

# PREPARING FOR CHANGE:

## UNDERSTANDING HOW THE AMENDMENTS TO THE MENTAL HEALTH ACT 1983 WILL AFFECT ASW PRACTICE

### Tutor Notes:

#### Introduction

CSIP has commissioned a specialist module for ASWs to help them to understand the changes the Mental Health Act 2007 will bring to the Mental Health Act 1983.

These materials address all the changes **except** those related to the Deprivation of Liberty (DoL) procedures. Specialist training will be available prior to the implementation of these DoL procedures (due in April 2009).

The ASW training materials include the following material:

- A workbook, with examples and background notes, that can be worked through either individually or as a group;
- These tutor notes;
- A PowerPoint presentation on the Act, with integrated links to activities within the workbook;
- An on-line version of the workbook;
- An on-line legal test that allows training managers to track performance.

A Resource Guide for AMHPs, which provides more detail on the changes the Mental Health Act 2007 will bring to Mental Health law and practice, as well as other aspects of AMHP law and practice, will be available free from September 2008. Some examples from that Guide have been used to provide background knowledge in the workbook.

#### How to use these materials

The materials are designed to be flexible, and can be adapted to meet the local needs of ASWs, for instance, by using local examples or additional activities.

The materials form a framework for one day's training, but some trainers may choose to use the book over two days. In field trials, people found the learning could most usefully be split into thirds: the initial two thirds cover all the general amendments to the Act whereas the final third focuses on Supervised Community Treatment.

The first activity for the afternoon session is around the nearest relative. This is designed both to introduce a new concept **and** to engage people and raise their spirits by reminding them of a familiar subject where they already know a lot! Additionally, it helps to introduce some 'energy' into the afternoon session.

## How issues were selected

When considering the changes, this workset focuses on those issues ASWs are likely to find most challenging, and require the use of professional judgement (such as the appropriate medical treatment test); but only mentions in passing issues that are more straightforward. When extending the material over two days, the suggestion is to cover some of the issues only mentioned in passing in more detail at the beginning of Day One.

After the field testing, a lot of background information was added to the workbook (most of which is also in these notes) to support people's learning, and act as a useful guide for future reference.

## Values and Principles Section:

During the field trials, participants' responses to this section appeared to depend largely on whether or not re-approval processes required people to consider such issues in depth. Where this was not the case, participants enjoyed and appreciated the activities provided. Tutors should therefore consider how to use these exercises as preparation for the course or a part of the day – and how much time to spend on each of them. For example, you could ask people to look at the section as a whole beforehand and focus on particular issues (such as the impact of Social Work values on the interpretation of the phrase "interview in a suitable manner") as a start to the day.

However, it is essential that ASWs are encouraged to consider the relationship between values and principles, and make the link between individual or professional values and the principles of the MCA and MHA as **legal guidance to support decision-making**.

## A day's training plan

Time	Activity
9.30	Introduction and values. <b>Activity 1</b>
9.50	Feedback: Values and Principles (links to professional decision-making and practice)
10.00	PowerPoint presentation: The Legal Status of the AMHP role
10.10	Legal Status of the AMHP. <b>Activity 2</b>
10.20	PowerPoint presentation: Transitional Information and Overview of the Changes
10.40	True or False? <b>Activity 3</b>
10.50	PowerPoint presentation: New Roles
11.00	Break
11.15	PowerPoint presentation: The MHA Code & Principles
11.25	The effect of the MHA principles on MHA assessment process. <b>Activity 4</b>
11.45	PowerPoint presentation: The MCA and MHA interface
11.55	ECT and MCA. <b>Activity 5</b>
12.10	PowerPoint presentation: The Simplified Criteria & the Appropriate Treatment Test
12.20	Applying the appropriate treatment test in practice. <b>Activity 6</b>
12.40	PowerPoint presentation: Involving appropriate people – conflict of interest regulations
12.50	Considering potential conflicts of interest. <b>Activity 7</b>
1.10	PowerPoint presentation: Making decisions & appropriate services for young people
<b>Lunch Break – 1.30-2.30</b>	
2.30	<b>Activity 8</b> – who is the nearest relative? Displacement and Nearest Relative Issues
2.50	PowerPoint Presentation: Displacement and Nearest Relative issues. <b>Activity 9</b>
3.15	PowerPoint Presentation: Supervised Community Treatment
3.30	<b>Activity 10</b> – Applying the criteria for Supervised Community Treatment
3.45	PowerPoint Presentation: role of the AMHP in the SCT application process
4.00	<b>Activity 11</b> – Considering suitable cases
4.15	Powerpoint Presentation: Supervised Community Treatment – recall and revocation
4.30	<b>Activity 12</b> – Recall and revocation

# FOUNDATIONS FOR ETHICAL AND LEGAL PRACTICE

## 1. Values-based practice

**Activity 1 – these questions relate to Values-based practice, and encourage workers to think about the influence of values on their working lives.**

These activities can either be provided in advance or used as an introduction to the day's work. Tutors should consider whether ASWs locally are used to considering such issues, in which case you may choose to focus on one or two of the later questions rather than the more general queries. (this also helps cover in case you have any latecomers!)

The difference between values and principles could be summarised as follows:

- **Values** are beliefs and feelings that influence the manner in which we interact with the world we live in, both personally and professionally. They may be individual but there is often a shared 'thread' or 'concept' of what we judge to be good practice. For example, Social Work values represent a shared agreement on issues that should be of concern to us in our professional lives. Such issues may at times conflict with one another and have to be balanced in decision-making.
- **Principles** provide a framework for decision-making in practice, represent the manner in which those values have been taken (in this case by parliament), debated and used to provide guidelines around the issues we must consider when making decisions in individual cases.

Choosing to focus on the question of how Social Work Values have influenced the interpretation of the words "interview in an appropriate manner" is useful on two counts: first by understanding that our individual values as social workers do, in fact, have a common basis; and second by seeing that such values have now been enshrined in the law, through the **Principles of the Code**. Such a focus therefore has two purposes:

- to raise people's professional confidence (arguably Social Work has been instrumental in defining what are now core principles for all professionals);
- to form a link to the later activity on the Code, its legal status and the use of the principles to influence decision-making.

**In the future, the Guiding Principles may very well develop a greater importance as court cases are likely to focus on how professionals have used the Principles when reaching individual decisions under the Act. It is therefore essential ASWs do appreciate their importance and feel confident in using them to inform decision-making.**

## 2 . Legal Frameworks

### Activity 2 – Legal Frameworks:

Only one slide is dedicated to this topic. To complete this activity, people will need to read the notes in the Resource Workbook.

A ‘Public Authority’ is a legal entity: it describes a person or service that exercises powers beyond those that would usually be available to members of the public.

AMHPs are ‘public authorities’. This means they have particular duties under Human Rights and Equality legislation to act within the law, and provide services or intervene in ways which comply with the relevant Act. The advice of the Code of Practice has been designed to be Human Rights and Equality compliant and therefore, when departing from the Code, it is important still to consider the applicability of the Human Rights Act and Equality Act. Using the Code’s principles to influence individual decision-making will help workers ensure that their decision-making continues to comply with these legal requirements.

**The workbook has more background information on these roles that ASWs can look at prior to completing activity 2.**

## 3. Information, Regulations, Similarities and Changes

If seeking to use these materials over two days, this is one of the sections you may wish to expand.

The purpose of this section is twofold: first to cover a number of the smaller changes quickly; and second to emphasise that, in fact, not a lot is changing in the **way** in which ASWs carry out their duty. These notes have been replicated in the workbook for ASWs to keep and read for themselves.

**“The Bill makes it clear that an AMHP carries out their functions on behalf of the LSSA. This underlines the independence of the AMHP from the Trust that may employ the doctors who also examine a patient’s case for admission. It also ensures that the responsibility for providing that an AMHP service is in place still clearly lies with the Local Social Services Authority.”**

**Baroness Royall of Blaisdon – for the Government**  
(Hansard, 17th January, 2007)

The slides in this section start with this useful quote (above) from the parliamentary process, plus a quote from the Code, to answer and illustrate a number of significant factors that have caused anxiety to many ASWs. Because it was said in Parliament and by the Government (and supported by all parties), it helpfully makes clear what the Government (and Parliament’s) intentions were when undertaking these changes. Additionally, in any future legal disputes (for example, over who is responsible for ensuring there are enough AMHPs in any given area), this quote could be used to illustrate the LSSA’s continuing responsibility for this function.

## **Use the information below to expand on the text within the slides:**

### **Information, 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 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.

### **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 on a 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 of 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 its 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.
- 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 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.

### **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:
  - o 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).
  - o 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.
  - o Age appropriate accommodation requirements are expected to come into effect in 2010.
  - o 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.
  - o 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.

- o 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.
- o 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.
- o Earlier automatic referrals to the Tribunal (reducing as resources allow from three years to one year).
- o It will now be possible to convey under Guardianship to the place where the Guardian wishes the person to reside, and
- o Since 30th April, 2008, it has been possible to transfer between places of safety.
- o Competent 16- and 17-year-olds can no longer be admitted to hospital against their wishes on the authority of their parents.
- o Civil partners are now included in the list of nearest relatives, and have equal status with husbands and wives.
- o Patients may now apply to the County Court to displace their own nearest relative.

### Activity 3: Information, Regulations and Responsibilities

Ask the group to consider the questions on page 15 of the workbook. The answers are as follows:

1	AMHPs need no longer be directly employed by the Local Social Service Authority	True: ASWs no longer need to be employed by the LSSA on whose behalf they are acting. However, current good practice would indicate that where the AMHP isn't a direct employee, a contract (such as an honorary contract) would be advisable to detail the expectations and protections available on both sides. This view is supported by ADASS.
2	If you start to work as an AMHP for another authority, you must inform the Local Social Service Authority that approves your practice	True: but the LSSA also has a duty to let that authority know as well
3	You must pass a legal test before you can work as an AMHP	False: whether or not you need to undertake a legal test is up to your approving authority.
4	You must undertake nine hours' worth of AMHP refresher training each year in order to maintain your approval	False: you need to undertake 18 hours of refresher training per year.
5	The Act continues to exclude alcohol or drug misuse, sexual deviance, promiscuity or other immoral conduct as forms of mental disorder	False: the Act only excludes alcohol or drug dependence.
6	New regulations around conflicts of interest (s12) only apply to doctors	False: conflict of interest rules apply to all professionals included in mental health assessments.
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'.	True: but they could also apply on any of the other grounds that already exist, as well as these new grounds.
8	There are no significant changes to the legal conditions for admission under section 2 of the Mental Health Act 1983	True: with the exception of the changes to exclusion under the Act.
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.	True: since the 1 <sup>st</sup> January, 2008.
10	It is now possible to transfer legally between places of safety under s135 and s136	True: since 30 <sup>th</sup> April, 2008.
11	It is now possible to convey a patient to the place they are required to live when they are subject to guardianship.	True: from the 3rd November it will be possible to convey a person subject to Guardianship to the place you want them to live. It is also possible to take them back to that place if they leave without permission.

# NEW PROFESSIONAL ROLES

## New Professional Roles

The workbook contains more information on the different roles, including lists of responsibilities for LSSAs and AMHPs, but the main focus in this instance is how these new roles will impact on the Mental Health Assessment process.

There are three key issues to ensure that people understand:

- **The difference between an Approved Clinician (AC) and a Responsible Clinician (RC)**

The 'Approved Clinician' is best described as a qualification or status, whereas the 'Responsible Clinician' is the role taken on when an AC accepts legal responsibility for a patient detained or subject to compulsion under the Act.

The RC is a role particularly related to someone subject to compulsion under the Act (in the same way that the RMO is in fact a title conferred by the current Act).

- **The fact that only a doctor (whether or not they are also an AC or have a s12 qualification) can make a recommendation for admission to hospital under s2, 3, 4, or 7 (or the equivalent forensic sections in Part 3 of the Act). A non-medical AC can only take responsibility after someone has been detained or made subject to compulsion.**
- **While the RC is in overall charge of the case, there may be another AC in charge of a particular aspect of treatment. This could be true even if the RC is a doctor.**

Once subject to compulsion, the idea is that the most appropriate AC for a particular case should be chosen. The AC might well change during the patient's 'pathway through compulsion' as their needs change (subject to the availability of different resources).

The Responsible Clinician has the following powers and responsibilities:

- To be responsible for the patient's overall case while subject to compulsion (including bringing in other professionals where appropriate);
- To discharge a patient from compulsion as soon as that person no longer meets the criteria of the Act;
- To renew, with the agreement of a second professional, the authority to detain a patient at the end of s3;
- To put patients on SCT where appropriate;
- To recall a SCT patient to hospital where appropriate ;
- To revoke SCT (if agreed by an AMHP) where appropriate;
- To write Tribunal and managers' hearing reports when requested to do so.

**So an AMHP and a non-medical RC can only make decisions together (for example, regarding the use of SCT) AFTER someone has already been detained by an AMHP and two doctors, one of whom must be s12 approved.**

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

## 1. Applying the Guiding Principle of the Code of Practice, and understanding its legal status

The slides provide a background to the principles of the Code, and how they should be used to inform our practice. The workbook provides more detail, and follows with the Activity. The important thing to emphasise is first the legal status of the Code; and, second, how to use the principles to make decisions.

**Activity 4: applying the principles of the Code in practice.** This exercise encourages people to think about how the principles might be applied during a Mental Health Act assessment and how they might improve practice. Direct people to chapter 10 of the Code (pp. 85 & 86) (or provide a copy of the 'applying principles' scenario) to help people undertake the exercise.

## 2. The Influence of the Mental Capacity Act on Mental Health Act Assessment

**The main thing to emphasise is that, before deciding to use the MHA, the MCA is an alternative that needs to be considered.**

In addition, it is important to emphasise that the MCA protections apply as much to people receiving care or treatment for a mental disorder as other people. However:

- The MCA is 'trumped' by the MHA when the decision relates to assessment or treatment for a mental disorder.
- The MHA can be used to overturn advance decisions or decisions of people with a LPA **except** that for ECT, special protections apply.
- Some MCA protections for mental disorder do apply to people on SCT.

### LPAs and Advance Decisions

Lasting Powers of Attorney and Advance Decisions: if they are valid (i.e. were signed while the person concerned had capacity) and are applicable to the particular situation, both need to be considered when setting up assessments. This is because someone with an appropriate LPA can agree to or refuse particular forms of treatment or care. Also, an approved worker should consider whether this provides a good enough alternative to the use of compulsion.

The MHA can be used to overturn a LPA or advance decision where these advanced decisions relate to assessment or treatment of a mental disorder. However, it is important to remember:

- LPAs and Advance Decisions related to other forms of medical treatment or care will remain valid;
- The LPA or Advance Decision will come back into effect once the use of the MHA stops, unless the person concerned regains capacity and agrees to overturn the previous authority; and

- Someone with a LPA may also be a nearest relative, and as such be able to object to admission under s3 or ask for the patients discharge.
- There are special rules that apply to people on SCT, that allow people with capacity to make LPAs or Advance decisions that must be respected unless the patient is recalled to hospital.

## **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 placed on section 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 works (ECT)**

Situation	Action
Except in emergencies	<p>detained (and SCT) patients who have capacity can now refuse ECT;</p> <p>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;</p> <p>no under 18 (whether detained or informal) can now be given ECT without the approval of a SOAD.</p>
Certificate-wise, the position is that (again, accept in emergencies):	<p>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.</p> <p>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.</p> <p>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).</p> <p>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).</p>
In practice, all this is achieved by means of four certificates:	<p>T4 for 18+ detained patients who consent – can be completed by SOAD or clinician in charge of the treatment)</p> <p>T5 for under 18s who consent (whether or not detained) – SOAD</p> <p>T6 for patients who can't consent (used for detained patients and informal under 18s) – SOAD</p> <p>CTO11 for SCT patients who have not been recalled to hospital – SOAD (and not just for ECT)</p>

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.

You will notice that special rules apply to children and young people who need ECT – in particular where the young person is also on SCT. It is probably best not to focus too much attention on what is likely to be a rare event but instead make people aware and then suggest if this does occur in practice they will need to refer to the Code or Reference Guide.

### **Activity 5: case study looking at capacity issues in Mental Health Act assessments**

Memet can use the advance decision to refuse ECT. The order appears to be valid (his brother, as a lawyer, would be aware of issues of competence and capacity), and is applicable to this situation.

His nearest relative, his mother, cannot overrule this because even though she is the person consulted under the Act (and can refuse consent for s3), the Act itself cannot be used to overrule this decision, except in an emergency. From the information provided, it is unclear that the situation could be classed as an emergency at this point.

If there was evidence that Memet had changed his mind, and his brother was willing to agree, ECT could be given.

However, the AMHP should consider whether there are alternative forms of treatment that Memet has not refused in advance. And if there are alternatives, then s/he should consider whether Memet could be treated under the Mental Capacity Act, and staff protected by s5. This would need the agreement of Memet's brother (as he has a LPA).

# MAKING DECISIONS

## 1. The Simplified criteria for mental disorder and the ‘Appropriate Medical Treatment Test.’

This test, together with the simplified ‘mental disorder’ criteria, have the consequence of making it more important to consider resources **prior** to setting up assessments, as in order to use sections related to treatment, knowledge and availability of ‘appropriate treatment’ is important.

### 1.1 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. that, under section 3, a person with a learning disability alone can only be detained if that LD 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-term 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.

## **2. The Appropriate Treatment Test**

### **2.1. Criteria for Detention**

#### **The Appropriate Treatment Test**

The Act introduces a new 'appropriate 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' which is appropriate to the patient's mental disorder and all other circumstances of the case' (COP) is available to that patient.

'Medical treatment' includes psychological treatment, nursing, habitation 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 state 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.

### **2.2 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 that 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 that is 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 18<sup>th</sup> birthday who prefers to be on an adult ward than be 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 place from 3<sup>rd</sup> November, 2008.

Although the changes in the Definition of Mental Disorder have a limited effect on compulsory admission for assessment, (s2) 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 – a case example looking at issues of what might constitute ‘appropriate medical treatment’**

*Both examples challenge ASWs to consider the issues that may arise as a result of this new rule. The challenge for tutors may be to resist requests for more information, and to challenge people to consider the issues based on the information that is available.*

*It is important to be aware that had Aneka been under 15, the admission would have been contrary to DH policy. A letter has been sent to all Trusts informing them of this.*

## **3. Conflict of Interest Regulations**

Civil partners – hopefully this will just be a reminder than civil partners now have equal status with husbands and wives.

SCT – Conflict of interest regulations do not apply to SCT, but the Code does make recommendations about what might be considered a conflict in this sort of situation.

### **3.1 Regulations around Conflicts of Interest**

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 they apply to doctors as well to themselves 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**

<b>AMHPs have a potential conflict if any of the following apply:</b>	
The AMHP has a financial interest in the outcome of the decision whether or not to make the application.	
The AMHP employs	the patient or  either of the doctors making the recommendations on which the application is based.
The AMHP directs the work of	
The AMHP is closely involved in the same business venture (which includes being a partner, director, other office-holder or major shareholder) as	
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	the patient or  either of the doctors making the recommendations on which the application is based.
The AMHP is living as if wife, husband or civil partner with	
The AMHP and <b>both</b> 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. <i>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.</i>	
The AMHP and the patient are members of the same team organised to work together for clinical purposes on a routine basis. <i>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.</i>	

**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 a particular 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.

## Activity 7. Conflict of Interest regulations

This activity asks people to consider the two areas for potential challenge for AMHPs – one, that only two of the three assessors may come from the same clinical team and two, that the AMHP must not be employed by or work under the direction of another assessor (i.e. a doctor).

A scenario is included to challenge people to think more deeply about the issue of what “working under the direction of” might entail. In this situation, assessing with either the line manager and the supervisor could cause a conflict. However, as the regulations do not apply to SCT, Jack’s main concern may be to ensure that if he does any assessments for s2 or 3, he could not be said to be employed by or directed by either of the doctors who make the recommendations. Clearly, this is an issue that will be informed by case law, but AMHPs will need to make professional judgements about this, and **record** their decision-making carefully in situations where such challenges are a possibility.

# THE NEAREST RELATIVE

## Activity 8. New issues for AMHPs, and reminders of other NR conundrums

This exercise has been set up after considering the mistakes most often made by approved workers when considering who the nearest relative is, and to introduce people to new concepts around the NR role. It is also intended to remind people how much they do know after sitting through a session with a lot of new information! It should be the last session before lunch when the course is being run as a one-day event, or the last session before leaving in a two-day course.

### Answers:

1. Two months ago, Margaret and Janet became each others nearest relative when they were joined as civil partners. The fact they have only lived together for three months is not relevant.
2. Robert's nearest relative is his son James. He is divorced and his son is older than 18 years. James' incapacity is irrelevant: unless Robert or someone else decides to go to court and ask that his son be displaced, James would remain as the nearest relative. In this circumstance, the AMHP could say that it wasn't 'practical' to consult James, but couldn't choose or move onto another person under the Act. If James were to die, presuming that Robert's father had no sibling, or none alive, Robert would have no nearest relative as cousins do not count and all other relatives are relatives by marriage and therefore have no blood relationship.
3. Rosemary cannot make such an advance decision as this issue is not about medical treatment. Advance Decisions only apply to the ability to refuse medical treatment.
4. Susan's nearest relative is her husband Pablo, not her son Juan. As Susan is 'ordinarily resident' in the USA, and her husband also lives there, he cannot be excluded on the basis that he lives outside the country where Susan normally resides.
5. Luke's nearest relative is his younger sister Helen, as she is a full-blood sibling as opposed to Vera who is a half-blood sibling.
6. Claude's nearest relative is his mother Vera. This is because Claude is not married or living with someone as a partner, has no children and his mother is the elder of the two parents.
7. This depends on professional decision-making! First, have the two men been 'living together' for five years? Are they 'living with' one another? As this is a decision that they have both freely made, the answer to that would be 'yes', and Julius would therefore go to the bottom of the list of possible nearest relatives. Second, should Julius be moved to the top of the list on the basis that he is now a relative, and 'lives with' Fredrick, despite the fact that Parliament said they should only be considered last? If you accept this argument, Fredrick's nearest relative would be Julius.
8. Marcus would appear to be the nearest relative (because he is providing substantial care), depending on your views about whether Julius and he are 'ordinarily resident' together.
9. Marcus is the children's NR on the basis of the residence order but if the LSSA had a full care order, the LSSA would be the nearest relative.

### Activity 9. What might “otherwise unsuitable” mean in practice?

First, it is important to note that because Eric isn't actually the nearest relative but has been delegated to operate the powers on **behalf** of the nearest relative, it wouldn't be Eric that Mary would need to displace, but her mother Vera!

So the first possibility would be to suggest Mary talks to her mother to see if she might be willing to consider nominating someone else to take on this role, but if she refuses, the discussion of what “otherwise unsuitable” might mean can continue.

There is no right answer to this, but the example is designed to challenge people to look at this situation from different people's perspective. If groups tend to go one or another way, act as devil's advocate and make them consider the different viewpoints that might exist.

# 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 that 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**<sup>1</sup> 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, S17 A(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).

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<sup>1</sup> 'Mental disorder' and 'nature or degree' have the same meaning as for s3 of the Act.

### 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/her CTO should be extended under s20A;
- That if a SOAD doctor needs to see him/her, s/he must also make himself available.

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 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:**

1. (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;
2. (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
3. (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 an SCT patient unless it is approved by a SOAD. The SOAD will complete a CTO11 form. The form can be used to both to detail the treatment the patient may be given in the community and 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 72hrs 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 IMHA (an Independent Mental Health Advocate – 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 of (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 renewal require that the RC state that the original criteria are still met, that 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 case study is designed to help ASW's think through the issues. Activity 10 is intended to challenge participants to think about how the criteria might apply in practice.

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

*Nick is on section 3, this and other forensic treatment sections like s37 make him eligible for the use of the order. Assessment based sections like s2 & s4 would not allow the use of SCT.*

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

*Nick has an established diagnosis and a history of stopping medication with the effect of increased paranoia and delusions.*

**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?**

*From the evidence, the nature of Nick's illness is that he has an established pattern of stopping medication, leading to a decline in his mental state and associated increase in risks to himself or others. The nature of his illness is therefore of particular significance. The degree of his illness is clear from the details here – but the important thing is that ASWs are able to identify the difference between these two concepts, and know why they are important.*

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

*When unwell, Nick presents risks to both himself and other people because of his propensity to carry weapons. He is at risk of neglect by living on the streets, and arguably his mental and physical health are also at risk as a result of his ill health.*

**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.**

*Nick's history indicates that he only ever accepts treatment when he is subject to compulsion. Previously this has meant admissions to hospital. Given his risk behaviour, were he to stop taking medication and his mental state decline, re-admission would be an appropriate outcome.*

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

*Nick appears to do well on medication. However, given his aversion to the side effects of medication and the need for him to consent to its administration in the community, it would be worth considering whether medication with fewer or more acceptable side effects might be available. It would be worth considering whether he needs other sorts of therapeutic intervention as well.*

## 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 that the criteria are met**, and also that 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;
- It is appropriate that the order be made; and
- Any conditions set meet the requirements of s17B(2) and you agree are "necessary or appropriate".

## Activity 11. Considering suitable cases

This is an opportunity both to consider 'real' cases and encourage ASWs to use a social perspective when thinking about whether SCT is appropriate.

It could be useful to ask people initially to record their reasons for saying SCT would have been appropriate in a particular case, and then ask them to cross out or mark any responses which are related to symptoms and other criteria before challenging them to really talk about the **overall** appropriateness of the use of the order, from a social perspective. In other words, challenge people not to think like psychiatrists, but instead to think like social workers!

# 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 they were subject to 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 subject to 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 that 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 & 25.58) say 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 patients 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 above (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 that the order should be revoked, the patient will be free to return to the community (at the latest, after 72hrs). It is the hospital managers' responsibility to make sure this happens.

## Activity 12

This activity again is designed to challenge ASW's to think about a situation from a 'social perspective'. It also challenges people to look at the whole situation. It has deliberately been divided into two sections, to emphasis the importance of gathering information from all available sources before making a decision.

In many ways, there isn't a 'right' outcome. There are arguments both for and against revoking the order. The important issue is that that ASWs can explore this further, and consider the different issues and dilemmas raised.

Answers from the question 'bubble':

- 1. The CPN/RC says that 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.**

This is not correct. Recall is not automatic on these grounds; neither is revocation.

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

You would need to be convinced he met the criteria for s3 and that revocation was, in all circumstances, 'appropriate' to his case.

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

Information on Nick's wider social situation, including the views of his family, are important. Also, an understanding from Nick's perspective of who the people are who have been staying at the flat; and his capacity to make decisions about whether or not they should stay is important. It may not be wise of him to allow them to stay, but has he made an informed decision or not?

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

Any and all the Guiding Principles are important. It is essential that people are able to balance the different principles and use them as a tool in decision-making. Some principles will be more important than others.