

Casenotes

Community Care and the Care Programme Approach: Confusion between two distinct assessment processes

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R (on the application of HP and KP) v London Borough of Islington [2004] EWHC 7 (Admin).

Queens Bench Division, Administrative Court (8th January 2004) Mr. Justice Munby.

The Facts

This case concerns alleged breaches by Islington of its duties under section 47 of the *National Health Service and Community Care Act 1990*¹. The judgment relates to the one issue unresolved by the time of the hearing, held on 15th December 2003, namely the adequacy of the community care assessment of Mr P by Islington LBC dated 18th March 2003².

The London Borough of Islington's policy *Mental Health Assessment Priorities and Entitlement Criteria* distinguished between Care Programme Approach (CPA) assessments and Community Care assessments (which relate to the provision of community care services other than under the Care Programme Approach). Where severe and enduring mental health needs existed, the adult mental health services would be responsible for future care. Where they did not, generic health or social services would be responsible. Eligibility for the CPA was determined by a list of illnesses, including persistent psychotic illness, depressive illness and other disorders where the risk of self-harm or harm to others had been serious enough for a hospital admission to have been considered within the previous two years³. The lawfulness of the policy had not been challenged in the proceedings.

The P family were Albanian asylum seekers from Kosovo. One member of the family, a six year old son, had been shot dead there by Serbian troops, whilst another, a teenage son, had been tortured. As a result of the traumatic events in Kosovo, Mr P had exhibited signs of depression and a loss of the will to live. Without the assistance of his family, the evidence suggested that he would not have been able to look after himself or even get out of bed. Prior to these events, he had

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1 Under section 47(1), the local authority must carry out an assessment of a person's needs for community care services if "it appears to the 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"

2 Para 1 of the judgment

3 *ibid*

lived a normal life and had worked to support the family.

A report following a visit from a community mental health nurse indicated that Mr P was unwilling to be interviewed and that he presented with symptoms suggestive of a depressive episode with psychotic symptoms, and possible symptoms of post-traumatic stress disorder. A consultant psychiatrist, Dr McK, concluded in August 2002 that he was suffering from reactive depression and possibly the early stages of dementia, although Mr P's lack of English made this difficult to assess properly. Even under normal circumstances Mr P would have had only a fairly low level of function. On the same day, Islington wrote to Mr P's solicitors that Mr P was not sectionable under the Mental Health Act 1983. He did not, in other words, satisfy the criteria for compulsory admission to hospital and detention under the powers provided by the Act⁴.

On 18th March 2003, Dr B, Dr McK's specialist registrar, visited Mr P and reported in a letter written on the same day that there was no evidence of the abnormal perception or auditory hallucinations which had presented previously, that Mr P had experienced some improvement while on his medication with respect to the paranoid symptoms, but there remained evidence of depressive symptoms.

On the same date, following a CPA meeting, a final version of Mr P's health and social care assessment was signed by Mr P's social worker and her team manager. It concluded that Mr P did not have a firm psychiatric diagnosis but might be suffering from reactive depression resulting from the traumatic events he had experienced in Kosovo. The depression was described as "reasonably appropriate to his circumstances"⁵ and was not a severe and enduring mental illness. At the same time, however, 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."⁶

The "statement of need" identified needs under five headings:

- (1) a need for prompting to attend to all aspects of daily living including personal care;
- (2) a need for reminders to take medication;
- (3) treatment with depression and bereavement issues;
- (4) safe accommodation with more privacy for Mr P and his family; and
- (5) a requirement of support with socialising.

The outcome of the assessment was that Mr P did not meet the eligibility criteria for care management⁷.

The CPA community care plan broadly repeated the needs identified in the first document. With the exception of the housing needs, which were to be met by the local authority, all the assessed needs were to be met by provision of support from Mr P's family.

These assessments were challenged immediately by Mr P's solicitors. On 1st April 2003, an independent social work report was obtained, which concluded that Mr P should be placed on an enhanced CPA on account of his "complex and long term mental health needs"⁸ and that he was

4 *The criteria for civil detention, outside the criminal justice system, are contained in sections 2(2) and 3(2) Mental Health Act 1983, and are not identical. It is not clear which criteria, those within section 2 or those within section 3, were being referred to in the Authority's letter; see also footnote 21*

5 *Para 9 of the judgment*

6 *ibid*

7 *Para 10*

8 *Para 13*

likely to be suffering from a psychotic illness, not a reactive depression. Further, according to the report, the effect of this on his daily functioning indicated that he should fulfil the criteria for care management and should be allocated a Care Co-ordinator⁹. In consequence two letters of complaint issued from P's solicitors in April 2003 criticising the quality of the community care assessment.

The London Borough of Islington responded on 25th April 2003, explaining that Mr P had been seen by two psychiatrists as part of the community care assessment and that the decision had been made not to provide community care services as Mr P did not have *a severe and enduring mental illness*¹⁰.

The Islington Crisis Resolution Team discharged him on 27th May 2003 following an apparent improvement in his mental state.

On 10th June 2003, the solicitors obtained an independent psychiatrist's report from Dr H, which contradicted that of the London Borough of Islington, concluding that Mr P was suffering from severe depression with psychotic symptoms, which was a very severe mental illness. He fulfilled the ICD 10¹¹ Diagnostic Criteria for Category F32.3, having suffered depressive symptoms of a psychotic intensity and been unwell for over two years. There was also concern that Mr P might be suffering from an organic brain disorder linked to a history of head injury. The symptoms of his depressive disorder were, moreover, being aggravated by noise from the neighbours. Mr P was therefore in need of regular supervision by mental health services, and without the support of his family would need in-patient care. The report recommended that they should also be well supported and given some respite if possible.

The London Borough of Islington refused to accept Dr H's conclusions, replying that as Mr P had no community care needs, no carer's assessment was required to be undertaken of B, Mr P's son, who was caring for his father¹². A file note written by the social worker on the same day indicated that there was insufficient evidence for changing Mr P's assessment, that the case should now be closed and the carers' assessment cancelled. On 15th July 2003 Islington wrote to Mr P's solicitors confirming its decision that Mr P did not have a severe and enduring mental illness "*thus warranting Community Care provision*"¹³.

Issues

Four complaints were raised on behalf of Mr P.

(1) The first complaint was founded on the statement in the 18th March 2003 health and social care assessment that there was no firm psychiatric diagnosis of Mr P. It was argued that it was therefore unlawful, in the absence of such a diagnosis, for Islington to conclude that Mr P did not have a need for community care services and/or that he did not meet its CPA eligibility criteria.

9 *ibid*

10 Para 14; *emphasis added*

11 *The International Statistical Classification of Diseases and Related Health Problems, 1989 Revision, Geneva, World Health Organization, 1992*

12 *Under the Carers (Recognition and Services) Act 1995 there is a duty, upon request, on the local authority to*

conduct an assessment of the ability of a carer to provide and continue to provide care; the Carers and Disabled Children Act 2000 now provides for a carer to be assessed at any time, not only when an assessment is being conducted of the needs of the person being cared for

13 *Para 22 of the judgment (emphasis added by Munby J)*

(2) That the London Borough of Islington failed to reconsider its assessment in the light of the independent psychiatric report from Dr H.

(3) That the authority had erred in its conclusion that Mr P did not meet its CPA eligibility criteria, especially as he had been considered for hospital admission within the previous two years.

(4) The final complaint, the fourth, was that even if Mr P did not meet the CPA criteria owing to the lack of a severe and enduring mental illness, this could not determine whether he had a need for generic health or social services community care.

Judgment

(1) Diagnosis Issue

This argument was rejected by Munby J, confusing as it did two different kinds of statement: one, that there was no firm diagnosis of any condition whatsoever, the other, that there was no firm diagnosis of a particular condition, but which would be consistent with a firm diagnosis of some other condition¹⁴. It is one thing to say that there is no firm psychiatric diagnosis, quite another to say there is no firm diagnosis of anything at all. Here there was a firm diagnosis, but not of a psychiatric illness falling within the CPA eligibility criteria. It was a diagnosis of reactive depression, on which basis the London Borough of Islington was entitled to proceed, and on the view of their doctors and social worker that Mr P was not suffering from any psychiatric illness within the eligibility criteria¹⁵.

(2) Reconsideration of Medical Opinions

This complaint was factually incorrect. Munby J was of the opinion that the real substance of the complaint was different. Rather, it appeared to be an assertion that, in the face of the clear diagnosis of the independent psychiatrist Dr H, Islington could not continue to rely on the uncertain diagnoses of Dr McK and his specialist registrar, Dr B. It was therefore, ran the argument, irrational to reject Dr H's diagnosis¹⁶.

The complaint also appeared to allege an absence of reasons in Islington's decision, with no indication of whether Dr H's diagnosis was dismissed as wrong or whether, in Islington's view, Mr P remained ineligible for services irrespective of a correct diagnosis¹⁷.

Munby J rejected this latter assertion on the grounds that Islington's refusal to review its decision was clearly based on an acceptance of Dr McK's opinion in preference to that of Dr H¹⁸. There was no doubt that Dr McK had read Dr H's report; he was, however, merely standing by his earlier opinion. Islington was simply maintaining its position that Mr P did not have a psychiatric condition within the CPA eligibility criteria qualifying him for community care provision.

Moreover, Islington's decision could not be said to be *Wednesbury*¹⁹ unreasonable. It could be argued that Dr H's independent report was based on a more recent visit and more up to date information than that available to either Dr McK or Dr B. In the opinion of Munby J, however, both medical opinions were worthy of careful consideration and neither could be said to be so

14 Para 26

15 *ibid*

16 Para 27

17 *ibid*

18 Para 28

19 *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223

obviously right as to justify rejecting the other. The views expressed earlier by Dr McK and Dr B, combined with those expressed by Dr McK on reading Dr H's report, did supply a rational basis for rejecting Dr H's diagnosis. Either opinion was one which a reasonable authority could have chosen to follow²⁰.

(3) Did Mr P meet the CPA eligibility criteria?

The eligibility test was a two-fold one. It depended on the existence of a relevant illness or disorder which also must be sufficiently serious to merit possible hospital admission. Here the authority had determined that Mr P was not sectionable at all²¹, and therefore this argument advanced on behalf of Mr P was also unsustainable. In the estimation of Munby J, Islington had not misunderstood or misapplied its own criteria²².

(4) Community Care other than under the Care Programme Approach

This proposition was one which Munby J had no hesitation in accepting²³. He also agreed with the argument advanced on behalf of Mr P that there had never been a proper Community Care assessment, only a CPA assessment²⁴.

The assessments of March 2003 identified some serious and pressing needs, as well as establishing that Mr P was at risk of severe self-neglect and "vulnerable to deterioration in his mental state"²⁵. It could not be said that there was no need for investigation. Islington's duty was to produce a "needs assessment" identifying needs which could be met by service provision and then to arrive at a "service provision decision"²⁶. This would confirm whether the needs were such as to warrant provision of services by the authority.

Even if it were to be assumed that the first stage of the process had been carried out properly (about which there was doubt) it was clear that the second stage had not been carried out properly or lawfully. Islington had committed an error of law in applying its decision on Mr P's CPA eligibility to the quite different question of his need for generic health or social services community care²⁷. It was not merely an administrative matter of filling in the wrong forms²⁸. The inherently flawed nature of its reasoning was revealed in crucial passages contained in letters from Islington²⁹ linking the decision not to provide community care services with the absence of a severe and enduring mental illness. The wrong test had been applied.

The effect of the error was not only to invalidate the second stage of the process, the service provision decision, but also to cast doubt on the valid execution of the first part, the "needs

20 Para 32

21 See footnote 4; in the case of section 2(2) Mental Health Act 1983, the following criteria would need to be satisfied: "An application for assessment may be made ... on the grounds that – (a) he is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment ... for at least a limited period; and (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

22 Para 36

23 Para 37

24 *ibid*

25 Para 38

26 *ibid*

27 This could have been, for example, under section 47(1) National Health Service and Community Care Act 1990, for social care needs; or Standard Two of the National Health Service Framework for Mental Health, Circular HSC 1999/223: LAC (99) 34, which offers medical assessment and treatment to service users (including those not within the CPA) with a common mental health problem

28 Para 39

29 *ibid*; see also paragraphs 14 and 22 of the judgment

assessment". The serious and demonstrable error evident in the approach taken to the fundamental underlying questions must invalidate both parts of the process³⁰.

The judgment concluded³¹ that there had never been a proper and comprehensive community care assessment of Mr P, only a CPA assessment, and in relation to Mr P's community care assessment, the process must begin again.

The Law

Given the complexity of the facts, and the importance of the issue of Mr P's diagnosis in the resolution of this case, it is perhaps hardly surprising that the factual discussion should have figured so prominently in this judgment. It is nevertheless unfortunate that the relevant law and guidance were not afforded greater elaboration, as a judicial analysis would have strengthened the decision against future challenges and provided greater clarity for future claimants and their legal advisers. The judge's thoughts on the distinction between the basis for community care assessments and CPA assessments would have been especially useful.

The Nature of Community Care Services

These are services which a local authority can provide or arrange, under powers contained in "community care" legislation³², for the benefit of specified classes of people, who are subject to health problems or disabilities which increase their need for care or support. Common examples include the provision of residential accommodation under section 21 of the *National Assistance Act 1948*³³; provision of support services under section 29 of the same Act³⁴; provision of recreational facilities and practical adaptations to the home under section 2 of the *Chronically Sick and Disabled Persons Act 1970*³⁵; and the provision of after-care services under section 117 of the *Mental Health Act 1983*³⁶.

In the case of the section 117 after-care services³⁷, a joint duty is imposed on both the health and social services authorities:

30 Para 40

31 Para 41

32 Listed in section 46(3) *National Health Service and Community Care Act 1990*, as: Part III *National Assistance Act 1948*; section 45 *Health Services and Public Health Act 1968*; section 21 and Schedule 8 *National Health Service Act 1977*; and section 117 *Mental Health Act 1983*

33 For "persons aged eighteen years or 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" and for "expectant and nursing mothers who are in need of care and attention not otherwise available"

34 Under section 29(1) "... the local authority shall make arrangements for promoting the welfare of ... persons aged eighteen or over who are blind, deaf or dumb or who suffer from mental disorder of any description, and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity ..."

35 See section 29(1) *National Assistance Act 1948* for people to whom the section 2 *CSDPA 1970* duty applies. Section 28A extends the duty to disabled children in relation to whom a local authority have functions under Part III *Children Act 1989* "as it applies in relation to persons to whom section 29 of the *National Assistance Act 1948* applies." Services provided under the *Chronically Sick and Disabled Persons Act 1970* are now regarded as community care services: *Wyatt v. London Borough of Hillingdon* [1976] LQJR 727, although this continues to take place via the 'gateway' of section 29 *National Assistance Act 1948*, see *R v. Powys County Council ex parte Hambidge* (1998) 40 BMLR 73, *Court of Appeal* (1999) 45 BMLR 203

36 See also *National Health Service Act 1977*, paragraph 2(1), Schedule 8

37 According to section 117 (1) *Mental Health Act 1983*: those eligible to receive these services have left hospital after ceasing to be detained under sections 3, 37, 45A, 47 and 48 of the Act

“It shall be the duty of the [Primary Care Trust or] [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 [Primary Care Trust or] [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services ...”³⁸

Some community care legislative provisions are expressed in mandatory language, imposing a duty on the responsible authorities, such as section 117 of the *Mental Health Act 1983*. Others introduce nothing more than a power to provide the services, although this has sometimes been converted subsequently to a duty³⁹.

The purpose of these provisions, it could be said, is to ensure, by the provision of services, a minimum quality of life for an individual in the community, whether at home or elsewhere; sometimes the purpose is to enable him or her to live independently away from hospital or residential care⁴⁰. It is however difficult to find a universal purpose here as there appear to be no unifying principles underlying what has been described as a “hotchpotch of conflicting statutes”⁴¹.

A Two-Stage Process: (i) The Duty to Assess and the Right to an Assessment

The local authority must carry out an assessment of a person’s needs for community care services if section 47(1) *National Health Service and Community Care Act 1990* applies:

“... 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.”

Section 47(1) clearly indicates the existence of a two-stage process: an assessment of that person’s needs (the “needs assessment”), which a local authority is obliged to carry out; followed by a decision as to whether those needs can be met by, and are such as to warrant, provision of any community care services (the “service provision decision”).

The first stage, the duty to assess, arises on the ‘appearance of need’⁴²: “where it appears ... that any person ... may be in need ...”. There need be no proof or certainty that the person definitely does need the services⁴³: the possibility that they may need them is sufficient to put the authority on notice that an assessment is required. This duty may be triggered by a request from a potential service user or a carer; but a request is not essential: it is probably sufficient that a local authority

38 Section 117(2), as amended by the Health Authorities Act 1995, section 2(1), Schedule 1, para 107(8)

39 The power to provide accommodation under section 21 *National Assistance Act 1948* has been converted to a duty by directions, see circular LAC (93) 10 Appendix 1; likewise, the power to provide services under section 29, see circular LAC 93(10) Appendix 2.

40 The Code of Practice to the *Mental Health Act 1983* takes the view with respect to section 117 *Mental Health Act 1983* after-care that “a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully

without danger to themselves or other people”: para 27.1, Code of Practice, third edition, Department of Health and Welsh Office, 1999. There are striking similarities with the purpose of the Care Programme Approach: see discussion below

41 See Luke Clements, *Community Care and the Law*, p. 8, third edition, Legal Action Group, 2004

42 Luke Clements, *op. cit.*, pp. 62–68

43 See also Richard Gordon and Nicola Mackintosh, *Community Care Assessments: A Practical Legal Framework*, p. 21, second edition, published by FT Law & Tax, 1996

has the knowledge, from whatever source, that a person may be in need of community care services⁴⁴. The availability of resources should not be considered at the point of determining the need to assess, as the obligation to assess is triggered once an applicant has crossed the threshold test that there *may* be some need for a community care service⁴⁵.

A Two-Stage process: (ii) The Service Provision Decision

The duty to carry out the second stage of the process, the service provision decision, is introduced by section 47(1)(b) of the *National Health Service and Community Care Act 1990*. The decision is taken once the needs assessment is complete and discretion is exercised, including resource considerations, as to how to match the services available, or any potential services which could be provided⁴⁶, to the needs identified⁴⁷. Guidance on the eligibility of individuals for services has been produced by the Department of Health⁴⁸, which proposes four eligibility bands according to the level of an individual's needs, with each authority setting the level of provision for each band and taking resources into account⁴⁹.

The Care Programme Approach

The Care Programme Approach (CPA) embodies the basic principles governing the discharge from care and continuing care of all people diagnosed with a mental illness, including dementia. Relevant guidance states that the same approach should also be applied to the after-care of other "mentally disordered" patients⁵⁰. The CPA was required to be introduced by authorities in 1991⁵¹. There need not have been a *Mental Health Act* detention in order for the CPA to apply⁵². Neither does a person need to have been in hospital⁵³. It provides a framework for the care of mentally ill people outside hospital⁵⁴. It is intended to apply to all those receiving treatment and care from specialist psychiatric services⁵⁵. The guidance is explicit on the point that those who have been

44 Virginia Bottomley, HCD, 15/2/1990, col.1025, mentioned by Michael Mandelstam, in *Community Care Practice and The Law*, second edition, p. 73, Jessica Kingsley Publishers, 1999

45 *R v. Bristol City Council ex parte Penfold* (1998) 1 CCLR 315

46 *The assessment should consider whether there is a potential need for all services the local authority has an obligation or a power to provide, not only those which it provides currently: R v. Berkshire County Council ex parte Parker* [1998] 1 CCLR 141

47 However see the Gloucestershire litigation, especially in relation to provision of services under section 2 Chronically Sick and Disabled Persons Act 1970, where resources may be a relevant consideration in establishing whether this is a "need" which must be met: *R v. Gloucestershire County Council ex parte Barry* [1996] 4 All ER 421 (Court of Appeal); [1997] 2 All ER 1 (House of Lords)

48 Circular LAC (2002) 13, Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care

49 Luke Clements argues that community care service provision has developed in a way which is now more 'resource' than 'rights' oriented: *Community Care and the Law*, p. 6, third edition, Legal Action Group, 2004

50 *Health Service Guidelines HSG (94) 27, para 7. The Guidance also states that the CPA circular (see note 51 below) applies only to mentally ill people, but the good practices promoted by the CPA "are equally relevant" to those diagnosed with personality (or psychopathic) disorders who can be "safely and suitably" cared for by specialist psychiatric services in the community, para 20. Likewise, similar arrangements may need to be considered in respect of some people with learning disabilities discharged from in-patient care, para 21*

51 *Health Circular (90)23/Local Authority Social Services Letter (90)11. It appears, however, that strictly speaking it is purchasers of mental health services who bear the bulk of the responsibility of ensuring successful local implementation of the CPA, as it is they who are to ensure that key elements of the CPA are implemented through contracts with providers: HSG (94) 27, paras 39 and 40*

52 HSG (94) 27, para 8

53 *ibid*, para 9

54 *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people*, Department of Health, November 1995, para 1.3.4

55 *Code of Practice to the Mental Health Act 1983, op. cit*, para 27.2

detained under, and discharged from, certain sections of the *Mental Health Act 1983* may fall within both the statutory after-care regime under section 117 *Mental Health Act 1983* and the care programme procedure⁵⁶. Thus the community care provisions and the CPA are not mutually exclusive. There is nothing to indicate that an individual could not be subject to both processes. However, some individuals will be subject to one process, but not to the other⁵⁷.

The purpose of the CPA is stated to be “to ensure the support of mentally ill people in the community thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention”⁵⁸. The essential elements of an effective care programme include:

- systematic assessment of health and social care needs both in the immediate and longer term;
- a written care plan agreed between professionals, the “patient” and carers;
- the allocation of a key worker (nowadays a care co-ordinator⁵⁹) who will co-ordinate the process by keeping in touch with the patient and monitoring delivery of the agreed programme of care; and,
- a regular review of any progress made by the patient and his or her health and social care needs⁶⁰.

Priority is to be given to the most severely mentally ill patients⁶¹.

The Guidance stresses the importance of systematic recording of decisions and actions and of clear arrangements for communication between members of the care team⁶². Great concern is expressed regarding the need for continuity of care and for the avoidance of gaps in service provision (“falling through the net”⁶³) owing to poor co-ordination of services or communication. This is to be achieved by introducing and maintaining co-ordinated arrangements for inter-agency working⁶⁴.

Finally the Guidance indicates that an overlap does exist between the CPA arrangements and a local authority’s statutory duty to assess needs for community care services under the *National Health Service and Community Care Act 1990*, as this duty, it suggests, will be fulfilled if a multi-disciplinary assessment under the CPA is implemented properly⁶⁵. Health and Social Services authorities will need to ensure proper co-ordination between CPA and care management arrangements⁶⁶, as it has been suggested that “one way of looking at the CPA is as a specialist variant of care management

56 HSG (94), para 8

57 For example, those who could be subject to the CPA but not section 117 *Mental Health Act 1983* after-care planning include those discharged from a section 2 *Mental Health Act* detention, those discharged from voluntary in-patient care, and those who have always received medical treatment for mental health problems in the community; see section 117(1) for further details of who falls within the authorities’ duty to provide after-care

58 HSG (94) 27, para 9; see also *Building Bridges*, op. cit., para 1.3.6

59 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*, Department of Health, 1999, paras 26, 60

60 HSG (94) 27, para 10

61 *ibid*, para 40

62 *ibid*, para 11

63 *ibid*, para 14

64 *ibid*, paras 14 and 15; part of this strategy in relation to higher-risk patients would have been their inclusion on a supervision register (although these have since been withdrawn, see footnote 69): *Code of Practice to the Mental Health Act 1983, 1999*, at para 27.6

65 See *Building Bridges*, op. cit., para 1.3.8; but the author doubts whether this can be true in every case, see discussion post

66 HSG (94) 27, para 16; ‘care management’ has been defined in *Building Bridges* in Appendix 1.1 as applying to “all people subject to the CPA who have associated care needs”

for people with mental health problems”⁶⁷. Moreover since April 2001 the CPA has been integrated with care management to form a single approach for adults with mental health problems⁶⁸, with different levels of CPA now in existence⁶⁹ to cater for simpler or more complex needs⁷⁰.

Comment

The cogent and well-reasoned judgment in this case highlights the very serious consequences for the individual which may flow from an inadequate appreciation on the part of public bodies, of the nature and purpose of processes in which their legal duties oblige them to engage. Happily, on this occasion, the right decision was reached. Injustice to the Claimant and a potential breach of his rights were averted. Mr P’s case was sent back to the Authority for a fresh assessment, from which a more promising outcome could be awaited. What remains is to seek to understand why the confusion between the two processes arose, when they have been in operation for the past decade⁷¹, and to expand on the implications of this.

It cannot be denied that similarities do exist between the two processes and that they can be confused. They may appear to fulfil similar aims⁷², answer the same needs, and can involve the same patients, and the same professionals. They are alike in imposing no legal obligations on recipients of services⁷³. Notwithstanding these apparent similarities, it is submitted that there exist important and fundamental differences in terms of creation and underlying purpose.

The CPA process is a strategy introduced by guidance and, unlike community care service provision, has never had a statutory basis⁷⁴. A CPA assessment is not driven by the need to comply with a source of legal authority⁷⁵; it is not clear what sanction a failure to undertake it would attract.

67 *Building Bridges, op. cit., para 3.2.8*

68 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, Department of Health, 1999, paras 21, 35 to 40; also National Service Framework for Mental Health, Department of Health, 1999; e.g. there should be a single care plan and a single key worker for each person, and any duplications between care management and CPA resolved: Building Bridges, op. cit., para 3.2.12*

69 E.g. ‘standard’ and ‘enhanced’ levels of CPA : *Effective Care Co-ordination in Mental Health Services, op. cit., paras 24, 56–58; see also Building Bridges, op. cit., paras 3.2.2 to 3.2.5; enhanced CPAs now supersede use of the supervision register, Effective Care Co-ordination, paras 25, 59*

70 A patient with less complex needs should still receive an assessment, not necessarily multi-disciplinary, and a care plan: *Building Bridges, op. cit., para 3.1.6; there is a right to a thorough assessment of needs, Effective Care Co-ordination in Mental Health Services, op. cit., para 18*

71 They both date from 1990: *Health Circular (90)23/Local Authority Services Letter (90)11 and the*

National Health Service and Community Care Act 1990

72 “The care programme approach is being developed ... to ensure that ... future patients treated in the community ... receive the health and social care they need, by ... ensuring proper arrangements are made ... for the continuing health and social care of those patients ...” *HC (90) 23/LASSL (90) 11, para 4*

73 There is scant legal authority for this proposition but it is one which finds favour with other commentators: *Richard Gordon and Nicola Mackintosh, op.cit., p.23; but as for the right to refuse an assessment, see Luke Clements, op.cit., p. 64*

74 *Circulars not issued under section 7 Local Authority Social Services Act 1970 were treated as strongly persuasive rather than binding in nature, but since the case of R. v. Islington Borough Council ex parte Rixon [1998] 1 CCLR 119, the position seems to be that the guidance contained in them should not be departed from without good reason*

75 *Introducing the Care Programme Approach placed no new requirement to provide services on health or social services authorities: Circular HC (90) 23/LASSL (90) 11, para 1*

The CPA singles out the “mentally ill” for attention and particularly prioritises those who have been diagnosed as “severely mentally ill”⁷⁶. Its overriding concern is for those judged to be at risk of losing contact with the services⁷⁷. It seeks to introduce systems designed to avoid this possibility, chiefly through the co-ordination of administrative procedures for recording, monitoring and reviewing meetings between professionals and service users, and for following up any gaps or anomalies uncovered by these measures. The use of supervision registers was an important example of the thinking behind this strategy: a sort of tracking or ‘keeping tabs on’ exercise. The details of eligibility criteria for care under the CPA may vary between authorities. The Department of Health has stated that the Care Programme Approach is an approach, and nothing more, and that the NHS Executive will not prescribe exactly what should happen at a local level⁷⁸.

Community care service provision is more likely to give rise to legal duties and obligations⁷⁹, and even where it does not appear to do so, it is still clearly underpinned by the community care legislation. This means that where an authority has a power to act, but not a duty, it must still exercise its discretion whether or not to use the power. This is a decision which must be made in accordance with the principles of administrative law⁸⁰. Here there was, however, a duty to assess and not merely a power.

The question arises of whether there was an ‘appearance of need’ which would have triggered the duty to assess Mr P under the *National Health Service and Community Care Act 1990*. Both the purpose and target group of the legislation here, it is submitted, are broader in scope than those within the Care Programme Approach guidance. The language of section 47(1) *National Health Service and Community Care Act 1990* is couched in appropriately inclusive terms:

“... where it appears to a local authority that *any person for whom they may provide or arrange for the provision of community care services*⁸¹ may be in need of any such services, ... the authority shall carry out an assessment ...”

Although there is a single gateway to obtaining community care services – the needs assessment – for an individual in a given situation there may be a variety of ways of satisfying the legal criteria for obtaining services. For the same individual there may be only one set of criteria to be satisfied under the Care Programme Approach, but this should not be surprising considering its self-avowed singleness of purpose. A set of eligibility of criteria which filters out those with a less acutely urgent need of treatment and monitoring reflects that purpose perfectly. If a person fails to satisfy these criteria, however tightly drawn, he or she will simply be treated as “discharged”, thereafter to disappear from the CPA picture, regardless of any appearance of need for community care or health services.

76 See footnote 61

77 In the second edition of his book (*Legal Action Group*, 2000) (at page 185) Luke Clements stated that the CPA is dominated by ‘risk assessment’ issues and is targeted especially at those eligible for section 117 Mental Health Act 1983 after-care services

78 *Building Bridges*, *op. cit.*, at para 1.3.6

79 E.g. section 47(1) *National Health Service and Community Care Act 1990*: “where it appears to a

local authority that any person ... may be in need of any such services, the authority ... shall carry out an assessment ...; and ... shall then decide whether his needs call for the provision by them of any such services.” Section 117(2) Mental Health Act 1983: “it shall be the duty of the ... [Health Authority] and the local social services authority to provide ... after-care services ...”

80 See Clements, *op.cit.*, p. 10

81 *Emphasis supplied*

Conclusion

This latter hurdle appears to have been the one which Mr P failed to clear. He failed to satisfy the authorities that he suffered from one of the illnesses listed in the criteria, with a risk of self-harm or harm to others serious enough to have warranted consideration for hospital admission during the preceding two years. Yet had a true community care assessment been carried out, it is possible to argue that, for example, he need only, to have qualified for support services under section 29 *National Assistance Act 1948*, have demonstrated the presence of a “mental disorder of any description”⁸², arguably a far easier test for him to have satisfied, but for which he was never assessed.

There are many factors within the knowledge of the Local Authority which could have constituted the ‘appearance of need’ of community care services necessary to trigger the duty to carry out an assessment. These include Mr P’s reactions to his traumatic experiences in Kosovo, resulting in medical evidence for the existence of post traumatic stress disorder symptoms. These undoubtedly affected his ability to function and to cope with the normal demands of life in a new country, as there seems to have been common agreement, at least on this point, that without the support of his family, Mr P could not have survived here. There was evidence for ongoing depressive symptoms, notwithstanding the Authority’s verdict that this was not a severe and enduring mental illness. The possibility of dementia and head injury were also mentioned. In spite of the difficulties of confirming the precise psychiatric diagnosis, with conflicting evidence for and against the presence of a serious mental illness, Mr P’s ‘statement of need’ demonstrated clearly the presence of needs which could have been met by community care service provision. Finally, assessments prepared in March 2003 identified him as at risk of “severe self-neglect” and “vulnerable to deterioration in his mental state”.

These were the material factors which should have triggered the duty to carry out an assessment. Astonishingly, none of them succeeded in doing so. Not only did the Authority in this case err in rejecting him for consideration for community care service provision on the basis of his eligibility under the Care Programme Approach; the much more serious procedural error and fundamental breach of statutory duty was in failing completely to consider carrying out a proper assessment under section 47 *National Health Service and Community Care Act 1990*, which does not require any consideration of the CPA eligibility criteria. The result was to leave the Claimant, assessed as being at risk and vulnerable to deterioration by the Authority itself, entirely devoid of any support apart from that provided by his family, to whom the whole responsibility of his care was thus consigned.

It is a cause of great concern that such a wholesale misunderstanding of the law should occur at all, and that the effect of an apparent legal compliance on the part of authorities could potentially be to render many individuals like Mr P invisible to the services until such time as they seek redress, or their health and ability to care for themselves deteriorate to the extent that their cases are re-considered. It is perhaps time to press for the drafting of guidance which would set out clearly all the duties which local authorities may have to assess an individual’s needs of community care services, the sources of those duties, and the factors which should be considered during the assessment process.

82 Section 29(1)