BACKGROUND

The legislation governing the compulsory assessment and treatment of people who have a mental disorder is the Mental Health Act of 1983 (MHA – please see box below). The Mental Health Act 2007 brings in certain amendments to this Act. The Mental Health Act 2007 has also been used to introduce the "Deprivation of Liberty safeguards" through amending the Mental Capacity Act 2005 (MCA) and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004.

Please note that throughout this workbook the following definitions and terminologies are used:

MHA – *means the Mental Health Act 1983 as amended by the Mental Health Act 2007. (When occasional reference is made to the existing MHA, this refers to the Mental Health Act 1983.)*

MCA – *means the Mental Capacity Act 2005 as amended by the Mental Health Act 2007.*

HRA – *means the Human Rights Act 1998.*

COP – *means the Code of Practice to the Mental Health Act*

RG – *means the (draft) Reference Guide to the MHA which accompanies the COP.*

Patient – *means a service user, client or customer of mental health services. The MHA and COP both use this term, and for consistency this workbook will do the same*

The MHA is largely concerned with the circumstances in which a person who has a mental disorder can be detained for assessment or treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients, to ensure they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where this is necessary.

The Mental Health Act 2007 was given Royal Assent in July 2007, and the timetable for implementation of the majority of changes brought about by the new legislation is 3rd November, 2008. In order to achieve MHA implementation readiness, service providers are expected to have wide-ranging training provisions in place in advance of November 2008, and beyond that date to support implementation still further.

The Department of Health has tasked the Care Services Improvement Partnership and the National Institute for Mental Health in England (CSIP/NIMHE) with a key role in:

- informing those involved in mental health care of the proposed changes and the impact they may have;
- supporting implementation by service providers, directly and by signposting sources of information;
- providing opportunities to influence national policy.

To achieve these important aims six specialist areas (workstreams) are working nationally to provide the materials and information for roll-out by the eight regional leads working out of CSIP/NIMHE's Regional Development Centres. These six workstreams are:

- Administration
- Advocacy
- Children and Young People
- Supervised Community Treatment
- Training
- Workforce

This workbook forms part of the materials provided by NIMHE/CSIP for the implementation of the MHA.

This workbook's objective is to introduce Approved Social Workers (ASWs) to the legal changes they need to be aware of when the MHA 2007 is introduced.

It should be used in conjunction with the PowerPoint presentation and Tutor Notes, and is intended to be used during the initial preparatory training so that ASWs have a reasonable knowledge of how the MHA will amend and affect the working of the existing MHA.

Activities are designed to be used as the basis for group work; an e-version of this training set will also be available.

As well as information that is available from the trainer, the workbook also includes background information on the changes that the Mental Health Act will bring.

Throughout the book, the ideas of Values-based practice are interlinked with the Guiding Principles of the Code of Practice to the MHA.

FOUNDATIONS FOR ETHICAL AND LEGAL PRACTICE

1. VALUES-BASED PRACTICE

Social Work Values underpinned the Approved Social Work role and will continue to do so with the move to the Approved Mental Health Professional role. This initial section of the workbook should be used as preparation for the course, particularly for people who have not recently had the opportunity to consider the principles and values that underpin their work as social workers. Particular focus should be on the interaction between social work values, the principles of the Code of Practice, and ASW/AMHP practice.

Throughout this workbook we will consider our own values, how they relate to the principles we work from within the current ASW role, and how the Guiding Principles in the Code of Practice will influence the way we work in the future.

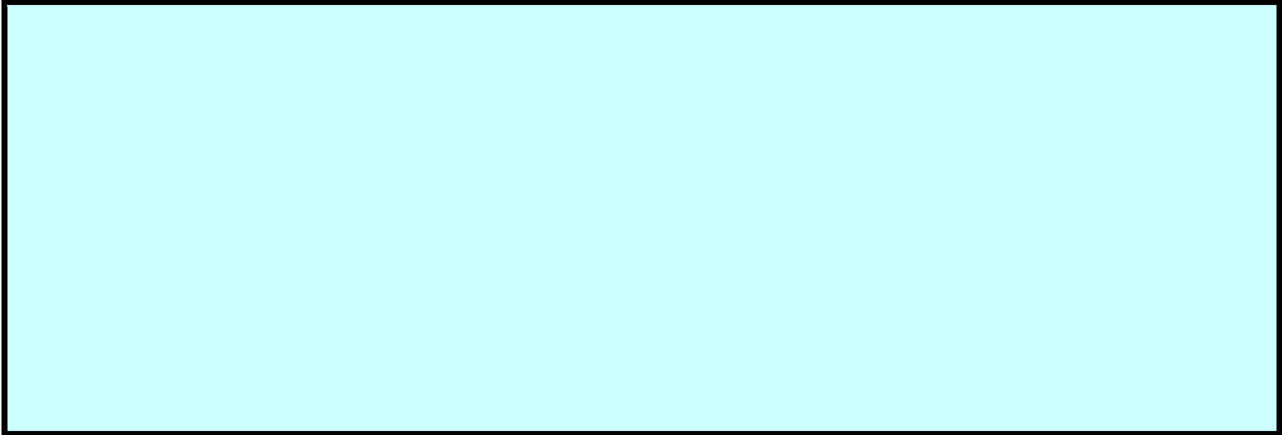
ACTIVITY 1 – PREPARATION ON VALUES AND PRINCIPLES

Please read the following questions and note down your answers in the boxes.

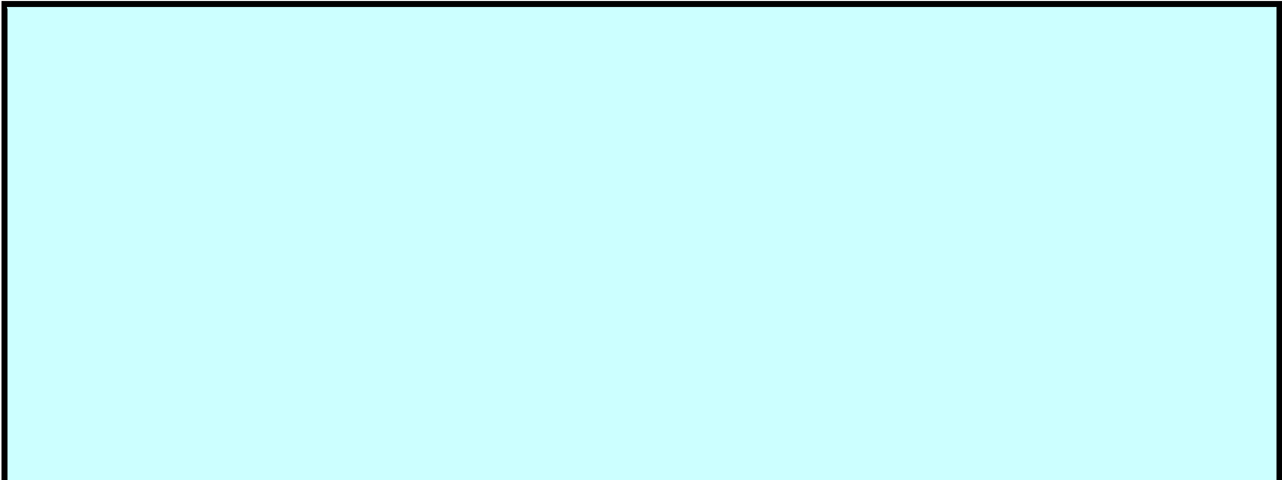
1. What are values?

2. What values do you bring to your work?

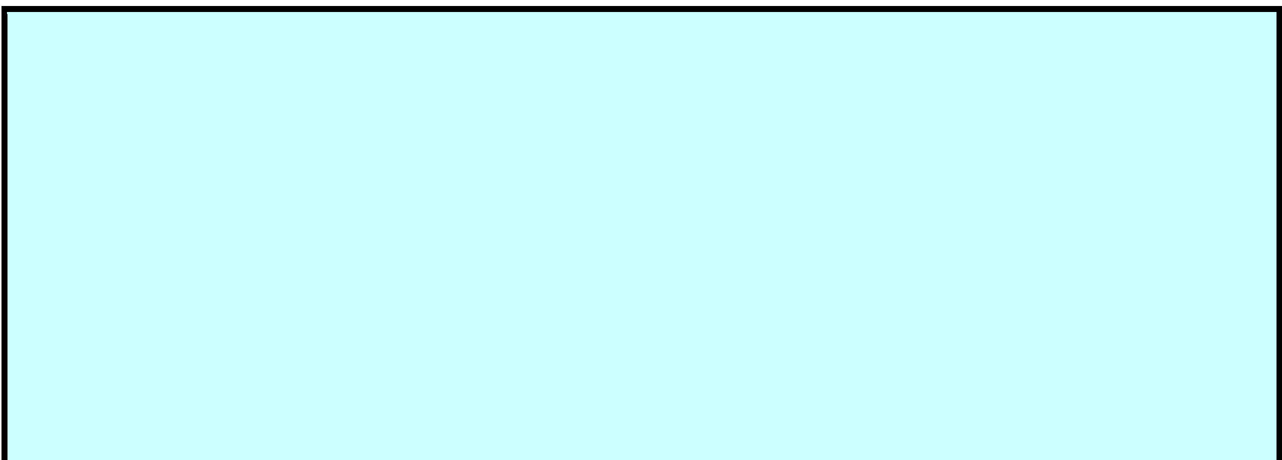
3. **What values currently underpin the work that you undertake as an Approved Social Worker?**



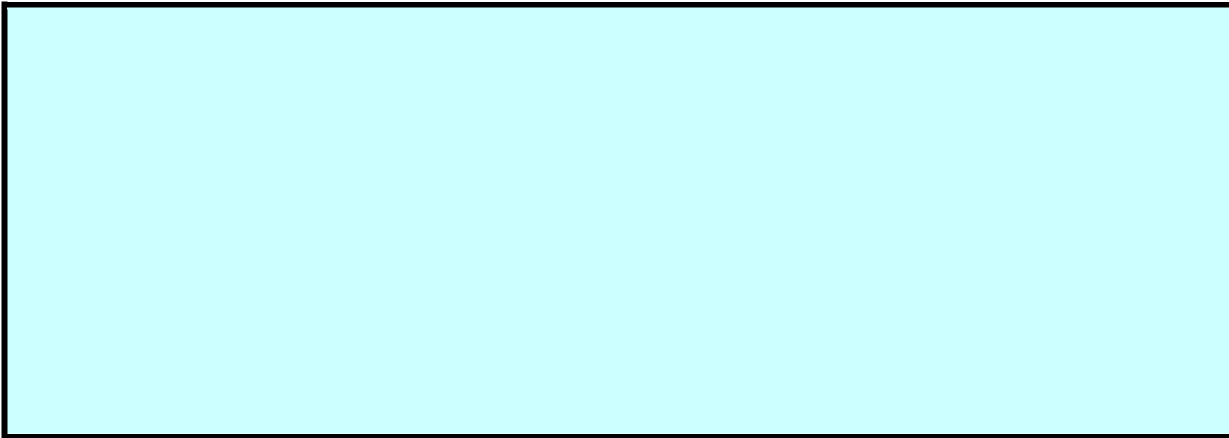
4. **How have your values changed since you first qualified as a Social Worker or as an Approved Social Worker?**



5. **What is the difference between Values and Principles?**

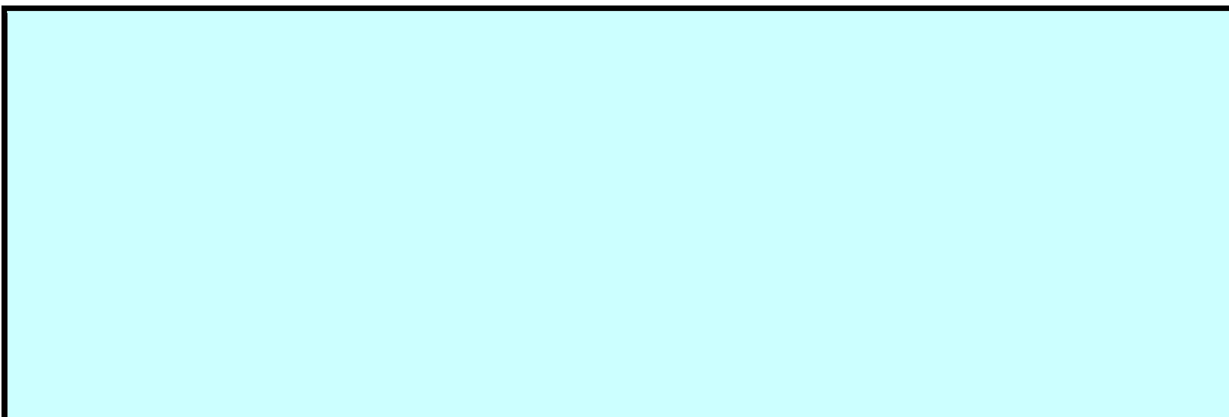


6. **S13 of the Mental Health Act instructs AMHPs to interview patients in a 'suitable manner'. Thinking about your own principles and values, how have they affected your understanding of what should be meant by a 'suitable manner'?**



7. **Social work values emphasise the importance of empowerment. In the process of the Mental Health Act assessment, how do you use your power to enable patients, carers and others to be more empowered?**

8. **Look at the Principles of the Mental Capacity Act (in the appendix of this book), and those of the Code to the Mental Health Act. How different are they from the Personal and Social Work values you work within?**



2. LEGAL FRAMEWORKS: THE LEGAL STATUS OF THE AMHP

2.1 Background Information: AMHPs as 'Public Authorities'

AMHPs are 'public authorities' because a) they have powers that a private body or citizen would not normally have (see *Aston Cantlow 2004 1AC 546*[1]*), and b)* they carry out functions in their role which are 'of a public nature' (Human Rights Act s6(3)). Because of this status AMHPs have particular duties under not only the Human Rights Act 1998, but also under the Equality Act 2006 and the Freedom of Information Act 2000.

2.2 The Human Rights Act 1998

The Human Rights Act 1998 works by imposing a duty on 'public authorities' (such as AMHPs) to only 'act in a way' compatible with the European Convention on Human Rights (ECHR, section 6 (1)).

However, this clause is further defined in section 3 of the HRA in the following manner:

1. 'So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with Convention rights'.

2. This section:

    a. Applies to primary legislation and subordinate legislation whenever enacted;

    b. Does not affect the validity, continuing operation or enforcement of any incompatible primary legislation; and

    c. Does not affect the validity, continuing operation or enforcement of any incompatible secondary legislation if (disregarding any possible revocation) primary legislation prevents removal of the incompatibility.

Positive Obligations?

'The ECHR has stated that many of the Articles also have positive obligations. A positive obligation in this sense means that not only must a state not infringe the relevant Article, it must also put in place a framework by which the person's right is protected, including preventing other people (including private citizens) from infringing their rights.'

Alisdair Gillespie
The English Legal System – Oxford University Press, 2006

This means both not doing things that infringe people's rights AND intervening to ensure people's rights are protected.

In effect, the law tells us to interpret the MHA (and all other forms of legislation) in ways that, wherever possible, are compatible with human rights. However, Parliament was careful to reserve for itself the ability to 'strike down' or amend primary legislation that was not compatible. The courts can only reach a decision that it is impossible for them to

[1] Aston Cantelow and Willcote with Billesley Parochial Church Council v Wallbank [2004] 1AC 546

interpret a piece of legislation in a manner that would be Human Rights compliant, and rule that a particular Act or section of an Act is non-compliant.

2.3 The Equality Act 2006

The Equality Act 2006 has brought together a number of pieces of legislation (such as the Sex Discrimination Act and the Race Relations Act) and the institutions they created. The Act was developed by the Department for Trade and Industry (now called the Department for Business, Enterprise and Regulatory Reform) which, among other things, has a responsibility for employment law. The pragmatic approach of the Department is evident both in the title of the original consultation document ('Equality and Diversity: Making it Happen') and the drafting of the Act which makes general duties explicit and sets out in practical terms how businesses, public authorities and others would be expected to behave in order to avoid acting in discriminatory ways. It extends concepts of discrimination to include discrimination on the basis of faith or sexual orientation, and clarifies that such discrimination may relate to:

> ***'the provision of goods facilities and services, education, the use and disposal of premises, and the exercise of public functions'.***

The Act confirms that a 'public authority' includes 'any person who has functions of a public nature' (s52) and that public authorities, such as AMHPs, have a duty to promote equality of opportunity between men and women and prohibit sex discrimination and harassment in the exercise of public functions.

This duty joins the existing duty to:

- 'eliminate unlawful racial discrimination and promote equality of opportunity and good relations between persons of different racial groups' (Race Relations Act 1976, s71);

and the following prohibition:

- It is unlawful for a public authority … to do any act which constitutes … discrimination or harassment.' (Sex Discrimination Act 1975, s21A)

The Code of Practice to the Mental Health Act and other guidance has been written to comply with these underlying duties, and it is important to be aware that the duties do exist and need to influence the manner in which we work. This is particularly important where professionals decide to depart from the advice of the Code – in which case actions or decisions taken may be justified in terms of Human Rights or Equality Rights.

ACTIVITY 2 — LEGAL FRAMEWORKS

Please read the following questions and note down your answers in the boxes.

1. Approved Mental Health Professionals have the legal status of being 'Public Authorities'. What does this mean?

2. What duties do Public Authorities have under the following Acts?

The Human Rights Act 1998

The Equality Act 2006

Considering your own practice, what implications does this status have for the way in which you work?

3. INFORMATION AND A SUMMARY OF THE LEGAL CHANGES

- The majority of the amendments commence in November 2008. This includes the change in title from 'Approved Social Worker' to 'Approved Mental Health Professional'.
- There is a recommendation that all ASWs have two days' worth of preparatory training prior to 3rd November, 2008, and a third day (as a minimum) prior to the start of the Deprivation of Liberty (DoL) procedures in April 2009. Managers should agree at a local level what their expectations of ASWs will be with regard to this.
- From 3rd November, 2008, new regulations and competences will exist for the AMHP role. These competences will need to be used both as the basis for initial AMHP training and when people are considered for re-approval.
- How authorities determine an AMHP's competence to work under the amended Act is a matter for local decision.
- All ASWs become AMHPs automatically and should be re-approved on the same timescales as used previously.

3.1 Regulations and Responsibilities

- Local Social Service Authorities (LSSAs) maintain responsibility for ensuring they have sufficient AMHPs in the workforce to provide a 24-hour, 365-day access to Mental Health Act assessments.
- The LSSA has responsibility for any assessments needed in their area, **unless** the person concerned is detained under section 2, and this detention was arranged by another LSSA. In this case, the originating LSSA has a legal responsibility for carrying out the assessment. Clearly, the intention of this amendment is to ensure an individual's own Local Authority maintains responsibility for the person's care. However, this does not prevent a Local Authority instructing an AMHP to undertake an assessment either within or outside their authority's area.
- All AMHPs will need to undertake 18 hours' worth of refresher training/learning per year. It is up to their approving authority to decide what counts as refresher training. Approval is conditional on undertaking this training, and an AMHP who did not complete the training could not legally undertake Mental Health Act Assessments. The 18 hours run from anniversary of the date when the ASW was originally approved by their LSSA, not the calendar year, financial year or any other calculation. For example, for all existing ASWs who become AMHPs on the 3rd November, by virtue of the transitional arrangements, their training year would start from the 3rd November. However, when they were reapproved, their training year would start again from that new date.
- All AMHPs will need an approving Local Authority but they may be authorised to work within ('act on behalf of') a number of different authorities. The AMHP has a responsibility to inform his or her approving Authority if he or she is authorised to act on behalf of (or decides to stop acting on behalf of) another LSSA. The authorising authority also has a responsibility to inform other authorities involved when such arrangements start or finish.

- The approval period is five years. It is not possible to be approved for less.
- The ability to approve and authorise AMHPs remains with LSSAs, as does the importance of the LSSA protecting the independence of individuals and the system.
- LSSAs have a power (but not a duty) to train, approve and authorise nurses, OTs and psychologists, as well as social workers as AMHPs. All prospective AMHPs must complete the AMHP course. There are practical problems around pay, contracts, etc. that still need to be resolved in many areas. Pressure to train non-social workers may come from other eligible professionals seeing the AMHP role as a part of their career development, with staff leaving to join areas that do allow them to train if they feel this would advantage them.

3.2 Similarities and changes

- It is important to emphasise that more of the 1983 Act is the same than has changed. In fact, arguably the AMHP role has been enhanced by the new Act.
- The AMHP is still the applicant for s2, 3, 4 and 7 and now has to be involved in the making, extension and revocation of Community Treatment Orders which give effect to Supervised Community Treatment. They may also be asked to be the 'second professional' in the renewal of detention for patients subject to s3 where the person is known to them. The importance of independent decision-making and the use of a 'social perspective' which takes account of the lived experience the person, their family and their community, are both emphasised by the Code of Practice and the AMHP competences.
- The AMHP continues to be an 'Independent Public Authority/Body'. This means they have legal powers beyond those of a normal citizen and are therefore expected to abide by certain pieces of legislation (in particular the Human Rights Act 1998 and the Equality Act 2006).
- Most of the changes are discussed in detail later in the workbook, but the following are worth bearing in mind:
  - Supervised discharge is abolished (transitional arrangements will be in place to transfer people to Supervised Community Treatment or another source of authority such as Guardianship, if this is appropriate).
  - Advocacy is expected to be introduced in April 2009. It will provide for all people subject to compulsion (s2, 3, 4, SCT, Guardianship) to have access to Independent Mental Health Advocates (IMHAs). IMHAs will have more powers than current advocates.
  - Age appropriate accommodation requirements are expected to come into effect in 2010.
  - The requirement for s3, SCT and other longer-term forms of compulsion related to treatment that 'appropriate medical treatment is available', will relate to all those detained for treatment, whatever their age.
  - New conflict of interest regulations now exist that apply to **all** professionals involved in assessments, not just doctors. These address issues including conflicts caused by financial, business and personal relationships. This normally means that no more than two assessors from the same clinical team may assess together; and an AMHP (or doctor) may not be managed or directed by another assessor.

- The only exclusion from the simplified criteria for mental disorder is dependence on alcohol or drugs, but a learning disability qualification continues to apply to s3 and other longer-term forms of compulsion.
- A second professional opinion is now needed to renew s3 orders. This must be in writing and come from someone who is involved in the care of the person concerned, but who comes from a different professional background.
- Earlier automatic referrals to the Tribunal (reducing as resources allow from three years to one year).
- It will now be possible to convey under Guardianship to the place where the Guardian wishes the person to reside, and
- Since 30th April, 2008, it has been possible to transfer between places of safety.
- Competent 16- and 17-year-olds can no longer be admitted to hospital against their wishes on the authority of their parents.
- Civil partners are now included in the list of nearest relatives, and have equal status with husbands and wives.
- Patients may now apply to the County Court to displace their own nearest relative.

ACTIVITY 3 — TRUE OR FALSE?

Tick true or false for each of the statements below.

	Statement	True	False
1.	AMHPs need no longer be directly employed by the Local Social Service Authority	☐	☐
2.	If you start to work as an AMHP for another authority, you must inform the Local Social Service Authority that approves your practice	☐	☐
3.	You must pass a legal test before you can work as an AMHP	☐	☐
4.	You must undertake nine hours' worth of AMHP refresher training each year in order to maintain your approval	☐	☐
5.	The Act continues to exclude alcohol or drug misuse, and sexual deviance, promiscuity and other immoral conduct as forms of mental disorder	☐	☐
6.	New regulations around conflicts of interest (s12) only apply to doctors	☐	☐
7.	The patient is now able to displace their own nearest relative by going to the County Court and displacing them on the basis that they are 'unsuitable'.	☐	☐
8.	There are no changes to the legal conditions for admission under section 2 of the Mental Health Act 1983.	☐	☐
9.	It is no longer possible to admit a competent 16- or 17-year-old on the say so of their parents if the young person objects to admission.	☐	☐
10.	It is now possible to transfer legally between places of safety under s135 and s136	☐	☐
11.	It is now possible to convey a patient to the place they are required to live when they are subject to guardianship.	☐	☐

1. NEW PROFESSIONAL ROLES: HOW THE CHANGES WILL WORK AND HOW THEY ARE LIKELY TO AFFECT PRACTICE

1.1 Background Information

One of the major changes in the MHA is the broadening of the professional groups that can train to take on particular roles. This means that the traditional roles of Responsible Medical Officer (RMO) and Approved Social Worker (ASW) may be filled by appropriately skilled and experienced workers from other professional groups. There are also changes in the titles: the Responsible Medical Officer (RMO) will now become a Responsible Clinician (RC); and the ASW – as the role will incorporate other professions – will be known as an Approved Mental Health Professional (AMHP).

A doctor will still need to be involved in the initial assessments to determine, with an AMHP, whether someone has a mental disorder of a nature or degree which warrants admission under the MHA. But once compulsion applies, the role of RMO is replaced by that of the RC. This means that a suitably experienced and qualified professional from either a medical, psychological, nursing, social work or occupational therapy background can take on the overall responsibility for a patient's case and the continued use of compulsion.

The implications in practice are that, where previously the RMO under the existing MHA always had to be a doctor, under the MHA the corresponding role of Responsible Clinician (RC) role can be taken on by a psychologist, social worker, occupational therapist or nurse. With the exception of doctors, the AMHP training course and role can now be undertaken by the same wider group of professionals.

The term 'compulsion' is deliberately used over the term 'detention' to reflect the fact that the use of the available powers does not just relate to detention in hospital, but also to the use of compulsion in the community.

1.2 The Changes in Detail

Approved Clinician (AC) and Responsible Clinician (RC)

As highlighted above, a **Responsible** Clinician (RC) is the role that replaces the RMO. However, to act as a patient's RC, a professional must first be recognised as an **Approved** Clinician (AC).

- Being an RC means they have accepted responsibility for a particular patient.
- The status of Approved Clinician (AC) is best described as a qualification. It is given by a Strategic Health Authority on the basis that a professional from one of the five eligible groups (medical, nursing, psychology, OT and social work) fulfils all the required professional competences, has reached an advanced level of experience and has undertaken an 'Approved Clinician's course'.

The Competences of the Approved Clinician

- Assessment (including assessment and the management of risk)
- Effective communication
- Improve quality, equity and cultural diversity
- Care planning
- Leadership in multi-disciplinary team working
- Treatment

In their application of all of the above areas of competence, the AC should be influenced by the 'Guiding Principles'.

Someone who is in an AC will not automatically be 'in charge' (i.e. the RC) for a particular case with which they are involved. They might be in charge of a particular episode or type of treatment while another team member takes on the role of the RC.

For example: Dr A is a clinical psychologist (and is an AC) and is involved with a patient because the treatment of choice is Cognitive Behavioural Therapy, but works alongside the RC who is a Consultant Psychiatrist**.** Equally, if Dr A were the Responsible Clinician for this particular patient, a doctor who was also an Approved Clinician might still need to be involved to allow some forms of treatment (such as medication treatment under s63, which must be "by or under the direction of an approved clinician") to be given, because Dr A cannot as a psychologist prescribe medication.

Responsible Clinician

Anyone who takes on the role as a RC must first have been approved as an AC (see above). Their role is to have the overall responsibility for an individual's case. As in the example given above, a member from another profession may be approved as an AC, for example a psychologist, but the role of RC might remain with the Consultant Psychiatrist. However, the choice of RC should be based upon the individual needs of the patient concerned, and where, for example, a patient's treatment needs change, a change of RC might be made. For example, with the case above if psychological therapies became central to the treatment of the patient then the psychologist may take on the role of RC.

The allocation of a temporary RC may be necessary, and may be used in the first instance in order that a patient has a RC promptly upon detention in hospital. However, as soon possible after a patient's treatment needs are assessed, an AC with the most appropriate expertise must be allocated.

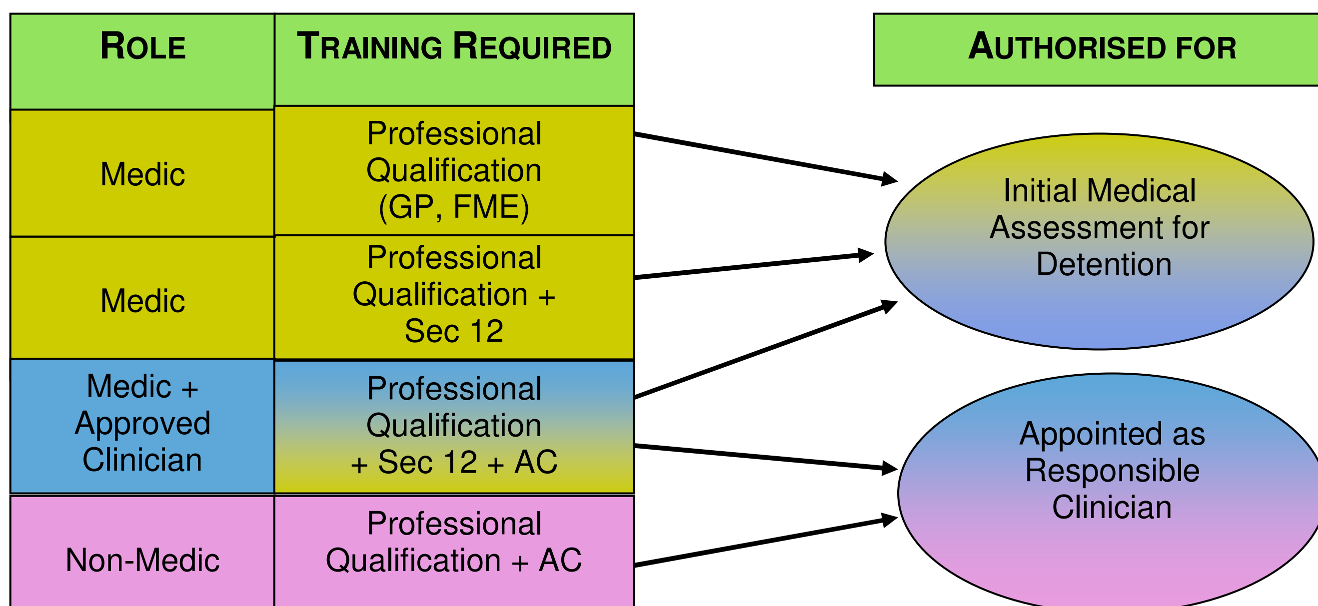
> *"Every patient must be allocated a responsible clinician, who is the approved clinician with overall responsibility for the patient's case. Hospital managers should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between hospitals. A patient's responsible clinician should be the available approved clinician with the most appropriate expertise to meet the patient's main treatment needs"* (DH, 2007).

It is also important that the suitability of the RC is kept under review by the hospital managers. Any change of RC must considered carefully, and be consistent with the changing needs of the patient.

Hospital managers have been advised to keep available an up-to-date list of Approved Clinicians, from which the Responsible Clinician for a particular patient can be selected.

Approved Clinicians who are also Section 12 Approved Doctors

Only a doctor (who may also be an AC or s12 approved) can make recommendations for detention in hospital under s2, 3 or 4. It is only after the patient has been admitted that an Approved Clinician from a different professional background would be able to take responsibility for a patient's care and make decisions about the continued use of, or the ending of, compulsion. The roles (and training) requirements for ACs and section 12 doctors are shown in the diagram below.



Approved Mental Health Professional

One of the changes that may have a significant early impact for the workforce is that of the introduction of the Approved Mental Health Professional (AMHP). The broadening of the professional roles means that the role of the ASW will now become known as the AMHP. This is to allow persons with the right skills, experience and training to carry out key tasks rather than restricting them to a particular profession. The role of AMHP may now be taken on by a psychologist, nurse or occupational therapist in addition to social workers. The role and training of the AMHP will be fundamentally the same as those of the ASW, with expectations that those taking on the role are able to work within a social work value base, but with additional functions relating to Supervised Community Treatment.

Professionals who wish to take on the role of AMHP will have to undergo training that is based upon that of the previous roles for ASWs. It will be offered to practitioners with suitable experience and working at a suitable level so they can integrate the new role into their current position. Because AMHPs assess on behalf of Local Social Service Authorities (LSSAs), agreements between Trusts and LSSAs are needed before other professionals can be nominated to train as AMHPs. AMHP training courses will be approved by the General Social Care Council.

The AMHP must be approved by a Local Social Services Authority (LSSA). When an AMHP assess someone under the Mental Health Act they will be assessing "on behalf of" a Local Social Service Authority and are expected to maintain an independent point of view. The LSSA is expected to support AMHPs taking on the role, for example, by ensuring access to support and legal advice is available.

The approval will be based upon the LSSA being satisfied that the practitioner has developed the appropriate competence in assessing people who are suffering from mental disorder.

Due to this broadening of professional roles an AMHP need not be employed by the LSSA on whose behalf they are acting and it may be that a LSSA will enter into arrangements with NHS Trusts to provide the AMHP service on their behalf. However, the LSSA retains the ultimate responsibility for the quality and availability of the service and clear governance mechanisms need to be in place to support the role. For example, this means it is important for individual AMHPs to be clear who will provide them with training and legal advice, who will provide their legal indemnity cover, and who will sort out any problems or difficulties they experience while working in the role.

Functions of Approved Mental Health Professional

- Responsible for coordinating the initial examination process, along with two doctors, one of whom must be Section 12 approved.
- In an emergency setting an AMHP may assess with one doctor.
- The AMHP (as should the doctors) must be satisfied that all the criteria are met.
- To agree whether Supervised Community Treatment (SCT) itself, and any conditions suggested by the RC, are necessary or appropriate in a particular case; and if the RC wants to revoke the SCT, the AMHP must also agree to this.
- To interview the patient in a suitable manner prior to any applications being made.

- Consider whether the use of compulsion is necessary and appropriate, and how that should be reflected in the proposed care. For example, is there appropriate medical treatment and is it available?
- To make applications for admission to hospital or a Guardianship and ensure that a detained patient arrives safely at the hospital when they are detained.
- To consider whether or not to agree with the extension of Supervised Community Treatment.

The AMHP will have regard to the following when exercising their role

- An overall view of circumstances, including social and situational issues that are affecting the patient and contributing to the need for the assessment or treatment.
- To therapeutically engage – as best possible – with the patient in the context of all other influences that are apparent.
- To consider and use the resources available at any given time or opportunity.
- To ensure that any intervention is the least restrictive necessary in the circumstances.
- To ensure strict compliance with the law. For example, it is the business of the AMHP, rather than that of the doctor, to make sure someone is detained for treatment under s3 only in situations where there is not a different, less restrictive way available in which necessary treatment could be provided.
- AMHPs also have to make sure they are aware of and work within other laws such as the Human Rights Act 1998 and Equality Act 2006. In the case of children and young people under the age of 18, awareness of the Children's Acts is also essential. Following the guidance of the Code of Practice and its principles is one of the main ways that AMHPs can make sure they continue to work within the law.
- To apply an approach which takes into account a broad 'social' perspective rather than a narrow 'medical' perspective and which also takes into account a social model that offers alternatives to detention.
- To consider and take into account the wishes of relatives and all other relevant circumstances when considering whether to proceed with an application.

These duties are placed on the AMHP themselves and not the employing authority. Therefore, **an AMHP is personally liable for their actions while performing their functions under the MHA**. However, it should be clear which organisation will be providing the AMHP with public indemnity, particularly where they are not directly employed by the LSSA.

It is the role of the AMHP to provide a counterbalance to the medical model, and provide a view independent of that held by doctors and other professionals who wish to subject the person to compulsion, either in hospital or in the community. They need to use a **social perspective** to understand the broader position of the patient and their situation. This will aid in the production of an objective and appropriate decision being made for the patient.

The role and its competences are now covered by regulations. These include the fact that AMHPs must undertake 18 hours' worth of refresher training each year in order to maintain their approval status.

Responsibilities of Local Social Services Authority in connection with AMHPs

These are to:

- Ensure that a 24-hour AMHP service is available for their respective area, including reaching agreements within local Mental Health Trusts if the service is to be provided at an operational level by the Trust.
- Protect the independence of the AMHP role, and ensure AMHPs are supported to make judgements independent of the doctors employed by the Trust who may be admitting the patient to one of their wards.
- Approve AMHPs, and keep records of all AMHPs who are approved or acting on their behalf within their area.
- Ensure there is a sufficient number of AMHPs to meet the needs of their local community
- Ensure the professional competence of the AMHPs they approve and to end their approval if necessary.
- Ensure that AMHPs meet the mandatory training requirements of 18 hours annually, and the other conditions required for approval.

APPLYING MHA PRINCIPLES TO AMHP PRACTICE & THE INFLUENCE OF THE MCA

1. The Code of Practice to the Mental Health Act

1.1 Background Information

When the Code of Practice was rewritten in 1999, the Statement of Principles was highlighted and extended in Chapter 1.

How have the current principles influenced the manner in which you practice?

As a result of amendments to section 118 of the Mental Health Act 1983, the Code of Practice must now include a Statement of Principles that must address the 11 issues mentioned in the Act. There are five principles in the Code which address these matters.

1.2 Guiding Principles: MHA Code of Practice (Chapter 1)

Purpose principle
1.2.1 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least restriction principle
1.2.2 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect principle
1.2.3 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation principle
1.2.4 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible.

The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity principle
1.2.5 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and to achieve the purpose for which the decision was taken.

1.3 Status of the Code of Practice

S118 of the MHA also clarified the legal status of the Code of Practice. The status of the Code is that it is statutory guidance to which AMHPs and other professionals must have regard.

AMHPs and other professionals involved with the care of people who have a mental disorder therefore have a duty to follow the advice in the Code, or explain why they have not done so.

1.4 How the MHA, Code and Principles 'fit' together

- **The Act tells us *what* to do;**
- **The Code explains *how* to do it; and**
- **The Guiding Principles help us to apply the Act in *individual situations*.**

ACTIVITY 4 — APPLYING THE PRINCIPLES TO PRACTICE

Considering the list of principles, and looking at the Code of Practice itself, how might you apply these principles in the following areas; and how might this be different from what you do now?

1. Setting up assessments

2. Managing assessments

3. Making decisions

4. Since 30th April, 2008, it has been possible to move someone on a s135 or 136 between places of safety. Thinking about a case that you have been involved with and the advice of the Code, how might you have used the principles to decide whether or not to transfer the patient under these new powers?

2. The Influence of the Mental Capacity Act on MHA Assessments

2.1 Background Information: How the Mental Capacity Act influences MHA Assessments

Section 2
(2) An application for admission for assessment may be made in respect of a patient on the grounds that —

(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) 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.

Section 3
(2) An application for admission for treatment may be made in respect of a patient on the grounds that —

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
(b) (deleted)
(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and **it cannot be provided unless he is detained under this section**; and
(d) appropriate medical treatment is available for him.

S13
(2) Before making an application for the admission of a patient to hospital, an approved mental health professional shall interview the patient in a suitable manner and **satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment** of which the patient stands in need.

The above quotes from the Act have been highlighted to emphasise the legal importance of AMHPs considering the other ways in which a person suffering from mental disorder might receive the assessment or treatment they need, short of using the powers of the Act to detain them.

If alternative forms of authority exist and are sufficient, the Mental Health Act cannot be used. The obvious alternatives are either to rely on the person's own capacity to consent to assessment or treatment, or if they do not have capacity (and are 16 or over), to consider whether the Mental Capacity Act 2005 would provide sufficient authority to provide the care or treatment needed.

The **majority of people with mental health problems have capacity to make decisions** about their care and treatment needs – and are mostly seen within Primary Care services.

Some people will lack the capacity to make decisions about their care or treatment, but nonetheless accept care or treatment when they are advised or encouraged to take it. For example, some people cared for by Home Treatment or Crisis Intervention Teams don't have the capacity to understand the reasons for taking a particular treatment, but still take medication when it is provided to them. Provided workers in those teams have determined the person lacks the capacity to consent, and the treatment they are providing is in their best interests, the staff members involved will be protected from liability by section 5 of the MCA.

However, workers need to be sure any actions they take that might be termed as 'restraint' or 'restrictions' on the life of the individual (including chemical restraint using medication) is proportionate to the risks to the individual. It would also not be legal to detain a person under the Mental Capacity Act – although this will be possible once the Deprivation of Liberty Safeguards come into effect (expected in April 2009), subject to certain conditions.

Additionally, the authority of the MCA can only be used in situations where the action required would be in the best interest of the person concerned. The MCA cannot therefore be used in situations where intervention is needed **solely** for the protection of other people.

Similar rules will apply to people in the community but subject to Supervised Community Treatment. What this means is that people with capacity subject to SCT cannot be forced to accept treatment against their will without being recalled to hospital. Professionals can continue to provide treatment to people without capacity who are subject to SCT, provided that (apart from limited emergency circumstances) force does not need to be used because the person concerned objects to the treatment being given. Additionally, an advance decision opposing a particular treatment will continue to have legal force while someone is in the community and subject to SCT, and people who have LPA powers and deputies from the Court of Protection can both provide consent and withhold it, provided they have the appropriate powers. (See below for more information.)

Some people will have made advance decisions or have appointed someone with the LPA, or have a deputy from the Court of Protection who objects to the necessary treatment or care and thus prohibits the use of a particular treatment for their mental disorder. They can only be treated if detained by the MHA.

Clearly, as the MHA expects professionals to use alternatives to compulsory admission to hospital wherever possible, **treating people under the MCA rather than MHA, or informally if they retain capacity to take treatment decisions, these must be preferable.**

Situations where it would not be possible or sufficient to rely on the authority of the MCA

1. **The person concerned is aged under 16 years:** the MCA applies only to those aged 16 or above. An alternative source of authority to treat must be considered
   a. If the young person has the competence to consent, they could be admitted or treated on that basis if they agree.
   b. If a competent young person does not agree to admission or treatment, it would be good practice to considering an assessment under the Mental Health Act, or applying to court for the authority to treat. (Though possible, reliance on parental authority in these circumstances may not be appropriate.)
   c. If the young person lacks competence, those with parental authority can provide authority.

2. **The person has an Advance Decision, LPA or Deputy from the Court of Protection objecting to the care or treatment needed.** In this case, the authority of the MCA could not be used, and the use of the Mental Health Act may need to be considered (see below).

The COP suggests the MHA might be more appropriate for one of the following reasons:
   a. Although the patient lacks capacity for some decisions, they retain capacity in regard to other issues (e.g. objecting to hospital admission) and they are objecting to this vital aspects of the care plan. (COP, 4.20)
   b. The patient's lack of capacity is fluctuating or temporary and the likely to start objecting to the care or treatment needed when they regain capacity (based on past evidence). (COP, 4.21)

3. **The care or treatment needed would amount to a deprivation of liberty**, or need to be provided in a situation that amounted to deprivation of liberty (e.g. you need to detain them in order to assess or treat them). (COP, 4.16)

4. **A degree of restraint needs to be used** which is justified by the risk to other people but **which** is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally. (COP, 4.21)

5. **There is some other specific identifiable risk** that the person might not receive the treatment they need if the MCA is relied on and that either the person or others might potentially suffer harm as a result. (COP, 4.21)

> *"Otherwise, if the MCA can be used safely and effectively to assess or treat a patient, it is likely to be difficult to demonstrate that the criteria for detaining the patient under the Mental Health Act are met."* (COP, 4.22)

2.3 Advance Decisions, Lasting Powers of Attorney or Deputies appointed by the Court of Protection

In circumstances where people have made decisions when they were competent about how they want to be treated when unwell, or where they have given someone a LPA over personal welfare decisions, or where the Court of Protection is involved, these people and the decisions they represent have to be considered as part of the assessment process.

2.4 Advance decisions

People with mental health problems have the same rights as others to make advance decisions to refuse particular aspects of medical treatment provided that the decisions were made when they had the capacity to make them.

To make a valid advance decision, a person must:

- Be 18 or older, and
- Have capacity to make the specific decision.

Advance decisions are more likely to be more useful if they are **explicit rather than general**, so that it can easily be applied to a given situation (for example, refusing to have a particular type of anti-psychotic medication).

Assessors must also be confident the person concerned was aware of all the appropriate information and was anticipating the decision be used in the current situation when they made the advance decision and would not have made a different choice had they been aware of the current situation or newer information.

> *"An Advance Decision is not applicable to the treatment in question if –*
> *(a) that treatment is not the treatment specified in the advance decision,*
> *(b) any circumstances in the advance decision are absent, or*
> *(c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them."*
>
> MCA section 25 (4)

For example, where a patient makes a decision about not receiving a particular type of treatment because of side affects, but the decision was made some time ago prior to the development of a newer version of the treatment with a better side effect profile, the decision maker might well want to ask whether the person concerned might have made a different decision had they been aware of the new information.

It is also important to recognise the difference between advance decisions and advance statements:

- **Advance decisions** allow you to object in advance to particular sorts of medical treatment or intervention (such as objecting to ECT). Such decisions, as long as they are specific to the situation and were made at a time when the person had capacity, **are legally binding**. However, they may be overridden by the use of the MHA (except where they object to ECT – see below).

- **Advance statements** allow people to say what they would like to happen in a given situation. For example, asking that particular people are consulted or involved during a MHA assessment. Such statements are **not legally binding**, but should be strongly considered in the decision-making process. They are also dealt with in the Code of Practice to the MHA (COP, 17.12 - 17.22), so if you decide not to abide by an advance statement, you must justify your decision not to do so in your AMHP report.

An advance decision does not have to be written down for it to be valid, unless it involves the refusal of life sustaining treatment – in which case it **must:**

- be in writing;
- be signed;
- be witnessed; and
- state clearly that the decision applies even if life is at risk.

However, when considering helping people experiencing mental ill health to make a valid advance decision, because:

a. the person concerned has to have had capacity when the decision was made, and
b. the advance decision has to be available to people who might be called upon to make a decision in a MHA,

It is helpful for issues such as this to be considered early, for example, during the CPA or care management process, so that confirmation of capacity can be agreed and the decision recorded in a way that would make it available in times of emergency.

If a valid advance decision has been made (which is applicable to the decision needed in a MHA assessment), that treatment CANNOT be given under the MCA and the staff would not be protected from liability by the MCA. In this case the use of the MHA can be considered, to provide treatment, if the MHA legal criteria are met. **However:**

- An advance decision opposed to ECT cannot be overridden by the MHA (except in an emergency);
- Where a patient has made a valid advance decision banning the use of a particular treatment option, but is otherwise agreeable to other forms of treatment, the assessing AMHP should consider whether the use of formal powers is justified when other sorts of treatment are available and the patient does not object to accepting them (in which case they can be given informally with consent, or under the MCA if capacity is lacking). The important decision is why that particular type of treatment is appropriate as opposed to other available options.

Other things to remember about advance decisions:

- People with capacity can change their minds and change a previously made advance decision;
- If medication is given under the MHA in circumstances where an advance decision forbids it – unless the person regains capacity and agrees to the use of the treatment – **the advance decision will become valid and applicable again as soon as the MHA detention ends** and the professionals involved with that person's care will be obliged to stop using the treatment or risk losing their protection from liability.

2.5 ECT Protections

The MHA introduces a new section 58A for consent to treatment for Electro-Convulsive Therapy (ECT).

Parliament was determined to provide protection for patients from the use of ECT if they were opposed to it. In many cases under the existing MHA, when they object to being given ECT if they are informal, patients are detained under the MHA and given ECT by applying for a SOAD authorisation on a Form 39, which is used for non-compliant patients. Under the MHA this will no longer be possible. See the table below:

Table 1. How Section 58A (ECT) works

Situation	Action
Except in emergencies	detained (and SCT) patients who have capacity can now refuse ECT; detained (and SCT) patients who lack capacity can't now be given ECT contrary to an advance decision or the decision of a donee, deputy or the Court of Protection; no under 18 (whether detained or informal) can now be given ECT without the approval of a SOAD.
Certificate-wise, the position is that (again, accept in emergencies):	for ECT to be given to a detained patient who consents, the consent must be certified by the Approved Clinician in charge of the treatment (who needn't be the Responsible Clinician) or by a SOAD. for ECT to be given to a detained patient who can't consent, the lack of capacity and appropriateness of the ECT must be certified by a SOAD. The SOAD must also certify that there is no conflicting advance decision, etc. in the unlikely event of an SCT patient being given ECT without being recalled to hospital, it would have to be certified as appropriate by a SOAD (this could happen if the patient consents to it, and so doesn't need to be recalled). ECT cannot be given to any person under 18 (whether detained or not) unless it is certificated as appropriate by a SOAD, who will also either have to certify that the young person has the capacity or competence to consent, or that the patient doesn't. In the latter case, the SOAD will also have to certify there is no conflicting advance decision, etc. (though, in practice, that will either be wholly or largely irrelevant to under 18s).
In practice, all this is achieved by means of four certificates:	T4 for 18+ detained patients who consent – can be completed by SOAD or clinician in charge of the treatment) T5 for under 18s who consent (whether or not detained) – SOAD T6 for patients who can't consent (used for detained patients and informal under 18s) – SOAD CTO11 for SCT patients who have not been recalled to hospital – SOAD (and not just for ECT)
For informal under 18s who can't consent, the certificate is not enough to permit treatment. There must still be a lawful authority – which for 16 and 17s might be the MCA, and for under 16s could be a court order or, in principle, parental consent (although the Code advises against relying on parental consent because there is a risk that it would be found to be outside the "parental zone of control" – i.e. the legitimate scope of decisions which parents can take on behalf of their children).	

In other words:

- If someone has capacity and refuses to have ECT, they can only be forced to accept it in an emergency;
- Except in an emergency, if a detained patient lacks capacity, they can only be given ECT if a SOAD agrees the ECT is appropriate treatment for the patient, and that they do not have capacity to consent **and** there is no valid advance decision or other authority that objects to the use of ECT;
- If there is a valid advance decision or other authority opposed to ECT, the treatment could only be given under s62 as emergency treatment;
- No under 18-year-old can be given ECT unless a SOAD agrees (except in an emergency);
- However, an informal patient who lacks capacity *could* be given ECT under s5 of the MCA (best interests) as long as there is no valid Advance Decision or other valid authority that objects to the use of ECT.

ACTIVITY 5 — SCENARIO

Consider the following scenario. What factors would influence the manner in which the assessment would be set up?

Memet is 32-years-old, and has a bipolar disorder characterised by extreme highs and lows. In the past ECT treatment has been used when he is particularly low, but Memet has always disliked the loss of memory and control he experiences as a result. When well, he works competently as a book keeper in the family business.

Memet has given his older brother (who is a lawyer) a personal welfare power of attorney over his affairs. He has also made an Advanced Decision, which his brother witnessed, that he did not want to be given ECT treatment again under any circumstance. When he next becomes depressed, and is assessed, Memet's mother and nearest relative (Hera) is persuaded by professionals that ECT is the best treatment for her son. She has seen him get better quickly when it is used, and is willing to agree to her son being admitted on section 3 to be given this treatment.

1. **As nearest relative, can Hera overturn the LPA or advanced decision, and how might these MCA provisions affect the organisation of the assessment?**
2. **In this case a lot hinges around what might constitute an 'emergency'. What sort of factors do you think should be taken into account when deciding if a situation is an 'emergency'?**
3. **Look at the advice in the Code of Practice. How does this help your deliberations?**

DISCUSSION POINTS

How might you support people you work with to make use of these new protections?

MAKING DECISIONS

1. Changes in the Definition of 'Mental Disorder' and the 'Appropriate Medical Treatment Test'

1.1 Background Information

Single Definition of Mental Disorder

Definition of Mental Disorder

For sections of the MHA which apply to assessment under compulsion, the wording of the definition of mental disorder is very similar to that we have been working with under the unamended Act. It changes from "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind" to "**any disorder or disability of the mind**".

However, **this simplified definition now applies to all sections of the Act**. The four forms of mental disorder (mental illness, mental impairment, severe mental impairment and psychopathic disorder) have disappeared. This potentially means some people previously excluded from treatment are now included. For example, there may be some people with an acquired brain injury who were not covered by the term "mental impairment or severe mental impairment" who could now benefit from the protections of the Act.

The **Learning Disability Qualification** has been introduced to preserve the status quo (e.g. under section 3, a person with a learning disability alone can only be detained for treatment or be made subject to Guardianship if that learning disability is associated with abnormally aggressive or seriously irresponsible conduct.) and now applies to all those sections that relate to longer-term compulsory treatment or care for a mental disorder (in particular s3, s7 (Guardianship), s17A (Supervised Community Treatment) and forensic sections under Part 3 of the Act). It means that if the use of longer-terms forms of compulsion are being considered solely on the basis that a person has a learning disability, that disability **must** also be associated with abnormally aggressive or seriously irresponsible conduct. This does not, of course, preclude the use of compulsion for people who have another form of mental disorder (such as a mental illness) in **addition** to their learning disability.

When considering detaining someone for treatment for a mental disorder, in addition to conditions related to the presence of mental disorder and risk, the condition that "appropriate medical treatment" must be available also needs to be fulfilled.

Criteria for Detention

The Appropriate Medical Treatment Test

Introduces a new "appropriate medical treatment test" which will apply to all the longer-term powers of compulsion involving treatment (for example, section 3 and SCT). As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless **"medical treatment is available for the patient which is appropriate in his case taking into account the nature and degree of the mental disorder and all other circumstances of the case".**

"Medical treatment" includes psychological treatment, nursing, habilitation and rehabilitation as well as medicine.

It doesn't have to be the "perfect treatment", but it does have to be clear what the treatment will be, and that it will be available in a particular place. Doctors, for example, will be expected to confirm on their recommendations for s3 that appropriate medical treatment is available, and in which hospital(s) it will be available to the patient.

During the passage of the Act, debate highlighted the need to ensure services offered to children and young people were appropriate, and accessible in an emergency.

Age Appropriate Services

Admitting young people to suitable environments

The effect of this change is that hospital managers are placed under a duty to ensure patients under 18 who are admitted to hospital for assessment or for treatment under the legislation, or who are voluntary patients are in an environment suitable for their age (subject to their needs). There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient has an overriding or atypical need which would require consideration of an environment not usually considered appropriate. An example of an atypical need might be a young person a few weeks before their 18th birthday who prefers to be on an adult ward rather than with very much younger children if the CAMHS ward has only 13-year-olds on the ward.

A possible example of an overriding need is where the young person is in a crisis and there is no CAMHS bed available, and it is in the best interests of the child or young person to be kept safe on an adult ward rather than not be admitted at all.

However, if a child or young person is admitted to an adult ward, the environment must be safe for that young person (e.g. discrete accommodation, staff who are CRB-checked) and they must be moved as soon as possible to an age appropriate environment. This is expected to come into force in 2010, by which time it is hoped new services will be available.

S140 of the existing Mental Health Act has also been amended to put a duty on Primary Care Trusts to let Local Social Service Authorities know where services that can admit young people in an emergency are to be found. S39 places a similar duty on PCTs to tell the courts when asked in the case of under 18-year-olds at remand, committal or hospital order stage. The changes to S140 and 39 are likely to be in force from 3rd November, 2008.

1.2 Change in definition: Effects on assessment process

Although the changes in the definition of Mental Disorder have a limited effect on compulsory admission for assessment, the new simplified definition of Mental Disorder will have an impact on compulsory admission for treatment.

This appropriate medical treatment test, of course, is also an important part of the decision-making process, and needs to be taken into account when making decisions. It is the doctors who must specify on their recommendations that appropriate medical treatment is available (and where). However, the AMHP can also validly offer an opinion to ensure that they do take account of “all the circumstances of the case”.

ACTIVITY 6 - SCENARIOS

Considering the principles and interpretation of the Code of Practice, discuss the following scenarios.

Scenario 1
Anka is 16-years-old. She came to this country from Poland three years ago, and initially appeared to settle well at school. However, since returning to school last September she has gradually become more withdrawn. She started refusing to eat when anyone was looking, and dressed in baggy, shapeless layers. Anka insisted nothing was wrong, that people were worrying unnecessarily and should “leave her in peace”.

After talking to the parish priest, the family took Anka to see her GP, and he prescribed anti-depressants. Anka refused to take these. When they returned to the surgery, Anka was seen by a different, female, GP whom she allowed to weigh her. Her body mass index was 16 – an indication of a possible eating disorder. Her GP referred her to a specialist eating disorders service, which Anka attended sporadically for about four months, and despite forming a positive relationship with the consultant there, it made little positive impact on her eating or weight.

The consultant feels Anka’s eating problems are actually secondary to depression, but Anka continues to refuse anti-depressants. The psychologist within the team feels she is currently too depressed to make use of psychological interventions. She has started to cut herself and her weight continues to fall.
The consultant wants to admit Anka under the MHA, and suggests she could be admitted onto an adult ward with one-to-one support.

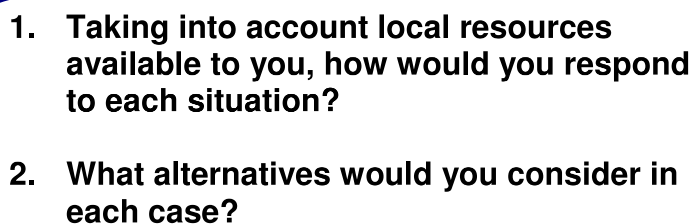
Scenario 2
Tom is 72-years-old. He has a diagnosis of schizophrenia, and has been known to mental health services since his mid 30s. He was transferred to the care of an older people’s team three years ago.

Until recently Tom had been maintained on a low dose antipsychotic via his GP. However, after his wife Elsie died four months ago his mental health has begun to suffer. He was referred to the CMHT for older people by his GP, allocated a CPN, and attempts were made to increase his depot – but these were abandoned due to increasingly adverse side effects.

Tom was admitted to hospital informally, was started on oral medication instead and initially improved. However, after discharge, he was too disorganised to remember to take the meds, despite extra support from his CPN.

Intervention from home carers was attempted, but he refused to let the staff into his house, believing that they were intent on poisoning him and had 'hidden' Elsie from him. This was because the carers had supported the couple while she was alive, and had been the ones to find Elsie dead from a heart attack while he was out shopping. His mental health continued to deteriorate.

Last night Tom tried to get into the rooms of another tenant in the sheltered block, insisting that the woman was hiding his wife. A Mental Health Act assessment was arranged. Tom's consultant psychiatrist, who knows him well, sees him in the community with his GP and an AMHP. When Tom refuses informal admission, the consultant wants to make recommendations for admission. However, the consultant wants Tom admitted to an adult ward but admission has been refused by the ward manager and the Crisis Resolution Team because he is too old and, in any case, he is refusing to allow people in. The only option would be to admit him to an older person's ward where most patients have dementia.



DISCUSSION POINTS

In circumstances where the criteria for compulsory admission are met but where a bed is not available, what processes exists locally to support AMHPs raise and resolve these issues? What processes need to develop locally to support AMHPs in this regard?

2. Conflicts of Interest

Background Information

> ***"These potential conflicts of interest may concern the relationship of AMHPs and doctors to each other, to the patient, to the nearest relative or to the hospital where the patient is to be admitted. They concern potential conflicts of interest for financial, business, professional and personal reasons."*** **(COP, 7.3**)

***The conflict of interest rules now apply to the AMHP as well as to doctors involved in assessments*.**

They are based on professionals making judgements about whether or not they would have any personal, financial or professional conflicts of interest if they undertook a particular assessment. However, it is important that AMHPs understand the rules as

"an application based on recommendations that clearly fell foul of these regulations would not be valid".

(Draft MHA Reference Guide, 2.53)

Financial Conflicts

For example:

One recommendation (but not both) in support of an application for admission to an independent hospital may now be given by a doctor on the staff of that hospital. This doesn't apply where people are admitted to NHS hospitals, or because they are paid a fee for making assessments and recommendations.

Business Conflicts

For example:

Where two or more of the assessors, or the assessor and the patient or their nearest relative, are involved in a business venture together. This applies even if the business venture has nothing to do with mental health or social care.

Professional Conflicts

Some examples:

a. One assessor employs or line manages another assessor, or the patient or the nearest relative.
b. An assessor is a member of the same team as a patient (i.e. where it is necessary to assessment someone employed within mental health services, the assessors should come from **outside** the team in which the patient usually works).
c. No more than two assessors may come from the same clinical team. A clinical team means "a group of professionals who work together for clinical purposes on a routine basis." (COP, 7.11).

Urgent Situations

These rules don't apply in urgent situations where "the patient's need for urgent assessment outweighs the desirability of waiting for another assessor who has no potential conflict of interest" (COP, 7.12). If you need to use assessors in this manner, you must always record why. Additionally, it is preferable to use two assessors who may have a conflict in preference to undertaking a s4 assessment (COP, 7.13).

Conflicts of interest [s12A and Conflict of Interest Regulations]

AMHPs may not make an application if they have a potential conflict of interest as defined in the Mental Health (Conflicts of Interest) (England) Regulations 2008 and described in the table below.

An application made by an AMHP who had a potential conflict of interest would be invalid and would not provide any authority for the patient's detention.

Table 2. Potential conflicts of interest for AMHPs

<table>
<tr><th colspan="2">AMHPs have a potential conflict if any of the following apply:</th></tr>
<tr><td colspan="2">The AMHP has a financial interest in the outcome of the decision whether or not to make the application.</td></tr>
<tr><td>The AMHP employs</td><td rowspan="3">the patient or
either of the doctors making the recommendations on which the application is based.</td></tr>
<tr><td>The AMHP directs the work of</td></tr>
<tr><td>The AMHP is closely involved in the same business venture (which includes being a partner, director, other office-holder or major shareholder) as</td></tr>
<tr><td>The AMHP is the wife, ex-wife, husband, ex-husband, civil partner, ex-civil partner, mother, father, sister, brother, half-sister, half-brother, daughter, son, aunt, uncle, grandmother, grandfather, grandson, granddaughter, first cousin, nephew, niece, mother-in-law, father-in-law, daughter- in-law, son-in-law, sister-in-law, brother-in-law, grandmother-in-law, grandfather-in-law, granddaughter-in-law, grandson-in-law, (including adoptive <u>and</u> step-relationships) of</td><td rowspan="2">the patient or
either of the doctors making the recommendations on which the application is based.</td></tr>
<tr><td>The AMHP is living as if wife, husband or civil partner with</td></tr>
<tr><td colspan="2">The AMHP and both the doctors making the recommendations on which the application is based are members of the same team organised to work together for clinical purposes on a routine basis. But this does not apply if the AMHP thinks that it is of urgent necessity that an application be made and a delay would involve serious risk to the health or safety of the patient or others.</td></tr>
<tr><td colspan="2">The AMHP and the patient are members of the same team organised to work together for clinical purposes on a routine basis. But this does not apply if the AMHP thinks that it is of urgent necessity that an application be made and a delay would involve serious risk to the health or safety of the patient or others.</td></tr>
</table>

Other Situations: Supervised Community Treatment

These regulations do not apply to SCT. This means it is fine for both the AMHP and the RC considering SCT to come from the same team. Indeed, it is envisaged that they will often do so.

However, the Code (7.16) says that the neither the RC or AMHP should have a financial interest in the outcome of whether an order is made or revoked, and neither should they be related, either to each other or the patient.

> **"The Act requires an AMHP to take an independent decision about whether or not to make an application under the Act. If an AMHP believes that they are being placed under undue pressure to make, or not make, an application, they should raise this through the appropriate channels. Local arrangements should be in place to deal with such circumstances."**
>
> **(COP, 7.17)**

ACTIVITY 7 - CONFLICT OF INTEREST REGULATIONS

There are now new regulations about conflicts of interest, which apply to AMHPs as well as to doctors.

As well as rules concerning financial interests and personal relationships, the regulations also make the following assessment arrangement unacceptable, except in urgent situations. Consider chapter 7 of the Code and read each arrangement and then answer the question that follows.

1. An Assessor may have a potential professional conflict of interest where he '(a) directs the work of, or employs, the patient or one of the other assessors'
(6(1a) the Mental Health Conflict of Interest regulations)

Question: What might "directs the work of" mean in practice? What might you need to do to ensure that you do not 'fall foul' of this regulation?

6. No more than two of the three assessors may work within the same "clinical team organised to work together on a regular basis".

Question: What might such a 'team' mean? Where consultants know each other well and work together on the same rota, could they be seen as part of the same team?

3. Consider the following scenario

Jack is an AMHP working in a service for people with serious and dangerous personality disorders. A number of people cared for by the team are subject to compulsion, including the use of SCT. Jack is line-managed by a nurse (Albert) and is provided with clinical supervision by Jenny who is a psychologist.

The team are part of a pilot for the new Responsible Clinician role. Both Albert and Jenny are now Approved Clinicians. They also have Tim, a staff grade psychiatrist, working within the team. Tim is section 12 approved.

Question: What issues might the team, and Jack in particular, have to consider as part of this change, with regard to the conflict of interest regulations?

THE NEAREST RELATIVE

1. New rules and existing quandaries related to the Nearest Relative role

The MHA has made some changes as to who should be considered the nearest relative. In particular, Civil Partners are given equal status with husbands and wives. Given that identifying the nearest relative is one of the issues that most concerns Approved Workers, the following exercise is aimed a helping ASWs consider some of the quandaries and areas where mistakes are most easily made.

ACTIVITY 8 - IDENTIFICATION OF THE NEAREST RELATIVE

Below is the Gallagher/Brown family tree. First, go though all the questions quickly and see if you can answer them. Check your answers with colleagues (the correct answers are in the back of the book), and if it helps, look at the advice that follows the questions on how to select the correct nearest relative.

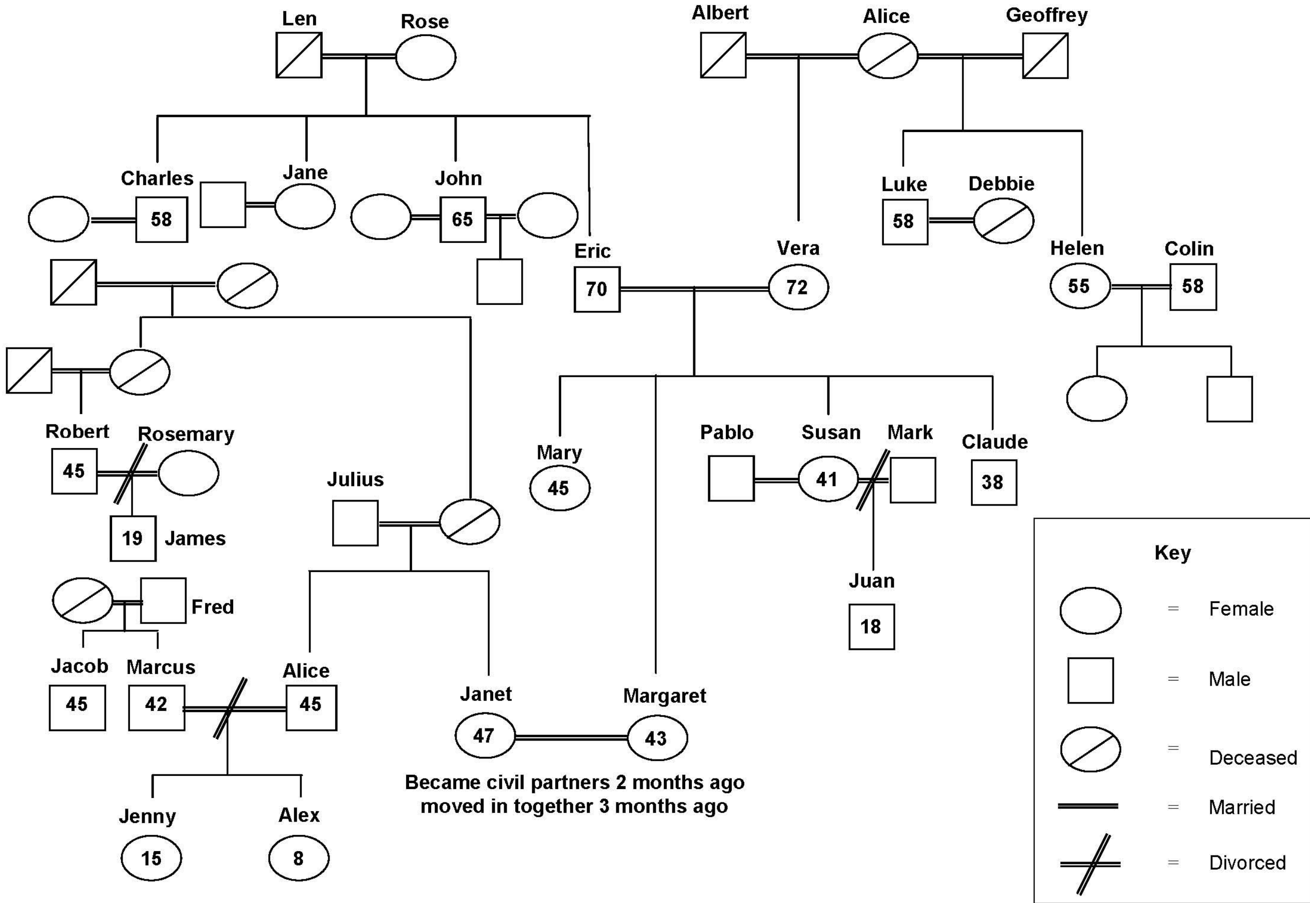


Figure 1. Gallagher/Brown Family Tree

1. Margaret and Janet met two years ago. They were a couple for 18 months before moving in together three months ago. Two months ago, they entered into a civil partnership. At what point in the last two years did they become each other's nearest relative?

2. Janet's cousin Robert is 45 years of age. He is divorced from his wife Rosemary. They have one son, James, who is 19 years of age. James has profound learning disabilities and lives with his mother Rosemary. Who is Robert's nearest relative? If James died, would the situation be the same?

3. Rosemary makes an Advance Decision saying that if she loses capacity she wants to delegate her role as nearest relative for James to Janet. Is this possible? Give reasons for your answer.

4. Susan and her current husband Pablo live in California, USA. Susan and her 18-year-old son Juan are visiting Margaret and Janet. Mark, Juan's father, still lives in this country. Who is Susan's nearest relative?

5. Luke married Debbie but they never had any children. Debbie died two years ago. Who would be Luke's nearest relative?

6. Who is Claude's nearest relative?

7. Fred and Julius have always got on. After the death of their respective wives, they decided to sell up and buy a two-bedroomed apartment, each with its own en-suite bathroom, but with shared kitchen facilities. This was eight years ago. Who is Fred's nearest relative?

8. Fred has two sons, Jacob and Marcus. Marcus (the younger son) visits and shops for his father, whereas Jacob phones and talks to him every week. When they hear you are considering assessing Fred, they both make contact and insist they should be considered as the nearest relative. What do you think?

9. Marcus was married and has two children, Alex (8) and Jenny (15). After he divorced, the children initially stayed with their mother, but two months ago Marcus gained a residence order and the children came to live with him. Their mother, Alice is older than Marcus, and still maintains contact. Who would be the children's nearest relative? Would this be the same if the LSSA had a full care order on the children?

1.1 Identifying the nearest relative

For the person concerned in each question, look at the list in s26.

THE NEAREST RELATIVE CAN BE:

- **a)** **HUSBAND, WIFE OR *CIVIL PARTNER***
- **b)** **SON OR DAUGHTER**
- **c)** **FATHER OR MOTHER**
- **d)** **BROTHER OR SISTER**
- **e)** **GRANDPARENT**
- **f)** **GRANDCHILD**
- **g)** **UNCLE OR AUNT**
- **h)** **NEPHEW OR NIECE**
- **i)** **A PERSON WHO HAS ORINARILY LIVED WITH THE PATIENT FOR FIVE YEARS OR MORE**

Identify possible nearest relative candidates

1. Write down all the names that fall within the categories on the list.
2. Are there any cousins or in-laws (or even husbands and wives of people who are 'blood' uncles and aunts) on the list? If there are, cross them out! **They do not appear on the list and are therefore excluded.**
3. Include anyone who has lived with the patient as common law husband or wife or same sex partner for 6 months or more at the top of the list.
4. Include on the list anyone who has lived together with the patient for five years or more (but list them last).
5. Look again at the list. Cross out anyone you have written down who is:
   a) under 18-years-old (unless they are the patient's spouse or civil partner)
   b) doesn't live in the UK in situations where the patient does usually live here (If the patient doesn't usually live in the UK, their NR **could not** be excluded on this basis)
   c) is divorced, or is permanently separated from the patient.
6. If a child is subject to a full care order, their nearest relative will be the local authority. Equally, if there is a residence order in place, the person with the residence order will be the NR.

Prioritise the list

1. Is there a husband, wife or civil partner. If one exists, as long as they are not divorced or permanently separated, they will always be the NR. This is the case even if they don't share a home, for example, where one partner lives in a residential home.
2. Does the subject share a home with anyone listed? Or are they provided with (sustained and substantial) practical or emotional care by anyone on the list? If they are, **this person is the nearest relative** (and if there is more than one person, then the **elder** or **eldest** on this list is the nearest relative.)
3. If the answers to 1 & 2 are 'no', list those people who are left on the list using the priority of the list in section 26 of the Act. Put the older in any category higher on the list (for example, with parents, list the older parent first). Where you have half-brothers or sisters, put full-blood brothers or sisters higher than half-blood relatives.

The person highest on the list will be the nearest relative.

2. Displacement of the Nearest Relative

"Local social services authorities (LSSAs) should provide clear practical guidance to help AMHPs decide whether to make an application [for displacement] and how to proceed. Before producing such guidance, LSSAs should consult with the county court. LSSAs should ensure that they have access to the necessary legal advice and support." (COP, 8.16)

2.1 Background Information

One of the significant changes brought about by the Mental Health Act 2007, is that now

> ***the patient themselves can apply to the County Court to displace their own nearest relative.***

It is likely that the (newly-established) Independent Mental Health Advocates will take a leading role in helping patients to understand and make use of this power. However, AMHPs, by virtue of their knowledge and experience, may also be involved. Therefore, this section will look at all the new rules that exist.

2.2 Delegation or Displacement?

Prior to considering displacement, it is always worth considering whether there are other ways in which to resolve any difficulties or concerns that the nearest relative may generate. First, if there is a disagreement with the nearest relative about an admission, or other use of compulsion, it would be good practice to explore the issues and attempt to resolve them. Second, it should be considered whether the nearest relative would be willing to delegate the responsibilities to someone else. If they do so, to whom they are delegating must be put in writing. The regulations do not limit who is chosen, except that the following people cannot be delegated:

- the patient;
- a person who, under section 25(6), is not eligible to be the patient's nearest relative (i.e. someone who has been excluded – for example, because they are divorced or permanently separated from the patient);
- a person who would currently be the nearest relative, except for an order of the court displacing them under section 29.

(Draft Reference Guide, 32.26)

It is important to remember that the nearest relative only delegates the powers: they can at any time decide to take the powers back and use them themselves.

Both the delegation and any revocation of it must be in writing.

2.3 The Law – s29 (as amended)

What are the grounds for displacement?

Table 3. Grounds for Displacing the Nearest Relative

The grounds	What it means
The patient doesn't have a nearest relative	You have tried to find a nearest relative but none exists. You may consider asking the County Court to appoint someone, particularly in situations where the patient lacks capacity to speak up on their own behalf.
The nearest relative can't take on the role because they themselves are ill	This includes physical as well as mental illness, e.g. a patient whose nearest relative (father) has dementia may decide to displace him and suggest someone else. Then, when he is admitted, someone he trusts is there to protect his interests.
The nearest relative unreasonably objects to a patient's compulsory admission or the use of Guardianship	Under the existing MHA, this was the ground most often used. However, it is important to remember you will need to show evidence to the judge about why you think the nearest relative is being unreasonable.
The nearest relative has discharged the patient from hospital or guardianship without considering the consequences for the patient or the public, or is likely to do so	Sometimes used in addition to the grounds above, this section is really concerned about risks to the patient or others.
The nearest relative is "otherwise unsuitable" for the role	The new ground: The COP is clear that this ground is not intended to allow the patient to change a nearest relative simply because they agreed to admission against the wishes of the patient, rather that there is evidence that the nearest relative isn't suitable for that role.

The process for displacement:

- In situations where AMHPs are seeking to displace an objecting or irresponsible nearest relative, the court will normally expect to see evidence that the patient does need to be admitted to hospital or Guardianship. This usually takes the form of a report from the psychiatrists involved. In some cases, a Court will ask to see copies of the doctors' recommendations.
- Where an AMHP is making an application the Local Social Service legal team will help make the application and check your reports. They will ask for an affidavit from the AMHP (a legal statement of facts) giving the reasons why displacement is necessary.
- Consider who should be the nearest relative. This could be someone else who knows the patient well, or it could be the LSSA itself.

Who can apply to displace the nearest relative?

- The patient
- Any relative of the patient
- Anyone who lives with the patient
- An AMHP

How long do the orders last?

Table 4 explains in detail how long the orders last in specific situations

Table 4. How long do the orders last?

Discharge on the basis of:	Length of time
a. there isn't a nearest relative b. the nearest relative is too unwell to hold this role c. the nearest relative is "otherwise unsuitable"	***Either*** it lasts for the period stated in the original order ***Or*** it can continue indefinitely, unless the patient, the new nearest relative or the original nearest relative go back to court and ask for a change.
d. the nearest relative had unreasonably objected to the application e. the nearest relative had discharged the patient without considering their welfare or others'.	***Either*** it will last for three months from the time the order was made ***Or*** if the patient was detained or subject to Guardianship at the time of the s29 Order or within three months of the Order, the Order will end when the section ends.

ACTIVITY 9 - DISPLACEMENT OF THE NEAREST RELATIVE

Given these new rules, consider the following case. What factors might the courts use when deciding whether a relative is "unsuitable"?

Mary's nearest relative is her mother Vera, However, after a stroke five years ago, Vera delegated the role to Mary's father Eric. Mary is unhappy with this arrangement. She has a bipolar disorder, and has been admitted annually (just before Christmas) for the last three years. Mary feels her father has a very "old-fashioned" and "patriarchal" view towards her. Because she has never married, but has instead chosen to focus on her career as a writer and textile artist (she has published a number of books about modern cross-stitch and other creative needlework), she says he still sees her as "a child" and "his responsibility". As a result she feels he sees problems where there is none, and does not let her take the risks she feels she should be able to take. It has been Eric who has requested assessments in the last three years, sometimes going to out-of-hours teams when he felt the assessment "couldn't wait".' Mary feels his attitude makes him "otherwise unsuitable" because he is not actually working in her best interests. She wants to displace him and approaches you for help and advice.

Eric is very hurt and angry when he hears about this. He and his wife have tried hard over the years to support Mary. They are proud of all she has achieved but also realistic about her limitations. They can spot when she isn't well, and while he says he can appreciate her point, he sees it as selfish. Her mother has already had one stroke as a result of the worry and stress of looking after her and this, Eric feels, will just make things worse.

1. **What do you think?**
2. **Would this meet the new criteria for being 'otherwise unsuitable'?**
3. **How might you use the Guiding Principles to support your decision-making?**

DISCUSSION POINTS

Consider a patient you have worked with in the past where they have expressed a desire to change their nearest relative. Would their situation have met the requirements of the Act? In what way would the criteria support or not their choice?

SUPERVISED COMMUNITY TREATMENT

1. Supervised Community Treatment

(Community Treatment Order – section 17A)

Summary

"The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery."

(COP, 25.2)

Like s25A (supervised discharge), the lead for the use of the section is the person's Responsible Clinician. The emphasis is on treatment: the criteria clearly focus the use of this section on those people who are likely to have established diagnoses where a treatment is available, but where the patient themselves stops or is likely to stop taking treatment on discharge, with a resulting decline in their mental state and risk to themselves or others.

1.1 The Process

Only people already detained on s3 (or similar treatment orientated forensic sections) can be considered for Supervised Community Treatment. S17 (2A) requires that where longer-term leave is being considered (defined as more than seven days taken together or separately), the Responsible Clinician (RC) should consider whether it is more appropriate to use a Community Treatment Order (17A). This is the order that gives effect to Supervised Community Treatment.

Unlike s2 or 3, applications are not, in fact, made to the hospital managers. The Responsible Clinician makes the CTO (in agreement with the AMHP) and furnishes the hospital managers with the original copy of the order (the CTO1).

The RC must complete the CTO1 when making the order, and this must also be signed by an AMHP.

Legally, the effect is to suspend the following elements of section 3:

- **the requirement to take *medication* under Part 4 of the Act,**
- **the liability *to be detained in hospital***

The patient has to follow treatment rules found in Part 4A of the Act. The effect is that a patient who has capacity has to consent to treatment in the community, and a patient without capacity can only be treated as long as they do not object.

When a patient is recalled, their liability to take medication and be detained in hospital comes back into effect. (See processes for recall and revocation.)

1.2 Criteria

The Responsible Clinician's role in the process

The Responsible Clinician must use form CTO1 when making the CTO.

The RC must state that s/he believes the following criteria are met, and an AMHP must agree with this judgement.

- The patient **is** suffering from a **mental disorder of a nature or degree**[2] which makes it appropriate for the patient to receive medical treatment;
- It is **necessary for his or her health or safety or for the protection** of other persons that the patient should receive such treatment;
- Subject to the patient being liable to recall … **such treatment can be provided without his/her continuing to be detained in hospital;**
- It is **necessary that the RC should be able to exercise the power** … to recall the patient to hospital;
- **Appropriate treatment is available.**

(MHA, S17A(5))

What "necessary" means in this context (s17A (6))

When weighing up how necessary recall is, the RC needs to consider the risks that might be associated with the patient were they not on SCT, i.e. they need to consider the risk of a decline in the patient's mental health, and the risks they may pose to themselves or others as a result. The RC has to have regard to the following factors when reaching this judgement:

- **The patient's history of mental disorder;**
- **Any other relevant factors;** (COP, 25.9)

There are no conditions related to age. Therefore **a young person under the age of 18** can go onto this order. There are some special considerations for child SCT patients (see COP, 36.65). If ECT is being considered you will need to be familiar with the special rules that apply (see COP, 24.18 onwards) and the treatment will need to be covered by a Part 4A certificate (CTO11).

1.3 Setting conditions

The CTO **must** include the following conditions:

- That the patient must make him- or herself available for examination as to whether his or her CTO should be extended under s20A;
- That if a SOAD doctor needs to see him/her, s/he must also make himself available.

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[2] **'Mental disorder' and 'nature or degree'** have the same meaning as for s3 of the Act

The RC **may** include other conditions (subject to the agreement of the AMHP) as long as any condition is necessary or appropriate for one or more of the following purposes:

1. **ensuring the patient receives medical treatment;** or
2. **preventing the risk of harm** to the patient's health or safety; or
3. **protecting** other people.

The Responsible Clinician can vary or suspend any of the conditions imposed after the order has started, without the agreement of the AMHP. However, changing recently agreed conditions without evidence of a change in circumstances is likely to be seen as poor practice. The RC doesn't need to complete a form when suspending conditions (although clearly it would be sensible to record the reasons), but when varying conditions s/he should use form CTO2.

1.4 The AMHP's role in the process

The AMHP must be satisfied that both the order and any additional conditions not only comply with the legal criteria, but also that the use of the order is **'appropriate'.**

If the AMHP decides that the criteria are not met, or the order is not appropriate, the Code says that a record of their reasons should be kept in the patient's notes.

1.5 Length of CTO order

The CTO lasts for six months from the point it is made, then a second period of six months, followed by recurrent periods of one year (if appropriate). If the order is revoked, the patient returns to the section they were on prior to being discharged onto SCT. In this case, a new period of detention starts from the beginning – i.e. with a six month period – however long the patient has been on SCT.

1.6 Treatment in the community

People on SCT are subject to the treatment rules contained in Part 4A of the Act.

Patients with capacity:
The rules mean that if the person has capacity they must consent to taking treatment or medication while they are in the community. In other words, a person with capacity would need to be recalled to hospital in order to be forced to receive treatment.

Patients without capacity:
Where the patient lacks capacity to consent, they may continue to be given treatment under the direction of an Approved Clinician, as long as force does not need to be used because they object to it. Alternatively, if there is an attorney (LPA) or deputy, or Court of Protection ruling that provides consent to treatment, this can be used to provide authority to treat the patient on SCT.

Situations where a patient without capacity cannot be given treatment in the community:

- (in the case of a patient aged 18 or over) the treatment would be contrary to a valid and applicable advance decision made by the patient;
- (in the case of a patient aged 16 or over) the treatment would be against the decision of someone with the authority under the Mental Capacity Act 2005 (MCA) to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection); or
- (in the case of a patient of any age) force needs to be used in order to administer the treatment and the patient objects to the treatment.

(COP, 23.16)

The SOAD's role

Except in emergencies, after the first month of SCT or three months from when they were first given medication while detained (whichever is the longer), medication cannot be given to a SCT patient unless it is approved by a SOAD. The SOAD will complete a CTO11 form. The form can be used both to detail the treatment the patient may be given in the community and to detail the treatment that the patient would be given if they were recalled to hospital or their order revoked. This enables the patient to be treated swiftly when recalled to hospital, without having to wait for a new Part 4 certificate to be obtained. **Using the form in this way could mean that the 72 hours is more likely to be enough time to ensure the patient receives necessary treatment, and thus avoids having to revoke the order unless absolutely necessary.**

1.7 Compulsory treatment

In most cases, a patient would have to be recalled to hospital prior to being given medication that they did not wish to take (but see below for details).

It is only in an emergency, in a situation where the patient also lacks capacity, that medication can be administered forcibly in the community. In such situations, medication can only be administered to prevent harm to the patient, and any use of force must be proportionate to the risks involved to the patient.

1.8 MCA interface issues

Although capacity (or the lack of it) is not a criterion for the use of SCT, and the MCA cannot be used to give SCT patients medical treatment for mental disorder, it is important to understand that some specific MCA protections do apply to medical treatment for someone on SCT.

Therefore it is important to remember that there may be donees of a LPA, or deputies from the court of protection, involved in some cases. Equally, other decisions or interventions needed in people's lives may be covered by the MCA, depending on the level of capacity someone has at a particular point in their lives.

1.9 Protections

- Anyone who is on SCT will have a right of access to an Independent Mental Health Advocate (IMHAs are expected to be available from April 2009) who will be able to provide advice and support. This right continues throughout the time the person is on the order.
- Those on SCT can apply both to the Tribunal or the hospital managers for discharge of their order.
- The SOAD rules also ensure that all those receiving medication have their medication plan checked and approved shortly after discharge onto the order.
- Where a patient on SCT has capacity, they have the right to make advance decisions or appoint someone to hold LPA powers to make medical treatment decisions on their behalf if in the future they do lack capacity. They can also object to having ECT in the same way that someone with capacity who is detained in hospital can.
- A person who is on SCT must also be discharged from that order as soon as they no longer meet the criteria.
- An AMHP must agree that the use (or extension) of SCT not only meets the criteria, but is also is ‘appropriate’.
- An AMHP must agree with any conditions that the RC wishes to impose in addition to the compulsory conditions that the patient must make themselves available to see the SOAD, and to be seen by the RC to consider extending the order.

1.10 Process for extending an order

The extension of s17A, like Guardianship, **can be considered at any time up to two months** prior to the ending of the order. The conditions for extension require that the RC state that the original criteria are still met. The AMHP must also state in writing (on form CTO7) that they agree the criteria are met and that it is appropriate to extend the period of SCT.

In addition to the AMHP, the RC must also consult one or more people who have been professionally involved with the patient’s care prior to extending the order.

ACTIVITY 10 - APPLYING THE CRITERIA FOR THE USE OF SCT

This scenario and the questions relate to the criteria for the use of SCT. Look at them and consider how Nick might fulfil the conditions for Supervised Community Treatment.

Nick is 32-years-old and has been known to mental health services for 13 years. He dislikes medication and following discharge from section has always reduced the dose he takes to the point where it ceases to have a clinical benefit. At this point, he loses insight and refuses to take any medication at all. When he becomes unwell, Nick becomes paranoid, carries knives for protection and has been known to leave his council flat to live on the street. This is because of his conviction that government agencies are tracking him

with a view to killing him for the 'chip' in his head. He has also 'allowed' drug dealers to use his flat, which has put his tenancy at risk.

Nick has previously been seriously assaulted while living on the streets and once assaulted a police officer when he was detained on s136. He has been admitted under section annually for the last four years. These admissions have been lengthy, as Nick takes a long time to get better. Without the support of the section, he would not cooperate with medication. He is currently subject to s3 of the Act and has been building up periods of home leave. Nick has now increased his leave to two days (including an overnight stay) twice a week. His care is now being reviewed.

1. **Does the section that Nick is on make him eligible for Supervised Community Treatment? If yes, which section(s) would not provide such eligibility?**

2. **Is he suffering from a mental disorder? What is your evidence for this?**

3. **Currently, is it the nature *or* degree of Nick's mental disorder that makes it appropriate for him to receive medical treatment? Which criteria would you choose?**

4. **In what ways is it necessary for his health or safety or the protection of others that he receives such treatment?**

5. **Does Nick need to be in hospital to receive the treatment – or could he be treated at home if he were subject to recall (if this becomes necessary)? If you think he could be discharged subject to recall, explain how you would justify this decision.**

6. **What sort of treatment would need to be available for him?**

2. The Role of the AMHP in the making of the Community Treatment Order – in detail

2.1 Background Information

The AMHP must provide a written supporting statement saying they **agree the criteria are met** and also that is it **appropriate** to make the order. **The AMHP also has to agree that any conditions imposed are necessary or appropriate.**

Necessary or appropriate

As with Guardianship, the requirements that an AMHP must decide whether the use of an order is 'appropriate' and whether the imposition of additional conditions is "necessary or appropriate" means that **they must consider the patient's wider context – their social situation. The AMHP must be convinced that in this patient's particular situation the powers are necessary or appropriate.**

"The AMHP must decide whether to agree with the patient's responsible clinician that the patient meets the criteria for SCT, and (if so) whether SCT is appropriate. Even if the criteria for SCT are met, it does not mean that the patient must be discharged onto SCT. In making that decision, the AMHP should consider the wider social context for the patient. Relevant factors may include any support networks the patient may have, the potential impact on the rest of the patient's family, and employment issues."

(COP, 25.24)

"The AMHP should consider how the patient's social and cultural background may influence the family environment in which they will be living and the support structures potentially available. But no assumptions should be made simply on the basis of the patient's ethnicity or social or cultural background."

(COP, 25.25)

As an AMHP you could be asked to provide an opinion on the use of a Community Treatment Order. You would be asked to state in writing (on form CTO1) that you are satisfied that:

- The criteria are met; and
- It is appropriate that the order be made; and
- Agree that any conditions set meet the requirements of s17B(2) and are "necessary or appropriate".

ACTIVITY 11 – SCT: CONSIDERING SUITABLE CASES

Thinking about one of your own clients (past or present), consider the issues below to determine whether the use of Supervised Community Treatment might be 'appropriate' to their case.

Consider the:

- **Impact of or on the wider social network of the patient's illness.**
- **Impact of or on the patient's close family and friends of the illness.**
- **Issues related to occupation, social support, etc.**
- **Impact of cultural issues.**

Having considered all these factors, do you consider that it would be (or would have been) appropriate to use the option of a Community Treatment Order to support the patient? Explain your answer.

DISCUSSION POINTS

How might these new powers benefit younger people? Are there benefits to be gained from using these powers to support young people to return home earlier, and avoid long periods of separation from family and friends?

3. Recall and Revocation

3.1 Background Information

These are two separate processes.

- ***Recall*** means the patient must come back to a hospital or other place for medical treatment, for up to 72 hours. The Responsible Clinician for a patient can make this decision on their own.
- ***Revocation*** means the patient has to stay in hospital, and their legal status has been changed back to either s3 or the section to which they were subject before they left hospital to go onto Supervised Community Treatment (e.g. s37). The RC must have the agreement of an AMHP before someone's Community Treatment Order can be revoked.

3.2 Recall: the details

The Responsible Clinician on their own can recall someone on SCT to hospital. Hospital in this context can mean a clinic within the hospital grounds. The effect is that the person has to return to hospital, and **becomes liable to detention and treatment for up to 72 hours.** However, medical treatment can only be given as long as the appropriate authority exists (e.g. the patient has been recalled within the first month of the order, or the CTO11 form has been completed so that treatment can begin immediately the patient arrives at the hospital).

The conditions that need to be fulfilled prior to recall are that:

- **the patient needs to receive treatment for mental disorder in hospital; and**
- **there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.**

If the patient does not comply with the compulsory conditions of the order (to be available to consider extending the order or to see a SOAD doctor), they may also be recalled, but the non-compliance of other conditions **on their own** does not justify recall. In such a case, the conditions above would also need to be fulfilled.

Process for recall. The COP (25.57 and 25.58) says that the power to recall will become active once:

> ***Either*** **the patient receives the recall notice in person**
>
> ***Or*** **the notice of recall was delivered (either by hand, to the patient's address or by post) to the last known address of the patient.**

When does the recall order takes effect?

- If the patient is handed the notice for recall, it is effective immediately.
- If the notice is posted through the letter box, it will take effect the following day.
- If the notice is sent by first class post, it will deem to have effect two working days after it was posted.

If the patient does not agree to return to hospital of their own free will, the patient can be treated as 'absent without leave' and police support engaged to find and return him/her to the designated hospital. The use of s135(2) may be appropriate if the patient is unwilling to allow you access to where he or she is living.

The liability to be detained in hospital comes into effect according to the formula set out at the end of the previous page (i.e. depending on how the notice for recall is delivered to the patient). However, the liability to accept treatment does not come into effect until the patient returns to hospital. The 72 hours start from the time he or she returns to the hospital.

When recalled, the patient must return to the hospital stated on the recall notice. (This doesn't have to be the patient's 'responsible' hospital whose managers hold the order.) However, the patient can be treated as an out-patient; he or she doesn't have to be admitted in order to administer the treatment. The exact arrangements will clearly depend on the situation and needs of the individual patient.

When a patient is recalled, it is important to remember you **must** send a copy of the recall notice to the managers of the responsible hospital.

3.3 Revocation: the details

If the RC wishes to detain the person in hospital beyond the 72-hour period, they need the agreement of an AMHP. The AMHP must agree that:

- the conditions for detaining someone under s3 are met; and
- it is appropriate (having regard to all of the circumstances) to revoke the order.

If the order is revoked the person would become subject to s3 again (or whichever section they were on prior to starting on SCT).

'Appropriate' has the same meaning here as when an application is made – i.e. the AMHP must consider the patient's situation 'in the round', see the patient and view the revocation of the order in the social context of the patient. It is only after considering all the aspects of the case that revocation should be agreed.

If the RC does not ask to revoke the order, or if the AMHP does not agree the order should be revoked, the patient will be free to return to the community (at the latest, after 72 hours). It is the hospital managers' responsibility to make sure this happens.

ACTIVITY 12 - RECALL AND REVOCATION

In this exercise, the scenario in Activity 10 (Nick) continues. You need to consider how to interpret the word 'appropriate' in the context of a request to revoke a Community Treatment Order.

Nick was placed on SCT and returned to live in his own flat. It was decided the most appropriate person to be his Responsible Clinician would be a CPN from the team, who is also an Approved Clinician. Conditions were imposed, in addition to the compulsory conditions, that he had to allow his Responsible Clinician (a nurse) or Social Worker (an AMHP) to visit him every week. He also had to allow a support worker to visit twice a week to help him with domestic duties such as shopping, cooking and housework.

The order worked well for 18 months. Nick saw his workers regularly, took medication (a depot injection), and started to re-engage with his family. He commenced a work placement at a local horticultural nursery.

A month ago, the support worker reported that strangers had been in the flat when she went for her usual visit. As previously agreed in the care plan, Nick was reminded to ask them to leave so that he and the support worker could continue with the support plan. The group of three (two men and one woman) left but appeared resentful, making comments to Nick about him "letting some girl push him around".

The support worker reported her concerns to Nick's key worker including the points that there had been a strong smell of cannabis in the flat, that Nick appeared "stressed out" during the visit and didn't engage as much as he would normally have done.

Over the next couple of weeks, the friends were not there when the regular visits took place, but it was evident that they were still around. The support worker was concerned they may be staying with Nick, possibly with two of the three taking over Nick's bedroom. Nick insisted that he was OK with this as they were his friends. He continued to take his depot but concerns were expressed that he was less well than previously, his voices had started to bother him, and he was more withdrawn.

Last week Nick would not let his support worker in, saying he was "too busy". She could hear the friends giggling in the background and felt he looked more unkempt than usual. He did not answer the door when his CPN/RC visited and, having refused admission this week as well, had now missed two depot injections.

Nick's CPN/RC became very anxious after the second refusal and decided to recall him to hospital. The notice of recall was delivered to his address by hand, and he became 'liable to be detained' the following day. Nick refused to open the door or talk to the team members so, given this refusal, a s135 (2) warrant was obtained (as he was now "liable to be detained"). Access to his house was gained with police support and Nick was removed to hospital. The locks were changed. On admission to hospital, Nick was given medication. The following day Nick's CPN/RC interviewed him and decided he wanted to revoke the CTO to allow time for Nick's flat to be cleared and his friends discouraged from visiting.

As the AMHP in this case, it is your job to decide whether or not you agree with this judgement, or whether Nick should be allowed to go back home. Please answer the question below.

1. The CPN/RC says you must revoke SCT because Nick has not complied with the conditions of his order (that he allow certain professionals to visit). Is this correct? Explain your answer.

2. What are the grounds on which you should base your decision?

3. What other information would you like in order to make your decision?

4. Which of the Guiding Principles might inform your decision-making?

Additional information on Nick is now available.

When you make contact with Nick's family, they tell you they haven't seen him for about a month, except for one short visit by his father to Nick's flat the previous week. Nick's father confirms that two of the three friends (the two men) appear to be a couple and are sharing the bedroom, leaving Nick to sleep on the sofa or the floor depending on whether the woman stays or not. They are also concerned that Nick appears not to have as much money as usual, but are surprised by his recall as he isn't "that unwell" at the moment. His parents are upset by this setback as he has been doing so well for such a long time.

Nick's parents suggest that he should come back and live with them for a while. However, in the past this option has proved stressful for Nick. Nick's brother is also willing for him to stay, but he lives across town. It is unlikely he would be able to get to his work placement at the nursery on his own because of lack of a direct bus route.

When you contact the housing department, they are not currently too concerned. Nick is in credit with his rent, but they have had one complaint from a neighbour about loud music. As long as this is a one-off, they do not intend to take any further action.

Given the above information, do you think it is appropriate to revoke the order as requested? Why have you come to this conclusion?

DISCUSSION POINTS

One of the concerns about the use of SCT is people remaining on the orders for many years. How might you make judgements about whether or not to continue with an order? How might the Guiding Principles be of use?

Appendix 1. Amendments to the Mental Health Act 1983

The main changes to the Mental Health Act 1983 are set out in the following table

Section	Commencement date	Effect
Section 1	Nov 2008	The four separate categories of mental disorder used in sections concerning treatment have been abolished and replaced by one broader definition. Only dependence on alcohol or drugs has been explicitly excluded as a category of mental disorder. It is made very clear in the Code that sexual orientation and immoral conduct should not be considered a mental disorder.
Section 1 (2A)	Nov 2008	For the purposes of section 3 and similar sections, Learning Disability will continue to only be classed as a mental disorder where it is also associated with **abnormally aggressive or seriously irresponsible conduct**. However, under the Mental Capacity Act Deprivation of Liberty Arrangements this extra condition **does not apply**.
Section s3,7,36, 37,38	Nov 2008	The four separate categories of mental disorder used in sections concerning treatment have been abolished and replaced by one simplified definition. In addition, "appropriate treatment must be available" to the patient, and the treatability test has been abolished.
Section 7	Nov 2008	Under s18, people subject to Guardianship can now be conveyed to the place they are required to reside.
Sections 12 & 12A	Nov 2008	New rules around what constitutes a "conflict of interest" have been developed, and they now apply to all professionals involved in the decision-making process, not just to doctors.
Section 13	Nov 2008	Section 13 (the duty of an AMHP to make applications for admission or guardianship) has been largely redrafted. The duty remains on the Local Social Service Authority (LSSA) to arrange for an assessment to take place, and the AMHP now assesses "on behalf of" the LSSA. A requirement has been added that, where an initial assessment results in an admission under section 2 outside the area of the LSSA, that original Local Authority maintains responsibility for subsequent assessments under section 3. The independence of the AMHP under s13 (5) is maintained.
Section 17 and 17A-G	Nov 2008	Section 17A (Community Treatment Orders give effect to Supervised Community Treatment – SCT) have been introduced, and supervised discharge (s25A) abolished. Under s17, the Responsible Clinician (RC) is required to consider a CTO where the leave of absence cumulatively will amount to more than seven days. A CTO requires the agreement of a RC and an AMHP, as do any conditions that are attached. Any conditions must be related to the treatment of the person's mental disorder, or needed for reasons of health or safety. SCT includes the power to recall to hospital, but (except in an emergency, where the patient lacks capacity), treatment can only be given forcibly once the patient is recalled to hospital.
Section 18 (7)	Nov 2008	Power to convey people to the 'hospital or place' they are required to reside has been inserted. This amendment provides a power to convey people under Guardianship to the place where they are required to live.
Section 20 Section 20A	Nov 2008	A renewal of a section 3 Order now needs the written agreement of a second professional in addition to the Responsible Clinician and with a different professional background from the RC. This second professional must have been involved in the person's care (e.g. a care coordinator or an AC). An AMHP must also be involved in extending the order. The AMHP must agree in writing that the criteria for SCT are still met, and that it continues to be appropriate to have the patient on SCT.

Section	Commencement Date	Effect
Section 26	1st Dec, 2007	Civil partners have been added to the list of nearest relatives, as having equivalent status to a husband or wife.
Section 29	Nov 2008	Patients can now apply to the county court to replace their own nearest relative. The duration of orders has been clarified, and an additional ground for displacement, that the nearest relative is "otherwise not suitable" has been added.
Pt 3 of the Act		Remains largely unchanged
Pt 4 of the Act	Nov 2008	Greater protections for people being considered for ECT have been introduced – including that it is now possible for a valid decisions made under the Mental Capacity Act to be used to prevent the use of ECT – even where someone is subject to compulsion under the Act.
Pt 5 of the Act		Faster access to automatic Tribunals in situations where the person does not request a review themselves
Pt 6 of the Act	Nov 2007	Clarifies how patients can be moved within the jurisdiction of the United Kingdom
Pt 7 of the Act	Nov 2007	Introduces the Approved Mental Health Professional Role. This provides a power (but not a duty) for LSSAs to train and employ registered nurses, OTs and chartered psychologists to take on the AMHP role. Training remains regulated by the GSCC, and employers' guidelines emphasise the importance of the LSSA in the process.
S118	Nov 2008	The Code of Practice must now include principles covering areas set down in section 118, and clarifies the duty on all professionals involved with clients to comply with its guidance, unless they have a good reason not to.
S130A	Nov 2009	Introduces the Independent Mental Health Advocate role.
S131	Jan 2008 (but child appropriate accommodation commences from 2010)	Makes it clear than anyone between the ages of 16 and 18 can consent to being admitted to hospital, but if they object, parental authority cannot be used to detain them against their will. S131A provides an obligation on managers of hospitals to ensure the environment of anyone under 18 who is detained under the Act is suitable given their age (subject to their needs).
S135 and s136	April 2008	Both now allow for the movement of people between places of safety, within the 72-hour period.
S140	Nov 2008	PCTs have a duty to provide LSSAs with information as to where people should be taken in situations of "special urgency" and for the provision of specialist accommodation for under 18-year-olds.

Section	Effect
MCA schedule A1 Currently planned to commence April 2009	This amendment to the Mental Capacity Act makes it lawful, in certain circumstances, to deprive someone of their liberty in a hospital or residential care home. This may happen where the patient lacks capacity to make such decisions regarding his or her care, does not object to the care being provided, and that care (being given in his or her best interest) amounts to a deprivation of his or her liberty.
	Other amendments are inserted throughout the Act to support the Deprivation of Liberty processes.

Appendix 2. A Summary of the Mental Capacity Act 2005

The Mental Capacity Act 2005 for England and Wales received Royal Assent on 7th April, 2005 and came fully into force on 1st October, 2007.
The Act generally only affects people aged 16 or over and provides a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries who may lack capacity to make certain decisions.

Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to an accident or being under anaesthetic or their ability to make a decision may be affected by the influence of alcohol or drugs.
It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lack capacity. The Act covers major decisions about someone's property and affairs, healthcare treatment and where the person lives as well as everyday decisions about personal care (such as what someone eats), where the person lacks capacity to make the decisions themselves.

Five key principles

The whole Act is underpinned by a set of five key principles set out in Section 1:

- *A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;*
- *Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;*
- *Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision;*
- *Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests; and*
- *Less restrictive option – anything done for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms if they are as effective as the proposed option.*

What does the Act do?
The Act enshrines in statute current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It replaces current statutory schemes for Enduring Powers of Attorney and Court of Protection receivers with reformed and updated schemes.

The Act deals with the assessment of a person's capacity and acts by carers of those who lack capacity:

- **Assessing lack of capacity** – The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" and "time-specific" test. No-one can be labelled "incapable" simply as a result of a particular medical condition or diagnosis. Section 2 of the Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour that might lead others to make unjustified assumptions about capacity.

- **Best Interests** – An act done or decision made for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a non-exhaustive checklist of factors that decision makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. In addition, people involved in caring for the person lacking capacity have to be consulted concerning a person's best interests.

- **Acts in connection with care or treatment** – Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity**.** This could cover actions that might otherwise attract criminal prosecution or civil liability, e.g. if someone has to interfere with the person's body or property in the course of providing care or treatment.

- **Restraint** – Section 6 of the Act sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. This section does not extend to deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights. The Government has introduced additional safeguards for people who lack capacity and are deprived of their liberty but do not receive mental health legislation safeguards, as a result of the European Court of Human Rights judgement in HL v United Kingdom (the "Bournewood" case). The Government has introduced these safeguards by amending the Mental Capacity Act via the Mental Health Act 2007 which gained Royal Assent in July 2007, and it is planned to introduce them during 2008.

The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

- **Lasting Powers of Attorney (LPAs)** – The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the current Enduring Power of Attorney (EPA) in relation to property and affairs, but the Act also

allows people to empower an attorney make health and welfare decisions. Before it can be used a LPA must be registered with the Office of the Public Guardian (see below). EPAs created before October 2007 can be registered after the implementation date but it will not be possible to create EPAs after this time.

- **Court appointed deputies** – The Act provides for a system of court appointed deputies to replace the current system of receivership in the existing Court of Protection. Deputies will be able to be appointed to take decisions on welfare, healthcare and financial matters as authorised by the new Court of Protection (see below) but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues. People appointed as receivers before October 2007 will retain their powers concerning property and affairs after 1st October, 2007 and are now treated as deputies.

The Act creates a new public body and a new official to support the statutory framework, both of which will be designed around the needs of those who lack capacity:

- **A new Court of Protection** – The new Court will have jurisdiction relating to the whole Act. It will have its own procedures and nominated judges. It will be able to make declarations, decisions and orders affecting people who lack capacity and make decisions for (or appoint deputies to make decisions on behalf of) people lacking capacity. It will deal with decisions concerning both property and affairs, as well as health and welfare decisions. It will be particularly important in resolving complex or disputed cases involving, for example, whether someone lacks capacity or what is in their best interests. The Court will be based in venues in a small number of locations across England and Wales and will be supported by a central administration in London. The Senior Judge of the Court is the current Master Lush. The new Court was launched on 1st October, 2007.

- **A new Public Guardian** – The Public Guardian has several duties under the Act and will be supported in carrying these out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his functions. The Public Guardian will be required to produce an Annual Report about the discharge of his functions. Richard Brook is the new Public Guardian and Chief Executive of the Office of the Public Guardian (OPG). The OPG is based in Archway, North London.

The Act also includes three further key provisions to protect vulnerable people:

- **Independent Mental Capacity Advocate (IMCA)** – An IMCA is someone instructed to support a person who lacks capacity but has no one to speak for him or her, such as family or friends. They have to be involved where decisions are being made about serious medical treatment or a change in the person’s accommodation where it is provided, or arranged, by the National Health Service or a local authority, and may be involved in abuse cases. The IMCA makes representations about the person’s wishes, feelings, beliefs and values, at the same time as bringing to the attention of the

decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. The IMCA service has been available since 1st April, 2007 in England and in Wales since 1st October, 2007.

- **Advance decisions to refuse treatment** – The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk" which must also be in writing, signed and witnessed. You are now able to make advance decisions and some advance decisions to refuse life sustaining treatment, made before 1st October, 2007, are protected by transitional provisions agreed by Parliament.

- **A criminal offence** – The Act introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years. The new criminal offence has been effective from 1st April, 2007 in England and in Wales.

The Act also sets out clear parameters for research:

- Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights.

- Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.

Code of Practice

- There is a statutory Code of Practice to accompany the Act. The Code will provide guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do these things themselves. Those who will have a duty of care to a person lacking capacity, such as attorneys, deputies, IMCAs, professionals and paid carers must have regard to the Code. The Code of Practice was issued by the Lord Chancellor on 23rd April, 2007.

Contact details:

If you would like any further information on the Act please contact us at

email: customerservices@publicguardian.gsi.gov.uk

Telephone: 0845 330 2900

Website: including downloadable forms and information

http://www.publicguardian.gov.uk

Website: including downloadable training materials

http://dh.gov.uk/mentalcapacityact

Appendix 3. Copies of Forms

Form A2 *Regulation 4(1)(a)(ii)*

Mental Health Act 1983 section 2 — application by an Approved Mental Health Professional for admission for assessment

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for assessment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [PRINT name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different]

Complete the following if you know who the nearest relative is.

Complete (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief [PRINT full name and address] is the patient's nearest relative within the meaning of the Act.

(b) I understand that [PRINT full name and address] has been authorised by a county court/the patient's nearest relative* to exercise the functions under the Act of the patient's nearest relative.
*<*Delete the phrase which does not apply>*

I have/have not yet* informed that person that this application is to be made and of the nearest relative's power to order the discharge of the patient. *<*Delete the phrase which does not apply>*

Complete the following if you do not know who the nearest relative is.

Delete (a) or (b).

(a) I have been unable to ascertain who is the patient's nearest relative within the meaning of the Act.

(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

The remainder of the form must be completed in all cases.

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed…..…………………………………….
Date ……………………………………….…………

Form A3 *Regulation 4(1)(b)(i)*

Mental Health Act 1983 section 2 — joint medical recommendation for admission for assessment

We, registered medical practitioners, recommend that [PRINT full name and address of patient] be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I [PRINT full name and address of first practitioner] last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

*<*Delete if not applicable>*

I [PRINT full name and address of second practitioner] last examined this patient on [date].

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

*<*Delete if not applicable>*

In our opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

(b) ought to be so detained
- (i) in the interests of the patient's own health
- (ii) in the interests of the patient's own safety
- (iii) with a view to the protection of other persons.

<Delete the indents not applicable>

Our reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.]

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed………………………………………………
Date…………………………………………………
Signed………………………………………………
Date…………………………………………………

NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.

Form A4 *Regulation 4(1)(b)(ii)*

Mental Health Act 1983 section 2 — medical recommendation for admission for assessment

I [PRINT full name and address of medical practitioner], a registered medical practitioner, recommend that [PRINT full name and address of patient] be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date].

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
*<*Delete if not applicable>*

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

(b) ought to be so detained
- (i) in the interests of the patient's own health
- (ii) in the interests of the patient's own safety
- (iii) with a view to the protection of other persons.

<Delete the indents not applicable>

My reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.]
…………………………………………………………………………………………………….
…………………………………………………………………………………………………….
…………………………………………………………………………………………………….

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed…………………………………………
Date……………………………………………

Form A6 *Regulation 4(1)(c)(ii)*

Mental Health Act 1983 section 3 — application by an Approved Mental Health Professional for admission for treatment

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for treatment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority [name of local social services authority that approved you, if different]

Complete the following where consultation with the nearest relative has taken place. Complete (a) or (b) and delete the other.

(a) I have consulted [PRINT full name and address] who to the best of my knowledge and belief is the patient's nearest relative within the meaning of the Act.

(b) I have consulted [PRINT full name and address] who I understand has been authorised by a county court/the patient's nearest relative* to exercise the functions under the Act of the patient's nearest relative.
*<*Delete the phrase which does not apply>*

That person has not notified me or the local social services authority on whose behalf I am acting that he or she objects to this application being made.

Complete the following where the nearest relative has not been consulted. Delete whichever two of (a), (b) and (c) do not apply.

(a) I have been unable to ascertain who is this patient's nearest relative within the meaning of the Act.

(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

(c) I understand that [PRINT full name and address] is
(i) this patient's nearest relative within the meaning of the Act,
(ii) authorised to exercise the functions of this patient's nearest relative under the Act,*<Delete either (i) or (ii)>*
but in my opinion it is not reasonably practicable/would involve unreasonable delay *<delete as appropriate>* to consult that person before making this application, because:
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

The remainder of this form must be completed in all cases.

I saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed…………………………………………
Date……………………………………………

Form A7 *Regulation 4(1)(d)(i)*

Mental Health Act 1983 section 3 — joint medical recommendation for admission for treatment

We, registered medical practitioners, recommend that [PRINT full name and address of patient] be admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I [PRINT full name and address of first practitioner] last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
*<*Delete if not applicable>*

I [PRINT name and address of second practitioner]

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
*<*Delete if not applicable>*

In our opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
   (i) for the patient's own health
   (ii) for the patient's own safety
   (iii) for the protection of other persons
   <delete the indents not applicable>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained under section 3 of the Act,

because — [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]
…………………………………………………………………………………………………..

We are also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):-

[Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.]
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..

Signed……………………………………………
Date………………………………………………

Signed……………………………………………
Date………………………………………………

NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.

Form A8 *Regulation 4(1)(d)(ii)*

Mental Health Act 1983 section 3 — medical recommendation for admission for treatment

I [PRINT full name and address of practitioner], a registered medical practitioner, recommend that [PRINT full name and address of patient] be admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
*<*Delete if not applicable>*

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
- (i) for the patient's own health
- (ii) for the patient's own safety
- (iii) for the protection of other persons

<delete the indents not applicable>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained under section 3 of the Act,

because — [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):—
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
[Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.]

Signed………………………………………………
Date…………………………………………………

I would like to thank the many people who have helped in the production of these training materials, in particular:

The ASW leads, Managers and front line staff who took part in the field trials and made comments on the drafts, especially from Essex, West Sussex and the ASWIG area.

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And finally my family for putting up with my absences!

Claire Barcham
AMHP Leads Network / CSIP/NIMHE Implementation Team

Learning Log –
The Mental Health Act 1983 (as amended by the Mental Health Act 2007)

Name:………………………………………………….

Organisation:……………………………………….

Date:…………………………………………………..

Use the boxes below to describe the 5 most important learning points for you, and how these points will affect the way in which you work.

What you have learnt	How this will influence the way in which you work

Below, describe anything you will need to learn months about in the next 6 months.

Use this form as evidence for your continued professional development file