Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Mental Health Act 2007: Workshop

Approved Clinicians and Responsible Clinicians

Participant Pack

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Introduction

This pack has been developed to support the training workshop for those involved in the provision of mental health and learning disability services in the role of approved clinician (AC) or responsible clinician (RC). The workshop aims to provide practitioners with the knowledge and understanding they need to perform their statutory functions under the Mental Health Act 1983 as amended by the Mental Health Act 2007 and within the framework of the relevant secondary legislation.

Before studying this workshop, you should have already completed the Core Module workbook or attended the workshop. This material builds on the information which that contains.

Except where noted otherwise in the workbook, these changes will come into effect on 3 November 2008.

In preparation, please read the information provided in this pack and identify any issues that you would like to explore or gain further clarification.

Point to note

This workshop concentrates on the procedures and practices that apply once a patient has been initially detained under the MHA.

There is a separate workshop that deals with the statutory roles and responsibilities of doctors approved under section 12(2) of the 1983 Act, including those that apply during the initial assessment and decision making stages.

Professional roles

Overview

One of the main changes to the Mental Health Act 1983 made by the 2007 Act was the broadening of the group of practitioners who could take on the functions previously performed by the responsible medical officer (RMO) and the approved social worker (ASW).

The role of responsible clinician (RC) has replaced that of responsible medical officer. The RC does not need to be a consultant psychiatrist, but must be an approved clinician (AC).

The role of the ASW has been replaced with that of an approved mental health professional (AMHP).

Responsible clinician

Under the 1983 Act, the RMO was the registered medical practitioner in charge of the patient's treatment. The RMO had various designated functions, such as deciding when patients could be allowed out on leave and discharged. In practice, RMOs have usually been consultant psychiatrists.

RCs have taken over most of the functions of RMOs and have also taken on new functions in relation to supervised community treatment (SCT).

- Thus, where a patient is subject to compulsion, guardianship or is on SCT, the RC will have overall responsibility for the case. He or she has various duties, particularly in relation to the ongoing review of whether compulsory measures continue to be appropriate.

- Where they are appropriately qualified, a RC may be directly responsible for overseeing the administration of medication under compulsion.

Under the new system, the RC may be any practitioner who has been approved for that purpose - i.e. an approved clinician (AC).

The functions of the RC are no longer restricted to medical practitioners. It may be undertaken by practitioners from other professions, such as nursing, psychology, occupational therapy and social work, this by virtue of the fact that Directions specify these professional groups as ones from which ACs may be drawn (see below).

Approved Clinicians

In Wales, an AC is a person approved as such by the Welsh Ministers for the purposes of this Act. Generally such approvals are delegated to Local Health Boards.

The professions whose members may be approved and the type of skill and experience required have been set out in the *Mental Health Act 1983 Approved Clinician Directions 2008* issued by the Welsh Ministers.

The criteria set out in the Directions for a person to be 'approved' are that:

- they fulfil the professional requirements
- they are able to demonstrate that they possess the relevant competencies, and
- they have completed, within the last two years, a course for the initial training of ACs.

To fulfil the professional requirements, a person must be one of:

- a registered medical practitioner
- or a chartered psychologist
- or a first level nurse whose field of practice is mental health or learning disabilities nursing
- or an occupational therapist
- or a registered social worker.

Approval under the Directions also requires an individual to demonstrate a comprehensive understanding of the role of the AC, the role of the RC, legal responsibilities and key functions.

The competencies required include:

- role of the approved clinician
- assessment
- leadership and multi disciplinary team working
- care planning
- treatment

- equality and cultural diversity
- mental health legislation and policy
- communication.

Point to note

Under the transitional provisions of the 2007 Act, people acting in the role of RMO when the changes commence automatically become ACs and RCs in respect of the patients for whom they were acting. They do not need to complete the initial training.

Appointment of the responsible clinician

Where a patient becomes subject to compulsion, the hospital managers have a responsibility to ensure that the patient is allocated an appropriate RC. [see Chapter 11 of the Code]

The hospital managers must ensure that the RC for each patient is clearly identified. Other ACs who are involved in the delivery of aspects of the patient's care should also be clearly identified.

The day to day responsibility for appointing or changing the RC will normally be delegated to staff or other officers of the hospital. Nevertheless, overall accountability will remain with the hospital managers.

The decisions on who to appoint as the RC will be based on the individual needs of the patient concerned.

Point to note

As the needs of the patient may well change over time, the appointment of the RC should be kept under review.

The patient's RC may change during an episode of care, if such a change helps to meet the needs of the patient more effectively. This may happen for example where a patient is discharged from hospital onto a compulsory treatment order.

It is also possible that a patient may request for an alternative RC to be appointed. Where this is appropriate or practical, such a request may be accommodated.

Approved mental health professional

The overall role of the AMHP is broadly the same as that previously fulfilled by the ASW.

AMHPs are responsible in the first place for assessing whether an application for a patient's admission under Part 2 of the 1983 Act should be made (unless the application is made by the patient's nearest relative).

They arrange and co-ordinate the assessment, taking into account all factors to determine if detention in hospital is the best option for a patient or if there is a less restrictive alternative.

As well as social workers, AMHPs may be drawn from a wider group of professionals (by virtue of Regulations made by the Welsh Ministers), as long as they have the right skills, experience and training, and are approved by a Local Social Services Authority (LSSA) to do so. This means that in future first level nurses, occupational therapists and chartered psychologists may act as an AMHP.

There is no requirement for an AMHP to be an employee of an LSSA.

Point to note

A registered medical practitioner is specifically prohibited from being approved to act as an AMHP. This means that there will be a mix of professional perspectives at the point in time when a decision is being made regarding a patient's detention.

This does not prevent all those involved from being employed by the NHS, but the skills and training required of AMHPs are intended to ensure that they provide an independent social perspective.

Duties and powers of clinicians

Approved and responsible clinicians play a key role under the 1983 Act. In particular they are integral to the on-going management of patients subject to compulsory admissions, guardianship, and community treatment orders (CTOs).

Under the Act, RCs (and ACs) are given specific powers and duties. Bear in mind that a duty is a statutory obligation: it is something that must be done. This should be contrasted with powers, which generally may be used in support of a duty.

Before we go on to look at the practical implications, let's just take an overview of the most important of those powers and duties, as set out in the current legislation.

Again, you will certainly be aware of most of these from your previous experience. However, it is worthwhile spending a few minutes just to recap on them. Bear in mind that some of these are new (such as the role of the RC regarding SCT) and that for others there have been changes in the specific duties and powers.

Duties of approved and responsible clinicians

The 1983 Act (as amended) confers the following duties on ACs and RCs:

Part 2 - Compulsory Treatment

- Section 20(3) - (5) Review of detention for treatment
  The duty of the RC to examine a patient who is compulsorily detained for treatment within the two months before the period of detention expires, to determine whether they continue to meet the criteria for detention.

  If the criteria are met and the RC considers that it is appropriate to renew the detention, the RC must make a report to the hospital managers , in order that the period of detention will be renewed.

  Before making their report the RC has a duty to 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 and that person has confirmed in writing that he or she agrees that the grounds are met.

- Section 20(6) - (8) Review of guardianship
  The duty of the RC to examine a patient who is subject to guardianship within the two months before the period of guardianship expires, to determine whether the patient continues to meet the criteria for guardianship.

  If the criteria are met, and the RC considers that it is appropriate to renew the guardianship, the RC must make a report to the guardian (and the LSSA if there is a private guardian), so that the period of guardianship will be renewed.

- Section 20A(4) - (9) Review of community treatment
  The duty of the RC to examine a patient who is on SCT (referred to in the Act as a community patient) within the two months before the CTO expires, to determine whether the patient continues to meet the criteria for community treatment.

  In determining whether the criteria are met, the RC has a specific duty to consider what risk there would be of a deterioration of the patient's condition if the patient were to continue to be treated in the community, rather than being detained in a hospital.

  If the criteria are met and the RC considers that it is appropriate to extend the CTO, the RC must make a report to the hospital managers of the responsible hospital so that the order may be extended.

  Before making their report the RC has a duty to consult at least one other person who has been professionally concerned with the patient's medical treatment, and must obtain a written statement for an AMHP confirming their agreement that it is appropriate to extend the community treatment period.

- Section 21B Absence without leave
  Where a patient is taken into custody or returns after more than 28 days absence without leave, there is a duty for an appropriate practitioner to examine the patient and, if it appears that the relevant conditions are satisfied, to furnish to the appropriate body a report to that effect.

  In this case, the appropriate practitioner will be the RC.

Part 3 - Criminal Proceedings

- Sections 41(6), 45B(3) and 49(3) restriction orders and directions
  The duty of the RC to 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.

Powers of approved and responsible clinicians

The principal powers conferred on ACs and RCs by the Act include:

Part 2: Compulsory Admissions

- Section 5(2) Application in respect of patient already in hospital
  Where a person is an in-patient in a hospital, if it appears to the AC in charge of their treatment that an application ought to be made for compulsory admission, he/she may make a report in writing to that effect to the managers.

- Section 17(1) - (4) Leave of absence from hospital
  The RC may grant leave to be absent from the hospital to a patient who is compulsorily detained, subject to such conditions (if any) as are considered necessary in the interests of the patient or for the protection of other persons.

  The RC may revoke such leave of absence (in writing) and recall the patient to the hospital if it appears necessary to do so in the interests of the patient's health or safety or for the protection of other persons.

- Section 17A(1) - (6) Community Treatment Orders
  The RC may make a CTO discharging a detained patient from hospital subject to the patient being liable to recall.

  The RC may only do this if the relevant criteria are met and an AMHP agrees that it is appropriate to make the order. The RC must consider what risk there would be of a deterioration of the patient's condition if he or she were not detained in a hospital.

- Section 17B - CTO Conditions
  The RC may specify such conditions for a CTO as he or she thinks necessary or appropriate, subject to the agreement of the AMHP. The RC may from time to time vary or suspend the conditions specified in a CTO.

- Section 17E - Power to recall to hospital
  The RC may recall a community patient to hospital if the patient requires medical treatment in hospital for his/her mental disorder, and there would otherwise be a risk of harm to the health or safety of the patient or to other persons.

- Section 17F - Powers in respect of recalled patients
  The RC may revoke the CTO where a patient has been recalled to hospital if the criteria for detention are met and an AMHP agrees.

- Section 18(2A) - Return and readmission of patients absent without leave
  Where a community patient is at any time absent from a hospital to which he or she is recalled, the RC may authorise a person (in writing) to take the patient into custody and returned the patient to the hospital.

- Section 23 - Discharge of patients
  The RC may make an order in writing discharging a patient absolutely from detention, community treatment or guardianship.

  Note: This power is not confined solely to the RC.

- Section 25 - Restrictions on discharge by Nearest Relative
  Where the RC is of the opinion that a patient, if discharged, would be likely to act in a manner dangerous to the patient or others, the RC may make a report to the hospital managers so as to prevent discharge by the nearest relative.

  No further order for the discharge of the patient can be made by that relative during the period of six months beginning with the date of the report.

What does this mean in practice?

Responsibilities under Part 2 of the Act

Where a patient is subject to compulsory admission to hospital or guardianship, the RC has taken over the duties previously fulfilled by the RMO. The RC has also taken on a similar role in respect of SCT.

Note that:

- Where the patient is liable to be detained or a community patient, the RC is defined as the AC with overall responsibility for the patient's case

- Where the patient is subject to guardianship, the RC is defined as the AC authorised by the responsible LSSA to act.

Responsibilities under Part 3 of the Act

In relation to patients who are the subject of criminal proceedings, RCs have the same functions as previously fulfilled by RMOs.

In addition, certain functions previously restricted to registered medical practitioners can now also be exercised also by ACs. For example, an AC may now be responsible for the report on the medical condition of a person remanded to hospital for that purpose under section 35 of the 1983 Act.

Responsibilities for consent to treatment

Certain treatments require a second opinion (either as well as or in place of the patient's consent) and that in some circumstances treatment can be imposed without the patient's consent.

In all these situations, the AC or other person in charge of the treatment now has the functions previously held by the RMO. A typical example of this would be signing a certificate to say that a patient is capable and willing to consent to the treatment.

Mental Health Review Tribunal for Wales

An AC can visit and examine the patient for the purposes of a reference or application to the Tribunal under those provisions. It is no longer necessary for this duty to be performed by a registered medical practitioner.

Who will be the RC?

In all cases the RC will be the AC with overall responsibility for the patient's case. This is set out in section 34(1) of the 1983 Act.

If the RC is not qualified to make decisions about a particular treatment then another appropriately qualified professional will take charge of that matter, with the RC continuing to retain overall responsibility for the patient's case. For example, where a patient is receiving SCT, it is possible that a social worker who is an AC will be named as their RC, being well placed to oversee the patient's progress while living in the community. In such a case, there may well be a medical component to the overall care plan, but the social worker acting as the RC, will not have to make decisions on that particular aspect; an AC who is a registered medical practitioner will take on that responsibility.

Point to note

This means that the RC does not need to have any concerns about being asked to take on any responsibilities that are outside their own professional qualifications and competence.

Bear in mind also that the person appointed as the RC may change over time in order that the individual's needs continue to be met. Thus, in the example quoted, it is possible that such a change would have occurred when the person was discharged onto SCT, with the role moving from a registered medical practitioner who is an AC to a social worker who is an AC.

Patients under 18

Whenever possible, the RC for a patient under 18 should be a specialist in child and adolescent mental health services.

If this is not possible, it is good practice for the clinical staff at least to have access to such specialist practitioners for advice and consultation.

Ongoing detention in practice

The provisions of the Act are further amplified in the *Mental Health (Hospital, Guardianship, Community Treatment, and Consent to Treatment) (Wales) Regulations 2008.*

Section 20 of the MHA provides the legislative framework for all these actions, and the basic process for making this decision remains much as it was before.

Responsibilities of the RC in the process

The RC has overall responsibility for co-ordinating the process and, where he or she decides that detention should be continued, for implementing that decision.

Examine the patient

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

Point to note

The examination should be conducted within the spirit of the guiding principles of the Code of Practice for Wales.

Consultation

The RC is under a statutory requirement to consult with one or more persons who have been professionally involved with the patient's medical treatment.

Point to note

Before submitting a report recommending continuing detention, the RC must secure the written agreement from one such second professional that the conditions are satisfied.

Furthermore, that professional must belong to a different profession from the RC.

The RC should also consult wherever possible with others who have been involved with the patient’s care, including the statutory, voluntary or independent services.

The value of involving carers and family in the decision making process is well recognised because it provides a particular perspective of the patient’s circumstances and experiences.

Decision

There is a statutory obligation on the RC to make a report recommending continued detention if he/she is satisfied both that the statutory criteria are met and that continued detention is appropriate.

It is possible for the statutory criteria to be met yet the RC decide that detention is not appropriate.

The RC is, in fact, the only person who has the authority to renew the detention of a patient under section 3 of the 1983 Act.

Making the report

Once the RC has come to a decision that continued detention is appropriate, a report must be made on the appropriate statutory form:

Signpost

When you have the opportunity, it would be worthwhile to get a copy of the statutory form. Take a few minutes to read through it and satisfy yourself that you understand its contents.

Point to note

Following a decision not to recommend continued detention because the person no longer meets the criteria or it is no longer appropriate, section 23(2)(a) gives the patient's RC the power to discharge them from detention. Such discharge must be in the form set out in the Regulations, and must be served on the managers of the hospital in which the patient has been detained.

Grounds for detention

Before a person can continue to be detained for treatment under section 3, the RC must be sure that all the following criteria are met:

- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital, and
- it is necessary for their own health or safety or for the protection of other persons that they should receive such treatment and it cannot be provided unless the person is detained under this section, and
- appropriate medical treatment is available for the person.

These are essentially the same criteria that would now have to be satisfied before a patient could be subjected to compulsory measures in the first place.

Points to note

As an experienced mental health professional, you will wish to note that in this respect, the main changes to the 1983 Act made by the 2007 Act are:

- Definition of mental disorder:
  The legislation now defines mental disorder as 'any disorder or disability of the mind'. This new definition provides a single, simple definition rather than specifying categories of disorder.

  These amendments complement the changes to the grounds for detention.

- Grounds for detention:
  If patients are to be detained for treatment under section 3 and related sections of Part 3 there is an important addition to the criteria that 'appropriate medical treatment' is available for the patient. As a result, it will not be possible for patients to be compulsorily detained or their detention renewed unless medical treatment is available for them which is appropriate taking into account the nature and degree of their mental disorder and all the other circumstances of their case. The previously used 'treatability test' (as it was called) has now been abolished.

Mental disorder

Definition of mental disorder

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

This new definition provides a single, simple definition rather than specifying categories of disorder. So what does qualify as mental disorder?

1. Clearly this definition would include clinically recognised mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities

2. It would also, for example, encompass forms of personality disorder

3. Disabilities of the brain would not be classified as mental disorders unless they give rise to a disability or disorder of the mind as well.

Point to note

The fact that a person suffers from a mental disorder does not, of itself, mean that any action can or should be taken in respect of them.

Action can be taken only where criteria are met.

Exclusions from the operation of the Act

Learning disability

A person may not be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct.

Point to note

The wording is very explicit that any abnormally aggressive or seriously irresponsible conduct must be associated with a learning disability.

It does not have to be caused by it.

Drug or alcohol dependence

The legislation contains an important exclusion stating that 'dependence on alcohol or drugs is not considered to be a disorder or disability of the mind'.

This is important because dependence on alcohol and drugs is generally regarded clinically as a mental disorder. However, under the wording of the exclusion, no action can be taken under the Act simply because a person is dependent on alcohol or drugs.

Point to note

This does not mean that such people are excluded entirely from the scope of the 1983 Act. A person who is dependent on alcohol or drugs may also suffer from another mental disorder arising as a result of that dependence which warrants action under the 1983 Act.

Appropriate medical treatment

Overview

One of the three criteria that must be met before a patient can be (or continue to be) subject to powers of detention in hospital for treatment or discharged onto SCT is that appropriate medical treatment is available for them.

This requirement – sometimes referred to as the appropriate medical treatment test - is a new addition to the criteria for detention under the 1983 Act, introduced by the 2007 Act.

Point to note

This new appropriate medical treatment test replaces the previously so-called treatability' test. That test required the decision-makers to determine whether medical treatment was 'likely to alleviate or prevent deterioration in the patient's condition'. This requirement no longer applies.

What is meant by appropriate medical treatment?

Section 3(4) of the Act sets this out quite explicitly:

"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."

What is meant by medical treatment?

The definition of medical treatment has been amended to read:

"Medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care".[section 145 of the Act]

This definition covers medical treatment in its normal sense as well as the other forms of treatment mentioned.

Purpose of treatment

The Act also stipulates that the purpose of medical treatment *"is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*".

Point to note

An important factor here is that this is about the purpose of the treatment, rather than being about its likely outcome (as was the case in the previous 'treatability' test).

What is meant by 'available'?

Finally, 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.

Point to note

The overall effect then is that these criteria cannot be met unless medical treatment:

- is available to the patient in question
- is appropriate
- takes account of the nature and degree of the patient's mental disorder, and
- takes account of all other circumstances of the case.

The Mental Health Act 1983 Code of Practice for Wales

There is a statutory requirement that those performing certain functions under the 1983 Act must *"have regard to the Code of Practice"* published under it. The Code of Practice includes a statement of principles that must inform decisions taken under the Act.

Key content

The Mental Health Act 1983 sets out the legal framework that underpins the detention and treatment of patients under compulsion.

The Mental Health Act 1983 Code of Practice for Wales provides guidance, including good practice, as to how the Act should be applied. It also sets out principles which should inform decisions under the Act.

The Code of Practice highlights, where relevant, the connections between the 1983 Act and other legislation, such as the Mental Capacity Act 2005.

The 1983 Act provides that practitioners must have regard to the Code in relation to admitting persons to hospital or guardianship, community patients and in providing medical treatment to patients. Failure to do so could give rise to legal challenge. A court, in reviewing any departures from the Code, will scrutinise the reasons for the divergence to ensure there is sufficient and convincing justification in such circumstances.

Guiding principles

All such actions should be carried out in accordance with the guiding principles that underpin the Code of Practice.

Chapter 1 of the Code of Practice provides a set of nine guiding principles which should be considered whenever a decision has to be made about a course of action under the Act. The principles work together to form a balanced set of considerations which should inform all decision-making.

All of the other chapters of the Code of Practice should be read in the light of these principles.

Signpost

The nine guiding principles of the Code of Practice have already been covered in detail in the Core Module.

Supervised community treatment

Overview

One of the most important changes to the 1983 Act made by the 2007 Act is the introduction of supervised community treatment (SCT). This provides for some patients with a mental disorder to live in the community while still being subject to powers under the 1983 Act to ensure they continue with the medical treatment that they need.

The Act refers to patients on SCT as community patients.

Signpost

Chapter 30 of the Code of Practice deals in detail with the implementation of SCT. You may wish to read through that chapter when you have completed this module.

An individual may be discharged onto SCT, this being achieved by means of community treatment order (CTO) being made by the RC. The CTO allows conditions to be applied to the patient and provides the means to recall the patient to hospital should this become necessary.

Point to note

In order for a patient to be discharged onto SCT, various criteria need to be met. We will examine those criteria shortly. An AMHP also needs to agree that SCT is appropriate.

Patients who are discharged onto SCT will be subject to conditions whilst living in the community.

- Most conditions will depend on individual circumstances but must be for the purpose of ensuring the patient receives medical treatment, or to prevent risk of harm to the patient or others
- The conditions will form part of the patient's CTO.

Patients discharged onto SCT may be recalled to hospital for treatment should this become necessary. Afterwards they may then resume living in the community or, if they need to be treated as an in-patient again, their RC may revoke the CTO.

SCT offers an alternative to the current use of section 17 by RCs to give patients long term leave of absence from hospital. It allows patients who do not need to continue receiving treatment in hospital to be discharged into the community, but with powers of recall to hospital if necessary.

Point to note

RCs can still grant leave of absence under section 17 of the 1983 Act, but should only consider this as a means of giving a patient short periods of leave (normally up to seven days) as part of the person's overall management within hospital or as preparation for their discharge.

RCs cannot grant leave of absence under section 17 for part 2 or unrestricted part 3 patients for longer than 7 consecutive days without first considering whether the patient should be subject to SCT. In effect, RCs will have to demonstrate that SCT has been considered and show why section 17 was more appropriate.

Supervised community treatment in operation

Purpose and eligibility

Purpose

One of the principal aims of supervised community treatment (SCT) is to provide eligible patients with a statutory framework for the delivery of their after-care in the community.

It is designed to help prevent relapse, but where relapse does occur, it enables the effective management of risk and helps to prevent crisis by removing obstacles to the efficient delivery of treatment and care.

Point to note

The aim is to break the cycle in which some patients leave hospital and do not continue with their treatment. Their health then deteriorates and they require detention again.

Eligibility

The only patients who are eligible to be discharged on to SCT are those who are detained in hospital for treatment under section 3 or an unrestricted order under Part 3 of the 1983 Act.

The RC may make a CTO only with the agreement of an AMHP.

Criteria for SCT

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

1. the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment

2. it is necessary for the patient's health or safety or for the protection of other persons that he should receive such treatment

3. subject to the patient being liable to be recalled ... such treatment can be provided without his/her continuing to be detained in a hospital

4. it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital

5. appropriate medical treatment is available for the patient.

Point to note

As well as agreeing that the criteria are met, the RC and AMHP must also concur that a SCT is appropriate for that patient. The CTO, and the AMHP's agreement to it, will be in writing.

Making a community treatment order

It is important to remember that in all cases the RC must reach an independent professional view.

Deciding on the criteria

The first step is to decide whether the individual meets the criteria.

When making these decisions, the RC must consider the risk that the patient's condition will deteriorate after discharge from hospital. For example, this could happen as a result of their refusing to receive the treatment they need.

In considering that risk, the RC must have regard to the patient's history of mental disorder and any other relevant factors.

Consideration of alternatives

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

Alternatives to consider would be:

- Discharge from hospital and detention under the Act
  With an up to date and agreed care and treatment plan to be implemented and monitored by community professionals within primary care and/or a community mental health team.

- Leave of absence (section 17 of the Act)
  For short duration leave as part of the delivery of the patient's care plan, and in preparation for discharge from hospital, leave of absence could be an alternative. However, SCT is usually more appropriate for longer term arrangements than action under section 17.

- Transfer into guardianship (section 7 of the Act)
  Guardianship confers upon the guardian the ability to supervise the patient within the community. The patient is not liable to be detained and is not subject to recall to hospital. Guardianship is most appropriately used to enable health and social care agencies to provide a framework that ensures the welfare of eligible patients.

Making the CTO

If the RC and the AMHP agree that it is appropriate to proceed, the next step is the making of the CTO.

The RC is responsible for initiating the process of making a CTO. The decision to make the order must be supported by an AMHP.

For a CTO to be made, the RC must be satisfied that all of the criteria are met and must have the written agreement of an AMHP that they are met, and that it is appropriate to make the order.

Point to note

If the RC cannot obtain agreement from the AMHP that a CTO should be made, or to the suggested conditions, the SCT cannot proceed.

It will be necessary to consider alternatives.

Conditions of the CTO

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

There are two conditions that must appear in all CTOs:

1. The patient must make him/herself available for medical examinations as required for the purposes of determining whether the CTO should be extended

2. The patient must make him/herself available for medical examinations to allow a 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.

Point to note

The term 'medical treatment' has a much wider interpretation than just the administration of medication it includes.

The RC and an AMHP must agree the conditions. The RC may subsequently vary the conditions, or suspend any of them.

Typical conditions might include such items as:

- stipulating where the patient is to live
- arrangements for receiving treatment in the community.

Point to note

Conditions should be the minimum necessary to achieve their purpose and be in keeping with the Code of Practice's guiding principles.

Consultation and Information

Consultation should be undertaken at all stages of the SCT. The people to be consulted include:

- the patient, who may be supported by an Independent Mental Health Advocate
- the nearest relative and any carers (unless the patient objects or it 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, and
- other relevant professionals.

Point to note

Consultation is clearly vital when SCT is first considered for a patient but should also take place on any review of the SCT.

Once a CTO is made, the RC should inform the patient, orally and in writing, of the reasons for it, the conditions to be applied, and of the right to appeal to a MHRT for Wales for discharge.

Other people to keep informed are:

- the nearest relative
- the patient's GP
- those who are directly involved in the care and service delivery plans of the patient, including members of voluntary services.

Clinical oversight in the community

Where SCT is agreed to be the right option for the patient, it is important that the arrangements for the clinical oversight of the patient's care once discharged onto SCT are considered as soon as possible.

At this point, it will also be appropriate to consider who is best placed to fulfil the role of RC once the patient moves into the community. It may well be that at this stage the responsibility may move to another professional.

Under the new arrangements, the role may be fulfilled by a number of different professionals, including registered social workers, occupational therapists, and first level nurses.

Point to note

If a different RC is to take over responsibility for the patient, clearly early liaison with that clinician, and the community team, will be essential.

Continuing the CTO

How long does the CTO last for?

A new CTO 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.

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.

Point to note

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

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.

Once the RC and AMHP have come to a decision that it is appropriate for the SCT to continue, the report should be made on the appropriate statutory form.

Signpost

When you have the opportunity, you should get a copy of the form. Take a few minutes to read through it and satisfy yourself that you understand its contents.

Varying and suspending the CTO conditions

While the CTO is in force, the RC has the power to vary or suspend any of the conditions.

This might be appropriate, for example:

- where the patient's treatment needs or living circumstances have changed
- to allow for the patient's temporary absence such as to go on holiday.

There is no requirement for the RC to obtain an AMHP's agreement to such changes, but it would be good practice to do so. Thus the RC should, where practicable, discuss these matters with an AMHP.

When does a CTO end?

A CTO comes to an end if:

- the period of the CTO runs out and the CTO is not extended, or
- the patient is discharged from the powers of the 1983 Act, or

- the RC revokes the CTO following the patient's recall to hospital.

Point to note

Patients should not remain on SCT for longer than necessary. Consideration of whether the patient continues to meet the criteria for SCT should be held under constant review. If the patient no longer meets the criteria the RC should discharge the patient from SCT.

Recall to hospital

A community patient may be recalled to hospital if the RC decides:

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

Both conditions must be met. 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.

Patient's can also be recalled to hospital if they fail to comply with the condition that they must make themselves available for examination.

Point to note

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.

The RC can recall a patient only for a maximum of 72 hours without revoking the CTO. The RC may release a recalled patient from detention at any time within the first 72 hours, or release will occur at the end of that period, unless the CTO has been revoked.

If released the patient will continue to remain subject to the CTO.

It is also important to note that:

- Patient's can be recalled even if they are already in hospital having been admitted informally. SCT does not prevent informal admission.
- Patients need not be recalled to the same hospital that they were discharged from or is now their responsible hospital.

Revocation of the CTO

If the RC decides that a patient who is subject to a CTO meets the criteria for detention for treatment in hospital, they may revoke the patient's CTO. This will require an AMHP's agreement that it is appropriate. . If the AMHP does not agree, the patient will remain on SCT.

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

The patient's detention under the section of the Act applying to their particular treatment regime will be re-instated from the date of revocation. A new detention period begins for the purposes of subsequent review.

Discharge from SCT

Expiry of community treatment order

A community patient will be discharged absolutely from liability to recall on the expiry of the CTO, if the order has not previously ceased to be in force (for example, if the CTO has been revoked).

Order for discharge

Community patients can be absolutely discharged from SCT (and therefore liability to be recalled to hospital), under section 23 of the 1983 Act, in the same way as patients can be discharged from detention by:

- the RC at any time
- the hospital managers of the responsible hospital, or by
- the nearest relative making an application to the hospital managers (Part 2 patients only), giving not less than 72 hours notice

The patient may also be discharged by the MHRT for Wales.

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

The restriction on discharge by a nearest relative applies to community patients in the same way as it does to detained patients. The nearest relative must give 72 hours notice in writing to the managers if they wish to make the order and the RC can bar the order for discharge from taking effect by making a report to the hospital managers that certifies that the patient is likely to act in a dangerous manner if discharged from SCT.

Application to MHRT

A community patient may apply to the MHRT for Wales for discharge:

- when a CTO is made
- when it is revoked
- when it is extended (after six months or a year), and
- when an order is extended after the patient has been absent without leave for more than 28 days.

If the person was under a hospital order before being discharged onto SCT, the power to apply to the MHRT for Wales when a CTO is made or revoked cannot be exercised until six months after the date of the hospital order.

The nearest relative may also apply to the MHRT for Wales if they make a discharge order which is not put into effect because the RC reports that the patient would be likely to act in a dangerous manner if discharged. He or she may also make reference to the MHRT for Wales if displaced by a court order.

Responsibilities of the RC and the AMHP in regard to SCT and CTOs

The responsible clinician

The RC is responsible for:

- giving appropriate consideration to SCT as an alternative to longer-term section 17 leave, if that is proposed
- determining the eligibility and suitability of a patient for SCT
- examining the patient
- consultation with the patient, nearest relative, carer and other professionals
- making the CTO in accordance with the statutory requirements
- determining the conditions to be applied to a CTO
- suspending or varying the CTO conditions
- oversight of the patient's care and treatment in the community
- revoking, with the involvement of an AMHP, the CTO if that becomes necessary

- exercising the power of recall
- extension of the CTO
- discharging a patient from SCT if the patient no longer meets the criteria.

The approved medical health professional

The AMHP is responsible for:

- assessing the eligibility and suitability of a patient for SCT
- considering and agreeing the conditions with the RC
- assessing the appropriate decisions with regard to extension of the CTO
- considering the revocation of the CTO, as requested by the responsible clinician.

Conflicts of interest

Overview

The 2007 Act inserts new provisions to deal with conflicts of interest into the 1983 Act.

Specifically, these are intended to ensure that in circumstances where there would be a potential conflict of interest:

- an AMHP may not make an application for detention
- a registered medical practitioner (RMP) may not give a recommendation for the purposes of an application for detention .

A new section 12A has been inserted into the 1983 Act which permits the Welsh Ministers to make regulations specifying circumstances under which an AMHP or RMP would be prohibited from making or recommending an application where they may be subject to such a conflict.

In Wales, it is the *Mental Health (Conflicts of Interests) (Wales) Regulations 2008* that set out the circumstances in which a conflict of interest will arise for the purposes of section 12A of the Act. For simplicity, these are usually referred to just as the conflicts regulations.

How does this apply to the responsible clinician?

On the face of it, these provisions do not affect RCs directly, when viewed purely in the context of that role. For example, the RC has no role in making an application for compulsory admission. Neither the Act nor the Conflicts Regulations cover potential conflicts of interest relating to SCT.

However, Chapter 3 of the Code of Practice makes it clear that it would be good practice for the RC and the AMHP responsible for making the decision as to whether to place a patient on SCT to ensure that they do not place themselves in similar circumstances of conflicts, either as between each other or in respect of the patient. The same will apply to any decision to recall the patient. The Code of Practice also sets out that similar consideration needs to be given to other decisions taken under the Act, such renewal of detention.

It follows therefore that in your role as RC, you will need to be familiar with the Conflicts Regulations and to consider the principles within them in relation to decisions you take under the 1983 Act.

Point to note

The purpose of this is to avoid a situation which compromises (or could be seen to compromise) the objectivity or independence of the decision making process.

The conflicts regulations

The conflicts regulations set out the circumstances in which a conflict of interest may affect an AMHP or RMP (both of whom are referred to as 'assessors' within the regulations).

The potential conflict of interest may concern the assessors' relationships:

- to each other
- to the patient
- to the nearest relative
- to the hospital where the patient is to be admitted.

It could arise as a result of professional, financial, business or personal relationships.

When assessors are subject to a potential conflict of interest, they are generally prohibited from making an application or recommendation.

However, the Conflicts Regulations allow for them to act in emergency situations where not to do so would cause a delay that might put the health or safety of the patient or others at serious risk.

Applications for admission or guardianship

As you have already seen, under section 12A of the Mental Health Act, the Conflicts Regulations only cover conflicts in relation to AMHPs making applications and doctors making medical recommendations, which do not affect the RC directly.

Extension of Compulsory Detention

The Conflicts Regulations do not cover potential conflicts of interest relating to extension of compulsory detention.

However, the Code of Practice makes it clear that the principles which they embody should be borne in mind when making decisions in this respect.

Supervised community treatment

Likewise, the Conflicts Regulations do not cover potential conflicts of interest relating to SCT. Even so, it is good practice to ensure that the RC and the AMHP responsible for making the decisions do not place themselves in comparable situations of conflict or apparent conflict.

Independence of RC

Irrespective of the provisions of section 12A, the 1983 Act requires the RC to take independent decisions when fulfilling their duties and exercising their powers under the Act.

If, in your role as RC, you ever believe that you are being placed under undue pressure to make (or not make) a particular decision, then you should raise this through the appropriate channels. There should be local arrangements in place for dealing with such circumstances.

Point to note

The RC should always arrive at their own independent decisions, although in most cases these independent decisions will be informed by and take into account the views of a number of professionals, carers and others involved

Safeguards for patients

The roles of the RC and the AC in charge of treatment in relation to Part 4 and Part 4A

Overview

Part 4

Part 4 of the 1983 Act deals with consent to treatment. It provides specific statutory authority for specific types of medical treatment for mental disorder to be given without their consent to most patients liable to be detained with or without their consent, in certain circumstances.

The 2007 Act has amended the provisions of Part 4 so that the AC or other person in charge of a particular treatment has the functions previously held by the RMO. This might include, for example, signing a certificate to say that a patient is capable and willing to consent to the treatment.

Part 4A

The 2007 Act has added a new Part 4A to the 1983 Act. This contains provisions similar to those in Part 4, but relating to treatment for patients discharged onto SCT.

Responsibilities under Part 4 and 4A

The overall responsibilities of the RC and the AC as follows:

- The patient's RC has overall responsibility for ensuring that Part 4 and Part 4A procedures are followed. This is a continuing responsibility; it continues to apply even if another professional is in charge of a particular aspect of the patient's treatment.

- The AC who is in charge of a particular treatment has the responsibility of ensuring compliance with the Act's provisions relating to that medical treatment.

In the majority of cases, the AC in charge of the treatment will be the patient's RC. However, if the RC is not qualified to make decisions about a particular treatment, then another appropriately qualified professional will take charge of that aspect.

This would occur, for example, in respect of prescribing medication where the RC is neither a doctor nor a nurse prescriber.

Point to note

In such cases, as we have already noted, the RC will still have overall responsibility for the patient's case.

Where the AC in charge of a particular treatment is not the patient's RC, he or she should ensure that the RC is kept informed about the treatment and that treatment decisions are discussed with the RC.

When is an AC required?

The Act sets out when the person in charge of a particular treatment must be an AC, and when this is not necessary.

The person in charge of a treatment must be an AC where the treatment is given:

- under section 58 (treatment requiring consent or a second opinion), or
- under s58A (electro-convulsive therapy) to a person other than an informal patient under 18 year old, or
- to a person who lacks capacity under Part 4A (SCT).

The person in charge of a particular treatment does not need to be an AC where the treatment is given:

- under section 57 (treatments requiring consents and a second opinion), or
- under section 58A (electro-convulsive therapy) to an informal patient who is under 18 years old, or
- to a patient with capacity under Part 4A (SCT).

Second opinions

The role of the Second Opinion Appointed Doctor (SOAD) under both Part 4 (sections 57 and 58) and Part 4A (section 64) of the Act is to provide an additional safeguard to protect patients' rights.

The patient's RC (if they have one) and the person in charge of their treatment (if that is a different person) are excluded from acting as the SOAD for the patient. They are prevented from being one of the professionals the SOAD has a statutory duty to consult.

This is to ensure that there is an independent assessment of whether treatment should be given.

Safeguards for patients undergoing ECT

Overview

A new section 58A has been inserted into Part 4 of the 1983 Act.

This introduces new safeguards for patients concerning the use of electro-convulsive therapy (ECT). Chief among these is the abolition of the power to administer ECT on a detained patient who has the capacity to consent but is refusing the treatment, other than in an emergency situation by virtue of section 62.

Signpost

The Code of Practice covers the safeguards for patients undergoing ECT in detail in chapter 17.

Need for consent

The main provision is that ECT can only be given when the patient:

- has capacity to decide and gives consent, or
- is incapable of giving consent.

The patient's consent must be certified by an appropriate professional:

- where a detained adult patient consents to treatment with ECT, their consent must be certified by either the AC in charge of their treatment or by a SOAD
- where a patient under 18 years of age who is either a detained patient or an informal patient not on SCT consents to such treatment, a SOAD must certify their consent and that it is appropriate for the treatment to be given.

Where a patient is incapable of consent, the SOAD must certify that:

- the patient is not capable of understanding the nature, purpose and likely effects of the treatment, and
- it is appropriate for the patient to receive the treatment.

Urgent treatment

Section 62 of the 1983 Act allows for a patient to be given ECT in an emergency if there is insufficient time to apply the normal procedures.

This extends to a patient who is not consenting. However, it is vital to point out that it is only in the most exceptional circumstances that a person who has capacity would be given ECT against their will.

The conditions that must be met before ECT may be given in an emergency are that the treatment:

- is immediately necessary to save the patient's life
- or it is immediately necessary to prevent a serious deterioration of his condition and is not irreversible.

Deprivation of liberty safeguards

The Mental Capacity Act 2005 has been amended to provide additional safeguards for people who lack capacity to consent and whose care or treatment necessarily involves a deprivation of liberty, but who either are not, or cannot be, detained under the Mental Health Act 1983.

These safeguards are referred to as deprivation of liberty safeguards'. They have been introduced to the Mental Capacity Act 2005 through the relevant amendments made by the Mental Health Act 2007. It is expected that these will come into force in April 2009. You should be familiar with these safeguards from working through the Core Module of your training. However, before moving on, it will be worthwhile to spend a little time to recap on their main provisions.

Signpost

Chapter 13 of the Code of Practice gives more information on the revised provisions of the Mental Capacity Act 2005.

In addition, there is a separate Code of Practice specifically regarding the deprivation of liberty safeguards that supplements the main Mental Capacity Act 2005 Code of Practice.

Deprivation or restriction of a person's liberty

The principal question that is likely to concern you in your role is whether a particular set of circumstances amounts to actual deprivation of someone's liberty or whether it is a restriction of liberty.

The European Court of Human Rights has said that the difference between restriction and deprivation of liberty is one of degree or intensity rather than of nature or substance.

To determine whether a person is being deprived of liberty, there must be an assessment of the specific factors in each individual case. Every case must be assessed on its own terms, and every possible instance has to be taken on a 'case by case' basis.

Based on existing case law, the following factors might well be considered by the courts to be relevant when considering whether or not deprivation of liberty is occurring:

- The person is not allowed to leave the facility

- The person has no, or very limited, choice about their life within the care home or hospital
- The person is prevented from maintaining contact with the world outside the care home or hospital.

This is not an exhaustive list and there are other factors, or combination of factors that the courts may consider amount to a deprivation of liberty.

Practically, this means that the question of whether a person is being deprived of their liberty will need to be kept under review and addressed explicitly whenever a change is made to their care plan.

It is important to maintain a proper perspective. There should not be a 'flood' of cases of deprivation coming forward at any one time.

Standard and urgent authorisations

Standard authorisations

Requesting authorisation

The managing authority must request authorisation from the supervisory body for a person to be detained as a resident in a hospital or care home in circumstances which amount to deprivation of their liberty.

Qualifying requirements

Before a managing authority applies to the supervisory body for a standard authorisation to detain a person as a resident in a hospital or care home in circumstances which amount to deprivation of their liberty, it must be satisfied that the individual appears to meet the qualifying requirements.

There are six qualifying requirements against which the case will be assessed by the supervisory body.

1. age requirement
   - the person must be aged 18 or over.

2. mental health requirement
   - the person must be suffering from a mental disorder within the meaning of the 1983 Act.

3. mental capacity requirement
   - the person must lack capacity to decide whether or not they should be a resident in the hospital or care home.

4. best interests requirement
   - the deprivation of liberty authorised must be in the best interests of the person.

5. eligibility requirement
   - a person is ineligible if they are already actually detained in hospital under the 1983 Act, or if they are on leave of absence from such detention or subject to guardianship, SCT or conditional discharge and in connection with that are subject to a measure which would be inconsistent with the authorisation if granted.

6. no refusals requirement
   - if there is a conflict, with another existing authority for decision-making for the person, a standard authorisation for deprivation of liberty may not be given.

Urgent authorisations

The managing authority can itself give an urgent authorisation for deprivation of liberty where it:

- is required to make a request to the supervisory body for a standard authorisation, but believes that the need for a person to be deprived of liberty is so urgent that it is appropriate to begin the deprivation before the request is made, or

- has made a request for a standard authorisation but believes that the need for a person to be deprived of liberty has now become so urgent that it is appropriate to begin the deprivation before the request is dealt with by the supervisory body.

This means that an urgent authorisation can never be issued without a request for a standard authorisation being made.

An urgent authorisation can only last for a maximum of 7 days unless in exceptional circumstances it is extended to 14 days by the supervisory body.