Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Mental Health Act 2007: Workshop

Approved Clinicians and Responsible Clinicians

Facilitator Resource Pack

Introduction

This workshop aims to provide Approved Clinicians and Responsible Clinicians with the knowledge they need to perform their statutory duties and functions following the implementation of the Mental Health Act 2007.

Learning objectives

The workshop will enable participants to:

- explain the statutory roles and responsibilities of approved and responsible clinicians
- explain what is meant by 'appropriate treatment' for the patient and what should be taken into account when considering treatment
- determine the grounds for ongoing detention taking into account relevant factors
- explain the revised procedures under section 20 regarding renewal of detention
- apply appropriately the guiding principles of the Mental Health Act 1983 Code of Practice for Wales
- identify circumstances of potential conflicts of interest that might compromise the role of the responsible clinician
- identify the new safeguards for patients undergoing ECT
- explain the purpose of supervised community treatment (SCT) and the processes of application, recall, and revocation and functions of the responsible clinician and approved clinicians within those
- explain the different roles of the responsible clinician and the approved clinician in charge of treatment in relation to Part 4 and Part 4A (Consent to treatment provisions)
- explain the deprivation of liberty safeguards and the relationship of the Mental Health Act 1983 to the Mental Capacity Act 2005.

Activity 1: Powers and duties

In your groups discuss whether you think these statements refer to approved clinicians and responsible clinicians powers or duties.

	Power	Duty
When considering renewal, examine a patient who is compulsorily detained for treatment within the two months before the period of detention expires.		
Recall a community patient to hospital if the patient requires medical treatment in hospital for his/her mental disorder.		
Revoke the CTO where a patient has been recalled to hospital if the criteria for detention are met and an AMHP agrees.		
Before making a report, consult at least one other person who has been professionally concerned with the patient's medical treatment and who belongs to a profession other than that of the RC.		
When considering renewal, examine a patient who is on SCT within the two months before the CTO expires, to determine whether the patient continues to meet the criteria for community treatment.		
Specify conditions for a CTO, subject to the agreement of the AMHP.		
Suspend the conditions specified in a CTO.		
Make an order in writing discharging a patient absolutely from detention, community treatment or guardianship.		
In determining whether criteria are met for renewal, consider what risk there would be of a deterioration of the patient's condition if the patient were to be treated in the community rather than being detained in a hospital.		
Examine and report to the Secretary of State for Justice at least once a year on a person who is subject to a restriction order or direction.		
Grant leave to be absent from the hospital to a patient who is compulsorily detained.		
Revoke leave of absence and recall the patient to the hospital.		
Make a CTO discharging a detained patient from hospital subject to the patient being liable to recall.		
Authorise a person (in writing) to take the patient into custody and returned the patient to hospital.		
Prevent discharge by the nearest relative if discharge, would be likely to act in a manner dangerous to the patient or others.		
Make a report to the hospital managers in order that the period of detention will be renewed.		

Activity 1: Feedback

	Power	Duty
When considering renewal, examine a patient who is compulsorily detained for treatment within the two months before the period of detention expires.		√
Recall a community patient to hospital if the patient requires medical treatment in hospital for his/her mental disorder.	√	
Revoke the CTO where a patient has been recalled to hospital if the criteria for detention are met and an AMHP agrees.	√	
Before making a report, consult at least one other person who has been professionally concerned with the patient's medical treatment and who belongs to a profession other than that of the RC.		√
When considering renewal, examine a patient who is on SCT within the two months before the CTO expires, to determine whether the patient continues to meet the criteria for community treatment.		√
Specify conditions for a CTO, subject to the agreement of the AMHP.	√	
Suspend the conditions specified in a CTO.	√	
Make an order in writing discharging a patient absolutely from detention, community treatment or guardianship.	√	
In determining whether criteria are met for renewal, consider what risk there would be of a deterioration of the patient's condition if the patient were to be treated in the community rather than being detained in a hospital.		√
Examine and report to the Secretary of State for Justice at least once a year on a person who is subject to a restriction order or direction.		√
Grant leave to be absent from the hospital to a patient who is compulsorily detained.	√	
Revoke leave of absence and recall the patient to the hospital.	√	
Make a CTO discharging a detained patient from hospital subject to the patient being liable to recall.	√	
Authorise a person (in writing) to take the patient into custody and returned the patient to hospital.	√	
Prevent discharge by the nearest relative if discharge, would be likely to act in a manner dangerous to the patient or others.	√	
Make a report to the hospital managers in order that the period of detention will be renewed.		√

Activity 2: Jane

In your groups read through the information about Jane, and then work through the questions that you will find in the following section.

As you work through the questions, you may find that you need to consult the following reference materials:

- The Mental Health Act 1983 (as amended by The Mental Health Act 2007)
- The Mental Health Act Code of Practice for Wales 2008
- The *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*.

Background details

Jane is a 24 year old single woman who has a diagnosis of borderline personality disorder. She is well known to the community mental health team and often requires intensive support in the community from the crisis team for her repetitive self harm behaviour, which includes taking overdoses of drugs and excessive consumption of alcohol and also cutting her arms.

A few months ago, Jane came into the Poisons Unit of the local District General Hospital following a very serious overdose, her fourth in as many weeks. She continued to express suicidal ideas and wanted to leave. The deputy of the approved clinician in charge placed her under section 5(2) to allow an assessment to be undertaken as it was felt that if allowed to leave she would be very likely to take another overdose or carry out further self harm

A formal assessment under the 1983 Act was arranged, following which Jane was compulsorily admitted to her local psychiatric hospital for assessment. This was followed by her compulsory admission for treatment.

Assessment of the need for ongoing detention

It is now some 17 weeks since Jane was admitted. Her treatment has consisted of general psychotherapeutic care aimed at helping her to settle down while keeping her safe from harm.

Overall, it would appear that she has made some progress while under treatment, although there have also been several instances of severe deterioration as evidenced by her behaviour. During these periods, she has continued to manifest self-harming behaviour, and to express suicidal ideas. She is currently in one of these periods of relapse.

1. How long will Jane’s detention last from the point when she is first admitted to hospital for compulsory treatment (under section 3)?

2. Who has responsibility for considering whether Jane's detention should be renewed when the time comes?

3. Is there a duty for anyone else to be consulted before a decision is made concerning the renewal (or otherwise) of Jane's detention?

4. What are the criteria on which such a decision would be made?

5. For the purposes of coming to a decision, what do you understand by the term 'mental disorder'? Does it appear to you that Jane is suffering from such a disorder and that it is of a nature that makes it appropriate for her to receive treatment in hospital?

6. How would you interpret the requirement for appropriate medical treatment to be available for her? Does it have any relevance that she is not receiving any specific treatment for her disorder?

7. It has been suggested that Jane might respond to dialectical behaviour therapy (DBT). However, this is not available locally. If it is correct that DBT would be the most appropriate treatment for her, can she continue to be detained without it being available to her?

8. It seems that Jane does not represent any danger to the safety of anyone other than herself. Does this mean that she falls outside the criteria for continued detention?

9. How should the RC proceed if he/she comes to the conclusion that Jane's detention should be continued?

10. How should the RC proceed if he/she comes to the conclusion that Jane does not meet the criteria for her detention to be continued?

Activity 2: Feedback

1. How long will Jane's detention last from the point when she is first admitted to hospital for compulsory treatment (under section 3)?

The periods for which detention will last have not changed from those that applied previously. This means that:

- Initially, Jane will be detained for a period not exceeding six months beginning with the day on which she was admitted for treatment
- After the expiration of this first period, her detention may be extended for a further period of six months
- From the expiration of the second or any further period of renewal, her detention may be extended for a further period of one year, and so on for periods of one year at a time.

2. Who has responsibility for considering whether Jane's detention should be extended when the time comes?

It is Jane's RC who has the responsibility under the Act for assessing whether she should continue in detention.

There is a statutory requirement that the RC must examine the patient within the period of two months ending on the day on which liability for detention would cease.

If the RC is satisfied that the statutory criteria for continued detention are met, there is a further statutory obligation on the RC to make a report recommending continued detention provided that he/she believes that this would be appropriate in all the circumstances of Jane's case.

The RC is, in fact, the only person who has the authority to extend the period of detention in this way.

3. Is there a duty for anyone else to be consulted before a decision is made concerning the renewal (or otherwise) of Jane's detention?

The RC who is assessing Jane is under a statutory duty consult with one or more professionals who have been involved with the patient's medical treatment. Before furnishing a renewal report, the RC must secure the written agreement of one such professional.

The professional(s) consulted in this way must be members of a different professional grouping from that to which the RC belongs.

In addition, it would be good practice, wherever possible, for the RC to consult with others who have been involved with the patient's care. This could include members of the statutory, voluntary or independent services.

However, there is no specific duty to do so.

4. What are the criteria on which such a decision would be made?

The criteria on which Jane's continued detention would be judged are essentially the same as those that had to be satisfied before she became subject to compulsory measures in the first place.

These are that:

- She is suffering from a mental disorder of a nature or degree which makes it appropriate for her to receive medical treatment in hospital, and
- It is necessary for her own health or safety or for the protection of other persons that she should receive such treatment and it cannot be provided unless she is detained, and
- Appropriate medical treatment is available for her.

If Jane is to continue to be detained for treatment under section 3, the RC must be sure that all three of the above criteria are met.

5. For the purposes of coming to a decision, what do you understand by the term 'mental disorder'? Does it appear to you that Jane is suffering from such a disorder and that it is of a nature that makes it appropriate for her to receive treatment in hospital?

The legislation defines mental disorder as 'any disorder or disability of the mind'.

The definition of mental disorder within the 1983 Act has been amended by the 2007 Act. It provides a single, simple definition rather than specifying categories of disorder, as was previously the case.

All clinically recognised mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression would fall under this definition. So too would personality disorders, eating disorders, autistic spectrum disorders and learning disabilities.

Clearly, then, the RC would be justified in concluding that Jane does indeed meet this criterion.

6. How would you interpret the requirement for appropriate medical treatment to be available for her? Does it have any relevance that she is not receiving any specific treatment for her disorder?

Section 3(4) of the Act states:

"In this Act, 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."

For a treatment to be 'appropriate', it should be intended to *"alleviate or prevent a worsening of the disorder or one or more of its symptoms"*. (section 145)

The care that Jane is receiving is clearly intended at least to alleviate symptoms of her disorder, and consequently her continued detention falls within that particular criterion.

7. It has been suggested that Jane might respond to dialectical behaviour therapy (DBT). However, this is not available locally. If it is correct that DBT would be the most appropriate treatment for her, can she continue to be detained without it being available to her?

There is nothing in the wording of the Act to suggest that there is any requirement for treatment to be demonstrably the most appropriate treatment. If there is more than one treatment that could justifiably be classed as appropriate, taking into account all the circumstances, any of them would meet this criterion.

In Jane's case, it may well be arguable that dialectical behaviour therapy (DBT) would be the most appropriate treatment for her. The fact that this treatment is currently unavailable in Jane's local psychiatric hospital does not necessarily mean that she cannot be detained there, provided that an appropriate alternative treatment is available at this hospital.

It would appear then that she could continue to be detained and treated.

8. It seems that Jane does not represent any danger to the safety of anyone other than herself. Does this mean that she falls outside the criteria for continued detention?

No. It is enough for there to be a threat to Jane's own health or safety.

The second of the criteria for detention is that *"it is necessary for their own health or safety or for the protection of other persons that he or she should receive such treatment".*

9. How should the RC proceed if he/she comes to the conclusion that Jane's detention should be continued?

If the RC is satisfied that the statutory criteria for continued detention are met, there is a statutory obligation for him/her to make a report to the hospital managers that this should happen, provided that he/she believes that this would be appropriate in all the circumstances of Jane's case.

Thus, once the RC has come to a decision that continued detention is appropriate, a report should be made on the appropriate statutory form which is used for this purpose. This form is set out in Regulations. This will also require the written agreement of the second professional whom the RC has been under a duty to consult. This written agreement is provided on the statutory form.

10. How should the RC proceed if he/she comes to the conclusion that Jane does not meet the criteria for her detention to be continued?

If Jane does not meet the criteria for continued detention, section 23(2)(a) of the Act gives her RC the power to discharge her from detention.

This discharge must be in the form set out in the appropriate statutory form. This will be served on the managers of the hospital in which Jane has been detained.

Note that, as always in respect of the Act, discharge refers to discharge from detention and does not refer to discharge from hospital.

Activity 3: Applying the Mental Health Act 1983 Code of Practice

In your groups, using the case study about Jane, answer the questions about the impact of the Code on some of the decisions made about her continuing detention.

As with the case study itself, as you work through the questions, you may find that you need to consult the following reference materials:

- The Mental Health Act 1983 (as amended by The Mental Health Act 2007)
- The Mental Health Act 1983 Code of Practice for Wales 2008
- The *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*.

1. What does Code have to say about who should be involved in planning Jane's treatment?

2. What does the Code have to say about applying the appropriate medical treatment test?

3. Some of the guiding principles of the Code of Practice relate to 'effectiveness'. How does this fit with the fact that DBT is not immediately available for Jane?

4. Must the RC consult with the Nearest Relative (NR) before making a decision on whether to renew Jane's detention?

5. Are there any particular factors relating to the 'equity' principles within the code that the RC should be considering in planning Jane's treatment?

6. One of the groupings of guiding principles of the Code of Practice are the 'empowerment principles'. What should the RC be doing to meet these in Jane's case?

Activity 3: Feedback

1. What does the Code have to say about who should be involved in planning Jane's treatment?

Chapter 14 of the Code emphasises the importance of a holistic approach to providing care and treatment, and of involving users and carers in creating and reviewing the care plan. It also sets out that those who should be involved in preparing the care plan to meet the patient's needs include:
- the patient, if he or she wishes and/or a nominated
- the patient's responsible clinician
- the patient's care coordinator
- the patient's carer (where they will be providing care that is identified in the care plan)
- members of the inpatient care team (if the patient is in hospital).

The Code also indicates that the development of a fully-agreed care plan should be based on a thorough assessment and clearly identified needs. It should cover the time when the patient is detained in hospital and also preparing for and covering the time after discharge. The care plan should be regularly reviewed to ensure it continues to meet the patient's assessed needs and to check that the outcomes of the interventions are being achieved.

2. What does the Code have to say about applying the appropriate medical treatment test?

Chapter 4 of the Code makes it clear that the test requires a judgement about whether, in all the circumstances, medical treatment is available to the patient which is appropriate. This needs consideration of the nature and degree of the patient's mental disorder and all other circumstances of the patient's case. These other circumstance might, for example, include the patient's physical health – how it might impact on the effectiveness of the available medical treatment for mental disorder and the impact that treatment might have in return:

- any physical difficulties that 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
- its implications for the patient's education or work

- the consequences of not providing the treatment for mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence).

  Clearly, not all of these are fully relevant for Jane, but several are.

3. Some of the guiding principles of the Code relate to 'effectiveness'. How does this fit with the fact that DBT is not immediately available for Jane?

One of the principles within the Code is that any person made subject to compulsion under the Act should be provided with evidence based treatment and care. The purpose of medical treatment should be *"to alleviate, or prevent a worsening of, that person's mental disorder, or any of its symptoms or manifestations".*

So clearly, any treatment proposed for Jane should meet that requirement.

Chapter 4 of the Code makes it clear that available treatment need not necessarily be the most appropriate medical treatment that could ideally be made available. But the treatment to be offered must be an appropriate response to the patient's condition and situation.

4. Must the RC consult with the nearest relative before making a decision on whether to renew Jane's detention?

There is no statutory requirement to involve the nearest relative in any decision to renew Jane's detention.

However, the Code makes it clear that the nearest relative plays a vital role under the Act and represents a significant safeguard for patients who are detained under Part 2.

Unless there are any particular reasons to the contrary, it follows that ideally the RC should be involving Jane's nearest relative as far as possible.

5. Are there any particular factors relating to the 'equity' principles within the Code that the RC should be considering in planning Jane's treatment?

One factor that is immediately apparent relates to the topic of communication.

The Code requires that all who are involved in the assessment, treatment and care of patients should ensure that everything possible is done to overcome any barriers to communication that may exist.

The Code also makes it clear that wherever possible the care plan should always be discussed with a patient, with a view to enabling him or her to contribute to it and express agreement or disagreement.

6. One of the groupings of guiding principles of the Code of Practice are the 'empowerment principles'. What should the RC be doing to meet these in Jane's case?

The focus on empowerment means that people who perform functions under the Act need to pay particular attention to ensuring the maintenance of the rights and dignity of patients. This is particularly important when planning for Jane's care and treatment. The RC must ensure that the least restrictive options are always considered.

However, this must always be balanced with ensuring that Jane receives treatment that is appropriate to her needs.

Activity 4a: Clive

In your groups read through the information about Clive, and then work through the questions.

As you work through the questions, you may find that you need to consult the following reference materials:

- The Mental Health Act 1983 (as amended by The Mental Health Act 2007)
- The Mental Health Act 1983 Code of Practice for Wales
- The *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*.

Background details

Clive is 35 year old single man who suffers from schizophrenia. He is well known to his community mental health team and has a Care Plan under CPA. His parents, and other members of his local extended family, have shown a real willingness to help him through his severe and enduring mental illness over the last 15 years but, despite their support, the negative pattern of his illness has become well established, resulting in regular hospital admissions.

Briefly, that pattern is that his mental health is stable as long as he takes his medication but, as he recovers, he decides he is now well and no longer needs his depot injection, ignoring the advice of his family, GP and community mental health team. As his schizophrenic symptoms inevitably increase, he becomes grandiose and threatening, and will only return to hospital when “sectioned”. It is probably true to say that it is only because of the prompt response of the community mental health team, when it is needed, that his behaviour has not reached the point where his family relationships are jeopardised and that neighbours begin to complain.

Stage 1 - Making a CTO

On this occasion, Clive was again admitted to hospital under section 3 ten weeks ago and his active schizophrenic symptoms are already well controlled.

However, this time Clive's care team have suggested that it would be worthwhile to consider SCT for his future treatment.

1. What might be achieved by use of SCT? Do you think that it is appropriate in Clive's case?

2. Who would take responsibility for instigating the process for discharging Clive onto SCT?

3. Does the RC have to gain agreement from anyone else when SCT is being actively considered?

4. Does the RC need to consult anyone else besides the AMHP in reaching a decision on SCT?

5. What criteria should the RC apply in deciding whether SCT would be suitable for Clive? Do you think it likely that Clive will satisfy these criteria?

6. Are there any alternatives to SCT that might be considered, other than continuing Clive's detention in hospital? Do you think that any of these might be more appropriate than SCT?

7. What conditions are likely to be attached to a CTO for Clive?

8. If the AMHP and the RC are in full agreement, how is the CTO actually put into effect?

Activity 4a: Feedback

1. What might be achieved by use of SCT? Do you think that it is appropriate in Clive's case?

The Care Team is probably keen to break the pattern of repeated breakdown and re-admission to hospital, and to ensure Clive's continuing compliance with his care and treatment plan when he returns home.

This is precisely the purpose for which SCT has been introduced. Furthermore, Clive's previous behaviour shows exactly the type of cyclical pattern that SCT may help to remedy.

The CTO allows conditions to be applied to the patient while providing the means to recall the patient to hospital, should this become necessary.

The only patients who are eligible to be treated as community patients by way of SCT are those who are under section 3 or and unrestricted Part 3 order. Clearly, Clive is therefore eligible for consideration.

2. Who would take responsibility for instigating the process for discharging Clive onto SCT?

Clive's RC must take the lead in deciding whether to discharge him onto SCT..

3. Does the RC have to gain agreement from anyone else when a CTO is being actively considered?

Whilst Clive's RC will take the lead in deciding whether to discharge him onto SCT, section 17A of the 1983 Act states that he or she can only make a CTO if an AMHP:

- agrees to such an order (in writing), and
- confirms that it is appropriate for the order to be made, and
- agrees that the specific conditions set out in the CTO are necessary and appropriate.

The AMHP must reach an independent professional view, albeit in close consultation with the RC.

The AMHP will provide a different professional perspective. In particular, he or she will be able to consider the patient's wider social circumstances including any cultural issues. For example, this might include:

- any support networks the patient may have

- the potential impact on the patient's family, employment and educational circumstances.

4. Does the RC need to consult anyone else besides the AMHP in reaching a decision on SCT?

Consultation should be undertaken at all stages of SCT, but it is particularly important when it is first being set up. The people to be consulted might include:

- the patient
- the nearest relative and any carers (unless the patient objects or consultation is not reasonably practicable)
- the multidisciplinary team involved in the patient's care
- anyone with authority to act on the patient's behalf
- the GP
- other relevant professionals.

This will all help the RC to build up a clear picture of Clive and his situation.

5. What criteria should the RC apply in deciding whether SCT would be suitable for Clive? Do you think it likely that Clive will satisfy these criteria?

The RC and AMHP must both be satisfied that the following five criteria are met:

- the patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment
- it is necessary for the patient's health or safety or for the protection of other persons that the patient should receive such treatment
- subject to the patient being liable to be recalled ... such treatment can be provided without the patient continuing to be detained in a hospital
- it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital
- appropriate medical treatment is available for the patient.

On the face of it, Clive would seem to fit these criteria very well. In particular, his previous history of relapse means that the power to recall him to hospital if necessary may be vital.

6. Are there any alternatives to SCT that might be considered, other than continuing Clive's detention in hospital? Do you think that any of these might be more appropriate than SCT?

In line with the guiding principles of the Code of Practice, the RC and AMHP should consider whether the objectives of the proposed CTO could safely and effectively be achieved in a less restrictive way.

Alternatives to consider would be:

- leave of absence (section 17 of the Act)
- transfer into guardianship (section 7 of the Act)

Chapter 30 of the Code considers these alternatives in more detail. In Clive's case however, it would appear that neither section 17 nor guardianship appears to be as appropriate for him as SCT.

Leave of absence is intended for short duration leave usually in preparation for discharge from hospital; SCT is generally more appropriate for longer term arrangements, as in Clive's case.

Transfer into guardianship allows the guardian to supervise the patient within the community. However, the patient is not liable to be detained and is not subject to recall to hospital. Given's Clive's history of non-compliance with medication resulting in relapse and readmission, these important safeguards should be retained.

7. What conditions are likely to be attached to a CTO for Clive?

All CTOs must specify the conditions to which a community patient will be subject.

There are two conditions that must appear in all CTOs:

- the patient must make him/herself available for medical examinations as required for the purposes of determining whether the CTO should be extended
- the patient must also make him/herself available for medical examinations to allow a second opinion approved doctor (SOAD) to make a Part 4A certificate.

Further conditions will be set as required, depending on the patient's individual circumstances, with the intention of:

- ensuring that the patient receives medical treatment,
- and/or preventing risk of harm to the patient's health or safety,
- and/or protecting other persons.

In Clive's case, further conditions might include such items as:

- stipulating where he is to live
- arrangements for receiving his treatment in the community
- permitting visits by the local care team.

8. If the AMHP and the RC are in full agreement, how is the CTO actually put into effect?

The AMHP and the RC each complete and sign the appropriate sections of the relevant statutory form.

This sets out, amongst other things:

- their individual agreement that the CTO is appropriate and necessary
- the conditions that are attached to the CTO.

Activity 4b: The CTO is made for Clive

9. How long does the CTO last for?

10. How would the CTO be extended?

11. Does the RC have to gain agreement from anyone else before extending the CTO?

12. Does Clive have access to independent advocacy services while he is on SCT?

13. Does Clive have any rights of appeal against the CTO being made?

14. It seems that the CTO could continue being renewed indefinitely. Is Clive going to be subject to it for the rest of his life unless he makes a successful application for his discharge?

15. Who has the power to order the discharge of a patient from SCT?

16. Under what circumstances might Clive be recalled to hospital? Who makes the decision for such a recall?

17. Could Clive be recalled to hospital because he had failed to comply with the conditions set out in his CTO?

18. If Clive were to be recalled to hospital at any time, how long could he be detained for before being allowed to leave hospital? Can the RC decide alone on allowing him to leave?

19. Under what circumstances might Clive's CTO be revoked? What would be the effect of this? What role does the RC play, and does anyone else need to be consulted?

Activity 4b: Feedback

9. How long does the CTO last for?

The CTO for Clive will initially last for six months from the date when the order was made. The order can then be extended for a further six months and following that it can be extended for periods of one year at a time.

10. How would the CTO be extended?

For an order to be extended, the RC must examine the patient and provide a report to the hospital managers confirming that the necessary criteria are met.

These are exactly the same criteria as when the CTO was first made. Thus the RC can only make a report to extend the CTO if the grounds for SCT still apply.

There is a standard statutory form for making the report.

11. Does the RC have to gain agreement from anyone else before extending the CTO?

The RC must consult one or more people who have been professionally concerned with the patient's treatment and take their views into account.

An AMHP must agree that the criteria for extension of the CTO are satisfied and that it is appropriate to extend the CTO before the report can be made.

The agreement of the AMHP is recorded by him or her on the statutory form.

12. Does Clive have access to independent advocacy services while he is on SCT?

Whether detained under section 3 or as a community patient, Clive is eligible to receive support from an independent mental health advocate (IMHA).

The RC is the "responsible person" who should provide information about this eligibility and ensure that Clive knows of his entitlement.

13. Does Clive have any rights of appeal against the CTO being made?

Clive does not have any right of appeal against the order itself being made, but once he has been discharged onto SCT he may apply to the Mental Health Review Tribunal for Wales (MHRT for Wales) for discharge. He can also apply for discharge:

- when the CTO is revoked
- when it is extended, and
- if an order is extended if he been absent without leave for more than 28 days.

Clive can also apply to the hospital managers at any time during the CTO being in force.

He cannot appeal against the conditions of the CTO to either the MHRT for Wales or the hospital managers, only to seek his absolute discharge.

14. It seems that the CTO could continue being renewed indefinitely. Is Clive going to be subject to it for the rest of his life unless he makes a successful application for his discharge?

We have already noted that the CTO can be extended only if the RC and the AMHP concur that Clive continues to meet the relevant criteria and that the order remains appropriate and necessary.

In addition, the question of whether the patient continues to meet the criteria for a CTO should be held under constant review by the RC, not just at the points when extension is being considered. If at any time it becomes apparent that Clive no longer meets the criteria, the RC should discharge him from SCT and the CTO.

The underlying principle is that a patient should not remain on SCT for longer than is necessary.

15. Who has the power to order the discharge of a patient from SCT?

Community patients can be absolutely discharged from SCT (and therefore liability to recall to hospital) in the same way as patients can be discharged from detention by:

- the RC
- the hospital managers of the responsible hospital
- the nearest relative
- the Mental Health Review Tribunal for Wales.

If the patient is received into guardianship, that will also discharge them from SCT.

The AMHP has no statutory duty in this respect, although the RC may choose to consult with him/her on the advisability of discharge.

16. Under what circumstances might Clive be recalled to hospital? Who makes the decision for such a recall?

Under section 17E of the Act, Clive could be recalled to hospital if the RC decides:

- that he needs to receive treatment for his mental disorder in a hospital, and
- that without this treatment, there would be a risk of harm to his health or safety, or to other people.

Both conditions must be met.

He can also be recalled to hospital if he fails to comply with the condition of making himself available for examination.

The RC is responsible for recall and this can be enforced without recourse to anyone else. The AMHP has no statutory role in this process.

There is a statutory form which is used by the RC to inform the patient of the recall.

17. Could Clive be recalled to hospital because he had failed to comply with the conditions set out in his CTO?

Other than the conditions about availability for examination, the conditions specified under the CTO are not in themselves enforceable. However, if a patient fails to comply with any condition, the RC may take that into account when considering if it is necessary to use the recall power.

It should be noted that if the criteria for recall are met, the recall power may still be exercised even if the patient is complying with the conditions set out in the CTO.

18. If Clive were to be recalled to hospital at any time, how long could he be detained for before being allowed to leave hospital? Can the RC decide alone on allowing him to leave?

The RC can recall a patient only for a maximum of 72 hours without revoking the CTO.

The RC may allow a recalled patient to return to the community at any time within that 72 hour period. Otherwise, the patient can leave hospital at the end of that period, unless the CTO has been revoked.

To cover these situations the Act and the Code refer to a patient being “released” and, “release” has the specific meaning that the patient continues to remain subject to the CTO after leaving hospital following recall, if the CTO has not been revoked.

19. Under what circumstances might Clive's CTO be revoked? What would be the effect of this? What role does the RC play, and does anyone else need to be consulted?

If the RC decides that while he is subject to the CTO, Clive meets the criteria for detention for treatment in hospital (as set out in section 3(2) of the 1983 Act),he/she may revoke the CTO.

Where a CTO is revoked in this way, authority to detain the patient applies exactly as if he had never been a community patient.

Clive’s detention under his original treatment section of the Act will be re-instated from the date of revocation. A new detention period begins for the purposes of subsequent review.

In the event that Clive’s RC decides to revoke the CTO which has been made, the AMHP then has the same role as he/she had in making it; the revocation requires the AMHP’s agreement that it is appropriate.

Action plan

Learning points Including key points learned from today's workshop	**Action points** Including reading, further study and issues to resolve

Evaluation

1. How well did you feel that your personal goals were achieved during this workshop?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   Please use this space if you would like to give reasons for your answer

2. How well did the workshop meet its stated objectives? Do you now feel able to:

   – explain the statutory roles and responsibilities of Approved and Responsible Clinicians*?*

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – explain what is meant by 'appropriate treatment' for the patient and what should be taken into account when considering treatment?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – determine the grounds for ongoing detention taking into account relevant factors*?*

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – explain the revised procedures under section 20 regarding renewal of detention?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – apply appropriately the guiding principles of the Mental Health Act 1983 Code of Practice for Wales?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – identify the new safeguards for patients undergoing ECT?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

   – explain the purpose of supervised community treatment (SCT) and the processes of application, recall, and revocation and functions of the responsible clinician and approved clinicians within those?

   Not very well 1 … 2 … 3 … 4 … 5 Very well

- explain the different roles of the responsible clinician and the approved clinician in charge of treatment in relation to Part 4 and Part 4A (Consent to treatment provisions)?

  Not very well 1 … 2 … 3 … 4 … 5 Very well

- explain the deprivation of liberty safeguards and the relationship of the Mental Health Act 1983 to the Mental Capacity Act 2005?

  Not very well 1 … 2 … 3 … 4 … 5 Very well

3. Which of the workshop sessions was/were the most useful and interesting for you? Please give brief reasons for your answer.

4. Which of the workshop sessions was/were the least useful and interesting for you? Please give brief reasons for your answer.

5. How do you rate the effectiveness of the facilitators?

   Not very good 1 … 2 … 3 … 4 … 5 Excellent

   Please use this space if you would like to make a comment about individual facilitators.

6. How do you rate the training/learning methods used?

   Not very good 1 … 2 … 3 … 4 … 5 Excellent

7. How would you rate the standard of the handouts and visual aids?

   Not very good 1 … 2 … 3 … 4 … 5 Excellent

8. How do you rate the workshop overall?

   Not very good 1 … 2 … 3 … 4 … 5 Excellent

9. Please note any further learning or development needs that you have now identified.

Thank you for your help.