

caredata CD Full Text - copyright NISW/Pepar Publications

Ann McDonald and Margaret Taylor

The Mental Health Act 1983 - Discharge from Hospital

The Provision of Community Services, Guardianship and Financial Protection

The third and final article in this series on mental health care and older people looks at discharge from hospital and the provision of community services. Protecting the financial affairs of vulnerable older people is also discussed.

Discharge from Detention

Informal patients may discharge themselves from hospital with or without the consent of the doctor responsible for their care. Detained patients may be discharged by the Responsible Medical Officer (RMO), by their nearest relative (unless barred by the RMO), by the hospital managers at review, or by a Mental Health Review Tribunal. By contrast with the legal formalities which must be observed at the time of admission, discharge from hospital is largely unregulated. Despite the importance of careful planning for a return home after any period in hospital, there is only one section in the Mental Health Act 1983 which explicitly requires after-care services to be provided. That is section 117 which for our purposes relates to patients detained under section 3 of the Act. Section 117(2) states:

"It shall be the duty of the District Health Authority and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the District Health Authority and the local social services are satisfied that the person concerned is no longer in need of such services."

Section 117 does not however define the type or quality of after-care services to be provided, and their duration is left to the separate discretions of the health authority and the social services authority. Detained persons who receive inadequate after-care provision under section 117 should be able to bring an action in public law to enforce that duty, and may be able to bring an action for breach of statutory duty in private law for damages if they suffer personal loss as a result of services not being provided. Section 117 may thus be an exception to the general rule that duties imposed upon the National Health Service to provide a comprehensive health service are not legally enforceable, but exist only in the arena of public policy.

The Care Programme Approach

Patients who are referred to specialist psychiatric services are eligible to be dealt with through what is known as the 'care programme approach'. The care programme approach is aimed at ensuring that specific support plans are in place for people with a mental illness who either remain in the community after referral or who are discharged into the community following hospital admission. The programme is health authority-led and focuses only on services for people with a mental illness; having

been introduced in April 1991, it predates the system of care management with which it often operates in parallel.

The care programme approach, though it is contained in guidance, is not statutory and does not guarantee that any particular allocation of services will be made. What it provides is a monitoring system through the appointment of key workers and a procedure for the assessment and review of both social and health care needs. To this end the guidance recommends that local care programme policies should be drawn up to ensure efficient implementation of systems.

Insofar as discharge from psychiatric hospital care is concerned, the Mental Health Act Code of Practice replicates the care programme approach by providing for a multi-disciplinary discussion which leads to the establishment of a care plan and the appointment of a key worker (paragraph 27.9). The care plan should be recorded in writing (27.10) and should be regularly reviewed (27.11). The patient and his nearest relative should be fully involved and their wishes taken into account.

Supervision registers of people who are severely mentally ill and who pose a risk to themselves or others in the community have been introduced from October 1994. Elderly people have been included in these registers. There is a continuing debate about the effectiveness of such registers and the extent to which they are a breach of civil liberties.

The introduction of community supervision orders will, by contrast, require legislation as they will break down the barrier between voluntary treatment in the community and compulsory treatment in hospital.

Services in the Community

The Mental Illness Specific Grant, introduced by section 50 of the National Health Service and Community Care Act 1990, has been made available as an additional source of funding for services in the community for people with mental illness. It should not be used as a substitute source of finance for care already provided; the intention is that it should be used imaginatively to fund new projects. The bulk of the grant is allocated to a formula of 50:50 for those under and over 65.

It is also worth noting that people suffering from mental disorder are 'disabled' for the purposes of the Chronically Sick and Disabled Persons Act 1970 which, subject to assessment of need, gives mandatory access to a range of local authority services including home care, assistance with holidays and payment of telephone installation and rental charges. In many instances, it will be preferable to argue for entitlement to services under the Chronically Sick and Disabled Persons Act 1970, rather than assessment under the National Health Service and Community Care Act 1990. The provision of services under the 1970 Act is mandatory; whereas under the 1990 Act, local authorities are increasingly limiting services, and in some cases even the availability of assessment, to the most vulnerable groups.

Guardianship

The power of guardianship contained in sections 7-11 of the Mental Health Act 1983 is rarely used (only 200 cases a year) though it has much potential. Guardianship is an administrative, not a judicial process and is available both as an alternative to admission to hospital and as a means of securing control over the discharge of a patient back into the community.

The Mental Health Act Commission has consistently drawn attention to what it regards as the under-use of guardianship and the Code of Practice regards it as a 'positive alternative' when making decisions about a patient's treatment and welfare (paragraph 13.2). Why then has guardianship been so unpopular? The conventional reason given is that the powers that guardianship gives are limited and there are no sanctions for their breach. The powers are threefold:

- i. the power to require a patient to reside at a place specified by the guardian;
- ii. the power to require the patient to attend for (but not receive) medical treatment;
- iii. the power to require access to the patient to be given to a doctor or approved social worker.

There seems, however, to be another, more pragmatic reason for the small use made of guardianship. In the majority of cases the local authority will act as guardian (though the appointment of a private individual as a guardian is quite possible). The local authority may not relish the additional work and responsibility, including visiting duties and regular reviews, involved in guardianship, particularly with older people where there is a general absence of statutory responsibility compared with childcare.

Guardianship is avowedly paternalistic. The criteria for admission to guardianship are contained within section 7 of the Mental Health Act 1983; they are that the patient must be suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment of a nature or degree which warrants his reception into guardianship, and it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received. Though this is similar to the wording of section 3 (admission for treatment), there is no 'treatability' test, and the criterion is the 'welfare' of the patient, rather than his health and safety. Nevertheless, there are arguments for increasing the use of guardianship in relation to older people where this is the only way of ensuring the acceptance of community care services. Paragraph 13.4 of the Code of Practice regards this use of guardianship as legitimate but only when it is used as part of a comprehensive care plan, and as inappropriate if no such power is needed to achieve any part of that plan. In addition, as well as carrying out his protective role, the guardian should also act as advocate in securing necessary services for his client (paragraph 13.5); this advocacy aspect of guardianship is certainly one which could be further developed.

Guardianship and Residential Care

If guardianship gives power to specify a place of residence (paragraph 8(1)(a)), could it then be used to transfer an unwilling person to residential care? The Code of Practice (paragraph 13.9) is clear that guardianship should never be used solely for the purpose of a compulsory admission (and in fact there is no power in guardianship to remove or convey persons subject to guardianship to the premises specified). However, paragraph 13.9 of the Code of Practice appears to say that guardianship may be used in difficult cases of incapacity to consent:

"where an adult is assessed as requiring residential care but due to mental incapacity is unable to make a decision as to whether he wishes to be placed in residential care, those responsible for his care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about his current and future care can be planned."

Guardianship would thus act as an honest (and legally challenge-able) use of power in situations which are commonly de facto compulsory admissions without access to review processes and tribunals. Guardianship would also then act as a legal source of authority for constraints upon people in residential care who are seeking to exercise their right to leave when to do so would be clearly contrary to their welfare. The person who seeks to leave would, without guardianship, either be locked in by staff, or diverted by them to other activities. If a confrontation arose, many staff would prefer to know that they were secure in their interpretation of the law.

Financial Matters

Guardianship itself gives no powers to deal with financial matters; when dealing with a person who lacks capacity to deal with his own financial affairs, a separate application to the Court of Protection must be made for the appointment of a receiver unless the person has signed an Enduring Power of Attorney during a period of capacity or the only monies to be handled are state benefits which can be dealt with by the Department of Social Security's own appointeeship system. This unnecessarily complicates matters where, for example, a person under guardianship is to enter residential care and a financial contribution is sought. The Law Commission has looked into the whole difficult area of mentally incapacitated adults and decision making in three reports published in 1993 (HMSO). One of their proposals is for the appointment of personal and financial managers to deal only with those decisions where competence is lacking. When the availability of services is so much linked to the ability to pay, such a system would seem to have much to commend it.

Enduing Power of Attorney

An Enduring Power of Attorney (EPA) is a particular form of power of attorney whereby one person (known as the donor) appoints another or others to be his attorney, i.e. his representative in certain transactions. Generally the donors of an EPA are older people appointing younger relatives, friends or professional

advisors to act in connection with their personal finances, bank accounts, etc. The EPA can be general "in connection with all property and affairs" or specific "to deal with all my monies in X Bank" and can contain restrictions. It also has to follow a specific form. At the time the donor signs the EPA he must have sufficient mental understanding to understand the implications of the document, that he is giving power to a named person in connection with his personal finances and that the appointment will continue even if the donor's mental capacity fails. The vital element of an EPA is that it continues into the donor's mental incapacity, something impossible with a power of attorney prior to the Enduring Power of Attorney Act 1985.

The essential factor of an EPA is that the donor has the choice of who handles his finances for him. Whilst he retains mental capacity, the donor is able to control the attorney's actions and authorises what he is and is not to do. Whilst he has capacity, it is always open to the donor to cancel the EPA. Once the attorney considers the donor "is or is becoming mentally incapable", the attorney is obliged to register the EPA in the Court of Protection. A registration fee of £50 is paid to the Court, a minimum of three relatives of the donor are informed of the application and the Court has an initial 35-day period in which to process the application unless objections are raised by the donor or relatives, or the Court becomes aware of any other circumstances in which either the application should be delayed for further investigation or refused. If the EPA is registered, the attorney then acts under the power but without the donor's guidance, and so should take those actions and make the decisions with regard to the donor's finances, which he believes the donor would make in the particular circumstances. The EPA can only give authority to deal with finances, it does not give the attorney power to say where the donor may live.

Court of Protection

If someone loses mental capacity and there is no EPA, then, if there are finances to be managed, there is no option but for an application to be made to the Court of Protection for receivership proceedings to be commenced. The Court of Protection's jurisdiction arises under the Mental Health Act 1983 and only where the person concerned, "the Patient", is unable to handle their affairs due to mental incapacity; if the problems arise because of drink or drugs, the Court has no jurisdiction.

If there are few assets to administer, generally £5,000 worth or less, then there is a short form procedure which the Court will use, once satisfied by medical certificate that it has jurisdiction.

If the patient's assets exceed £5,000, the Court of Protection generally institutes full proceedings during which it appoints a Receiver - someone to handle the Patient's pensions and income from investments, and to deal with any other assets, for example selling freehold property, as the Court may order. It is usual for the Receiver to produce accounts of his dealings in the Patient's assets on an annual basis. If capital is required, the Court is approached for an order authorising the required transaction. It is also possible for the Court to make a will for a Patient, or to agree to family or tax planning arrangements

on the Patient's behalf.

Whilst the Court of Protection can be slow and may be expensive in relation to the Patient's overall wealth, it is the only way of dealing with an incapable person's assets if an EPA was not signed whilst he was capable, and does see that not only are the Patient's assets protected because of the Courts regular scrutiny, but also that the Receiver is protected from unjust accusation. The Court officials are very helpful and the Court itself realistic in its approach to the affairs of those for whom it has responsibility.

Conclusion

Though legal intervention in the lives of mentally disordered people is rare, it need not necessarily be viewed in negative terms. Legal action may in fact be seen as an honest use of authority when admission to hospital or residential care is contemplated, and the person himself is incapable of consenting or refuses consent. If the ethical dilemma of conflict between the perceived best interests of the patient and his or her expressed wishes is to be resolved, as indeed it must be, then the Mental Health Act at least provides a framework for decision making which incorporates procedural safeguards and rights of appeal.

In a similar way, the assumption of financial responsibility by a trusted attorney or receiver appointed by the Court of Protection may serve as a safeguard against abuse or exploitation, and allows proper financial planning to take place.

Ann McDonald graduated in Law from Hull University and taught law at degree level for a number of years. She later qualified as a social worker and has worked in Derbyshire and in Norfolk as a generic worker and as a specialist working with older people. She is currently a lecturer in social work law at the University of East Anglia, Norwich.

Margaret Taylor, after having graduated in Law from London University in 1975, trained with Ward Gethin in King's Lynn and qualified as a solicitor in 1979. She is now a partner in the same firm, specialising in the law relating to older people, taxation and probate.

They are co-authors of the highly successful book, "Elders and the Law", published by PEPAR Publications, The Gatehouse, 112 Park Hill Road, Harborne, Birmingham B17 9HD, priced £5.50.

Note: This is the third article in the series by both authors. The second article which was published in the last journal should have had both authors' names appended. Unfortunately, Margaret Taylor's name was missed out. We apologise for this omission.

caredata CD Full Text - copyright NISW/Pepar Publications