National Institute for
Mental Health in England

WORKBOOK TO SUPPORT IMPLEMENTATION OF THE MENTAL HEALTH ACT 1983 AS AMENDED BY THE MENTAL HEALTH ACT 2007

(Final Version – 6 August 2008)

Dear Colleague,

The Mental Health Act is changing. In preparation, I am pleased to introduce you to the training materials which NIMHE has devised to support each of us as practitioners to be ready for implementation.

The training materials describe the key changes. They are designed to equip professional staff and a range of service providers to practice under the amended Act. They are well informed by the revised code of practice and will support us all in applying the new guiding principles in a modern, recovery oriented context. They are evidence based and culturally specific, applying values based practice.

The practical modules within the workbook support continuing professional development portfolios. They include some powerful materials developed by service users and carers which vividly portray personal experience of compulsion. I am particularly grateful for this part of the work, which brings alive the sprit of the Act, alongside an equally important understanding of what the law now says, and why it does so.

The training can be accessed in a number of ways – through your own organisation's training events, as 'e-learning' which teams can work on together or as individuals and as hard copies.

However you are using this training within your own workplace, I encourage you to take time to prepare for the significant changes which are coming. We can all use this as a chance to reflect upon our own practice. This is an important opportunity to continue to raise standards in delivering the best possible care we can to service users, their families and to serve the whole community well as providers of confident, competent mental health services.

Professor Louis Appleby CBE
National Director for Mental Health

This workbook and other training materials produced to support the implementation of the 2007 Mental Health Act are intended not only to increase awareness of the new legislation but also as a tool to improve practice. For this reason, the importance of the Guiding Principles which underpin the legislation is emphasised throughout the material

The workbook is aimed primarily for those working under the framework of the 1983 Mental Health Act in the statutory, voluntary and independent sectors. The workbook firstly gives a brief overview of the key changes brought about by the 2007 Mental Health Act and then explores each change in greater detail. The design of the workbook enables both trainers and participants to undertake the modules most relevant to their situation.

The first two modules (Foundation and Guiding Principles) are also available as a separate workbook and in an e-learning format for those who may only want a brief overview of the changes for example service users, carers and those in support services.

It is hoped that those completing the modules will be better equipped to meet the needs of those requiring the support of mental health services, particularly when compulsory treatment is involved or being considered.

If you need any further information on the training materials or issues relating to implementation please contact me on malcolm.king@csip.org.uk.

Malcolm King
National Implementation Lead

CONTENTS

THE MENTAL HEALTH ACT 1983 AS AMENDED BY THE MENTAL HEALTH ACT 2007 LEARNING RESOURCE WORKBOOK

Background 1

FOUNDATION MODULE

Introduction to the Module 9
Learning Outcomes 9
Activity 1 – Step 1: Coming into Compulsion 15
Activity 2 – Step 2: Making Decisions 18
Activity 3 – Step 3: Supervised Community Treatment 21
Activity 4 – Step 4: Ending Compulsion 22
Activity 5 – What do you mean by values? 28
Activity 6 – Scenario: Rosemary 32
Activity 7 – Scenario: Carol (1) 33

GUIDING PRINCIPLES MODULE

Introduction to the Module 37
Learning Outcomes 38
Activity 1 41
Activity 2 – Scenario: Andrew 42
Activity 3 – Scenario: Carol (2) 44
Activity 4 – Scenario: Raj 45
Activity 5 – Scenario: Diana 47
Activity 6 – Scenario: Eddie (1) 49

MODULE 1: COMING INTO COMPULSION

Introduction to the Module 53
Learning Outcomes 53
Activity 1 – Scenario: David 57
Activity 2 60
Activity 3 – Scenario: Eddie (2) 63
Activity 4 – Self Assessment 69

Module 2: Making Decisions

Introduction to the Module	73
Learning Outcomes	73
Activity 1 – Scenario: Eddie (3)	79
Activity 2	82
Activity 3	85
Activity 4 – Scenario: Wayne	88
Activity 5 – Self Assessment	91

Module 3: Supervised Community Treatment

Introduction to the Module	95
Learning Outcomes	96
Activity 1	98
Activity 2 – Scenario: Eddie (4)	102
Activity 3	107
Activity 4	110
Activity 5 – Self Assessment	112

Module 4: Ending Compulsion

Introduction to the Module	117
Learning Outcomes	117
Activity 1 – Scenario: Eddie (5)	123
Activity 2 – Self Assessment	131

Website Links 133

Contributors & Acknowledgements 134

Appendix 1: Comments on Scenarios 135

Appendix 2: Answers to Self Assessment 142

Glossary 143

THE MENTAL HEALTH ACT 1983 AS AMENDED BY THE MENTAL HEALTH ACT 2007 LEARNING RESOURCE WORKBOOK

BACKGROUND

The legislation governing the compulsory assessment and treatment of certain people who have a mental disorder is the Mental Health Act 1983, and the Mental Health Act 2007 (MHA – please see box below) brings in certain amendments to the previous legislation. It is also being used to introduce "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.

The MHA is largely concerned with the circumstances in which a person with 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 that threaten their health or safety or the safety of other people can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others.

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 (occasional reference is made to the existing MHA and this refers to the Mental Health Act 1983. Also "the Act" is used when direct quotes from the COP or the MHA are included).*
COP	–	*means the Code of Practice to the MHA (the "Code" is used when direct quotes from the COP or the MHA are included).*
Reference Guide	–	*means the 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 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 required to have wide-ranging training provisions in place in advance of 3rd November 2008, and beyond the date to support implementation.

The Department of Health has tasked the Care Services Improvement Partnership and the National Institute for Mental Health in England (CSIP/NIMHE) to have 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, both directly and by signposting other sources of information;
- providing opportunities to influence national policy.

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

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

This learning resource book has been developed by the training workstream as part of an overall Training Programme to ensure educational material is easily accessible to all staff. The Training Programme itself aims to produce a package of training materials in support of the MHA, using e-learning and other methods, and drawing upon experienced trainers to deliver a 'train the trainers' roll-out.

The training materials will focus on the changes introduced by the MHA and related provisions of the COP. The materials will be set in a values-based practice context through a series of case examples that illustrate the impact of the Guiding Principles (the "principles") that will be included in the COP.

The objectives of the Training Support Programme are to:

- offer a framework of training and guidance relevant to all levels of staff within organisations and identify who is responsible for provision;
- provide access to appropriate training materials in a variety of appropriate formats in respect of the key changes in legislation and indicate the implications for new responsibilities and practice;
- ensure that any training materials are presented in a practical context that reflects best practice and supports ease of access for all appropriate staff;
- involve patients in the design, development and roll-out of the training;
- secure a consistent approach leading to MHA readiness across England.

Training Materials

In addition to this workbook, the Training Programme will be delivered using a range of training materials and methods, including:

- e-Learning (web-learning and CD-ROM);
- Interactive learning materials;
- Specialist training modules for specific staff (e.g. Approved Social Workers (ASW); MHA Administrators; Managers & Non-Executives; Responsible Medical Officers (RMO), Children and Young People (CAMHS) and non-mental health specialist staff including police and ambulance services);
- PowerPoint presentations;
- Learning sets;
- Train the Trainer events;
- Four DVDs on patients' and BME carers' perspectives on compulsory treatment, children and young people, advocacy.

All the above materials complement each other and learners are advised to participate in as many as possible (where appropriate) to achieve the maximum benefit.

Who is this Workbook for?

This workbook is for anyone affected by the MHA, whether as a patient or service provider. However, the main aim of the resource is to support changes in mental health legislation in England by helping to prepare mental health staff to understand and work safely and effectively within the MHA.

In this sense, it is important to recognise that it is not guidance and should not be used to inform legal decision-making.

"Mental health staff" refers to all those who have no statutory legislative function under the MHA, yet by virtue of their work need to be aware of its implications. This group consists of a wide range of disciplines within health, social work, voluntary and independent sectors.

Although patients and carers may find this education resource of some assistance, they may find the streamlined version (which contains only the Foundation and Guiding Principles Modules) more useful. All staff groups can use the resource, but some of the material may be more relevant to certain groups than others.

Content of Workbook

The content of the paper-based material is also on the web and the CD-ROM with minor differences in the location of information in the paper format. This is to accommodate different learning styles and will not affect how you use the material.

The workbook contains a number of colour-coded modules: one that provides an overview of MHA changes (Foundation Module); one that covers the Guiding Principles (Guiding Principles Module), and four "key change" modules that cover in more detail all nine key changes to the MHA (i.e. Modules 1, 2, 3 and 4).

The training materials have been developed with support and input from many individuals and groups representing both patient and service provider perspectives (see Authors and Acknowledgements at the end of this workbook).

An overview of each module (and their colour code) is shown in Table 1.

Table 1. Content of Workbook

FOUNDATION MODULE –	**an overview of the nine key changes to legislation brought about by the MHA. The module describes these changes as four steps in a pathway through compulsion.**
GUIDING PRINCIPLES MODULE –	**a detailed module on the Guiding Principles, exploring how each of them could be applied in different health and social care contexts.**
MODULE 1 –	**COMING INTO COMPULSION** **Step 1 in the pathway through compulsion incorporating:** • **Key Change 1 - Single Definition of Mental Disorder** • **Key Change 2 - Appropriate Medical Treatment** • **Key Change 3 - Age Appropriate Services**
MODULE 2 –	**MAKING DECISIONS** **Step 2 in the pathway through compulsion incorporating:** • **Key Change 4 - Broadening Professional Groups** • **Key Change 5 - Nearest Relative** • **Key Change 6 - Advocacy Services** • **Key Change 7 - Electro-Convulsive Therapy**
MODULE 3 –	**SUPERVISED COMMUNITY TREATMENT** **Step 3 in the pathway through compulsion incorporating:** • **Key Change 8 - Supervised Community Treatment** **Note: this module also contains a detailed step-by-step ‘pathway’ (also on the attached CD-ROM) that will help you track the stages of how Supervised Community Treatment is applied in practice.**
MODULE 4 –	**ENDING COMPULSION** **Step 4 in the pathway through compulsion incorporating:** • **Key Change 9 - Mental Health Review Tribunals**

Workbook Objectives

This workbook has a number of objectives, which are to:

- provide a learning experience – primarily to professionals with roles and responsibilities in relation to the MHA – but also to help others (such as patients and carers who may also access learning opportunities and resources) understand the changes underlying the operation of the MHA;
- be an integral part of the training programme undertaken by professionals as a requirement of being a practitioner or manager with professional responsibilities under the MHA;
- provide learners with the opportunity to work through a number of case examples and practical scenarios to help understand the implications of the MHA;
- provide learners the opportunity of understanding the principles of the COP and the effect these will have on mental health practice within a values-based framework.

How to use the Workbook

All the modules are open and you can move through them at your own pace and in whatever order you wish. However, it is recommended that you complete the Foundation and the Guiding Principles Modules before moving on to other modules.

The modules are broadly structured in the same way, comprising:

- An introduction to the module;
- Preparation;
- Learning Outcomes;
- Topic text with activities, questions and reflections;
- Scenarios with questions and suggested discussion points;
- Self assessment questions.

The workbook contains a series of practical exercises that ask you to reflect on the changes brought about by the MHA and how they will affect you in practice.

It is really important to do the exercises!

Best practice within the MHA depends not just on knowing what changes have been introduced, but on making the changes very much part of the skills base of your day-to-day practice. This is particularly important as the MHA includes an enhanced role for these principles and for the new COP. Skills development depends on practice, and doing the exercises gives you the opportunity to do it ‘for real’.

You may find yourself under pressure to rush through the workbook rather than doing the exercises, but if you *do* take the time to work through the exercises, you will find you are able to take in the MHA more quickly. This is highly likely to save you time in the long run.

Working Alone or in a Group?

The workbook and CD-ROM are intended for small group work, but they are also designed so you can work through them on your own. Although working by yourself is an option, please bear in mind that most people find they learn more easily as part of a group. Having mixed groups, with different members bringing different backgrounds, skills and experiences, both as patients and service providers, is a really effective way to learn. Your choice of approach really depends on your own circumstances and your access to other people. However, wherever possible share your learning and ideas with others.

Give yourself time to work through each of the exercises and to reflect on them before moving on.

FOUNDATION MODULE

FOUNDATION MODULE

INTRODUCTION TO THE MODULE

In this module the key changes to mental health law as implemented by the MHA are considered. As there is an expectation that everyone involved in mental health practice should be aware of the COP, its principles and its enhanced legal status, these and how they fit together with the MHA itself will also be discussed in some detail.

In brief, the MHA:

- Makes Nine Key Changes to the existing MHA (Mental Health Act 1983);
- Introduces – through a revised COP – five Guiding Principles ("the principles");
- The legal status of the COP has been redefined so that professionals must have regard for the code and must follow the guidance unless they have a good reason not to.

This module, therefore, as well as increasing your knowledge of the various areas outlined above, should also equip you with the tools you need to undertake the other modules. For example, there is no point looking at the module relating to Supervised Community Treatment unless you know how, with whom and when to consider using such powers. As you work through this module, you will find that, as well as reading the text you are asked to undertake various activities. The activities are designed to help you develop your understanding of the areas under discussion and to think about how the MHA will impact on you. The activities include looking at various scenarios, either described in the text or gained from your own experiences.

LEARNING OUTCOMES

On completion of this study you should be able to:

- ***Know what changes have been made by the Mental Health Act 2007 and how they will affect you in practice;***
- ***Know what principles are introduced into the new COP and how they will affect you in practice;***
- ***Understand how the MHA, the COP and the principles work together to support best practice;***
- ***Work through a case example illustrating how the COP and principles guide the way any particular change made by the MHA (e.g. Single Definition) is applied in practice.***

THE NINE KEY CHANGES

Introducing the Nine Key Changes

The Nine Key Changes in the MHA are concerned with:

Key Change 1 Introducing a **Simplified Single Definition of Mental Disorder**.

Key Change 2 Abolishing the Treatability Test and introducing a new **Appropriate Medical Treatment** Test.

Key Change 3 Ensuring that **Age Appropriate Services** are available to any patients admitted to hospital who are aged under 18 (*anticipated by 2010*).

Key Change 4 Broadening the **Professional Groups** that can take particular roles.

Key Change 5 Introducing the right for patients to apply to court to displace their **Nearest Relative**.

Key Change 6 Ensuring that patients have a right to an **Advocacy Service** when under compulsion (*implemented in 2009*).

Key Change 7 Introducing new safeguards regarding **Patients and Electro-Convulsive Therapy**.

Key Change 8 Introducing a new provision to allow **Supervised Community Treatment**. This allows a patient detained on a treatment order to receive their treatment in the community rather than as an in-patient.

Key Change 9 Making provision for earlier automatic referral to a **Mental Health Review Tribunal (Tribunal)** where patients don't apply themselves.

All these changes need to be seen within the context of the Guiding Principles and the clarified legal status of the COP.

- **The MHA tells us WHAT to do**
- **The COP explains HOW to do it**
- **The Guiding Principles help us to apply the MHA and COP in INDIVIDUAL SITUATIONS**

Note that the MHA also introduces other more minor changes which are not covered in this Training Pack. All these changes come into effect before November 2008) and include:

- abolishing **Finite Restriction Orders** so that when offenders are given restricted hospital orders (under section 37 and 41) they will always now be without limit of time;
- amendments to **Sections 135 and 136** so a person detained in a place of safety can be transferred to another place of safety, subject to the overall time limit for detention of 72 hours;
- changes to the powers of delegation for managers of **NHS Foundation Trusts**;
- extending the **Rights of Victims** under the Domestic Violence, Crime and Victims Act 2004;
- changes to the arrangements for **Informal Admission of Patients aged 16 or 17**.

The Key Changes as Steps in a Pathway through Compulsion

When the MHA has been in force for a while, these changes will become second nature. In the meantime, one way to remember them is to think of them as a series of key steps in the pathway into and out of compulsion. These steps are:

Step 1 – Coming Into Compulsion

Step 2 – Making Decisions

Step 3 – Supervised Community Treatment

Step 4 – Ending Compulsion

Step 1 – Coming Into Compulsion

This step covers the first three changes regarding a patient when they are first detained. These changes are:

Key Change 1: Simplified Single Definition of Mental Disorder
This is part of the 'first step' in compulsion because having a mental disorder is a pre-condition for the MHA to be relevant at all.

Key Change 2: Appropriate Medical Treatment
Even if a person has a mental disorder, they still have to satisfy a number of other criteria before the MHA can be used. A key new criterion in the MHA for those being detained for treatment and other longer-term forms of compulsion is that "Appropriate Medical Treatment" must be available, not just in theory but for the particular person concerned and in their particular situation.

Key Change 3: Age Appropriate Services
When a young person (under 18) is admitted to hospital for a mental disorder, it is important they are treated in an environment suitable for their age and needs. It is hoped such services will be in place for 2010.

Step 2 – Making Decisions

Once a person has been admitted, the MHA makes four key changes as to who can be involved in making decisions concerning that person's detention. These changes concern:

Key Change 4: Professional Groups

The MHA broadens the range of professionals who are able to take on particular roles and responsibilities in deciding whether someone should come into hospital compulsorily, and then in managing their treatment and care. Thus, the Approved Social Worker (ASW) in the existing Mental Health Act had to be a social worker, but under the MHA the ASW is replaced by an Approved Mental Health Professional (AMHP) who could be, for example, a nurse, psychologist or occupational therapist as well as a social worker. Similarly, the Responsible Medical Officer for a patient in the existing Mental Health Act always had to be a doctor; but in the MHA the corresponding role of Responsible Clinician could also be taken by a psychologist, nurse, occupational therapist or social worker.

Key Change 5: Nearest Relative

People subject to compulsion under the MHA have a "Nearest Relative" who has certain powers and responsibilities. For example, the Nearest Relative (NR) can ask for assessment, and in some cases prevent hospital admission. The MHA now gives the patient more say in who that person can be by allowing them to go to court themselves to ask that their NR be displaced in favour of someone else of the patient's choice.

Key Change 6: The Independent Mental Health Advocacy Service

From an anticipated start date of April 2009, there will be a duty upon the Secretary of State to provide advocacy services for all detained patients (except those under holding sections 4, 5, 135 or 136), Guardianship patients and patients subject to Community Treatment Orders. Service providers also have a duty to provide qualifying patients with information that advocacy services are available.

Key Change 7: Patients and Electro-Convulsive Therapy

There are now greater protections available to people detained under the MHA concerning whether or not they should receive electro-convulsive therapy (ECT). If a detained patient has capacity, then – except in emergencies - they can decide whether or not they wish to have ECT. A detained patient with a valid advance decision **opposed** to being given ECT cannot be treated by it, except in an emergency. Also, unless it is an emergency, no under 18 (whether or not detained) can be given ECT without the approval of a second opinion approved doctor (SOAD).

Step 3 – Supervised Community Treatment

The MHA makes another change as to where a detained person can be treated. This involves:

Key Change 8: Supervised Community Treatment (SCT)

After a person has been detained in hospital for treatment, the MHA will now make it possible in appropriate circumstances for some patients to continue to receive their care and treatment in the community while still under compulsion. SCT patients cannot be **forced** to have treatment in the community but may be recalled to a hospital (or to a clinical setting which is part of that hospital) if they need to receive the treatment they are refusing and without which there would be a risk to themselves or other people.

Step 4 – Ending Compulsion

Finally, the MHA makes some changes to how a period of compulsion can be brought to an end. Specifically:

> ***Key Change 9: Mental Health Review Tribunal (Tribunal)***
> An important safeguard for patients receiving treatment under the existing MHA is the opportunity for their compulsion to be reviewed by an independent Mental Health Review Tribunal. SCT patients whose community treatment orders are revoked will have to be referred automatically to the Tribunal by the hospital managers. In addition, there are changes to when hospital managers must refer other patients who do not apply themselves – meaning that some patients will be referred earlier than at present

Read through the above summaries quickly to get an overall idea of the changes. Then come back to each of them for a closer look as you work through the exercises in the next section of the module. As you will see, these exercises ask you to explore what the changes are in more detail and to consider what they will mean for you in your particular situation.

Understanding what the Key Changes mean to you

In this part of the module, you are going to work through the changes in the MHA.

With each of the exercises in the next section, you will be asked to think about the changes in relation to how things work from your own experience in real life, whether as a patient, carer or service provider.

Some of the changes may not be directly relevant to you, but it is still worth trying to imagine an actual example rather than thinking about the change in a general way. With each of the exercises – if you are working in a group – fill in your own answers first, then take time to discuss your answers together.

COMMON MYTH – THE MHA	
MYTH	**REALITY**
The Mental Health Act 2007 (MHA) replaces the Mental Health Act 1983 (existing MHA)	No, it does not! Basic mental health legislation remains with the existing Mental Health Act 1983 – the MHA just amends it. Therefore, a lot of the Act will remain the same – for example, when to use section 2 of the MHA.

THE AMENDMENTS IN DETAIL

Each step is now examined in detail along with activities to help you reflect on the amendments.

STEP 1 – COMING INTO COMPULSION

The three changes in Step 1 are described in Details Boxes 1, 2 and 3.

Details Box 1. Single Definition of Mental Disorder

Definition of Mental Disorder:
For sections of the MHA that apply to assessment under compulsion, the wording of the definition of mental disorder is very similar to that used under the existing Mental Health 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.

Details Box 2. Appropriate Medical Treatment

The Appropriate Medical Treatment Test

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

"Medical treatment" includes psychological treatment, nursing, and specialist mental health habilitation, rehabilitation and care as well as medicine. It does not have to be the "perfect treatment but doctors will be expected to satisfy themselves that appropriate treatment, taking into account all the circumstances of the case, and state in their recommendations in which hospital(s) it will be available to the patient.

Details Box 3. 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 (subject to their needs) in an environment that is suitable for their age. There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient's needs are better met this way. This is expected to come into force in 2010, by which time it is hoped new services will be available. Section 140 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.

ACTIVITY 1 – STEP 1: COMING INTO COMPULSION

Consider one of the three changes in Step 1 of the pathway into compulsion. What do you think about this change? As said above, do not just think about it in general terms, but come up with one or more examples from your own background and experience. Use the Activity Box overleaf (or use your own materials) to:

1. Summarise the example;
2. Say how the existing MHA would have worked in that case; and then:
3. Say how the changes introduced in the MHA would work. Do you think it makes a difference? Do you think it helps? What challenges and opportunities does this change present?

Activity Box 1. Step 1: Coming into compulsion

Summary of my example
Existing MHA
MHA *Would it make a difference?* *Would it help?* *Challenges and Opportunities?*

STEP 2 – MAKING DECISIONS

The four changes in Step 2 are described in Details Boxes 4, 5, 6 and 7.

Details Box 4. Broadening Professional Roles

This change widens the group of practitioners able to train to fulfil functions currently undertaken by Approved Social Workers (ASWs) and Responsible Medical Officers (RMOs). It does this by introducing two new roles:

Approved Mental Health Professionals (AMHPs). AMHPs are mental health professionals with specialist training in mental health assessment and legislation. The training will be opened up to include mental health and learning disability nurses, clinical psychologists and occupational therapists as well as social workers. AMHPs will assess "on behalf" of Local Authorities, who will continue to be responsible for approving AMHPs and for ensuring a 24hr AMHP service is available.

The final part of this change concerns the **Approved Clinician** (AC), the professional status a practitioner must obtain before they can become a **Responsible Clinician** (RC).

The RC is the old Responsible Medical Officer role which has now been opened up to include social workers, mental health and learning disability nurses, clinical psychologists and occupational therapists. The RC has overall responsibility for a patient's case. This change allows more flexibility – for example, making it possible to transfer responsibility to professionals from different groups of staff as the patient's needs change.

Directions make it clear that all professionals who want to be a RC need to meet particular levels of competence, undertake a short course to demonstrate their state of readiness and be approved by Strategic Health Authority as an AC.

Details Box 5. Nearest Relative (NR)

Changes give patients the right to make an application to court to displace their nearest relative and introduces a new ground for displacement: that the current NR is "otherwise unsuitable for the role". The provisions for determining who is the NR have also been amended to include civil partners on equal terms with a husband or wife.

Details Box 6. Advocates

Gives the right for patients who are subject to compulsion to have access to advocacy services. Advocates will have the right to meet with patients in private. They will also have access to patient records, where a patient with capacity gives consent. In the case of patients lacking capacity to make such decisions, access must not conflict with decisions made by a deputy, Lasting Power of Attorney (LPA) donee or Court of Protection, and the person holding the records must agree that such access is "appropriate". The principles of the COP should be used to decide whether it is appropriate to disclose information in a particular case.

It is planned that the new "Independent Mental Health Advocacy" services will be available from April 2009.

Details Box 7. Patients and Electro-Convulsive Therapy

Except in emergencies, detained patients may in future only be given ECT if they have capacity and agree or, (as now) if they do not have capacity, the ECT is authorised by a Second Opinion Appointed Doctor (SOAD).

In other words, this means that a detained patient can **refuse** to have ECT, and, except in emergencies, this can be overturned only if a SOAD agrees that the patient does not have capacity to make the decision and that giving the ECT treatment would be appropriate. In this case, the SOAD also needs to be sure that there is no valid advance decision refusing the use of ECT. If such an advance decision has been made, then ECT cannot be given, except in an emergency.

In the case of young people (aged under 18), even if a child with competence agrees, unless it is an emergency, they may only be given ECT with the additional agreement of a SOAD. These rules apply to young people **whether or not they are detained**.

If an under 16-year-old has sufficient competence to refuse ECT, legally it would not be prudent to rely on parental authority in order to give it. An application to court should be considered, unless the patient meets the criteria for detention under the Mental Health Act.

In all these cases, it is only an emergency if the ECT is immediately necessary to save the patient's life or prevent serious deterioration in their condition.

What is an emergency? (COP, 24.33)

It is an emergency if the treatment in question is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration of the patient's condition (and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed).

Activity 2 – Step 2: Making Decisions

Consider one of the above four changes in Step 2 of the pathway into compulsion. What do you think about this change? As said above, do not just think it in general terms, but come up with one or more examples from your own background and experience. Use the Activity Box overleaf (or use your own materials) to:

1. Summarise the example;
2. Say how the existing MHA would have worked in that case; and then:
3. Say how the changes introduced in the MHA would work. Do you think it makes a difference? Do you think it helps? What challenges and opportunities does this change present?

Activity Box 2. Step 2: Making Decisions

Summary of my example
Existing MHA
MHA *Would it make a difference?* *Would it help?* *Challenges and Opportunities?*

STEP 3 – SUPERVISED COMMUNITY TREATMENT

The change in Step 3 is described in Details Box 8.

Details Box 8. Supervised Community Treatment (SCT)

Introduces Supervised Community Treatment (SCT) for patients following a period of detention in hospital for treatment (mainly those on section 3 or unrestricted forensic sections such as section 37). It will allow a small number of patients with a mental disorder to live in the community while subject to certain conditions. This is to ensure they continue with the treatment they need.

Currently some patients leave hospital and do not continue their treatment with the result that their health deteriorates to the point that they again require detention. SCT is a way to manage the care of these patients. It can also be used for patients who are at risk of deterioration in their condition for whatever reason, if that would cause a risk to the patient's health or safety, or to someone else.

As a statutory framework, SCT is intended to support such vulnerable patients (including some who may pose a risk to others) to:

- live in the community;
- help improve engagement with the care team by shifting the balance of power more in the patient's favour;
- act upon any clinical signs of relapse at an early stage;
- be a mechanism to manage actual or potential relapse; and
- ensure that services are aware of and responsive to any changes of circumstances which arise for the patient or their carers.

It replaces the existing MHA section 25(A) Supervised Discharge Order, which in practice has not been widely used.

The criteria for consideration of the use of SCT include:

- the person is suffering from a mental disorder;
- the need for medical treatment;
- the existence of a risk to the patient's health or safety or that of others;
- that appropriate treatment is available; and that the patient does not need to be in hospital to receive it but does need to be liable to recall to hospital to ensure that the risk can be managed; and
- that it is necessary for the patient's health or safety or the protection of others that the patient remains liable to recall.

ACTIVITY 3 – STEP 3: SUPERVISED COMMUNITY TREATMENT

Consider the above change in Step 3 of the pathway into compulsion. What do you think about this change? As said above, do not just think about it in general terms, but come up with an example from your own background and experience. Use the Activity Box overleaf (or use your own materials) to:

1. Summarise the example;
2. Say how the existing MHA would have worked in that case: and then:
3. Say how the changes introduced in the MHA would work. Do you think it makes a difference? Do you think it helps? What challenges and opportunities does this change present?

Activity Box 3. Step 3: Supervised Community Treatment

Summary of my example
Existing MHA
MHA *Would it make a difference?* *Would it help?* *Challenges and Opportunities?*

STEP 4 – ENDING COMPULSION

The change in Step 4 is described in Details Box 9.

Details Box 9. Mental Health Review Tribunals

Changes to the MHA have introduced earlier referrals by Hospital Managers of detained patients who have not used their rights of appeal to the Tribunal.

The six month referral rule will now take into account any time that a patient may have been detained under section 2. This means that patients who are detained on section 2 before going onto section 3 will need to be referred earlier than now, if they do not apply themselves once on section 3. It also means that if a patient's section 2 has been extended under section 29 because it has been necessary to go to court to displace their nearest relative, and if the displacement application is not concluded quickly, the patient's case will have to be referred to the Tribunal when they have been detained for six months.

Hospital managers will still have to refer patients who've been detained for more than three years without a Tribunal hearing. However, they will now have to do it as soon as the three years are up, rather than at the next renewal date as now.

For under 16s, the three year period will still be one year instead – and this will now apply to 16 and 17 year olds as well.

The Secretary of State has the power to reduce further these periods for referral by Hospital Managers in the future.

The MHA has also introduced the immediate referral of patients who have had their SCT revoked.

The existing multiple Regional Tribunals are to be replaced with two Tribunals, one for England and one for Wales.

ACTIVITY 4 – STEP 4: ENDING COMPULSION

Consider the above change in Step 4 of the pathway into compulsion. What do you think about this change? As said above, do not just think about it in general terms, but come up with an example from your own background and experience. Use the Activity Box overleaf (or use your own materials) to:

1. Summarise the example;
2. Say how the existing MHA would have worked in that case; and then:
3. Say how the changes introduced in the MHA would work. Do you think it makes a difference? Do you think it helps? What challenges and opportunities does this change present?

Activity Box 4. Step 4: Ending Compulsion

Summary of my example
Existing MHA
MHA *Would it make a difference?* *Would it help?* *Challenges and Opportunities?*

THE NINE KEY CHANGES AND BEST PRACTICE

Changes to the existing Mental Health Act were much debated both before the publication of the Amending Bill and right through the parliamentary process leading to amendment.

Many agreed that changes were needed to bring the existing Mental Health Act up to date. Best practice in mental health and social care had changed in many respects since 1983 when the existing Mental Health Act first became law, but there was wide disagreement about exactly how to capture these changes in law.

Details Box 10 shows some of the changes in mental health and social care practice since 1983, and how they link to the changes in the MHA.

Details Box 10. The Nine Key Changes and their link to developments in practice

Changes in the Mental Health Act	Changes in Best Practice in mental health and social care since 1983
1. Simplified Definition of Mental Disorder	This recognises that some disorders don't fit easily into the four categories of mental disorder and certain people may have been excluded from treatment as a result.
2. Appropriate Medical Treatment	This reflects the belief that the Treatability Test was not deemed in the patient's interest, and encourages a move away from the medical model. It is also an attempt to get away from the idea that there are disorders which are inherently "untreatable".
3. Age Appropriate Services	Recognition that children have been inappropriately detained on adult wards in the past, and that facilities and services appropriate to their age and needs must be made available.
4. Broadening Professional Groups	Direct reflection of the move to multi-disciplinary or multi-agency teams as the basis of service delivery in mental health and social care.
5. Nearest Relative 6. Advocacy Services 7. Electro-Convulsive Therapy	Recognition of the importance of strengthening the patient's voice.
8. Supervised Community Treatment	Shift to treatment and care for mental health in the community rather than in hospital.
9. Earlier Referral to MHRT	Recognition of the need for strengthening protections for patients.

THE ROLE OF THE CODE OF PRACTICE AND THE GUIDING PRINCIPLES

The main changes brought about by the MHA have now been worked through. This part of the module introduces the new principles and explores how they fit together with the COP and the MHA to support best practice.

The section only provides an overview of the new principles. For a comprehensive examination of them you are referred to the next module which explores each principle in detail and looks at how they may affect you in practice.

Before thinking about how the COP and principles may help you to apply the MHA in individual situations, a brief overview of the purpose and status of the COP (taken directly from the COP) is given in Details Box 11.

Details Box 11. Purpose and Legal Status of the COP (COP, page 2)

ii **The Code provides guidance to registered medical practitioners ("doctors"), approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking duties under the Act.**

iii **It also gives guidance to doctors and other professionals about certain aspects of medical treatment for mental disorder more generally.**

iv **While the Act does not impose a legal duty to comply with the Code, the people listed above to whom the Code is addressed must have regard to the Code. The reasons for any departure should be recorded. Departures from the Code could give rise to legal challenge, and a court, in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure that there is sufficiently convincing justification in the circumstances.**

v **The Code should also be beneficial to the police and ambulance services and others in health and social services (including the independent and voluntary sectors) involved in providing services to people who are, or may become, subject to compulsory measures under the Act.**

vi **It is intended that the Code will also be helpful to patients, their representatives, carers, families and friends, and others who support them.**

How do the MHA, the COP and the Guiding Principles fit together?

This can be summarised as follows:

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

Obviously, this simplifies things somewhat, but the key point to remember is that 'the law is the law'. The law says what can and cannot be done and the purpose of the COP is to help explain what applying the law means in practice.

So why are the principles needed?

The problem is that every decision taken involves unique individuals in unique situations. So, however carefully the law and the COP spell out what to do and how to do it, they can never cover all situations in sufficient detail. The principles guide us in individual situations by providing a framework of important considerations that should always be kept in mind when making decisions under the MHA.

For example, the COP talks about **Advance Decisions** to refuse treatment (which have a legal status under the Mental Capacity Act 2005) and **Advance Statements** of wishes and feelings (which do not have a legal status). The COP suggests professionals should seriously consider the wishes of patients made in advance statements, but professionals will need to rely on the principles to decide whether or not to abide by them in an individual case.

Exactly just what is an "important consideration" will vary from situation to situation, but the idea behind the principles is that there are some things that are **so** important – like treating people with respect, for example – that attention should **always** be paid to them whatever the situation.

The COP expresses this by saying that practitioners must always "have regard" to the principles.

The MHA requires that a Statement of Principles is included in the COP and it spells out the minimum issues they should cover. The COP itself (and these training materials) strengthens the status of the principles further by giving them much greater visibility and significance. The principles themselves have a chapter of their own in the COP (Chapter 1) and they have a module in this training workbook.

The Guiding Principles as a Framework for Practice

The principles in the COP reflect the requirements of the MHA and were finalised in light of consultations with stakeholders.

If you carried out your own exercise to examine the range of principles that exist in your group you may find differences, but you are also likely to find considerable overlap in the principles that people came up with. It is this overlap, this 'shared vision', developed through the parliamentary process, that the principles in the new COP aim to cover.

The significance of the overlap of principles for practice will be easier to see if you are working in a mixed group that includes patients and carers as well as service providers with different professional backgrounds.

A group like this will always come up with some differences of principles and they will also have differences about the relative importance of the principles they agree on. So what is needed to guide you in practice is a shared vision of what best practice really means, and it is this that the principles aim to provide.

The principles thus aim to reflect a shared vision between patients and the many different provider groups in both the voluntary and statutory sectors concerned with best practice and compulsion.

This is why the principles provide a framework that supports stakeholders in applying the MHA, guided by the COP, to the particular and often very complex circumstances of individual situations in day-to-day practice.

The Guiding Principles as a Framework of Values

In the next part of this module you are going to run through each of the principles in the new COP, see what they mean, and think about how they might help you in situations from your own experience.

The way to approach this is to think of the principles as a framework of *values* that are important for best practice in the use of compulsion. This is what it means to say that the principles reflect a series of "important considerations".

However, 'values' is a term that means different things to different people. So before going on to the details of the COP principles, a question that needs asking is exactly what are 'values'.

ACTIVITY 5 – WHAT DO YOU MEAN BY VALUES?

Use the space in the box below to write down three words or short phrases that mean 'values' to **you**. This is not a test! It is not asking what you think someone else (a philosopher or politician, etc) might say. It is what **you** personally think. It is what comes into **your** head when someone talks about values.

Activity Box 5. What do *you* mean by values?

This exercise usually shows just what different things different people do mean by 'values'! You will probably have found that everyone in your group came up with a different set of three words that means 'values' to them. However, most groups also find that when they talk through their different lists, there is a common thread, on the lines that values mean things that are **important to us**, in a positive or negative way, and that **guide our actions**.

This is the link between saying, at the end of the last section, that the principles are a "framework for practice"; and then saying, at the start of this section, that the principles are a "framework of values". The principles are things that are important to us in one way or another, positive or negative, and that guide best practice in compulsion. For example, in Activity Box 5 above, you may have identified 'respect' as one of the "important considerations" that almost everyone includes as something you should always have in mind when you are involved with compulsory treatment in practice. So 'respect' is an important shared value that guides best practice.

Values-Based Practice and Evidence-Based Practice

However, as you may have found in the activities in the last section, while there is an important overlap – a shared vision – there are also many differences: between groups and between individuals, in the principles they choose and in the relative importance they attach to different principles.

These different priorities, as differences of values, are one reason why decision-making is often so difficult in day-to-day practice. The **values** that guide our decisions are complex and often conflicting. The other main reason is similar. It is that the **facts** that guide our decisions – the evidence drawn upon – are often also complex and conflicting. This is why both values-based practice and evidence-based practice are needed.

Values-based practice goes to the heart of what is so difficult about compulsion. In most situations throughout health and social care, while those involved may have some differences of values (for example, about what is the best treatment to use from different points of view), usually they will all more or less be working together to the same ends. But with compulsory treatment there is a direct **clash of values**. In short, the person concerned wants one thing (not to be treated) while everybody else wants the opposite (that s/he gets treatment).

Further reading on values-based practice is given at the end of this module.

The Guiding Principles in the new COP

The principles themselves – as set out in Chapter 1 of the COP – are now described in Details Box 12.

Details Box 12. List of Guiding Principles in the new COP (COP, 1.2 to 1.6)

Purpose	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	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	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	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	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 achieve the purpose for which the decision was taken.

Balancing Different Values

The way to think about the principles is as a framework of important values to guide practice. As you may have identified in the previous activity, values cover anything that is important to you. They motivate you and hence guide your actions. Values include, for example, needs, wishes, expectations and hopes. The principles in the COP aim to reflect all the important issues (i.e. values) relating to compulsion that were raised by stakeholders in the consultation on the revised MHA and in Parliament. This is why they are called **Guiding** Principles: they represent key values that should guide you in applying the MHA in practice.

Illustrated below is how the principles help you in practice. As you will see, in any given situation one or more of the principles may be more important than others; also, there will sometimes be direct tensions between them (e.g. between 'purpose' and 'effectiveness, efficiency and equity'). However, the key point to remember is that, as important values, all five principles always need to be weighed in coming to a balanced decision in any particular situation in practice.

This key idea, that the principles are a framework of important values that need to be balanced in particular situations, is shown in Figure 1 as a diagram where each of the principles has an equal place. None of the principles is more important than others but in different individual situations different principles will have to be balanced in various ways to support best practice in applying the provisions of the MHA guided by the COP.

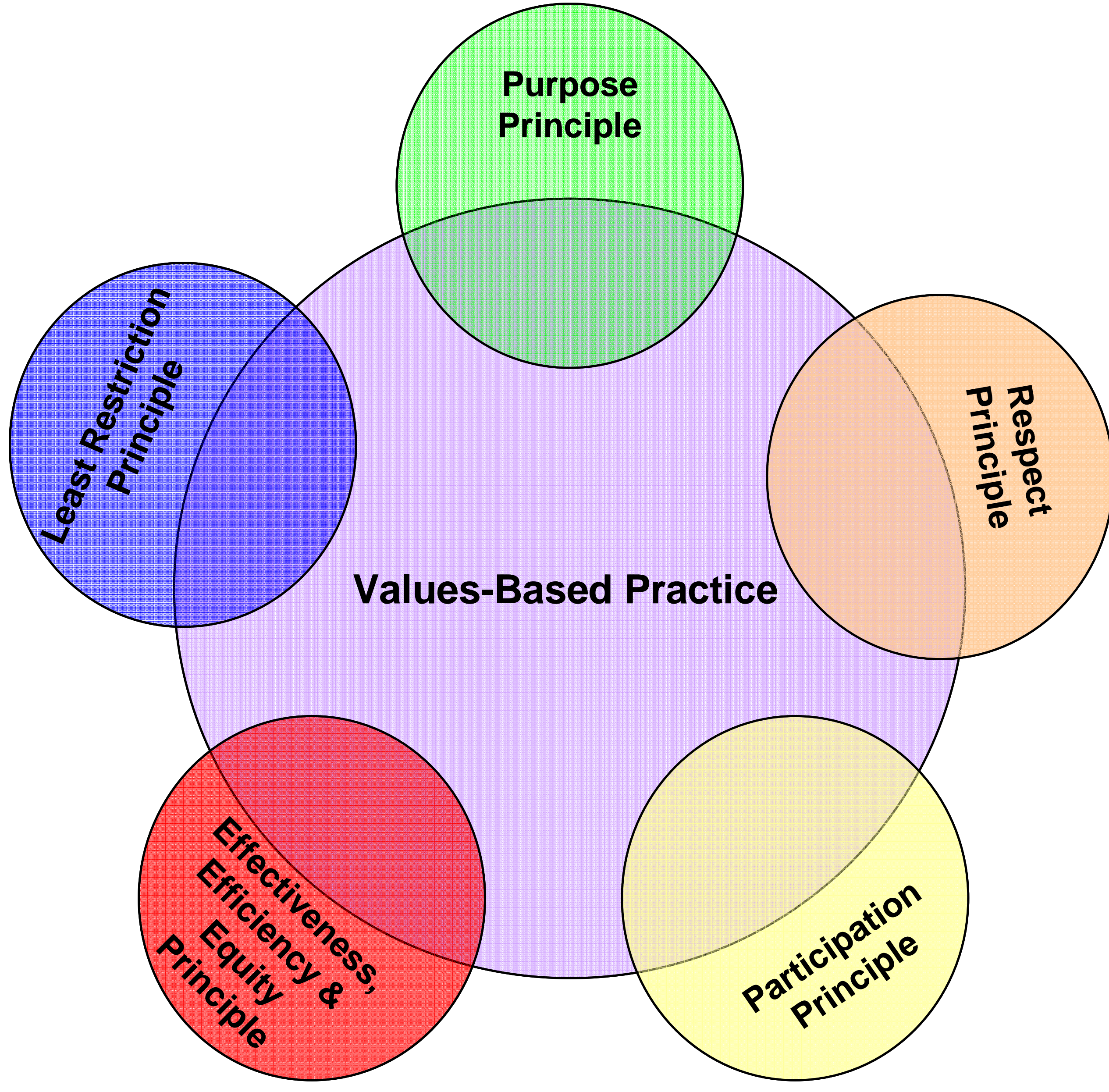

Figure 1. Framework of Principles

In the final part of this module you will be working through practical examples of how values and the ‘Framework of Principles’ supports balanced decision-making in applying the MHA guided by the COP.

In running through the activities in the next part of this module, you may find it helpful to keep the diagram of the ‘Framework of Principles’ in front of you.

PUTTING IT ALL TOGETHER

In this final part of the module, you will pull together the work you have done so far by:

- working through a case example and reflecting on how the MHA, the COP and the principles work together to support best practice;
- looking briefly at the wider framework of law, policy and practice guidance that are also important to supporting best practice on compulsion; and
- noting further training resources, in addition to the materials in this set, for improving practice on compulsion.

ACTIVITY 6 – SCENARIO: ROSEMARY

Below is a brief scenario: read it, then answer the questions in the box below.

Rosemary is a 42-year-old African woman who says she has been hearing the voice of a long deceased ancestor for the last two months. Some members of her church believe that hearing this voice means she is possessed, and they have been trying to exorcise the "demon" in her. Rosemary is beginning to isolate herself from her family and is becoming increasingly agitated. Her sister has contacted the GP for help who in turn has arranged for Rosemary to be seen by the mental health team.

1. **What values may be important here?**
2. **Consider the principles and discuss how they may apply to this situation.**

DISCUSSION POINTS

Please note that comments on most scenarios are provided in Appendix 1. In Rosemary's case comments have not been included, allowing you to start to develop your own understanding of the values and principles involved.

ACTIVITY 7 – SCENARIO: CAROL (1)

Below is another scenario: read it, then answer the questions in the box below.

Carol is a 23-year-old African-Caribbean woman living in a bedsit. Her mother has suspected that Carol has been using drugs (heroin). Carol's behaviour has changed significantly and she has been behaving very oddly at different times. When challenged, Carol has always denied any involvement with drugs, but offers no other explanation and does not accept she has changed in any way. As a result of her concerns, her mother has been staying at Carol's bedsit for the past week.

For the past two nights Carol's mother has become increasingly concerned as Carol appears not to be sleeping, and she has often heard Carol talking as if someone is in the bedroom. Matters came to a head today after Carol told her mother she was hearing the 'voice' of an unknown male threatening to harm her. As a consequence Carol is currently hyper-vigilant, anxious and feels she needs to carry a knife for her 'own protection'. She appears paranoid and agitated.

Carol's mother has contacted their GP to ask for help.

1. **Which of the MHA's principles might be most important in this situation?**
2. **Does Carol fit the definition of 'mental disorder' given in the MHA?**
3. **Based on your answers to 1 and 2, what action (if any) do you think the GP should take?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, page 135

Throughout the exercise, it is really important to think of Carol 'for real'. Imagine that she is your client or patient or, if you are a patient, that you are either Carol herself or involved with her as a carer or family member. It is only by working in this way – i.e. imagining yourself in a real-life situation with real decisions to take rather than discussing things in a theoretical way – that you can get a clear sense of how the MHA, the COP and the principles work together to support best practice in compulsion.

The Wider Framework

In addition to the MHA with its COP and the principles, there are many other sources of support for best practice in compulsion. These include:

- other legislation
- other policies
- other good practice guidance

END OF MODULE

You have now completed this module and can move on to the other modules. What you have learned will equip you to undertake the more detailed modules that follow. If you wish to do some further reading in relation to the topics covered in this module, here are some suggestions.

Further Reading

Department for Constitutional Affairs (2007). Mental Capacity Act 2005. London: TSO. (*Also available from the Office of Public Sector Information website)*

Department for Constitutional Affairs (2007). Mental Capacity Act 2005 Code of Practice. London: TSO. (*Also available from Ministry of Justice website)*

Department of Health (1999). National Service Framework for Mental Health: Modern Standards and Service Models. London: DH

Department of Health (2008). Mental Health Act 1983 as amended by the Mental Health Act 2007 (unofficial version). London: DH *(Available on Department of Health website*)

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Great Britain (2008). Mental Health Act 2007: Elizabeth II - Chapter 12 - Explanatory Notes. London: TSO.

Ministry of Justice (2008). Deprivation of Liberty Safeguards, Addendum to the Mental Capacity Act 2005 Code of Practice. Crown Copyright (pending publication.

NIMHE (2007). Mental Health: New Ways of Working. Developing and sustaining a capable and flexible workforce. London: DH.

Woodbridge, K. and Fulford, B. (2004). Whose Values? A Workbook for Values Based Practice in Mental Health. London: Sainsbury Centre for Mental Health.

GUIDING PRINCIPLES MODULE

GUIDING PRINCIPLES MODULE

INTRODUCTION TO THE MODULE

This module will raise awareness around the five Guiding Principles ("the principles") contained within the Code of Practice (COP). These principles are designed to inform decisions: they do not determine them. However, the context will be the all-deciding factor as to which of these principles is employed in a particular case. It is imperative that all the principles inform every decision made under the MHA. The principles are designed primarily to safeguard the rights of patients. They also cover carers and family who have the right to a fair and sensitive service for their relative.

The exercises within this module are designed to provoke discussion and debate around the principles while applying the skills of value-based practice. With this in mind, there will be no answers offered as the discussions should take into account the local context, the individuals involved and service delivery, all of which contribute to determining the way in which you work and, therefore, how you apply these principles. Comments to guide you in your discussions will supplement the exercises.

PREPARATION

*Before undertaking this module, it is important that you complete the **Foundation Module**, particularly Part Three on the role of the Code of Practice and the Guiding Principles. You are also advised to read the relevant sections in the **Code of Practice (Chapter 1)** and the **Reference Guide**.*

The principles from the COP are:

1) **Purpose principle**

2) **Least restriction principle**

3) **Respect principle**

4) **Participation principle**

5) **Effectiveness, efficiency and equity principle**

The key principles will be linked to case examples that will assist you through the module and offer an increased understanding of how they will be best applied in practice. These examples are designed to help you develop your understanding of the principles being discussed and this will enable you to think through how the MHA will impact upon your practice.

LEARNING OUTCOMES

On completion of this study participants should:

- ***Be able to define the principles contained with the Code of Practice;***
- ***Have gained clarity around the inclusion and practical application of the principles when using the MHA and Code;***
- ***Understand the relationship between the principles and the role of the practitioner;***
- ***Be able to demonstrate the principles in practice in order to safeguard the rights of the patient and their carers.***

VALUES-BASED PRACTICE, EVIDENCE-BASED PRACTICE AND THE GUIDING PRINCIPLES

The principles within the COP offer a greater opportunity to utilise and apply evidence-based and value-based approaches while working with the MHA. Practitioners will have to consider the principles when dealing with the MHA, and their practice may be called into question if the Guiding Principles are not seen to be applied along with the letter of the MHA.

As you will see in this module, the principles provide a framework of important considerations i.e. values that have to be balanced when applying them all in individual situations. This is why the skills of value-based practice are helpful in difficult situations like those involving the use of the MHA.

Clarity around evidence-based and values-based approaches may be required in some instances.

Evidence-based approaches are:

> ***"…interventions for which there is consistent scientific evidence showing that they improve client outcomes" (Drake et. al., 2001).***

However, you need to be careful not to use 'just any evidence' or inappropriate evidence. Evidence-based approaches should provoke more questions to determine what is 'good enough' evidence and how this evidence should inform best practice. Dawes (1999) suggests these questions should focus on the evidence of how treatment can be shown to be effective.

Values-based approaches are complex and in their broadest sense are associated with ethics. This could include anything that is valued by any person. **Values-based approaches are based upon mutual respect and attend to the values of everyone concerned** (Woodbridge and Fulford, 2004).

How do the MHA, the Code of Practice and the Guiding Principles fit together?

As shown in the previous module:

- The MHA tells us **What** to do
- The COP explains **How** to do it
- The Guiding Principles help us apply the MHA and COP in **individual situations**

This relationship is underpinned by section 118 of the MHA, which states the following:

(2A) The code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act.

(2B) In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed:

(a) respect for patients' past and present wishes and feelings,

(b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006),

(c) minimising restrictions on liberty,

(d) involvement of patients in planning, developing and delivering care and treatment appropriate to them,

(e) avoidance of unlawful discrimination,

(f) effectiveness of treatment,

(g) views of carers and other interested parties,

(h) patient wellbeing and safety, and

(i) public safety.

(2C) The Secretary of State shall also have regard to the desirability of ensuring:

(a) the efficient use of resources, and

(b) the equitable distribution of services.

(2D) In performing functions under this Act persons mentioned in subsection (1) (a) or (b) shall have regard to the code[1].

[1] The persons in these subsections are registered medical practitioners; approved clinicians; managers and staff of hospitals, independent hospitals and care homes, and approved mental health professionals.

The diagram below demonstrates how the MHA provides the foundation or 'bedrock' for application. To build upon this you need to be sure 'how you do it'. This can be assisted by the use of the COP. To top off the process, the Guiding Principles provide the 'fine-tuning' which allows the MHA to be applied in an evidence- and values-based manner to individuals. This can hopefully ensure that any distress is kept to an absolute minimum.

Guiding Principles

(Assisting the application of the Act in 'individual situations')

Code of Practice

('How to do it')

Mental Health Act

('What to do')

The notion is that the principles are a framework of important values that need to be balanced in particular situations. **The principles make the practitioner consider the questions, 'Who?' 'How?' and 'Why?'** These questions must be asked by practitioners in connection with evidence-based approaches that may maximise well-being and minimise compulsion at all stages of the process.

It is also important to understand the difference between personal or professional values and the principles. While personal and professional values express accepted good practice, the principles have been debated and agreed in Parliament and therefore have an enhanced legal status.

The principles may also prove useful as a broad overview for patients and carers to help them understand how professionals reach the decisions that they do, and may also provoke appropriate questions about the process as a whole.

For example, if a new (unfamiliar) practitioner or patient/carer is taking part in the process of assessment under the MHA for the first time, they may find it helpful to be given a copy of the principles in order to understand the process a lot more clearly.

ACTIVITY 1

Consider the Guiding Principles and section 118 (2A-2D) of the MHA shown above.

Relate each of the statements in (2B) and (2C) to each of the Guiding Principles.

The Principles in Detail

1. Purpose principle

When decisions are made under the MHA, these and the actions of the practitioners must be accounted for at all times. This includes being able to explain why a particular action or decision was taken. The well-being (psychological and physical) and safety of the patient must also be considered at all times. Along with this are the safety and protection from harm of both the patient and the public (which includes carers, family and practitioners). Decisions should also be informed by an assessment of risk.

Patients will have the right to advocacy, and Independent Mental Health Advocates (IMHAs) will be available to all patients who are subject to compulsion either in hospital (s2 or 3) or in the community (Guardianship and Supervised Community Treatment). The purpose of IMHAs is to make sure people who are subject to compulsion are aware of and able to make use of their rights and protections (for example, being able to appeal against a section of the Act).

Activity 2 – Scenario: Andrew

Below is a case study. Please read and answer the questions that follow.

Andrew is a 56-year-old man and has had a diagnosis of schizophrenia for 34 years. He has just been detained under the MHA as a result of a relapse in his mental state. He has previously been on several different types of anti-psychotic medication and has led a rather sedentary life style over the years. He has also recently been diagnosed with diabetes and is recognised as being clinically obese.

1. **What observations and monitoring may need to be taken into consideration for Andrew's overall well-being?**
2. **What links can be established between Andrew's lifestyle, well-being and the Purpose principle?**
3. **How would this be documented and built into a future care package for Andrew?**

When a patient is detained under the MHA it is not only his mental health that needs to be addressed. The Purpose principle includes all aspects of care for the patient. Therefore Andrew's physical health and overall well-being must be acknowledged and addressed. However, the **purpose** of the use of the MHA is the assessment of mental disorder. Although it can't be used to force Andrew to accept treatment for physical illness, professionals continue to have a responsibility to **consider how his physical health problems may interact with his mental welfare**, and to consider whether Andrew has the capacity to understand and make decisions about his physical health.

Andrew has a right to make decisions about his physical health, even if he is on section or professionals feel these decisions are putting his physical health at risk, unless it can be demonstrated that he does not understand the risks he is taking. Even in this case, professionals would need to apply the 'Best Interest Checklist' from the Mental Capacity Act, and think about issues such as what his views **would** have been – for example, to stop smoking – when he had capacity to make such decisions.

Risk assessments are the tools utilised to gather information and provide a 'snapshot' of risk at any given point in time. A **risk management plan however is more comprehensive, details strategies to be implemented** and should also include contingency plans. The latter is good practice and useful throughout the delivery of care whereas an assessment can be renewed at any given point in proceedings and will help advise the decision to be made regarding detention.

Risk management is a component of the Purpose principle and is of paramount importance and, in order that the safety of the patient and others is maintained at all times, this cannot be overlooked.

2. Least restriction principle

The patient must be afforded as much freedom as possible within the realms of safe practice. This means that a balance needs to be made, using thorough risk assessment and management plans, to ensure that the patient's rights to freedom are balanced with their own right to be protected from the consequences of their mental disorder, and the rights of others (such as members of the public) not to be in danger of harm.

Any interventions that are made without the patient's consent must attempt to minimise the restrictions on the patient's liberty.

Today there is more community-based provision than ever and the community is now the focus for the majority of mental health resources and services. This increases the potential to manage the care of a patient within the community as an alternative to hospital admission. Options may include the use of Crisis Resolution and Home Treatment Teams and community crisis beds if available. All these options may be beneficial depending on the situation and issues being addressed at any given time. This emphasises the need for each case to be dealt with on its individual merits.

Creative and collaborative approaches to care for patients can be the most beneficial way of ensuring that restrictions are minimised. For professionals to understand the anxieties that may be present in a person facing a loss of freedom and liberties would be a beneficial and empathic place to start.

ACTIVITY 3 – SCENARIO: CAROL (2)

Below is a case study. Please read and answer the questions that follow.

Consider Carol from page 32. Carol has been invited to visit the CMHT for an assessment, but has failed to attend the two appointments offered to her. Her mother is increasingly concerned over the rise in Carol's strange behaviour due to increased paranoia.

1. **What judgements are automatically assumed that may convince us Carol requires an admission in hospital rather than an alternative?**
2. **How may this scenario be reframed to address a more collaborative and creative approach?**
3. **If the decision remains that Carol requires a hospital admission, how might:**
   a) **an empathic approach be used to support Carol through her distress?**
   b) **the issues be addressed so that if they were to recur Carol may remain in the community?**

Despite the difficulties in remaining absolutely non-judgemental, assumptions must be suspended as far as possible in order to offer a service that is fair, equitable and offers the least restriction for the patient.

3. Respect principle

The diversity of a population has to be respected and acknowledged by others, and this is also true of mental health patients. It is unfortunate that mental health patients are often marginalised by others in society. Therefore an anti-discriminatory approach must be upheld at all times to ensure equitable and fair practice. Respect must be acknowledged for a patient's age, race, disability, religion, culture, gender or sexual orientation. Patients should be treated with respect for their qualities as unique individuals. For example, such an approach should be to the fore in any interactions with Black and Minority Ethnic (BME) patients who are disproportionately over-represented in receiving compulsory treatment.

The wishes and feelings of the patients must also be taken into account, whether offered in advance or at the time of any intervention, so far as these may be reasonably ascertained; and wishes should be respected wherever that is practicable. There must be avoidance of unlawful discrimination and a respect for diversity as stated in the Equality Act (2006).

ACTIVITY 4 – SCENARIO: RAJ

Below is a case study. Please read and answer the questions that follow.

Raj is a 68-year-old man of Indian origin. He has been in England since he was 10-years-old when his family emigrated. He has had contact with mental health services for approximately 35 years and has a diagnosis of paranoid schizophrenia. He has two sons who are working in India and one daughter who lives 130 miles away from him. His wife died three months ago and, following the funeral, his children returned to their respective homes and work. This has left Raj living alone in his bungalow. Despite the support of a Social Worker from the local Community Mental Health Team, and a support worker from a local, private (non-statutory) organisation, his symptoms have increased and he has been more distressed as a consequence. He has been offered an informal admission to hospital for assessment and a medication review but this can only be made available on an older person's ward where many of the patients have dementia. Raj declined this and has been trying to manage in the community.

1. **What aspects need to be considered for Raj to ensure adequate respect for him is maintained throughout his care package?**
2. **What might need to be done in order to ensure that appropriate services are available for Raj?**
3. **If Raj continues to refuse admission and he experiences deterioration in mental health, what conflicts may occur between the principles of respect and his on-going welfare and/or the safety of others?**

Appropriate services for patients of Raj's age are certainly necessary, but there may also be contextual and individual needs that require the forethought and attention of service providers if a service is to guarantee full respect for the patient. It may also become increasingly difficult and sensitive to manage if detention is deemed necessary. Carers, family members and other interested parties should also be treated with respect and, where appropriate and practicable, involved in decision-making processes.

4. Participation principle

Where practicable, patients should be involved in planning and developing their own care in order to assist in making this care appropriate and effective. This involvement should also be extended to encourage carers, family members and other people who have a genuine interest in the patient's welfare unless there are particular reasons to the contrary. The views of all parties involved should be taken seriously in the overall care management.

ACTIVITY 5 – SCENARIO: DIANA

Below is a case study. Please read and answer the questions that follow.

Diana is a 28-year-old living with her husband and her seven-year-old son in a busy part of town. She has been working in a bookshop for her father-in-law for the past four years. Diana was diagnosed with bi-polar disorder nine years ago. She has been detained under a section of the Mental Health Act on two previous occasions when she became hypomanic. On both occasions, the police were involved and Diana felt greatly ashamed for months afterwards and felt she was the talk of the local area. Despite this, she is happy to accept contact from secondary mental health services for the present so long as it does not interfere with the rest of her life. As a consequence, her CPN visits every four to six weeks. Diana is managing well and has promised to call the CPN if she begins to feel unwell.

1. **How can the CPN maintain or increase Diana's participation in her care package?**
2. **What would be the advantages of using an advance statement at this stage in proceedings?**
3. **What might be the fears/concerns of Diana and her family and mental health services if Diana were to develop symptoms of hypomania once more?**

It would certainly be good practice, if involvement by the patient had not been possible, that a plan be instigated and circulated to the appropriate parties for future participation. The use of advance statements, relapse management plans and 'wish lists' may be useful additions to the care package of a patient and enhance the opportunity for participation. The past and present wishes of the patient should be considered so far as they are known. Decisions on the use of compulsory powers should take into consideration all available perspectives, particularly those of the patient, any carer(s) and other involved professionals. Decisions by professionals and statutory bodies should be made in a transparent way.

Family therapy is advocated within the National Institute Clinical Excellence (NICE) Guidelines for Schizophrenia (NICE, 2002). The uptake of such therapeutic approaches would certainly be advantageous and seen as good practice but also has implications regarding the appropriate training for practitioners. However, this is certainly movement in the right direction when addressing principles of participation.

5. Effectiveness, efficiency and equity principle

Every patient deserves a good and fair service, and this has to be considered and ultimately offered on each occasion. Efficient use of resources and effective and equitable distribution of services is important and needs to be considered. Adopting a broad angle of view with regard to the Effectiveness, efficiency and equity principle urges decision makers to take account of other people's perspectives on what may be required. Integrated teams are becoming the dominant mode of service delivery and these offer a multi-disciplinary approach that pools and shares resources as well as combining knowledge to offer a much improved service.

ACTIVITY 6 – SCENARIO: EDDIE (1)

Below is a case study. Please read and answer the questions that follow.

Eddie is 19-years-old. He has been taken to the local section 136 suite by the police for assessment under the section 136 of the MHA. This was due to Eddie wandering among traffic and causing a disturbance. He was subsequently arrested and removed to a place of safety. This is the first time he has been involved with the police.

Eddie was seen by a psychiatrist three weeks ago for an initial out-patient appointment and has been referred to a Community Mental Health Team. He has not, as yet, been allocated a care coordinator. He suffers from auditory hallucinations and is quite withdrawn at present. He did disclose that 'voices' told him to walk into the road but is not saying much else. He is known to use cannabis and amphetamines, but has not been drug screened yet.

1. **What resources are already in place? And which other agencies need to be involved?**
2. **How might the agencies/teams be encouraged to work together?**
3. **How can it be ensured that knowledge is combined and shared?**
4. **How might this approach enhance the care and/or treatment of Eddie?**

Guidance from other agencies such as the National Institute for Clinical Excellence or Social Care Institute for Excellence (SCIE) on certain issues may prove to be beneficial in enabling the most clinically effective approach to care. Prescribing anti-psychotic medication may be used from the clinical guidance on schizophrenia as well as assessment tools and recognised pathways in approaches to care.

In conclusion, the Guiding Principles are to be used to inform the decision-making process and should be heeded by all practitioners. While some case examples have been offered here, the Guiding Principles should be considered and applied in **all** cases. It is also vital to remember that none of the Guiding Principles carries more weight, importance or significance than any other. The principles provide a framework of important considerations that should always be kept in mind when decisions are made under the MHA, and may also be used in general practice.

END OF MODULE

You have now completed this module and can move on to the other modules. What you have learned will equip you to undertake the more detailed modules that follow. If you wish to do some further reading in relation to the topics covered in this module, here are some suggestions.

Further Reading

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Woodbridge, K. and Fulford, B. (2004). Whose Values? A Workbook for Values-Based Practice in Mental Health. London: Sainsbury Centre for Mental Health.

References

Dawes, M. (1999) Chapter 1: Evidence-Based Practice *in* M. Dawes, P. Davies, A. Gray, J. Grant, J. Mant, K. Seers & R. Snowball (1999) Evidence-Based Practice: A primer for health care professionals. Churchill Livingstone. Edinburgh.

Drake, R.E.; Goldman, H.H.; Leff, H.S.; Lehman, A.F; Dixon, L.; Mueser, K.T.; & Torrey, W.C. (2001). Implementing Evidence-Based Practices in Routine Mental Health Service Settings. Psychiatric Services Journal 52 (2) 179-182.

NICE (2002). Guidelines for Schizophrenia. National Institute for Clinical Excellence.

Woodbridge, K. & Fulford, B. (2004) Whose Values? A Workbook for Values-Based Practice in Mental Health Care. London: Sainsbury Centre for Mental Health.

MODULE 1: COMING INTO COMPULSION

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INTRODUCTION TO THE MODULE

This module examines the changes made in the MHA that affect a patient when they first come into contact with mental health services and compulsory assessment or treatment is being considered. These changes are: the **definition of mental disorder; the new appropriate medical treatment criteria; and age appropriate services and protections.**

The MHA changes the way mental disorder is defined so that a simplified definition applies throughout the Act and references to categories of disorder are abolished. It also introduces a new "appropriate medical treatment" test which will apply to all the longer-term, treatment-based powers and forms of compulsion. As a result it will not be possible for patients to be compulsorily detained for treatment (e.g. section 3) or have their detention continued **unless medical treatment appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient**. Finally, the MHA introduces "age appropriate services" so that when a young person (under 18) is admitted to hospital with a mental disorder they are treated (subject to their needs) in an environment suitable for their age.

The amendments covered in this module are identified in the Foundation Module as Key Changes 1, 2 and 3 in the pathway through compulsion.

PREPARATION

Before undertaking this module it is important that you complete the ***Foundation Module****, particularly Step 1 in the pathway through compulsion. You are also advised to read the relevant sections in the* ***Code of Practice (Chapters 3, 6, 34 & 36)*** *and the* ***Reference Guide.***

LEARNING OUTCOMES

On completion of the module and some independent study, you will be able to:

- ***Show awareness and understanding of the definition of mental disorder contained within the MHA;***
- ***Understand appropriate medical treatment as defined in the MHA;***
- ***Apply the Guiding Principles in relation to appropriate treatment;***
- ***Understand the age appropriate services duty.***

DEFINITION OF MENTAL DISORDER

The MHA changes the way mental disorder is defined so that a single definition applies throughout. It also abolishes references to categories of disorder. These amendments complement the new "appropriate medical treatment" test).

In other words, the new definition of mental disorder ensures **people are not excluded** inappropriately from mental health services, while the appropriate medical treatment test ensures people with a mental disorder can **only be detained for treatment where treatment for the purpose of improving or preventing a worsening of the disorder, its symptoms or manifestations, is really available to them**. In addition, of course, the existing criteria for the use of compulsion (such as those related to risk) also continue to apply.

Definition of Mental Disorder – changes to key provisions

How is mental disorder defined in the Act?

The wording of the definition of mental disorder in existing MHA 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**".

Examples of clinically recognised mental disorders include mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities.

The four categories of mental disorder are abolished, so that:

(a) section 3 etc now applies to all mental disorders, whether or not they can be put into one of the categories;

(b) there is no longer any need for doctors to determine a legal category for the patient's disorder;

(c) the criteria for compulsion are no longer different for different categories of disorder.

Difference does not equal mental disorder – issues that should not influence decision-making

Culturally inappropriate beliefs may be symptoms of mental disorders, but on their own (without evidence that there is also a mental disorder of some sort) you should not assume that this must be a sign of illness. Similarly, sexual orientation does not equal mental disorder.

"Difference should not be confused with disorder. No-one may be considered to be mentally disordered solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind. The same is true of a person's involvement, or likely involvement, in illegal, anti-social or "immoral" behaviour. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger."

(COP, 3.6)

This means that having different beliefs, or behaving differently from other people, should not be thought of as mental disorder unless there is a clear link between the belief or behaviour and mental ill health.

Exclusions from the Definitions of Mental Disorder

Dependence on alcohol or drugs on its own should not be considered as a mental disorder for the purposes of the MHA. This means there are no grounds for detaining a person in hospital (or using other compulsory measures) because of alcohol or drug dependence alone.

However, it is possible to detain a person who is dependent on alcohol or drugs if s/he is also suffering from a mental disorder, which is within the MHA definition. For example, where a person is depressed, suicidal and abuses alcohol as a way of coping, it may be possible to detain them for assessment and treatment of the depression.

COMMON MYTH – DEFINITION OF MENTAL DISORDER	
MYTH	**REALITY**
The definition is being widened	Not exactly. • New basic definition "any disorder or disability of the mind" means the same as the old definition, just shorter. But … • "Sexual deviancy" is no longer excluded – so some mental disorders related to this area are now included. • Four categories of disorder abolished – so there may be a few disorders now covered by section 3, etc., which were previously excluded from treatment in the unamended Act – for example, Asperger's Syndrome.

The Learning Disability Qualification

This qualification applies to section 3, Guardianship, SCT and other longer-term forms of compulsion. The MHA defines a learning disability as *"a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning"*.

To be subject to one of those types of compulsion **only** on the basis of a learning disability that learning disability must be associated with "*abnormally aggressive or seriously irresponsible"* conduct on the part of the person concerned

> *"In assessing whether a patient's learning disability is associated with conduct that could not only be categorised as aggressive, but as abnormally so, relevant factors may include:*
>
> - *when such aggressive behaviour has been observed, and how persistent and severe it has been;*
> - *whether it has occurred without a specific trigger or seems out of proportion to the circumstances that triggered it;*
> - *whether, and to what degree, it has in fact resulted in harm or distress to other people, or actual damage to property;*
> - *how likely, if it has not been observed recently, it is to recur; and*
> - *how common similar behaviour is in the population generally."*
>
> (COP, 34.8)

It is important to remember that people who have a learning disability may also experience mental ill health: they may need to be detained in hospital for assessment or treatment of that disorder quite separately from their learning disability. In that case, the qualification would not need to apply.

COMMON MYTH – LEARNING DISABILITIES	
MYTH	**REALITY**
Learning disabilities aren't mental disorders unless they cause abnormally aggressive or seriously irresponsible behaviour	Not quite. • Learning disability qualification excludes learning disabilities unless they "are associated with" (not "cause") abnormally aggressive/ seriously irresponsible behaviour. • The qualification only applies to certain sections (NOT section 2 or section 136, for example). • The effect is basically the same as now. • People with a learning disability can develop a mental illness that needs assessment or treatment quite separately from their learning disability – and they can be detained in hospital to make sure they receive that treatment, whatever their behaviour is like.

Below is a case study. Please read and answer the questions that follow.

ACTIVITY 1 – SCENARIO: DAVID

David is a man in his late 50s who lives alone and has not previously been known to mental health services. Recently he has been making 'odd' telephone calls to his GP surgery and his GP has become increasingly concerned about his mental state. Despite being offered numerous appointments, David has not attended the surgery. Following the most recent telephone call the GP decided to visit David at home. When the GP arrives, David opens the door and although a bit excited and perhaps confused, he appears to show no initial signs of mental illness. On entering the property, the GP sees that the gas appliances have been removed from their permanent fixtures and various electrical wires have been disconnected from light switches and sockets. When asked about this, David states that he has had to do this to stop 'them' listening in on him. There is also a strong smell of gas in the house.

1. **Which of the MHA's principles might be most important in this situation?**
2. **Does David fit the definition of 'mental disorder' given in the MHA?**
3. **Depending on your answers to Questions 1 and 2 what are the next appropriate steps to take?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, p 136

APPROPRIATE MEDICAL TREATMENT

The MHA introduces an appropriate medical treatment test that will apply to all the longer-term powers of compulsion associated with treatment. This includes section 3 and SCT. As a result, it will not be possible for patients to be subject to compulsion for treatment, or their compulsion continued, unless treatment appropriate to the patient's mental disorder and all other circumstances of the case is available to them. The test requires that appropriate treatment is actually available for the patient. It is not enough that appropriate treatment exists in theory for the patient's condition.

In Part 2 of the MHA it states that:

> *"…references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case."*

(MHA, 3(4))

The test is not applied to the use of compulsion for assessment, for example, under section 2.

The appropriate treatment test needs to be applied to:

- **Detention under section 3**
- **Supervised Community Treatment**
- **Forensic sections associated with treatment**
- **When renewal and discharge of these sections is being considered**

To meet this test, professionals who make decisions must be convinced that the patient:

- Will have treatment **available** at a particular place; and
- That the intended treatment is appropriate **to their needs and circumstances.**

To be appropriate the treatment must:

- Be right for the nature and degree of mental disorder the person has. For example, for someone with a personality disorder, therapy might be the most appropriate treatment whereas someone with a mental illness might need medication;
- Take account of the individual circumstances of the patient. For example, a mother with a new baby and who has become psychotic should have her needs as a new mother taken into account.

What other circumstances should be considered?

Other factors which may be considered are shown in Box 1.

Box 1. All other circumstances of the case (COP, 6.11)

When considering whether 'all other circumstances of the patient's case' is appropriate, the COP suggests the following factors be considered:

- the patient's physical health – how this might impact on the effectiveness of the available medical treatment for the patient's mental disorder and the impact that the treatment might have in return;
- any physical disabilities the patient has;
- the patient's culture and ethnicity;
- the patient's age;
- the patient's gender, gender identity and sexual orientation;
- the location of the available treatment;
- the implications of the treatment for the patient's family and social relationships, including their role as a parent;
- its implications for the patient's education or work; and
- the consequences for the patient, and other people, if the patient does not receive the treatment available. (For mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence.)

This ensures that professionals develop a wider social focus when they consider whether treatment is appropriate. It is important to view the person within their social, cultural and practical circumstances when considering whether treatment is suitable to their needs.

The COP says that appropriate treatment will vary between patients.

A patient's attitude towards proposed treatment is also a factor, and certain treatments and therapies require a patient's cooperation to be effective. Generally, co-operation (especially for treatments while the patient is subject to SCT) is an important factor. However, in some cases where therapy is the main form of treatment, it may be the availability of the treatment rather than a person's willingness to engage with it that is sufficient justification to meet these criteria.

ACTIVITY 2

To be appropriate, treatment must be suitable to a person's individual situation, including their cultural needs.

1. **Consider and reflect on what constitutes 'appropriate treatment'?**
2. **Can you think of an example from your own practice or experience where taking account of a person's cultural needs would improve or benefit the patient's care or treatment?**

Medical Treatment

The MHA provides a specific definition of "medical treatment". It makes it clear that as well as medication, treatment can also include:

- Nursing
- Psychological interventions
- Specialist mental health habilitation, rehabilitation (including education and training in work, social and independent living skills) and care

However, the MHA also tells us that:

> *"Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations."*
>
> (s145 (4))

In other words, medical treatment proposed under the MHA must have the purpose of improving, or at least preventing a worsening of, the mental disorder or the symptoms of the disorder from which someone is suffering. The MHA cannot be used if the treatment is not for that purpose. Together with the appropriate treatment test, these changes to the definition in the MHA provide a framework of safeguards for the patient and treatment of a mental disorder.

Nature or Degree?

The appropriate treatment test does not exist in isolation from other criteria that need to be met before someone can be detained. In particular, it needs to be considered whether the **nature** or **degree** of a person's mental disorder makes it appropriate to make them subject to compulsion. The treatment must also be appropriate *"in all other circumstances of the case"* (see Box 1).

Appropriate treatment encompasses the question of whether proposed medical treatment is clinically appropriate for the nature or degree of the patient's mental disorder (see Box 2).

Box 2. Nature or Degree?

The words "nature or degree" are already part of the criteria for the use of compulsion in the existing MHA.

Case law has established that "nature" refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. In other words, **the pattern** that the disorder takes in a particular patient's case.

"Degree" refers to the current manifestation of the patient's disorder – in other words **the intensity** with which the patient is experiencing the symptoms. (Regina v Mental Health Review Tribunal for the South Thames Region. Ex. P. Smith [1999].)

It is important to appreciate that, to meet the criteria of the MHA, a mental disorder may be **either** of a nature **or** of a degree.

COMMON MYTHS – APPROPRIATE MEDICAL TREATMENT TEST	
MYTH	**REALITY**
It is just Treatability by another name	No, it really isn't. • Treatability test focused on the "likelihood" of the outcome of treatment. The Appropriate Medical Treatment Test (AMTT) does not require anyone to say what is likely to happen. • AMTT goes much wider – it is about appropriateness in the round. • AMTT applies equally to all groups of patients (though not to all patients, because it is not part of the criteria for section 2 for example).
The Appropriate Medical Treatment Test enables the detention of people with personality disorders	No, that could be done anyway, BUT it does have practical effects: • Doctors making recommendations will need to know in advance where the patient is likely to be detained (because otherwise they can't say whether appropriate treatment is available). • Risk of challenge – providers need to think about appropriateness to the individual. A one-size-fits-all mentality is now a legal issue, not just poor practice.

Activity 3 continues Eddie's pathway through compulsion (see page 49).

ACTIVITY 3 – SCENARIO: EDDIE (2)

Following a Mental Health Act Assessment, Eddie was placed on section 2 and admitted to hospital. Following a period in hospital he was re-assessed and placed in a section 3 treatment order. He has not responded to medication and has continued to exhibit signs of a psychotic nature. He has no insight into his condition and is frequently a disturbing influence on the ward.

He has appealed against his section, saying he is not receiving any useful treatment, and demands a MHRT discharges him.

1. **Given that Eddie isn't happy with his present treatment plan, what other treatment options could be explored to complement medication?**

2. **Which of the MHA's principles might be most important in this situation?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, p 137

What might an appropriate treatment plan look like?

The treatment that is actually given to a patient can focus on more than just the reasons for the patient's detention or other use of compulsion. For example, the treatment package for patients who have been detained for the protection of others will also aim to protect their own mental health. Nor does the test tie the decision maker to the particular package envisaged at the point of detention: it may be replaced by either a modified or a wholly different approach to treatment that may be more appropriate.

AGE APPROPRIATE SERVICES

One of the most significant changes in relation to children and young people is the introduction of the duty to provide an age appropriate environment. Section 131A requires the managers of an NHS or independent hospital to ensure that "*the environment in the hospital is suitable for the patient having regard to the patient's age (subject to the patient's needs)".* This applies to all patients under 18, whether they are liable to be detained or admitted to hospital as an informal patient (including those who have been admitted informally on the basis of parental consent). The purpose of this provision is to ensure children and young people are not admitted inappropriately onto adult psychiatric wards.

Who is responsible for making sure this happens?

When considering how to meet this requirement, **the managers of the hospital** must consult with a person who appears to them to have the requisite knowledge or experience of cases involving patients under 18. This person will usually be a child and adolescent mental health professional.

When will these requirements start?

The government has committed to bring this into force in April 2010, thus allowing commissioners and providers of mental health services time to plan and implement any changes necessary to ensure compliance with this duty.

Factors determining whether the environment is suitable

The question whether the environment is suitable will depend on the particular circumstances of the child or young person. Relevant factors, in addition to the age of the child or young person, will include matters such as the nature and severity of the mental disorder, whether immediate admission is required and the likely length of admission (for example, whether it is intended to be an interim measure until a more suitable placement can be arranged).

Practitioners should consider the following questions when determining if an environment is suitable, having regard to the patient's age and individual needs:

1. **What constitutes an environment suitable for a patient of this age?**
2. **Is there something about the patient which means you should use an environment which would not normally be deemed suitable?**
3. **If no age appropriate environment is available, do the patient's needs justify using other accommodation instead?**

Each of these questions is considered below.

1. What constitutes an environment suitable for a patient of this age?

What is meant by a suitable environment for children and young people is not specified in the MHA. However, the COP identifies the following areas that need to be addressed:

- **Physical facilities:** these should be appropriate for children and young people,
- **Educational opportunities:** children and young people should have the same access to educational opportunities as their peers, so far as they are able to do so, taking into account their mental health,
- **Hospital routine:** Think about the need of younger patients for structure in the day and a planned timetable of activities including mealtimes, therapeutic activities, exercise and leisure.

2. Is there something about the patient which means you should use an environment which would not normally be deemed suitable?

An environment that would be suitable for the patient's age might not be a suitable environment for the patient. For example, a young person who is likely to require an admission for more than a few days and who will become 18 two weeks after admission may be better off placed on an adult ward so that care does not have to be transferred within a very short time and so that therapeutic engagement with the adult team can start as soon as possible.

3. If no age appropriate environment is available, do the patient's needs justify using other accommodation instead?

Such a situation may arise if there is an overriding need to ensure the patient is admitted to hospital and where a hospital environment that is not age appropriate is better than no hospital environment at all. For example, a 16-year-old in a psychotic crisis may have to be admitted immediately to a bed on an adult ward if no suitable CAMHS bed is immediately available.

However, see below for the PCT's obligation to provide information about access to emergency care for young people and children.

While there may be crisis situations where the admission of a child or young person onto an adult ward is considered suitable because the main priority is providing a safe environment, this will only be acceptable in the short term. Thus, in the case described above, the 16-year-old should be transferred to a CAMHS ward as soon as possible.

> *"Once the initial emergency situation is over, hospital mangers, in determining whether the environment continues to be suitable, would need to consider issues such as whether the patient can mix with individuals of their own age, can receive visitors of all ages and has access to education. Hospital managers have a duty to consider whether a patient should be transferred to more appropriate accommodation and, if so, for this to be arranged as soon as possible."*
>
> (COP, 36.71)

In exceptional cases in which a child or young person is admitted on to an adult ward attention should be given to ensuring:

- provision of discrete accommodation;
- all those involved in the care and treatment of the child or young person are child specialists, wherever possible, or at least have child care training;
- such staff to always be criminal background (CRB) vetted; and
- if it is not possible for a CAMHS specialist to be in charge of the child or young person's treatment, arrangements are made for the clinical staff to have access to a CAMHS specialist for advice and consultation.

When thinking about 'discrete accommodation':

> *This should be areas that have been specifically set aside for this use and are single sex. There should be appropriately segregated sleeping and bathroom areas – using only a curtain to separate this area from the rest of the ward would not be appropriate.*

Where a child under the age of 16 is admitted onto an adult ward the relevant Strategic Health Authority must notify the Department of Health under the Serious Untoward Incident procedures.

Interests of other children and young people

Where a child or young person's presence on an age appropriate ward may have a detrimental effect on other patients under 18, the interests of those already admitted must also be protected. However the needs of the other young patients should not override the need to ensure that the child or young person is accommodated in an age appropriate environment, albeit in a different age appropriate environment.

Duty to provide information on age appropriate facilities

Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales are required to advise the Local Social Services Authorities in their area of hospitals providing accommodation or facilities designed to be specially suitable for patients under 18 (section 140).

Forensic patients

Courts considering whether to make a hospital order (section 37), an interim hospital order (section 38), remanding the person to hospital for a report on their mental condition (section 35) for treatment (section 36) or committal by Magistrates (section 44) can require that PCTs and LHBs provide them with information on the availability of accommodation or facilities designed to be specially suitable for patients under 18 (section 39 (1A)(1B)).

Admission to hospital

Although patients of any age can be admitted to hospital under the MHA, practitioners will need to be aware of the wide variety of overlapping powers to authorise children and young people's admission to hospital for treatment for mental disorder.

For example, the Children Act 1989 also provides powers to detain children and young people. In some circumstances those with parental responsibility will be able to authorise admission and treatment. Furthermore, the main provisions of the Mental Capacity Act 2005, which came into force in October 2007, apply to individuals aged 16 or over and may therefore be relevant to decisions concerning the admission and/or treatment of 16- and 17-year-olds who lack capacity to make decisions for themselves.

The MHA has been amended so that now 16- and 17-year-olds who have the capacity to make such decisions can either consent to, or refuse, admission to hospital for treatment for mental disorder. Their decision cannot be overridden by a person with parental responsibility.

Notification of hospitals having arrangements for reception of urgent special cases (section 140)

It shall be the duty of every Primary Care Trust and of every Local Health Board to give notice to every Local Social Services Authority … (in their area) ... arrangements are from time to time in force for the reception, in case of special urgency, of patients requiring treatment for mental disorder:

a) for the reception of patients in cases of special urgency;
b) or the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years.

COMMON MYTHS – AGE APPROPRIATE SERVICES	
MYTH	**REALITY**
You can use an adult ward for a child if it'll meet the child's needs	Not exactly. Hospital managers will be under a duty to ensure the environment is suitable having regard to the patient's age (subject to the patient's needs).This means factors such as the physical environment, the educational opportunities, the ward routine and the availability of suitably qualified and experienced staff all need to be taken into account. There may be cases where it is permissible (or even better) to use an adult ward, because of the patient's particular needs. However, if you could equally well meet needs in an age suitable environment or another one – then you have to use the age suitable one.

ACTIVITY 4 – SELF ASSESSMENT (answers in Appendix 2, p 142)

Please answer the following questions as per the instructions.

1. Which of the following forms of mental disorder continue to be excluded by the amended Mental Health Act? *(tick correct box or boxes)*

a) Sexual deviancies ☐

b) Head injuries ☐

c) Addictions to drugs or alcohol ☐

2. The learning disability qualification means that if you wish to detain someone only because they have a learning disability, that learning disability must be associated with 'abnormally aggressive or seriously irresponsible behaviour'. However, it does <u>not</u> apply to all sections of the Mental Health Act. To which of the following sections does it apply? *(tick correct box or boxes)*

a) Section 136 (police powers to detain a person who appears to be mentally disordered) ☐

b) Section 2 (the power to detain for assessment or assessment followed by treatment) ☐

c) Section 3 (the power to detain for treatment) ☐

d) Section 17A (Supervised Community Treatment) ☐

3. The Appropriate Treatment Test applies to situations (such as s3) where someone needs to be detained for treatment. What factors should decision makers take into account when applying this test? *(tick correct box or boxes)*

a) Where treatment is available ☐

b) When treatment will be available ☐

c) Whether treatment is suitable for the sort of mental disorder the person is experiencing ☐

d) Whether the treatment suggested takes account of the individual social or cultural needs of the person ☐

4. What does the term 'medical treatment' now include? (write in answer)

5. True or False? *(tick correct box)*

	T	F
a) Treatment provided under the MHA must have the purpose of alleviating symptoms, or preventing the worsening of the patient's mental disorder or its symptoms or manifestations	☐	☐
b) The MHA allows you to detain somebody only if there is a risk to themselves or other people	☐	☐
c) It is not possible to detain someone who has a drug induced psychosis, because alcohol and drug dependency is excluded under the MHA	☐	☐

End of Module

You have now completed this module and can move on to the other modules. If you wish to do some further reading in relation to the topics covered in this module here are some suggestions.

Further Reading

Department for Constitutional Affairs (2007). Mental Capacity Act 2005. London: TSO. (*Also available from the Office of Public Sector Information website)*

Department for Constitutional Affairs (2007). Mental Capacity Act 2005 Code of Practice. London: TSO. (*Also available from Ministry of Justice website)*

Department of Health (1997). The Childrens Act 1989 - Guidance and Regulation. London: DH. *(Also available from DH website.)*

Department of Health (2008). Mental Health Act 1983 as amended by the Mental Health Act 2007 (unofficial version). London: DH *(Available on Department of Health website*)

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Great Britain (2008). Mental Health Act 2007: Elizabeth II - Chapter 12 - Explanatory Notes. London: TSO.

References

Regina v Mental Health Review Tribunal for the South Thames Region, ex parte Smith (1999) COD148 in *Crown Office digest.*

Module 2: Making Decisions

MODULE 2: MAKING DECISIONS

INTRODUCTION TO THE MODULE

This module examines the changes made by the MHA that affect who can make decisions about the compulsory admission of a patient, and who can take responsibility for their care and make decisions about the use of compulsion after they are admitted to hospital or Guardianship. These amendments are identified in the Foundation Module as Step 2 in the pathway through compulsion and involve new responsibilities for mental health professionals (Key Change 4); the nearest relative (Key Change 5); advocates (Key Change 6); and, finally, patients themselves regarding their consent in receiving electro-convulsive therapy (Key Change 7).

PREPARATION

*Before undertaking this module, it is important you complete the **Foundation Module**, particularly Step 2 in the pathway through compulsion. You are also advised to read the relevant sections in the **Code of Practice (Chapters 4, 8, 14, 20 & 24)**.*

LEARNING OUTCOMES

On completion of the module and some independent study, you will be able to:

- ***Explain the responsibilities of the new Approved Mental Health Professional, the Approved Clinician and the Responsible Clinician roles;***
- ***Understand the powers and responsibilities of the 'Nearest Relative';***
- ***Understand the role of an advocate in relation to a person with mental disorder;***
- ***Understand the new legislation regarding a patient's rights over electro-convulsive therapy;***
- ***Understand the roles and responsibilites of the Local Social Services Authority (LSSA) and the Health Trust with regard to the new roles.***

PROFESSIONAL ROLES

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 changes in the MHA now open up the traditional roles of Responsible Medical Officer (RMO) and Approved Social Worker (ASW) to more 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).

Although a doctor will still need to be involved in the initial assessments to determine, with an AMHP, whether someone should be detained under the MHA, once subject to compulsion, the role of a RMO is replaced by that of the RC. A suitably experienced and qualified professional from either a medical, psychological, nursing, social work or occupational therapy background can take on this responsibility for a patient's care and the continued use of compulsion.

The implications in practice are that where previously the RMO in the existing MHA always had to be a doctor, in the MHA the corresponding role of Responsible Clinician (RC) 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 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 a RC means they have accepted responsibility for a particular patient. Being approved by a Strategic Health Authority as having the necessary competence to have Approved Clinician Status requires a professional from one of the nominated professional groups to have reached an advanced level of experience and competence, to have undertaken an 'Approved Clinician's course', and to be able to demonstrate how they meet all the areas of competence.

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 directed by the Guiding Principles.

Someone who is in an AC will not automatically be 'in charge' (i.e. the RC) for a particular case in 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**.**

Almost always, treatment can only be given under the MHA without consent, if an AC is in charge of that treatment, and it is being given by the AC or under the AC's direction. However, the AC does not necessarily have to be the RC.

Responsible Clinician

Anyone who takes on the role of a RC must first have been approved as an AC (see above). Their role is to have 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 will 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 alteration, 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 as possible after a patient's treatment needs are assessed, an AC with the most appropriate expertise must be allocated.

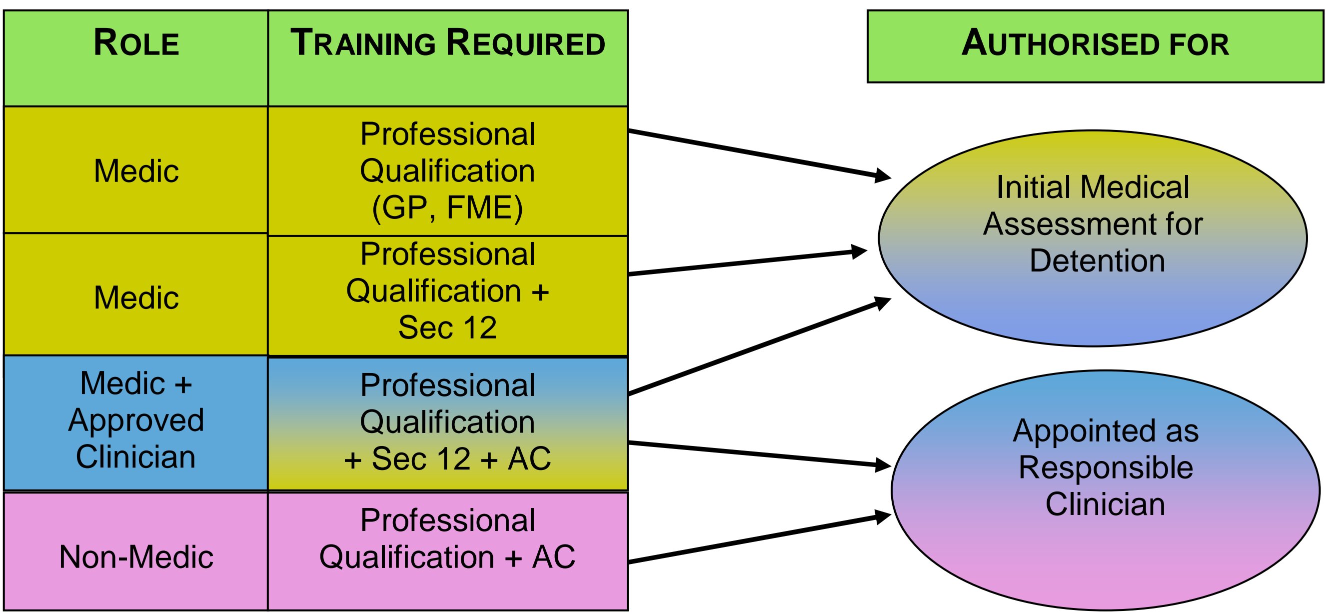
> *"Hospital managers should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between hospitals or from the hospital to the community and vice versa. The protocols should:*
>
> - *ensure that the patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs;*
> - *ensure that it can be easily determined who a particular patient's responsible clinician is;*
> - *ensure that cover arrangements are in place when the responsible clinician is not available (e.g. during nonworking hours, annual leave etc);*
> - *include a system for keeping the appropriateness of the responsible clinician under review."*
>
> (COP, 14.3)

It is also important that the suitability of the RC be kept under review by hospital managers. Any change of RC must be considered carefully and be consistent with the changing needs of the patient. The RC and hospital managers should discuss any suggested change with anyone involved with the patient (including their carer) as well, of course, as the patient themselves. The multi-disciplinary team must informed the RC of all decisions which will be discussed by them within the context of the patient's overall situation.

Hospital managers have been advised to keep an up-to-date list of ACs available from which the RC for a particular patient can be chosen.

Approved Clinicians who are also Section 12 Approved Doctors

Only an AC who is also a doctor can make recommendations for detention in hospital under section 2, 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, or the ending of, compulsion. The role (and training) requirements for ACs and section 12 doctors is shown in the diagram below.



Approved Mental Health Professional

One of the changes that may have a big 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 ASW will now become known as AMHP. This is to allow people 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 psychologists, nurses or occupational therapists 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 values-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 based upon that of the previous roles of 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 an AMHP. 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 they assess someone under the MHA, they will be assessing 'on behalf' of the LSSA, and are expected to maintain an independent point of view. The LSSA is expected to support AMHPs taking on the role.

The approval will be based upon the LSSA being satisfied 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 difficulties they experience while working in the role.

Functions of Approved Mental Health Professional (AMHP)

- Responsible for coordinating the initial examination process, along with two doctors one of whom must be section 12 approved.
- In an emergency, the AMHP may assess with one doctor to make an application under section 4.
- The AMHP must be satisfied that all criteria are met (as should the doctors).
- 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 this should be reflected in the proposed care. For example: Is there appropriate treatment, and is it available?
- To make applications for admission to hospital or a Guardianship order, and ensure that a detained patient arrives safely at the hospital if they are to be detained elsewhere.
- To agree whether Supervised Community Treatment (SCT) itself (and any conditions suggested by the RC) is necessary or appropriate in a particular case, and if the RC wants to revoke the SCT, the AMHP must also agree to this.

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

- To have an overall view of circumstances including social and situational issues that are affecting the patient and contributing to the need for the assessment.
- To engage therapeutically – as best as 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 strict compliance with the law. For example, it is the business of the AMHP to make sure someone is detained for treatment under section 3 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. Following the guidance of the COP and its principles is one of the main ways that AMHPs can make sure they do so.

- To apply an approach that takes into account a broad 'social' perspective rather than a narrow 'medical' perspective, and that also takes into account a social model which 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, they should be provided with public indemnity by the LSSA when they are assessing on the LSSA's behalf.

It is the role of the AMHP to provide a counterbalance to the medical model, and provide a view that is independent of the 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 context of the patient and their situation. This will aid in producing an objective and appropriate decision 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 approved status.

Responsibilities of the 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 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 re-approval.

LSSAs are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, LSSA's must have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.

(COP, 4.33)

COMMON MYTH – APPROVED MENTAL HEALTH PROFESSIONALS (AMHPS)	
MYTH	**REALITY**
The Government wants AMHPs to be health professionals employed by NHS trusts	No, the MHA gives choice. Local Social Services Authorities (LSSAs) decide what to do. The amended Act provides a power, not a duty, to train non-social workers for the role. Whoever substantively employs AMHPs, they can only assess people under the Mental Health Act if they are acting on behalf of a LSSA. LSSAs have ultimate control over who does what on their behalf (but cannot tell AMHPs what decision to reach, of course).

Activity 1 continues Eddie's pathway through compulsion (see pages 49 and 63).

ACTIVITY 1 – SCENARIO: EDDIE (3)

Eddie was discharged into the community, and over the following two years had a number of re-admissions. He was diagnosed as having paranoid schizophrenia. On discharge, he would stop taking medication because he did not believe he was unwell, and avoided services for the same reason. His last admission happened after he was picked up by the police on a section 136 in a neighbouring area and then placed on section 2. After having been returned to his sector hospital and ward, Eddie was reassessed by his own RC and placed on section 3. He has remained in hospital for four months. During this time, his RC reviewed his overall care plan, and he is now being considered for SCT. The MDT has arranged a review to determine the most appropriate available AC to be the RC in charge of his care once he leaves hospital.

1. **Based on your responses to the previous activity regarding Eddie, which AC has the expertise to best meet his treatment needs?**
2. **What principles may inform the selection of the most appropriate RC for Eddie?**
3. **Which other professionals would need to be involved in his longer-term care?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, page 138

NEAREST RELATIVE

Three main changes have have been made by the MHA that deal with nearest relatives.

The first involves the new status given to a civil partner who is now recognised in the same way as a spouse. The second involves patients themselves who may now apply to displace (or change) their nearest relative. The third is that there is a new ground on which nearest relatives can be displaced, namely that they are "unsuitable". These changes are now examined in more detail.

Change 1: Civil Partners are given equal status with married partners in the nearest relative hierarchy list

To avoid confusion to all concerned it is wise to start this section with a definition of who can be the 'Nearest Relative' (see box below). Professionals taking on the new role of AMHP will need to familiarise themselves with this concept, and it may also be useful for patients, carers and other professionals.

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 ORDINARILY BEEN RESIDING WITH THE PATIENT FOR FIVE YEARS OR MORE**

'Husband', 'wife' or 'civil partner' includes people living with a patient as if they were a couple, provided they have done so for at least six months prior to the patient's admission to hospital. The inclusion of 'civil partners' is the first of two changes that affect the nearest relative role in the MHA. Civil partners now have the same status as husband or wife.

Notice that not all relatives are included in the list: cousins and in-laws cannot usually be considered as a 'nearest relative'.

However, if you think about your own family or the family of a patient, there may be a number of people who could be included in the list. There are also rules about how you can be added to the list (for example, if you have lived with someone for five years or more, you could be included on the list); and in what circumstances people might be excluded (for example, a divorced partner will be excluded). It is the AMHP's job at the point of admission to decide who is the nearest relative, and they do so using a set of 'rules' laid down in section 26 of the MHA.

How to decide who on the list should be considered as *the* nearest relative is determined by a complex set of rules. For example:

- Usually the person highest on the list will be the nearest relative, but there are exceptions. For example, a relative who lives with or cares for the patient takes precedence over other relatives (and over other younger relatives in the same position). Also, if a relative usually lives abroad, or if they used to be married to the patient but are permanently separated, they will also be excluded.
- "Relative" also includes people who are not (in the usual sense) relatives but who are living ("ordinarily residing") with a patient and have done so for at least five years prior to admission to hospital.
- Relationships of "whole blood" take priority over those of "half blood".
- Relationships established through adoption (e.g. adoptive parent and child, adoptive aunt and nephew) are also included, but step-relationships are not included.
- Within each category, male and female relatives are treated equally, with the older person in each category group being given priority.
- Where two or more people come in the same place on the list (e.g. where someone has brother and sisters), then the elder or eldest takes precedence.

It is important that the AMHP or hospital manager identifies and consults with the right person because the nearest relative has a number of powers and responsibilities. For example, they can ask for someone to be assessed under the MHA, and in some circumstances can prevent someone being admitted. However, it is useful for others to know who that person is, and why their role is so important. It is also important to be aware that the nearest relative can change, and in what circumstances.

Nearest Relative Powers and Responsibilities

The MHA confers various rights and powers on patients' nearest relatives in connection with detention, Supervised Community Treatment and Guardianship under the MHA. These include the right to:

- apply for detention or Guardianship;
- object to Approved Mental Health Professionals making applications for admission to hospital for treatment or for Guardianship;
- ask that their relative be assessed under the MHA, and receive written information if the decision is taken not to admit that person; and
- to discharge patients (with various exceptions) or (in certain cases) to apply to the Mental Health Review Tribunal instead.

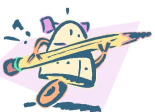
Nearest relatives are also entitled to be given information in respect of patients in a variety of circumstances. They therefore provide a significant protection for people who experience mental distress – both in terms of helping them to get help when they need it and in being able to question and prevent the use of compulsion if it is not truly necessary.

Changes 2 & 3: How to change the Nearest Relative – processes for displacement

The second change to affect the nearest relative is that of ‘displacement’. Changes to the MHA now mean that the patient themselves can apply to court to replace their nearest relative with someone of their choice rather than accepting the decision of the ‘list’. It is anticipated that IMHAs and AMHPs will support or provide information to patients who wish to displace their nearest relative.

The third change is that there is an extra ground for displacing nearest relatives – namely that they are “otherwise unsuitable” to act as such.

‘Displacement’ means the process by which a nearest relative can be replaced.



ACTIVITY 2

Can you think of a situation in your own experience where a patient wanted to change their nearest relative?

Take some time to reflect on the situation. Think about how the inability to control this choice affected the person you have in mind, and how the new opportunity to displace might change the care or support you were able to offer.

Make a note of your reflections.

The Process for Displacement

Who can displace a Nearest Relative?

There are a number of people who can apply to court to displace a nearest relative:

- The patient
- Any relative of the patient (i.e. anyone in the list of possible nearest relatives described above)
- Anyone who lives with the patient
- An AMHP

What are the grounds for displacement?

If a patient or someone else wishes to make an application to the County Court for an order to displace their nearest relative, they may do so on a number of grounds:

1. That there is no nearest relative;
2. That the nearest relative is too ill to take on the role;
3. That the nearest relative has objected unreasonably to admission;
4. That the nearest relative has discharged the patient without regard to that person (or other people's) safety;
5. **That the nearest relative is 'otherwise unsuitable'.**

Note: the last ground for displacement has been added by the MHA.

Clearly, the patient is more likely to displace on the grounds 1, 2 or 5 than the other grounds. Grounds 3 and 4 are more likely to be used by an AMHP who was applying for displacement.

The County Court, who will have to hear the application, would have to consider everyone's point of view, including not just the point of view of the patient but also that of the person they wish to replace. Tables 1 and 2 explain in more detail the grounds for displacement and how long the orders may last.

Table 1. 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 Courts 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 (or is likely to be do so) without due regard for consequences for the patient or the public	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 the nearest relative isn't suitable for that role.

Table 2. 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 or others' welfare	**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 it, the order will end when the section ends.

Delegating the role of the Nearest Relative

It is also possible for a nearest relative to choose someone to take on their role (this is called 'delegation'). If they do so, this should be put in writing.

Automatic change of Nearest Relative

The identity of the nearest relative will change if the current nearest relative dies, or the patient marries or enters into a civil partnership, or if that or a co-habiting relationship ends.

It may also change for some other reason not directly involving the existing nearest relative, e.g. a son or daughter reaches the age of 18, or a relative comes to live in the UK, and therefore becomes eligible to be the nearest relative.

For further reading and information on the nearest relative please consult the Reference Guide to the MHA.

ACTIVITY 3

1. **The Courts will have to decide what factors should be considered when deciding if a nominated nearest relative should be considered 'unsuitable'. What do you think? What sorts of behaviour or beliefs might make a nearest relative 'unsuitable'?**
2. **How do you think the nearest relative may react to this assessment of them, and what could you do to ensure the care and treatment of the patient is not compromised?**

ADVOCACY

From April 2009 there will be a duty upon the Secretary of State to provide Independent Mental Health Advocacy (IMHA) services for all patients who are subject to compulsion (except those held under sections 4, 5, 135 or 136, i.e. shorter-term sections designed to allow a person to be kept in hospital for up to 72 hours (or three days) to allow a proper Mental Health Act Assessment to take place).

Those who have a right of access to the IMHA service will include Guardianship patients and patients subject to Community Treatment Orders (i.e. those on Supervised Community Treatment). Service providers also have a duty to inform such patients that advocacy services are available.

The CSIP/NIMHE Advocacy team has already done a considerable amount of work with advocacy services and other stakeholders to develop ideas on how IMHA should be provided, staffed, commissioned, delivered and monitored. The team is working on three key areas:

1. Researching and promoting good advocacy practice for detained patients;
2. Developing guidance for commissioners of Mental Health Advocacy;
3. Working with the Independent Mental Capacity Advocacy team to develop a national advocacy qualification.

Key aspects of IMHA

IMHA will be made available to qualifying patients. It is hoped the service will be available from April 2009. The advocacy should, so far as is practicable, be provided by a person who is independent of any professional concerned with the patient's medical treatment. Advocates will be regulated and may be paid.

The function of IMHA will include helping patients obtain information about and understanding of:

- the provisions of the legislation to which s/he is subject;
- any conditions or restrictions to which s/he is subject;
- the medical treatment being given, proposed or discussed, the authority under which this would be given, and any requirements that would apply.

IMHA would also help a patient obtain information about and an understanding of their rights, and how to exercise those rights. In order to provide this help, Independent Mental Health Advocates will be able to:

- visit and interview a patient in private;
- visit and interview any person concerned with the patient's medical treatment;
- require the production and inspection of any records relating to the detention or treatment in any hospital or registered establishment or to any after-care services provided under section 117;
- require the production of and inspection of any Social Services Authority records which relate to the patient.

Access to records

IMHA will only be able to look at records

either

when the patient has capacity and gives consent

or

if the patient lacks capacity the production and inspection of records does not conflict with a decision of a deputy or the Court of Protection (Mental Capacity Act 2005), and the person holding the records decides that seeing the records "may be relevant to the help to be provided by the advocate and the production or inspection (of the notes) is appropriate".

(MHA, section 130A)

When deciding whether or not to provide access to notes when a patient does not have capacity, the people who have the records should be guided by the principles of the COP as well as its specific guidance.

Responding to referrals

IMHA will have a duty to visit a patient when a reasonable request is made by a nearest relative, responsible clinician or Approved Mental Health Professional. However, the patient can decline support from the advocate.

Qualifying for an IMHA

Patients will qualify for an IMHA if they are:

- liable to compulsory treatment under the powers of the Act, except in certain emergency situations;
- on Supervised Community Treatment;
- informal patients who are discussing the possibility of treatment to which section 57 or section 58A applies (neurosurgery for mental disorder or ECT for patients under 18 years).

Informing patients about IMHA

A duty is placed on hospital managers, responsible clinicians and social services (in the case of Guardianship) to inform patients about the advocacy service and to take all practicable steps to ensure they understand what is available to them and how they can obtain help.

Nearest Relative

Information about the advocacy service and how it can be contacted also normally has to be given to the nearest relative unless the patient asks that it is not given them, or it would not be reasonably practicable.

ACTIVITY 4 – SCENARIO: WAYNE

Wayne is 30 years old and has had a diagnosis of paranoid schizophrenia since he was 20. He also has a moderate learning disability. He has an extensive history of engagement with mental health services since the time of his original diagnosis 10 years ago.

Following a serious relapse whilst living at home, it was necessary to admit Wayne to hospital on Section 2 of the MHA and after further assessment he was then placed on Section 3. Wayne has been subject to Section 3 for two months and is making little progress on the ward.

The ward staff became concerned about Wayne's understanding of his situation and his views on his current treatment. The treatment is primarily antipsychotic medication that is making Wayne extremely docile and is resulting in significant weight gain.

There are difficulties in communicating with Wayne at the present time. Consequently, the ward staff have discussed the possibilities of Wayne engaging with an Independent Mental Heath Act Advocate (IMHA).

Wayne does not seem able to understand what this might mean to him and what the IMHA would be doing for him.

1. **What should the ward have in place with regard to detained patients having access to an IMHA?**
2. **If Wayne does not understand the role of the IMHA and request one to be involved on his behalf, can an IMHA be appointed for Wayne?**
3. **If an IMHA is involved with Wayne, what should he or she be doing on his behalf? What can the IMHA expect from the mental health service providers?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, page 139

ELECTRO-CONVULSIVE THERAPY

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 Table 1 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, except 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 section 62 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.

The exceptions for emergencies, only apply where the ECT is is immediately necessary to:

- save the patient's life or
- prevent a serious deterioration of the patient's condition (and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.)

For other types of treatment, there are two other categories of immediate necessity – but they do not apply to ECT.

ACTIVITY 5 – SELF ASSESSMENT (answers in Appendix 2, p 142)

Please answer the following questions as per the instructions.

1. The status of 'Approved Clinician' indicates that a mental health professional has reached an advanced level of professional skill and expertise, and has proved their competence to the Strategic Health Authority. What does the term 'Responsible Clinician' mean?

a) That they are sufficiently competent to section someone, detain them under s2 or s3 ☐

b) That they can take on the legal responsibility for a patient who has been detained under the Mental Health Act ☐

c) That they are responsible for deciding whether someone they are responsible for under the Mental Health Act continues to meet the criteria for detention, and for discharging them if they no longer meet the criteria ☐

d) That they can decide, after consultation with another professional and with the agreement of an AMHP, whether to renew a person's Community Treatment Order (the order which gives effect to Supervised Community Treatment) ☐

2. Approved Mental Health Professionals (AMHP) no longer have to be employed by a Local Social Service Authority (LSSA), but do assess 'on behalf' of the LSSA that approves them. However, which organisation is responsible for ensuring there are enough AMHPs in a particular area to run a 24 hour service?

3. Which new group has been added to the list of people who can be a person's 'nearest relative' under the act?

4. Displacement is the process by which someone's nearest relative can be changed. Which of the following statements are true?	**T**	**F**
a) A patient can change their nearest relative without going to court	☐	☐
b) Anyone who lives with the patient can apply to a court to change the patient's nearest relative	☐	☐
c) The MHA now has a new ground for displacement – that the nearest relative is "otherwise unsuitable"	☐	☐

5. The MHA introduces a new role, that of the 'Independent Mental Health Advocate' (IMHA). Which additional powers will IMHAs have compared to advocates who previously worked in mental health?

END OF MODULE

You have now completed this module and can move on to the other modules. If you wish to do some further reading in relation to the topics covered in this module, here are some suggestions.

Further Reading

Department for Constitutional Affairs (2007). Mental Capacity Act 2005. London: TSO. (*Also available from the Office of Public Sector Information website)*

Department for Constitutional Affairs (2007). Mental Capacity Act 2005 Code of Practice. London: TSO. (*Also available from Ministry of Justice website)*

Department of Health (2008). Mental Health Act 1983 as amended by the Mental Health Act 2007 (unofficial version). London: DH *(Available on Department of Health website*)

Department of Health (2008). Refocusing the Care Programme Approach: Policy and Positive Practice Guidance. London: DH.

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Great Britain (2008). Mental Health Act 2007: Elizabeth II - Chapter 12 - Explanatory Notes. London: TSO.

MODULE 3: SUPERVISED COMMUNITY TREATMENT

MODULE 3: SUPERVISED COMMUNITY TREATMENT

INTRODUCTION TO THE MODULE

This module examines the compulsory power contained within the MHA that makes it possible in appropriate circumstances for some patients to continue to receive their care and treatment in the community. This compulsory power is called Supervised Community Treatment (SCT) which is identified in the Foundation Module as Key Change 8 in the pathway through compulsion.

"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 mental health outside hospital and to promote recovery."

(COP, 25.2)

Like section 25A (supervised discharge), the lead for the use of the section is the person's Responsible Clinician. The SCT's emphasis on treatment and the criteria focuses the use of this section on those people:

- who have an established diagnosed mental disorderis);
- for whom a treatment is available;
- who stop or are likely to stop taking treatment on discharge with a resulting decline in their mental state and who may become a risk to themselves or others, or may become a risk even if they do continue treatment.

PREPARATION

Before undertaking this module it is important that you complete the ***Foundation Module****, particularly the exercise on SCT.*

Also look at the ***Code of Practice (Chapters 25, 28 & 29),*** *the* ***Reference Guide*** *and* ***Best Practice Guide to SCT*** *for more information.*

In this module each of the following learning outcomes is discussed in turn. As you work through the module you will find that as well as reading the text you are asked to undertake various activities. The activities are designed to help you develop your understanding of the areas under discussion and to think about how the MHA will impact on your practice. You may be doing these exercises as an individual or as a group with a tutor. There is a PowerPoint presentation for the tutor to use to help you understand the different issues. The activities include looking at two case studies and a series of self assessment questions at the end of this module. You may therefore want to make some notes as you read.

LEARNING OUTCOMES

This module is intended to help you:

- ***Understand what Supervised Community Treatment (SCT) is and who it is intended to support;***
- ***Understand the processes for making an order, recalling someone to hospital who is on SCT, renewing the order and making decisions about whether or not to revoke the order;***
- ***Understand how the Guiding principles in the COP can be used to support your decision making;***
- ***Be clear about the treatment rules that relate to SCT;***
- ***Understand what protections are available for people who are on SCT.***

SUPERVISED COMMUNITY TREATMENT

Introduction and Summary of Issues

- The MHA introduces provisions that allow some patients with a mental disorder to live in the community while still subject to powers under the existing MHA.
- SCT enables patients to return home while receiving treatment and care on a compulsory basis.
- SCT provides a framework to assist the support of patients who might otherwise lose contact with services on discharge and subsequently relapse, leading to a cycle of compulsory re-admissions. SCT can promote stability for some ‘revolving door’ patients.
- Patients are put onto SCT by a Community Treatment Order (CTO), which sets out conditions the patient is asked to keep in order to ensure they receive the treatment they need to prevent harm to the patient or to others.
- The principles underpinning the MHA need to be taken into account when considering SCT, particularly the principles of minimising restrictions on liberty balanced against that of patient and public safety.

COMMON MYTHS – SUPERVISED COMMUNITY TREATMENT (SCT)	
MYTH	**REALITY**
You don’t have to be detained first	Yes, you do. You need to be detained for treatment.
SCT is only for people who need medication in the community	No, it is not. “Medical treatment” goes much wider than medication. Medical treatment also includes psychological interventions, nursing, habilitation and rehabilitation.
Recall means in-patient admission	No, recall can be for out-patient treatment as well.
A Responsible Clinician for SCT will be a hospital clinician	No, the one who first makes the Community Treatment Order will be; but after that the Responsible Clinician can change as appropriate.

The Process for making a CTO

Only people **already detained for treatment** on section 3 (or similar unrestricted forensic sections) can be considered for supervised community treatment . Section 17 (2A) suggests that where longer-term leave is being considered (defined as more than seven days) the Responsible Clinician (RC) should consider whether it is more appropriate to use a CTO (s17A). This is the order that gives effect to SCT. The order is addressed to hospital managers.

The order is made by the RC and has to be made in writing and agreed in writing by an AMHP

Legally, the effect is to suspend the treatment section, namely:

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

Therefore, when a patient is recalled, their requirement to take medication and be detained in hospital comes back into effect (see processes for recall and revocation).

People on SCT are subject to Part 4A.

ACTIVITY 1

Reflect on what you have read about Supervised Community Treatment (SCT) and then answer the following questions:

1. **What effects do you think SCT will have on your practice?**
2. **How do you think SCT will affect relationships between patients and community-based support staff (statutory and non-statutory)?**
3. **How can awareness of the principles underpinning the COP work to alleviate tensions that arise from SCT?**

Criteria

The RC's role in the process: The RC may make a CTO where s/he believes the following criteria are met, provided that this judgement is also held by an AMHP:

- The patient is suffering from a **mental disorder of a nature or degree**[2] which makes it appropriate for him to receive medical treatment
- It is **necessary** for his health or safety or for the protection of other persons that he should receive such treatment
- Subject to his being liable to recall … such treatment can be provided without his 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, section 17A(5))

Nature or Degree

Because SCT is intended to support people who have already been in hospital for a while, and have been receiving treatment, it is likely that although the 'degree' will be relevant to the decision to process an order it is the 'nature' of the person's mental disorder that will be more important for making that decision.

When people talk about the **'nature' of a mental disorder,** they are talking about what it is 'like'. For example, **what are the symptoms** that professionals might see, or the patient might experience. 'Nature' also refers to how a particular person might be affected by those symptoms, both now and in the future. i.e. the 'pattern' of the person's illness over time.

Where the **'degree' of a mental disorder** is being discussed, professionals are concerned with how acute or severe the symptoms are currently.

How does the RC decide if SCT is necessary?

The RC has to have regard to the following factors when reaching this judgement:

- The patient's history of mental disorder;
- The increased risk of decline in the patient's mental health if they were not on SCT; and
- Any other relevant factors.

There are no criteria related to age: therefore, a **young person under the age of 18** can go onto SCT.

[2] 'Mental disorder' and 'nature or degree' have the same meaning as for section 3 of the MHA.

Conditions

When on SCT there are requirements or conditions a person will be expected to follow (section 17B of the MHA). There are both ‘compulsory’ conditions that will apply to all patients on SCT and other ‘specific’ conditions that can be placed on a particular patient. If imposed, these conditions must be necessary or appropriate to ensure the person receives medical treatment, or to prevent risk of harm to self or to protect others.

The additional conditions can only be imposed if an AMHP also agrees they are **necessary** or **appropriate** for the individual patient’s circumstances.

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 section 20A;
- that the patient must also make him/herself available if a SOAD doctor needs to see him/her

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

1. ensure that the patient receives medical treatment, or
2. prevent risk of harm to the patient’s health or safety, or
3. to protect other people.

Although the RC and an AHMP must agree the conditions, the RC may vary or suspend them without the AMHP’s agreement.

The RC 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.

Varying the conditions might be appropriate where a patient’s needs or living arrangements have changed. A RC should always consider specific cultural needs and background when negotiating or varying the conditions.

The Role of the AMHP in the process for making a CTO

The AMHP plays a major role in the SCT process and they provide some of the most significant protections for patients. Neither the CTO nor additional conditions can be made if an AMHP does not agree. They also have to agree to the renewal of an order and for the order to be revoked.

The AMHP must provide a written supporting statement in Form CTO1 saying they agree that the criteria are met and 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

The requirements that an AMHP must decide whether the use of an order or the imposition of conditions is necessary or appropriate, means they must consider the patient’s wider context – their social situation. The AMHP must be convinced that in a patient’s situation the powers are necessary or appropriate.

> “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)

Therefore the AMHP must agree, in writing that:

- the criteria are met;
- it is appropriate that the order be made; and
- any conditions set meet the requirements of section 17B(2)

ACTIVITY 2 – SCENARIO: EDDIE (4)

After a five month admission on section 3 Eddie is in the process of being discharged from hospital. Following admission to an acute ward, he was transferred to a rehabilitation unit where he has continued to develop social and domestic living skills. His mental health has also improved. The RC and the MDT reviewed his case and decided he would be suitable for SCT. An AMHP was asked to consider the case. Eddie and the RC also discussed SCT and the conditions that might be imposed.

1. **What considerations would bring to the fore a recommendation that Eddie would best be placed on Supervised Community Treatment (SCT)?**
2. **How might Eddie benefit from SCT?**
3. **What conditions might Eddie be subject to while SCT remains in force?**
4. **Which of the MHA's Guiding principles might be most important in this situation?**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, page 140

Time limits and Reviews

As with other forms of detention, the RC has a duty to review SCT regularly and to end it if the criteria are no longer met or if in his/her opinion the patient meets the criteria for detention in hospital under section 3(2).

The initial period of SCT lasts for six months from the point of discharge from hospital into SCT. This can be followed by a second period of six months, then periods of one year.

The renewal of SCT can be considered at any time within the two month period prior to the ending of the order. The conditions for renewal require that:

- the RC states that the criteria are still met; and
- the AMHP agrees (in writing) the criteria are met; and
- the AMHP must also state in writing that it is appropriate to extend the period of SCT.

The RC must consult "one or more other persons who have been professionally concerned with the patient's treatment". This might mean the MDT in practice but doesn't have to be.

If a patient is recalled to hospital and their order revoked, they go back onto the section they were on prior to discharge. This section will start again and will last for six months.

Hospital managers will be required to refer a patient who has their CTO revoked as soon as possible to the Mental Health Review Tribunal.

Protections

- From April 2009, anyone who is on SCT will have a right of access to an IMHA who will be able to provide advice and support. This right continues thoughout the time the person is on SCT.
- Those on SCT can appeal both to the Mental Health Review Tribunal or the hospital managers for discharge.
- The SOAD rules also ensure all those receiving section 58 medication have their treatment plan approved.
- A patient with capacity cannot be forced to accept treatment while in the community. Neither can a patient without capacity except in rare emergency situations
- The patient's nearest relative can apply for discharge in the same way as for section 2 or 3.
- A person who is on SCT must also be discharged from the CTO as soon as they no longer meet the criteria for its use.

Access to Information

"The Act requires hospital managers to take steps to ensure that patients who are detained in hospital under the Act, or who are on supervised community treatment (SCT), understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or SCT. This information must also be given to SCT patients who are recalled to hospital."

(COP, 2.8)

Treatment Issues for People on SCT

Treatment while people on SCT are in the community

Once discharged onto SCT patients are no longer subject to Part 4 of the MHA (which can enforce treatment) and are instead subject to Part 4A. This means they cannot be treated by force in the community, except in emergency situations when the patient lacks capacity. It also means that, for the most part, they cannot be given medication (or ECT) unless it is covered by a SOAD certificate (even if they consent).

Authority to treat

Part 4A of the MHA says when there is "authority to treat" SCT patients who haven't been recalled to hospital (This includes SCT patients who back in hospital voluntarily, rather than having been recalled).

Specifically:

- If the patient has capacity, they must agree to take medication and/or undertake treatment, even if there is a requirement for them to do so;
- If the patient lacks capacity, but someone else has the authority to consent on their behalf, then they can be treated if that person consents. Only the donee of a lasting power of attorney, a deputy appointed by the court under the Mental Capacity Act or the Court of Protection would be able to do that;
- Otherwise, unless it is an emergency, a patient who lacks capacity to consent can be treated provided the treatment is given by, or under the direction of, the approved clinician in charge of the particular treatment, unless:
    - it would conflict with a decision that their donee, deputy or the Court of Protection has the authority to take on their behalf;
    - they have made an advance decision refusing the particular treatment in question;
    - they object (in any way) to being treated and force would have to be used to administer the treatment.

If it is an emergency (because the treatment is immediately necessary as defined in section 64G of the MHA), these restrictions on treating patients without capacity don't apply, provided any force used is proportionate to the risk to the patient. In that case, the treatment does not have to be given by or under the direction of an approved clinician.

Patients with capacity to consent cannot be treated without their consent, even if it is an emergency.

If it is necessary to treat an SCT patient who can't be treated under these rules, they have to be recalled to hospital.

Part 4A Certificates

Part 4A also spells out the “certificate requirements” for SCT patients.

Unless it is an emergency, SCT patients cannot be given medication (or ECT) unless it has been approved by a second opinion appointed doctor (SOAD) on a “Part 4A certificate”. This applies even if the patient is consenting.

The only exceptions are that a certificate is not needed for medication:

- during the first month following the patient’s discharge from detention onto SCT, or
- if less than three months have passed since the patient was first given medication while under compulsion (either while still detained or after being discharged onto SCT).

SOADs can make their approval subject to conditions. SOADs can also use Part 4A certificates to approve treatment to be given if the patient is recalled to hospital (see below).

The approved clinician in charge of treatment must, on request, provide a report to the Mental Health Act Commission (MHAC) on the treatment given on the basis of a Part 4A certificate and on the patient’s progress.

MHAC can withdraw Part 4A certificates in the same way as other SOAD certificates. As with other withdrawn SOAD certificates, treatment can continue while a new certificate is sought, if the approved clinician in charge believes it is necessary to avoid serious suffering to the patient.

Emergencies

For SCT patients, an emergency means that treatment is immediately necessary to:

- Save the patient’s life; or
- Prevent serious deterioration in the patient’s condition and is not irreversible; or
- Prevent serious suffering by the patient and is not irreversible or hazardous; or
- Prevent the patient behaving violently or being a danger to himself or others, as long as the treatment is the minimum interference necessary, and is neither irreversible nor hazardous.

(only the first two apply to ECT)

These are the same as the criteria for emergency treatment for detained patients under the existing MHA (section 62). Moreover, like section 62, “irreversible” means that the treatment has unfavourable physical or psychological consequences that cannot be reversed, and “hazardous” means it entails significant physical hazard.

Other interface issues with the Mental Capacity Act

1. **Advance Decisions.** Advance Decisions are **legally binding** decisions that allow someone who has capacity to make arrangements in advance to **refuse a particular medical treatment**. People with mental health problems have as much right as anyone else to make these decisions. For example, someone might use an Advance Decision to refuse to take a particular anti-psychotic if they become unwell. The Advance Decision does not have to be in writing, unless it refers to a life-sustaining treatment, but it can be useful to record such issues so that a patient's capacity is noted. The effect for a patient on SCT is that they cannot be given the treatment that they have objected to while competent, unless they are recalled to hospital.

2. **Lasting Powers of Attorney (LPA) and Deputies of the Court of Protection.** It is now possible for someone to be appointed either by the Court of Protection or by the person themselves **while they have capacity to make decisions about welfare and medical issues once they lose capacity**. In relation to SCT, a deputy or someone who was the donee of an LPA would have the authority to agree to medical treatment in the community for a patient who lacked capacity even if the patient was objecting. This is providing they are satisfied that treatment would meet the 'best interests' check list in the MCA and that force needed to give it would be proportionate to the benefit of being given it.

RELATIONSHIP WITH LEAVE OF ABSENCE

The MHA amends the provisions in the existing MHA that authorises leave of absence from hospital (s17). Before granting leave longer than seven consecutive days, a RC must consider whether SCT is the more appropriate way of managing the patient in the community.

Table 1 outlines factors in the use of the options.

Table 1. SCT or longer-term leave of absence? Relevant factors to consider:

Factors suggesting use of longer-term leave	Factors suggesting use of SCT
• Discharge from hospital is for a specific purpose or a fixed period (the patient's discharge is deliberately on a 'trial' basis) • Patient is likely to need further in-patient treatment without their consent or compliance • Risk of arrangements in the community breaking down or being unsatisfactory is high	• Confidence that the patient is ready for discharge from hospital on more than a trial basis • Good reasons to expect that the patient will not need to be detained in hospital for the treatment they need to be given • Patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary • Risk of arrangements in the community breaking down or patient needing to be recalled to hospital for treatment is sufficiently serious to justify SCT, but not so high that it is very likely to happen

ACTIVITY 3

Currently, we work with a number of people. Some are subject to extended section 17 leave arrangements. In the future SCT offers an additional option. How might you use it?

Thinking about your own work, can you recall a case where you have been working with someone in the community, or thinking about discharging them from hospital, where the use of SCT might have been a better option than the powers currently available to you?

Recall and Revocation

Background Information

These are two separate processes:

1. **Recall** means the patient must attend a hospital or other place for medical treatment for up to 72 hours. The RC for a patient can make this decision on their own.
2. **Revocation** means the patient has to stay in hospital for treatment, and their legal status has reverted to either s3 or the treatment section to which they were subject before going onto SCT. The RC must have the agreement of an AMHP before someone's Community Treatment Order can be revoked.

Recall: The details

The RC on their own can recall to hospital someone on SCT. The effect is that the person has to return to hospital and becomes liable to detention in hospital and treatment for up to 72 hours.

The 72 hours time limit for recall starts from the point when they arrive at the hospital or place of treatment. It is the hospital managers' duty to make sure that someone who has been recalled isn't kept in hospital for more than 72 hours, unless the order has been revoked.

The conditions that need to be for filled 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 with other conditions **on their own** does not justify recall. In such a case, the conditions above would also need to be fulfilled. **If the RC decides these conditions have not been fulfilled, the patient cannot be recalled** unless they have broken the compulsory conditions.

Process for recall

The Statutory Form CTO3 will need to be completed by the RC and the notice of recall will become active once:

- **the patient receives a written copy of the recall in person at which point the recall is immediately enforceable, or**
- **the notice of recall is delivered by hand to the patient's address in which case it becomes enforceable on the following day, or**
- **if it is sent by first class mail to the last known address of the patient, then it will become enforceable two working days after it is posted**

Once this has happened if the patient does not present her/himself at the hospital on the recall form, the patient can be treated as 'absent without leave'. The AWOL procedure should then be implemented 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 they are living.

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 section 3 are met; and**
- **it is appropriate (having regard to all of the circumstances) to revoke the order.**

In this case, the person would become subject to s3 again (or whichever section they were on prior to starting SCT).

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 (after 72 hours at the latest). It is the hospital managers' responsibility to make sure this happens.

Treatment on recall and revocation

When they have been recalled, patients become subject to Part 4 of the MHA again, which means they can be treated without their consent like other detained patients, even if they are refusing or objecting to treatment.

The normal rules about SOAD certificates apply to medication and SCT, except that section 62A says that:

- a new certificate is not required for recalled patients if the treatment in question has been specifically approved by a SOAD on the patient's Part 4A certifcate for administration on recall.

- a certificate isn't needed for medication if less than one month has passed since the patient first went onto SCT (because during that period a Part 4A certificate isn't required for medication either).

If a patient's community treatment order is revoked, these exceptions only apply pending compliance with the normal requirements of Part 4 for detained patients – so the approved clinician in charge of the treatment in question must immediately put in hand the process of obtaining any certificate that is needed as soon as the responsible clinician revokes the order.

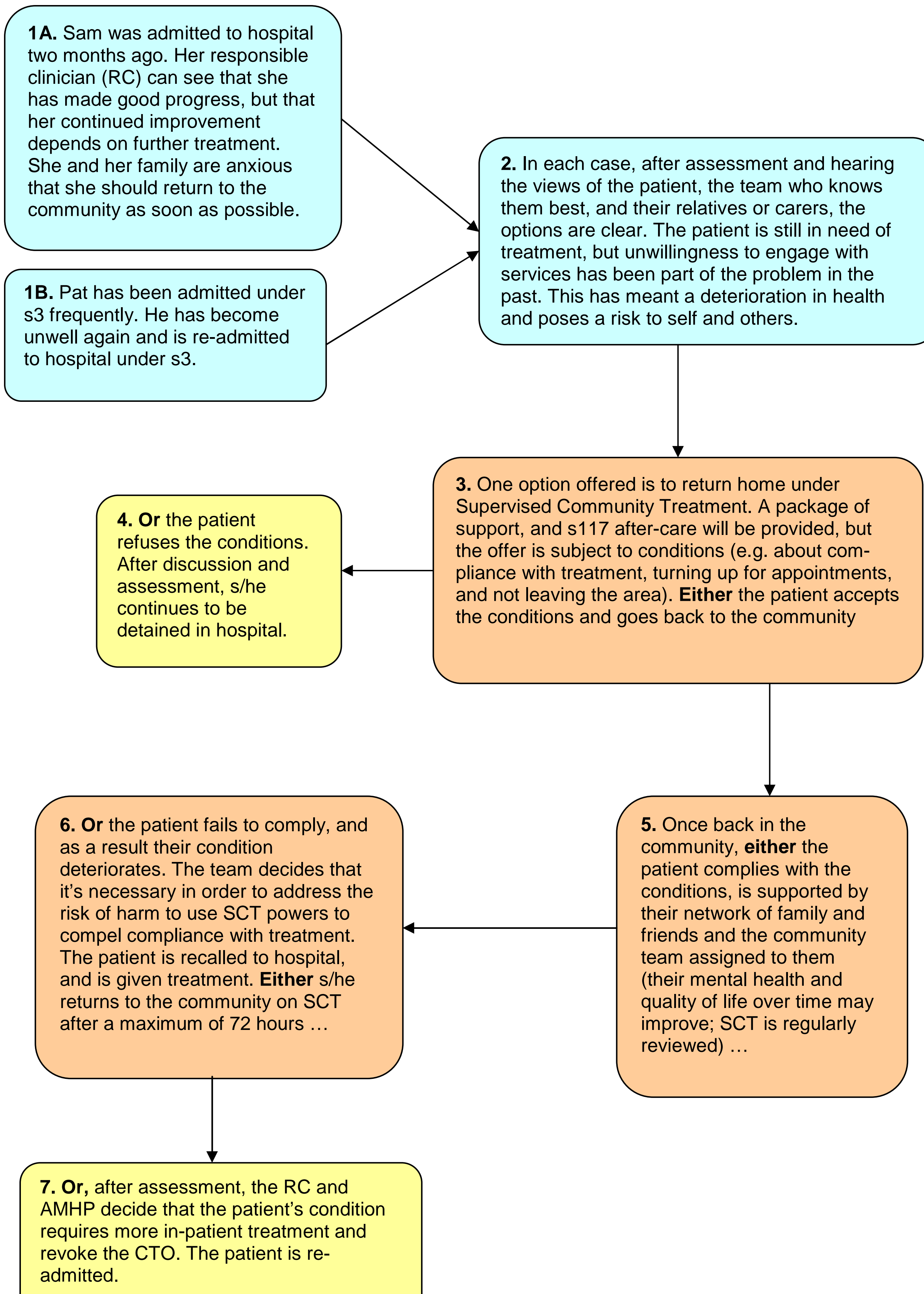
The approved clinician in charge of the treatment must report to MHAC on treatment given to a recalled SCT patients under a Part 4A certificate in the same way as they have report on treatment given under other SOAD certificates. That has to be done the next time the patient's responsible clinician extends the patient's period of SCT or (if the SCT has been revoked) renews the patient's detention), or whenever MHAC requests a report.

ACTIVITY 4

Look again at these questions from the first exercise. How do you feel about them now?

1. **What effects do you think SCT will have on your practice?**
2. **How do you think SCT will affect relationships between patients and community-based support staff (statutory and non-statutory)?**
3. **How can awareness of the principles underpinning the COP work to alleviate tensions that arise from SCT?**

Figure 1. The Patient Pathway (from the Best Practice Guide)



Activity 5 – Self Assessment (answers in Appendix 2, p 142)

Which of the following situations are True (T) or False (F)?

		T	F
1.	***The criterion for SCT is:***	**T**	**F**
a)	patient detained under s2 of the MHA can be considered for SCT	☐	☐
b)	a patient detained under s3 of the MHA can be considered for SCT	☐	☐
c)	a patient living in the community can be detained under SCT without admission to hospital	☐	☐
2.	***The Responsible Clinician may put someone on SCT if:***		
a)	the relevant criteria are met	☐	☐
b)	an AMHP does not agree with his/her opinion	☐	☐
c)	s/he doesn't think the patient needs any medical treatment for the time being, but might need it again at some point on the future	☐	☐
3.	***Under what circumstances can a patient be recalled?***		
a)	to add more conditions	☐	☐
b)	when non-compliant with conditions	☐	☐
c)	when the nearest relative requests it	☐	☐
4.	***A SCT period is:***		
a)	Six months, 6 months and then annually	☐	☐
b)	One year, and can be extended for another one year	☐	☐
c)	For as long as the RC and AMHP deems it necessary	☐	☐
5.	**Community patients 16 and over without capacity to consent can:**		
a)	Be treated whether or not an attorney or court-appointed deputy refuses under s64B	☐	☐
b)	Be treated under s64D provided patient does not object to treatment and it is not necessary to use force	☐	☐
c)	Can be treated in emergencies with force, but only if it is immediately necessary	☐	☐

END OF MODULE

You have now completed this module and can move on to the other modules. If you wish to do some further reading in relation to the topics covered in this module, here are some suggestions.

Department of Health (2008). Mental Health Act 1983 as amended by the Mental Health Act 2007 (unofficial version). London: DH *(Available on Department of Health website)*

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Great Britain (2008). Mental Health Act 2007: Elizabeth II - Chapter 12 - Explanatory Notes. London: TSO.

Mental Capacity Act 2005. Code of Practice. London TSO. (*Also available from Ministry of Justice website)*

NIMHE/CSIP (2008). Best Practice Guide to Supervised Community Treatment. London: NIMHE/CSIP. (*Available from the CSIP website: http://nimhe.csip.org.uk/*)

MODULE 4: ENDING COMPULSION

MODULE 4: ENDING COMPULSION

INTRODUCTION TO THE MODULE

This module covers the legislation in the MHA that helps to end a patient's compulsory treatment earlier than that possible in the existing MHA. As well as going over the existing ways in which compulsion may end, the module also explains changes to the Mental Health Act 1983 that introduce an order-making power which enables the Secretary of State to reduce the time before a case has to be referred to the Mental Health Review Tribunal (Tribunal) by the hospital managers. This area is identified in the Foundation Module as Key Change 9 in the pathway through compulsion.

In the module, you will therefore learn about Tribunals and the central role of hospital managers in operating the provisions of the MHA. You will also learn about other powers other decision makers have to end someone's compulsion.

PREPARATION

Before undertaking this module it is important that you complete the ***Foundation Module*** *in this training pack, particularly the exercise 'Ending Compulsion' (Step 4). You are also advised to read the relevant sections in the* ***Code of Practice (Chapters 31 & 32)*** *and the* ***Reference Guide****.*

LEARNING OUTCOMES

On completion of the module and some independent study, you will be able to:

- ***Understand the legal basis for discharge;***
- ***Discuss the role of a Mental Health Review Tribunal;***
- ***Understand the role of Hospital Managers.***

EXISTING POWERS TO DISCHARGE PATIENTS FROM COMPULSION

In most cases it is the Responsible Clinician (whether or not they are a doctor) who will have the responsibility of deciding whether or not a patient continues to meet the criteria for the use of compulsion. In other words, it is the RC who usually decides when to take people off section. However, other people or bodies also have powers of discharge.

Tables 1 and 2 below explain the circumstances.

Table 1. Existing Powers of Discharge (‘Holding’ Powers and Sections 2,3,4)

<table>
<tr><th>Order</th><th>Who can discharge the order?</th><th>Is there any power to override this?</th></tr>
<tr><td>‘Holding’ powers (s135/136) which allow people to be detained for assessment to take place</td><td>A doctor must discharge the order if they decide the person doesn’t have a mental disorder, or (in the case of s5) that they have a disorder but don’t need to be detained.

An AMHP must otherwise see and assess a patient’s need for admission or the use of community support.</td><td>No</td></tr>
<tr><td>Section 4</td><td>A doctor if they decide not to make a second medical recommendation, the s4 order will come to an end.</td><td>No</td></tr>
<tr><td rowspan="2">Sections 2, 3 and 4</td><td>The RC must discharge the section if they decide the person no longer meets the criteria for the use of compulsion.

Hospital managers can discharge a patient.</td><td>No</td></tr>
<tr><td>The Mental Health Review Tribunal can discharge a patient.

The patients’s nearest relative can ask for the patient’s discharge, as long as they do so in writing giving 72 hours notice.</td><td>RC can veto discharge by nearest relative by furnishing a report stating that the patient is likely to act in a manner that would endanger himself or others.</td></tr>
</table>

Table 2. Existing Powers of Discharge (Section 7, SCT and Forensic)

Order	**Who can discharge the order?**	**Is there any power to overide this?**
Section 7 (Guardianship)	**The RC** must discharge the section if they decide the person no longer meets the criteria for the use of compulsion. **The Local Social Service Authority** (LSSA) can discharge the patient. **The Mental Health Review Tribunal** can discharge a patient. **The patient's nearest relative** can ask for the patient's discharge by putting their request in writing to the LSSA.	No The nearest relative's right to discharge is absolute: it cannot be blocked. However, the discharge could be used as evidence for dis-placement should it put the patient or others at risk.
Section 17A (SCT)	**The RC** must discharge the section if they decide the person no longer meets the criteria for the power of recall. **The hospital managers** can discharge a patient. **The Mental Health Review Tribunal** can discharge a patient. **The patient's nearest relative** can ask for the patient's discharge, as long as they do so in writing giving 72 hours notice.	No RC can veto discharge by nearest relative by furnishing a report stating that the patient is likely to act in a manner that would endanger himself or others.
Hospital orders, hospital directions and transfer directions under Part 3 of the MHA (unrestricted)	**The RC** must discharge the section if they decide the person no longer meets the criteria for the use of compulsion. **Hospital managers** can discharge a patient. **The Mental Health Review Tribunal** can discharge a patient.	No
Hospital orders, hospital directions and transfer directions under Part 3 of the MHA (restricted)	**The RC** can discharge the patient. **Hospital managers** can discharge a patient. **The Mental Health Review Tribunal** can discharge a patient or place a patient on conditional discharge. **The Secretary of State for Justice** can discharge a patient or place a patient on conditional discharge.	No If the patient is subject to special restrictions (under s41, s45A or s49 of the MHA) the RC and hospital managers cannot discharge unless the Secretary of State for Justice agrees.

MENTAL HEALTH REVIEW TRIBUNALS

These "amend the Act to achieve earlier access to the Mental Health Review Tribunal for all civil patients".

The Mental Health Review Tribunal (Tribunal) is the statutory body responsible for hearing statutory appeals against liability to detention or recall. Tribunal panels include legal members, medical members and 'lay' or non-legal members. Lay members are required to have some special expertise.

This section looks at how the tribunal system works, and how the changes being made will affect day-to-day work with patients.

Note: under the Tribunals, Courts and Enforcement Act 2007, the MHRT in England is to be abolished and its functions taken over by the Health, Education and Social Care Chamber of the new First-tier Tribunal from 3 November 2008. There will still be an MHRT for Wales.

In practice, this should not make much difference to the way that MHA cases are handled, except that there will be a new right of appeal (on a point of law) to a new Upper Tribunal.

Overview of Tribunals

> *"The Tribunal is an independent judicial body. Its main purpose is to review the cases of detained, conditionally discharged and supervised community treatment (SCT) patients under the Act and to direct the discharge of any patients where it thinks it appropriate. It also considers applications for discharge from guardianship."*
>
> (COP, 32.2)

> *"The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Act. Those giving evidence at hearings should do what they can to help enable Tribunal hearings to be conducted in a professional manner, which includes having regard to the patient's wishes and feelings and ensuring that the patient feels as comfortable with the proceedings as possible."*
>
> (COP, 32.3)

> *"It is for those who believe that a patient should continue to be detained or remain an SCT patient to prove their case, not for the patient to disprove it. They will therefore need to present the Tribunal with sufficient evidence to support continuing liability to detention or SCT. Clinical and social reports form the backbone of this evidence. Care should be given to ensure that all information is as up to date as possible to avoid adjournment. In order to support the Tribunal in making its decision all information should be clear and concise."*
>
> (COP, 32.4)

The Tribunal considers a patient's case (either on application from the patient or the patient's Nearest Relative) on referral from the Secretary of State or, if the Tribunal has not reviewed the case within a given period, on referral by hospital managers. Under the existing MHA, section 68 sets outs the rules about when hospital managers must make a referral. Clause 30 in the MHA amends this section so that it applies to a wider group of patients:

- those who are still subject to section 2 at the point of referral;
- those who are on Supervised Community Treatment (SCT).

Extending this right to those on section 2 is important, because if a person is on this section and a decision is taken to go to court to displace their nearest relative (for example, because the NR is objecting to the patient being detained longer on s3), their section 2 is extended until the court process has finished. Sometimes this can take months, and at the moment the person on section 2 loses their right to appeal to the Tribunal after 14 days. This change therefore could be used to ensure people on extended section 2 orders are better protected. Patients who continue to be detained for assessment while the County Court determines who their nearest relative is should be referred to a Tribunal.

Whenever detention or Supervised Community Treatment (SCT) is renewed, and whenever a patient's status under legislation changes (for example from s3 to SCT), the Hospital Managers must ensure that patients are given information about their rights to apply to Tribunal and entitlement to free legal advice and representation.

Changes made by the MHA

A number of changes have been brought about by the MHA.

These are as follows:

- SCT patients will be able to apply or be referred to the Tribunal
- The Tribunal itself will not be able to put someone onto SCT, but it will be able to recommend that the responsible clinician considers it
- Referral to the Tribunal by Hospital Managers after the first six months for patients on section 3, who have not lodged an appeal to the Tribunal during that period, will take into account any time they may have been detained under section 2. The duty to refer patients after six months will also now apply to patients whose detention under section 2 has been extended while the courts consider an application to displace their nearest relative
- Hospital managers will still have to refer patients who have been detained for more than three years without a Tribunal hearing. But they will now have to do it as soon as the three years are up, rather than at the next renewal date
- For under 16s, the three year period will still be one year instead – and this will now apply to 16 and 17 year olds as well

- The Secretary of State will be able to reduce the current referral period to the Tribunal as and when he thinks fit
- Automatic referrals to the Tribunal by Hospital Managers of SCT patients who have their CTO revoked under section 17F
- The current Rules of the Tribunal will be replaced by a combination of new Rules and Practice Directions (Rule 6 that reports must be submitted within three weeks of receipt of an application is not expected to change).

The Tribunal is based in Leicester and can be contacted by referring to the official website which gives details of appropriate contact details for the various areas in England and Wales at http://www.mhrt.org.uk/

COMMON MYTH – MENTAL HEALTH REVIEW TRIBUNALS	
MYTH	**REALITY**
The Act is widening access to the Tribunal	Up to a point. Rights to apply are not really changing, just being adapted to deal with SCT. The changes are to Hospital Managers' duty to refer people who do not apply themselves. Those changes are: • Duty to refer Part 2 patients who don't apply themselves in first six months will now take into account any time spent on section 2 prior to being placed on section 3 (and applications made while they were s2 patients will be ignored). • Three-year rule will now mean literally three years, not "first renewal after three years are up". • "For three years read one year" rule will now apply to under 18s, not just under 16s.

ACTIVITY 1 – SCENARIO: EDDIE (5)

Activity 1 continues Eddie's pathway through compulsion (see pages 49, 63, 79 and 102).

Eddie has now been subject to SCT for 14 months. Having had an extended period of stability in the community, Eddie has discussed his situation with his Advocate and now wants to request discharge from his CTO. The MDT disagrees but Eddie feels they are being unduly cautious. The Advocate supports Eddie in applying to the MHRT for discharge.

1. **Who might attend the MHRT?**
2. **What factors would the MHRT have to consider?**
3. **What information would be required?**
4. **You have been asked to write a report for the Tribunal. From your own standpoint consider how you might argue for or against Eddie's perspective.**

DISCUSSION POINTS

You can get comments responding to the above questions in Appendix 1, page 141

Responsibility of Professionals (Information required by the Tribunal)

The law allowing a registered medical practitioner to **visit and examine the patient** for the purposes of gathering information in preparation for the Tribunal **is extended to allow an Approved Clinician (AC) to visit and examine, and is extended to cover SCT patients.**

Providing information and reports: the legal status of the Tribunal

It is important that key information is available in good time for any Tribunal hearing. Missing, out-of-date or inadequate reports can lead to adjournments or unnecessarily long hearings that can disrupt the patient and their family and tie up valuable professional time. **Because the tribunal also has the same legal status as a court of law, you could also find yourself in contempt of court!**

Where clinicians, social workers or other healthcare professionals are required to provide reports, they should do this promptly and certainly within the statutory timescale. Where those responsible for providing a report have failed to do so, the Tribunal may direct that they do so by using a subpoena.

It is up to professionals to prove that a person still meets the criteria for compulsion, not for the patient or nearest relative to prove they do not

It is the responsibility of the detaining authority to present the Tribunal with sufficient evidence to support their decision to treat a patient using the MHA. The reports form the backbone of this evidence. Care should be given to ensure that all information is as up-to-date as possible and the necessary information is contained within the report to justify the decision to continue to treat under the Act. Where information is ‘hearsay’, it should be stated as such. In order to support the Tribunal in making its decision all information should be clear and concise.

HOSPITAL MANAGERS

This section is designed to help you understand the roles of the hospital managers, and how their role will alter as a result of changes to the MHA. This includes how Managers' Hearings work, and the test they need to apply when deciding whether or not to discharge someone.

The Role of Hospital Managers

The managers of the hospital or registered establishment in which a patient is detained are responsible for making sure a patient who is subject to compulsion (in hospital or on SCT) understands what this means, and what their rights to appeal are. This should happen as soon as possible once the patient is placed on section.

Managers also have a responsibility to make sure a patient's nearest relative is given information about the patient's admission and rights to appeal. However, if the patient does not want this to happen, they can ask the managers not to send any information.

> *"In England, NHS hospitals are managed by NHS trusts, NHS foundation trusts and primary care trusts (PCTs). For these hospitals, the trusts themselves are defined as the hospital managers for the purposes of the Act. In an independent hospital, the person or persons in whose name the hospital is registered are the managers for the purposes of the Act."*
>
> (COP, 30.2)

> *"It is the hospital managers who have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights."*
>
> (COP, 30.3)

The Wider Role of Hospital Managers

Hospital Managers' responsibilities are wider than simply making sure people have access to information, and making decisions about whether to keep people on section. They also have more general responsibilities. For example:

- Responsibility for age appropriate accomodation for young people;
- Responsibility for the ways in which the hospital as a whole operates mental health law;
- Making sure that when they delegate duties to other people (for example, to nurses who receive papers on their behalf) that those people are able to exercise those duties competently;
- Ensuring that transfer to other hospitals is for the benefit of the patient's care;
- Authorising detained patients' transfers to other hospitals.

Hospital Managers are also the managers of the “responsible hospital”, i.e. the hospital in which the patient was liable to be detained immediately before going onto SCT.

It is the managers of the responsible hospital who are responsible for making sure SCT is used lawfully, and for various specific legal functions (including providing reports for the Tribunal, referring patients to the Tribunal where that is required, and deciding whether to discharge the patient from SCT.)

Responsibility can be assigned from one hospital to another (and therefore one set of managers to another) in accordance with regulations.

Responsibilities of Managers of Foundation Trusts

In the case of an NHS foundation trust, a panel can consist of any three or more people appointed for the purpose by the trust, whether or not they are members of the trust itself or any of its committees or sub-committees.

Example

Appleyard Hospital decided to reform its managers committee to enhance its governance functions, recognising that this would help protect both the organisation and the patients by ensuring that the protections of the Mental Health Act were correctly applied.

The Governance Committee was chaired by a director, and made up of members elected from among its hospital managers as well as practitioners such as the AMHP Lead officer, frontline AMHPs, Responsible Clinicians, nurses and representatives from the legal department of its Local Social Service Authority. There was also a representative from the commissioning PCT.

The committee was empowered by the executive to scrutinise reports on the use of the Mental Health Act, ask for clarification or action. They were expected to make annual reports to the board, and the chair was empowered to take action on more urgent issues between reports. Incident reports that related to MHA issues would be scrutinised by the Committee, and action taken.

Soon after being created, they noted a number of incidents being reported of AMHPs being asked to wait more than two hours for transportation. The AMHP representative was asked to investigate. She reported that the ambulance service had recently instituted a new service level agreement with their commissioners which meant that hospital-to-hospital transfers were all being ‘graded’ as low need except in cases of physical emergency. The reported waits were due to people being left in A&E after assessment. This was tying up police, AMHP and A&E staff time. More incidents of assault had also been reported in A&E during this period.

The PCT representative undertook to ask commissioners to review this policy, and a new agreement was reached whereby A&E requests following Mental Health Assessments were treated with equal urgency to Community Assessment requests.

The Legal Basis for Hospital Managers and Changes brought about by the MHA

Hospital Managers' functions arise from the various sections of the MHA including:

- Section 23 – power of discharge;
- Section 132 – duty to inform a detained patient of their rights; and
- Section 133 – duty to inform a detained patient's nearest relative of their rights under the MHA.

The MHA has not changed the rules about how hospital managers should operate when they think about whether or not to discharge someone from section, but the COP introduced with the MHA does lay stress on a number of new areas of concern for hospital managers.

The MHA which has introduced Supervised Community Treatment has retained the function of hospital managers to order discharge and the requirement to review this will now follow patients into the community.

The criteria for the use of compulsion have changed and these are also reflected in the criteria considered for discharge.

Hospital Managers' Hearings and Reviews

The effect of the appropriate treatment test

Hospital Managers will need to familiarise themselves with the new appropriate medical treatment test and the criteria for the use of SCT, so they are able to arrive at informed decisions when reviewing patients' detentions, renewals of detention and SCT.

Rules around blocking a nearest relative's request to discharge the patient

Reviews of the blocking of discharge orders will not change.

Reviews of people who are on Supervised Community Treatment

When managers are looking at cases of **people who are on section 3 and on leave***,* they will need to think about whether the person would be better supported by SCT. However, they cannot put a patient on SCT themselves.

When considering appeals against SCT by patients and others, it is likely that the **nature** (or pattern) of the patient's mental disorder will often be more important to the panel's decision than the **degree** (or intensity) of the illness or symptoms they are experiencing. Panels will need to think differently, and be provided with different sorts of evidence by professionals involved with patients, in order to make appropriate judgements.

Hospital Managers and Referrals to the Tribunal

Under the existing MHA, hospital managers have to refer section 3 patients to the Tribunal after the first six months on that section, if neither they nor their nearest relative has applied to the Tribunal during that period, and their cases hasn't been referred by the Secretary of State for Health.

That duty is now extended to include section 2 and SCT patients. And for section 3 and SCT patients who were initially detained under section 2, the six months now starts from when they were first detained.

As a result, hospital managers must refer patients who are detained under sections 2 or 3 or who have been detained under section 3 but who have since become SCT patients after six months from when they are first detained, unless the patient has applied to the Tribunal them (or their case has been referred to the Tribunal someone else) while they are on section 3 or SCT. (Applications made while the patient was on section 2 do not affect the duty to refer after 6 months).

One effect of this is that a patient who is detained under section 2 for four weeks, before going onto section 3, will reach the six-month referral point 4 weeks earlier than now. In addition, the fact that they applied to the Tribunal while they were on section 2 won't affect whether they need to be referred after six months.

Hospital managers must also refer an SCT patient's case to the Tribunal as soon as possible if the patient's community treatment order is revoked.

How often patients who stay on section for a long time need to be referred to the Tribunal

New powers reduces periods under Section 68

Most patients stay on section for only short periods of time, but some patients need the support of the Act over long periods of time to make sure they receive the care and treatment they need.

The MHA requires that if someone who is on section for a long time does not choose to apply to the Tribunal themselves, then the managers **must** refer them to the Tribunal.

At present, the managers must refer the case of someone who has not chosen to appeal themselves after six months and thereafter the patient's case must be referred to the Tribunal every three years. This "three year referral" now must happen as soon as the three years is up as opposed to the current system which calls for a referral when detention is next reviewed. The MHA sticks to these limits for the moment but, once the system has the capacity to cope with the increased number of hearings, it will give the Secretary of State for Health the ability to reduce the period before managers must refer people to the Tribunal.

Automatic Tribunal referrals for people who are aged under 18 years

Under the old MHA, anyone aged under 16 years had to be seen by the Tribunal at least once a year. The MHA has extended this so that anyone aged under 18 must be seen every year by the Tribunal.

Transferring patients between England and other places in the UK

Knowing when a transferred patient's period of compulsion is deemed to have started
This is the date from which managers will need to calculate their responsibility to refer a patient to the Tribunal, if they do not appeal themselves, and the date from which the length of their section will be calculated:

For patients transferring from Scotland to England and Wales the date of their hospital admission in England or Wales (for detained patients) and their date of arrival at their place of residence (for community patients) **will be the date on which application is deemed to have been made in England and Wales**. The CTO is deemed to have been made on the day of the patient's arrival. The RC – with the agreement of an AMHP – has to decide the conditions to be applied to the (deemed) CTO.]

A community patient transferred from Scotland to England and Wales will not need be detained in hospital following their transfer prior to becoming a community patient in England and Wales.

Examples

A young man on a treatment order in hospital in Scotland is transferred to England on the 5th of April; he will be treated as if he had been admitted to hospital in England on the 5th of April.

A community patient transferred from Scotland to England and arriving at their place of residence in England on the 10th of April will have a Community Treatment Order (CTO) made in England and dated the 10th of April.

The dates 5th and 10th of April will therefore be the start dates (applicable dates) under the existing MHA respectively for each patient.

Relevance of Adequate After-care to Managers' and Tribunals' decision-making

Under section 117 of the existing MHA, it is the duty of the Primary Care Trust and the Local Social Services Authority to provide in co-operation with relevant voluntary agencies, after-care services for all discharged section 3 patients, SCT patients and also section 37 patients and other specified categories until such times as they are satisfied the person no longer needs such services. There can be no charges made for section 117 after-care (Regina v LB Richmond ex. p. W). The "duty" to provide after-care is a duty to use best endeavours as to provision.

An initial after-care plan should be available before a Tribunal or Hospital Managers' hearing takes place. The propositions arising from case law are:

i. that Tribunals should not make the assumption that after-care will be available if it is needed before release can be allowed;
ii. there is a public law power to plan for the provision of after-care services in advance of a Tribunal decision.

In other words, the Tribunal or managers' hearing will expect professionals to provide them with information about what the after-care plan for a patient would look like, even if the professional or team do not believe that a patient should be discharged.

However, the Tribunal or Managers' Hearing cannot presume that the services needed will be immediately available if they do decide to discharge a patient.

The plan should say what someone needs and when, or if, it might be available.

ACTIVITY 2 – SELF ASSESSMENT (answers in Appendix 2, p 142)

Please write in your responses to the following questions.

1. What is the maximum amount of time a young person (aged under 18) can be subject to compulsion under the amended Act, before their case must be referred to the Mental Health Review Tribunal?

2. Who has the power to end a patient's detention or compulsion under the MHA?

3. Which three groups of people make up a Tribunal panel?

4. In what circumstances might someone who is under section 2 be referred by the hospital managers to the MHRT?

5. Think about someone you know, or have worked with, who in the future might be made subject to Supervised Community Treatment. How might the evidence you give to a Managers' Hearing or Tribunal be different if they appealed against the use of SCT compared to what might have happened in the past?

END OF MODULE

You have now completed this module and can move on to the other modules. If you wish to do some further reading in relation to the topics covered in this module, here are some suggestions.

Further Reading

Department of Health (2008). Mental Health Act 1983 as amended by the Mental Health Act 2007 (unofficial version). London: DH *(Available on Department of Health website*)

Department of Health (2008). Mental Health Act 1983 Code of Practice - 2008 Revision. London: TSO. *(Also available from DH website)*

Department of Health (2008). Draft Reference Guide to the Mental Health Act 1983 Guide as amended by the Mental Health Act 2007. London: DH.

Great Britain (2008). Mental Health Act 2007: Elizabeth II - Chapter 12 - Explanatory Notes. London: TSO.

WEBSITE LINKS

Microsite for CSIP/NIMHE Implementation Programme	http://mhact.csip.org.uk/
CSIP/NIMHE	http://nimhe.csip.org.uk/
CSIP/NIMHE Knowledge Community	http://kc.csip.org.uk/
The Mental Health Act 2007 (pdf file)	http://www.opsi.gov.uk/acts/acts2007/pdf/ukpga_20070012_en.pdf
Web link for COP when it's ready	
Background on reforming the 1983 Act	http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_077352
Patient information	http://www.mind.org.uk/Information/Factsheets/
DH BME and Mental Health	http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/BMEmentalhealth/index.htm
Delivering Race Equality	http://www.drenetwork.org/
Community-based Compulsory Treatment Orders in Scotland: The Early Evidence	http://www.kingsfund.org.uk/publications/kings_fund_publications/communitybased.html
A Question of Numbers: The potential impact of community-based treatment orders in England and Wales	http://www.kingsfund.org.uk/publications/kings_fund_publications/a_question_of_1.html
Good Advocacy Practice	http://www.advocacymapping.org.uk/
Making sense of ECT (MIND)	http://www.mind.org.uk/Information/Booklets/Making+sense/ECT.htm
Department of Health: Mental Health	http://www.dh.gov.uk/MentalHealth

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Appendix 1: Comments on Scenarios

Please note that these are not definitive "answers" to the questions posed in the scenarios. The comments have been provided to address some of the issues you might want to raise in your discussions. For each activity, you are encouraged to expand on the comments and identify further discussion points not covered in the Appendix.

Foundation Module Activity 7 – Scenario: Carol (1) *[p 33]*

Question 1

Each principle and how they may relate to Carol is examined here.

1. Purpose principle
Are there safety and well-being (mental and physical) considerations relating to Carol, her mother and public protection from harm?

2. Least restriction principle
In the event of a Mental Health Act Assessment concluding that Carol should go to hospital, any intervention without her consent must attempt to minimise the restrictions placed on her liberty, having regard to the purpose for which they are imposed. What is the reason for hospitalisation and how might the principles steer future actions and intervention? Is there an alternative to admission/section?

3. Respect principle
Relevant issues here might be considerations regarding gender, race, and sexual orientation. Is Carol expressing any wishes or feelings (currently or advanced)? There must be no unlawful discrimination. Decision makers must recognise and respect her diverse needs including her race, religion, gender, age and sexual orientation.

4. Participation principle
Carol should be involved, as far as is practicable in the circumstances, in planning and developing her own care to help ensure it is delivered in a way that is as appropriate and effective for them as possible. The involvement of her mother as principal carer should be encouraged (unless there are particular reasons to the contrary) and her views taken seriously.

5. Effectiveness, efficiency and equity principle
In the decision regarding how to respond to Carol's needs, decision makers must seek to use the resources available to them and to patients in the most effective, efficient and equitable way. They must also consider other people's perspectives on what is required.

Question 2

Regarding the definition of "mental disorder", there does appear to be some evidence of mental illness, but in this case is this enough to convince us that Carol meets the definition of mental disorder? On top of her possible heroin use, she may also be using cannabis, and it is this combination that is making her experience paranoia and agitation. The GP would need to undertake further assessment in order to convince him/herself that Carol meets the definition before proceeding with any compulsory powers.

In the meantime, there are some more immediate concerns in relation to the safety of Carol and the public, particularly with regard to men due to Carol's insistence on carrying a knife. The priority for the GP must be the safety of Carol and the public. The best course of action, therefore, would be for the GP to seek the opinion of a specialist doctor (duty psychiatrist) or the appropriate organisation responsible for Mental Health Act Assessment.

MODULE 1 ACTIVITY 1 – SCENARIO: DAVID *[P 57]*

Question 1

One of the challenges in this scenario is that there is not a lot of information to go on (as is sometimes the case in practice). However, the principles and how they relate to David are examined here:

1. Purpose principle
Are there issues of safety and well-being (mental and physical) around David and the public that would inform what actions should be taken?

2. Least restriction principle
It is unlikely that David will agree with the professionals on what action is required, consequently the professionals must consider minimising the restrictions on the patient's liberty having regard for the purpose they are imposed.

3. Respect principle
Are there any potential issues of race, religion, culture, gender, age and sexual orientation that should be recognised and respected?

4. Participation principle:
Can David be involved in the decision and planning of any intervention to make it as appropriate and effective as possible? Does he have any carers, family members or others who could be involved in any decisions and planning?

5. Effectiveness, efficiency and equity principle
What resources might be available to the decision makers? How can they be used in the most effective, efficient and equitable way in relation to David's current needs?

Question 2

Regarding mental disorder, there is some evidence of mental illness, but once again is it enough to convince us that David meets the definition of mental disorder? It might be that David is a heavy cannabis user who is experiencing paranoia or is experiencing extreme alcohol withdrawal. The GP would need to undertake further assessment in order to convince him/herself that David meets the definition before proceeding with any compulsory powers. In the meantime there are some more immediate concerns in relation to the safety of David and any other nearby residents. The priority for the GP must be the safety of David and his property. The best course of action, therefore, would be for the GP to contact the local social work department and with a view to requesting that an AMHP convene a Mental Health Act assessment. Clearly, the GP would also consider how to intervene to ensure the safety of the patient, the property and the public.

MODULE 1 ACTIVITY 3 – SCENARIO: EDDIE (2) *[P 63]*

Question 1

Treatment within the meaning of the MHA does not only refer to medication. What other interventions might help Eddie in terms of recovery and a move towards ending complusion?

Question 2

1. Purpose principle
Has the decision regarding Eddie remaining on section and in hospital against his wishes, taken into account the maximisation of the safety and well-being of Eddie and the public?

2. Least restriction principle
Clearly, Eddie does not wish to remain in hospital and is being detained and treated without consent. Is the proposed course of action minimising the restrictions on Eddie's liberty and consistent with the purpose of why they are being imposed?

3. Respect principle
Does Eddie have any diverse needs, values and circumstances that need to be taken into account? (Race, religion, culture, gender, age and sexual orientation are all included in the COP.) Are we aware of any wishes and feelings that have been expressed by Eddie?

4. Participation principle
Has Eddie been involved in the planning and development of his care and treatment to make it as effective and appropriate as possible? Have his carers and family, and other people who may have an interest in his welfare, been encouraged to be involved in his treatment and care plan and their views taken seriously? While the activity gives no information regarding this, it is important to restate the Guiding Principle.

5. Effectiveness, efficiency and equity principle
Have available resources been used in the most effective, efficient and equitable way to enhance and maximise Eddie's care and treatment and been taken into account by the decision makers? It is clear that at Tribunal this will be considered by the MHRT.

MODULE 2 ACTIVITY 1 – SCENARIO: EDDIE (3) *[P 79]*

Question 1

The decision to select the most appropriate AC should be based on Eddie's needs, and in conjunction with who is available within the organisation. The predominant need should indicate who the AC should be (e.g. in a community setting one might well argue that this should be a nurse or social worker acting as Eddie's lead clinician; in an acute setting it is likely to be a psychiatrist). This will be largely dependent on availability if choice is to be available.

Question 2

1. Purpose principle
In considering Eddie's suitability for SCT consideration must be made with regard to minimising the potential harm of his mental disorder (mentally and physically), and must maximise both his and the public's protection from harm.

Is the choice of Responsible Clinician likely to affect Eddie's well-being in any other way?

2. Least restriction principle
Any consideration for SCT would require Eddie to agree, and could be justified within this principle as being a less restrictive option for Eddie.

Are there any reasons to think that the choice of Responsible Clinician will affect decisions about Eddie's compulsion?

3. Respect principle
Considerations of race, culture, religion, gender, age and sexual orientation must be taken into account.

Does Eddie have any views about who should be the RC?

Is there any reason to think he would prefer a male rather than a female clinician?

4. Participation principle
Has Eddie been involved in decisions about who the most appropriate AC would be in his case? What do we do if he has an opposing view or there is no available AC from the profession he has requested?

Can we explain the options and ask Eddie for his view?

Should Eddie's family be contacted? Does Eddie want his family to be contacted? If 'yes', do they have any view?

5. Effectiveness, efficiency and equity principle
This relates to the issue above. There may be trusts who only have medical ACs, certainly in the early period post-implementation of the Act. Decision makers have to use the resources available to them and to patients in the most effective, efficient and equitable way.

Question 3

Having been admitted previously, before allocating an RC to Eddie his views needs to be taken into account under the Participation principle. This RC needs to be clinician appropriate and available?

If Eddie's wishes are to be accommodated, they need to be taken into account so there is not a disproportionate effect on the resources available to clinicians and other patients.

MODULE 2 ACTIVITY 4 – SCENARIO: WAYNE *[P 88]*

Question 1

All patients detained under the MHA should be told as part of their section 132 Rights information about their entitlement to have the support and help of an IMHA. All wards which might have detained patients must have contact details to enable them to access their IMHA service on behalf of patients or to enable patients to be able to make contact with the service themselves if they prefer. A local policy and protocol should be in place to ensure that patients are able to benefit from the services of an IMHA.

Question 2

Patients can not be forced to see an IMHA but in cases where the patient does not understand the service and support they can provide it is possible to introduce an IMHA to the patient to see whether the patient wishes to engage with her/him. Nursing staff and key workers should understand the role of an IMHA so that they are able to convey the benefits of the service they provide effectively to the patients who would qualify.

Question 3

An IMHA should be making sure that Wayne understands his rights under the MHA and what Wayne can expect of the care team. He/she should ensure that the Guiding Principles are being applied in decisions made about Wayne's treatment plan which includes ensuring that both Wayne's mental and physical health needs are being addressed. The IMHA should be able to meet with Wayne in private and if the latter wishes the IMHA to raise issues with any of the professionals regarding his care plan then the facility should be there for the IMHA to do so. There should also be a protocol in place which enables IMHAs to access relevant patient notes if patients request that they are able to do so.

Question 1

Supervised Community Treatment enables Eddie to live in the community while managed in a manner that could prevent a more rapid re-admission. The conditions leading to the admission of Eddie need to be addressed and safeguards put in place to ensure that as far as possible precautions are taken to avoid them recurring.

Question 2

Eddie may benefit from being subject to SCT as it could facilitate an earlier discharge from hospital for him. This would be done in the knowledge that access would be granted for staff to support Eddie after he leaves hospital. He would then be monitored and reviewed, which would mean that any change in his presentation could be addressed in a timely manner to avoid re-admission to hospital.

Question 3

The conditions of the SCT that may apply to Eddie are primarily that he receives medical treatment and makes himself available for examination. Any other conditions will be discussed and imposed by the RC with agreement from the AMHP. These may be, or include, the living arrangements for Eddie and monitoring of compliance with medication. Although treatment of any kind cannot be forcibly administered in the home, the amended Act 2007 authorises detention in a hospital setting for such treatment.

Question 4

This principles that should take priority in this situation are as follows.

1. **Least restriction principle**
   Surely discharge on a CTO would be less restrictive than remaining in hospital.

2. **Participation principle**
   A CTO would require Eddie to be involved in the decision-making programme and to be in agreement with this outcome.

3. **Effectiveness, efficiency and equity principle**
   If Eddie is ready for discharge on a CTO then they are using resources available to them and to patients in the most effective, efficient and equitable way. They would need to ensure that appropriate resources are available within the community to support Eddie in this less restrictive way.

Question 1

Refer to MHRT rules which now also require a nurse's report; this may not be required under the revised rules for SCT hearings. In this case only the RC and the author of the Social Circumstances report may be required to attend. For Part 2 sections include the NR and IMHA plus a legal representative.

Question 2

The RC, AMHP and Nurse. The last named may not be required. Reports will have to demonstrate that the nature of the mental disorder continues to pose a risk to the patient or others which make it necessary to continue to have the power of recall to hospital.

The panel may also wish to review the conditions attached to the CTO to assess whether these are proportionate to the risks associated with the patient or others coming to harm.

Question 3

The mental disorder, the nature of the disorder, the risks associated with the non-compliance with treatment and conditions attached to the CTO. A record of compliance and progress made.

The social circumstances report will need to include:

- Opportunities for employment, or for occupation;
- Comments on the effectiveness of the community support available to the patient and whether this would continue if discharged from SCT;
- The patient's domestic and financial circumstances.

Question 4

In reviewing your arguments, you will need to take account of the nature of Eddie's disorder and apply the Guiding Principles to his continuing recovery.

APPENDIX 2 : ANSWERS TO SELF ASSESSMENTS

MODULE 1 ACTIVITY 4 – SELF ASSESSMENT [P 69]

1. c)
2. c) & d) (in fact all sections that relate to treatment rather than assessment for a mental disorder)
3. a), b), c) & d)
4. Medication, nursing care, psychological intervention, habilitation, rehabilitation and care
5. a) True; b) False; c) False

MODULE 2 ACTIVITY 5 – SELF ASSESSMENT [P 91]

1. b), c) & d)
2. The LSSA
3. Someone who is a civil partner
4. a)-False, b)-True, c)-True
5. The right to: a) see a patient in private, b) see patient records, c) talk to any person involved with the patient's care

MODULE 3 ACTIVITY 5 – SELF ASSESSMENT [P 112]

1. a)-False, b)-True, c)-False
2. a)-True, b)-False, c)-False
3. a)-False, b)-True, c)-False
4. a)-True, b)-False, c)-False
5. a)-False, b)-True, c)-True

MODULE 4 ACTIVITY 2 – SELF ASSESSMENT [P 131]

1. 6 months initially and then 12 months thereafter.
2. Their RC, a Managers' Hearing, a MHRT hearing, the patient's NR, subject in most cases to their request not being blocked by the RC. The exception is Guardianship, where the NR's power to discharge is absolute.
3. A legal member, a medical member and a lay person with specialist interest/ knowledge in the area.
4. Where the patient's section 2 has been extended because the County Court has been asked to displace their nearest relative, and the case is still on-going.
5. More emphasis on *nature* as opposed to the *degree* of the disorder, and more focus on the service or treatment available and whether it was necessary or appropriate.

GLOSSARY

AC	Approved Clinician
AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
BME	Black and Minority Ethnic
CMHT	Community Mental Health Team
COP	Code of Practice
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSIP	Care Services Improvement Partnership
CTO	Community Treatment Order
DH	Department of Health
DRE	Delivering Race Equality
EBP	Evidence-Based Practice
ECHR	European Convention on Human Rights
ECT	Electro-Convulsive Therapy
FME	Forensic Medical Examiner
GSCC	General Social Care Council
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LPA	Lasting Power of Attorney
LSSA	Local Social Services Authority
MCA	Mental Capacity Act 2005
MDT	Multi-Disciplinary Team
MHA	Mental Heath Act 1983 as amended by the Mental Health Act 2007
MHRT	Mental Health Review Tribunal
NHSFT	National Health Service Foundation Trust
NIMHE	National Institute for Mental Health in England
NICE	National Institute for Clinical Excellence
NR	Nearest Relative
OT	Occupational Therapist
PACE	Police and Criminal Evidence Acts 1984
PCT	Primary Care Trust
RC	Responsible Clinician
RMO	Responsible Medical Officer
SCIE	Social Care Institute for Excellence
SCT	Supervised Community Treatment
SW	Social Worker
SOAD	Second Opinion Appointed Doctor
VBP	Values-Based Practice