Caring for People*

HC(90)23 is the first time in which the policy background is referred to: ‘The 1975 White Paper “Better Services for the Mentally Ill”<sup>42</sup> ... first set the general policy within which care programmes should be introduced: this general policy has been endorsed by the Government in the 1989 White Paper “Caring for People”<sup>43</sup> ...’<sup>44</sup>.

The 1975 White Paper is essentially about the development of community psychiatry, as we know it today, at a time when services were in transition from asylum-based services. One of the practical implications of this change it notes, is that ‘the pattern we are advocating entails at least in part a transfer of responsibility to the social services and an increase in resources for this purpose’<sup>45</sup>. It emphasises the need for joint planning between health and local authorities<sup>46</sup>; at this point in history services, including day and residential services, are envisaged as being based on the district general hospital.

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<sup>42</sup> Better Services for the Mentally Ill, Cmnd. 6233, HMSO, London, October 1975

<sup>43</sup> Caring for People. Care in the Next Decade and Beyond, Caring for the 1990s Cmnd. 849, HMSO, London, November 1989, hereafter referred to as ‘Caring for People’

<sup>44</sup> HC (90) 23/LASSL (90) 11 Annex at para. 2

<sup>45</sup> Better Services for the Mentally Ill, Cmnd. 6233, HMSO, London, October 1975 at para. 11.11

<sup>46</sup> See *ibid.* at para. 11.13

The reference to CPA in ‘Caring for People’ appears under the heading ‘Health Care’ and once again emphasises the lead role of health authorities who ‘From 1 April 1991 ... will be required to have instituted *in collaboration with social services authorities*, a care programme approach...’<sup>47</sup>. It is submitted that this is really nothing more than a regurgitation of the imperative wording in HC(88)43.

It is, however, noteworthy that under the heading ‘Social Care’ which follows, the government, accepting ‘that social services authorities should continue to be responsible for providing social care to those with a mental illness who require it’<sup>48</sup> uses the ‘proposals in relation to the continuing health and social care of those with a mental illness’<sup>49</sup> – i.e. CPA – as a reason not to implement s.7 of the *Disabled Persons (Services, Consultation and Representation) Act 1986*<sup>50</sup>. This section, although only applying only to people (with mental disorder) who have been in hospital for 6 months or more, would have *required* both health and local authorities to assess people’s needs. The Social Services Committee recommended that the government brought it ‘into force as soon as possible’<sup>51</sup> and in its second

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<sup>47</sup> Caring for People. Care in the Next Decade and Beyond, op. cit. at 7.7, author’s emphasis

<sup>48</sup> Ibid. at 7.13

<sup>49</sup> Ibid. at 7.17

<sup>50</sup> Disabled Persons (Services, Consultation and Representation) Act 1986 (c 33) also known as ‘Tom Clarke’s Act’ and hereafter referred to as DS(SCR)A; the main purpose of which was to provide for the appointment of authorised representatives for disabled people. At s. 7 – see Appendix B

<sup>51</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, House of Commons, Social Services Committee, Eleventh Report, op. cit. at para. 92

biennial report the MHAC stated that s. 117 *MHA*<sup>52</sup> must be read in conjunction with it when it is brought into force<sup>53</sup>.

However, the Government stood by its intention not to but instead 'to reconsider the implementation'<sup>54</sup> in the light of the CPA and the response to the specific grant - it has not been implemented to date<sup>55</sup>. Since the shortage of accommodation for the chronically mentally ill was, and still is, a major source of delay in discharging people from hospital<sup>56</sup> it is submitted that the decision not to implement this section may well be one of the reasons why CPA has failed to deliver in the field of social care and in particular, accommodation.

It should be noted that at this stage of its development CPA was only applied to mental *illness*; throughout it is only applicable to people referred to the specialist psychiatric services. Much is made of devolution to localities with '[i]ndividual health authorities, in discussion with relevant social services authorities [agreeing] the exact form the [CPA] will take locally'<sup>57</sup>. Nevertheless, there were 'key elements'<sup>58</sup>; these were the assessment and review of the health and social care needs and a method of ensuring they were provided. The arrangements for assessing social care are interesting in

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<sup>52</sup> Mental Health Act 1983 (c. 20) at s. 117

<sup>53</sup> The Mental Health Act Commission Second Biennial Report, op. cit. at para. 11.4

<sup>54</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, Government Response to the Eleventh Report from the Social Services Committee, Session 1989-90, Cmnd. 1522, Department of Health, April 1991 at para. 23

<sup>55</sup> And 'will probably never be enforced [sic]' according to Lord Allen of Abbeydale HL Deb 10 May 1990 vol. 518 at c. 1578

<sup>56</sup> See for example North, C., Ritchie, J. (1993) Factors Influencing the Implementation of The Care Programme Approach, HMSO, London at p. 45

<sup>57</sup> HC (90) 23/LASSL (90) 11 Annex at para. 5

<sup>58</sup> Loc. cit.



that, firstly they are to be ‘*agreed* with appropriate social service authorities’<sup>59</sup>, implying that the health authority is the prime mover and secondly that the purpose of these assessments is ‘to give [people] the opportunity of *benefiting from treatment* in the community’<sup>60</sup>; in other words they are very much seen as being subsidiary to medical treatment. This contrasts with ‘Better Services for the Mentally Ill’, which describes a much more equal partnership, with social work staff ‘[helping] people and their families to cope with the emotional, social and environmental problems, and any residual disabilities, which may accompany mental illness or its aftermath’<sup>61</sup>.

Examining this in its historical context, it should be recalled that HC(90)23 (endorsed as the Department of Health says by ‘Caring for People’<sup>62</sup>) was issued at more or less the same time<sup>63</sup> as the *NHSCCA* came into being<sup>64</sup>, albeit nearly 3 years before the assessment procedures were implemented<sup>65</sup>. The juxtaposition of dates affecting these two key measures is set out in table form in Appendix H, alongside other key dates in community care history. S.47 of this Act, which will be addressed separately, spells out what is required of social services in terms of assessment of need, yet there is no

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<sup>59</sup> Ibid. at para. 5. ii, author’s emphasis

<sup>60</sup> Loc. cit.

<sup>61</sup> Better Services for the Mentally Ill, op. cit. at para. 3.14

<sup>62</sup> Caring for People. Care in the Next Decade and Beyond, op. cit.

<sup>63</sup> Melanie Arnold: DH Publications Department stated in an e-mail addressed to the author dated 7<sup>th</sup> September 2004: ‘Despite my investigations, I am unable to say with certainty what the issue date for HC (90)23/LASSL (90)11 was. I am afraid that an expiry date of September does not necessarily indicate an issue date of September. The closest I would say is that it was issued in the latter half of 1990.’

<sup>64</sup> NHSCCA received Royal Assent on 29<sup>th</sup> June 1990

<sup>65</sup> S.47 NHSCCA was implemented on 1<sup>st</sup> April 1993 by the National Health Service and Community Care Act 1990 (Commencement No 10) Order 1992, SI 1992/2975, Schedule (art 2 (2)). See also Caring for People. Care in the Next Decade and Beyond, Policy Guidance, Department of Health, November 1990 at Appendix A

reference to this. It is submitted that *at this point* the Department of Health had not perceived a relationship between needs assessment when it forms part of CPA and the generic needs assessment of s.47 NHSCCA.

The Social Services Committee asked the government to ‘clarify the relationship between the care programme approach and the arrangements for assessment and case management proposed in ‘Caring for People’, including the respective roles of case managers and keyworkers<sup>66</sup>. The government’s response was that guidance was contained in ‘Community Care in the Next Decade and Beyond [sic] – Policy Guidance <sup>67</sup>. The Government believes that this document gives ... sufficient guidance to be able to introduce the care programme approach...’<sup>68</sup>. However, as will be seen in chapter 4, this document in no way clarifies the relationship.

What is clear, however, from the annex to HC(90)23 is that the government perceived the monitoring of both health and social care needs as ‘a narrower concept than that of case management as envisaged in ... ‘Caring for People’<sup>69</sup>. The essential elements of case management according to ‘Caring for People’ are ‘identification of people in need, ... assessment of care needs ... planning and securing the delivery of care ... monitoring the quality of care ... [and] review of client needs’<sup>70</sup>. It is explicit that the case manager

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<sup>66</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, House of Commons, Social Services Committee, Eleventh Report op. cit. at para. 87

<sup>67</sup> Correct title: Caring for People. Care in the Next Decade and Beyond, Policy Guidance, Department of Health, November 1990

<sup>68</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, Government Response to the Eleventh Report from the Social Services Committee, Session 1989-90, op. cit at para. 19

<sup>69</sup> HC (90) 23/LASSL (90) 11 (Annex) at para. 14

<sup>70</sup> Caring for People, Care in the Next Decade and Beyond, op. cit. at 3.3.4

does not need to be a social worker, 'Caring for People' mentions, amongst others, community nurses as potential case managers<sup>71</sup>.

Although HC(90)23 makes the point that specific guidance will only later be given as to what is meant by case management<sup>72</sup> it does not seem immediately obvious why the assessment and monitoring under CPA should be 'a narrower concept'. It is submitted that whatever the intent, the effect is to subtly devalue the CPA and reduce expectations.

#### *Ordinary Residence*

CPA receives its next mention in a document entitled 'Ordinary Residence' under the heading 'People Who Have Been Detained for Treatment Under The Mental Health Act 1983'<sup>73</sup>. Despite the heading, the wording makes clear that this applies to 'all in-patients about to be discharged from *mental illness* hospitals and all *new* patients accepted by the specialist psychiatric services'<sup>74</sup>. So at this stage CPA was not supposed to be universally applied, but only to those discharged by psychiatrists and new patients taken on and at this stage only patients with mental *illness* were targeted.

#### *Resources*

CPA was supposed to simply 'operationalise[...] good professional practice'<sup>75</sup> and therefore no new resources were allocated to it despite advice from the Social Services Committee who thought that the government's

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<sup>71</sup> Loc. cit.

<sup>72</sup> HC (90) 23/LASSL (90) 11 (Annex) at para. 14

<sup>73</sup> LAC (93) 7 Department of Health, March 1993

<sup>74</sup> Ibid. at para. 23, author's emphasis

<sup>75</sup> Loc. cit.

plans to introduce CPA ‘shows inconsistent logic’ and recommended **‘that the Government allocate sufficient “start-up” resources to ensure the successful implementation of the care programme approach’**<sup>76</sup>. The government, for its part, believed that ‘health authorities are expected to meet any health service costs arising from the introduction of more systematic *procedures* from existing resources’<sup>77</sup>. The truth though, as Ryan says, is that ‘Health Authorities may have to assess people, but there is no obligation placed on them – or on local authorities – to provide or purchase the services assessed as necessary’<sup>78</sup>. As the Social Services Committee said:

‘If the care programme approach is being introduced because it has been identified that people are not receiving adequate services when they are discharged, then this implies that new services *will* be required’<sup>79</sup>.

And MIND said:

‘... in the absence of new resources, this system, designed to prevent people from “slipping through the net” of dispersed services, could fail precisely because there *is* no net. Co-ordination systems are no substitute for an insufficient infrastructure of community services’<sup>80</sup>.

The author concurs.

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<sup>76</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, House of Commons, Social Services Committee, Eleventh Report op. cit. at para. 93, bold in original

<sup>77</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, Government Response to the Eleventh Report from the Social Services Committee, op. cit. at para. 24, emphasis in the original

<sup>78</sup> Ryan, P., Ford, R., Clifford P. (1991) Case Management and Community Care, op. cit. at p. 28

<sup>79</sup> Community Care: Services for People with a Mental Handicap and People with a Mental Illness, House of Commons, Social Services Committee, Eleventh Report, op. cit. at para. 93, emphasis in the original

<sup>80</sup> CC35B, Supplementary Memorandum submitted to Social Services Committee by MIND, June, 1990 on the Care Programme Approach, at para. 1, emphasis in the original

## CHAPTER TWO

### THE CARE PROGRAMME APPROACH AFTER THE TEN-POINT PLAN

#### *The Ten-Point Plan*

In 1992 Ben Silcock jumped into the lion's enclosure at London Zoo<sup>81</sup> causing the government to commission a Department of Health working-party<sup>82</sup>. This led, in August 1993, to Virginia Bottomley's<sup>83</sup> famous 'ten-point plan'<sup>84 85</sup>, which included a promise of legislation for supervised discharge and the introduction of Supervision Registers<sup>86 87</sup>. It also introduced the formal concept of risk assessment prior to discharge in HSG(94)27<sup>88</sup>. The emphasis in this circular is on minimising and managing the risk to public and patients; it emphasises that the *MHA* can be used to detain people with mental disorder solely in the interests of their health. This led to the revision of the wording in the Code of Practice<sup>89</sup> to reflect this.

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<sup>81</sup> In fact this case was not a good example of the need for formal after-care since it emerged that he was, in fact, taking medication at the time; see Fennell, P. *Treatment without consent* (1996) Routledge, London at p. 287

<sup>82</sup> Shortly after this working-party started sitting, Christopher Clunis stabbed and killed Jonathan Zito on the London Underground; this was also a high profile case leading to the Ritchie Report (Ritchie, J.H., QC, Dick., D. and Lingham, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, HMSO, London) and the foundation of the Zito Trust

<sup>83</sup> Secretary of State – Department of Health and Social Security

<sup>84</sup> See Appendix C. This was revealed in the form of a press release from the Department of Health dated 12<sup>th</sup> August 1993. The main title was 'Legislation planned to provide for supervised discharge of psychiatric patients' with a subheading: 'Virginia Bottomley announces ten-point plan for developing successful and safe community care'

<sup>85</sup> See also Fennell, P., *Treatment without consent*, op. cit. at p. 287

<sup>86</sup> HSG (94) 5 NHS Executive, 1994. Interestingly these were abolished 5 years later (subject to Regional Office approval) where it was deemed that the enhanced level of CPA provided sufficient safeguards for vulnerable patients – see *Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services*, op. cit. at para. 59

<sup>87</sup> See also Fennell, P., *Treatment without consent*, op. cit. at p. 287

<sup>88</sup> HSG (94) 27/LASSL (94) 4 NHS Executive, 10<sup>th</sup> May 1994

<sup>89</sup> Code of Practice to the Mental Health Act 1983, 1999 op. cit. at para 2.6; this emphasises that detention solely in the interests of the patient's health is possible without reference to his/her safety or the protection of others

However, along the way two other important developments occurred. The first was a statement that CPA ‘should be applied, *so far as it is relevant*, to the after-care of other mentally disordered patients’<sup>90</sup>. This is later clarified as referring to ‘patients with personality (or psychopathic) disorders who can safely and suitably be looked after by specialist psychiatric services in the community’<sup>91</sup> and ‘some people with *learning disabilities* discharged from in-patient care’<sup>92</sup>. It is submitted that this does not provide very clear guidelines as to when CPA should apply.

The second development, more relevant to the discussion which follows, is the first recognition of a connection with s.47 *NHSCCA*, which, of course, had only been implemented the previous year: ‘Multi-disciplinary assessment under the Care Programme Approach, *if properly implemented*, will fulfil... duties [under the *NHSCCA*]’<sup>93</sup>. The circular goes on to say that health and social services departments need to ensure that CPA and care management arrangements are properly coordinated. It is submitted that this is a key development for CPA; up until this point it was not seen as necessary to have a social worker at a CPA meeting and there was much criticism of them for not attending meetings arranged by consultants<sup>94</sup>.

Unfortunately the picture across the country was not so good in practice with ‘barely more than half of the Local Authorities surveyed [having] completed

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<sup>90</sup> HSG (94) 27/LASSL (94) 4 NHS Executive, op. cit. at para. 7, author’s emphasis

<sup>91</sup> Ibid. at para. 20, brackets in original

<sup>92</sup> Ibid. at para. 21, emphasis/bold in original

<sup>93</sup> Ibid. at para.16, author’s emphasis

<sup>94</sup> North, C., Ritchie, J. (1993) Factors Influencing the Implementation of The Care Programme Approach, op. cit. at p. 75

a comprehensive assessment of need'<sup>95</sup>. Of the needs assessments carried out 'only two thirds had been carried out in partnership with Health Authorities'<sup>96</sup>. 'Health Authorities cited a number of barriers to more effective and efficient performance. ... A shortage of ordinary housing and a lack of 24 hour staffed residential accommodation were cited as major causes of people staying longer than necessary in hospital...'<sup>97</sup>. Yet, as will be seen in the discussion of s.47 *NHSCCA*, the law provides at least a theoretical solution which health authorities were missing out on because of their failure to grasp the nettle of properly incorporating needs assessments into CPA and, it is submitted, compounded by the failure of the government to implement s.7 of *DP(SCR)A*<sup>98</sup>.

### *Building Bridges*

In 1996 'Building Bridges'<sup>99</sup> was published as part of the 'Health of the Nation' series; chapter 3 is devoted to the working of CPA and introduces the concept of a tiered approach<sup>100</sup>. It starts by making the point that CPA should not be a 'form-filling process'<sup>101</sup> but then goes on to dictate exactly what has to be done in terms of the bureaucracy it is supposed to eschew<sup>102</sup>, down to the details of the practicalities<sup>103</sup> and the form to be filled in<sup>104</sup>.

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<sup>95</sup> Modernising Mental Health Services. Safe, Sound and Supportive, Department of Health, 1998 at para. 3.6

<sup>96</sup> Ibid. at para. 3.7

<sup>97</sup> Ibid. at para. 3.8

<sup>98</sup> See Appendix B; this section discussed in Chapter 1, if implemented, would have required health and local authorities to assess the needs of people with mental disorder who have been in hospital for 6 months or more

<sup>99</sup> Building Bridges. A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people Department of Health, 1996

<sup>100</sup> Ibid. at para. 3.0.1

<sup>101</sup> Ibid. at para. 3.0.2

<sup>102</sup> Ibid. at para. 3.1.1 especially figure 2

<sup>103</sup> Ibid. at para. 3.1.9, which starts a checklist with the question: Is there a room available for the meeting?

<sup>104</sup> Ibid. at para. 3.1.12 – although its use is said not to be mandatory

Now it seems that CPA ‘... applies to **all** mentally *ill* patients who are accepted by the specialist mental health services.’<sup>105</sup>. Once again the concept seems to have become narrowed and people with other forms of mental disorder are arbitrarily excluded.

Under the section entitled ‘Needs assessment’, ‘Building Bridges’ highlights the fact that ‘[a]n arrangement needs to be reached that whoever is responsible for carrying out such assessments they are acceptable to social services as an assessment for care management purposes. Duplication of social care assessments, for CPA and Care Management *can and should be avoided*’<sup>106</sup>. It goes on to say that the same assessment should occur whatever the route into the services. This is significant because a care management assessment is based on statutory requirements and the courts relate to this, rather than the less well defined requirements of CPA, as will be discussed in chapters 9 and 10. ‘Building Bridges’ fails to grasp this nettle, with its major resource implications, and rather weakly states that ‘A number of services are using the assessment process to identify and record service shortfalls ... These might refer to accommodation, employment, social support...’<sup>107</sup>. It goes on to say that the purpose of this is to plan services but no mention is made of the service user’s statutory rights for these services to be provided under s.47 *NHSCCA*.

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<sup>105</sup> Ibid. at para. 3.0.3, bold print in original; emphasis added by author

<sup>106</sup> Ibid. at para. 3.1.5. Different use of upper and lower case in the original. Emphasis added by author. NB: since the early days of CPA ‘case management’ had been renamed ‘care management’, this is discussed in chapter 4

<sup>107</sup> Ibid. at para. 3.1.7



Nor is there any thought given to training key workers in the requirements of s.47 *NHSCCA* though they are to be trained in the *MHA* and risk assessment<sup>108</sup>. This would appear to be a serious omission given that ‘for people subject to the Care Programme Approach in essence the key worker and care management functions are the same’<sup>109</sup>. Indeed we are told that ‘[o]ne way of looking at CPA is as a specialist variant of care management for people with mental health problems and the two systems should be capable of being fully integrated with one another.’<sup>110</sup>. ‘Building Bridges’ goes on to say that ‘**any** model of care management can – and should – be integrated with the CPA’<sup>111</sup> and that there should be ‘a **single** care plan’<sup>112</sup>. As will be discussed in chapter 10, this has considerable significance in terms of the meaning attributed to the term ‘care plan’ by the courts.

Meanwhile ‘Building Bridges’ struggles with the implications of what it proposes. Whilst ‘requir[ing] the key worker/care manager to have the ability to co-ordinate services in other disciplines and other agencies’<sup>113</sup> it maintains that this does not mean that s/he ‘must be in a position to anticipate or second guess decisions that rightly and legally fall to others’<sup>114</sup>. Yet the failure to develop a shared method of care management under the umbrella of s.47 *NHSCCA* weakens the rationale for the existence of CPA at all. As a final point: in the question and answer section at the end of the chapter the

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<sup>108</sup> Ibid. at para. 3.1.19

<sup>109</sup> Ibid. at para. 3.2.8

<sup>110</sup> Loc. cit.

<sup>111</sup> Ibid. at para. 3.2.12, bold in the original

<sup>112</sup> Loc. cit., bold in the original

<sup>113</sup> Ibid. at para. 3.2.15

<sup>114</sup> Loc. cit.

difference between needs assessment and care planning is highlighted. The point is made that even if these occur in one meeting, they should be distinguished from one another. This is a fundamental point; if, as in the author's experience, services are planned solely on the basis of what is available, the whole concept of needs assessment is negated.

*Modernising Mental Health Services & Modernising the Care Programme Approach*

In December 1998 the government produced a document entitled 'Modernising Mental Health Services' in which it announced that one of its intentions was to achieve 'harmonisation between CPA and care management'<sup>115</sup>. Guidance duly arrived in the shape of 'Modernising the Care Programme Approach'<sup>116</sup>. This starts by 'confirm[ing] the government's commitment to the CPA as the framework for care co-ordination and resource allocation in mental health care'<sup>117</sup>.

It is submitted that this is less about confirmation than clarification of a previously confused relationship. The document is divided into four sections, the first of which is aimed at 'Achieving integration of the CPA and Care Management'<sup>118</sup>. It goes on to restrict CPA to 'adults of working age *in contact* with the secondary mental health system (health and social care)'<sup>119</sup>. Although it states that '[t]he principles of the CPA are relevant to the care

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<sup>115</sup> Modernising Mental Health Services. Safe, Sound and Supportive, op. cit. at para. 4.47

<sup>116</sup> Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services, op. cit.

<sup>117</sup> Ibid. at para. 6, underlining in the original

<sup>118</sup> Ibid. at para. 8

<sup>119</sup> Ibid. at para. 17, words in brackets in original, author's emphasis

and treatment of younger and older people'<sup>120</sup> this is, in fact the first mention of an age qualification on the CPA. By default this implies no diagnostic limitation, effectively reducing its applicability to an age-defined group of people whilst simultaneously expanding it to include people who may not have mental *illness* and may not even be looked after by specialist services over any period of time. There is also a subtle shift in responsibility for implementation (of the changes at least) which now 'rests with the Chief Executive of the Mental Health provider Trust *in conjunction with* their partner Directors of Social Services'<sup>121</sup>.

It then makes the interesting claim that 'CPA is Care Management'<sup>122</sup> – albeit only 'for those of working age in contact with specialist mental health and social care services'<sup>123</sup>. It then proves just how untrue this is in practice by stating that social services on the whole define 'eligibility for services using descriptions of vulnerability and risk, whilst many CPA systems define access ... by legal status or diagnosis'<sup>124</sup>. The former method is favoured though not prescribed which has some implications for the courts, which will be explored in chapter 10.

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<sup>120</sup> Loc. cit.

<sup>121</sup> Ibid. at para. 34, author's emphasis

<sup>122</sup> Ibid. at para. 35, underlining in original

<sup>123</sup> Loc. cit.

<sup>124</sup> Ibid. at para. 38

*Still Building Bridges*

Published in March 1999, 'Still Building Bridges'<sup>125</sup> was the report of an inspection into CPA management. It noted that there were instances where social services required community care assessment forms as well as CPA forms to be filled in<sup>126</sup>; otherwise 'the majority of ... care plans ... only identified the services provided or commissioned by [social services]'<sup>127</sup>. The inspectors comment that 'the care plan has an essential role in the process of care management and CPA'<sup>128</sup> yet it is evident from their research that the dichotomy between CPA and care management was being perpetuated. More worryingly 'few [care plans] provided the necessary information about ... assessed need'<sup>129</sup> despite the criteria identified by the Social Services Inspectorate: 'The combination of services provided to individuals meets the needs identified through assessment'<sup>130</sup> and 'Assessments are based on principles and values which enable the objective identification of individual needs'<sup>131</sup>.

However, perhaps we should not be surprised by this dichotomy since the background to the inspection perpetuates the perception that CPA and care management are separate entities despite earlier statements to the contrary<sup>132</sup>.

It states that 'HC(90)23/LASSL(90)11 described an expectation that Social

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<sup>125</sup> Still Building Bridges. The report of a National Inspection of Arrangements for the Integration of the Care Programme Approach with Care Management, Department of Health and Social Services Inspectorate, March 1999 at para. 1.28

<sup>126</sup> Ibid. at para. 1.28

<sup>127</sup> Ibid. at para. 4.8

<sup>128</sup> Loc. cit.

<sup>129</sup> Ibid. at para.3.9

<sup>130</sup> Ibid. at Appendix A Standard 1 Criteria 3.

<sup>131</sup> Ibid. at Appendix A Standard 2 Criteria 5.

<sup>132</sup> See HSG (94) 27, op. cit. at para.16 and Modernising the Care Programme Approach, Effective Care Co-ordination in Mental Health Services, op. cit. at para. 35, discussed above

Services Departments and Health, with Health in the lead, would work together using ... CPA'<sup>133</sup>, but goes on to say that the *NHSCCA* 'introduced care management systems to provide *similar* co-ordinated packages of care and support'<sup>134</sup>; a remarkable statement given all the discussion above about co-ordination. Although the paragraph correctly point out that social services is the lead agency for *NHSCCA*, it is submitted that a more accurate historical summary would be that social services leads on the s.47 *NHSCCA* needs assessment which *forms part of* the CPA which Health leads on.

#### *National Service Framework*

The National Service Framework for Mental Health<sup>135</sup> does not advance the debate; standards four and five refer to the requirement for written care plans for people on CPA in the community and 'away from home' respectively<sup>136</sup> and apart from stating that 'Care management and CPA should be fully integrated'<sup>137</sup> the only reference to care management within the CPA is to an example of a 'Beacon Service' in Dewsbury where a CPA care manager has developed CPA 'in line with social services care management systems'<sup>138</sup>.

#### *Discharge from Hospital*

'Discharge from Hospital'<sup>139</sup> is the latest government publication to address CPA. Although aimed across the entire spectrum of health, the minister who

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<sup>133</sup> Still Building Bridges op. cit. at Appendix D, para. D1

<sup>134</sup> Ibid. at Appendix D, para. D2, author's emphasis

<sup>135</sup> The National Service Framework for Mental Health Modern Standards & Service Models, Department of Health September 1999

<sup>136</sup> Ibid. at p. 41

<sup>137</sup> Ibid. at p. 53

<sup>138</sup> Ibid. at p. 54

<sup>139</sup> Discharge from hospital: pathway, process and practice, Department of Health, January 2003

introduced it, Jacqui Smith, includes mental health in her brief. The only reference to CPA is one paragraph confirming the status quo<sup>140</sup>.

### *The European Dimension*

Article 12 of the Council of Europe Recommendation (2004) 10 provides that ‘the treatment plan should be prepared in consultation with the persons concerned and his or her opinion should be taken into account. *The plan should be regularly reviewed and, if necessary, revised*’<sup>141</sup>. This is clearly support for the original concept that CPA operationalises good professional practice. Apparently though, this was too much for the government, in the person of Rosie Winterton<sup>142</sup>, which ‘wished to reserve its right not to comply with the provisions of the Recommendation generally’<sup>143</sup>.

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<sup>140</sup> Ibid. at p. 11

<sup>141</sup> Council of Europe Recommendation (220) 10 at art. 12 (1), [http://www.coe.int/T/E/Legal\\_Affairs/Legal\\_co-operation/Bioethics/News/Rec\(2004\)10%20e.pdf](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/News/Rec(2004)10%20e.pdf), author’s emphasis

<sup>142</sup> Minister of Health

<sup>143</sup> HC Deb 20 October 2004 vol. 425 at c. 796W

**CHAPTER THREE**  
**THE ORIGINS AND EVOLUTION OF THE NATIONAL HEALTH**  
**SERVICE AND COMMUNITY CARE ACT 1990**

*Runaway costs*

There is considerable strength in the argument put forward by Lewis and Glennerster that the origins of the *NHSCCA* can be traced back to an anomaly in the supplementary benefit rules introduced by statutory instrument in November 1980, under which people could claim board and lodging expenses<sup>144</sup>. Essentially individuals without sufficient resources to provide for their own residential care were funded by the state up to the 'local limit' which was an average of prices in their area. Running care homes became big business with social services leaping at the chance to use the social security budget to fund care which had previously been their responsibility and hospitals delighting at the opportunity for an 'exit plan' for elderly patients 'blocking' their beds. Within 5 years the sum spent had risen from £10 million to £500 million a year despite attempts to introduce a freeze on limits in December 1984 and a national limit in April 1985<sup>145</sup>.

*Making a Reality of Community Care*

In 1986 the Audit Commission stepped in with a report entitled 'Making a Reality of Community Care'. This criticised the fragmented nature of care and the many agencies involved<sup>146</sup> and opined that many people were either

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<sup>144</sup> Lewis, J., Glennerster, H. (1994) *Implementing the new community care*, Open University Press, Buckingham at p. 3

<sup>145</sup> *Ibid.* at p. 5

<sup>146</sup> *Making a Reality of Community Care*, Audit Commission 1986, HMSO, London

getting the wrong kind of care or not getting it at all. However as Lewis and Glennerster remark: ‘None of this was new’<sup>147</sup>, similar points having been made by the Guillebaud Committee in 1956<sup>148</sup>. ‘What was new was the exposure of what was happening to the social security funding of residential care’<sup>149</sup>. The Audit Commission outlined a number of options stating that ‘Care management will play a key part in achieving the government’s objectives for community care by ... ensuring that the resources available ... are used in the most effective way...’ and they recommended a ‘high-level review’. ‘The one option that is not tenable is to do nothing’<sup>150</sup>. Yet as Lewis and Glennerster say, ‘nothing’ is exactly what the government did, so that by 1991 annual spending had risen to over £2000 million a year<sup>151</sup>. Their explanation was that Mrs Thatcher did not want to cut off the ‘lifeblood’ of the many small private businesses that were benefiting from this largesse.

### *Agenda for Action*

Sir Roy Griffiths, who had already reported on the NHS, was brought in and he produced ‘Community Care: Agenda for Action’ also known as the ‘Griffiths Report’<sup>152</sup>, which stated that the social security payments to individuals should cease and the money transferred to local authorities, who would effectively act as the gatekeepers to care. In the introduction to his

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<sup>147</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p. 5

<sup>148</sup> Report of the Committee of Inquiry into the Cost of the National Health Service (1956) (Guillebaud Enquiry), HMSO, London

<sup>149</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p. 5

<sup>150</sup> Making a Reality of Community Care, op. cit. at p. 4, author’s emphasis

<sup>151</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p. 6

<sup>152</sup> Community Care: Agenda for Action. A report to the secretary of state for social services by Sir Roy Griffiths, HMSO, 1988



report Griffiths says: ‘Dominant in discussions and visits was the question of the closure of the large mental hospitals’<sup>153</sup> – so mental illness was always at the heart of thinking about social care needs. He stated that ‘the role of social services authorities should be [to ensure] that the needs of individuals ... are identified. ... The type of services to be provided would be derived from analysis of the individual care needs’<sup>154</sup>. He divided the duties neatly into six headings: ‘to identify those who have need’, to ‘assess those needs’, ‘decide [on] packages of care’, ‘determine ... priority’, ‘arrange delivery’ and ‘review’<sup>155</sup>. These, of course, were taken on board by ‘Caring for People’<sup>156</sup> but are not discussed or developed in the context of CPA<sup>157</sup>, rather in the evolution of the *NHSCCA*.

Griffiths recommended a specific grant to *partially* fund his programme<sup>158</sup>, which was adopted by government<sup>159</sup>; the underlying principle is that social services authorities are responsible for providing the services. He also talked about *care* management, making clear that the care manager should ‘oversee the assessment and re-assessment function and manage the resulting action’<sup>160</sup>.

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<sup>153</sup> Ibid. at v, para. 18

<sup>154</sup> Ibid. at vii, para. 24

<sup>155</sup> Ibid. at para. 3.8

<sup>156</sup> The essential elements of case management according to Caring for People. Care in the Next Decade and Beyond op. cit., at para. 3.3.4, are ‘identification of people in need, ... assessment of care needs ... planning and securing the delivery of care ... monitoring the quality of care ... [and] review of client needs’

<sup>157</sup> Despite being ‘key elements’ of CPA- see HC (90) 23/LASSL (90) 11 op. cit. Annex at para. 5. These are essentially assessment and review of the health and social care needs and a method of ensuring they are provided.

<sup>158</sup> Community Care: Agenda for Action, op. cit. at para. 6.23

<sup>159</sup> Caring for People. Care in the Next Decade and Beyond, op. cit. at para. 7.15

<sup>160</sup> Community Care: Agenda for Action, op. cit. at para. 6.6

### *Caring for People*

Lewis and Glennerster argue that the reforms were ‘hurried ideas pushed through to meet a crisis’<sup>161</sup> and only came to fruition as part of a package involving the market forces element incorporated in the Griffiths proposals<sup>162</sup>:

‘[The reforms] were not primarily driven by a desire to ... help those emerging from mental hospitals [but by] the need to stop the haemorrhage in the social security budget ... in a way which would minimise political outcry and not give additional resources to the local authorities...’<sup>163</sup>.

Perhaps, therefore, we should not be surprised that though CPA also had its roots in ‘Caring for People’<sup>164</sup> its growth and development, as will be argued below, seems to have progressed in parallel and largely in ignorance of *NHSCCA*.

Under the heading ‘Principles of Assessment’, ‘Caring for People’ states: ‘The objective of assessment is to determine the best available way to help’<sup>165</sup>. It continues: ‘Assessment should not focus only on the user’s suitability for a particular existing service’<sup>166</sup>. It was envisaged that there would be ‘a wide range of referral routes, or entry points, into the assessment procedure’<sup>167</sup> and the government wanted ‘assessments [to be] carried out timeously’<sup>168</sup>, something which the courts would later express a view on<sup>169</sup>;

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<sup>161</sup> Lewis, J., Glennerster, H. (1994) *Implementing the new community care*, op. cit. at p. 8

<sup>162</sup> *Ibid.* at p. 7

<sup>163</sup> Lewis, J., Glennerster, H. (1994) *Implementing the new community care*, op. cit. at p. 8

<sup>164</sup> *Caring for People. Care in the Next Decade and Beyond*, op. cit.

<sup>165</sup> *Ibid.* at para. 3.2.3

<sup>166</sup> *Loc. cit.*

<sup>167</sup> *Ibid.* at para. 3.2.9

<sup>168</sup> *Ibid.* at para. 3.2.11

<sup>169</sup> See *R v Sutton LBC ex parte Tucker* [1998] 1 CCLR 251

and '[p]riority ... given to those whose needs are greatest'<sup>170</sup>. The system was now to be known as *case management*<sup>171</sup> and the intention was to tie it to budgetary management<sup>172</sup>.

*Section 42 in Committee*

S.42, as it then was, of the National Health Service and Community Care Bill was described as the 'linchpin of the hopes which we have for the new community care system'<sup>173</sup> and was discussed by Standing Committee E in the 1989-90 session. Despite much debate the committee left it unchanged. One significant rejected amendment proposed by Mr Andrew Rowe was an attempt to change the wording of what is now s. 47(1)(b) to read: 'if, as a result of that assessment, they decide that his needs call for the provision of any such services it shall be the duty of that authority to make arrangements for their provision'<sup>174</sup>. This, of course would have taken away much of the discretion which the current wording gives<sup>175</sup> and the failure to change the wording had considerable significance in the light of later attempts to minimise the consequences of an assessment<sup>176</sup>. As Mr Andrew Rowe said: 'there is no point in an assessment which states that the individual concerned requires a certain kind of service if there is no obligation on the local authority to provide that service'<sup>177</sup>.

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<sup>170</sup> Caring for People. Care in the Next Decade and Beyond op. cit. at para. 3.2.12

<sup>171</sup> See Chapter 4 for a discussion of the significance of the name

<sup>172</sup> Ibid. at para. 3.3.5

<sup>173</sup> SC Deb (E) 15 February 1990 vol. 250 at c. 1002: Mr Andrew Rowe. NB Until c. 1013 (the date in the printed version is erroneously given as 15<sup>th</sup> February 1989)

<sup>174</sup> Ibid: The Chairman (Dame Janet Fookes). Amendment No. 274

<sup>175</sup> See Appendix D

<sup>176</sup> See discussion under 'The Laming Letter' below

<sup>177</sup> SC Deb (E) op. cit. at c. 1003: Mr Andrew Rowe

There was, in addition, concern from Sir George Young that a dichotomy would be created between those with a statutory right to request assessment under s.4 *DP(SCR)A*<sup>178</sup> and those otherwise brought under this clause<sup>179</sup>. The combination of these two issues would mean firstly that social services could choose whether to assess someone and secondly choose not to provide them with services. Although, as will be seen in chapter 6, s.2(1) *Chronically Sick and Disabled Persons Act 1970*<sup>180</sup> means that people with mental ill health have a right to be provided with services, being assessed is not always that easy and in practice receiving services remains a problem for many people.

The debate on this amendment combined with other proposed amendments became very lengthy and other issues were raised including requests for more training of social workers<sup>181</sup>, concerns about divided loyalties if the case manager were also the budget holder<sup>182</sup> and worries about over-bureaucratic multidisciplinary assessments<sup>183</sup>. Nevertheless at the end of the day, based on Mrs Bottomley's assurance that local authorities would be given guidance on how to carry out their duties and that this would be kept under close scrutiny, Mr Rowe withdrew his amendment. However his specific reason for withdrawing it was the anxiety, which he shared with Mrs Bottomley 'that we should not put upon local authorities a statutory duty to pursue every

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<sup>178</sup> Disabled Persons (Services, Consultation and Representation) Act 1986 (c 33) at s. 4; this is referred to in s.47 (2) (a) NHSCCA – see Appendix D

<sup>179</sup> SC Deb (E) op. cit. at c. 1007: Sir George Young

<sup>180</sup> Chronically Sick and Disabled Persons Act 1970 (c. 44), hereafter referred to a CSDPA, at s. 2 (1)

<sup>181</sup> Ibid. at c. 1014: Mr James Couchman

<sup>182</sup> Ibid. at c. 1019: Mr Ieuan Wyn Jones

<sup>183</sup> Ibid. at c. 1020: Mr Ieuan Wyn Jones

request, regardless of whether it is realistic'<sup>184</sup>. It is submitted that this was truly a missed opportunity as the amendment would never have put an obligation on a local authority to *assess* but to provide for *assessed need*.

The other rejected amendment, of relevance to this discussion, was that assessment teams should, by law, include '(a) at least one nurse; (b) at least one social worker; (c) at least one person representative of the medical profession; and (d) at least one person representative of any relevant district health authority'<sup>185</sup>. Whilst the exact wording, particularly the inclusion of the health authority representative, may be a trifle over-prescriptive the principle is clear: surely this is a description of CPA. As Roger Sims said: 'The concept of case management ... will offer an ideal opportunity for health and local authority personnel to work together in producing plans for the treatment of individual clients'<sup>186</sup>. He makes the valid point that 'Caring for People' calls for interagency working<sup>187</sup> but that this is not specified anywhere in the Bill. Indeed it is not and, because this amendment was not incorporated into the Act, this remains the case, and, as will be argued below, it is this dichotomy between the statutory nature of care management and the non-statutory nature of CPA, which continues to dog this area of practice.

#### *Section 45 in the House of Lords*

S.45 of the Bill, as it was when it arrived in the House, was only debated in the Lords. Lord Peston wanted to introduce an amendment requiring social

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<sup>184</sup> Ibid. at c. 1029: Mr Andrew Rowe

<sup>185</sup> Ibid. at c. 1030: The Chairman – Amendment No. 720

<sup>186</sup> Loc. cit.: Mr Roger Sims

<sup>187</sup> Caring for People. Care in the Next Decade and Beyond op. cit. at para. 3.2.7

services to assess ‘when required to do so by any person’<sup>188</sup> but was reluctantly persuaded by Baroness Blatch to withdraw as she maintained that the obligation to assess *in appropriate cases* was created by the original wording<sup>189</sup>. Baroness Seear wanted the needs of carers to be assessed too<sup>190</sup>, but Baroness Hooper felt it was inappropriate to single them out<sup>191</sup> and the amendment was disagreed to on a division<sup>192</sup> leaving this to be dealt with at a later date<sup>193</sup>.

Lord Carter moved an amendment very similar to that discussed in committee proposing putting a duty on authorities to provide services they assess as being needed<sup>194</sup>. Baroness Hooper, in opposing this<sup>195</sup> cited the existing obligation created by s.2(1) *CSDPA*<sup>196</sup> to provide services under s.2.2(2) *NHSCCA*<sup>197</sup>. She went on to opine that ‘Decisions must take account of what is available and affordable’<sup>198</sup>. This is an interesting view in the light of subsequent court decisions<sup>199</sup> but one which she makes no bones about: ‘...we do not think it would be desirable to impose on an authority a specific

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<sup>188</sup> HL Deb 10<sup>th</sup> May 1990 vol. 518 at c. 1550: Amendment No. 113BE Lord Peston

<sup>189</sup> *Ibid.* at c. 1552 et seq.

<sup>190</sup> HL Deb op. cit at c. 1555: Amendment No. 113BF

<sup>191</sup> *Ibid.* at cc. 1560-1561

<sup>192</sup> *Ibid.* at c. 1562: Division no. 4

<sup>193</sup> See chapter 6

<sup>194</sup> *Ibid.* Amendment No. 113D

<sup>195</sup> *Ibid.* at c. 1563

<sup>196</sup> Chronically Sick and Disabled Persons Act 1970 (c. 44) at s. 2 (1)

<sup>197</sup> However this is not, by any means as clear cut as she implied. In *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (HL) (1997) 1 CCLR 40, Lord Clyde opined that s. 2(1) CSDPA was a means of flagging up the duty to provide services under s. 2.2(2) NHSCCA (which singles out disabled people, including those with severe and enduring mental health problems) whilst Lord Lloyd submitted that it actually took them out of an otherwise discretionary regime of s. 47 (1) NHSCCA and put them into a mandatory regime.

<sup>198</sup> HL Deb op. cit at c. 1563.

<sup>199</sup> Like *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (HL), op. cit. or *R (on the application of Batantu) v Islington* (2001) 4 CCLR 445 where it was held that once the need to provide housing has been established it must be met

duty to provide services to meet all individuals' assessed needs'<sup>200</sup>. Lord Carter picked up on the word 'affordable' but withdrew the amendment.<sup>201</sup>

Lord Peston then moved an amendment that would have *required* an authority notified of a person's likely needs to co-operate in an assessment<sup>202</sup> as opposed to the wording which finally got into the *NHSCCA* which merely 'invite[s] them to assist'<sup>203</sup>. He eventually withdrew his amendment on the basis that 'guidance' would be issued by the Government on this matter and that 'directions' would replace this if not followed<sup>204</sup>. Sadly life does not always emulate House of Lords debates; for example in *R v Lewisham LBC ex parte Pinzon and Patino*<sup>205</sup> it was held that recommendations that local and housing authorities work together do not amount to a legally enforceable duty.

Lord Allen of Abbeydale wanted ss.1 & 2 *DP(SCR)A* to be implemented at the same time as the same time as s.45<sup>206</sup>. S.1 gives the disabled person the right to an authorised representative and s.2 lays down the rights of this person. Baroness Hooper could not accept this on behalf of the government as the resource implications had not been addressed and the amendment was withdrawn with some dissatisfaction<sup>207</sup>.

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<sup>200</sup> Ibid. at c. 1564

<sup>201</sup> Loc. cit.

<sup>202</sup> Loc. cit.: Amendment No. 113E

<sup>203</sup> National Health Service and Community Care Act 1990 (c. 19) at s. 47 (3). This was originally moved as an alternative amendment: No. 114ZA: HL Deb op. cit at c. 1577: Baroness Hooper

<sup>204</sup> HL Deb op. cit at c. 1571: Baroness Hooper

<sup>205</sup> *R v Lewisham LBC ex parte Pinzon and Patino* (1999) 2 CCLR 152

<sup>206</sup> HL Deb op. cit at c. 1578: Lord Allen of Abbeydale

<sup>207</sup> Ibid. at c. 1582

A similar amendment for s.3 *DP(SCR)A* to be implemented was, moved by Lord Henderson. This would have given disabled people a right to make representations concerning their needs, to have a written statement of the outcome of the assessment and the right of review against the outcome of the assessment<sup>208</sup> and was something the Social Services Committee had been recommending for some time<sup>209</sup>. He withdrew this after some debate about a consultation letter, which the government had sent out to local authorities. This asked whether implementation of the remaining sections of the *DP(SCR)A* should be ‘deferred until at least the community reforms ... have been put into effect and have had time to settle down’<sup>210</sup>. From what has been argued earlier in the chapter we should not be too surprised that the government was not very keen on a piece of legislation with no clear price tag which gave considerable rights to people with disabilities.

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<sup>208</sup> See Appendix E

<sup>209</sup> In *Community Care: Services for People with a Mental Handicap and People with a Mental Illness*, House of Commons, Social Services Committee, Eleventh Report, op. cit. the committee state (at para. 91) that they had been recommending bringing into force ss. 1-3 of the Disabled Persons (Services, Consultations and Representation Act 1986 (c. 33) since their Sixth Report, 1989-90 (HC 444 at para. 43) but Mrs Bottomley declined to implement them on the grounds that: ‘From 1 April 1991 local authorities are required by directions under section 50 of the National Health Service and Community Care Act to have procedures for considering representations about needs and services. Anyone acting on behalf of a disabled person can make representations, including complaints, about needs and services, and local authorities are obliged to consider them.’ (HC Deb 22 March 1991 vol. 188 cc. 253W )

<sup>210</sup> HL Deb op. cit at c. 1580: Baroness Darcy de Knayth



**CHAPTER FOUR**

**SECTION 47 OF THE NATIONAL HEALTH SERVICE AND  
COMMUNITY CARE ACT 1990 IN THE 1990s**

*Case Management becomes Care Management again*

Between ‘Caring for People’ and the *NHSCCA* there was a change of nomenclature. Case management as proposed in ‘Caring for People’ ‘has its origins in the American community care development of the late 1960s and early 1970s’<sup>211</sup>. It is characterised by the same assessment and monitoring principles as care management but the crucial difference is that the same person assesses and manages care. As Ryan puts it: ‘By one named person becoming involved in the whole process, something ... occurs: engagement’<sup>212</sup>.

Although the original pure model has not been universally applied or has become diluted with time, the emphasis in the early days of care management, as discussed below, was on the separation of the assessment process from the provision of care and much energy and time was put into this. *Care* management is theoretically incompatible with CPA as the care manager and key worker/care-coordinator roles cannot be combined. Whilst the keyworker/care-coordinator may both assess and deliver *health* needs, the assessment of *social care* needs is, separated from its delivery. With *case* management, to use Ryan’s words again, ‘...the key functions of assessment, co-ordination of packages of care, monitoring and review are organically

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<sup>211</sup> Ryan, P., Ford, R., Clifford P. (1991) *Case Management and Community Care*, op. cit. at p. 7

<sup>212</sup> *Ibid.* at p. 37

interwoven within the whole process of service provision'<sup>213</sup>. However it is clear that even '[c]ase management is not a substitute for the provision of an adequate range of services'<sup>214</sup>.

### *Policy Guidance*

'Caring for People. Care in the Next Decade and Beyond, Policy Guidance' was published in 1990<sup>215</sup>. Here the change to the word *care* management was justified 'in terms of the fact that it is the care which is being managed and that the word case may be demeaning'<sup>216</sup>. It was envisaged that '[t]he development of community care planning and community care plans ... [would] be evolutionary'<sup>217</sup> and this was ostensibly why the government phased in the introduction of various parts of the *NHSCCA* with s.47 not coming into force until April 1993<sup>218</sup>. A more cynical interpretation of this delay is that '...the changes to the NHS, coming on top of the poll tax fiasco, were causing such political embarrassment that ministers decided that one battle front at a time was quite enough'<sup>219</sup>; indeed 'the [original] expected date for full implementation was April 1991'<sup>220</sup>.

The idea was that there would be 'a progressive separation of assessment from service provision'<sup>221</sup>, very much as required in a pure *care* management

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<sup>213</sup> Ryan, P., Ford, R., Clifford P. (1991) Case Management and Community Care, op. cit. at p. 9

<sup>214</sup> Shepherd, G. (1990) Case Management, Health Trends, Vol. 22, No. 2, pp. 59-61

<sup>215</sup> Caring for People. Care in the Next Decade and Beyond, Policy Guidance op. cit.

<sup>216</sup> Challis, D. in Malin, N. (ed.) (1994) Implementing community care, Open University Press, Buckingham at p. 60

<sup>217</sup> Ibid. at para. 2.4

<sup>218</sup> Ibid. at Appendix A

<sup>219</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p. 10

<sup>220</sup> Malin, N. in Malin, N. (ed.) (1994) Implementing community care, op. cit. at p. 8

<sup>221</sup> Caring for People Care in the Next Decade and Beyond, Policy Guidance, op. cit. at para. 3.15

model<sup>222</sup>. This was supposed to be a fundamental reform in the way services were provided and is characterised particularly by the separation of the role of assessor or care manager from that of key worker<sup>223</sup>. Interestingly though, this latter term was an ‘essential element’ of CPA there is no mention of CPA in the entire document.

The way in which ‘the services to be provided and the objectives of any intervention should be agreed’<sup>224</sup> was to be via a ‘care plan’; which would describe the ‘care package’ to be delivered<sup>225</sup>. The Government stated that it did ‘not wish to see ... a duplication of effort [f]or instance, where a patient has already been assessed for discharge from hospital, this should form the basis of the assessment decision’<sup>226</sup>. On the other hand there was concern that ‘local authorities should not be expected to endorse decisions about an individual’s care needs, or ways of meeting them, taken by health authorities’<sup>227</sup>, which, the guidance states, is the responsibility of social services. Surely these are the issues at the very heart of CPA, yet there is no mention of it and no mention of HC(90)23, which was published at virtually the same time.

More amazingly still the Policy Guidance contains the following sentence under the heading ‘Collaboration with Other Agencies’: ‘Where a service user has complex needs, it may *occasionally* be necessary to call together

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<sup>222</sup> See discussion above

<sup>223</sup> Ibid. at para. 3.11

<sup>224</sup> Ibid. at para. 3.24

<sup>225</sup> Ibid. at para. 3.9

<sup>226</sup> Caring for People. Care in the Next Decade and Beyond, op. cit. at para. 3.2.11

<sup>227</sup> Ibid. at para. 3.43

staff from all the agencies concerned for a case conference; the individual and his or her carers should then be invited to attend'<sup>228</sup>. The author respectfully suggests that no-one with even a passing understanding of CPA could have written this line. The idea that the whole policy guidance was written in complete ignorance of CPA gains even further currency when one reads under the next heading 'Assessment of Nursing Care Needs': 'The new arrangements create opportunities to assess possibilities for supporting users with nursing care needs through community care nursing services whether in their own homes, or in residential care homes, or in sheltered ... housing'<sup>229</sup>. Surely this is the 'bread and butter' of CPA yet there is no mention of the term at all.

*Care Management and Assessment & Assessment Systems and Community Care*

Following closely on the heels of the Policy Guidance was a series of booklets to assist people involved in implementing the *NHSCCA*. The Practitioners' Guide<sup>230</sup> helpfully describes the process of needs assessment stating that the basis should be '**[t]he proper identification of the cause**'<sup>231</sup> and that the key is '**[o]bjective setting**'<sup>232</sup>. It goes on to describe the process of care planning stating that '**All users in need of a continuing service should have a care plan**'<sup>233</sup> and, when implemented, '**a date should be set**

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<sup>228</sup> Caring for People. Care in the Next Decade and Beyond, Policy Guidance op. cit. at para. 3.35, author's emphasis

<sup>229</sup> Ibid. at para. 3.37

<sup>230</sup> Care Management and Assessment: Practitioners' Guide, Department of Health, Social Services Inspectorate and Scottish Office Social Work Group, 1991

<sup>231</sup> Ibid. at para. 3.32, bold in original

<sup>232</sup> Ibid. at para. 3.51, bold in original

<sup>233</sup> Ibid. at para. 4.3, bold in original

**for the first review**<sup>234</sup>. The concept of recording unmet need is also introduced with the proviso that '[t]here should ... be a **ready means of prioritising**'<sup>235</sup>.

In the Practice Guidance<sup>236</sup> under the heading 'Making agency agreements' and sub-heading 'Community nursing and therapy staff' it is stated that community nurses 'may be the most appropriate practitioners to assume the responsibility for care management, or it may be shared with other community health professionals'<sup>237</sup>. However, it goes on to say that this individual 'is identified with assessment rather than service provision. Practitioners who retain responsibility for both functions (for example some therapy staff) may not readily assume care management responsibilities'<sup>238</sup>. Here, it is submitted, we begin to see some of the philosophical differences perceived between care management and CPA at this time, though the latter is never mentioned by name.

The Managers' Guide<sup>239</sup> talks of '**Ensuring better integration within and between agencies**'<sup>240</sup> and how this is a statutory requirement emanating from the *NHSCCA*<sup>241</sup>. Health authorities are supposed to 'identify health care professionals to contribute to the local authority assessment of care needs'<sup>242</sup>.

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<sup>234</sup> Ibid. at para. 4.30, bold in original

<sup>235</sup> Ibid. at para. 4.34, bold in original

<sup>236</sup> Care Management and Assessment: Summary of Practice Guidance, Department of Health, Social Services Inspectorate and Scottish Office Social Work Group, 1991

<sup>237</sup> Ibid. at para. 91

<sup>238</sup> Ibid. at para. 92

<sup>239</sup> Care Management and Assessment: Managers' Guide, Department of Health, Social Services Inspectorate and Scottish Office Social Work Group, 1991

<sup>240</sup> Ibid. at Summary of Practice Guidance point 10., p. 20, bold in original

<sup>241</sup> Ibid. at Summary of Practice Guidance para. 57

<sup>242</sup> Ibid. at Section 1 para.1.4

It also specifies that the ‘co-ordinating function may be delegated to practitioners in other agencies’<sup>243</sup>. All this points to the ‘progressive separation of assessment from service provision’<sup>244</sup> that lies behind the whole process. However it is not until the section entitled ‘Hospital Discharges’ that we hear about CPA, which is mentioned alongside the requirement to have clear discharge plans as ‘reinforced by the Code of Practice on the *Mental Health Act 1983* and by the introduction of [CPA]’<sup>245</sup>. So firstly, CPA is seen here only as a subset of hospital discharge planning. Secondly, an important, though it is submitted spurious, distinction is drawn: ‘The major difference between [CPA] and care management is that under the former, the key worker may have some responsibility for service delivery whereas this would not normally apply to care management’<sup>246</sup>. This philosophical tack seems to be diametrically opposed to the later idea that ‘CPA is Care Management’<sup>247</sup> and there is considerable strength in the argument that, despite later efforts to assert otherwise, this dichotomy has persisted in the way in which social services have interpreted their role.

The perception that CPA, at this point in history, was perceived to be totally unrelated to care management is strengthened by reading ‘Assessment Systems and Community Care’<sup>248</sup>. There is no mention of CPA in this publication particularly bearing in mind the following theoretically relevant

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<sup>243</sup> Ibid. at Summary of Practice Guidance para. 52

<sup>244</sup> Ibid. at Section 1 para. 1.11

<sup>245</sup> Ibid. at Section 4 para. 4.54, italics in original

<sup>246</sup> Loc. cit.

<sup>247</sup> Modernising the Care Programme Approach, Effective Care Co-ordination in Mental Health Services, op. cit. at para. 35, underlining in original, see chapter 2

<sup>248</sup> Assessment Systems and Community Care. A joint review by Social Information Systems and the Social Services Inspectorate of the Department of Health, 1991

headings: ‘Links between assessment and other systems’<sup>249</sup>, ‘Criteria for interagency assessment’<sup>250</sup> and ‘Criteria for convening interagency case conferences’<sup>251</sup>.

### *The Laming Letter*

CPA is also not mentioned in the infamous letter from Sir Herbert Laming<sup>252</sup>, which states that the assessment process ‘will need to take into account ... whether other organisations could more appropriately meet the needs identified’<sup>253</sup>. Beyond this specific point the letter states that ‘the assessment of need and decisions about the services to be provided are separate stages in the process’<sup>254</sup>, and that ‘authorities do not need to assess on request but only where they think that the person may be in need of services *they provide*’<sup>255</sup>. Lewis and Glennerster describe this letter as ‘a real circle-squaring job’<sup>256</sup> meaning that ‘a judgement of need can be made before an assessment of need and even though a person may be judged in need the legislation does not require action to meet it’<sup>257</sup>. Indeed guidance circulated by the Social Services Inspectorate actually suggested doing a full needs assessment to be followed by a care package *tailored to the resources available*<sup>258</sup>.

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<sup>249</sup> Ibid. at para. 2.7

<sup>250</sup> Ibid. at para. 4.1

<sup>251</sup> Ibid. at para. 4.3

<sup>252</sup> Chief Inspector of the Social Services Inspectorate at the time of this letter (1992)

<sup>253</sup> CI (92) 34 Social Services Inspectorate, 14<sup>th</sup> December 1992 at para. 3

<sup>254</sup> Loc. cit.

<sup>255</sup> CI (92) 34 Social Services Inspectorate, op. cit. quoted in ibid. p. 15, author’s italics

<sup>256</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p.14

<sup>257</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p.15

<sup>258</sup> Feedback on Purchase of Service and Purchaser/Provider Workshops (1992) Department of Health and Price Waterhouse, London

Sir Herbert recognised all too well that ‘[o]nce the authority has indicated that a service should be provided ... [it] is under a legal obligation to provide it or arrange for its provision’<sup>259</sup>. He, therefore, cautioned practitioners ‘to be sensitive to the need not to raise unrealistic expectations on the part of users and carers’<sup>260</sup> and also to bear in mind that whatever they write in their notes might be accessed under access to information legislation. Or as Lewis and Glennerster put it: ‘...do not tell clients what their real needs are and ... do not write them down in case you get found out and have to provide for them’<sup>261</sup>.

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<sup>259</sup> CI (92) 34 Social Services Inspectorate, op. cit at para. 5

<sup>260</sup> Ibid. at para. 25

<sup>261</sup> Lewis, J., Glennerster, H. (1994) Implementing the new community care, op. cit. at p.15



**CHAPTER FIVE**

**SECTION 47 OF THE NATIONAL HEALTH SERVICE AND  
COMMUNITY CARE ACT 1990 IN THE 2000s**

*Continuing Care: NHS and Local Councils' Responsibilities*

In 2001 the government published guidance<sup>262</sup> which stated that '[t]he NHS is responsible for arranging and funding a range of services ... either at home, in a nursing home or a residential home includ[ing] ... community health services'<sup>263</sup>. The NHS was expected to develop 'local eligibility criteria for continuing care based on the nature or complexity or intensity or unpredictability of health care needs'<sup>264</sup>. Annex C gives 'key issues to consider when establishing NHS health care eligibility criteria'. One is that any combination of the above criteria 'requires regular supervision by a member of the NHS multidisciplinary team'<sup>265</sup>, another is that '[t]he individual has a rapidly deteriorating or unstable ... mental health condition'<sup>266</sup> that merits similar intervention. This circular was written in the context of ensuring that social services could provide continuing care in nursing homes employing registered nurses.

Whilst at first blush the statement that '[a] need for care or supervision from a registered nurse ... is not, by itself, sufficient reason to continue receiving

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<sup>262</sup> HSC 2001/015: LAC (2001)18, Continuing Care: NHS and Local Councils' responsibilities, Department of Health 28 June 2001. This advice was published in the wake of the judgement in *R v North and East Devon Health Authority ex parte Coughlan* [1999] 2 CCLR 285 and cancelled HC 1999/180: LAC (99) 30 – 'Ex parte Coughlan: Follow up action'

<sup>263</sup> *Ibid.* at para. 16

<sup>264</sup> *Ibid.* at para. 18

<sup>265</sup> *Ibid.* at Annex C para. 2

<sup>266</sup> *Ibid.* at Annex C para. 4

NHS health care<sup>267</sup> may simply be perceived as unhelpful to mentally ill people, there is some strength in the argument that community nursing care for people with mental ill health could be provided under the specific duties of the *NHSCCA* rather than the public law duties<sup>268</sup> of the *National Health Service Act 1977*<sup>269</sup> particularly where health and local authorities are in partnership arrangements<sup>270</sup>.

### *Fair Access to Care Services*

‘Fair access to care services: Guidance on eligibility criteria for adult social care’<sup>271</sup> was supposed to have been implemented by 7<sup>th</sup> April 2003<sup>272</sup>. It was accompanied by practice guidance: ‘Implementation questions and answers’<sup>273</sup> which includes an annex: ‘Case examples of risks to independence and eligibility’. The introductory notes on the Department of Health website state: ‘At the heart of the guidance is the principle that councils should operate just one eligibility decision for adults seeking social care support; that is, should people be helped or not?’<sup>274</sup>. ‘This decision should be made following assessment of an individual’s *presenting needs*’<sup>275</sup>. The Practice Guidance makes clear that it ‘adds to ... “Caring for People” guidance’<sup>276</sup> and updates it. It adds that ‘detailed assessment and

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<sup>267</sup> Ibid. at Annex C para. 6

<sup>268</sup> See chapter 7 for a discussion of the meaning of these terms

<sup>269</sup> National Health Service Act 1977 (c. 49), hereafter referred to as NHS Act, see Chapter 6

<sup>270</sup> Under s. 31 Health Act 1999 (c. 8)

<sup>271</sup> Fair access to care services: Guidance on eligibility criteria for adult social care (FACS) op. cit., see Appendix F

<sup>272</sup> Fair access to care services, op. cit. at para. 1

<sup>273</sup> FACS Practice Guidance Implementation questions and answers, originally published on 2<sup>nd</sup> August 2002, it was updated on 6<sup>th</sup> March 2003, hereafter referred to as Practice Guidance

<sup>274</sup> [http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/FairAccessToCare/FairAccessArticle/fs/en?CONTENT\\_ID=4015619&chk=8g5YN1](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/FairAccessToCare/FairAccessArticle/fs/en?CONTENT_ID=4015619&chk=8g5YN1)

<sup>275</sup> Fair access to care services, op. cit. at para. 2, bold italics in original

<sup>276</sup> FACS Practice Guidance Implementation questions and answers at Q 8.1 (A)

care planning frameworks have been published<sup>277</sup>, quoting inter alia the National Service Framework for Mental Health<sup>278</sup> and ‘Modernising the Care Programme Approach,’<sup>279</sup>. These documents have already been discussed in chapter 2; the main issue from the point of view of this discussion, it is submitted, is that the *tendency* of social services to define ‘eligibility for services using descriptions of vulnerability and risk’<sup>280</sup> is converted into an *imperative* by FACS. ‘Modernising the Care Programme Approach’, it will be remembered, is not prescriptive on this point but clearly favours this approach; FACS however, takes this a stage further. It points out that ‘Local health bodies and councils were requested to agree their respective responsibilities for continuing health and social care services by 1 March 2002’<sup>281</sup>. Furthermore, ‘where local health bodies and councils are operating partnership arrangements<sup>282</sup> ... this guidance should be used ... as a starting point to help them determine joint eligibility’<sup>283</sup>. There is considerable strength, then, in the argument that since 7<sup>th</sup> April 2003 the only correct way to apply the CPA to social care is via FACS. Whether this also amounts to the only lawful way will be discussed further in chapter 6 and by reference to case law in chapter 10.

Despite this some local authorities continue to have published guidelines for Care Management which fly in the face of FACS. Hammersmith and

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<sup>277</sup> Loc. cit.

<sup>278</sup> The National Service Framework for Mental Health Modern Standards & Service Models, op. cit.

<sup>279</sup> Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services, op. cit.

<sup>280</sup> Ibid. at para. 38

<sup>281</sup> Fair access to care services, op. cit. at para. 7; reference is to HSC 2001/015; LAC (2001) 18

<sup>282</sup> Under s. 31 Health Act 1999 (c. 8)

<sup>283</sup> Fair access to care services, op. cit. at para. 8

Fulham, for example, continue to use detention under the *MHA* as their primary criterion, followed by the presence of ‘a severe mental disorder as defined in the [*MHA*],<sup>284 285</sup>. Another criterion is based on the amount of time spent in hospital: ‘the service user must have spent *at least* 16 weeks of inpatient treatment over the past year *and* be in need of substantial and regular assistance’,<sup>286</sup>.

The eligibility criteria<sup>287</sup> within FACS are based, perforce, on statutory responsibilities. The two which impact most on adults with mental ill health are s.117 *MHA*<sup>288</sup> and s.2(1) *CSDPA*<sup>289</sup>, which are dealt with in more detail in chapter 6. The framework is prescriptive and is divided into 4 bands: critical, substantive, moderate and low<sup>290</sup>; with each broadly defined. There is thus only limited room for local variation. Furthermore:

‘With reference to [s.47(1) [*NHSCCA*], before starting a community care assessment councils should first ascertain whether a person appears to be in need of community care services. In exercising this judgement councils should set a low threshold, and avoid screening individuals out of the assessment process before sufficient information is known about them’,<sup>291</sup>.

We shall return to this in the discussion in chapter 10.

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<sup>284</sup> Assessment & Care Management in the Mental Health Service: Integrated Policy and Procedure, Hammersmith & Fulham Social Services, December 1999 at s. 6

<sup>285</sup> A severe mental disorder is nowhere defined in the *MHA*

<sup>286</sup> *Loc. cit.*, italics in original

<sup>287</sup> *Ibid.* at para. 14

<sup>288</sup> Mental Health Act 1983 (c. 20) at s. 117

<sup>289</sup> Chronically Sick and Disabled Persons Act 1970 (c. 44) at s. 2 (1)

<sup>290</sup> Fair access to care services, *op. cit.* at para. 16

<sup>291</sup> *Ibid.* at para. 30

In line with *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (House of Lords)<sup>292</sup> and LASSL(97)13<sup>293</sup> resources may only be taken into account when drawing up eligibility criteria<sup>294</sup>; '[o]nce eligible needs are identified, councils should meet them'<sup>295</sup> and indeed 'is under a duty to provide those services'<sup>296</sup>. What is not clear from FACS itself but is mentioned in the Practice Guidance is that it is on the basis of these eligibility criteria that councils will set a threshold below which they will *not* provide services<sup>297</sup>. The way in which they are to do this is laid out clearly<sup>298</sup> - in simple terms they estimate the cost of funding people with needs from each band and, starting from critical and working their way down, see how much, if any, money is left over. As Clements notes '...the guidance sanctions a continuation of ... the so called 'postcode lottery''<sup>299</sup>, a conclusion with which Mencap agrees<sup>300</sup>. Clements continues: 'Arguments concerning the need for local authorities to have flexibility over their eligibility criteria are not wholly convincing'<sup>301</sup> largely because from April 2003 the Finance Formula Grant<sup>302</sup> was introduced to 'iron out' this very inequity.

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<sup>292</sup> *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (HL), op. cit., hereafter referred to as *Barry* (HL)

<sup>293</sup> LASSL (97) 13, Responsibilities of Local Authority Social Services Departments: Implications of Recent Legal Judgements, Department of Health, 11<sup>th</sup> November 1997

<sup>294</sup> Fair access to care services, op. cit. at para. 52

<sup>295</sup> Ibid. at para. 43

<sup>296</sup> Ibid. at para. 52

<sup>297</sup> FACS Practice Guidance Implementation questions and answers at Q 3.11 (A)

<sup>298</sup> Ibid. at Q 3.9 (A)

<sup>299</sup> Clements, L. (2004) *Community Care and the Law*, Legal Action Group, London at para. 4.80

<sup>300</sup> Fair Access to Care Services – Mencap briefing Guidance on Eligibility Criteria for Adult Social Care Local Authority Circular (2002) 13, Susan Boddy, 31<sup>st</sup> July 2002 at p. 5

<sup>301</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 4.80

<sup>302</sup> Finance Spending Shares were introduced to replace Standard Spending Assessments to ensure sensitivity to local variation in line with the local government White Paper: Strong Local Leadership – Quality Public Services, December 2001

Furthermore, as Hirst LJ held in *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (Court of Appeal) resources can be ‘no more than one factor in an overall assessment, where no doubt the objective needs of the individual disabled person will always be the paramount consideration’<sup>303</sup>. In pointing out that ‘[t]here is a point at which resource availability ceases to be a legitimate reason for refusing to provide services’<sup>304</sup> Clements notes that *Barry (HL)* was decided prior to the introduction of the Human Rights Act 1998<sup>305</sup> and that whilst ‘[t]here can be little doubt that domestic law recognises a core set of ‘positive’ justiciable, non-resource dependent rights – the uncertainty relates to their scope’<sup>306</sup> and ‘Human rights probably also include ... a positive obligation upon the state to provide every citizen with certain basic necessities which he needs in order to be able to function as a human being’<sup>307</sup>.

FACS also reinforces the principle that where someone is deemed to have eligible needs, the local authority must develop a care plan which should include a note of needs and risks, preferred outcomes, contingency plans, details of services to be provided, contributions of carers and a review date<sup>308</sup>. With respect to adults with mental ill health, it is submitted, this equates to a CPA plan in all but name.

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<sup>303</sup> *R v Gloucestershire CC and Secretary of State for Health ex parte Barry* (CA) (1997) 1 CCLR 19 at 31G, hereafter referred to as *Barry* (CA)

<sup>304</sup> Clements, L (2004) *Community Care and the Law*, op. cit. at para. 4.116

<sup>305</sup> Human Rights Act 1998 (c. 42), hereafter referred to as HRA

<sup>306</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 4.117

<sup>307</sup> Hoffman, L. (2001) *The Separation of Powers*; Annual Commercial Bar Lecture, unpublished transcript, London: COMBAR, quoted in Clements, L. (2004) *Community Care and the Law*, op. cit. at p. 98 footnote 130

<sup>308</sup> Fair access to care services, op. cit. at para. 47

## CHAPTER SIX

### OTHER STATUTES GOVERNING THE COMMUNITY CARE OF PEOPLE WITH MENTAL ILL HEALTH

#### *National Health Service Act 1977*

S.47 *NHSCCA* leaves adults with mental ill health in a less than clear position with regard to CPA if they are assessed as falling below social services eligibility criteria. Clearly the NHS has duties to provide aftercare for mentally ill people; these are specifically contained in s.3(1) *NHSA*<sup>309</sup> but ‘[h]ealth services, though recognised by *guidance* as ... essential to care in the community, are ... not legally defined as ‘community care services’<sup>310,311</sup>. Furthermore ‘a person cannot generally lay claim to any particular NHS service at any particular time at any particular place’<sup>312</sup>. Notwithstanding the duty contained in s.47(3) *NHSCCA* to *notify* a health authority and *invite* them to assist, ‘health authorities do not ... have an explicit duty to participate in the pivotal process of the community care system-assessment’<sup>313</sup>.

Furthermore, the *NHSA* duty is a public law duty<sup>314</sup> rather than one aimed at the individual and only obliges the NHS to provide services if they are

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<sup>309</sup> National Health Service Act 1977 (c. 49) at s. 3 (1)

<sup>310</sup> Community care services are defined by s. 46 (3) of the National Health Service and Community Care Act 1990 (c. 19) as being those services which an LA may provide under Part III National Assistance Act 1948 (11 & 12 Geo. 6, c. 29), s.45 (as amended) Health Services and Public Health Act 1968 (c. 46), s.21 (as amended) and sch. 8 National Health Service Act 1977 (c. 49) and s. 117 Mental Health Act, 1983

<sup>311</sup> Mandelstam, M (1999) *Community Care Practice*, Jessica Kingsley, London at p. 343, author’s emphasis

<sup>312</sup> *Loc. cit.*

<sup>313</sup> *Loc. cit.*

<sup>314</sup> See chapter 7 for a fuller discussion of this term

‘necessary to meet all reasonable requirements’<sup>315</sup> and it is for health authorities to determine priorities and allocate resources. As Mandelstam says:

‘The effect of this discretion appears to be that although services as a whole are covered by the general duties to provide health services, the level (or even provision at all) of any one service is not mandatory, so long as its level (or even non-provision) is justifiable in terms of local resources’<sup>316</sup>.

### *Chronically Sick and Disabled Persons Act 1970*

‘Most people with a mental health difficulty receive their community care services under [this Act]’<sup>317 318</sup>, which ‘augment[s the] power [to provide welfare services under s.29 *National Assistance Act 1948*<sup>319</sup>] with a duty’<sup>320</sup>. Its significance in law lies with the fact that *Barry (HL)*<sup>321</sup> (which allows local authorities to allow resources to be taken into account ‘to some extent’ in assessing need) was decided on the basis of services provided under this Act. The judgement in this case, although taken to apply generally to s.47. *NHSCCA*, was highly controversial and has been criticised<sup>322</sup>. In an effort to ameliorate its effect, subsequent judgements have either stated that resource arguments are ‘largely restricted’ to *CSDPA 1970* s.2 cases as in *Re T (A Minor)*<sup>323</sup>, or have effectively distinguished *Barry (HL)* ‘as one peculiar to the situation under *CSDPA 1970* s.2’<sup>324</sup> as in *R v Sefton MBC ex parte Help*

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<sup>315</sup> National Health Service Act 1977 (c. 49) at s. 3(1)

<sup>316</sup> Mandelstam, M (1999) *Community Care Practice* op. cit. at p. 345

<sup>317</sup> Clements, L (2004) *Community Care and the Law*, op. cit. at I.20

<sup>318</sup> *Chronically Sick and Disabled Persons Act 1970* (c. 44) at s. 2 (1)

<sup>319</sup> *National Assistance Act 1948* (11 &12 Geo. 6, c. 29), hereafter referred to as NAA, at s. 29

<sup>320</sup> Bartlett, P. and Sandland, R. (2003) *Mental Health Law Policy & Practice*, Oxford University Press, Oxford at p. 514

<sup>321</sup> *R v Gloucestershire CC and Secretary of State for Health ex parte Barry (HL)* op. cit.

<sup>322</sup> See Rayment, B. (1997) *Ex parte Barry* in the House of Lords, *Judicial Review* Vol. 2, issue 3 and Clements, L. (1997) *The collapsing duty*, *Judicial Review* Vol. 2, issue 3

<sup>323</sup> *Re T (A Minor) sub nom R v East Sussex CC ex parte Tandy* (1998) 1 CCLR 352

<sup>324</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at 4.92



*the Aged*<sup>325</sup>. However, because the original judgement has not been overturned, people with a mental illness are bound by it so long as they are not subject to after care duties<sup>326</sup>.

*Section 4 Disabled Persons (Services, Consultation and Representation) Act 1986*

This legislation adds a ‘gloss’ to the duties of *CSDPA* by empowering disabled people, their authorised representative or carers to request an assessment of needs under *CSDPA*<sup>327</sup>. It is moot whether, with the advent of *S.47 NHSCCA* which requires local authorities to assess need ‘where it appears to [them] that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services’<sup>328</sup>, this section has any great meaning any longer.

*Section 117 Mental Health Act 1983*

As compared to the *NHSA*, a specific duty (i.e. one owed to the individual<sup>329</sup>) is owed to people subject to the aftercare provisions of the *MHA*<sup>330 331</sup> and community care services may not be charged for<sup>332</sup>. Though the duty only arises on discharge from hospital the health authority concerned has the

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<sup>325</sup> *R v Sefton MBC ex parte Help the Aged and Charlotte Blanchard* [1997] 1 CCLR 57

<sup>326</sup> Under *Mental Health Act 1983* (c. 20) at s. 117; see below

<sup>327</sup> *Chronically Sick and Disabled Persons Act 1970* (c. 44) at s. 2 (1)

<sup>328</sup> *National Health Service and Community Care Act 1990* (c. 19) at s. 47 (1)

<sup>329</sup> See chapter 7 for a fuller discussion of this term

<sup>330</sup> *Mental Health Act 1983* (c. 20) at s. 117

<sup>331</sup> *R v Ealing District Health Authority ex parte Fox* [1993] 1 WLR 373, at 385

<sup>332</sup> See *R v Manchester City Council ex parte Stennett et al* [2002] UKHL 34

power to take preparatory steps prior to discharge<sup>333</sup>. It also creates a specific duty to provide social care services<sup>334</sup>.

However, where a mental health review tribunal deems it necessary, the duty to provide professional services<sup>335</sup> and accommodation<sup>336</sup> is confined to ‘us[ing] its best efforts to procure’<sup>337</sup> them. These services are also available to patients on s.17 leave<sup>338 339</sup> and must be continued until the health and local authorities are satisfied that they are no longer necessary<sup>340</sup>. The duty is shared between the health and local authorities of the place in which the patient was resident when s/he was detained<sup>341</sup>. There is no restriction on the type of services that can be provided<sup>342</sup> and guidance suggests that these may include ‘appropriate daytime activities, accommodation, treatment, personal and practical support, 24-hour emergency cover and assistance in welfare rights and financial advice [as well as] support for informal carers’<sup>343</sup>.

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<sup>333</sup> See *R (K) v Camden and Islington Health Authority* [2001] EWCA Civ. 240 at [20]

<sup>334</sup> See *R v Ealing District Health Authority ex parte Fox* op. cit.

<sup>335</sup> *R (IH) v Secretary of State for the Home Department and others* [2003] UKHL 59

<sup>336</sup> *R (on the application of W) v Doncaster Metropolitan Borough Council* [2004] WL 852414 which also held that the applicant was not unlawfully detained and that his article 5 ECHR rights were not breached whilst accommodation was being searched for. This provides an interesting contrast with the decision in *R (on the application of Batantu) v Islington* op. cit. – see below under ‘National Assistance Act 1948’

<sup>337</sup> *R (IH) v Secretary of State for the Home Department and others*, op. cit. at [29]

<sup>338</sup> Mental Health Act 1983 (c. 20) at s. 17 – the power of the responsible medical officer to authorise leave under part II of the Act

<sup>339</sup> See Code of Practice to the Mental Health Act 1983, 1999 op. cit. at para. 20.7. This was confirmed in *R v Richmond LBC and other ex parte Watson and others* (1999) *The Times* 15<sup>th</sup> October

<sup>340</sup> See *R v Richmond LBC and other ex parte Watson and others*, op. cit.

<sup>341</sup> See *R v Mental Health Review Tribunal ex parte Hall* [1999] 4 All ER 883

<sup>342</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 15.25

<sup>343</sup> Guidance on Mental Health (Patients in the Community) Act 1995 (c. 52) accompanying LAC (96) 8 and HSG (96) 11, at para. 18

*Housing Act 1996*

Notwithstanding the powers of s.47 *NHSCCA*, when it comes to accommodation, both by original definition<sup>344</sup> and historical change in the law<sup>345</sup>, it is housing legislation that must be explored first. In non-unitary authorities the s.47 *NHSCCA* gives Local Authorities a duty<sup>346</sup> to *inform* the housing authority if it appears to them that there may be a need for any ‘housing functions’<sup>347</sup>. Clements argues that by this process ‘parallel needs under the *Housing Act 1996*<sup>348</sup> may well be triggered’<sup>349</sup> because ‘the housing authority will be under an obligation to receive applications<sup>350</sup> and ... make enquiries ... in cases of homelessness and apparent priority need. As the application does not have to be in any particular form<sup>351</sup> ... the notification ... amounts in itself to an application made on behalf of the assessed person’<sup>352</sup>. Unfortunately in *R v Tower Hamlets LBC ex parte Begum*<sup>353</sup> it was held that disabled adults with insufficient mental capacity are not able to make an application<sup>354</sup> or even authorise someone else to do so thus ‘den[ying many] people with a mental illness ... who are homeless, access to the ... provisions on local authority assistance<sup>355</sup>.

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<sup>344</sup> National Assistance Act 1948 (11 & 12 Geo. 6, c. 29) at s. 1 (a)

<sup>345</sup> ‘The primary duty to accommodate homeless people was transferred to housing authorities via Stephen Ross MP’s private member’s Bill which became the Housing (Homeless Persons) Act ) 1977 [c. 48]’ Clements, L. (2004) *Community Care and the Law*, op. cit. at I. 9

<sup>346</sup> Under National Health Service and Community Care Act 1990 (c. 19) at .s. 47 (3) (b)

<sup>347</sup> As defined by Housing Act 1996 (c. 52) at s. 228 onwards

<sup>348</sup> Housing Act 1996 (c. 52) at s. 184

<sup>349</sup> Clements, L. (2004) *Community Care and the Law*, op. cit at para. 17.10

<sup>350</sup> See *R v Camden LBC ex parte Gillan* (1988) Independent 13 October DC

<sup>351</sup> See *R v Chiltern DC ex parte Roberts* (1990) 23 HLR 387 DC

<sup>352</sup> Clements, L. (2004) *Community Care and the Law* op. cit. at para 17.10

<sup>353</sup> *R v Tower Hamlets LBC ex parte Begum* (1993) 25 HLR 319 HL

<sup>354</sup> Under Part VII Housing Act 1996 (c. 52)

<sup>355</sup> Edmunds, R. (1994) *Locking the Mentally Ill out of the Homelessness Legislation*, *Journal of Forensic Psychiatry*, vol.5 (2), p. 355

On the other hand, in *R (Patrick) v Newham LBC* Henriques J held that an apparent refusal of accommodation by a psychiatrically ill applicant did not put an end to the housing authority's obligations<sup>356</sup>.

Once in accommodation, though, *North Devon Homes Ltd v Brazier*<sup>357</sup> showed that the eviction of a mentally ill person due to offensive behaviour was in breach of both the *Disability Discrimination Act 1995*<sup>358</sup> and her *ECHR* Art. 8<sup>359</sup> right to respect for family life as 'most if not all of the conduct that is perpetrated is due to her mental problems'<sup>360</sup>.

#### *National Assistance Act 1948*

S.21 *NAA*<sup>361</sup> gives powers, subject to the Secretary of State's approval, to provide: 'residential accommodation for persons aged 18 and over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them'<sup>362</sup>. The approvals and directions contained in LAC(93)10<sup>363</sup> convert these powers to duties for people with mental ill health<sup>364</sup>. Case law suggests that once a needs assessment has decided what is required, this should be made available within about 6 months and may mean that accommodation has to be specially rented or purchased for this purpose<sup>365</sup>.

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<sup>356</sup> *R (Patrick) v Newham LBC* (2001) 4 CCLR 48 at 53D; this case dealt with accommodation under Housing Act 1996 (c. 52) at Part III (residential accommodation)

<sup>357</sup> *North Devon Homes Ltd v Brazier* (2003) 6 CCLR 245

<sup>358</sup> *Disability Discrimination Act 1995* (c. 50) at s. 22

<sup>359</sup> *European Convention on Human Rights, Human Rights Act 1998* (c. 42) at sch. 1, art. 8

<sup>360</sup> *North Devon Homes Ltd v Brazier* op. cit. at para. 17

<sup>361</sup> *National Assistance Act 1948* (11 & 12 Geo. 6, c. 29), at Pt. III, s. 21

<sup>362</sup> *Ibid.* at s. 1(a);

<sup>363</sup> LAC (93) 10 Department of Health, 1993

<sup>364</sup> Secretary of State's Approvals and Directions under section 21 (1) of the *National Assistance Act 1948* (LAC (93) 10 Appendix 1) at para. 2 (3) and (4)

<sup>365</sup> *R (on the application of Batantu) v Islington*, op. cit.

*Community Care (Direct Payments) Act 1996*<sup>366</sup>

This act enables people to purchase services they need. Local authorities need to demonstrate that a person is in need of this form of service<sup>367</sup> but it can be a useful way of supplementing care particularly where a need may not fall into one of the FACS bands which the local authority has to provide services under. Unfortunately it has been held that it does not extend to housing<sup>368</sup> as s.21 NAA requires a local authority to ‘make arrangements’<sup>369</sup>.

*The Various Carers Acts*

The *Carers (Recognition and Services) Act 1995*<sup>370</sup> gave limited rights to carers to be assessed at the same time as the person they care for but they had to actually request the assessment. The *Carers and Disabled Children Act 2000*<sup>371</sup> gave them a ‘freestanding right to a carer’s assessment’<sup>372</sup> and social services guidance requires that they are informed of this right<sup>373</sup> and given a leaflet<sup>374</sup>. The Community Care Assessment Directions 2004<sup>375</sup> formalise the requirement to involve carers (as well as the person being assessed) in assessment and care planning. The *C(RS)A* does not confer any *rights* to services for the carer but in traditional piecemeal fashion the *Carers (Equal Opportunities) Act 2004*<sup>376</sup> is supposed to plug this gap, as well as informing

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<sup>366</sup> Community Care (Direct Payments) Act 1996 (c. 15)

<sup>367</sup> Bartlett, P. and Sandland, R. (2003) *Mental Health Law Policy & Practice* op. cit. at p. 547

<sup>368</sup> See *R v Secretary of State for Health ex parte LB Hammersmith and Fulham (and others)*, *The Independent*, 15<sup>th</sup> July 1997 (HC)

<sup>369</sup> National Assistance Act 1948 (11 &12 Geo. 6, c. 29) at s. 21

<sup>370</sup> Carers (Recognition and Services) Act 1995 (c 12), hereafter referred to as C(RS)A

<sup>371</sup> Carers and Disabled Children Act 2000 (c 16)

<sup>372</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 11.16

<sup>373</sup> LAC (96) 7, Department of Health 1996 at para. 20

<sup>374</sup> *Ibid.* at para. 9

<sup>375</sup> LAC(2004)24, Department of Health 2004

<sup>376</sup> Carers (Equal Opportunities) Act 2004 (c. 15)

carers of their rights and 'extend[ing] the scope of carers' assessment',<sup>377</sup>  
when it is brought into force, hopefully in April 2005.

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<sup>377</sup> Overview of Recent Developments, The Carers (Equal Opportunities) Act 2004, The Review of Mental Health Law, Issue No 15, October 2004, Arden Davies, London at p. 12

## CHAPTER SEVEN

### SOCIAL SERVICES AND THE NHS AS ‘LAWMAKERS’

#### *Duties and Powers*

‘Social services authorities are the creatures of statute’<sup>378</sup> and thus anything they do is largely governed by the *Local Authority Social Services Act 1970*<sup>379</sup> although the *Local Government Act 2000*<sup>380</sup> now significantly ameliorates this. Social services functions can either be obligatory – normally expressed as a ‘statutory duty’ or discretionary – normally expressed as a ‘statutory power’<sup>381</sup>. ‘Where an authority has a power to act, but not a duty, it must (...) exercise its discretion’<sup>382</sup>. This must be done in accordance with administrative law insofar as this does not breach the *ECHR*<sup>383 384</sup>.

‘Statutory duties owed by public bodies can be divided into two categories’<sup>385</sup>. Public law duties, which are expressed in general terms, are known as ‘target duties’ and duties worded in personal terms are known as ‘specific duties’, ‘intended to confer enforceable rights on individuals’<sup>386</sup>. This has considerable significance for our discussion because, as McCowan LJ held in *R v Gloucestershire County Council ex parte Mahfood*, once an

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<sup>378</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.1

<sup>379</sup> *Local Authority Social Services Act 1970* (c. 42), hereafter known as LASSA

<sup>380</sup> *Local Government Act 2000* (c. 22) at Pt I

<sup>381</sup> See Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.3

<sup>382</sup> *Ibid.* at para. 1.4

<sup>383</sup> *European Convention on Human Rights, Human Rights Act 1998* (c. 42) at sch. 1

<sup>384</sup> See *R (J) v Enfield LBC and Secretary of State for Health (intervener)* (2002) 5 CCLR 434 at [72], *R (W) v Lambeth LBC* (2002) 5 CCLR 203 at [74] – [75] and *R (A and B) v East Sussex CC (No 1)* [2002] EWHC 2771 (Admin)

<sup>385</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.5

<sup>386</sup> *Loc. cit.*

authority decides that it is under a duty to make arrangements under s. 2 CSDPA (which he held created specific law duties) ‘it was under an absolute duty to provide them. It is a duty owed to a specific individual and not a target duty’<sup>387</sup>. This was confirmed by Sedley J (as he then was) in *R v Islington LBC ex parte Rixon*<sup>388</sup> and s.117 MHA has also been held capable of being an individual public law duty<sup>389</sup>. Other duties are described as hybrid: ‘general duties crystallising<sup>390</sup> into specific public law duties owed to individual service users’<sup>391</sup> as for example with s.21(1)(a) NAA which is converted from the general duty to provide residential accommodation for adults to a specific duty by virtue of a s.47 NHSCCA needs assessment<sup>392</sup>. This is particularly important when it is clear that up and down the country local authorities are making short-term stop-gap decisions completely bypassing s.47(1)(b) NHSCCA<sup>393</sup>, particularly, it is submitted, by virtue of incomplete implementation of the CPA, i.e. by not using FACS guidance to assess social care needs, as discussed in chapter 5.

Even where the courts intervene we should not, perhaps be surprised given the history of NHSCCA discussed in chapter 3, that they are anxious about the resource implications of their judgements<sup>394</sup>. However in a post *HRA* era

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<sup>387</sup> *R v Gloucestershire CC ex parte Mahfood* (1997) 1 CCLR 7 at 16G

<sup>388</sup> *R v Islington LBC ex parte Rixon* (1997-8) 1 CCLR 119 at 125H, hereafter referred to as *Rixon*

<sup>389</sup> *R (IH) v Secretary of State for Home Department and others* [2003] UKHL 59

<sup>390</sup> See the comments of Laws LJ in *R (A) v Lambeth LBC* (2001) 4 CCLR 486 at 499D (based on Richard Gordon QC’s use of this term)

<sup>391</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.11

<sup>392</sup> See *R v Sefton MBC ex parte Help the Aged and Charlotte Blanchard* op. cit. and *R v Kensington and Chelsea RLBC ex parte Kujtim* [1999] 2 CCLR 340

<sup>393</sup> See *R v Sutton LBC ex parte Tucker* op. cit.

<sup>394</sup> See Lord Hoffman’s comments in the 2001 Commercial Bar lecture: ‘...even when a case appears to involve no more than the construction of a statute or interpretation of common a law rule, the courts are very circumspect about giving an answer which would materially affect the distribution of public expenditure.’



‘the artificial distinction between target and specific public law duties ... is proving to be insufficient to mediate between the complexities of state responsibilities ... and individual need’,<sup>395</sup>.

### *Directions and Regulations versus Guidance*

Both directions and guidance are informal rules for the practitioners or officers concerned. ‘Directions which are binding on officials, are couched in more detailed, imperative language, and possess a structure which is hardly distinguishable from conventional secondary legislation’,<sup>396</sup>. ‘Guidance is less closely structured, less formal, and less peremptory in language’,<sup>397</sup>. This allows discretion and the courts take note of the differences. For example in *R v Social Fund Inspector and Secretary of State for Social Security ex parte Roberts*<sup>398</sup> it was held that the Secretary of State was acting in excess of his statutory powers when he published Guidelines couched in the language of Directions. ‘Regulations have the same status [as directions] - they count as secondary or subordinate legislation and therefore as **law**. They tend to be written in even more legalistic language than Directions, and the power to make them is always found in parent legislation of full statutory status’,<sup>399</sup>.

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<sup>395</sup>Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.13

<sup>396</sup> Holland, J., Webb, J. (2002) *Learning Legal Rules*, Blackstone Press, London at p. 7

<sup>397</sup> Loc. Cit.

<sup>398</sup> *R v Social Fund Inspector and Secretary of State for Social Security ex parte Roberts*, *The Times*, 23<sup>rd</sup> February 1990

<sup>399</sup> Belinda Schwehr, *Care and Health Law*: <http://www.careandhealthlaw.com/Public/Index.aspx?ContentID=-66&IndexType=2&TopicID=46&Category=1>, bold in original

Sometimes Directions are issued to ‘firm up’ earlier Guidance. An example of this can be found in The Community Care Assessment Directions 2004<sup>400</sup> issued by the Department of Health to formalise the Guidance to involve individuals and their carers in assessment and care planning.

### *Social Services Guidance*

This falls into two main categories. Formal guidance or ‘Policy Guidance’ is ‘issued by the secretary of state specifically declaring that it is issued under [s.7(1) LASSA]’<sup>401</sup>. General guidance or ‘Practice Guidance’ is ‘advice which an authority should have regard to when reaching a decision, but which it is not required to follow slavishly’<sup>402</sup>. FACS guidance falls into the category of ‘Policy Guidance’ of which Sedley J held in *Rixon*:

‘Parliament by section 7(1) has required local authorities to follow the path charted by the secretary of state’s guidance, with liberty to deviate from it where the local authority judges on admissible grounds that there is good reason to do so, but without the freedom to take a substantially different course’<sup>403</sup>.

The dissenting view of Hirst LJ in *Barry (CA)*<sup>404</sup> was in agreement and was upheld in the House of Lords<sup>405</sup>. It follows from this ‘that if a local authority decides not to follow policy guidance it must give clear and adequate reasons for its decision’<sup>406</sup> and, as will be seen below, it ‘cannot be used to amend or frustrate primary or subordinate legislation’<sup>407</sup>.

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<sup>400</sup> LAC (2004) 24, Community Care Assessment Directions, Department of Health, 2004

<sup>401</sup> Clements, L. (2004) Community Care and the Law, op. cit. at para. 1.29

<sup>402</sup> Loc. cit.

<sup>403</sup> R v Islington LBC ex parte Rixon op. cit. at 123

<sup>404</sup> R v Gloucestershire CC and Secretary of State for Health ex parte Barry (CA) op. cit. at 24

<sup>405</sup> R v Gloucestershire CC and Secretary of State for Health ex parte Barry (HL) op. cit.

<sup>406</sup> Clements, L. (2004) Community Care and the Law, op. cit. at para. 1.35

<sup>407</sup> Ibid. at para. 1.36

In view of the above then, it was somewhat surprising that Keith J held in *R (B and H) v Hackney LBC*<sup>408</sup> that '[s.7(1) LASSA] policy guidance was not 'strong guidance' in relation to the *assessment process* under [s.47(1) *NHSCCA*]. His ratio decidendi was that '[s.47 *NHSCCA*] is unusual, in that subsection (4) gives the secretary of state the power to issue *directions* 'as to the manner in which an assessment ... is to be carried out and that in the absence of any such directions, assessments can be carried out 'as the local authority considers appropriate'<sup>409</sup>. Clements is understandably sceptical about whether this view is correct as 'it conflicts with other High Court decisions and the Court of Appeal in ... [*Barry (CA)*]<sup>410</sup>,<sup>411</sup>. If this judgement were deemed correct the force of FACS guidance would be downgraded so that it is strong 'policy guidance' only insofar as the *care planning and service provision* is concerned<sup>412</sup>.

### *NHS Guidance*

*NHSA* empowers the Secretary of State to issue directions to NHS bodies<sup>413</sup> and some of this power is now delegated to Strategic Health Authorities to direct Primary Care Trusts<sup>414</sup>. Unlike social services 'there is no specific provision ... concerning the issuing of guidance'<sup>415</sup>, although under s.45

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<sup>408</sup> *R (B and H) v Hackney LBC* [2003] EWHC 1654 (Admin), hereafter referred to as Hackney

<sup>409</sup> Loc. cit.

<sup>410</sup> *R v Gloucestershire CC and Secretary of State for Health ex parte Barry (CA)* op. cit.

<sup>411</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 4.49

<sup>412</sup> See loc. cit

<sup>413</sup> *National Health Service Act 1977* (c. 49) at. s. 17

<sup>414</sup> *Ibid.* at s. 17A

<sup>415</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 10.27

*Health and Social Care Act 2001*<sup>416</sup> care trusts<sup>417</sup> are subject to s.7 *LASSA* guidance<sup>418</sup>. However under the *NHSA* the Secretary of State has the power to do ‘anything whatsoever which is calculated to facilitate or is conducive or incidental to, the discharge of’<sup>419</sup> the duty to promote a comprehensive health service so the ability to issue guidance must be implicit in that duty<sup>420</sup>. Though the *NHSA* is otherwise silent on the subject of guidance much guidance given to health bodies as health service circulars is combined with a local authority circular, as we have seen with regard to CPA above. Where the advice is ‘primarily aimed at health authorities, it is not unreasonable to assume that its legal force [is] no less in relation to them than it [is] to social service authorities, especially [where] the circular states that it is ‘policy guidance’ insofar as it applies to social services’<sup>421</sup>.

In *R v North Derbyshire Health Authority ex parte Fisher*<sup>422</sup>, a case concerning Department of Health guidance on prescribing beta-interferon for the treatment of Multiple Sclerosis, Dyson J held that whilst directions *can* be contained in government circulars, that the wording in that case was not sufficiently mandatory as to constitute a direction. Nevertheless, it was to be construed as ‘strong guidance’, meaning that failure to *have regard to it* was unlawful. A Health Authority was not obliged to follow such guidance but

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<sup>416</sup> Health and Social Care Act 2001 (c. 30)

<sup>417</sup> An effective merger under Pt. III Health and Social Care Act 2001(c. 30) between a Primary Care Trust and a Local Authority which goes beyond the partnership arrangement of s. 31 Health Act 1999 (c. 8) (where liability remain with the original body

<sup>418</sup> Local Authority Social Services Act 1970 (c. 42) at s. 7

<sup>419</sup> National Health Service Act 1977 (c. 49) at s. 2 (b)

<sup>420</sup> See Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 10.27

<sup>421</sup> Loc. cit.

<sup>422</sup> *R v North Derbyshire Health Authority ex parte Fisher* [1998] 8 MLR 327

could only depart from it by giving clear reasons for so doing and these would be amenable to a *Wednesbury*<sup>423</sup> challenge.

Conversely, and perhaps not surprisingly, NHS guidance cannot be used as a device to amend or contradict primary or subordinate legislation. In *R v Secretary of State for Health ex parte Pfizer Ltd*<sup>424</sup>:

‘Collins J held that HSC 1998/158, which suggested that [general practitioners] should not prescribe Viagra, was unlawful in that it sought ... to restrict the [general practitioner’s] duty to provide patients with all necessary and appropriate personal medical services pursuant to NHS (General Medical Services) Regulations 1992 Sch. 2 para. 12(1),<sup>425</sup>

The implications for CPA will be explored more in the next chapter.

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<sup>423</sup> *Associated Provincial Picture Houses Ltd v Wednesbury Corp* [1948] 1 K.B. 223

<sup>424</sup> *R v Secretary of State for Health ex parte Pfizer Ltd* (1999) 2 CCLR 270, *The Times*, 17<sup>th</sup> June

<sup>425</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 10.29

**CHAPTER EIGHT**

**THE POWER OF CIRCULARS, THE CODE OF PRACTICE TO THE  
MENTAL HEALTH ACT AND THE DRAFT MENTAL HEALTH  
BILL IN RELATION TO CPA**

*The Power of Circulars in relation to CPA*

Having established the general principles underlying non-statutory measures with regard to social services and the NHS we will now look outside this area to see what we can learn from case law. What exactly is meant by CPA, as we have seen above, is difficult to define and the fact that the s.47 *NHSCCA* largely parallels it needs to be taken into account when considering it.

In *Regina v C (Young person: Persistent offender)*<sup>426</sup> it was held that the definition of a persistent offender for the purposes of s.73(2) of the *Crime and Disorder Act 1998*<sup>427</sup> is ‘a matter of fact’ and is not to be defined by a government circular<sup>428</sup> which purported to do so. The implication for CPA might be that it cannot be used as an arbiter of eligibility where this conflicts with s.47 *NHSCCA*.

In *E C Gransden & Co Ltd v Secretary of State for the Environment*<sup>429</sup> it was held that a material consideration cannot be excluded by a government circular if it is a proper one under s.29 *Town and Country Planning Act*

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<sup>426</sup> *Regina v C (Young person: Persistent offender)* The Times, 11<sup>th</sup> October 2000

<sup>427</sup> *Crime and Disorder Act 1998* (c. 37)

<sup>428</sup> Namely ‘Tackling Delays in the Youth Justice System’, 1997, HMSO, October 15<sup>th</sup>

<sup>429</sup> *E C Gransden & Co Ltd v Secretary of State for the Environment* (1987) 54 P & CR 86

1971<sup>430</sup>. Again this may have implications for who may be eligible for CPA in terms of the statutory ‘entry criteria’ for assessment under s.47 *NHSCCA*.

Clements’ comments quoted above about not following guidance slavishly echo the decision in *Wycombe D C v Secretary of State for the Environment and Queensgate Developments*<sup>431</sup> where it was held that proper regard had to be had to policy contained in circulars but there was no requirement that it should be slavishly followed provided reasons are set out clearly and intelligibly. This might be applicable to the way in which a CPA assessment is carried out; for example following s.47 *NHSCCA* assessment procedures may be sufficient.

More radically, in *R v Department of Education and Science ex parte Dudley MBC*<sup>432</sup> the court held that it was lawful for the Secretary of State for Education to recoup money from the council for a grant-maintained school in accordance with the Education (Grant-Maintained Schools) Finance Regulations 1989<sup>433</sup> despite the fact that 3 circulars *issued by his own department* counselled against this<sup>434</sup>. If this were to be applied to CPA there would be scope for arguing (albeit controversially) that simply following

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<sup>430</sup> Town and Country Planning Act 1971 (c. 78)

<sup>431</sup> *Wycombe D C v Secretary of State for the Environment and Queensgate Developments* [1988] JPL 111

<sup>432</sup> *R v Department of Education and Science ex parte Dudley MBC* [1992] FLR 483

<sup>433</sup> Education (Grant-Maintained Schools) Finance) Regulations 1989, at reg. 3 (NB comments above about regulations having the force of law)

<sup>434</sup> These stated that sums recouped would represent expenditure incurred by a council during the time a school was within the council’s control and that the change to grant-maintained status would not change the financial position of the school or the council

relevant primary legislation is sufficient, given that CPA arguably adds nothing to it.

Lastly in *R v Chief Constables of C and D ex parte A*<sup>435</sup> Turner J held that failure to comply with a government circular was not an actionable illegality though it could be properly relied upon as evidence that a *public body*, which should observe its provisions, had not complied with some other administrative duty in a lawful manner. Extrapolating this to CPA, the onus would be upon the health authority rather than the individual practitioner – indeed the circulars and the Code of Practice (as we shall see below) are couched in this way.

The court also held that a circular could not impose fetters on the obligations of the police authorities to pass information between each other. The requirement to plan care in accordance with CPA might similarly be overridden by other obligations; an example would be the need to protect other patients from violent or drug-abusing patients on a ward by curtailing the stay of one individual in hospital.

#### *CPA and the Code of Practice to the Mental Health Act*

S.118 *MHA* requires '[t]he secretary of state [to] prepare, and from time to time revise, a code of practice'<sup>436</sup> to guide professionals. 'It has been held that the code is – in effect – strong policy guidance'<sup>437</sup>; in other words it has

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<sup>435</sup> *R v Chief Constables of C and D ex parte A* [2001] 1 WLR 461

<sup>436</sup> Mental Health Act 1983 (c. 20) at s. 118

<sup>437</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 15.13



quasi-legal significance although of course ‘it cannot amend or frustrate primary or subordinate legislation’<sup>438</sup>.

Furthermore we know from *Munjaz v Mersey Care NHS Trust and others*<sup>439</sup> that the Code of Practice should be followed unless, in an individual case there is a good reason for departing from it. It can, by definition, only apply to people subject to the *MHA* although it is submitted that almost certainly a kind of ‘halo effect’ applies whereby it becomes more difficult to justify a different or lesser standard of assessment or care for those not subject to the *MHA* but with similar problems or apparent needs.

Three editions have been prepared; the first appeared in 1990<sup>440</sup>, introduced by the usual government circular<sup>441</sup> and this, of course, preceded the introduction of CPA. Consequently aftercare arrangements are related to HC(89)5<sup>442</sup> and Department of Health booklet ‘Discharge of Patients from Hospitals’<sup>443</sup> which are discussed in chapter 1. Notably the duty is upon managers in the health service and directors of social services to *make staff aware* of the arrangements.<sup>444</sup> ‘[I]t is the responsibility of the r m o<sup>445</sup> to *ensure that a discussion takes place* to establish a care-plan to *organise the*

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<sup>438</sup> Ibid. at para. 1.36

<sup>439</sup> *Munjaz v Mersey Care NHS Trust and others* [2003] EWCA Civ 1036, hereafter referred to as *Munjaz*

<sup>440</sup> Code of Practice to the Mental Health Act 1983, Department of Health and Welsh Office, 1990, HMSO, London

<sup>441</sup> EL (90) P/85, LASSL (90) 5, WHC (90) 38, Department of Health, 1990

<sup>442</sup> Op. cit.

<sup>443</sup> Code of Practice to the Mental Health Act 1983, 1990, op. cit. at para. 26.5

<sup>444</sup> Loc. cit., author’s emphasis

<sup>445</sup> Responsible medical officer as defined by Mental Health Act 1983 (c. 20) at s. 34 (1), hereafter referred to as RMO

*management* of the patient's continuing health and social care needs',<sup>446</sup> *when* a decision to discharge or grant leave is made.

The second edition of the Code of Practice was published in 1993<sup>447</sup>; the wording in this is very similar. This time it was the responsibility of '[m]anagers in the health service, NHS Trusts and Directors of Social Services [to] ensure that all staff *are aware of* the care programme approach as laid down in circular HC(90)23/LASSL(90)11...'<sup>448</sup>. The duty of the RMO to establish a care-plan remains the same; s/he must still ensure a discussion takes place.

In the 1999 Code of Practice the responsibility of NHS Managers and Directors of Social Services is to ensure that all staff are aware of the care programme approach and *related provisions*. These are summarised as being contained in HSG(94)27 and are essentially about risk assessment<sup>449</sup> and indeed the RMO is given this responsibility directly by the Code of Practice<sup>450</sup>. This paragraph goes on to state that '[t]he relationship between the CPA, section 117<sup>451</sup> aftercare and local authority arrangements for care management is more fully explained in *Building Bridges*...'<sup>452</sup>. This, of course, as discussed in chapter 2 is the document which stated inter alia that

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<sup>446</sup> Code of Practice to the Mental Health Act 1983, 1990, op. cit. at para. 26.6, author's emphasis

<sup>447</sup> Code of Practice to the Mental Health Act 1983, Department of Health and Welsh Office, 1993, HMSO, London

<sup>448</sup> Ibid. at para. 27.5, author's emphasis

<sup>449</sup> HSG (94) 27/LASSL (94) 4 NHS Executive, op. cit. as far as England is concerned. This circular was discussed in Chapter 2.

<sup>450</sup> Code of Practice to the Mental Health Act 1983, Department of Health and Welsh Office, 1999, op. cit. at para. 27.6

<sup>451</sup> Mental Health Act 1983 (c. 20) at s. 117

<sup>452</sup> Ibid. at para. 27.4, italics in original

‘[d]uplication of social care assessments, for CPA and Care Management can and should be avoided’<sup>453</sup>.

The RMO still has to ensure the discussion takes place to establish a care-plan but now this must take place *before* the decision to discharge is taken. From the point of this paper the significant change is arguably that the RMO now has a ‘responsibility to ensure, in consultation with the other professionals concerned, that the patient’s *needs for health and social care are fully assessed* and the care plan addresses them’<sup>454</sup>. The exact mechanism for assessing healthcare need is not subject to any statutory or formal guidance. However, the mechanism for social care needs assessment is and since it has been established above that policy guidance cannot amend or frustrate primary or subordinate legislation’<sup>455</sup> it is submitted that the social needs assessment must be carried out in accordance with primary legislation, i.e. s.47 *NHSCCA*. With regard to how this is carried out, as has been established above that FACS guidance equates to ‘strong guidance’ only insofar as the *care planning and service provision* is concerned. Combining *Munjaz with Hackney*<sup>456</sup> there may be an argument in an individual case that the *assessment process* need not be carried out using the FACS guidance but, given the caveats concerning the *Hackney* judgement discussed above, it is submitted that a local authority would be ill-advised to rely on this.

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<sup>453</sup> Building Bridges. A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, op. cit. at para. 3.1.5

<sup>454</sup> Code of Practice to the Mental Health Act 1983, 1999 op. cit. at para. 27.5, author’s emphasis

<sup>455</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 1.36

<sup>456</sup> *R (B and H) v Hackney* op. cit. and discussed above

It is therefore submitted that, with respect to detained patients at least, whilst the managers have a responsibility to disseminate information about CPA, the primary responsibility of the RMO is to ensure that the patient's health and social care needs are fully assessed. Whilst in theory there should be no dichotomy between these two aims, there is considerable strength in the argument that where a Trust or local authority is failing in its duty to ensure that social care needs are fully assessed in accordance with s.47 *NHSCCA* and the FACS guidance, that the RMO cannot hide behind this failure; s/he has a personal duty not only to assess health need (or ensure that this takes place) but also to ensure that social services and/or the Trust do their duty<sup>457</sup>.

#### *CPA in the Draft Mental Health Bill 2004*

There is little doubt that were ss.31 and 32 Draft Mental Health Bill 2004<sup>458</sup> to be enacted they would elevate the status of something called a 'care plan' onto a statutory footing for those subject to the Act. However, what exactly this would consist of is an unknown since it is dependent on, as yet unwritten, regulations. Given that it is something that needs to be drawn up from the point of detention it may be a more 'watered-down' version than the theoretical full-blown health and social needs assessment of CPA but there is no indication that the bill would give any added power to CPA.

#### *Summary of the Power of CPA*

A summary might be a lot easier were CPA simply based on a single circular; exactly what CPA is and which circular 'requires' it are not clear.

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<sup>457</sup> See proposed RMO's letter to Social Services in Appendix J

<sup>458</sup> Op. cit. See Appendix G

This combined with the unsettled position of the courts as to what is meant by strong 'policy guidance' means that the true power of CPA remains unknown.

One can say, however, that there is nothing within CPA that confers any extra rights on people with mental ill health. Secondly it is difficult, if not impossible, to tease out what benefits the supposed structure of CPA brings to the patient. Indeed it is submitted that the requirement to assess (taking risk into account) and provide for health and social needs within the aegis of s.47 *NHSCCA*, is identical and is more clearly understood by the courts. Not only do statutory powers trump CPA but also the power of any type of Guidance (when compared with Regulations and Directions) is weak.

Furthermore, if we had hoped for 'added value' for those detained under the *MHA* we would be disappointed for this only puts an onus on managers to *tell* staff about CPA. The responsibility on the RMO, it is submitted, is in fact to ensure that s.47 *NHSCCA* is implemented.

## CHAPTER NINE

### CPA CASE LAW – R v LONDON BOROUGH OF RICHMOND EX

#### PARTE H AND THE MATERIAL FACTS IN

#### R (ON THE APPLICATION OF HP AND KP) V LONDON

#### BOROUGH OF ISLINGTON

##### *R v London Borough of Richmond ex parte H*

This case<sup>459</sup> concerns a man with a long history of mental health problems and a diagnosis of schizophrenia. It was common ground between the parties that the respondent, the London Borough of Richmond, was under a duty to *provide* the applicant with accommodation pursuant to s.47(1)(b) *NHSCCA* and s.21 *NAA*. The issue, from the point of view of our discussion, is whether the local authority had actually *assessed* his needs in accordance with s.47(1) (a) *NHSCCA*. The case commentary is silent on the issue but there are some clues within the text.

There was an agreement amongst the professionals responsible for his care that the applicant was no longer appropriately placed in his accommodation. How this conclusion was reached is not explained but the narrative begins with a meeting that took place on 22<sup>nd</sup> February 2000. The nature of this meeting is unclear, but a Dr Mukherjee represented the local authority; it may be that Dr Mukherjee was their medical assessor but we are not told. It seems unlikely that he was a social worker or the person who carried out a formal needs assessment for the local authority. However, the end-point of

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<sup>459</sup> R v London Borough of Richmond ex parte H [2000] WL 1480193

this meeting was to produce a care plan because Dr Mukherjee requested that this contain a clear description of his housing needs which remained as they were when described to Hammersmith, presumably the authority where he had previously resided or was residing at that time.

The entries in the care plan are described in the commentary; they contain a 'needs' column and an 'objectives/goals' column. Dr Mukherjee states that offering the applicant a flat in a housing estate would have a significantly adverse effect on his mental health. Essentially, he is asserting that the applicant has a psychological need for a self-contained flat and the court cited *R v Avon CC ex parte M* in support of this position - in this case it was held that the entrenched position of the applicant, identified by expert opinion as part of his psychological needs, 'may properly [be] include[d]' in a needs assessment<sup>460</sup>. In the instant case it is not clear whose opinion is being relied upon nor whether this view has been incorporated into a comprehensive needs assessment.

When the applicant is being asked whether he would consider alternative accommodation the implication is that the need for a self-contained flat was, in fact, decided at a CPA meeting<sup>461</sup>. The court does not appear to pick up on whether the applicant's needs were in fact assessed in any formal way. Admittedly, the local authority was free to determine the mode of assessment, this being prior to the introduction of FACS, but no evidence is presented that any assessment actually took place. Instead, it seems more

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<sup>460</sup> *R v Avon CC ex parte M* [1994] 2 FLR 1006

<sup>461</sup> *R v London Borough of Richmond ex parte H* op. cit. at para. 11

likely that Dr Mukherjee simply took on board the views of the treating team as expressed at the CPA meeting and this was later interpreted as an assessment.

Therefore, as a result of the *CPA care plan* stating the need for one type of accommodation counsel for the applicant was later able to assert quite correctly, that when different accommodation was offered no 'proper reassessment, as the law requires' had taken place<sup>462</sup>. The question, it is submitted, could also be put as to whether any proper *primary* assessment had taken place. It is submitted that this case illustrates the way in which CPA acts as a smokescreen, blinding people, including the courts, to the possibility that the law is not actually being complied with. Having a meeting at which things are stated and recorded, is not the same as assessing need

*R (on the application of HP and KP) v London Borough of Islington*<sup>463</sup> -  
*Material Facts*

Mr P was an ethnic Albanian asylum-seeker from Kosovo who was living in the UK. He spent much of his time in bed and without the constant assistance of his family would not have attended to his personal hygiene, taken medication etc. The evidence presented to the court suggested that prior to the traumatic events in Kosovo he had been able to work and was said to have 'been quite normal, albeit not functioning at a high level'<sup>464</sup>.

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<sup>462</sup> Loc. cit. at para. 18 (2)

<sup>463</sup> *R (on the application of HP and KP) v London Borough of Islington* op. cit.

<sup>464</sup> *Ibid.* at para. 3



In his judgement, Munby J seeks to express his situation in layman's terms as having 'sunk in[to] depression'<sup>465</sup> and to connect this with the traumatic events described, namely the killing of his 6 year old son and the torture of another son, 18 at the time of the case. However, it is submitted that this attempt to make his illness appear understandable to the lay person carries with it the risk of normalising it, which as we will see below, has significant consequences.

Mr P was not happy talking to professionals, so much of the history on 4th April 2002 was obtained from his wife and son who explained that Mr P was not happy to be seen by a doctor because he believed (presumably irrationally) that he was going to be killed (it is not clear whether he believed the doctor would kill him or someone else). However Mr P told professionals that he was hearing voices. On examination Mr P was sitting on his bed with poor eye contact and was not very cooperative. He became tearful when discussing his deceased son. His speech was retarded and he was depressed and irritable in mood, though he did not express any suicidal ideas. His ideas about being killed were, unsurprisingly, described as persecutory delusions, but it was impossible to elicit much else about his mental state because of his lack of cooperation, due in all probability to the aforementioned delusions. No firm diagnosis was made as a result of that visit and at least 3 differential diagnoses were put forward: depression, with psychotic symptoms, a grief reaction and 'symptoms suggestive of Post Traumatic Stress Disorder'<sup>466</sup>.

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<sup>465</sup> Loc. cit.

<sup>466</sup> Ibid. at para. 4

The next recorded interview was on 31st July 2002 when he was seen by a community psychiatric nurse 'who formed the view that he was psychotic and that a formal mental health assessment by a consultant psychiatrist was necessary'<sup>467</sup>. Dr McK saw him with Mr P's social worker on 6th August 2002. It was noted that he had to be interviewed via an interpreter as he spoke no English. Dr McK noted that the family felt he had deteriorated since coming to the UK and had been low in mood and forgetful. When he questioned him there appeared to be no suicidal ideation and no psychotic symptoms. Dr McK stated that *his family* was of the view that his housing situation exacerbated his condition. Interestingly it is at this point that we learn that Mr P had been taking an antidepressant and an antipsychotic. Dr McK thought that the latter should be stopped slowly. We are not told why, and no legal report questions this, but it is relevant since all the reports up to this point are clear that he was psychotic. It is submitted that we should not necessarily be surprised if the antipsychotic medication worked to abolish the symptoms, but one also needs to understand that they are a treatment, not a cure, and hence stopping them would be very likely to cause any underlying psychosis to return.

We are then told that on the same day as Dr McK reported his visit (12th August), Islington wrote to Mr P's solicitors to say that Mr P was not sectionable under the *MHA*. We are not told of the connection but it is reasonable to assume that the request for a 'formal mental health assessment' mentioned above meant an assessment under the *MHA* and this was what had occurred on 6th August 2002. Indeed it would be hard to see why Mr P

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<sup>467</sup> Ibid. at para. 5

would have been deemed sectionable since by all accounts he was taking prescribed medication (the only medical treatment being offered) in the community and the need for hospitalisation is not self-evident.

Islington went on to tell Mr P's solicitors that they would be sending a social worker to fully assess his needs and after several visits a draft 'Health and Social Care Assessment' was prepared and sent to his solicitors on 23rd January 2003. Dr McK's specialist registrar<sup>468</sup> visited with his social worker and an interpreter on 18th March 2003. His wife gave a good account of how he had been over the last year stating, inter alia, that she had noticed an improvement in his aggression, suicidal thoughts and paranoid ideation though she remained concerned that he spent most of the day in bed and remained agitated, tremulous and occasionally tearful. The specialist registrar noted an objectively low mood and psychomotor retardation<sup>469</sup>. The conclusion was that whilst there appeared to have been some improvement some depression and perhaps even some paranoia remained.

There was a CPA meeting the same day and 2 plans emerged. One was the CPA community care plan and the other was the final version of the 'Health and Social Care Assessment', presumably a care-plan under s.47 *NHSCCA*. The latter document was said to have 'reflected matters which we have already seen noted in the case papers'<sup>470</sup>. In summarising these, Munby J talks of the absence of 'a firm psychiatric diagnosis. He *may* be suffering

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<sup>468</sup> A specialist registrar is the grade below consultant – essentially a trainee consultant

<sup>469</sup> The slowed-up thinking commonly associated with depressive illness

<sup>470</sup> R (on the application of HP and KP) v London Borough of Islington op. cit at para. 9

from reactive depression resulting from traumatic events in Kosovo<sup>471</sup>. The assessment goes on to raise an issue not raised before - namely that there 'may be an organic root to his problems but it is not clear whether a neurological assessment has been arranged'<sup>472</sup>. It then makes this didactic statement: 'Mr P *appears* to be suffering from a form of depression known as "reactive" ... This is not a severe and enduring mental illness'<sup>473</sup>.

It is submitted that the key problem here is that the social worker has misinterpreted the totality of the medical evidence to reach a minimalistic conclusion based on a non-recognised diagnostic formulation<sup>474</sup>. Using this she asserts that the patient, who had been receiving care from a community mental health team, including medication for depression and psychosis, for about a year, did not have a severe and enduring mental illness. She then asserts, in the face of the evidence it is submitted, that it was not possible to assess *any aspect* of his mental state, though she contradicts this by stating that he 'was assessed as being at risk of severe self-neglect and vulnerable to deterioration in his mental state *particularly if he stops taking his medication*'<sup>475</sup>.

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<sup>471</sup> Loc. cit, author's emphasis

<sup>472</sup> Loc. cit.

<sup>473</sup> Loc. cit., author's emphasis

<sup>474</sup> The term reactive depression was much in vogue about 30 years ago (see for example: Tredgold, R. F., Wolff, H. H. (1975) U.C.H. Handbook of Psychiatry, Duckworth, London at p. 78) but does not appear in the 2 universally recognised codes of mental illness: Diagnostic and Statistical Manual of Mental Disorders (2000) 4th Edition, Text Revision, American Psychiatric Association, Washington DC or The ICD-10 Classification of Mental and Behavioural Disorders (1992) World Health Organisation, Geneva

<sup>475</sup> R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 9, author's emphasis

The 'statement of need' associated with the above identifies the requirement for prompting with all aspects of daily living including personal care, reminders to take medication, treatment for depression and 'bereavement issues', safe accommodation with more privacy and support and prompting to go out and socialise. To the question 'Does the service user meet the eligibility criteria for care management?', the answer 'No' is given<sup>476</sup>.

The CPA community care plan mirrored the 'statement of need' but conflated the points about reminding him to take medication and needing treatment for depression and bereavement issues and assigned this combined role to the family. The only role left for professionals was to 'sort out' his housing.

Mr P's solicitors challenged Islington's assessments and obtained an independent social work report, which opined that Mr P had complex and long-term mental health needs and should be placed on enhanced CPA. It disagreed with the diagnosis and said that this was likely to be a psychotic illness. It went on to say that 'with such severe impact upon his daily functioning, and his stated vulnerability and adverse social circumstances, he should fulfil the eligibility criteria for Care Management...'<sup>477</sup>. In response to Mr P's solicitors' assertion that the community care assessment was of 'appallingly poor quality', Islington responded that Mr P had had a proper community care assessment and defended their decision not to provide services on the grounds that Mr P did not have a severe and enduring mental illness, citing in support the fact that he was seen by two psychiatrists.

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<sup>476</sup> R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 10

<sup>477</sup> Ibid. at para. 13

Mr P's solicitors obtained an independent medical opinion, which stated that Mr P suffered from depression with psychotic symptoms<sup>478</sup> and that this was a very severe mental illness<sup>479</sup>. It is submitted that these findings were essentially the same as those of the previous doctors who had seen him. He pointed out that his illness was severe as it had reached psychotic intensity and enduring as, by that stage, it had lasted 2 years. He agreed with the *present* care plan for treating him in the community. It is not clear if this referred to the extant plan involving a community psychiatric nurse but it probably did because he opined that Mr P was in need of regular supervision by the psychiatric services<sup>480</sup>.

Islington were sent a copy of this report on 23rd June 2003 and on 2nd July 2003 wrote to Mr P's solicitors saying that Mr P had no community care needs and that accordingly no carer's assessment would be performed on his son<sup>481</sup>. It appears that the report was shown to Dr McK but his views are never made overt, nor is it clear whether Islington based their response on anything that Dr McK said when shown the report. They merely said that '[t]he advice given is that there is insufficient evidence to suggest that we change our assessment of Mr P.'<sup>482</sup>

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<sup>478</sup> As defined by The ICD-10 Classification of Mental and Behavioural Disorders, op. cit.

<sup>479</sup> Ibid. at para. 16

<sup>480</sup> Ibid. at para. 18

<sup>481</sup> Ibid. at para. 19

<sup>482</sup> Loc. cit

**CHAPTER TEN**

**CPA CASE LAW – CRITICAL ANALYSIS OF THE JUDGMENT IN**

**R (ON THE APPLICATION OF HP AND KP) V LONDON**

**BOROUGH OF ISLINGTON**

*Complaint One: Diagnosis as a Basis for Assessing Need*

The applicant asserted that in the absence of a 'firm psychiatric diagnosis' Islington could not conclude that there was no need for community care services. Munby J exercised by the semantic meaning of the phrase 'no firm psychiatric diagnosis', made much of the difference between no firm diagnosis of X being consistent with a diagnosis of Y or Z<sup>483</sup>. In doing so he accepted without dissent that diagnosis alone could be determinative of eligibility for CPA.

It is submitted that this judgement is flawed on several grounds. Firstly, the letter written by Dr McK subsequent to a *MHA* assessment has been elevated to a status that it clearly cannot deserve. Quite apart from the fact that in this letter Dr McK raises the possibility of early dementia (an incurable and deteriorating condition which would qualify as enduring and would be liable to become severe), the totality of the medical evidence is not examined on an equal footing with the independent medical opinion. An informed reading of the overall care shows that Mr P was being treated for an illness containing a depressive element, severe enough to merit treatment with antidepressants and a psychotic element severe enough to merit treatment with

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<sup>483</sup> Ibid. at para. 26

antipsychotics. This had been going on within the community mental health team to which Dr McK was presumably the consultant and was confirmed by the specialist registrar. Dr McK was never given the opportunity to express the totality of his view; instead it is viewed solely through the prism of the social worker's understanding, which it is submitted, was flawed. Had the court had the benefit of a report or the opportunity to hear from Dr McK directly it would have been able to judge his conclusions against those of the independent doctor using the criteria outlined in *R (on the application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital*<sup>484</sup>.

Secondly, there is the issue of CPA eligibility criteria. Whilst prior to 'Modernising the Care Programme Approach'<sup>485</sup> it might have been acceptable to define access to CPA systems by legal status or diagnosis<sup>486</sup>, since then systems ought to have become coordinated, on the whole using descriptions of vulnerability and risk as eligibility criteria. Even if this gentle persuasion were not enough, we saw in chapter 5 that the NHS was expected to develop 'local eligibility criteria for continuing care based on the nature or complexity or intensity or unpredictability of health care needs'<sup>487</sup>. And we also know that key issues to consider when establishing NHS health care eligibility criteria include the eventuality that any combination of the above criteria 'requires regular supervision by a member of the NHS

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<sup>484</sup> *R (on the application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital* [2001] All ER (D) 294 (Oct), hereafter referred to as *Wilkinson*. Essentially the court held that where different medical views exist the court should be given the opportunity of testing the evidence

<sup>485</sup> *Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services*, op. cit.

<sup>486</sup> See *ibid.* at para. 38

<sup>487</sup> *Continuing Care: NHS and Local Council's responsibilities*, op. cit. at para. 18



multidisciplinary team'<sup>488</sup> or that '[t]he individual has a rapidly deteriorating or unstable ... mental health condition'<sup>489</sup> that merits similar intervention. So, it is submitted that Islington's CPA eligibility criteria were not in accordance with policy guidance in 2002 and therefore quite probably not lawful.

*Complaint Two: Failing to Reconsider Assessment*

Munby J characterises the complaint as being firstly that Islington could not maintain its reliance on Dr McK and his specialist registrar's 'admittedly uncertain diagnoses' in the face of the independent medical opinion's clear diagnosis. Secondly, that Islington's decision is devoid of reason - with reference to the different perceived medical opinions.

Munby J maintains there is no substance in the second part of the complaint as Dr McK's further advice on 2nd July 2003 is allegedly that 'Mr P does not have a psychiatric condition bringing him within its CPA eligibility criteria'<sup>490</sup>. However, it is submitted that this is his interpretation of what was actually said. In fact, as indicated above the temporal and causative relationship between Dr McK reading the report and Islington's response is less than clear. Munby J asserts that Islington chose to accept Dr McK's opinion in preference to the independent opinion but, as indicated above we are not comparing like for like. The report is written for the court, the other is the social worker interpreting Dr McK's clinical opinion.

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<sup>488</sup> Ibid. at Annex C, para. 2

<sup>489</sup> Ibid. at Annex C, para. 4

<sup>490</sup> R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 28

Munby J maintains that the real point is the first one and that the issue is of *Wednesbury*<sup>491</sup> unreasonableness. Again, he characterises the report and the social worker's interpretations as being on a par, alluding only to the fact that the independent report was done later. However, it is submitted that once again this misses the point as we are not comparing like with like; furthermore in the author's submission the appropriate test is *Wilkinson*<sup>492</sup>.

### *Complaint Three: CPA Eligibility Criteria*

The complaint is defined as being that Islington erred in concluding that Mr P did not meet its own eligibility criteria essentially because he had been *considered for hospital admission*. Munby J says that this complaint must fall because the eligibility criteria require two sets of conditions to be met: firstly the presence of an illness and secondly a marker of severity namely that the 'risk of self-harm or harm to others has been sufficiently serious to consider hospital admission within the past two years'<sup>493</sup>. Since 'the patient is simply not sectionable at all'<sup>494</sup>, he asserts that this negates the second condition. Again it is submitted that this judgement is flawed.

Munby J makes no comment about the illness; he lists depressive illness as a possible 'qualifying condition' but does not comment on whether 'reactive depression' would qualify. For the sake of the argument, let us assume it may do; we then pass on to the second condition. This mirrors two of the criteria to be considered when assessing someone under the *MHA*, namely

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<sup>491</sup> *Associated Provincial Picture Houses Ltd v Wednesbury Corp*, op. cit

<sup>492</sup> *R (on the application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital* op. cit.

<sup>493</sup> *R (on the application of HP and KP) v London Borough of Islington* op. cit at para. 35

<sup>494</sup> Loc. cit.

the safety of the individual or the protection of others<sup>495</sup>. It is submitted that the error Munby J makes is that he conflates two issues: 'considering hospital admission' and 'sectionability'. On a simple reading of the facts, it is clear that Mr P was *considered* for hospital admission; this must have been at least part of the thinking behind of his community psychiatric nurse asking for a *MHA* assessment. But it is possible that someone is found to have an illness where the risk of self-harm (which presumably can include passive starvation) or harm to others is sufficiently serious, but where they are not considered 'sectionable' because detention is not necessary to provide treatment. Indeed, this is not just an academic example, since Mr P had been receiving treatment in the community for some while.

*Complaint Four: The Need for s.47 NHSCCA Assessment*

This was the only complaint which Munby J upheld. He held that 'even if Islington was right in that Mr P did not meet its CPA eligibility criteria ... that was not determinative of whether he nonetheless had a need for generic *health* or social services community care'<sup>496</sup>. He went on to hold: 'In my judgement there has never been a proper and comprehensive Community Care assessment of Mr P, only a CPA assessment'<sup>497</sup>.

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<sup>495</sup> The third criterion, as to whether detention is necessary, is that it is necessary in the interest of the patient's own health. It is submitted that CPA eligibility criteria which fail to take this into account must in any case be flawed otherwise it would be possible to exclude someone detained under the Mental Health Act 1983 (c. 20) who would be eligible for s.117 aftercare. Furthermore, the primary criterion for CPA is that someone is under the care of the specialist psychiatric services

<sup>496</sup> Ibid. at para. 37, author's emphasis

<sup>497</sup> R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 40

This decision and has been much commented on not least by Joanna Sulek, firstly in ‘Mind Newsletter’<sup>498</sup>, and more recently in the Journal of Mental Health Law where she states: ‘It cannot be denied that similarities do exist between the two processes and they *can* be confused. They may appear to fulfil similar aims, answer the same needs, and can involve the same patients’<sup>499</sup>. However, it is submitted that though it is very true that in this case there was no proper community care assessment, what has been created here is a false dichotomy. As we have seen above, at various points in its history CPA has had a variable relationship with s.47 *NHSCCA*. However, at no point has it been suggested that a CPA assessment of social care needs *should* be different from a s.47 *NHSCCA* needs assessment. On the contrary, as we have seen in chapter 2 ‘[d]uplication of social care assessments, for CPA and Care Management can and *should be avoided*’<sup>500</sup> and ... *the same assessment should occur* whatever the route into the services<sup>501</sup>. Furthermore, ‘...care management can – and should – be integrated with the CPA’<sup>502</sup> and there should be ‘a **single** care plan’<sup>503</sup>.

Latterly, as has been argued in chapter 4, the only correct way to assess social needs for CPA purposes has been through s.47 *NHSCCA*. The community care plan in this case was prepared on 18th March 2003; FACS

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<sup>498</sup> Sulek, J. (2004) Mind Newsletter, March 2004

<sup>499</sup> Sulek, J. (2004) Community Care and the Care Programme Approach: Confusion between two distinct assessment processes, Journal of Mental Health Law, September 2004, 154-165 at p. 163

<sup>500</sup> Building Bridges. A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, op. cit.. at para. 3.1.5, author’s emphasis

<sup>501</sup> Loc. cit.

<sup>502</sup> Ibid. at para. 3.2.12

<sup>503</sup> Loc. cit., bold in the original

guidance should have been implemented by 7<sup>th</sup> April 2003<sup>504</sup>, so whilst Islington might not technically have *had to* comply with it they were, at the very least slow in implementing it and their published 'Mental Health Assessment Priorities & Entitlement Criteria' policy should theoretically have been on the verge of becoming obsolete, requiring as it did, a judgement to be made as to whether need is at the higher, medium or low level<sup>505</sup>.

Secondly, it is submitted, there is a complete failure to understand CPA as the 'ongoing process' envisaged in 'Modernising the Care Programme Approach'<sup>506</sup>. It is clear from the narrative that specialist psychiatric services had been involved with Mr P for some time; he was first seen by a community psychiatric nurse on 4th April 2002 and thereafter by the Crisis Resolution Team<sup>507</sup>, hence he had, by definition, already entered into the CPA and should have had an 'proper and comprehensive' community care assessment of both his health and social needs much earlier and a care plan based on this. It is submitted that at the point where a dispute arose the issue was, in fact, whether to *terminate* extant specialist psychiatric health care and whether social care was instead needed, since both form part of the specialist psychiatric services. A differentiation between CPA and s.47 *NHSCCA* could only have been possible if Mr P had never entered the specialist psychiatric services. Many local authorities no longer have generic teams so

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<sup>504</sup> Fair access to care services: Guidance on eligibility criteria for adult social care, op. cit. at para. 1

<sup>505</sup> See R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 2

<sup>506</sup> Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services. op. cit.

<sup>507</sup> R (on the application of HP and KP) v London Borough of Islington op. cit. at para. 4

if mental health social workers deem someone eligible for any services it is submitted that this equates to being subject to CPA.

Interestingly, as Munby J points out there is a requirement (in s.47(3)(a) *NHSCCA*) to assess the need for health as well as social care needs<sup>508</sup>. The requirement to arrange health input is contained in s.47(3) *NHSCCA* and presumably this may be provided by specialist psychiatric services or a Primary Care Trust. This raises the question, which we shall return to in chapter 11, of what added value, if any, CPA adds to the services available to people with mental ill health.

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<sup>508</sup> Ibid. at para. 37, author's emphasis

## CHAPTER ELEVEN

### CONCLUSIONS AND RECOMMENDATIONS

#### *Non-joined up Government*

The first conclusion one can draw from examining the development of CPA alongside that of s.47 *NHSCCA* as outlined in the first 5 chapters, is that there has been a complete absence of coordinated thinking within government. A comparison of the dates of key events<sup>509</sup> shows how these two initiatives have existed alongside each other for more than a decade, only touching when someone in government comes up with a new document. Worse still this confusion has enabled the key institutions concerned to avoid implementing either properly and the courts, where they have become involved, have concentrated solely on statutory responsibilities.

#### *What has CPA ever done for people with mental ill health?*

It is therefore incumbent upon us to ask what added benefit CPA has brought to the care of people with mental ill health. Firstly, it should be clear from a reading of chapters 1, 2 and 6 that it confers no rights on them. What rights they have flow only from the many statutes which make up community care law; held together loosely by s.47 *NHSCCA*.

Secondly, there is no evidence that its structure provides anything over and above that provided for by s.47 *NHSCCA*. Assessment, including that of risk, and provision of health and social care need, care-plans and regular

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<sup>509</sup> See Appendix H

reviews involving the individual are all contained in s.47 *NHSCCA* and the other statutory provisions discussed above.

Perhaps the most that could be said for CPA is that it is a special provision, only for people with mental ill health of one description or another, and this group of people deserve special consideration. However, as will be argued below this could be a very high price to pay for losing out on very real rights.

### *Hindrance*

A more challenging question is whether, as well of being of no real assistance, CPA has actually stood in the way of people with mental ill health receiving the services they are entitled to. This question is, of course complicated by the poor way in which the alternative has been implemented. However, it is submitted that on balance CPA has been an impediment to people with mental ill health receiving the services they are entitled to, particularly accommodation. Furthermore, it is submitted that were it not for the requirement to comply with the bureaucratic imperatives of CPA, institutions and advocates of patients' rights would be able to concentrate on improving compliance with s.47 *NHSCCA* which, at least has the force of statute and some case law behind it.

### *Piecemeal law*

As we have seen above, particularly in chapter 6, Clements is correct when he states that '[c]ommunity care law remains a hotchpotch of conflicting



statutes'<sup>510</sup>. This, it is submitted, is the primary impediment to s.47 *NHSCCA* acting as a credible alternative to CPA. There is no doubt that what is required is a complete overhaul of the legislation, bringing the disparate statutory provisions together and clarifying the areas of uncertainty and dispute<sup>511</sup>. It is submitted that this should be rights-based, drawing on the best of the principles behind DS(SCR)A but also retaining the principles of s.47 *NHSCCA*. Such a statute would also enable the government to withdraw gracefully from CPA, by allowing it to be superseded by a wider-ranging and non-stigmatising piece of legislation.

#### *Legal Obligations Departments*

Whilst we are waiting for the law to change though, it is submitted that there are things which can be done to improve the lot of people with mental ill health. Most Mental Health Trusts have a Mental Health Act Department. However, the planned demise of the MHAC, to be replaced by the Commission for Healthcare Audit and Inspection (CHAI or the Healthcare Commission)<sup>512</sup>, means that the special status of this Act or its successor will decline. Furthermore, CHAI's vision statement specifically states that in carrying out 'those functions of the Mental Health Act Commission as are commensurate with the current legislation until such time as a new Mental Health Act becomes law... CHAI will seek to ensure that, to the extent which is appropriate, the assessment of the care provided under the current

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<sup>510</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at I30

<sup>511</sup> The 'Richardson Committee' also recognised this – see 'Review of the Mental Health Act 1983, Report of the Expert Committee, Department of Health November 1999 at 1.11 – but decided not to deal with it because they were reassured it was being dealt with elsewhere (ibid. at 1.12)

<sup>512</sup> Established under s. 41 Health and Social Care (Community Health and Standards) Act 2003 (c. 43)

law, particularly as regards the links between healthcare and social care, proceeds on the same basis as the assessment of other forms of care<sup>513</sup>.

In the modern NHS, the role of a department based solely on one Act of Parliament is questionable at least and given that many Trusts are now in partnership with Social Services they now have much broader responsibility including that of complying with community care legislation. Hence, it is recommended that Trusts broaden their existing departments and combine them with the legal departments that already exist in local authorities to create Legal Obligations Departments.

Such departments should be able to advise and educate practitioners and patients about their duties and rights respectively. Their staff should have proper education and training. Information about community care law will also enable Trusts to formulate better policies and make more appropriate commissioning decisions and reduce the need for legal action against them.

#### *Rights of Service Users*

Service users and carers are poorly informed about their rights. Because of the preoccupation of Trusts with the dual imperatives of CPA and the MHA, these are usually the only subjects which people receive written information about. This can be rectified and an example of a patient information leaflet designed by the author is shown in Appendix I.

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<sup>513</sup> Healthcare Commission Vision Document: <http://www.healthcarecommission.org.uk/assetRoot/04/00/00/20/04000020.pdf> at Chapter 5, para. 24, author's emphasis

### *Duties of Social Services*

It has been highlighted above, that Social Services departments do not always comply with their obligations. It is submitted that RMOs looking after people detained under the *MHA* are in a particularly strong position to change the culture, given the conclusions from chapter 8 about the code of practice. Appendix J shows a form of letter to social services designed by the author, which could be considered for use.

### *Life without CPA?*

Finally, is it possible to live without CPA? If it were abolished tomorrow what would happen? A case has been made that CPA is of no assistance and probably a hindrance to the rights of people with mental ill health. It is submitted that s.47 *NHSCCA* is potentially a more constructive entry portal into the care system. There is a precedent for social services acting as a lead agency in carrying out *MHA* assessments, which seems to work well. S.47 *NHSCCA* already contains all the elements needed for health to be involved as was clear from the analysis of *R (on the application of HP and KP) v London Borough of Islington*<sup>514</sup> whilst the Community Care Assessment Directions 2004<sup>515</sup> require the local authority to involve the person being assessed and their carers in assessment and care planning. Insofar as health is not obliged to be involved in any particular case, as we have seen in chapter 6, CPA does not provide any additional rights. Lastly, as was argued in chapter 5, even community nursing care might be provided under the specific duties of the *NHSCCA*.

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<sup>514</sup> *R (on the application of HP and KP) v London Borough of Islington*, op. cit.

<sup>515</sup> LAC (2004) 24, Community Care Assessment Directions, op. cit.

The evidence of the cases discussed in chapters 9 and 10, as well as many of the other cases cited above, suggests that poor access to social care and housing are the major issues impeding the progress of people with mental ill health. It is, therefore, submitted that it makes sense for social services to take a lead on needs assessments and to provide the 'one-stop' portal of entry into the system envisaged by 'Modernising the Care Programme Approach',<sup>516</sup>.

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<sup>516</sup> Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services, op. cit.

**APPENDIX A**

**BUCKINGHAMSHIRE MENTAL HEALTH NHS TRUST**

**CPA ASSESSMENT FORM, AUGUST 2004**

**BMHT CPA ASSESSMENT FORM**

**Person's Name:**

**PIMS No.  
SWIFT No.**

**Assessment start date**

**Assessment completed date**

**Person's View (of Referral):**

**Carer's View (of Referral):**

**Current Mental Health Situation/Professional Network:**

**Recent events leading to this assessment:**

**Date of most recent referral:**

**If in hospital – ward and date admitted:**

**Other significant contacts:**

**Other Mental Health Professionals involved/current services**

*Other professional views:*

**Past Mental Health (Psychiatric) History: (incl. treatment)**

**Previous services:**

**Forensic History (to include all court convictions and police cautions)**

Factual details of Abuse/Neglect

**Family History:**

**Personal & Social History:**

**Ethnic/Cultural/Religious consideration**

**Present situation**

*Education*

*Employment*

*Environment*

**Previous Medical History:**

**Current Physical Issues ( Please include Allergies):**

Healthcare needs

Personal care

Mobility

**Current Mental Health Treatment (incl. medication):**

**Tobacco, Alcohol and non-prescribed drug use:**

Substance misuse

Outline of drug/alcohol history

Present alcohol/drug use

**Current Social Circumstances:**

Present location (if not home address)

*Advocacy*

*Financial circumstances*

*Home circumstances*

*Housing*

*Leisure/Social*

*Legal issues*

*Personal goals*

**Independent Living Skills:**

**Current Mental State:**

**Formulation/Summary:**

**Checklist of Needs (this section is optional)**

(only tick needs identified, specify how these affect the Service User/Patient and include their views and their carers' views)

**Daily Living Skill Issues**

**Description of Identified Need/s**

- Budgeting**
- Cleaning/Laundry**
- Shopping/Cooking**
- Ability to use  
Public Transport**
- Other**

**Physical Health Issues**

**Description of Identified Need/s**

- General Health**
- Cleaning/Laundry**
- Shopping/Cooking**
- Ability to use  
Public Transport**
- Other**

**Accommodation Issues**

**Description of Identified Need/s**

- Level of Support**
- Environmental  
Conditions**
- Local Relationships**
- Security of Tenure**
- Access to Facilities**
- Other**

**Personal Care Issues**

**Description of Identified Need/s**

- Hygiene**
- Clothing**
- Diet**
- Medication**
- Other**

**Financial-related Needs**

**Description of Identified Need/s**

- Benefits etc.**
- Debts**
- Other**

**Current dependants (If ANY children - this box must be completed)  
(family, children, pets etc.)**

**Name (and age/DoB) Relationship Dependence and Support Issues**

**Are Social Services Eligibility Criteria met?  Yes  No**

**Any Identified Gap in Service Description of Identified Gap and who is informed**

**Carer's Assessment offered to the Principal Carer? - Yes / No.  
(Please include Young Carers)**

**Carer's Assessment completed? - Yes / No (if No state why)**

**Date Assessment completed:**

**CPA Level Standard Enhanced Not Accepted for CPA**

**Social Services Assessment Outcome Code** see Guidance Notes

**Reason for 'Not Accepted for CPA', and summary of action to be taken:**

**Has the Person contributed to this assessment - Yes / No (If 'No' please give details)**

**Has the Person seen this assessment - Yes / No (If 'No' please give details)**

**Has the Person agreed with this assessment - Yes / No (If 'No' please give details)**

**Person agrees that this assessment can be shared with their Carer/Relative-Yes/No (If 'No' please give details)**

**Has the Person been given information about PALS – Yes /No**

**Any Other Relevant Information:**

**Name/s of person/s contributing Signature/s Job Title and Base Date to this Assessment**

**Signature of the Person being assessed**

**Date:**



CLIENT						WORKER								
	Needs Tab					Planning Tab			Plans Tab					Service Tab
Need Identified. Assessment Type.⊙	Priority / Eligibility ★	Date Identified	Status ★★	Objectives ★★★	Description (free text)	Option Action / Service ◆	Responsibility ◆◆	Proceed to Plan	Plan Type	Start Date	Date Care plan given	Operational Date	Link Options	Status ◆◆◆
Date.														
A-activities of daily living								Yes	MH/CPA				Yes	
A-difficulties with household roles & responsibilities								Yes	MH/CPA				Yes	
A-independent living/rehabilitation								Yes	MH/CPA				Yes	
A-Physical Health/Welfare of self & other								Yes	MH/CPA				Yes	
A-risk of abuse or neglect								Yes	MH/CPA				Yes	
A-social support & relationship issues								Yes	MH/CPA				Yes	
A-work education or learning issues								Yes	MH/CPA				Yes	

⊙ Enter Assessment Type and Date of Assessment

★ Please indicate: Low (L) / Moderate (M) / Substantial (S) / Critical (C)

★★ Please indicate: Eligible (E) / Ineligible (I) / Present Need Unassessed (P)

★★★ Please indicate: Improve (I) / Maintain (M) / Prevent (P) / Signpost (S) / Signpost Not Eligible (SNE)

◆ Option Action = no cost to Social Services (ENTER DESIGNATION e.g. Rehab Officer or Housing Support Worker)    Option Service = cost to Social Services

◆◆ Person undertaking the task.

◆◆◆ Awaiting Start (A) / Fully Meets Needs (F) / Partially Meets Needs (P) / Unable to Currently Meet Need (U) :- ONLY RELEVANT TO OPTION SERVICES

## APPENDIX B

### S. 7 DISABLED PERSONS (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

#### CHAPTER 33

Amendment as at: October 1, 2002

s. 7 Persons discharged from hospital

(NOT IMPLEMENTED)

(1) When a person is to be discharged from a hospital after having received medical treatment for mental disorder as an in-patient for a continuous period of not less than 6 months ending with the date on which he is to be discharged, the managers of the hospital shall give written notification of that date—

(a) to the health authority in whose area it appears to the managers that that person is likely to reside after his discharge (unless the managers are that authority),

(b) to the local authority in whose area it appears to them that that person is likely then to reside, and

(c) in the case of a person under the relevant age on that date, to the appropriate officer of that local authority, as soon as is reasonably practicable after that date is known to the managers.

(2) Where—

(a) a person liable to be detained under the 1983 Act or the 1984 Act is discharged from a hospital in pursuance of an order for his immediate discharge made by a Mental Health Review Tribunal or, in Scotland, by the Mental Welfare Commission for Scotland or by the sheriff, and

(b) he is so discharged after having received medical treatment for mental disorder as an in-patient for a continuous period of not less than 6 months ending with the date of his discharge, the managers of the hospital shall give written notification of that person's discharge in accordance with paragraphs (a), (b), and (c) of subsection (1) above as soon as is reasonably practicable.

(3) Where—

(a) a health authority receive a notification given with respect to a person under subsection (1) or (2), or

(b) the managers of a hospital from which a person is to be, or is, discharged as mentioned in subsection (1) or (2) are the health authority referred to in

subsection (1)(a), that authority shall (subject to subsection (7)) make arrangements for an assessment of the needs of that person with respect to the provision of any services under the 1977 Act or 1978 Act which the Secretary of State is under a duty to provide; and in making any such arrangements a health authority falling within paragraph (a) above shall consult the managers of the hospital in question.

(4) Where a local authority receive a notification given with respect to a person under subsection (1) or (2), the authority shall (subject to subsection (7)) make arrangements for an assessment of the needs of that person with respect to the provision of any services under any of the welfare enactments.

(5) A health authority and a local authority who are by virtue of subsections (3) and (4) each required to make arrangements for an assessment of the needs of a particular person shall co-operate with each other in the making of those arrangements.

(6) Any assessment for which arrangements are required to be made by virtue of subsection (3) or (4) shall be carried out—

(a) where the notification in question was given under subsection (1), not later than the date mentioned in that subsection, or

(b) where the notification in question was given under subsection (2), as soon as is reasonably practicable after receipt of the notification.

(7) A health authority or a local authority shall not be required to make arrangements for an assessment of the needs of a person by virtue of subsection (3) or (4) if that person has requested them not to make any such arrangements.

(8) Nothing in this section shall apply in relation to a person who is being discharged from a hospital for the purpose of being transferred to another hospital in which he will be an in-patient (whether or not he will be receiving medical treatment for mental disorder); but any reference in subsection (1) or (2) to a person's having received medical treatment for mental disorder as an in-patient for the period mentioned in that subsection is a reference to his having received such treatment for that period as an in-patient in one or more hospitals (any interruption of that period attributable to his being transferred between hospitals being disregarded).

(9) In this section—

"the appropriate officer" of a local authority is such officer discharging functions of that authority in their capacity as a local education authority, or in Scotland an education authority, as may be appointed by the authority for the purposes of this section;

"health authority"—

(a) in relation to England, means a Primary Care Trust,

(aa) in relation to Wales, means a Health Authority, and

(b) in relation to Scotland, means a Health Board; "the managers"—

(a) in relation to—

(i) a health service hospital within the meaning of the 1977 Act (other than a hospital vested in a National Health Service trust or a Primary Care Trust),

(ii) a health service hospital within the meaning of the 1978 Act (other than a State hospital or a hospital vested in a National Health Service trust),  
, or

(iii) any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under the 1977 Act, means the [Strategic Health Authority,] [FN1] Health Authority or Special Health Authority, or (as the case may be) the Health Board who are responsible for the administration of the hospital;

(bb) in relation to a hospital vested in a Primary Care Trust, means that trust;

(c) in relation to a State hospital, means a State Hospital Management Committee constituted by the Secretary of State to manage the hospital on his behalf or (where no such committee has been constituted) the Secretary of State;

(cc) in relation to a hospital vested in a National Health Service trust means the directors of that trust; and

(d) in relation to any other hospital, means the persons for the time being having the management of the hospital;

"medical treatment"—

(a) in relation to England and Wales, has the meaning given by section 145(1) of the 1983 Act; and

(b) in relation to Scotland, has the meaning given by section 125(1) of the 1984 Act; and

"the relevant age"—

(a) in relation to England and Wales, means the age of 19; and

(b) in relation to Scotland, means the age of 18.

[FN1] words inserted by National Health Service Reform and Health Care Professions Act (2002 c.17), Sch 1 (2) Para 38 (2)

## **APPENDIX C**

### **THE TEN-POINT PLAN**

1. Strengthened powers to supervise the care of patients detained under the 1983 Mental Health Act who need special support after they leave hospital. These comprise:
  - a) the new power of supervised discharge; and
  - b) extending from six months to one year the period during which patients given extended leave under existing arrangements can be recalled to hospital.
2. Publication of the Department of Health team's report of its review of the 1983 Mental Health Act.
3. Publication of an improved version of the Code of Practice, which spells out clearly the criteria for compulsory admission under the 1983 Act.
4. Fresh guidance to ensure both that psychiatric patients are not discharged from hospital inappropriately, and that those who leave get the right support from the different agencies.
5. Better training for key workers in their duties under the care programme approach. This will cover the new Code of Practice and guidance, and will take account of the lessons from the cases which have gone wrong, and from the Royal College of Psychiatrists' confidential inquiry into homicides and suicides by mentally ill people.
6. Encouraging the development of better information systems, including special supervision registers of patients who may be most at risk and need most support.
7. A review, by the Clinical Standards Advisory Group, of standards of care for people with schizophrenia, both in hospital and in the community.
8. An agreed work programme for the Government's Mental Health Task Force, which supports health authorities in moving to locally-based care.
9. Ensuring the health authority and GP fund-holder purchasing plans cover the essential needs for mental health services.
10. The London Implementation Group will take forward an action programme to help improve mental health services in the capital, identifying and spreading best practice.

## APPENDIX D

### SECTION 47 NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

#### CHAPTER 19

Amendment as at: October 1, 2002

s 47 Assessment of needs for community care services.

(1) Subject to subsections (5) and (6) below, where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority—

(a) shall carry out an assessment of his needs for those services; and

(b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.

(2) If at any time during the assessment of the needs of any person under subsection (1)(a) above it appears to a local authority that he is a disabled person, the authority—

(a) shall proceed to make such a decision as to the services he requires as is mentioned in section 4 of the Disabled Persons (Services, Consultation and Representation) Act 1986 without his requesting them to do so under that section; and

(b) shall inform him that they will be doing so and of his rights under that Act.

(3) If at any time during the assessment of the needs of any person under subsection (1)(a) above, it appears to a local authority—

(a) that there may be a need for the provision to that person by such Primary Care Trust or Health Authority as may be determined in accordance with regulations of any services under the National Health Service Act 1977, or

(b) that there may be a need for the provision to him of any services which fall within the functions of a local housing authority (within the meaning of the Housing Act 1985) which is not the local authority carrying out the assessment,

the local authority shall notify that [Primary Care Trust,] [FN1] Health Authority or local housing authority and invite them to assist, to such extent as is reasonable in the circumstances, in the making of the assessment; and, in making their decision as to the provision of the services needed for the person in question, the local authority shall take into account any services which are likely to be made available for him by that [Primary Care Trust,] [FN2] Health Authority or local housing authority.

(4) The Secretary of State may give directions as to the manner in which an assessment under this section is to be carried out or the form it is to take but, subject to any such directions and to subsection (7) below, it shall be carried out in such manner and take such form as the local authority consider appropriate.

(5) Nothing in this section shall prevent a local authority from temporarily providing or arranging for the provision of community care services for any person without carrying out a prior assessment of his needs in accordance with the preceding provisions of this section if, in the opinion of the authority, the condition of that person is such that he requires those services as a matter of urgency.

(6) If, by virtue of subsection (5) above, community care services have been provided temporarily for any person as a matter of urgency, then, as soon as practicable thereafter, an assessment of his needs shall be made in accordance with the preceding provisions of this section.

(7) This section is without prejudice to section 3 of the Disabled Persons (Services, Consultation and Representation) Act 1986.

(8) In this section—

"disabled person" has the same meaning as in that Act; and "local authority" and "community care services" have the same meanings as in section 46 above.

[FN1] words inserted by National Health Service Reform and Health Care Professions Act (2002 c.17), Sch 2 (2) Para 56 (b)

[FN2] words inserted by National Health Service Reform and Health Care Professions Act (2002 c.17), Sch 2 (2) Para 56 (b)

## APPENDIX E

### S. 3 DISABLED PERSONS (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

#### CHAPTER 33

s 3 Assessment by local authorities of needs of disabled persons.

(NOT IMPLEMENTED)

(1) Where—

(a) on any assessment carried out by them in pursuance of any provision of this Act, or

(b) on any other occasion,  
it falls to a local authority to decide whether the needs of a disabled person call for the provision by the authority (in accordance with any of the welfare enactments) of any statutory services for that person, the authority shall afford an opportunity to the disabled person or his authorised representative to make, within such reasonable period as the authority may allow for the purpose, representations to an officer of the authority as to any needs of the disabled person calling for the provision by the authority (in accordance with any of those enactments) of any statutory services for him.

(2) Where any such representations have been made to a local authority in accordance with subsection (1) or the period mentioned in that subsection has expired without any such representations being made, and the authority have reached a decision on the question referred to in that subsection (having taken into account any representations made as mentioned above), the authority shall, if so requested by the disabled person or his authorised representative, supply the person making the request with a written statement—

(a) either specifying—

(i) any needs of the disabled person which in the opinion of the authority call for the provision by them of any statutory services; and

(ii) in the case of each such need, the statutory services that they propose to provide to meet that need,  
or stating that, in their opinion, the disabled person has no needs calling for the provision by them of any such services; and

(b) giving an explanation of their decision; and



(c) containing particulars of the right of the disabled person or his authorised representative to make representations with respect to the statement under subsection (4).

(3) Where the local authority do not propose to provide any statutory services to meet a particular need identified in any representations under subsection (1), any statement supplied under subsection (2) must state that fact together with the reasons why the authority do not propose to provide any such services.

(4) If the disabled person or his authorised representative is dissatisfied with any matter included in the statement supplied under subsection (2), that person may, within such reasonable period as the authority may allow for the purpose, make representations to an officer of the authority with respect to that matter.

(5) Where any such representations have been made to the authority in accordance with subsection (4), the authority shall—

(a) consider (or, as the case may be, reconsider) whether any, and (if so) what, statutory services should be provided by them for the disabled person to meet any need identified in the representations; and

(b) inform the disabled person or his authorised representative in writing of their decision on that question and their reasons for that decision.

(6) Where—

(a) the disabled person or his authorised representative is unable to communicate, or (as the case may be) be communicated with, orally or in writing (or in each of those ways) by reason of any mental or physical incapacity, or

(b) both of those persons are in that position (whether by reason of the same incapacity or not),  
the local authority shall provide such services as, in their opinion, are necessary to ensure that any such incapacity does not—

(i) prevent the authority from discharging their functions under this section in relation to the disabled person, or

(ii) prevent the making of representations under this section by or on behalf of that person.

(7) In determining whether they are required to provide any services under subsection (6) to meet any need of the disabled person or his authorised representative, and (if so) what those services should be, the local authority shall have regard to any views expressed by either of those persons as to the necessity for any such services or (as appropriate) to any views so expressed as to the services which should be so provided.

(8) In this section "representations" means representations made orally or in writing (or both).

## APPENDIX F

### THE FACS ELIGIBILITY FRAMEWORK

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

#### **Critical – when**

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

#### **Substantial – when**

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

### **Moderate – when**

- ❑ there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- ❑ involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- ❑ several social support systems and relationships cannot or will not be sustained; and/or
- ❑ several family and other social roles and responsibilities cannot or will not be undertaken.

### **Low – when**

- ❑ there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- ❑ involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- ❑ one or two social support systems and relationships cannot or will not be sustained; and/or
- ❑ one or two family and other social roles and responsibilities cannot or will not be undertaken.

## APPENDIX G

### SECTIONS 31 AND 32 DRAFT MENTAL HEALTH BILL 2004

Cmnd. 6305-1

#### **31 Care plans**

- (1) The managers of a hospital with which a patient is registered under section 22(1) must secure that -
  - (a) a care plan is prepared for the patient by the clinical supervisor, and
  - (b) the plan is included in the patient's records, within the initial period.
- (2) The plan must-
  - (a) include the required information, and
  - (b) be prepared in the form prescribed by the appropriate authority in regulations.
- (3) In subsection (2)(a), the "required information", in relation to the patient, means -
  - (a) a description of the medical treatment which is to be provided to the patient during the period for which the plan is in force, and
  - (b) such other information relating to the care of the patient during that period as may be prescribed by the appropriate authority in regulations.
- (4) In preparing a plan for the patient, the clinical supervisor must consult the following persons about the medical treatment to be specified in the plan -
  - (a) the patient, unless inappropriate or impracticable,
  - (b) if the patient is aged under 16, each person with parental responsibility for him, subject to section 11,
  - (c) the patient's nominated person (unless he falls within paragraph (b)), if practicable, and
  - (d) any carer of the patient (unless he falls within paragraph (b) or (c)), subject to section 12 and if practicable.
- (5) The clinical supervisor must send a copy of the plan to -
  - (a) the patient,
  - (b) if the patient is aged under 16, each person with parental responsibility for him, subject to section 32,
  - (c) the patient's nominated person (unless he falls within paragraph (b)), subject to that section, as soon as practicable after the plan is in force.
- (6) The clinical supervisor may amend the patient's plan at any time during the period for which it is in force; but he must consider amending the plan on or before the patient's review day.
- (7) If the clinical supervisor amends the patient's plan -
  - (a) the managers must secure that the amended plan is included in the patient's records as soon as practicable after it is prepared, and
  - (b) subsections (2) to (6), this subsection and section 32 apply as if references to the plan were references to the amended plan.

- (8) A plan, or amended plan, is in force for the period –
  - (a) beginning with its inclusion in the patient's records, and
  - (b) ending with -
    - (i) the inclusion of an amended, or further amended, plan in the patient's records, or
    - (ii) the end of the assessment period of the patient, (whichever is earlier).
  
- (9) In this section –
 

"initial period", in relation to a patient, means the period of 5 days beginning with the day on which he was admitted in pursuance of subsection (1) of section 23 or the imposition of conditions in respect of him was authorised under subsection (4) of that section (as the case may be);

"review day", in relation to a patient, means the day falling 10 days after that day; .

and any reference to the patient's records is to the records relating to the patient which are kept by the clinical supervisor.
  
- (10) This section applies to the managers of a hospital with which a patient, Is subsequently registered under section 78(2) as it applies to the managers of the hospital with which the patient was registered under section 22(1).

### **31 Care plans: supplementary**

- (1) The clinical supervisor may not send a copy of the care plan to -
  - (a) any particular person with parental responsibility for a patient under paragraph (b) of subsection (5) of section 31, or
  - (b) the patient's nominated person under paragraph (c) of that subsection,
 

without first ascertaining the patient's wishes and feelings about his so sending such a copy {unless it is inappropriate or impracticable to do so}.
  
- (2) The clinical supervisor must -
  - (a) make a determination about whether it would be appropriate to send a copy of the plan to the person in question, and
  - (b) have regard to the patient's wishes and feelings in making that determination.
  
- (3) If the clinical supervisor determines that it would not be appropriate to send a copy of the plan to the person in question, he must not do so and, accordingly, the requirement under section 31(5)(b) or (c) (as the case may require) so to send such a copy ceases to have effect.
  
- (4) The clinical supervisor need not send a copy of the care plan to any particular person with parental responsibility for a patient if it is impracticable to do so.

## APPENDIX H

### CHRONOLOGY OF PUBLICATIONS AND KEY EVENTS FOR THE CARE PROGRAMME APPROACH AND SECTION 47 NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

Year	CPA	S. 47 NHSCCA	Other
<b>1948</b>			National Assistance Act
<b>1970</b>		Local Authority Social Services Act	Chronically Sick and Disabled Persons Act
<b>1975</b>	White Paper Better Services for the Mentally Ill		
<b>1977</b>			National Health Service Act
<b>1983</b>			Mental Health Act
<b>1985</b>			6th Social Services Committee Report
<b>1986</b>		Audit Commission: Making a Reality of Community Care	Disabled Persons (Services, Consultation and Representation) Act
<b>1987</b>			Mental Health Act Commission 2 <sup>nd</sup> Biennial Report
<b>1988</b>	HC(88)43 Envisages CPA	Community Care: Agenda for Action	
<b>1989</b>	HC(89)5 Precursor to CPA?	White Paper: Caring for People	

<b>1990</b>	Introduction of CPA in HC(90)23	National Health Service and Community Care Act (NHSCCA)  Policy Guidance	11th Social Services Committee Report  First Code of Practice to <i>MHA</i>
<b>1991</b>		Care Management and Assessment  Assessment Systems and Community Care	
<b>1992</b>		The Laming Letter	
<b>1993</b>		CPA multidisciplinary assessment fulfils NHSCCA duties	Ten-Point Plan  Second Code of Practice to <i>MHA</i>
<b>1994</b>	Extension of CPA beyond mental <i>illness</i> in HSG(94)27		
<b>1995</b>	Building Bridges		Carers (Recognition and Services) Act
<b>1996</b>			Housing Act  Community Care (Direct Payments) Act
<b>1997</b>		R v Gloucestershire CC and Secretary of State for Health ex parte Barry and others (CA) and (HL)  LASSL(97)13: Impact of resources on eligibility criteria	

<b>1998</b>	Modernising Mental Health Services		Third Code of Practice to <i>MHA</i>  Human Rights Act
<b>1999</b>	Still Building Bridges		R v North and East Devon Health Authority ex parte Coughlan
<b>1999</b>	Modernising the Care Programme Approach. Effective Care Co-ordination in Mental Health Services		National Service Framework
<b>2000</b>		Local Government Act	Carers and Disabled Children Act
<b>2001</b>		Health and Social Care Act	Continuing Care: NHS and Local Council's responsibilities
<b>2002</b>		Fair Access to Care Services	Draft Mental Health Bill
<b>2003</b>			Discharge of Patients from Hospitals
<b>2004</b>	R (HP and KP ) v London Borough of Islington  Article 12 of the Council of Europe Recommendation (2004) 10	Community Care Assessment Directions	Carers (Equal Opportunities) Act  Draft Mental Health Bill



**APPENDIX I**  
**PROPOSED RIGHTS LEAFLET**

Dear [patient]

As a person suffering from a mental illness you are legally classified as suffering from a disability. This entitles you to have your needs automatically<sup>517</sup> assessed by social services<sup>518</sup>. Psychological needs may properly be included in a needs assessment<sup>519</sup>. If for whatever reason you are not assessed in the way described below you or your carer are entitled to ask for such an assessment<sup>520</sup> and social services **must** provide it. Because social services for mental health services in [your area] is joined up with [your Trust]<sup>521</sup> this assessment may be performed by a member of the team who is not a social worker/care manager; however the responsibility to provide the assessment remains with social services.

This assessment must follow a strict protocol<sup>522</sup> and end up by classifying your needs as critical, substantial, medium or low. In [your area] if they are classed as [name FACS bands] social services **must** either provide for these needs themselves or make sure they are provided for by another agency (such as health, for example). You may ask for the results of your assessment, which should be set out as a care plan<sup>523</sup>. This could form part of your Care

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<sup>517</sup> Section 2(1) Chronically Sick and Disabled Persons Act 1970 (c. 44)

<sup>518</sup> Section 47(1) National Health Service and Community Care Act 1990 (c. 19)

<sup>519</sup> R v Avon CC ex parte M [1994] 2 FLR 1006

<sup>520</sup> Section 4 Disabled Persons (Services, Consultation and Representation) Act 1986 (c. 33)

<sup>521</sup> Section 31 Health Act 1999 (c. 8)

<sup>522</sup> Fair access to care services: Guidance on eligibility criteria for adult social care, published under cover of LAC (2002) 13

<sup>523</sup> Caring for People. Care in the Next Decade and Beyond, Policy Guidance, Department of Health, November 1990, HMSO, London at paragraph 3.24

Programme Approach (CPA)<sup>524</sup> care plan; but CPA is simply the **framework** in which this assessment should be conducted, it does not, of itself, confer any rights on you.

If you feel that the care plan you are shown does not comply with the above criteria you may apply for access to your social services file<sup>525</sup> (the same applies to your medical notes of course). Your care-coordinator or key nurse will be able to help you with this.

Amongst other things, social services has the ability to provide<sup>526 527</sup> or arrange<sup>528</sup> accommodation and case law suggests that failing to make a service provision decision or a proper care plan<sup>529</sup> is not acceptable<sup>530</sup>. Once a needs assessment has decided what is required, this should be made available within about 6 months and, in the case of accommodation, this may mean that this has to be specially rented or purchased for this purpose<sup>531</sup>.

If you have been detained under sections 3, 37, 47 or 48 of the Mental Health Act 1983<sup>532</sup> in the past and are still being looked after by specialist psychiatric services, even if you are no longer detained, the health and local

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<sup>524</sup> The Care Programme Approach for People with a Mental Illness Referred to Specialist Psychiatric Services, HC (90) 23/LASSL (90) 11

<sup>525</sup> By making a request under the Data Protection Act 1998 (c. 29)

<sup>526</sup> Section 21 National Assistance Act 1948 (11 & 12 Geo. 6, c. 29)

<sup>527</sup> Paragraph 2 (3) & (4) of the Secretary of State's Approvals and Directions under section 21(1) of the National Assistance Act 1948 (LAC (93) 10 Appendix 1)

<sup>528</sup> Section 184 Housing Act 1996 (c. 52)

<sup>529</sup> Caring for People. Care in the Next Decade and Beyond, Policy Guidance, Department of Health, November 1990 op. cit. at paras. 3.24, 3.41 and 3.25

<sup>530</sup> R v Sutton LBC ex parte Tucker [1998] 1 CCLR 251

<sup>531</sup> R (on the application of Batantu) v Islington (2001) 4 CCLR 445

<sup>532</sup> Mental Health Act 1983 (c. 20)

authorities of the place in which you were detained share a duty<sup>533</sup> to provide you with aftercare services<sup>534</sup> including social care<sup>535</sup> which they have the power to put into motion before you are discharged<sup>536</sup>; they may not charge you for these services<sup>537</sup>. If a mental health review tribunal has said that you need professional services<sup>538</sup> or accommodation<sup>539</sup> the Trust must ‘use its best efforts to procure’<sup>540</sup> them. These services are also available to patients on s.17 leave<sup>541 542</sup> and must be continued until the health and local authorities are satisfied that they are no longer necessary<sup>543</sup>. There is no restriction on the type of services that can be provided<sup>544</sup> and guidance suggests that these may include ‘appropriate daytime activities, accommodation, treatment, personal and practical support, 24-hour emergency cover and assistance in welfare rights and financial advice [as well as] support for informal carers’<sup>545</sup>.

Carers must be involved in the assessment and care planning process<sup>546 547</sup> and have a freestanding right to a carer’s assessment<sup>548 549</sup>. Social services

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<sup>533</sup> See *R v Mental Health Review Tribunal ex parte Hall* [1999] 4 All ER 883

<sup>534</sup> By virtue of s. 117 Mental Health Act 1983 (c. 20)

<sup>535</sup> *R v Ealing District Health Authority ex parte Fox* [1993] 1 WLR 373, at 385

<sup>536</sup> See *R (K) v Camden and Islington Health Authority* [2001] EWCA Civ. 240 at [20]

<sup>537</sup> See *R v Manchester City Council ex parte Stennett et al* [2002] UKHL 34

<sup>538</sup> *R (IH) v Secretary of State for the Home Department and others* [2003] UKHL 59

<sup>539</sup> *R (on the application of W) v Doncaster Metropolitan Borough Council* [2004] WL 852414

<sup>540</sup> *R (IH) v Secretary of State for the Home Department and others*, op. cit. at [29]

<sup>541</sup> Mental Health Act 1983 (c. 20) at s. 17 – the power of the responsible medical officer to authorise leave under part II of the Act

<sup>542</sup> See Code of Practice to the Mental Health Act 1983, 1999 op. cit. at para. 20.7. This was confirmed in *R v Richmond LBC and other ex parte Watson and others* (1999) *The Times* 15<sup>th</sup> October

<sup>543</sup> See *R v Richmond LBC and other ex parte Watson and others*, op. cit.

<sup>544</sup> Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 15.25

<sup>545</sup> Guidance on Mental Health (Patients in the Community) Act 1995 (c. 52) accompanying LAC (96) 8 and HSG (96) 11, at para. 18

<sup>546</sup> Carers (Recognition and Services) Act 1995 (c. 12)

<sup>547</sup> LAC (2004) 24, *Community Care Assessment Directions*, Department of Health, 2004

<sup>548</sup> Carers and Disabled Children Act 2000 (c. 16)

<sup>549</sup> See Clements, L. (2004) *Community Care and the Law*, op. cit. at para. 11.16

guidance requires that they are informed of this right<sup>550</sup> and given a leaflet<sup>551</sup>. When the *Carers (Equal Opportunities) Act 2004*<sup>552</sup> is brought into force, hopefully in April 2005, the scope of carers' assessment should be extended<sup>553</sup> so that carers will have the *right* to have services provided.

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<sup>550</sup> LAC (96) 7 at para. 20

<sup>551</sup> Ibid. at para. 9

<sup>552</sup> Carers (Equal Opportunities) Act 2004 (c. 15)

<sup>553</sup> The Review of Mental Health Law, Issue No: 15, October 2004, Arden Davies, London at p.12

## APPENDIX J

### PROPOSED RMO's LETTER TO SOCIAL SERVICES

Dear [Social Worker/Care Manager]

I am the RMO for [patient's name]; he is currently detained under section [number] of the Mental Health Act 1983. As his RMO I have a responsibility, emanating from the Code of Practice, to ensure, in consultation with the other professionals concerned, that the patient's needs for health and social care are fully assessed and that the care plan addresses them *before* discharge is decided on<sup>554</sup>. I have now completed my medical assessment of [patient's name]'s health needs. As you will probably know the Code of Practice should be followed unless, in an individual case, there is a good reason for departing from it<sup>555</sup> and it has been held that the code is – in effect – strong policy guidance<sup>556</sup>; in other words it has quasi-legal significance and it cannot amend or frustrate primary or subordinate legislation<sup>557 558</sup>. My understanding of this is that the social needs assessment must be carried out in accordance with primary legislation, i.e. a needs assessment under s. 47 National Health Service and Community Care Act 1990.

You will, of course, be aware that the latest guidance: 'Fair access to care services: Guidance on eligibility criteria for adult social care'<sup>559</sup> should have

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<sup>554</sup> Code of Practice to the Mental Health Act 1983, Department of Health and Welsh Office, 1999, The Stationery Office, London, at para. 27.5

<sup>555</sup> *Munjaz v Mersey Care NHS Trust and others* [2003] EWCA Civ 1036

<sup>556</sup> *Clements, L* (2004) *Community Care and the Law*, op. cit. at para. 15.13

<sup>557</sup> *Ibid.* at para. 1.36

<sup>558</sup> See also *State for Health ex parte Pfizer Ltd* (1999) 2 CCLR 270, *The Times*, 17<sup>th</sup> June

<sup>559</sup> *Fair access to care services: Guidance on eligibility criteria for adult social care*, published under cover of LAC (2002) 13, Department of Health, (FACS)

been implemented by 7<sup>th</sup> April 2003<sup>560</sup> and at the heart of the guidance is the principle that councils should operate just one eligibility decision for adults seeking social care support<sup>561</sup> and that this decision should be made following assessment of an individual's presenting needs<sup>562</sup>. Furthermore, where local health bodies and councils are operating partnership arrangements [as in our Trust]<sup>563</sup>, this guidance should be used as a starting point to help determine joint eligibility<sup>564</sup>.

It is therefore my understanding of my duty under the Code of Practice, that in order to ensure that my patient's social needs are fully assessed the only correct way (since 7<sup>th</sup> April 2003) is via a (s.47 National Health Service and Community Care Act 1990) needs assessment using the FACS guidance. My understanding of my responsibility under the Code of Practice, is that unless and until such a full assessment is carried out, I may not decide on discharge.

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<sup>560</sup> Fair access to care services, op. cit. at para. 1

<sup>561</sup> [http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/FairAccessToCare/FairAccessArticle/fs/en?CONTENT\\_ID=4015619&chk=8g5YN1](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/FairAccessToCare/FairAccessArticle/fs/en?CONTENT_ID=4015619&chk=8g5YN1)

<sup>562</sup> Fair access to care services, op. cit. at para. 2, bold italics in original

<sup>563</sup> Under s. 31 Health Act 1999 (c. 8)

<sup>564</sup> Fair access to care services, op. cit. at para. 8

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